HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Dr AR Douglas MP
Mr JD Hathaway MP
Mr JM Krause MP
Mr DE Shuttleworth MP

Staff present:

Sue Cawcutt, Research Director
Kathleen Dalladay, Principal Research Officer
Melissa Salisbury, Principal Research Officer

PUBLIC BRIEFING—MENTAL HEALTH BILL 2014

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 11 DECEMBER 2014

Brisbane

THURSDAY, 11 DECEMBER 2014

Committee met at 10.33 am

CHAIR: Good morning and welcome. I declare open the Health and Community Services Committee public briefing about the Mental Health Bill 2014. Today's briefing is being broadcast live on the parliamentary website and the video will remain available online for a short time. My name is Trev Ruthenberg. I am the member for Kallangur and chair of the committee. Also with me are Jo-Ann Miller MP, member for Bundamba and deputy chair, and Dale Shuttleworth MP, member for Ferny Grove. We also have dialled in to the briefing via telephone Mr Jon Krause MP, member for Beaudesert, and Ms Ros Bates MP, member for Mudgeeraba. We also have Mr John Hathaway joining us in 15 to 20 minutes via phone. When that occurs, for the purposes of Hansard I will stop the briefing and acknowledge his coming in to the briefing.

CLEARY, Dr Michael, Chief Operations Officer and Deputy Director-General, Queensland Health

CLUGSTON, Ms Bobbie, Director, Mental Health Act Review Implementation Team, Mental Health Alcohol and Other Drugs Branch, Queensland Health

KINGSWELL, Dr Bill, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health

CHAIR: I welcome the officials from the department of health. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Mobile phones should be turned off or switched to silent, please. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to.

The Mental Health Bill 2014 was referred to the committee for it to examine and report to parliament by 23 February 2015. The committee has invited written submissions on the bill by 19 January.

The committee is aware that some of the bill introduces new policy and some of it updates provisions that are in the current Mental Health Act. To assist the committee we have asked the department to include in its briefing some information about which elements of the bill are unchanged, which elements are unchanged other than updating the drafting style and which elements give effect to new policy. We have also asked the department to provide a diagrammatic flow chart of the process by which a person becomes an involuntary patient under a treatment authority in chapter 2 of the bill. Members, you should have received those this morning. Thank you for providing those documents to us electronically, Dr Cleary. Do you seek leave to table those documents now?

Dr Cleary: Yes, Chair. If I could provide those documents to the committee I would like to do so at this time.

CHAIR: Thank you. Members, is leave granted? Leave is granted. Dr Cleary, would you like to start? We will have some time for questions after you and your colleagues have briefed the committee about the bill.

Dr Cleary: Thank you. Before I speak about the bill, I would just like to take this opportunity to thank the committee for their time and support over the period I have been briefing the committee on health and health related matters. It has certainly been a privilege to attend the hearings and to have such a positive engagement with a committee that is so committed to and has such a detailed understanding of health and the Health portfolio. I guess on behalf of the department I would like to express the department's thanks and my personal thanks for your support during the year.

CHAIR: Thank you, Dr Cleary.

Dr Cleary: The Mental Health Bill 2014 repeals and replaces the Mental Health Act 2000. It is the result of an extensive review initiated by the Minister for Health into the mental health legislation in Queensland. The current Mental Health Act 2000 has been in operation for more than 10 years

now and is no longer reflective of the models of care used in mental health service delivery. For example, since the Mental Health Act 2000 came into effect, mental health service delivery has moved towards a recovery model of care which is not conceptualised in the current legislative framework. It is critical that the legislative framework reflect and support service delivery and, as such, the review of the act was focused on the broader areas for improvement of the mental health system.

The review commenced in June 2013 and included two rounds of public consultation. Through this consultation over 200 submissions were received by the review, and these came from stakeholders, individual members of the community, peak bodies, government agencies and community organisations.

Mental health legislation is by its very nature complex and at times results in differing views being expressed by stakeholders. Throughout the review process these views were welcomed and considered by the review team. The comprehensive community and stakeholder engagement has informed the development of the legislation, and this is reflected in the bill.

The primary purpose of the bill is to improve and maintain the wellbeing of people who have a mental illness who require treatment and who do not have the capacity to consent to that treatment. The bill enhances current diversionary processes that enable those persons who were of unsound mind at the time of an alleged offence or who were unfit for trial to be diverted from the criminal justice system to the health and disability system to receive care and treatment. Through these enhancements the bill will also strengthen mechanisms to protect the community where there is a risk identified in respect of a person being diverted from the criminal justice system.

The bill extensively amends and enhances the current mental health legislative framework in Queensland. These enhancements can be broadly covered under six categories, and I will talk to each of these. Firstly, it strengthens support for patients. Secondly, it improves legal processes. Thirdly, it enhances or strengthens community protection. Fourthly, it improves health service delivery. Fifthly, it provides greater transparency to services. Finally, it improves service management.

In relation to strengthening supports for patients, the bill establishes mechanisms whereby a person can be involuntarily treated for a mental illness. The treatment authorities will replace the involuntary treatment orders under the current Mental Health Act 2000 and will enable involuntary treatment to be provided to a person in circumstances where an authorised doctor considers treatment criteria apply.

Involuntary treatment impacts on a person’s autonomy and, where it is required, must be enacted in a manner that safeguards the rights of the patient. The bill strengthens safeguards and supports patients in the following ways. The criteria used to determine if a person is to be placed on a treatment authority for involuntary treatment have been refocused to increase the emphasis on a person’s lack of capacity to consent to treatment and the risks of serious harm to the person or others.

Involuntary treatment under a treatment authority will only be able to be delivered where an authorised doctor has first considered whether a person may be treated in a less restrictive way. The bill emphasises alternative considerations for involuntary treatment such as the use of advanced health directives or consent from the guardian or attorney. In this way, mental health treatment is better aligned to other forms of health care with involuntary treatment being used as a last resort.

If a person becomes an involuntary patient, the bill outlines the opportunity for the person to choose a nominated support person to support them during their care and treatment. The nominated support person may support the patient while they are an involuntary patient, including if the involuntary status is revoked and later reinstated because the patient becomes unwell. The role of the nominated support person is important to highlight. The role is recognised throughout the bill in treatment planning and review. Nominated support persons will be able to receive and discuss confidential information with the patient and their treating team as well as assist the patient to represent their views to the Mental Health Review Tribunal or request a second opinion.

In addition to the role of the nominated support person, the bill recognises the need for information about a patient’s rights and the legislative framework that the proposed act will operate under to be available to patients, families, carers and support persons. In this regard, the bill requires each public sector authorised mental health service to engage a patient rights adviser. The patient rights adviser must not be a member of the treating team in a service as they are an independent role that has the function of advising patients and others on their rights and obligations under the bill.

The important role of family, carers and support persons in supporting recovery was also highlighted by stakeholders throughout the review. This important role is recognised throughout the bill, for example by requiring treatment teams to involve support networks in treatment decisions through, for example, supporting visitation and communication.

The bill also continues to progress the national policy agenda that aims to reduce and eliminate the use of seclusion and restraint. The bill increases the level of oversight required for mechanical restraint, with approval required from the Chief Psychiatrist, and introduces reduction and elimination plans that require strategies to eliminate the use of seclusion and restraint for a patient.

The Mental Health Review Tribunal is a statutory body established under the bill that, amongst other things, reviews involuntary treatment. Patient rights in the tribunal process have been significantly strengthened, with legal representation being available to patients at no cost for hearings involving minors, where the Attorney-General is represented, for fitness-for-trial reviews, electroconvulsive therapy applications and reviews of certain monitoring conditions. The bill also regulates the performance of electroconvulsive therapy and non-ablative neurosurgery such as deep-brain stimulation. Psychosurgery is prohibited under this bill, and this policy is reflected in a similar manner in other states of Australia—

CHAIR: For the purposes of Hansard, Dr Douglas, member for Gaven, has joined the briefing. Dr Douglas, we are probably about five minutes into a briefing from the department and Dr Michael Cleary is speaking.

Dr DOUGLAS: Thank you. I apologise for being late, Michael.

Dr Cleary: Thank you. I might now move on to the second area of change, and that relates to improved legal processes. While the overarching objective of the legislation is to provide a framework for treatment of individuals who do not have capacity to consent to mental health treatment, the bill also provides a mechanism for individuals who have had interactions with the criminal justice system to be diverted into the health system where care and treatment is required. These mechanisms have been significantly amended and improved by the operation of the bill, most importantly through the powers for magistrates to deal with and discharge persons who appear to have been brought before them where they were thought to have been of unsound mind and at a time when an offence can be considered by the magistrate. The inclusion of powers for magistrates addresses a significant gap in the current system whereby magistrates currently do not have a clear legislative ability to consider a person's mental health when dealing with charges.

Additionally, the bill makes the following improvements to legal processes. Any person charged with a serious offence who is also on a treatment authority or another involuntary order will be able to request that a psychiatric report be prepared outlining whether the person was of unsound mind at the time of the alleged offence or is unfit for trial. The model for obtaining reports in the bill replaces the current system whereby reports are mandatorily prepared for all involuntary patients who may be charged with an offence. In replacing this, the bill also rectifies the human rights issues in the current system in relation to an individual's rights to pursue the legal defence of their choosing.

If a reference is made to the Mental Health Court for a person charged with a serious offence, the court will now have an additional option to make a court treatment order for a person instead of a forensic order. Forensic orders may be made by the court—

CHAIR: For the purposes of Hansard, Mr John Hathaway, member for Townsville, has joined the briefing via teleconference. John, we are about 10 minutes into the briefing from Dr Cleary and Dr Cleary has started under the heading of 'Improved legal processes'. Dr Cleary, if you would continue.

Dr Cleary: Thank you. I was talking through, for those people who have just joined us, the improved legal processes and more specifically in relation to the Mental Health Court and its new powers.

Forensic orders may be made by the court where a person is of unsound mind or is unfit for trial and provides for involuntary treatment or care. A court treatment order will be able to be made by the court in circumstances where a less intensive form of order is required. Court treatment orders also provide for involuntary treatment; however, they do not have the same level of oversight that applies to persons on forensic orders. For example, under a forensic order only the court or tribunal can set limits for community treatment. Under a court treatment order, however, the patient's treating doctor will be able to set limits and the default category for a court treatment order will be the community category.

Magistrates will be able to refer matters to the Mental Health Court where it appears there may be grounds for the court to make a forensic order or a court treatment order. Currently, only District and Supreme courts have this option available to them. The provisions of the bill that divert individuals from the criminal justice system also continue to consider the needs of offenders with intellectual and cognitive disability. In this regard the Mental Health Court may make a forensic order—disability that enables involuntary care to be provided to persons by forensic disability services or by an authorised mental health service. Additionally, magistrates will now be able to refer individuals to the department of communities if an offender appears to have a need for disability support.

Under the bill, a person in custody may be transferred to an authorised mental health service for treatment of a mental illness. The processes for transporting individuals from custody have been improved to facilitate the timely provision of treatment. Specifically, the bill requires the Chief Psychiatrist to be notified if a transfer of an acutely unwell person in custody has not occurred within 72 hours to ensure there is an appropriate plan in place for the person to receive mental health treatment.

The third area of change relates to strengthening community protection. The above diversionary process from the criminal justice system is balanced throughout the bill with the following proposals supporting community protection. Although the impetus for requesting psychiatric reports will primarily come from patients or their legal representative, the Chief Psychiatrist will also be able to request a report in the public interest. Currently, forensic orders made by the Mental Health Court may be revoked as soon as the tribunal is satisfied that a person no longer represents an unacceptable risk to the safety of themselves or others. To provide victims and the community with greater certainty, after a forensic order has been made the bill provides that the court can set a non-revoke period of up to seven years if a forensic order is made for a serious violent offence.

Where an involuntary patient absconds from an inpatient unit or disengages from treatment within the community, risks may arise in relation to the patient or others. The powers in the bill to return patients who have absconded have been amended to ensure there are clear and consistent guidelines for service providers and users. If police assistance is required to return a person to an authorised mental health service, a risk assessment must be provided to the police so that priority to responding by the police can be informed by the identified risks associated with the specific patient.

The bill also makes a number of improvements to provisions relating to victims of unlawful acts. Importantly, a statement of principles for victims has been included in the bill to guide the administration of the legislation. Additionally, current information-sharing restrictions across government agencies that create barriers for victims have been removed in the bill. As a result, victims of unlawful acts will be more readily identified across the police and mental health system so that victim support services can be offered to these people. Victims may also apply to the Chief Psychiatrist to receive specific information about the person who committed the relevant unlawful act. The provision of information to victims under the approved information notice will be enhanced with the current system to also include information about the reasons the patient is receiving community treatment.

The fourth area of major change relates to improved health service delivery. The delivery of health services has changed significantly since the introduction of the Mental Health Act 2000. The bill recognises these changes and makes the following amendments to the legislative framework to support health service delivery. Recovery-oriented services are supported in the bill through, for example, requiring involuntary treatment under treatment authorities and court orders to be provided in a community setting as far as is possible. The bill provides that admission to an inpatient unit may occur only where the patient's treatment and care needs are such that they cannot be provided in the community. Involuntary treatment will be able to be provided in any place that is clinically appropriate. Audiovisual technology will be able to be used by treating teams to support the delivery of treatment in the community. I note at this time that the committee has recently provided a review of telehealth services in the state. This may be an area that you have some interest in.

The Mental Health Review Tribunal will be empowered to step down a patient on a forensic order to a court treatment order or treatment authority where a less restrictive order is indicated for that particular person. The transfer of involuntary patients interstate will be streamlined. Forensic patients, for example, require a ministerial agreement between the transferring and receiving

jurisdictions. The bill removes the requirement for agreement and in so doing enables transfers to be made more easily. This in turn supports treatment being provided in the place that is of most benefit to the patient.

Most significantly, the bill emphasises the importance of supported decision making involving a patient's family, carers and support persons in treatment planning. These requirements align with good clinical practice and support the delivery of a recovery-oriented mental health service.

To move on to the fifth area, which relates to improved transparency, a significant amount of feedback from stakeholders arose during the review of the Mental Health Act in relation to the justice examination orders which, under the current act, enable a justice of the peace to issue a non-urgent involuntary examination order to a person based on information provided by a member of the community. The review concluded that there was a need to find alternatives to the justice examination order process. The bill does this by removing justice examination orders and replacing them with a more closely managed process where a person, in consultation with an authorised mental health service, may make an application to the Mental Health Review Tribunal for an examination authority. An application for an examination authority may be made to the tribunal only if it includes documented attempts to voluntarily engage or examine the person. Again, through this proposal the bill promotes involuntary processes as the last option to be considered.

Another area of change relates to emergency examination orders, which are currently included in the current act. These have been removed from the current act in this bill. Instead, the Public Health Act 2005 is to be amended to include emergency transport powers for police or ambulance to take a person who appears to have a mental illness or a serious mental impairment arising from alcohol or drug abuse to a public sector health facility for treatment and care. By placing these provisions in the Public Health Act, the role of the police, ambulance and public health services to safely care for a severely drug or alcohol affected person is accurately and appropriately reflected in the legislation.

In respect of statutory decision-making and administrative processes, the bill provides for clearer and consistent decision-making, documentation and public reporting requirements. For example, all of the Chief Psychiatrist's policies and practice guidelines must be made publicly available. Naming conventions throughout the bill have also been amended to ensure greater transparency. For example, the position of Director of Mental Health has been replaced by the Chief Psychiatrist to reflect the psychiatric expertise associated with the role. Finally, where a decision is required under the bill, it is now clearly outlined when and to whom notices are to be provided to the patient or to a member of their support network.

The final area to touch on is in relation to improved service management. The bill provides for the streamlining of health services by addressing operational difficulties in the current act with respect to searches, transportation and notifications. Where possible, the bill also devolves functions and decision making to authorised mental health services in line with the decentralisation of hospital and health services and empowers clinical staff at the front line. This includes the appointment of authorised mental health practitioners. The removal of mandatory psychiatric reports for all involuntary patients charged with an offence will also enable clinicians' time to be redirected to higher priority clinical functions.

In closing, I believe that this bill represents a benchmark in mental health legislation in that it is contemporary, reflects the community's views as well as the views of patients, consumers, carers, families and health service providers. The consultation with the community has been extensive and was led by Mr Paul Sheehy, who is unable to be with us here today. Finally, I would commend the bill to the committee. At this time I might conclude my presentation. We would be very happy to take any questions.

CHAIR: Thank you, Dr Cleary. I will start in the room first. Jo, would you like to start?

Mrs MILLER: Yes. Thank you for the presentation today, Dr Cleary. Dr Cleary, you said about three minutes ago that this bill reflects the community's views. You also said earlier that the bill talks about new models of care. It certainly does not reflect the views of the patients or the parents of the Barrett Centre, where there has been three deaths of patients. Can you tell me exactly how this reflects the community's views?

Dr Cleary: Thank you. I might make an introductory comment and then pass across to Dr Kingswell. In terms of the process that was undertaken with the review of the current legislation, there was an extensive consultation process. That included making visits to much of the regional part of Queensland, engaging with health service providers, community and carers and the two-stage consultation process where, initially, there were some more broadly based questions

being put to the community followed by some more specific questions that were put to the community. As I recall, approximately 85 per cent of the feedback that was received was incorporated into the legislation. So in terms of the feedback from the community, we were quite active in seeking that and were fortunate to receive a very comprehensive set of submissions, including the 200 that I mentioned earlier.

The second area that we have engaged with is the Queensland Mental Health Commission and the commissioner. Again, it is something that this committee would be well aware of, given that you were instrumental in finalising that particular piece of legislation on its way to parliament. The commissioner has been engaged throughout this process, as has the advisory committee that was established under the legislation. I had the privilege of meeting with the advisory committee on its second meeting and we outlined some of the changes that were being proposed. That committee is made up of a number of different groups, including carers and support people.

So in terms of the legislation, I believe that there has been a very active consultation process. Again, given that it is legislation related to mental health, we put in place a two-step formal consultation process and met with many of the other government departments and the Mental Health Commissioner so that we could gain their insight. I might hand across to Bill to talk through perhaps some of the details of the consultation and how the legislation fits with the feedback that we received from patients, family and carers.

Dr Kingswell: Thank you. I am not sure that I am specifically aware as to whether the Barrett Adolescent Centre group—either the young people or their parents—contributed to the review.

Mrs MILLER: I can inform you, Dr Kingswell, that the Minister for Health himself came out to the Barrett Centre with the Leader of the Opposition and I. He was there talking with the patients as well as the parents. So that might not have been part of your bureaucratic process, but he was certainly out there at the invitation of the Leader of the Opposition and to hear firsthand from the patients that they wanted the Barrett Centre to stay in its current form.

Dr Kingswell: Sorry, just in relation to the review of the act, I am not sure whether we can identify within the people who made submissions whether that group was included. They were certainly invited to make submissions and I think the act does deal with the rights of young people in a positive way, particularly in making sure they are represented at tribunal hearings if they happen to be detained as involuntary patients.

Mrs MILLER: So I take it from that that, even though the minister came out to speak directly with the patients and the parents, he may not have passed their requests on to you as the drafting officers direct to Parliamentary Counsel; is that correct?

CHAIR: Can I just ask a question. You were at that—

Mrs MILLER: Yes.

CHAIR: Are you aware of any of their comments that are not addressed in the bill?

Mrs MILLER: Yes.

CHAIR: Can we get to that?

Mrs MILLER: No, I just want to know whether or not the Minister for Health, Lawrence Springborg, passed on to the officers in front of us here today—Dr Kingswell, Dr Cleary and Ms Bobbie Clugston—any issues that he heard direct from the patients and from the parents at that meeting that we had at the Barrett Centre whilst it was still open. I want to know: yes or no?

Dr Cleary: I am not able to provide any commentary on the minister. Obviously, that is a matter for the minister's office. However, I can provide some further insight. I attended a number of meetings at the—

Mrs MILLER: You were not at that meeting, Dr Cleary. I was there and you were not there.

CHAIR: Dr Cleary is trying to answer your question.

Mrs MILLER: I am aware.

CHAIR: We are going to hear from him at this time.

Dr Cleary: If the chair was happy we might take that question on notice.

Mrs MILLER: Yes, thank you. I have another series of questions.

CHAIR: We will get there. I am happy for that to be taken on notice.

Mrs MILLER: Okay. I would just like you to turn please to page 12 of the explanatory notes of the Mental Health Bill. It relates to GPS tracking devices. I understand if you want to take this on notice. My questions are these. Firstly, do any of these devices infringe patients' individual liberties?

Secondly, does it place them at risk of harm in the community where such devices are associated with paedophiles and sex offenders? Thirdly, I would like to know how many tracking devices are now in hospitals in Queensland and which hospitals? Fourthly, how many mental health patients have these tracking devices been placed on to date or, alternatively, how many patients do you expect or plan for these tracking devices to be placed on? Lastly, do the GPS tracking device provisions comply with the principles of least restrictive practices?

Dr Cleary: The monitoring provisions provide for a range of monitoring arrangements to be put in place in the current legislation, and I believe the committee reviewed those new provisions when that legislation was introduced in the House. Many of the matters that I think were discussed then may be worth our reference. We would be pleased to go back and confirm some of the feedback that was provided at that time.

In terms of the enhanced security provisions and the strategy to reduce patients' absences without permission, I think the policy in that area has been very successful. We have reduced the number of patients who are absent without permission by 50 per cent over the last 12 months. For me as a clinician, I think that is a very important thing for us to have achieved, because once a psychiatrist has indicated that a patient should be detained in an acute facility it is important for the health system to make sure we make our best endeavours to comply with the legislation and to ensure those patients and clients are treated in accordance with the guidance from the psychiatrists.

I think the work that has been done to support that has been quite extraordinary, both at the hospital and health service level through the directors of mental health and through Dr Kingswell and his team. For me, the important thing is that it is improving safety for patients and reducing the risk of adverse events when patients may leave our facilities inappropriately. Overall I think the policy direction that has been set has been very successful and has improved patient safety.

In relation to the more specific questions around the monitoring devices, there is some data that I know Dr Kingswell will have with him and we will attempt to respond to questions on the numbers of devices. As the committee was involved in the original review of that legislation, it may be that we could provide you with a summary of the benefits of that legislative change and respond to that as well.

Mrs MILLER: Dr Cleary, I do not want only the benefits. I want to know the exact implications which also might be harmful effects particularly in relation to a patient's wellbeing. So you will take on notice the number of tracking devices? Have you got it now?

Dr Kingswell: Yes.

Mrs MILLER: Can you let us know?

Dr Kingswell: We have purchased 10 GPS tracking devices, and nominally five of them are allocated to the Townsville Hospital and Health Service to support the limited community treatment of patients in the secure unit at Townsville. There are five attached to the high-secure inpatient service at The Park Centre for Mental Health. To date those devices have been—and I will be corrected by Bobbie if I am wrong—for four patients. Of those four patients, three of those decisions have been overturned either by the Mental Health Review Tribunal or by the Mental Health Court. We have had some advice from the court around when it might or might not be appropriate to apply such a device, and it has limited us to really only being able to impose a device where there has been a significant material change to a patient's circumstances. The likelihood that the devices are going to be used in large numbers or frequently is very low. We would only really expect them to be employed for people who have been detained in relation to very serious offences. In that respect, we expect the devices to enhance their freedoms in that it would allow you the capacity to provide them some leave where you might otherwise not be able to entertain that leave at all.

Mrs MILLER: In relation to legal representation, I am looking at pages 6 and 7 of the explanatory notes, which state that legal representation will be provided for patients at no cost if they are a minor, if the Attorney-General is represented, in applications involving ECT and for reviews of fitness for trial. I would like to know how many patients you estimate will receive free legal representation at the Mental Health Review Tribunal. I would also like to know whether the patient will be able to choose their legal representative. In other words, will they be able to choose their own barrister? Will they be able to choose their own legal firm? I also want to know what on earth happens to people in the other categories—in other words, those who are not a minor and where the review is not about fitness for trial. Do they have to wear the cost themselves and in many cases they might not be legally represented at all?

Dr Kingswell: In relation to the numbers, we would need to take that on notice. We can give you an estimate of what that is likely to look like based on past experience.

Mrs MILLER: Okay.

Dr Kingswell: In relation to their choice of legal practitioner, that will be a matter for the Mental Health Review Tribunal. The budget for the legal representation of these people will sit with the Mental Health Review Tribunal. The Mental Health Review Tribunal will need to establish panel arrangements, whether that be with Legal Aid or another independent advocacy group which often helps us with our patient group. They will be constrained, I expect, within those panel arrangements and possibly not be able to choose the barrister that they wish.

Mrs MILLER: So what you are saying is that the Mental Health Review Tribunal will have a bucket of money, a budget, for legal representation but the expectation might be that that bucket of money is not adequate for the patient to choose their own barrister or their own solicitor; would that be right?

Dr Cleary: In terms of this provision, it was something that I know the Mental Health Commissioner has advocated for. Ever since she has been appointed to that role she has been seeking to have legal support provided to those people who would benefit from it at hearings such as the ones that you have outlined. I think it is a significant enhancement to the way the system operates for government to consider in terms of the legislation, which is still a bill, the provision of that level of support to patients and mental health consumers. From my perspective, having worked in large health services where we had a large mental health group of patients and consumers, I think this is a significant advance in terms of the way the community and consumers have the ability to advocate at those hearings.

In terms of the numbers, we have done modelling on various aspects of the changes that relate to this bill, and we will be building those additional funds into budgets in forward years. This will not be commencing in this financial year so it will be subject to parliament's consideration, potentially commencing in the following financial year. With any of the changes that are introduced through a legislative process, obviously we will be monitoring those and making sure that appropriate resources are made available to meet the needs of the government policy. At the moment we have indicative costs for the implementation of the bill: both the initial costs, which are one-off expenditures in terms of training, and probably the bigger one is in relation to the capital—

Dr Kingswell: Information system.

Dr Cleary: The mental health information system will need to be realigned to comply with this legislation. In terms of the recurrent costs, they will be related to some of those initiatives that I talked about such as the support provided in the court system, the support provided to patients and clients in the hospital system and the support provided in the legal system. I guess my view would be that those are all significant enhancements to the system that provides support to patients and clients of the system so that they can advocate for the best care possible.

Mrs MILLER: Can you please provide the committee with those indicative costs? You will probably need to take this on notice, and I am happy for that, but I would particularly like to know the budget amount for the Mental Health Review Tribunal in relation to legal representation. I would also like an answer for what happens to those patients who are not minors and who are not preparing for reviews for fitness for trial et cetera. Do they have to fund it themselves or do they not have legal representation at all?

Dr Kingswell: I suppose it is worth reflecting on how this policy was constructed. It was constructed through the consultation process with user groups, patients and the 200 submissions. In that process nobody thought it was practical to provide representation for the 6,601 people who were subjected to involuntary treatment orders last financial year.

Mrs MILLER: Was that question asked, though?

Dr Kingswell: Yes.

Mrs MILLER: Was it particularly asked?

Dr Kingswell: There was certainly consideration about whether it would be appropriate to have representation at all hearings, and practically that was not thought to be achievable or even necessarily desirable. The feedback was that these were the key things that people thought they should be properly represented at. So that is what we have built into the act and that is what we have costed.

Mrs MILLER: Okay. I have another question in relation to the mental health information system. Are you going to be contracting out that particular mental health information system? If so, who to and how much will it cost? Which firm?

Dr Kingswell: The answer is both yes and no in that we have the client integrated mental health record that we have been using for the existing act since 2008 and it will need to be extensively modified in order to meet the legislative requirements of this bill. The CIMHA (Consumer Integrated Mental Health Application) application has always relied on contractors for its construction and it will continue to rely on contractors for its construction. The existing contract is with Dialog. That is in place until I think early 2015 and will be reviewed soon. Then at some point in the future it will be put back into a contestable market, but yes it is a—

Mrs MILLER: And how much?

Dr Kingswell: I can take this on notice but off the top of my head I think the order of magnitude is about $3.2 million.

Mrs MILLER: Can you tell me what governance arrangements you have around the changes to that computer system?

Dr Cleary: It is probably worth talking about the governance model that we would see in place. In working with the committee over the last few years, there have been a number of major changes—the Health Ombudsman Act, the Queensland Mental Health Commission Act and the establishment of those two offices. For both of those projects we used a governance model that I think has been very effective in that we have been able to ensure those major policy directions of government were able to be implemented on time, on budget and within the scope that was set by government and parliament. The model relied generally on an interdepartmental steering group chaired by a senior officer from the department of health and with representatives from groups such as Queensland Treasury, the Premier's office and other appropriate agencies as well as the internal groups that have major work packages to deliver.

We envisage that we will provide the same governance model for the implementation of the Mental Health Bill. I feel very confident that we have used this model twice before and implemented legislative reforms that have been scrutinised by the committee. As I have indicated, they have been delivered on time and in scope. We would use those same arrangements. Obviously once the bill has been considered by parliament, the work of that group will come into full effect. However, we plan to commence that governance model in early 2015 so that the prework can be put in place. Clearly, the things they will be looking at will include the broader project planning around the implementation of such a complex change and the financial considerations that will need to be taken into account. Although we have done some preliminary estimates, once we engage in the more detailed planning some of those cost estimates may vary upwardly or downwardly.

In terms of the information system, as Queensland Health owns the information systems—we own the intellectual property and the software product—and we have a very skilled team which manages the software on a day-to-day basis, our level of confidence around the cost impact of the legislative change is very high as opposed to looking at a product that we have had limited experience with where the confidence in the assessment would be lower. Our mental health system operates very effectively across the state and is one of the larger information systems.

From my perspective, having had the opportunity to use it in my previous roles, and obviously Dr Kingswell more recently, it is a very appropriate system to have across the state because it means you have that single client record. Patients have the ability to have their clinical information available when they see health practitioners at different locations, and I think that has been a major improvement for us. The other benefit is the ability to look at and analyse some of the service provision that occurs across the state so we have a much better understanding of the types of services people are accessing, the frequency of access and so on.

In terms of the governance model, we would be very pleased to provide you with some further details. Again, I do not believe we have provided it to the committee during the consideration of some of the other major bills that were considered by the committee. Again, my level of confidence in that model has been derived from the fact that we have used the model twice, it has been effective, and I believe—and Dr Kingswell might correct me if I am wrong—I chair that group for the Mental Health Bill.

CHAIR: I need to give other members an opportunity to ask questions. Mr Hathaway, do you have any questions for the officials from the department?

Mr HATHAWAY: Not at this stage, Chair, but I reserve my right to have one later.

CHAIR: Thank you. Ms Bates, do you have anything that you would like to ask?

Ms BATES: No, I am fine.

CHAIR: Mr Krause?

Mr KRAUSE: I am okay.

CHAIR: Dr Douglas?

Dr DOUGLAS: Yes, I do. It is really an operational question and it is one which most doctors would really want to know the answer to. My concern is with the transition and the difficulty of getting someone on an order. I am trying to follow the new rules and I know you have put out some explanatory notes. The difficulty currently is that the nature of the types of people—I am sorry to the committee for getting more into the specifics of it—presenting leads people to having a problem whereby you almost have to get the police to pick them up and then have them create an offence as such. The problem is that, very much, these people who are the problem in the community, when you are trying to put them on an order, become almost toned out. You feel if you are a doctor that you have to try and put them on an order of some sort, but the police have sort of said that they are almost waiting for you to sort of say, 'What do we want to charge them with?' What in this bill makes it easier for medical people to get people into care in that way? People say, 'Well, you call the flying squad and things like that.' It is not as easy as that. Bill, I heard that you are there. Can you tell me what in this new order will make it easier for those patients? The doctor thing is one thing, but it is really about the patients themselves.

CHAIR: Just so we are aware, I will extend this hearing for another five minutes. So if you could be fairly brief, there is one other question I would like to ask.

Dr Cleary: Just to make a preliminary comment, when the previous bill was introduced there was an extraordinary level of education and training required across the state. That included health professionals in both the public and the private sector. We would envisage that the same general approach would be taken. There may be a different strategy used for education and training now that we have a more IT-literate community, but certainly there will be a major work package around the education and training relating to these changes.

I can certainly reflect on the changes when the last act was introduced. The materials we used were quite substantially different and I think will have the same effect on this occasion. There was a bedding-down process. Having said that—I will hand over to Dr Kingswell—one of the key changes is to streamline the process that underpins the bill and to make it simpler for health professionals overall to operate within the legislation.

Dr Kingswell: In relation to the operation of the act, it certainly will not make access any more difficult. The process for being placed on an involuntary treatment authority is simplified in that it removes what is currently required. At present you need a request, a recommendation and then an involuntary treatment order. It takes out one of those steps. You only need, in this bill, a recommendation and then an involuntary treatment authority to be made.

In relation to police involvement, it should be kept in mind that police involvement is the minority. So of the 8,100 involuntary treatment orders that were made last year, only 1,250 of those involved police, ambulance or a justice examination authority. The majority were done by clinicians in their offices and the people were then moved into hospital in that way.

The other thing this bill will do is put an extensive court liaison system in place. From that we would expect much better screening and detection of mental health problems appearing in the criminal justice system. So in that respect it will make access better.

CHAIR: Under the current act a doctor or senior registered nurse may use the minimum force that is necessary and reasonable in the circumstance to apply mechanical restraint to a patient or place a patient in seclusion. Does the bill allow staff to use minimal force if necessary to mechanically restrain or seclude a patient?

Dr Kingswell: Yes.

CHAIR: Okay. Thank you. That is all I really needed to know.

Mrs MILLER: I have one final question. I understand if you would like to take it on notice. It particularly relates to police officers and ambulance officers who take people to the emergency area to be assessed. It is a very big issue in a number of areas because the police and the ambulance officers are regarded as a revolving door. What I would like to know is the number of patients—just the numbers; I do not want the names—who are brought in by the police or ambulance to be assessed and are then let go within the 72 hours.

Dr Kingswell: Sure. I probably do not need to take that on notice. In the 2013-14 financial year there were 11,182 emergency examination orders made—4,961 by ambulance, 6,196 by police and 25 by psychiatrists. Of those emergency examination orders, 11 per cent—or about a thousand—resulted in an involuntary treatment order. Sixteen per cent resulted in a recommendation for assessment, so that allows detention for up to 72 hours. And in 64 per cent of cases the assessment criteria were not met at all. So you could take from that that there were about 6½ thousand to 7,000 patients who would have been released following their presentation on an emergency examination order.

Mrs MILLER: Thank you, Dr Kingswell. Are you able to break that down by hospital and health service, please?

Dr Kingswell: I can, but not—

Mrs MILLER: Can you take that on notice and break it down, please?

Dr Kingswell: It is published, so it is all available in the annual report of the Director of Mental Health that was tabled in parliament I think last week and released yesterday.

Mrs MILLER: Okay. It was released yesterday? Thank you.

CHAIR: Thank you. I am sorry, but the allocated time has expired. I thank Dr Cleary, Dr Kingswell and Ms Clugston. Thank you for your time. Thank you for attending here. I declare these proceedings of the Health and Community Services Committee closed.

Committee adjourned at 11.36 am