Mental Illness and Legal Support Accessibility in North Queensland

A comparative analysis between individuals in North Queensland and Brisbane with severe ongoing mental illness issues and the availability of appropriate legal support for Mental Health Review Tribunal hearings

Prepared by Tania Brown - Advocate

Overview and introduction

In the process of providing advocacy assistance for individuals with mental illness issues in the Townsville region, it has become quite apparent that not only are there several severely disadvantaged and vulnerable people who are confined to Queensland Health's Secure Mental Health facilities, but that it appears that these individuals have continued to remain confined to the facilities for what appears to be an unreasonably lengthy period of time. When beginning to explore how and why these individuals remain in these facilities, it has become obvious that there are commonalities with these individuals – all are bound by either an involuntary treatment order or a forensic order. When looking more closely at these individuals, their age bracket, their ongoing mental health condition, and the supports they have in place, it appears that each and every single one of them have remained on an order for a number of years. So a question was posited: why are these individuals continuing to remain bound to these orders, locked in secure facilities, when they are surrounded by an extensive treating team, who are there to not only intensively manage their illness, but to work towards stabilising the individual and eventually releasing the individual back into the community?

In order to properly examine this question, there are a number of factors that need careful analysis and consideration.

One option was to thoroughly observe the Mental Health Review Tribunal hearings for a 12 month period, where the decision is made to either confirm or revoke the order in place for the individual. The process would be explored in great detail to identify if there are any possible factors that may contribute to the individual remaining on an order for a longer period of time than is considered necessary.

Another option was to explore the individual's capacity and whether the presence or absence of a public trust or guardianship order has an impact, if any, on the client's overall status. This option examined the type of guardianship order in place and compared it with the type of health treatment order in place. Details relating to the Public Trustee and Adult Guardian were also sourced from the 2011-2012 Annual Report of the Adult Guardian.

Data was also compared and analysed by region, specifically comparing data from two different mental health facilities in Brisbane, where the metropolitan secure mental health facility is located in Queensland, and data from Cairns, where similar services, population and client demographics for people with disabilities. These two regions are North Queensland (covering the Cairns and Townsville regions, Townsville having the Secure Mental Health facility) and Metropolitan Brisbane (covering the Royal Brisbane Hospital and The Park Secure Mental Health facility). This data will be extracted from the 2011-2012 Mental Health Review Tribunal Annual Report, and the 2011-2012 Queensland Health Director of Mental Health's Annual Report.

The aim of this report is to effectively identify whether individuals in North Queensland, who are on involuntary treatment orders or forensic orders, have sufficient access to appropriate legal support during their mental health review tribunal hearings. It also aims to identify any issues that arise during mental health review tribunal hearings, and to ensure that all individuals have sufficient support in mental health review tribunals that will better assist them in reintegrating back into the community and eventually having their orders revoked. By meeting these aims, this report will consequently aim to create a stronger awareness of the importance of anyone having enough relevant support in place when in a state of vulnerability.

Definitions and Explanations:

Mental Health Review Tribunal
The Mental Health Review Tribunal is an independent panel of specifically trained staff representing a neutral grounds for the patient and the community. The panel consists of an independent legal specialist, an independent medical specialist, and an independent community representative.

Involuntary Treatment Order (ITO)
What is an ITO?
An ITO is an order made by an authorised doctor for the treatment of a person with a mental illness without that person's consent. An ITO can authorise the involuntary detention of the person receiving treatment at a mental health facility, or community-based treatment.

Who can make an ITO?
An ITO may be made by an authorised doctor. An authorised doctor is a doctor who has been appointed as such by the administrator of an authorised mental health service. A psychiatrist who is an authorised doctor is an authorised psychiatrist. The person making the ITO cannot be the same person who made the recommendation for assessment.

How is an ITO made?
Following an involuntary assessment, an authorised doctor may make an ITO if they are satisfied that the treatment criteria apply to the patient:

The **treatment criteria** for a person are all of the following:

(a) The person has a mental illness;
(b) The person's illness requires immediate treatment;
(c) The proposed treatment is available at an authorised mental health service;
(d) Because of the person's illness:
    (i) There is an imminent risk that the person will harm himself, herself or another person or
    (ii) the person is likely to suffer serious mental or physical deterioration;
(e) There is no less restrictive way of treating the person; and
(f) The person lacks the capacity to consent the treatment, or has unreasonably refused treatment

Only the person's **own** consent is relevant for the purpose of the last criteria. Therefore, an appointed guardian cannot give consent on the person's behalf.

An ITO must be in the approved form, state the time it was made, the basis upon which the doctor is satisfied that the treatment criteria apply to the patient and the authorised mental health service responsible for ensuring the person receives treatment.

Second Examination
If an ITO was made by an authorised doctor who is not a psychiatrist, or if the ITO was made solely on an assessment carried out using audio-visual link facilities, the ITO must be confirmed by an authorised psychiatrist following a "second examination". (This should not be confused with the preliminary examination carried out by a doctor following the issue of a Justices Examination Order (JEO) or an Emergency Examination Order (EEO).) If the original assessment was carried out by a psychiatrist using audio-visual link facilities only, then the second examination may be carried out by the same psychiatrist.

The process is:

- within 72 hours of the ITO being made, the patient must be examined by an authorised psychiatrist;
- the examination may only be carried out using audio-visual link facilities if the original assessment was carried out in person;
- the psychiatrist must **revoke** the order if they are satisfied that the treatment criteria do not apply to the patient;
- the psychiatrist must **confirm** the order if they are satisfied that the treatment criteria do apply to the patient;
- a revocation or confirmation must be endorsed on the order; and

- if the order is not confirmed or revoked within 72 hours:
- The patient ceases to be an involuntary patient, and
- The authorised doctor must inform the patient of this.

How long is an ITO in force?
An ITO made by an authorised doctor which is not confirmed by a psychiatrist within 72 hours ends at that time. Otherwise, an ITO remains in force until it is either revoked by the authorised doctor or the Director of Mental Health, or upon a review by the Mental Health Review Tribunal or appeal of that decision. If an authorised doctor for the patient's treating health service is satisfied that the treatment criteria no longer apply, he or she must revoke the ITO for the patient. Similarly, the Tribunal must revoke the ITO if any of the treatment criteria are not satisfied.

An order ends if the patient does not receive treatment under the order for 6 months.

What is the effect of an ITO?
There are two categories of ITO. These are:

(a) **In-patient** - where the patient needs to be treated as an in-patient of an authorised mental health service; or
(b) **Community** - where the patient receives treatment while living in the community. The patient is receiving community treatment: s 109, MHA.

If a person is classified as an in-patient, the patient may be detained in the patient's treating health service. An in-patient may be granted limited community treatment. The terms of this limited community treatment are set out in the patient's treatment plan.

A patient's category must be changed by an authorised doctor if:
- he or she is satisfied that it is necessary for the patient's needs, or
- if it is necessary to give effect to an order of the Tribunal.

What if I don't comply with an ITO?
Community ITO patients who do not comply with their treatment plans:
- must first be warned by their doctor about their non-compliance and the consequences of further non-compliance;
- if they again fail to comply with the treatment plan - may be given written notice to attend a mental health service for treatment: and
- if they fail to comply with the written notice - may be taken against their will to the health service for treatment and be detained until they have received treatment.

Power to take a patient to a mental health service
Health practitioners have the power in certain circumstances to take a patient to a health service against their will, for example, where the patient has not complied with their ITO or where the patient's category has changed from community to in-patient.
In exercising this power they:
- may have the help and use the force that is reasonable in the circumstances; and
- may enter a place if the occupier consents to the entry, the place is open to the public, or the entry is authorised by a warrant for apprehension of the patient given by a magistrate
- The health practitioner may request the help of the police. If asked, a police officer may help the practitioner to perform their functions and has the same powers and protections as the practitioner under the Mental Health Act.

What are my rights if I am subject to an ITO?
If a person is required under the MHA to do something and no time frame is given, then the provision must be complied with as soon as practicable. For example, a person may be required to prepare a document, or give a document to someone else, or to talk to or tell someone about something.

At the time the order is made
You have the right to:

- be told by your authorised doctor about the order, its category and the reasons why the order has been imposed
- have a treatment plan prepared for you and have your authorised doctor talk to you about your treatment under the plan.
- The contents of a treatment plan are set out at s 124 of the MHA;
- be given written notice of the order within 7 days of the order being made: s 113, MHA.

While receiving treatment
You have the right to:

- be treated as required under your treatment plan;
- be regularly assessed by an authorised psychiatrist as required by your treatment plan;
- have your ITO reviewed within the first 6 weeks and then every 6 months by the Mental Health Review Tribunal;
- apply for review of your ITO to the Mental Health Review Tribunal at any time;
- choose an allied person as a formal support person;
- be given a copy of the statement of rights for involuntary patients;
- receive visits from your own health practitioner or legal adviser at any reasonable time.

A person responsible for a patient's assessment, examination, detention or treatment must not ill-treat the patient. Ill-treatment includes wilful neglect or molestation.

If the order is revoked or changed
You have the right:

- if the ITO was not made by a psychiatrist and is not confirmed by a psychiatrist within 72 hours - to be told you are no longer an involuntary patient;
- if you have not received treatment under the ITO for 6 months - to receive written notice that the order has ended;
- if the ITO has been revoked - to receive written notice that the order has been revoked within 7 days of the revocation;
- if the category of ITO has been changed - to receive written notice of the change within 7 days and to have a discussion with your doctor about the change and the reasons for it, unless it is not reasonably practicable to do so or it is not in the interests of your health or safety or the safety of others.

Review of ITOs by the Mental Health Review Tribunal
Reviews of ITOs by the Mental Health Review Tribunal are conducted within the first 6 weeks of the ITO and then every 6 months, or at any time at the Tribunal's own initiative, or upon application by the patient. The Tribunal is usually made up of 3 members: a lawyer, a psychiatrist and a community member.

Reviews are carried out by way of a hearing. This means the Tribunal hears from the patient, their treating team and any other relevant people. The patient can be represented by a lawyer or their allied person. The patient can also be represented by a non-lawyer, or be accompanied by a support person, if the Tribunal agrees.

At least 7 days before the hearing, the patient's treating psychiatrist should have given a clinical report about the patient to the Tribunal. This report should also be given to the patient or at least the patient should have been told about its contents: s 3, *Mental Health Review Tribunal Rule* 2009 (Qld).
A patient can make their views known in writing before or at the hearing, or by talking to the Tribunal at the hearing.

At the end of the hearing, the Tribunal must decide whether to **confirm** or **revoke** the ITO. This will depend on whether the treatment criteria still apply to the patient having regard to:

- the patient's mental state and psychiatric history
- the patient's social circumstances; and
- the patient's response to treatment and willingness to continue treatment.

If the ITO is confirmed, the Tribunal also has the power to order that:

- the category of ITO be changed from community to in-patient or vice versa,
- order that an in-patient receive limited community treatment, or that limited community treatment be discontinued,
- a patient be transferred to another mental health service: s 191, MHA.

The Tribunal will usually tell the patient their decision at the end of the hearing. A written notice will also be posted to the patient within one week of the hearing. A patient may request reasons for the decision within 7 days after receiving notice of the decision.
A decision of the Mental Health Review Tribunal can be appealed to the Mental Health Court within 60 days of receiving notice of the decision.

Forensic Orders
What is a Forensic Order?
A forensic order gives authority for a person to be detained in an authorised mental health service or, in some cases a high security unit, for treatment or care. When a forensic order is made the person is described as a forensic patient.

Is a forensic patient able to reside in the community?
The Mental Health Court or the Mental Health Review Tribunal has the power to order limited community treatment, which enables the person to reside in the community with active monitoring by a mental health service. Limited community treatment can have various levels such as

- escorted on the grounds of the hospital,
- escorted off the hospital grounds;
- day leave;
- overnight leave and
- more than overnight leave.

When would the Mental Health Court make a forensic order?
If the court decides that the alleged offender was of sound mind at the time of the alleged offence but is temporarily unfit for trial the court must make a forensic order.

The court may make a forensic order if it decides that the alleged offender was either:

- of unsound mind at the time of the alleged offence, or
- is permanently unfit for trial

If the court decides that the alleged offender was not of unsound mind and is fit for trial then the matter will be returned to the criminal courts to proceed in the usual way. In these circumstances the court would not make a forensic order.

What does the Mental Health Court take into account when deciding whether to make a forensic order?
In deciding whether to make a forensic order the court must consider:

- the seriousness of the offence
- the person's treatment needs
- the protection of the community.

Where the court decides not to make a forensic order the court may make a non-contact order if the alleged offender had been charged with an offence of violence.

As a safeguard, an appeal can be made against the Mental Health Court's decision by a party to the proceedings. The parties to the proceedings are the alleged offender (represented by their legal representatives), the Director of Public Prosecutions and the Director of Mental Health.

The *Mental Health Act 2000* uses the terms 'victims' and 'concerned persons' to refer to the roles that a victim of crime or another person not a party to the hearing may have in the proceedings of the Mental Health Court and the Mental Health Review Tribunal.

How are forensic patients reviewed?
The Mental Health Review Tribunal is the body responsible for independent reviews of forensic patients. The Mental Health Review Tribunal that hears reviews for involuntary and forensic patients is usually made up of three members. In cases that represent greater concern (for example, where a person had committed a violent offence or whose condition and history indicates potential dangerousness), the panel size can be increased to up to five members to enable additional input or expertise.

How is fitness for trial reviewed?
Where the Mental Health Court has decided that the alleged offender is temporarily unfit for trial the Mental Health Review Tribunal will review that person's fitness for trial every three months for the first 12 months. After the first 12 months, reviews will be conducted at six-monthly intervals. The criminal proceedings will continue if the person becomes fit for trial, however proceedings will be discontinued if the person remains unfit for trial for three years. This period is extended to seven years where the person is charged with offences carrying a maximum sentence of life imprisonment.

Review of forensic orders in other circumstances
Where the Mental Health Court has made a forensic order because the alleged offender was either:

- of unsound mind at the time of the alleged offence, or
- is permanently unfit for trial.

The Mental Health Review Tribunal must review the patient's mental condition within six months of the making of the order and then at intervals of not more than six months.

Are patients assessed at other times?
The reviews of forensic orders discussed above are as stipulated in the Mental Health Act. Those reviews are in addition to the regular monitoring of the person's mental condition which occurs as part of their ongoing treatment.

How will I know when a forensic order is being reviewed?
The Mental Health Review Tribunal may order that a person with sufficient personal interest, for example a victim of crime or a patient's family member, is notified of hearing dates and decisions made about a forensic patient. Decisions about a forensic patient might include a decision to discharge the patient, to authorise limited community treatment, to order the transfer of the patient to another Mental Health Service, or for approval to move out of Queensland.

How do decisions concerning limited community treatment take into account the safety of the community?
The Mental Health Court or the Mental Health Review Tribunal must not grant limited community treatment unless the patient does not represent an unacceptable risk to his or her safety, or the safety of any member of the public.

In addition the Mental Health Court and Mental Health Review Tribunal must take into account:

- the patient's mental state and psychiatric history;
- each offence leading to the patient becoming a forensic patient;
- the patient's social circumstances;
- the patient's response to treatment; and
- willingness to continue treatment.

The Mental Health Court and the Tribunal are also obliged to consider whether to require, as a condition of any approval for limited community treatment, that a patient must not have contact with a victim or another specified person. If any condition is breached, limited community treatment can be revoked to ensure the person is immediately returned to the mental health facility. Police have powers to act in these circumstances, and have powers to search and enter premises.

How does a forensic order end?
The Mental Health Review Tribunal is the only body (except on appeal to the Mental Health Court or the Court of Appeal) with authority to revoke a forensic order.

The Mental Health Review Tribunal can only revoke the forensic order if a strict test is met. The Tribunal must be satisfied that the patient does not represent an unacceptable risk to their own safety or the safety of others, having regard to the patient's mental illness or intellectual ability. In making a decision to revoke the forensic order, the Tribunal must also consider the nature of the offence, and the patient's mental state and psychiatric history.

Office of the Adult Guardian
The Office of the Adult Guardian is an independent body, working to protect the rights and interests of adults who have an impaired capacity to make their own decisions. They strive to ensure that everyone is treated equally, regardless of their state of mind or health. Headed by a person appointed by the Governor in Council as the state's official Adult Guardian, they exercise the Adult Guardian's powers and functions independent of government and non-government organisations. While independent of the government of the day, the Office of the Adult Guardian is accountable to the people of Queensland by reporting to Parliament through the Minister for Justice and Attorney-General. Their charter is to:

- Make personal and health decisions for adults with impaired capacity if we are their guardian or attorney
- Investigate allegations of abuse, neglect or exploitation of adults with impaired capacity
- Advocate and mediate for people with impaired capacity, and educate the public on the guardianship system.

Public Trustee as Financial Administrator
What is an Administrator?
An Administrator is appointed by the Queensland Civil and Administrative Tribunal to make financial decisions, and legal decisions related to financial matters, on behalf of an adult who is unable to do so themselves. The Administrator must act in accordance with the provisions of the *Guardianship and Administration Act 2000* and the directions of the Tribunal Order.

What are the duties of an Administrator?
The *Guardianship and Administration Act 2000* outlines the General Principles that must be followed. In addition, when an Administrator is appointed they are required to develop and implement a financial management plan that ensures the effective and responsible administration of the adult's finances. This includes:

- Determine the full nature and extent of the adult's financial interests;
- Ensure all entitlements to income or benefits such as pensions are obtained;
- Develop a budget covering expected income and expenditure that ensures financial security and maximises the adult's independence and quality of life;
- Maintain clear and accurate records, including receipts, of all actions taken on the adult's behalf;
- Initiate or follow-up any matters that affect the adult including taxation, social security, legal claims and insurance;
- Ensure that the adult and their relatives and carers participate in the decision-making process;
- Recognise and take into account the adult's cultural and religious values;
- Act in accordance with Part 3 of the *Trusts Act 1973* (commonly known as the Prudent Person Rule when making or maintaining investments on behalf of the adult. This includes an obligation to review the performance of investments on an annual basis at minimum, to consider the risk of capital or income loss or depreciation, the likely income return and the timing of income return.

Who can be appointed as Administrator?
The Public Trustee of Queensland can be appointed as an Administrator.
If an individual wishes to be appointed as Administrator they must be:

- At least 18 years of age and;
- Not a paid carer or health provider for the adult (note: paid carer does not mean someone on the carer pension or similar benefit);

- Not a bankrupt or taking advantage of the laws of bankruptcy.
- A trustee company under the *Trustee Companies Act 1968* can also be appointed as Administrator.

Other than The Public Trustee, a proposed administrator must sign the application form to show they are willing to be appointed. An administrator cannot be appointed unless they consent to the appointment in writing. There is no need for a signature if The Public Trustee is proposed as The Public Trustee has given a commitment to the Tribunal to always act as administrator if needed.

Capacity

Capacity refers to the power, ability and competence of a person. It refers to the ability to make rational short term and long term decisions as an individual with regards to health care, accommodation, managing finances, accessing appropriate services, accessing legal advice, among others. It also refers to retaining the discernment to make ongoing rational choices to perform or refrain from performing certain acts and exhibiting certain socially challenging behaviours.

According to the Office of the Adult Guardian, the law presumes everyone has capacity to make their own decisions. They state that one cannot assume someone has impaired capacity without sufficient evidence.

They define 'Capacity' as the ability to:

- understand the nature and effect of decisions about a matter
- freely and voluntarily make decisions about the matter, and
- communicate the decisions in some way.

The Office of the Adult Guardian's stance is that *"just because someone has impaired capacity doesn't necessarily mean that they can't make any decisions. Many people with impaired capacity can be supported to make decisions for themselves. The law states that people with impaired capacity have a right to adequate and appropriate support in decision-making".*

Mental Health Review Tribunal observation

Several Mental Health Review Tribunal hearings were observed during this process for a number of IAT's clients. When providing advocacy and preparing for an MHRT hearing for a client, there is a specific process that is followed. This process involves receipt of the hearing notice, which involves information relating to who the tribunal hearing panel will be, who the current allied person is, who the current advocate is, and who the current legal representation is.

Allied Person

Who is an Allied Person?

Under the Mental Health Act 2000 the patient may choose an Allied Person. The person could be a parent or other relative of the patient, a guardian or personal attorney, or any other adult. The person is not automatically the Allied Person for the patient, but must be chosen by the patient to have that role. Forms for the patient to nominate an Allied Person are available from the mental health service.
In some cases, if the patient does not have capacity to choose an Allied Person, the administrator of the mental health service will appoint someone. The Allied Person must not be a paid carer of the patient, or an employee of the health service.

What does an Allied Person do?

The role of the Allied Person at a Tribunal hearing is to support the patient to put forward their views, wishes and interests about their involuntary treatment. For example, the Allied Person may help the patient explain how they are feeling, and what decision they would like from the hearing. The Allied Person also supports the patient at other times while they are receiving involuntary treatment.

Can the Allied Person apply for a review of the patient's involuntary treatment?

Yes, the Allied Person can apply to the Tribunal on behalf of the patient receiving involuntary treatment. An application form is part of the A Brief Guide to the Tribunal Brochure, and is available from the Tribunal's website or office, and from the mental health service.

How can the Allied Person help the patient before the hearing?

The Allied Person can help the patient with:

- finding a lawyer or advocate, if the patient wants to be represented at the hearing
- asking the Tribunal to arrange a language interpreter or cultural support to assist the patient, if necessary
- helping the patient to arrange to read the doctor's report before the hearing
- helping the patient to write his/her views about his/ her involuntary treatment to the Tribunal. The patient may complete a Self Report form which is also sent out with the hearing notice. It is also available from the Tribunal office.

Can the Allied Person attend the hearing?

Yes. The Allied Person may attend the hearing with (or on behalf of) the patient. The Tribunal will send a letter to the Allied Person, and the patient, that will state the date, time, and place of the hearing.

Can the Allied Person speak at the hearing?

Yes. The Allied Person can say anything that will support the patient in putting forward his/her views, wishes and interests. For example, the Allied Person may ask questions, give information and explain the patient's view of the situation. It is important that the Allied Person knows what the patient wants to say at the hearing.

Will the Allied Person be given the decision?

Yes. If the patient and the Allied Person attend the hearing, they will be given the decision on the day. A written decision will also be sent to both the patient and the Allied Person after the hearing.

Adult Guardian
The presence of an appointed adult guardian at an MHRT hearing ensures that the adult guardian remains aware, updated and informed of the progress of their client. The guardian plays an extremely important role in ensuring the client's needs are met, and that the client's wishes are catered for as much as possible. In the case of an involuntary patient, it is particularly important that the guardian attends the hearings, particularly if the guardian is appointed as the decision maker for accommodation, health matters and service provision. The adult guardian in this case is a key stakeholder in overseeing the tribunal process to ensure their decision making aligns with the treatment plan relating to the client.

What is an advocate?
An advocate is an independent third party who speaks, writes and acts on behalf of and in the best interests of the disadvantaged person to promote, protect and defend their welfare and justice. Advocates focus on the fundamental human needs and rights of people with disabilities. Advocates remain loyal and accountable to the disadvantaged person over the long term where necessary.

Advocacy strives to be independent, autonomous, on the side of the disadvantaged party and to minimise the risk of conflict of interest.

Advocacy's goal is for people with a disability to be included and seen as contributing and participating members of the community. Advocacy is emphatic, vigorous and costly to the advocacy group. It is distinct from service delivery and is not service provision or personal care support.

What does an advocate do?
An advocate tailors a specific plan with the client to reach a particular goal. In the instance of a Tribunal hearing, the goal is usually to support the patient to put forward their views, wishes and interests about their involuntary treatment, including any requests for service provision, ensuring legal support is being made accessible to the client and ensuring the client remains aware of their statement of rights, to ultimately ensure that their order is revoked. The advocate may help the patient to explain how they are feeling to the tribunal, and what decision they would like from the hearing. The advocate also supports the patient at other times while they are receiving involuntary treatment.

How can the advocate help the patient before the hearing?
The advocate can help the patient with:

- finding a lawyer if the patient wants to be represented at the hearing
- asking the Tribunal to arrange a language interpreter or cultural support to assist the patient, if necessary
- helping the patient to arrange to read the doctor's report before the hearing
- helping the patient to write his/her views about his/ her involuntary treatment to the Tribunal. The patient may complete a Self Report form which is also sent out with the hearing notice. It is also available from the Tribunal office.
- Ensuring that all relevant parties with an interest in the client's basic needs are informed and included in the MHRT process

Can the advocate attend the hearing?
Yes. The advocate may attend the hearing with (or on behalf of) the patient. The Tribunal will send a letter to the advocate, and the patient, that will state the date, time, and place of the hearing.

Can the advocate speak at the hearing?
Yes. The advocate can say anything that will support the patient in putting forward his/her views, wishes and interests. For example, the advocate may ask questions, give information and explain the patient's view of the situation. It is important that the advocate knows what the patient wants to say at the hearing.

Will the advocate be given the decision?
Yes. If the patient and the advocate attend the hearing, they will be given the decision on the day. A written decision will also be sent to both the patient and the advocate after the hearing.

Lawyer/Legal Representative

The presence of a lawyer with any MHRT hearing not only ensures that natural justice is maintained at hearings with respect to the client, but also the lawyer will also be able to highlight any discrepancies within the client's clinical report, and will also be able to voice concerns relating to the human rights of the client and ensure that the client is subject to the least restrictive practices possible, particularly when discussing Limited Community Treatment proposals and identifying whether the client has any legal rights in any other regard that need to be taken into consideration when discussing Limited Community Treatment.

Self-report

The self-report is a tool that is often used to gather information to present to the MHRT hearing on the day of the hearing. It gathers information about the client's feelings about being on the order, the result they are seeking from the hearing, any comments they have about the clinical report, how the client feels about their treatment, how the client feels in relation to the current people supporting them, how they feel they are progressing and how they currently manage their day-to-day dealings with life. This information is useful for the tribunal panel in terms of being able to see the client as a person dealing with a mental illness. Completing this report also gives the client some empowerment in terms of providing the panel with information they otherwise wouldn't feel comfortable delivering to the panel on the day. The role of the allied person or advocate is to ensure that if the self-report is completed, that the information in the self-report is communicated to the panel.

Clinical report

Another aspect of preparing for the MHRT hearing is to review the clinical report and highlight discrepancies from previous clinical reports to ensure all historical information is accurate, that all sections required are completed, and current information is succinct and doesn't conflict with other information provided by the treating team. It also allows the advocate or allied person to review the treating team's long term plans and goals for the client, where the allied person or advocate ensures the treatment options are the least restrictive options available for the client. The clinical report also makes note of the current Limited Community Treatment (LCT) provisions for the client being able to access the community and the level of risk associated with that.

The clinical report is very detailed with regards to the client's history and current status and treatment options, and there is a lot of input provided by a number of parties.

Treating Psychiatrist

The role of the treating psychiatrist in the MHRT process is one of the most important roles in any patient progressing and moving towards coming off their order. The treating psychiatrist prepares the clinical report, in conjunction with the rest of the treating team, including the key worker, other nursing staff, the mental health social worker, and, if applicable, the indigenous liaison officer and the district forensic liaison officer. The treating psychiatrist is responsible for ensuring the following on the clinical report are up to date and accurate:

- Diagnosis – this section covers the current diagnosis of the client and can include a provisional/differential diagnosis
- The mental health history – This section is to include all relevant dates, description and circumstances of symptoms observed, treatment progress and a history of willingness to undertake treatment. Usually it will include significant events and dates, as well as a brief 6 month summary since the last MHRT hearing to give the MHRT panel a better idea about where the patient is currently at with their treatment
- the circumstances leading to the order – to detail offences and circumstances leading to the patient being subject to a forensic order, including risk factors present at the time of the offence/s;
- current mental state assessment, outlining appearance, behaviour, mood, speech, thought patterns and insight into the mental illness, and
- the current treatment, which outlines the current medication regime, the patient's progress and response to involuntary treatment, and the patient's attitude to the prescribed treatment;

- A current risk assessment – this outlines two factors. The first factor discusses past criminal history where it mentions past history of violence, substance abuse history, past non-compliance, any history of impulsive or reckless behaviour, past use of weapons and a history of dangerous driving if applicable. The second factor discusses current risk factors (current for the immediate previous six months) including drug or alcohol misuse and impact on mental state, violence to self or others, non-compliance with treatment, lack of insight, unauthorised absence, likely contact with a victim (if known), vulnerability and environmental factors such as family issues or access to drugs)
- risk management – this section includes details of current strategies employed to manage risk, the role of supportive relationships, whether the triggering crisis is resolved, and the patient's conflict resolution skills
- limited community treatment plan, which outlines the current community treatment conditions; and
- recommendation, which includes the psychiatrist's professional opinion relating to whether they believe the patient needs to remain on the order, and a brief summary about their reasoning and decision

Indigenous liaison officer

The indigenous liaison officer is responsible for providing a detailed history of the cultural elements of the patient in the clinical report. This includes;

- the cultural background and focuses on the patient's clan group, the languages spoken and the community of origin;
- Community and outlines community networks and engagements, community supports and how these contribute to the patient's recovery, the family background, which focuses on the family dynamic, the kinship and cultural adoption, issues relating to the stolen generation, as well as grief and loss;
- cultural issues impacting on treatment, which includes the possible need for an interpreter, the spiritual beliefs and gender issues; and
- cultural support provided, which outlines the presence of a culturally appropriate mental health worker, cultural support worker or culturally appropriate community organisations providing adequate support

Social worker

The social worker provides details relating to the risks and protective factors in the patient's social environment including the carer and other significant relationships and the carer's capacity to support the patient.

District forensic liaison officer

Mental Health Services has a number of District Forensic Liaison Officers who play a critical role between the mental health service and the Prison Mental Health Service, as part of the forensic mental health system. These District Forensic Liaison Officers are also a point of contact for the Community Forensic Outreach Service (CFOS) for other clinicians. District Forensic Liaison Officers provide a number of services including:

Consultation and liaison

- Providing advice to clinical staff on the management of forensic patients and other mental health consumers who are considered to be 'high risk'
- Assisting with risk assessment and the development of management plans for forensic patients and high risk consumers
- Liaising with other agencies involved in the management of forensic patients, such as the police, watch house staff, prison mental health services and correctional services
- Liaising with community forensic mental health services around the management of forensic patients

Education and training

- Providing education on matters relating to forensic patients, such as risk management and *Mental Health Act 2000*

- Providing oversight of management of forensic patients
- Ensuring photographs of forensic patients are updated annually and as required
- Ensuring that case managers complete summaries of risk for forensic and classified patients (involuntary patient summary)
- Involvement in the development of risk management plans for forensic patients, particularly special notification forensic patients
- Regularly reviewing the management, treatment and risk management plans of forensic patients
- Monitoring compliance with conditions of Limited Community Treatment of forensic patients and assisting the treating team to problem-solve compliance issues
- Providing advice to treating teams on the ongoing monitoring and reporting requirements of forensic and classified patients

Case management

- Co-case managing forensic or high risk mental health clients - where they works closely with the case manager or treating team to assist and advise on clinical management.
- Case management of complex forensic patients for a time limited period.

Attending the hearing

The hearing is comprised of a number of people, depending on who have been notified about the hearing and how their input is crucial for the benefit of the hearing and the client.

The hearing is facilitated by the Authorised Mental Health Service, and is held in a conference room. The tribunal panel consists of a presiding member who chairs the hearing, and two other members. All members represent a different area within the community – one represents legal, one represents medical and the other represents the community. In the case of a forensic order being heard, there is usually a representative from the Office of the Attorney General.

In conjunction with these members, the treating health service has varying members attend depending on the individual needs of the client and the resources available. Known to attend are the treating psychiatrist, a treating health practitioner, the client's case manager, the district forensic liaison officer, the client's key worker, and the treating health team's psychologist. These people represent the treating health team. To represent the client, a number of people can attend. These people include the client themselves, the allied person, the advocate, and a legal representative appointed by either the client, allied person or advocate. In the instance that the client has an adult guardian appointed, particularly if they are appointed as decision maker for health, service provision or accommodation, it is prudent for the adult guardian to attend the hearing as the allied person.

The hearing is often quite informal and not like a court. The tribunal prefers that the client attend their hearing. The tribunal panel will listen to information that the treating psychiatrist and doctor provide about the current status of the client and provide a professional opinion about the client's illness. The hearing is an opportunity for the client to raise questions regarding treatment and their wishes, and to provide a perspective from their point of view. Every attendee has the opportunity to speak and provide information, raise any concerns and ask questions with regards to treatment and the current status of the client. Once the tribunal has received input from all attendees, they discuss the information provided by all parties and make a decision whether or not to revoke the involuntary treatment or forensic order. They also discuss what level of access to the community that the client is allowed to have and the frequency and method by which they access the community. A decision is usually made on the day of the hearing so the client knows the outcome by the end of the session.

After the hearing, the client is officially notified by way of letter to advise the decision of the tribunal and any changes in Limited Community Treatment options.

Results

Analysis of data from MHRT Annual Report and Director of Mental Health Annual Report

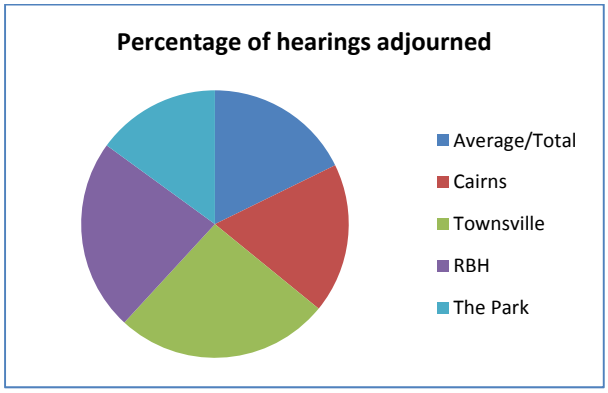
Note: All data presented refers specifically to the North Queensland region (Cairns and Townsville), and the Brisbane Metropolitan region (Royal Brisbane Hospital and The Park Secure Mental Health facility)

Mental Health Review Tribunal Annual Report Data

See Table 1.

Graphical representations and discussion:

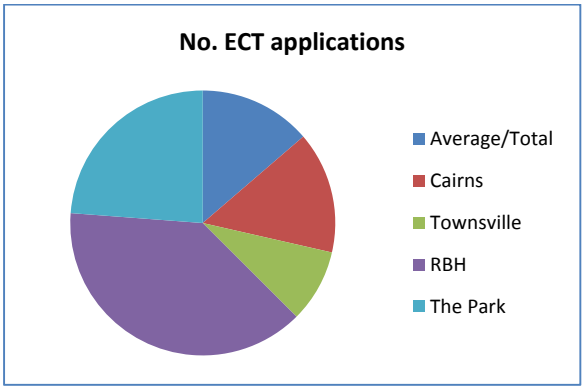
Graph 1. Percentage of MHRT hearings adjourned in the 2011-2012 financial year period



Cairns: 18% Townsville: 26% RBH: 23% The Park: 15%

When looking at the percentage of hearings adjourned in the 2011-2012 period, it was found that on average, 18% of all hearings were adjourned. North Queensland averaged approx. 22% of all hearings adjourned, whereas the Brisbane Metro area averaged approx. 19%. When looking at these statistics, it raises the question as to why the North Queensland region's average was somewhat higher than average. There is a need to identify why there were substantially more adjournments for North Queensland than there were for Brisbane. Possible reasons could include a lack of staffing from the MHRT, inefficiencies in the preparation of the clinical report, an adjournment being requested and a backlog of overdue hearings.

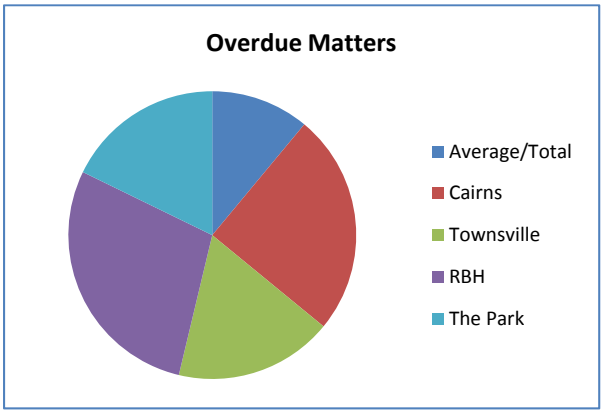
Graph 2. Percentage of Electroconvulsive Therapy Applications lodged



Cairns: 15% Townsville: 9% RBH: 39% The Park: 24%

The number of ECT applications for the North Queensland region was significantly lower than those for the Metro Brisbane area. It appears that the prevalence of mental illness in the Metro Brisbane area has a higher requirement for Electroconvulsive therapy. This raises the question of whether ECT is a preferred method of treatment and whether other treatment options are being sourced first.

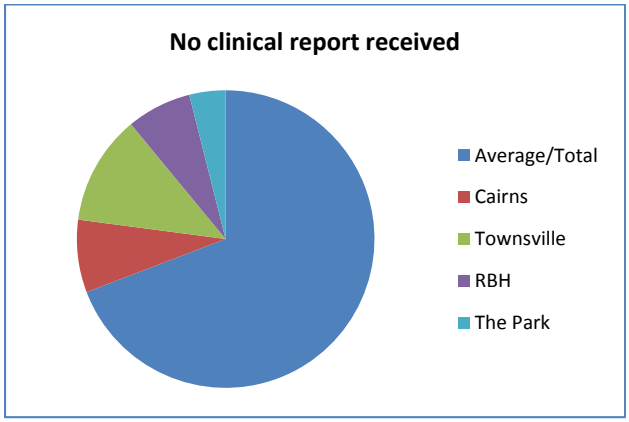
Graph 3. Percentage of Overdue Matters heard in the 2011-2012 financial year period



Cairns: 25% Townsville: 18% RBH: 28% The Park: 18%

The number of overdue matters for the North Queensland region were very high in comparison with the average, but were on par with the number of overdue matters in the Metro Brisbane area. The average for the state was 11% of all matters were overdue, however both the North Queensland area and the Brisbane Metro area had an overall percentage of 43% and 46% overdue matters respectively. Factors that would explain the number of overdue matters for both these regions could be due to a backlog of other overdue matters needing to be heard first, creating more of a backlog for matters to be heard on time, matters being adjourned, and lack of appropriate preparation of the clinical report for the matter to be heard in a timely manner.

Graph 4. Percentage of hearings where no clinical report was received



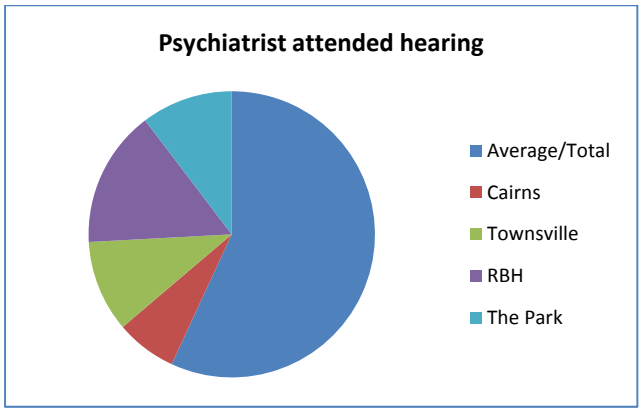
Cairns: 8% Townsville: 12% RBH: 7% The Park: 4%

The incidence of the client not receiving a clinical report for their hearing in Townsville was particularly alarming. Townsville had the highest incidence of clients not receiving their clinical report at all. What makes this even more alarming is the fact that for all of Independent Advocacy's clients, the psychiatrist advises that all clients have little to no insight of their mental illness, meaning their likelihood of recovery is poor. This raises the question of how the client is supposed to gain insight if they aren't being informed of their progress by the clinical report. Not only that, but is the lack of provision of a clinical report for a mental health review tribunal hearing serving to be detrimental to the patient's long term recovery? Does this pose as a significant threat to the client's progress to eventually come off the involuntary treatment order or forensic order?

Members of the treating team attended hearing

There was a general trend observed with members of the treating team attending mental health view tribunal hearings, where it was observed that on average, there was substantially more treating team participation for the Metro Brisbane area than the Townsville area.

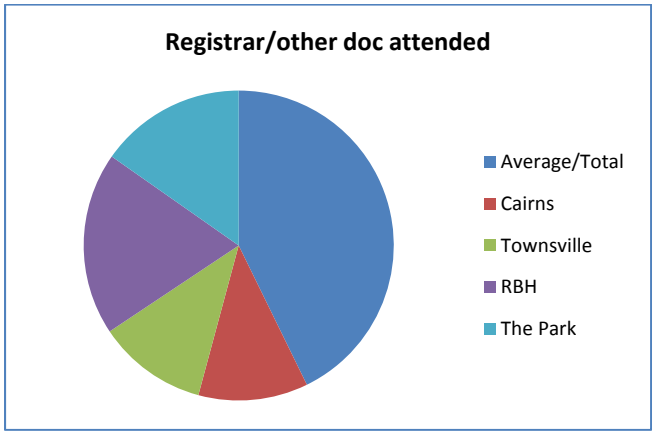
Graph 5. Percentage of hearings where the treating psychiatrist attended



Cairns: 7% Townsville: 10% RBH: 16% The Park: 10%

It was observed that for the treating psychiatrist to attend, the North Queensland region averaged 17% of hearings had the treating psychiatrist present, compared with the Metro Brisbane region, which averaged 26%. The treating psychiatrist's attendance should be viewed with a high level of importance, particularly when clinical reports have been provided late to the client or haven't been provided at all. The treating psychiatrist's input to the hearing is highly important, as it is primarily the professional opinion of the psychiatrist with regards to associated risks and safety to the community as to whether the tribunal panel makes the decision to confirm or revoke the involuntary order. When there are inaccuracies in the report, the absence of the treating psychologist could ultimately delay a client from having the order revoked, where the hearing could be adjourned pending additional information, or even confirmed with the view of having the psychiatrists information expanded upon more at the next hearing, which wouldn't be until 6 months after.

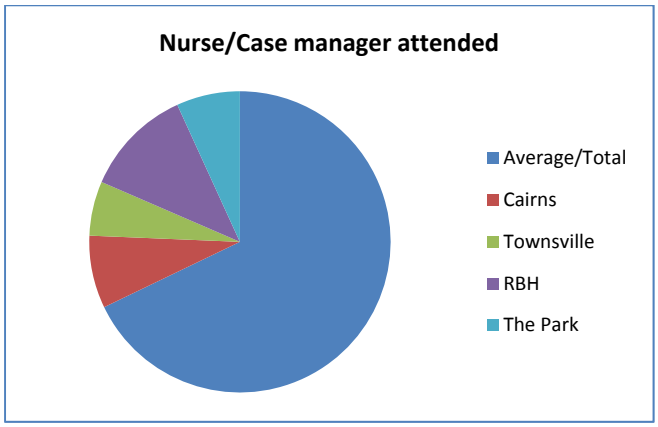
Graph 6. Percentage of hearings where the psychiatric registrar or another treating health practitioner attended the hearing



Cairns: 11% Townsville: 11% RBH: 19% The Park: 15%

It was observed that for the attendance of the registrar or another doctor, the North Queensland region averaged 22% of hearings had the registrar or other doctor attend. In comparison to the metro Brisbane area, who averaged 34%, this again demonstrated a clear discrepancy of treating team participation. The attendance of the registrar or another doctor is important in the hearing as the role of this person is to provide additional information in relation to the client and their overall health status. This person can provide more comprehensive information in relation to the client's overall mental health status from another point of view, as well as address any concerns relating to other health matters not relating to the client's mental health.

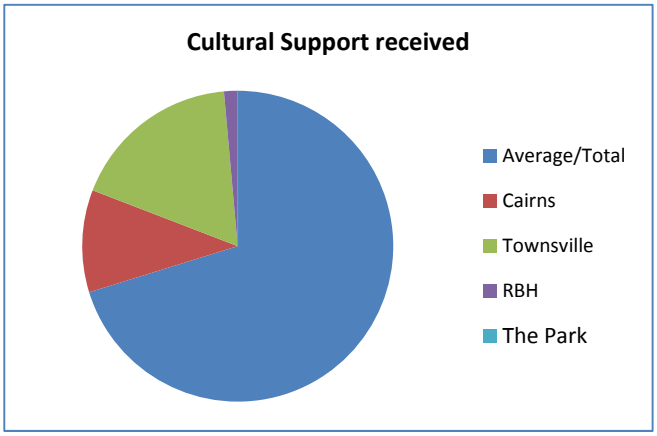
Graph 7. Percentage of hearings where the treating nurse or case manager attended the hearing



Cairns: 8% Townsville: 6% RBH: 12% The Park: 7%

It was observed that for the attendance of the nurse/case manager of the client, the North Queensland region averaged a mere 14%, with Townsville only averaging 6%, whereas the metro Brisbane area averaged 19% in total. The attendance of the nurse/case manager is important as they can outline to the panel the client's day to day outlook on life, their behaviours and interactions with other patients, and can discuss any incidences with regards to Limited Community Treatment and discuss them at length rather than having the panel merely reference them in the clinical report. The attendance of the nurse/case manager of the client is important as again, they can provide more in-depth information that they otherwise don't include in the clinical report. They can also serve as a support for the client in the hearing, and encourage the client to speak for themselves to the panel and to clarify why they behaved in a specific way if necessary.

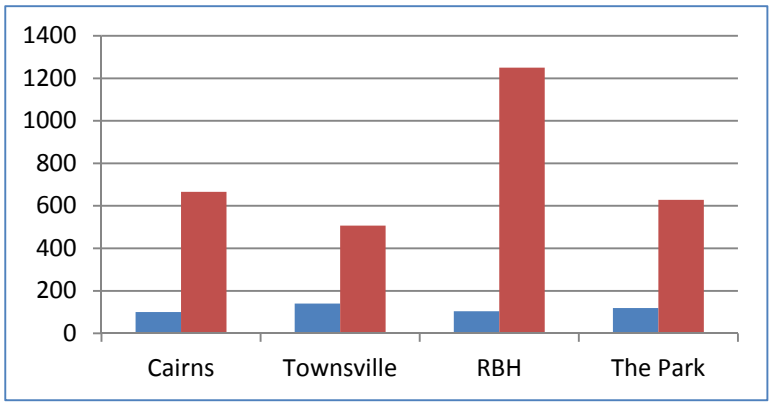
Graph 8. Percentage of hearings where cultural support was received and attended a hearing



Cairns: 11% Townsville: 18% RBH: 1% The Park: 0%

There was a good representation of cultural support provided for clients in the North Queensland region, with an average of 29%, as opposed to the Metro Brisbane area, which had a mere 1% representation. While the North Queensland region had a good representation of cultural support received, it is worth noting that there is quite a higher proportion of cultural diversity in the North Queensland region. From Independent Advocacy's point of view, from the total number of clients serviced with involuntary treatment orders or forensic orders averages 45%, so even though the North Queensland region had a much better cultural support representation, it is clear that there still needs to be more cultural support provided to ensure that the already vulnerable and marginalised population receives as much support as possible in their recovery.

Graph 9. Number of Forensic Orders and ITO's compared by region

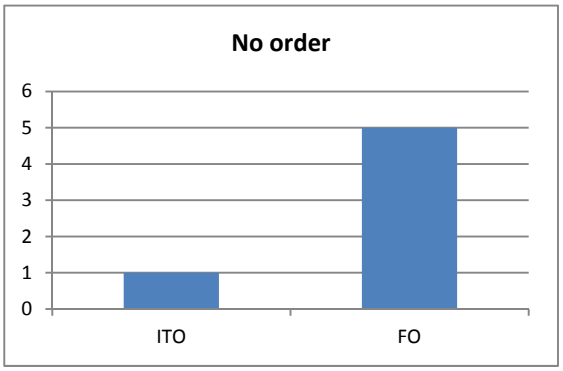


Cairns: ITO: 666 FO: 100 **Townsville**: ITO: 507 FO: 140 **BH**: ITO: 1250 FO: 104 **The Park**: ITO: 628 FO: 119

When examining the data for the number of ITO's and FO's in place for each region, it was calculated that for the North Queensland region, there were a total of 240 Forensic orders, and 1173 Involuntary Treatment orders in place. In comparison, for the Metro Brisbane region there were a total of 223 Forensic orders, and 1878 involuntary treatment orders. From this information, it is clear that there is a much higher rate of mental illness and crime in the North Queensland region, with a 20% proportion on forensic orders, in comparison to the client base in the Metro Brisbane region, where only 11% are on forensic orders. Disability Forensic orders were not noted in this information.

Independent Advocacy Individual Client demographic data
See Table 2.

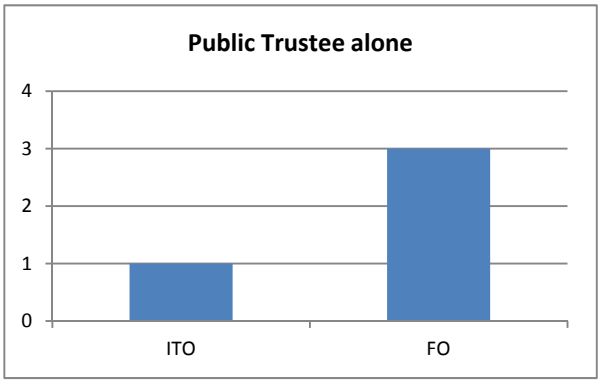
Graph 10. Number of clients on a forensic order or ITO with no financial administrator or adult guardian appointed



ITO - 1, Forensic Order – 5

Of Independent Advocacy's mental illness client base, it was found that there was only one client on an involuntary treatment order and five separate clients on forensic orders who had no guardian or financial administrator appointed. Of these clients, the client on the ITO had no legal support, however the client had their order revoked without legal support with the assistance of the treating psychiatrist. Of the forensic order clients, 3 clients had legal support for their hearings, one of which had the forensic order revoked. Of these clients, aside from 1 forensic order client, all had been placed under an order within a 2-4 year time frame.

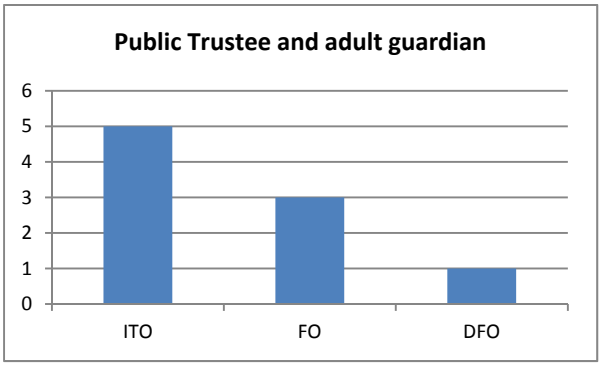
Graph 11. Number of clients on a Forensic Order or ITO with just a financial administrator appointed



ITO - 1, Forensic Order - 3

When examining Independent Advocacy's client base in terms of the number of clients on an order with a financial administrator appointed, it was identified that there was 1 client on an involuntary treatment order, and 3 clients on forensic orders. It was unknown whether the client on the ITO received legal support or representation for their mental health review tribunal, however the 3 clients on forensic orders all had legal support provided, all provided by the Aboriginal and Torres Strait Islander Legal Service. Without being provided with the information relating to how these clients came to have a financial administrator appointed, it can be postulated and assumed that clients who become unwell don't necessarily have family, friends or other outside supports available at the time, given that the financial administrator is usually looked upon as an option of last resort. It can also be assumed that the application for financial administrator to be appointed is lodged by the treating health service as a precautionary measure to ensure the client isn't placed at a disadvantage or left in any more of a vulnerable position in terms of finances. Of these clients, aside from one forensic order client, all had been placed under an order within a 3-8 year timeframe.

Graph 12. Number of clients on a Forensic Order, ITO or Disability Forensic Order with financial administrator and adult guardian appointed



ITO - 5, Forensic Order – 3, Disability Forensic Order - 1

When examining Independent Advocacy's client base in terms of the number of clients on an order with both a financial administrator and an adult guardian appointed, it was identified that there were 5 clients on involuntary treatment orders, 3 on forensic orders, and 1 on a disability forensic order. Interestingly, of all the 9 clients on involuntary treatment orders, forensic orders and disability forensic orders, not one received legal support for their mental health review tribunal hearings. Again, without being provided with the information relating to how these clients came to have a financial administrator and adult guardian appointed, it can be postulated and assumed as legislation states, that when clients become unwell, that the process of eliminating all outside supports such as family, friends and others have been sourced and eliminated before exploring the option of having both a financial administrator and an adult guardian appointed. It can also be assumed that the application for financial administrator and adult guardian to be appointed is lodged by the treating health service as not only a precautionary measure to ensure the client isn't placed at a disadvantage or left in any more of a vulnerable position in terms of finances, but for these clients who obviously are far more vulnerable, in terms of the appointment of an adult guardian, it appears that the client's needs and vulnerabilities are

viewed upon as more severe, more long term and in the best interests of the client. Of these clients, all had been placed under an order within a 1-6 year time frame. What was most concerning about these clients, was the lack of input the appointed guardian had in the mental health review tribunal hearing process. Not one of these clients had their guardian, who were appointed for a combination of accommodation matters, health matters, service provision matters and personal matters, attended the hearing. Not one guardian organised or facilitated any legal support for a client. This was alarming as the purpose of a guardian, as outlined in their position description, is to make decisions about, and in the best interests of, their clients. To not even have an appointed guardian attend any of the hearings demonstrates just how vulnerable these clients are, and how important it is that someone making decisions about matters involving the client's life, play an active role in that person's life. Even more concerning was the fact that a proportion of these clients had a family member or friend appointed as an allied person. It appears there is little to no emphasis placed on the importance of having legal support present for the hearings.

Legal support was attempted for these clients, however there were no agencies available to provide this support. When contacting Queensland Advocacy Incorporated (QAI), it was advised that if clients contact QAI directly they were able to provide legal advice but no representation and instead be placed on a wait list until someone was available to assist at the next hearing. When contacting Legal Aid Queensland (LAQ), applications for assistance were lodged but no response was provided in a short time frame. When contacting Aboriginal and Torres Strait Island Legal Service, ATSILS were able to provide assistance with short notice on most occasions, however even some clients who were previously linked in with ATSILS were unable to be provided with legal representation for their hearings. It appears that there is more legal support available for indigenous than for non-indigenous clients, who have the benefit of ATSILS in addition to QAI and LAQ.

What is most concerning about this situation is that these clients in particular, being the most vulnerable, have several stakeholders in their lives for varying purposes including disability support workers, the treating team at the secure unit, specialist medical practitioners, a public trust officer and an adult guardian, and yet not one of them, aside from the advocate, had attempted to provide linkages to the client to gain access to legal support. This raises even more of a concern for other individuals who are not linked in with advocates – are these people being neglected and allowed to continually sit pending for years at a time?

Recommendations

With regards to a number of issues highlighted in the resultant findings, Independent Advocacy makes the following recommendations:

Timely provision of the clinical report
There needs to be an effective strategy implemented to ensure clients are receiving their clinical reports at least 7 days before their hearing. Clients would benefit from being educated about their illness by their case worker, treating psychiatrist or other doctor, and would have a better understanding of the mental health review tribunal process. Upon liaison with MHRT staff, it was advised that the clinical reports are often delayed due to out-dated administrative processes and a lack in the effective use of electronic technology. Upon follow-up of late reports, MHRT staff have also advised that they had not yet received a copy of the clinical report from the treating psychiatrist. It is our recommendation that a system be implemented where the treating psychiatrist prepares the reports as soon as the allied mental health unit becomes aware that a client has an impending hearing. If the treating psychiatrist has issues with being able to submit the report on time, there needs to be a process in place to ensure that Queensland Health professional staff are supported enough in their role so that their workload is manageable. Oftentimes the reports can be quite lengthy, so our recommendation is that the clinical report provides a succinct overview of the client's current status.

Overall client education about their rights and role in the MHRT process
IAT recommends that clients are better educated on the statement of rights issued to them once placed on an order, and ensure that clients have this statement of rights reviewed prior to every mental health review tribunal hearing. Explaining the client's rights to them gives them a sense of empowerment, would give them more confidence in wanting to speak for themselves at hearings, and become more involved in the treatment process. Often the most vulnerable clients are poorly educated and struggle to understand systematic processes.

More comprehensive education on accessing LCT and a review of being able to access LCT
Clients would benefit from a more comprehensive education session on their rights to access LCT and the treating team could look towards more positive behaviour support plans for clients to be able to access their LCT even when there has been an incident in the unit. Clients are often locked in these facilities for a number of years without regular contact from family, friends and other social supports, are surrounded by other clients with varying degrees of mental illness, all undergoing varying degrees of treatment. It is important for the client to maintain a sense of independence within themselves as an individual away from the facility and withholding LCT for punishment, particularly for incidences that escalate as a result of ongoing frustration, need to be addressed differently without compromising the client's ability to access their leave.

Presence of the treating psychiatrist at hearings
Independent Advocacy recommends that the treating psychiatrist be present for most, if not all mental health review tribunal hearings. With the clinical report providing basic information, the treating psychiatrist can elaborate upon, and discuss in more detail, the progress and status of the client in a timeframe specified for the client. Doing so may be more time and resource efficient.

Presence of the registrar/doctor/nurse/case manager at hearings
Independent Advocacy also recommends the presence of the registrar or other doctor to be present for all applicable mental health review tribunal hearings, as well as the presence of a case manager or key worker. The registrar or other doctor can confirm any treatment options that don't relate to the client's current mental health status and answer any questions the tribunal panel may have, and the case manager/key worker can provide more comprehensive information relating to the client's day to day activities and behaviour.

Cultural Support
Independent Advocacy recommends a higher level of cultural support be provided at the mental health review tribunal, particularly in a region such as North Queensland where indigenous populations are higher. IAT also recommends the employment of more culturally appropriate treating health staff, such as indigenous psychiatrists and key workers, to provide more culturally sensitive treatment and support for indigenous clients. The Federal government has provided substantial funding through the "close the gap" initiative that Queensland Health should look at accessing to source and fund these staff.

Clearly defined transparent process in contacting family and friends instead of the public trustee and adult guardian in the first instance
IAT recommends that Queensland Health source a better option for contacting family, friends and other people from clients' networks when they present for being unwell. It appears that the vast majority of clients have at the very least a financial administrator appointed at the time where the client is acutely unwell. From there, once the client stabilises and reconnects with family and friends, the financial administrator remains in place, often for a long period of time.

Temporary financial management assistance instead of appointment of financial administrator
There needs to a be a process in place where a client can relinquish their rights to access their finances on a more informal temporary basis until their mental health condition stabilises enough to be placed in a high security accommodation facility, where a key worker can, with the support of disability support services, gain access to budgeting and financial planning services. Financial administration orders are often implemented for a number of years that restrict the client from being able to develop a sense of freedom and independence to give them something to work towards as a long term goal for their LCT and merging back into the community. Clients without advocates or a close network of support are left vulnerable and do not speak up for themselves because they feel helpless to do so, and are often the ones who if left long enough, deteriorate until an adult guardian is appointed.

Clients with adult guardians and financial administrators already appointed
IAT also has a number of recommendations for any client with an adult guardian and financial administrator appointed.

Treatment plans for urgent review by independent specialist treating team
Firstly, all clients with both adult guardian and financial administrator appointed should have their treatment plans reviewed by an independent specialist treating team. The reason for this is that often these clients will be the most vulnerable clients who have deteriorated and ceased responding to treatments after a number of years due to a sense of worthlessness, apathy and being institutionalised for a long period. An independent review of their treatment plan would ensure that the client is being looked at from a blank perspective, free from bias. The purpose of this would be to allow the client to be given a second opinion to confirm a diagnosis, review a medication regime, and identify other factors that may have been overlooked due to institutionalisation and remaining in the same mental state for a number of years. The specialist team could liaise with the current treating team and discuss different treatment methods and strategies for the clients. They could also identify if there are other factors relating to capacity of an individual for a specific matter relating to what the guardian is appointed for. For clients to be surrounded by so many stakeholders and continue to be unwell raises the question of whether they are receiving the correct treatment for their mental illness.

Locate family, relatives or friends to become guardian
Secondly, the guardianship order should be reviewed and alternative options sought. These options would include the more thorough attempts to locate a more suitable family member who has significant input into the client's life, as well as a more thorough educating of clients' family members or friends about what is actually required to be an effective decision-maker for someone else.

Guardian to be listed as allied person or advocate on all MHRT notifications and to attend hearings
The Adult Guardian can be listed as an allied person for the client. In the MHA, Chapter 9, Part 1 Section 339 the definition of an allied person for an involuntary patient is *"the person chosen or declared under this part to be the patient's allied person".*

Section 340 states the function of the allied person *"is to help the patient to represent the patient's views, wishes and interests relating to the patient's assessment, detention and treatment under this Act."*
Section 341 states "*the patient may choose any 1 of the following persons, other than a health service employee at the patient's treating health service, who is capable, readily available and willing to be the patient's allied person for this Act—*

(a) if the patient is a minor—a parent of the minor or the minor's guardian;
(b) if the patient has a personal guardian—the guardian;

(c) if the patient has a personal attorney—the attorney;
(d) an adult relative or adult close friend of the patient;
(e) an adult carer of the patient;
(f) another adult."

Section 342 part 4 states who the allied person is "if the patient does not have capacity to choose an allied person:

The person chosen must be—

(a) the first person in listed order of the persons mentioned in section 341 who is willing, readily available, capable (88 See the *Powers of Attorney Act 1998*, section 35 (Advance health directives)). and culturally appropriate to be the patient's allied person; or
(b) if no-one in the list is willing, readily available, capable and culturally appropriate to be the patient's allied person—
(i) if the patient is an adult—the adult guardian; or
(ii) if the patient is a minor—the Commissioner for Children and Young People and Child Guardian under the *Commission for Children and Young People and Child Guardian Act 2000*."

Alternatively, the Adult Guardian can be listed as the advocate for the client. In the Office of the Adult Guardian's 2011-2012 Annual Report, the Acting Adult Guardian, Lindsay Irons, made specific reference that part of the Adult Guardian's role is to advocate for their clients. On Page 29 of the 2011-2012 Annual Report, in particular, the reference to guardians appointed for legal matters was stated:

"Although OAG staff do not act as clients' legal representatives in Court and Tribunal proceedings, the role they play can have a significant and positive impact on client outcomes, including on:

- ***the Court's understanding of the client's impairment and vulnerabilities, and the impact of this on their offending behaviour***
- *whether a client is sentenced, and the nature of the sentence they receive*
- ***the ability of the client's legal representative to discharge their role***
- *whether a client can maintain contact with a child who has been placed in care*
- *whether a client will be granted bail.*

Much of the critical work undertaken by staff with respect to clients' legal matters occurs outside of Court proceedings. Staff routinely:

- ***advocate for clients to receive grants of aid from Legal Aid Queensland***
- ***source legal representation for clients (including pro bono representation)***
- ***advise legal representatives, to ensure they have all relevant information necessary to represent their client***
- *participate in family group meetings/conferences to help represent the client's interest in child protection matters*
- ***liaise and negotiate with service provider representatives in relation to the provision of clinical and non-clinical services for the client, insofar as this relates to the client's legal matters."***

Guardians be appointed for legal matters in addition to their current appointments
Independent Advocacy have identified that there is a distinct need for all clients who have a guardian appointed, and who also come under the MHA, have a guardian be appointed for legal matters immediately.

Legal support and representation is an effective and necessary method in which a client engaged under the Mental Health Act can exercise their rights as a patient, as outlined in the Statement of Rights. Due to the ongoing nature of an ITO or Forensic Order, the client requires ongoing legal support and representation for these hearings to ensure their rights are acknowledged, discussed, and protected at hearings. In addition, having legal personnel present ensures that discrepancies in the process are highlighted, examined and acted upon, in addition to ensuring natural justice is maintained at the hearing.

As per the Guardianship and Administration Act 2000 (GAA), Schedule 2, Part 13 Point 18 states: "A ***legal matter***, for an adult, includes a matter relating to—

(a) use of legal services to obtain information about the adult's legal rights; and
(b) use of legal services to undertake a transaction; and
(c) use of legal services to bring or defend a proceeding before a court, tribunal or other entity, including an application under the *Succession Act 1981*, part 4 or an application for compensation arising from a compulsory acquisition; and
(d) bringing or defending a proceeding, including settling a claim, whether before or after the start of a proceeding.

It has come to Independent Advocacy's attention that our clients who have a current appointed guardian are not, and historically have not, attended these hearings in any capacity, nor have they facilitated any legal support for the clients for the MHRT hearings. Upon contacting the Adult Guardian Information Hotline to clarify why this is the case, IAT were advised that guardians of clients on MHA orders do not attend MHRT hearings for clients in any way as the guardian is not *required* to attend these tribunal hearings. When further clarification was sought, IAT were advised that "*the MHA overrides the GAA so there is no requirement for a "decision maker" to attend the hearing*". This advice was obviously disconcerting from an advocacy viewpoint, as it seems logical that both Acts should work complementarily, ensuring the current decision-maker for the client remains aware and informed of the client's overall status, particularly as this client has a significant ongoing illness. These hearings include extensive discussion surrounding client treatment plans, ongoing health matters, service provision and accommodation issues, all of which are paramount to the client's ability to effectively recover from their illness.

IAT made a submission to the Queensland Civil and Administrative Tribunal that Adult Guardians have not been providing their clients with sufficient support and liaison when clients have had to attend their Mental Health Review Tribunal hearings. Of all hearings IAT have attended where a client has an adult guardian, there has been a concerning and distinct lack of participation from the appointed guardian. When the Adult Guardian plays such an important role as decision maker in an individual's life, to have them not attend appears to be of detriment to the client when such matters are discussed.

One key factor in having a client come off either an ITO or Forensic Order is for the client to be able to demonstrate they can access the community in a way that will ensure ongoing safety to the community as well as themselves, however when a guardian is appointed for matters such as service provision and a client does not have access to the service because they are on a register of need, a guardian will not realise the importance of having their client prioritised to be able to access support services to give the clients access to the community. What happens then is that the client continually sits on the register of need whilst locked up in a secure mental health facility, and their order drags on longer than necessary because they haven't been able to demonstrate their ability to function in the community.

Independent Advocacy have had a similar matter heard before the Queensland Civil and Administrative Tribunal where these points were not only identified by the tribunal, but agreed and acted upon, resulting in the appointment of a guardian for legal matters for this client. We feel this decision has set a precedent for not only our clients who are in a similar position, but for any client who falls under both the MHA and the GAA.

Legal support specialists

Independent Advocacy has identified a distinct lack of legal support services with specialisation in the Mental Health Act in the North Queensland region and recommends that Legal Aid funding be allocated to a specialist legal team who deal with all matters relating to the Mental Health Act. This team would need to cover at the very least the Townsville region, but could extend to the Cairns region. It can be seen from data that the North Queensland region has just as many clients on Forensic Orders as the Metro Brisbane area, however Townsville does not have nearly the number of quality of legal services available as the Brisbane area does.

References

QAI - www.qai.org.au

QCAT - www.qcat.qld.gov.au
Reference no. G10369 - Observation and participation in hearing

MHRT - www.mhrt.qld.gov.au

Annual report - http://www.mhrt.qld.gov.au/wp-content/uploads/2013/01/MHRT-Annual-Report-2012.pdf

Mental Health Act 2000 - http://www.mhrt.qld.gov.au/wp-content/uploads/2010/01/mentalhealthAct2000-010710.pdf

Director of Mental Health Annual Report -
http://www.health.qld.gov.au/mha2000/documents/annualrpt_2012.pdf

Position description for MHRT panel member http://www.mhrt.qld.gov.au/?page_id=1722

Queensland Health – www.health.qld.gov.au

Aboriginal and Torres Strait Islander Legal Service – www.atsils.org.au

Office of the Adult Guardian
http://www.justice.qld.gov.au/justice-services/guardianship/adult-guardian

Annual report - http://www.justice.qld.gov.au/__data/assets/pdf_file/0008/171179/office-of-the-adult-guardian-annual-report-2011-12.pdf

Guardianship and Administration Act 2000 -
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf

Queensland Criminal Justice Centre – http://www.qcjc.com.au/

Disability and the Queensland Criminal Justice System – Dan Toombs ISBN: 9780455229966

CAGQ telephone link up – discussion of the role of capacity -
http://www.qai.org.au/index.php?option=com_content&view=article&id=37&Itemid=45

Closing the Gap Initiative - http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/programs-services/closing-the-gap

Table 1. MHRT Annual Report Data

	Number of sittings	Number of hearings	Hearings/Tribunal	Number of Adjournments	% Hearings adjourned	Number of Forensic orders reviewed	Number of ITO's reviewed	No ECTs	Total Matters	Overdue matters	% overdue matters	Report received < 6 days prior	Report received between 3 to 6 days prior	Report received 1 to 2 days prior	Report received same day as hearing	Total reports not submitted on time	Report received after hearing	No clinical report received	Psych attended	Registrar and Other doc attended	Nurse and case manager attended	cultural support attended	Inpatient attended	Outpatient attended	Allied person other support attended
Cairns	**100**	**789**	**7.9**	**117**	**14.4**	**100**	**666**	**27**	**813**	**25**	**3.1**	**321**	**255**	**65**	**42**	**683**	**1**	**56**	**134**	**133**	**593**	**15**	**56**	**222**	**254**
Cairns Percentage from Total	**6%**	**7%**		**7%**		**6%**	**8%**	**5%**	**7%**	**7%**		**8%**	**9%**	**6%**	**2%**	**25%**	**5%**	**11%**	**4%**	**6%**	**8%**	**15%**	**3%**	**8%**	**7%**
Royal Brisbane and Women's Hospital	**164**	**1420**	**8.7**	**269**	**18.4**	**104**	**1250**	**72**	**1463**	**30**	**2.1**	**370**	**240**	**43**	**581**	**1234**	**4**	**50**	**324**	**242**	**876**	**2**	**132**	**337**	**204**
Royal Brisbane and Women's Hospital Percentage from Total	**11%**	**13%**		**17%**		**7%**	**14%**	**13%**	**13%**	**8%**		**9%**	**9%**	**4%**	**33%**	**54%**	**19%**	**10%**	**9%**	**10%**	**12%**	**2%**	**7%**	**12%**	**6%**
Townsville	**83**	**660**	**8**	**144**	**20.6**	**140**	**507**	**15**	**699**	**18**	**2.6**	**235**	**159**	**85**	**89**	**568**	**1**	**85**	**192**	**141**	**437**	**25**	**144**	**158**	**299**
Townsville Percentage from Total	**5%**	**6%**		**9%**		**9%**	**6%**	**3%**	**6%**	**5%**		**6%**	**6%**	**7%**	**5%**	**24%**	**5%**	**17%**	**6%**	**6%**	**6%**	**25%**	**8%**	**5%**	**9%**
The Park-Centre for Mental Health	98	788	8	99	11.9	119	628	44	834	17	2	293	264	85	72	714	3	28	198	193	547	0	123	226	269
The Park-Centre for Mental Health Percentage from Total	**6%**	**7%**		**6%**		**8%**	**7%**	**8%**	**7%**	**5%**		**7%**	**10%**	**7%**	**4%**	**28%**	**14%**	**6%**	**6%**	**8%**	**7%**	**0%**	**7%**	**8%**	**8%**
TOTAL	**1549**	**10972**	**7.10%**	**1628**	**14.10%**	**1583**	**8871**	**538**	**11584**	**359**	**0.031**	**3997**	**2731**	**1171**	**1787**	**9686**	**21**	**492**	**3462**	**2344**	**7310**	**99**	**1809**	**2910**	**3402**
Percent	13.4	94.7	7.10%	14.1	14.10%	13.7	76.6	4.6	100	3.1	3.10%	38.12	26.05	11.17	17.04	92.38	0.2	4.69	33	22.4	69.7	0.9	17.3	27.8	32.4

Table 2. Independent Advocacy Client Data

Client	Age	Gender	Cultural Background	MH Diagnosis	Other orders in place	Type of order	Legal Support provided	Report received 7 days prior	Client attended hearing
2013-0001	42	M	Non-ATSI	Chronic paranoid schizophrenia	None	Forensic order	None - QAI were contacted and could provide legal advice but no representation. Legal Aid were unable to provide advice or representation	No	Yes. Client spoke on behalf of himself as well.
2013-0002	48	F	Non-ATSI	Schizophrenia	Public Trustee, Adult Guardian	Involuntary Treatment Order	No legal support provided. LAQ were unable to assist, QAI provided general legal advice but no representation.	No	No
2013-0003	38	M	ATSI	Schizo-affective disorder, substance abuse disorder, mild intellectual disability	Public Trustee	Forensic order	ATSILS provided legal representation and advice	Yes	Yes
2013-0004	58	F	ATSI	Mood disorder, dementia, type 2 diabetes	Public Trustee, Adult Guardian	Involuntary Treatment Order	ATSILS provided legal representation and advice	No	Yes
2013-0005	45	M	ATSI	Dementia secondary to alcohol abuse, epilepsy, type 2 diabetes, hypothyroidism	Public Trustee, Adult Guardian	Forensic order	No Legal support provided	No	No
2013-0006	38	F	Non-ATSI	Paranoid schizophrenia	None	Forensic order	Legal advice provided by QAI, but no representation	No	No
2013-0007	48	M	ATSI	Acquired brain injury, polysubstance abuse, organic personality disorder	None	Forensic order	ATSILS provided legal representation and advice	No	Yes
2013-0008	42	M	ATSI	Paranoid schizophrenia, substance abuse disorder, borderline learning disability	Public Trustee	Forensic order	ATSILS provided legal representation and advice	Yes	Yes
2013-0009	44	M	Non-ATSI	Schizoaffective disorder	Public Trustee, Adult Guardian	Involuntary Treatment Order	No Legal support provided	Yes	No
2013-0010	42	M	ATSI	Resistant paranoid schizophrenia	Public Trustee, Adult Guardian	Involuntary Treatment Order	No Legal support provided	Yes. Provided by advocate	Yes
2013-0011	26	M	ATSI	Schizophrenia	Public Trustee	Involuntary Treatment Order	Unknown	Unknown	Unknown
2013-0012	46	M	Non-ATSI	Organic personality and behavioural disorder resultant to brain damage and function	Public Trustee, Adult Guardian	Forensic order	Unknown	Unknown	Unknown
2013-0013	38	M	ATSI	Paranoid schizophrenia	None	Forensic order	Legal advice provided by QAI, but no representation	Unknown	Unknown
2013-0014	27	M	ATSI	Intellectual disability, foetal alcohol syndrome	Public Trustee, Adult Guardian	Disability Forensic Order	No Legal support provided. ATSILS contacted but unable to provide. QAI were able to provide legal advice but no representation	No	Yes
2013-0015	54	F	Non-ATSI	Schizophrenia, cluster B traits	Adult Guardian, Public Trustee	Forensic order	No legal support provided	No	Yes
2013-0016	52	M	ATSI	Schizophrenia, dementia	Public Trustee	Forensic order	ATSILS provided legal representation and advice	No	Yes
2013-0017	31	F	Non-ATSI	Schizoaffective disorder	None	ITO	No Legal support provided. QAI advised were unable to assist. LAQ were not contacted.	Yes	Yes
2013-0018	34	F	ATSI	Schizoaffective disorder, manic type, behavioural disorder resulting from solvent abuse	Adult Guardian, Public Trustee	ITO - REVOKED	No legal support provided	Unknown	Hearing cancelled before attendance required
2013-0019	31	M	Non-ATSI	Bipolar affective disorder	None	Forensic order REVOKED	QAI provided legal support	No	yes
2013-0020	30	M	Non-ATSI	unknown	None	Unknown	Unknown	Unknown	Unknown
2013-0021	22	M	Non-ATSI	unknown	None	Unknown	Unknown	Unknown	Unknown
2013-0022	61	F	Non-ATSI	unknown	Public Trustee	ITO	Unknown	Unknown	yes
2013-0023	40	M	Non-ATSI	Schizophrenia	unknown	Forensic Order	QAI provided legal support	Unknown	Unknown