Acknowledgements

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This project and report has been produced with the financial support of Centacare Far North Queensland Partners In Recovery who share the vision to promote the values of wellness, recovery and community collaboration and to support the dignity, equality and participation of all people.

We welcome continued conversations that increase attendance and representation at the Queensland Mental Health Review Tribunal and your feedback on this report.

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Disclaimer

The views and recommendations in this report may not necessarily reflect those of Rights In Action or FNQ Partners In Recovery.

All direct quotes in this report are excerpts from the community forums, one on one and small group meetings, anonymous questionnaires and material obtained during and post the consultation process.

The report is a useful way to bring together the voices of people with lived experience, their families, carers and significant others, community and health service providers, legal practitioners and other interested persons.

By identifying and discussing the issues in this way, new ideas and solutions may be discovered. This information, in conjunction with other evidence and data may inform future Mental Health services, community awareness and legislation.
Executive Summary

This project was commissioned through the FNQ Partners in Recovery Initiative and was conducted by Rights in Action between July and December 2015.

Representation for People in the Mental Health System aimed to assess and evaluate the effectiveness of the mental health system with regards to the processes around involuntary treatment orders (ITOs) and the Mental Health Review Tribunal (MHRT), with a focus on attendance and representation at MHRT hearings.

The overall objective of the project was to facilitate recovery by improving people’s understanding of their rights, choices and access to supports within the mental health system. The removal of the rights of people with lived experience to determine their own treatment and associated processes can be detrimental to recovery and self-determination, and impact on friends, family, relationships with mental health providers, community services and the broader community.

Queensland has the lowest attendance and representation rates at the MHRT in Australia. Attendance and representation rates in the Cairns region are lower than that of Queensland. Changes to the Mental Health Act 2000 (Qld) provided an opportunity for increased participation and conversation around these processes.

Throughout the consultation period of the project, 70 people attended forums and over 150 people were directly contacted and engaged with regarding the report, predominantly in face to face meetings. This included 43 people with lived experience, as well as carers, family members and significant others, legal practitioners and 90 individual community and health workers from 29 local organisations. This was done through five forums, anonymous questionnaire and feedback forms, small group and one on one meetings and other flexible engagement based on community members.
The project aimed to:

- Gain feedback and perspectives from people on long term ITOs, their carers, family members, significant others, health and community service providers, and legal practitioners on where the project needed to go and recommendations for systemic reform
- Identify the discussion, training and education needed by community members to effectively participate in mental health system processes
- Provide information on legal and advocacy processes, including resources to promote self-determination and engagement

Through this consultation and information gathering process, a number of barriers to engagement with the system when on an ITO were highlighted, as well as what was working well. Key issues raised were in the areas of attendance and representation at a MHRT hearing, preparation for a hearing and continuity of care.

Based on this feedback, a number of recommendations were made (refer to Recommendations, pg. 74-77). Recommendations were identified based on the issues most frequently raised and determined as priorities by community members and the issues that impact most detrimentally on the recovery and the human rights of persons on ITOs.
Introduction
Introduction

Rationale

This project was established as a result of feedback from people on involuntary treatment orders (ITOs), carers, family members, significant others, service providers and lawyers, of the challenges faced when a person is on an ITO. It is acknowledged that these experiences also impact on family, friends, relationships with mental health providers, community services and the broader community.

Statistics\(^1\) from the Mental Health Review Tribunal (MHRT) indicate that in Australia, Queensland has the lowest rates of attendance at MHRT hearings at 39%. It also has the lowest rates of legal representation at 2.3%. Rates for the Cairns region are even lower. There was only 31% attendance by the person on the ITO. Only 0.7% of hearings involved legal representation. The Cairns region refers to the area that the Authorised Mental Health Service (AMHS) covers. This spans an area from Tully to the Torres Strait Islands.
With a new Mental Health Act expected to be introduced in Queensland in 2016, an opportunity was taken to examine how the current system impacts on people’s lives with the aim to improve experiences in the future. Changes in mental health legislation will impact people’s rights and the MHRT processes. It is hoped that community feedback will influence the government provision of education and information when the legislation is implemented; and also inform ongoing community education and information provision in this area.

An advocacy systemic reform framework was utilised that focused on conveying what is and is not working through the voices of the community and consequent recommendations. The direction of the project was driven by the community and developed organically as interested persons identified key issues.

It is based on the foundation that people have a right to understand the processes that affect them and participate in decision making around their lives. There was an assumption made that improving the understanding of rights, choices and supports within the mental health system could improve engagement and contribute to recovery. The more informed people are, the more effectively they can engage with the system.

**Involuntary treatment order (ITO)**
An ITO is an order made by an authorised doctor or psychiatrist 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.

**Mental Health Review Tribunal**
The MHRT is an independent statutory body whose primary purpose is to review the involuntary treatment of people with mental illness. The Tribunal decides if an ITO is revoked or continued based on whether the treatment criteria is met.
Mental Health Act

The purpose of the Mental Health Act is to provide for the involuntary assessment, treatment and protection of persons who have mental illness, while at the same time: safeguarding their rights and freedoms; and balancing their rights and freedoms with the rights and freedoms of other persons. Any power exercised under the Mental Health Act that affects the liberty and rights of the person should be exercised only if there is no less restrictive way to protect the person’s health and safety or to protect others.

The purpose of a MHRT hearing (sometimes called a review) is to safeguard the rights of a person receiving involuntary treatment for mental illness. The MHRT reviews the case presented by the treating team as to why a person should be on an ITO. The case presented by the treating team must satisfy all the treatment criteria. If it does not, then the MHRT is required to revoke the ITO. Attendance and representation enables the voice of the person on the ITO to be heard at the hearing. If the person’s voice is not present, then the Tribunal relies only on the perspective of the treating team and is unable to ensure that person’s rights are protected.

Treatment criteria

The treatment criteria for a person must all be met:
(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 may cause harm to himself, herself or someone else; or
   (ii) the person is likely to suffer serious mental or physical deterioration;
(e) there is no less restrictive way of ensuring the person receives appropriate treatment for the illness;
(f) the person –
   (i) lacks the capacity to consent to be treated for the illness; or
   (ii) has unreasonably refused proposed treatment for the illness: s 14(1), MHA.

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: s 14(2), MHA.
Scope of Project

This project sought to explore the barriers or issues related to attendance and representation at MHRT hearings for people on ITOs.

By engaging with a range of stakeholders affected by these processes, this project hoped to provide a snapshot of the Cairns area from the perspectives of those affected, as well as identify current gaps in the system to be addressed.

A lack of understanding and knowledge around the processes involved with regards to ITOs was acknowledged at the outset of this project. An important component of the project involved providing opportunities for people to increase their knowledge and identify what further discussion, training and education might be need by the community to improve engagement and a sense of self-determination.

Information was provided on current legal and advocacy processes through five forums in Cairns City with legal practitioners, service providers, people with lived experience and carers, family members and significant others. The core focus of the project was derived from community consultation and feedback at these forums.

Further feedback was gained from one on one and small group meetings, anonymous questionnaires, emails and teleconference calls with people with lived experience, carers, family members, service providers, legal practitioners, clinicians, members of the...
Queensland MHRT and of the equivalent Mental Health Review Tribunals in other states. Opportunities were taken to disseminate information and increase awareness through E-Bulletins and any contact with community members.

It is important to highlight that this was not a research project. In some areas comparisons between Queensland and other states are included to contextualise local statistics. The reasons for differences have not been explored, but could be an exciting area to pursue when looking for possible improvements to our mental health system. Research has only been undertaken when it has related specifically to community feedback on ITOs and MHRT processes.

**Objectives**

The objective of the project was to facilitate recovery through improving the communities understanding of their rights, choices and supports within the mental health system, specifically for those on ITOs and engaging with the MHRT.

Aims included increased representation and decision making for people engaging in the mental health system, increased sense of self-determination for these individuals, and increased awareness of the Mental Health Act among all stakeholders in order to promote social justice. It was hoped that improvements in these areas would assist in facilitating recovery.

Key issues in this area became clearer during the process of the project. Feedback indicated that increasing understanding, attendance, preparation for and representation at MHRT hearings can improve people’s experiences with this part of the mental health system. Continuity of care was also highlighted as an important issue in relation to people on ITOs. This feedback makes up the body of this report and was the foundation on which the recommendations were based.

1 Unless stated otherwise, all statistics in this report are from the Queensland Mental Health Review Tribunal 2014/2015 Annual Report
2 Mental Health Act 2000 (Qld) (Current as at 1 September 2015)
3 NSW Mental Health Review Tribunal 2014/15 Annual Report
Victoria Mental Health Tribunal 2014/2015 Annual Report
The Consultation Process

Project Outcomes
The Consultation Process

*Representation for People in the Mental Health System* took place between July and December 2015. Community consultation ran for a period of four months with the aim of providing community members with information on rights, choices and supports within the mental health system as well as receiving feedback on what ongoing discussion, training and education was needed by the community in this area. Community members who provided feedback were predominantly located in the Cairns City area, and some in the broader Cairns region between Mossman and Yarrabah.

It was a flexible process that sought feedback from as many interested stakeholders as possible through a number of methods of engagement. The engagement processes were open for adaptation based on what the participant or group preferred. The process of consultation involved the following:

**Forums**

Five forums were held over the 27th – 28th August 2015. Solicitor Julie Hearnden from Queensland Advocacy Incorporated (QAI) presented at every forum, sharing her in depth knowledge on mental health legislation and experiences working in the Mental Health Legal Service. Barry Thomas, President of the Mental Health Review Tribunal (MHRT) presented on the 27th and was able to provide unique insight into MHRT processes and opportunities for participation from stakeholders in these circumstances. Forums on the 27th were also attended by a representative of the Mental Health Commission and a Senior Clinician from Queensland Health.

70 people attended the forums from the Cairns community, including persons with lived experience, carers, family members, significant others, service providers, legal practitioners and other interested persons. Minutes were taken at the meetings including comments by the speakers and audience members; and questions from audience members. Discussion was encouraged throughout the forums.
Evaluation Forms

Four distinct evaluation forms were provided at the forums for different community groups. These evaluation forms were anonymous. There was an option on the form to provide personal details if participants wanted to be further involved with the project. The data gained from these forms was utilised anonymously. 45 evaluation forms were filled out and returned. The forms provided a range of questions and room for comments. The subject matter covered: experience with ITOs and the MHRT; barriers and improvements.

Overall feedback from the forums included:

- Overall understanding of the Mental Health Act (particularly involuntary treatment orders) was at 51.7% prior to the forum and increased to 69.8% post forum.

- Over 85% of all attendees indicated they would be interested in more information regarding mental health legislation, further information and updates on this project and a copy of the final report.

- 100% of attendees asked said they found the forums useful. Most attendees agreed that the most useful information provided was around the changes to the mental health legislation and the MHRT process.

- 100% of attendees asked said a Patient Rights Adviser role would be useful and 91% indicated that the role should be independent.

This suggests community interest in these issues and the need for the provision of this information. Feedback from specific community groups included:

- **Legal practitioners**
  - All legal practitioners who filled out evaluation forms indicated that they would consider representing people on ITOs at the MHRT with reference to a number of circumstances. These included the provision of appropriate state or federal funding to assist; fee for service; pro bono; fee for service at a concession rate for pension or low-income earners; and with Legal Aid grants.

- There was discussion around representing people who have limited capacity to advise a legal representative and issues pertaining to this (see Appendices for resources for legal practitioners, pg. 82).

- Queensland Advocacy Incorporated encouraged lawyers to contact QAI for advice or assistance and referrals for complex mental health cases.
• Carers, family members, significant others (referred to as support persons in this report)

- Key issues raised included a lack of advanced notice for support persons and the person on an ITO regarding their MHRT hearing dates, and the provision of clinical reports prior to the hearing.

- A particular interest was expressed concerning the rights and obligations of allied persons, and the processes relating to this. All support persons who contributed feedback said that they felt they didn’t have access to adequate information about mental health legislation and MHRT processes.

- The barrier most frequently identified by this group was a lack of access to information due to confidentiality reasons protecting the person on the ITO. The majority of carers recognised this as a legitimate reason but highlighted the necessity of their inclusion in some discussions due to the significant role they play in ongoing care and support for a person.

• Service providers (also referred to as health and community workers in this report)

- Key issues raised included the need for community awareness about rights and obligations under the Mental Health Act; access to information and advocacy in the Cairns area; systemic issues faced by people on ITOs, with particular concerns for persons on forensic orders; and the preference for a Patient Rights Adviser role to be independent.
- **Persons with lived experience (this refers to a person who has a lived experience of mental illness or mental health issues)**

  - A sense of confusion around ITOs and MHRT processes was expressed by the majority of persons with lived experience who contributed to this project. Consequences of this lack of understanding included feelings of stress and being overwhelmed; finding it easier to disengage rather than participate; and a sense that a person is unable to influence decision making around their lives even if they did participate.

  - It was particularly concerning that some people with lived experience perceived that ITOs were permanent.

  - It was consistently stated by persons with lived experience that there needs to be choice around the method through which information is provided as people engage differently.

  - A number of health workers from different services also expressed this concern. This misperception can result in a sense of hopelessness for some people and impacts on engagement with the MHRT process that has been established to protect a person’s rights.

  - There was an overwhelming amount of feedback from Aboriginal and Torres Strait Islander health and community workers that this was a common perception among Aboriginal and Torres Strait Islander people on ITOs.

  - It was consistently stated by persons with lived experience that there needs to be choice around the method through which information is provided as people engage differently.
Questionnaires
An anonymous questionnaire specifically for people with lived experience was distributed through community channels between September and October 2015. This questionnaire was available in hardcopy at services identified as engaging with people who may have been or currently are on ITOs.

Face to Face Engagement
Face to face meetings and teleconferences were facilitated throughout the project. These conversations consisted mainly of explaining what the project hoped to achieve, providing information or directing people to resources and receiving comments or stories from community members based on what they determined was relevant. People with lived experience most frequently selected one on one meetings as their preferred way of receiving information. There were efforts made not to interview or structure discussion with community members as Rights in Action intended the project to develop based on community feedback on issues. In this way, those who engaged with the project were able to pass on information that they had received to others, and this seemed to prompt an increase in the number of individuals and services who contacted Rights in Action to request information and offer feedback of their own experiences. Through these channels, community members recommended other community members and conversation was instigated in the broader community around ITO processes. There were no criteria limiting who could contribute.

There was recognition that many people would not feel comfortable in a face to face discussion with persons they may not have met before. For this reason, all people were encouraged to provide comments in any way they felt comfortable with. This resulted in some people sending emails to Rights in Action. All feedback was de-identified. Any person who provided a comment or contributed in any way was made aware that they could retract their contribution at any time.

Further Investigation
Literature, feedback and information from the MHRT, Queensland Advocacy Incorporated (QAI), the Queensland Public Interest Law Clearing House (QPILCH), Queensland Health and others assisted in the provision of information to increase community awareness around rights and resources (see Reference List, pg. 87-88).
The collation of all project feedback highlighted an overwhelming sense of confusion and lack of knowledge and understanding exhibited by all stakeholders in reference to rights when on involuntary treatment orders (ITOs), Mental Health Review Tribunal (MHRT) processes and the different roles at MHRT hearings. There were few community members from any group that had a comprehensive understanding of these issues. Local Tribunal members reflected that this can impact negatively on the effective running of a hearing and this affects the safeguarding of a person’s rights.

The small portion of community members who indicated that they felt confident in their understanding of the role of the MHRT and associated processes reported more positive experiences. This also included an understanding of reasons for attending the MHRT; preparation before a hearing; and knowledge of and access to supports and representation at the MHRT hearing.

This suggests that it is possible for people who are on ITOs to have an increased sense of self-determination and decision making in MHRT processes. There was widespread recognition in the community of the need for all stakeholders to have an understanding of mental health legislation, particularly rights when receiving involuntary treatment, and MHRT processes.
Why is Knowing Your Rights Important to You?

People said:
- “Knowing one’s rights and access thereof, enables consumers to have individual service delivery and personalised outcomes. Ultimately, for consumers to reach and gain full potential and recovery”
- “Then I would be able to speak for myself and not forced to do things, I don’t want”
- “So then it would better help the outcome”
- “Because I’m not sure why I’m still on it”
- “So I know what to say and do what right for me”
- “Allow for more informed decisions. Sense of participation as opposed to having things done to me”
- “Very important”
- “Reduce anxiety”
- “For a complete understanding of the issue”
- “To assist preventing the feeling that you do not have any control over outcomes”
People with lived experience

- **Information packs**

Currently, an orientation booklet and collection of information sheets is provided to patients entering the Mental Health Unit. For information on rights, the orientation booklet refers to MHRT brochures that should be available in the Mental Health Unit. If a person is put on an ITO then they receive an envelope with a photocopy of the MHRT brochure on rights as an involuntary patient and a person’s right to choose an allied person as well as the form for nominating an allied person.

Persons with lived experience said that existing processes were not sufficient to ensure understanding of rights, choices and available supports when on an ITO. Persons suggested a more comprehensive information pack be available from the Mental Health Unit and Cairns and Hinterland Mental Health and ATOD Service and abundantly at community access points, such as at GPs and appropriate service providers. Content of the pack would include general information on mental illness and social and emotional wellbeing; human rights; local services; mental health legislation including ITOs; and information for support persons and allied persons, as well as suggestions for people to contact so that a person is able to identify possible supports.

People may be unwell at the time of receiving a pack and highlighted the need for professional and personal supports to continue to follow up with a person around their understanding. As well, it should be a responsibility of the person who gives the information pack out to establish whether the person receiving the pack has any supports that may assist them to continue to engage with the information and make efforts to notify that support.

- **Information sheets and other diverse formats**

Health workers said that previously the MHRT sent brochures and DVDs to people with lived experience. These are no longer readily available in the community. Some health services need to print out the

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**Recommendation**

Increased and accessible training, education and information on people’s rights; mental health legislation; and MHRT processes for all stakeholders provided in ways that are relevant and effective to each group.
MHRT information brochures themselves. Processes should be in place to ensure the distribution of such resources is maintained.

- **Self-advocacy groups and peer support training**
  Benefits of receiving information from others with lived experience were identified as non-judgment; natural empathy; and being able to put your story on the table without competing. More access to self-advocacy groups where information can be engaged with and discussed in a safe place as well as peer support training to increase the availability of peer workers were suggested.

- **Consumer Companions**
  This role was valued for its capacity to establish relationships, have relaxed conversations and work alongside inpatients to address any issues they might have, including a lack of understanding around ITOs and the MHRT. A person with lived experience said that in order to access resources, you need to know they exist. A Consumer Companion assists with raising awareness about existing resources. The role of the Patient Rights Adviser in the proposed new legislation is also relevant here (refer to Continuity of Care, pg. 57-65).

- **General community discussion and awareness raising**
  Increased awareness for all stakeholders can assist in ensuring the understanding of the person on the ITO as they engage with a number of different people at different times. As well, understanding in this area should break down stigma and discrimination against people on ITOs.

**Carers, family members and significant others (support persons)**

- **A central point of contact for information and referrals to appropriate services**
  Suggestions to implement this include through the Patient Rights Adviser role (Pg. 59-61), a phoneline or educational forums. It was emphasised that being able to talk to and receive information from community and health workers, as well as members of a person’s treating team was very useful.
Staff working with people with lived experience at Queensland Health and other service providers (community and health workers)

- **Compulsory training regarding mental health legislation and MHRT processes from a human rights perspective**
  It is recognised that health and community workers have a range of mandatory and other training available in the community. Unless staff have undergone training that specifically covers mental health legislation (such as becoming an authorised mental health practitioner), most community and health workers said that they were not confident in their understanding of ITO and MHRT processes or where they could find this information.

These stakeholders are perfectly situated to provide this information to other community members. This training should highlight each professional’s role in protecting the rights of a person receiving involuntary treatment. A person should be aware of the rights they do have and feel they are able to continue to contribute to decision making around their lives.

Challenges identified by health staff include the turnover of staff in treating teams (psychiatrist, case manager) and in the Mental Health Unit, the size and multiple locations of the Mental Health Unit, large caseloads, and a lack of communication between inpatient and community staff (working with persons on ITOs living in the community) and between staff in both areas.

Challenges identified by community staff include the broadness of the term ‘community worker’ and the inconsistency of training required by these workers depending on where they are employed.

**Legal practitioners (and others wanting to understand the role of legal representation at the MHRT)**

- **Webinars**
  Due to the regional location of Cairns, it can be difficult to have regular training available. The production of a webinar on representing people at a MHRT hearing could address this.

- **Mental Health Legal Service**
  Consultation with community legal centres post the legal forum resulted in discussions around how a Mental Health Legal Service might be facilitated in the region.

**Allied persons (this term may become nominees in the new legislation)**

- **Information packs and education forums**
  When a person becomes nominated as an allied person, they should be immediately provided with information on their role and MHRT processes as well as how they can
access more information or advice. This should be further explored, but could be existing MHRT resources such as brochures and DVDs. Education forums were also nominated as an ideal way to disseminate information.

**Aboriginal and Torres Strait Islander peoples**

- **Training, resources and educational forums from a cultural perspective and facilitated or informed by Aboriginal and Torres Strait Islander people from the local area**

  This was highlighted by all Aboriginal and Torres Strait Islander people who contributed to the project. Due to time constraints and community feedback from a range of service providers, cultural advisers and other relevant persons, a recommendation will be made for the establishment of a similar project with a focus on Aboriginal and Torres Strait Islander people on ITOs. This would elaborate on appropriate recommendations for Aboriginal and Torres Strait Islander people engaging with the mental health system from the perspective of Aboriginal and Torres Strait Islander people (refer to Aboriginal and Torres Strait Islander people on ITOs, pg. 67-70).

- **Pictorial resources**

  The development of pictorial resources to convey information was emphasised by almost all Aboriginal and Torres Strait Islander health and community workers that engaged with the project. This was identified as the best form of communication and also able to address language barriers.

  Pictorial resources were identified as useful for those who have issues with literacy, people with disabilities and for people from culturally and linguistically diverse backgrounds.

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**Recommendation**

The MHRT must be adequately resourced to develop, disseminate and coordinate training, education and information resources to support all stakeholders in Queensland.
Key Issues
Attending the Mental Health Review Tribunal
Key Issues

Attending the Mental Health Review Tribunal

Queensland has the lowest attendance rates for people on involuntary treatment orders (ITOs) attending their Mental Health Review Tribunal (MHRT) hearings in Australia. Attendance rates in Cairns are even lower than state wide averages.

In Cairns, only 31% of people on ITOs attend their hearings compared with 39% state wide. If a person attends their hearing, they are ten times more likely to have their ITO revoked. Local Tribunal members said that it is unlikely that an order would be revoked if the person wasn’t present. This is because the treating psychiatrist can revoke it at any time.
It is optional for people to attend their hearings. People stated that they would only attend a MHRT hearing if there were positive and meaningful outcomes associated with it. Positive feedback from Cairns community members regarding attending a MHRT hearing included:

- The hearing providing a platform for all relevant people in a person’s life to speak openly and honestly about the reasons a person might be receiving involuntary treatment and issues to be addressed. A person has the opportunity to ask questions of all the people giving information at the hearing,

  “There was a lot of things that came out (at the hearing) that I didn’t know about my illnesses. I’m glad they were honest with me. Then I could go and talk to my psychiatrist about it”
  (Person with lived experience)

- A person on an ITO having the opportunity to have their voice heard and participate meaningfully in decision making regarding their own lives and mental health,

  “Once you’re in the hearing with the individual they are astonished at what the process is like. They [MHRT] do give the person a voice, they do ask questions. Individuals are surprised”
  (Health worker)

- A person’s ITO being revoked,

  “Some people attend after not attending for a while and it’s possible they may not have needed to be on an ITO for so long”
  (Legal representative)

- A person being able to use the discussion at the hearing to inform their own plan regarding their mental health and recovery, particularly for those whose ITOs are not revoked,

  “They can be really disappointed, but at least they’ve had a go, and had the opportunity to have a go – they’ve participated in their care plan. The more say you have in your care plan, it’s measurable to yourself”
  (Person with lived experience)

Unfortunately, the majority of feedback from people who are or have been on ITOs identified that there were a variety of barriers to a person attending their hearing. These included perceptions that their voice would not be heard and listened to at the Tribunal, feeling that the ITO was a form of punishment rather than a part of their recovery, as well as practical issues.
We Asked People, What Would Help You Attend?

Knowing Why I Am Going

The Tribunal is required to review your ITO within the first six weeks and then every six months. Reviews are carried out by way of a hearing. This means the Tribunal hears from the person on the ITO, their treating team and any other relevant people. The role of the MHRT is to balance the right of the patient to receive treatment with their right to autonomy and community safety. The person has the right to receive treatment in ways that enhance their quality of life and is least restrictive of their rights and liberty. The MHRT is required to encourage and respect the participation of a person and their representation.

There is widespread confusion around the purpose of the MHRT (refer to Project Outcomes, pg. 16-21). This appears to be a fundamental reason for people not attending their hearings. In addition, many people found it difficult to differentiate between the health and justice systems if they were engaged in both. People have a right to be well informed about their mental health care treatment.

“There can be a double disadvantage if people experience mental illness and alcohol and other drugs, intellectual disability or acquired brain injury. I don’t think they understand the Tribunal and how this part of the system actually works to protect them”

(Community worker)

YOU HAVE THE RIGHT TO ATTEND YOUR HEARING AND PUT FORWARD YOUR VIEWS

YOU HAVE THE RIGHT TO A FAIR AND TIMELY INDEPENDENT REVIEW
Knowing Who The MHRT Are

The MHRT is an independent statutory body that reviews ITOs. Its mission is to protect the rights and dignity of people in Queensland who receive involuntary treatment under the law. It aims to be fair and impartial. The MHRT is not part of Queensland Health or any Health Service.

It was concerning that persons on an ITO, their support persons and community and health workers who participated in this project perceived that the MHRT was part of Queensland Health. This assumption led to people not believing it was worth attending the hearing because it was a “rubber stamp” in favour of the treating team.

“Some people were aware that the MHRT is independent to Queensland Health, but believed that the treating psychiatrist made the decision on whether the ITO was continued.

“Psychiatrists, they have enormous power. What they say goes and everyone has to agree... Because when you’re in hospital, it’s their rules, it’s their house”

YOU HAVE THE RIGHT TO NATURAL JUSTICE

Natural Justice

Natural justice is concerned with the procedures used by the MHRT Tribunal members, rather than the outcome reached. It requires a fair and proper procedure be used when making a decision. The principles of natural justice include fairness, transparency, equality before the law, freedom from bias and the right to be heard.
Knowing Who Will Be There and Why

The Tribunal panel is normally made up of three members including a legal member, a psychiatrist (or another doctor if a psychiatrist is unavailable), and another person who is not a doctor or lawyer. This person is a community member with mental health experience. They may be a person with lived experience, a carer or an Aboriginal and Torres Strait Islander person for Aboriginal and Torres Strait Islander people attending hearings. These people are employed by the MHRT and they make the decisions at the hearing.

In Cairns, the psychiatrist panel member sits in Brisbane via videolink. Aboriginal and Torres Strait Islander community and health workers identified this as a particular issue for Aboriginal and Torres Strait Islander persons on ITOs.

Members of a person’s treating team will also be present at a hearing. It is most likely that a person’s case manager will attend or nurse if the person is currently staying in the Mental Health Unit (73%). It is also possible that the person’s psychiatrist (sometimes referred to as the treating, consultant or authorised psychiatrist) will be there (15%), the registrar or another doctor (11%) and a cultural support (0.01%). A cultural support would only be relevant for those persons who required a cultural support. The MHRT will make arrangements for a cultural support person or a language or sign interpreter to be present if this is requested. This is free of charge but requires advanced notice.

YOU HAVE THE RIGHT TO AN INTERPRETER
Supports

The MHRT aims to provide independent, timely, fair, informal and private review hearings where a person on an ITO is confident their voice will be heard and their rights protected. The Tribunal encourages a person’s participation in decisions about their future and supports questions and discussion around a person’s recovery and mental wellness. Hearings are not open to the public.

Being supported or represented, particularly by someone you know and trust, can improve a person’s experiences in a number of ways (refer to Representation at the Mental Health Review Tribunal, pg.45-56). Many people agreed that a person is more likely to attend their hearing if they are supported to do so. These supports play a significant role in that person’s life and mental health care and may include family members, carers, significant others, community or health workers as well as their treating team. Supports will play different roles according to the relationship they have with the person.

“The ones with the support, they turn up to the hearing and they have some good reports. The ones without the support – they don’t show up”
(Tribunal member)

“Service provider X attends with their clients. It’s positive, because there’s more prospects of them attending. They know intimately the circumstances of the person and can add context at the hearing”
(Tribunal member)

YOU HAVE THE RIGHT TO HAVE SOMEONE SUPPORT YOU
YOU HAVE THE RIGHT TO HAVE A LAWYER, ADVOCATE OR ALLIED PERSON REPRESENT YOU
Where the Hearing is Held

MHRT hearings are currently held at the hospital so that inpatients can attend. In some circumstances they have been held at the Cairns and Hinterland Mental Health and ATOD Service. Overwhelming feedback from all stakeholders expressed that having the hearings held at the Mental Health Unit may be a significant barrier to people attending their hearing.

“The hearing is in the wrong setting. There needs to be a choice of setting. On equity, there should be a choice of where to sit. If someone is engaged in community mental health, Tribunal hearings should be held in a community setting.

People who might be reactive to that setting or authority know that they could be marched straight to the Unit if they react badly. So it justifies from the institution’s perspective that they should be on an ITO”

(Person with lived experience)

A number of people made the point that if they were receiving treatment for their mental health in the community then they should be able to attend hearings in a community setting. They recalled that in the past, some hearings were held at an Aboriginal and Torres Strait Islander health service. Given this feedback it would be worth exploring the reasons why this no longer occurs and implications for how this may increase attendance if the hearings were to be held in community settings.

“A good, neutral venue makes a big difference. It changes the perspective of the person. People have generally had a bad experience in the hospital Mental Health Unit”

(Lawyer)

YOU HAVE THE RIGHT TO PRIVACY AND CONFIDENTIALITY
Being Able to Get There

Nearly 50% of people indicated that access to transport would help them attend a MHRT hearing. However others indicated this was not an issue as their mental health case manager, support persons or community and health workers had arranged to accompany them.

These inconsistencies remind us that simple, practical questions need to be discussed when planning to attend the hearing. Videolink and teleconferences can be facilitated by the MHRT if a person would prefer to attend this way.

Being Prepared

30% of people reported that the ITO helped their mental health recovery. Of these people, over 70% said that they felt they knew their rights when attending their MHRT hearing. 75% of those who said that an ITO did not help their recovery also reported that they did not know their rights when attending a hearing.

This could suggest that a person who knows their rights when attending a MHRT is more likely to feel that the process is conducive to their recovery. Community members have identified a number of positive ways they have prepared for their hearings, as well as barriers (refer to Preparing for the Mental Health Review Tribunal, pg. 33-44).

YOU HAVE THE RIGHT TO HAVE YOUR SAY

YOU HAVE THE RIGHT TO KNOW AND HAVE ACCESS TO THE INFORMATION THE TRIBUNAL IS GOING TO CONSIDER
Feeling I Can Influence the Outcome

The most frequently selected option of what would assist a person on an ITO to attend a MHRT hearing was feeling that they could influence the outcome. This suggests that feelings of disempowerment can impact on attendance at the MHRT.

“Clients are already aware of negative outcomes. People know and believe they’re not going to be able to influence the outcome. They don’t have the resources, the expertise, the persons, the ability to self-represent – knowing your rights and how to deliver it. It’s about how to present”
(Person with lived experience)

“My understanding is that people don’t really see an end date to their ITO so they don’t show up”
(Health worker)

People want to be engaged in their own mental health recovery. The perception that they are unable to influence decisions around their own lives and mental health care treatment is detrimental to recovery and self-determination. If people do not perceive that they are able to influence the outcome in any way, then there is little reason for them to attend their hearing.

YOU HAVE THE RIGHT TO RESPECT AND DIGNITY

YOU HAVE THE RIGHT TO PARTICIPATE IN DECISIONS ABOUT YOUR MENTAL HEALTH TREATMENT
Key Issues

Preparing for the Mental Health Review Tribunal
Preparing For The Mental Health Review Tribunal

If a person is confused about the purpose of the Mental Health Review Tribunal (MHRT) and their rights, or feeling unprepared for the hearing, then they may be unable to represent their views effectively. A person has the right to be fully informed about their involuntary status. They should understand the specific reasons they are on an involuntary treatment order (ITO) so that they can seek to address these reasons if they wish to do so. If a person is unclear about why they are on an ITO, then they are not able to effectively participate in their own recovery.

A person with lived experience who has been on an ITO for “about 10 years” said that the ITO had helped their mental health recovery “certainly in the past, but not anymore”. This person indicated that it would be helpful to have more information on a person’s rights under ITOs “because I’m not sure why I’m still on it”.

A person’s capacity to make decisions about their own lives and treatment is about meaningful engagement with their recovery. A number of people with lived experience said that not being able to make their own choices was the most negative aspect of the ITO.

“It can be very scary to have all of your control taken away from you”
(Person with lived experience)

“They lose their sense of empowerment, they lose their sense of control, they lose their decision making. Good, bad or ugly – they can make their own decisions”
(Community worker)

One person with lived experience said that he looked at the positives of the ITO including free medication and the support he needed at the time. When his order was revoked, “I had a sense of, I wouldn’t go as far as to say freedom, but I felt like I had a choice again”.

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Notification

The MHRT send people on ITOs in the community a letter of notification two weeks prior to their MHRT hearing. If they are an inpatient, this letter is given to them. If a person has an allied person, then that person also receives notification of the hearing. The allied person could ensure the person on the ITO is aware of the hearing date. A lack of advanced notice for the person on the ITO, allied persons and support persons was a key issue raised during the forums.

The Tribunal recognises that a number of people do not read their notification letter which may be because of patient mobility, reluctance to open formal letters and an increasingly homeless population. For those who do open their letters, there are added barriers for people who have literacy issues or are from a culturally and linguistically diverse (CALD) background.

This means that the responsibility of notifying a person of their hearing date often rests with the case manager. Most people on ITOs said that they depend on their case manager for this information. Community feedback suggests that this is inconsistent and influenced by the caseload of the case manager and when their next appointment with the person is; whether the case manager prioritises the MHRT process.

YOU HAVE THE RIGHT TO HAVE YOUR ITO REVIEWED BY THE MHRT WITHIN THE FIRST SIX WEEKS AND THEN EVERY SIX MONTHS

YOU HAVE THE RIGHT TO APPLY TO THE MHRT FOR A REVIEW OF YOUR ITO AT ANY TIME
Clinical Report

A clinical report is information that the treating team prepares before a hearing to tell the Tribunal members why a person should be on an ITO. The person on the ITO, their allied person and the Tribunal members should receive the clinical report 7 days prior to the hearing. Timely provision of the clinical report was an issue consistently identified by all stakeholders in all consultation processes, and one of the issues most frequently raised overall in the community feedback.

In the Cairns region, it was generally understood that case managers were likely to write the clinical report, with the psychiatrist signing it off. It is different in other health districts. A person with lived experience said “that needs to be done early! I’ve never received it except for five minutes before I go in there...It must be done early so it can be accurate for the judge”.

Feedback from health workers suggests that the completion of clinical reports in a timely manner depends on the individual writing the report. Tribunal members in Cairns received only 30% of clinical reports at least 6 days before the hearing. This does not include when the person on the ITO receives the report as this generally depends on when the case manager provides it to them.

When the clinical report is received was described as “ad hoc” and based in the individual practitioner’s priorities and whether they value the MHRT process. High caseloads were a factor in people’s capacity to produce reports in a timely manner. There have been a number of attempts to encourage practitioners to address this.

A person must have time to go through their clinical report prior to the hearing. This ensures understanding as a person may need to seek assistance to translate the medical terminology in the report. As well, it allows a person to prepare their response or decide what they would like to say at the hearing, talk to their allied person, ask questions and clarify what is likely to be discussed. A person may sometimes be emotionally affected by the content of the report and need time to process this and talk to their treating team or support persons.
Negative feedback about the clinical report described it as “badly formatted with the person’s history first”, “inaccurate”, “demeaning”, and lacking dignity and respect. A number of stakeholders had engaged with reports that included mistakes that a person wants rectified prior to the hearing. This is less likely to happen the later the report is received. If a person receives it on the day of their hearing, it can impair their ability to engage with the hearing and their behaviour may influence the decision of the Tribunal members.

“If the person receives their psychiatrist report on the day and goes through it before the hearing, a lot of the time they’re pissed off at the report. They don’t want to adjourn it because then it will just have to happen again in a month’s time”

(Person with lived experience)

It is important that case managers allocate time not just to deliver the clinical report, but to go through it with the client. If the report is provided in a timely manner, another support preferred by the person might go through the report. This is imperative if a person has issues with literacy, has difficulty concentrating or is from a CALD or Aboriginal and Torres Strait Islander background.

“Today, we have had a conversation for about an hour, but other people don’t have that amount of concentration. You need to have sensitive people who respond to the person and ask ‘is this what you mean?’”

(Person with lived experience)

Some people on ITOs may not feel comfortable going through the report with members of their treating team for various reasons. This might include not wanting to discuss their desires with a person they perceive as having control over the ITO. The person might not have either an established or a good relationship with members of their treating team. It is important for a person’s recovery that they are able to engage with their treating team, but these relationships can take time.

Requesting an adjournment
A person can request an adjournment if they do not feel adequately prepared for the hearing. This is welcomed by the MHRT if it means the person on the ITO will engage with the process.
“An option would be to have someone independent to discuss the report with. Because otherwise it’s all part of the treating team: case manager, psychiatrist etc. If you don’t get on with your case manager, then the system is not going to work for you”

(Community worker)

Lawyers with experience of representing people at hearings said that it was necessary for them to be able to engage with the clinical report so that they can effectively advocate for the client.

YOU HAVE THE RIGHT TO KNOW AND HAVE ACCESS TO THE INFORMATION THE TRIBUNAL IS GOING TO CONSIDER

Recommendation

The MHRT and the person on the ITO receive the clinical report at least seven days before the hearing date.
Self Report  
And Other Formats

The *Self Report* is a document that a person can fill out to help them convey their views to the Tribunal (Refer to Appendices for a copy of the *Self Report*, Pg. X). They can do this before they attend a hearing, submit it to a hearing via post or fax (and choose to attend or not attend), or bring it with them to a hearing to remind them what they wanted to say. Currently a person is unable to email the *Self Report* to the Tribunal and this could be an improvement. It is a tool designed by the Tribunal to encourage a person to contribute to their hearing. This is optional. A person only needs to give information to the Tribunal if they want to.

The benefit of the *Self Report* is that it suggests questions for a person on an ITO to think about what they might want to share in the hearing. It is a useful planning tool for a person to think about how they want to move forward, steps they are taking in their own recovery, what their current barriers are, how they feel about the ITO, their supports and the result they want from the hearing. It is directed to the particular areas that are relevant to the MHRT and is a valuable piece of information for the Tribunal members.

Hearings can be an intimidating process. A *Self Report* can be filled out at a time when the person is not under pressure and better able to express their thoughts. As well, if a person decides to leave their hearing before it concludes, then Tribunal members still have the *Self Report* to refer to, and the person’s voice is still present.

A person might prefer to give their own information in a different way such as writing a letter or reading a poem. Local Tribunal members in the Cairns region encourage a person to contribute in any way they feel comfortable with and are open to tailoring hearings to a person’s special requirements where possible. This can have positive impacts on a person’s engagement at a hearing. A person on an ITO emphasised that it was very
important for the Tribunal to recognise and appreciate their attendance and contribution to the hearing.

No people with lived experience that engaged with the project reported that they had used the Self Report. A person who has been on an ITO approximately three times for six months each time said, “haven’t heard of a Self Report. Possibly could have been useful. Sometimes when you’re on an ITO you don’t even notice it, it’s the times when you really rely on your Doctor about whether you can do things or not”.

A number of health and community workers said that they had used it with people they were working alongside and that it had been a positive tool to initiate discussion. Literacy must be considered. Feedback suggests that an increased awareness and use of Self Reports by all stakeholders could have a positive impact on persons on ITOs participating in their recovery and engaging with MHRT processes.

“Any tool that is of benefit to representing the consumer perspective is positive. It’s worth trying. Give me a few cues and clues and I can go do it myself”  
(Person with lived experience)

YOU HAVE THE RIGHT TO GIVE WRITTEN INFORMATION TO THE TRIBUNAL TO SUPPORT YOUR CASE
Responding To Things That Might Impact Your Mental Health At The Hearing

When a person has a Tribunal hearing it means that the psychiatrist thinks that the ITO should be continued. The psychiatrist has to include the reasons for this in the clinical report. The hearing will be an opportunity for the person to respond to and discuss these reasons.

To prepare, a person can think about how the ITO impacts their life, what they understand the treating team’s perspective to be, issues that might get brought up at the hearing, and their own plan for their mental health care and recovery. It could be positive to talk about this with their psychiatrist, case manager or a chosen support person.

A person must be in control of their own recovery and a clear plan is an essential part of this. This helps to identify and address the barriers that a person may face in their unique mental health recovery. A health worker said, “you need a clear plan of why you’re going on it and what you’re working toward. They walk in in darkness and walk out in total darkness. No one knows what they’re walking into”.

Through the process of filling out a Self Report, a community worker said that a person on an ITO was able to identify what would be beneficial to their recovery, bring this up at a hearing and subsequently had the circumstances of their order changed to achieve this.

A person who was on an ITO for five years said that he “was forced on it, cause I live alone. Forced to have a carer – who doesn’t help me”. It is not conducive to recovery to revoke an ITO because supports have been put in place that are against the wishes of the person. Planning and preparation prior to a hearing can contribute to a clearer understanding of what the person wants. It is not the role of the Tribunal to determine a person’s external supports, but it is a platform where those invested in a person’s recovery and treatment are present and discussion occurs in an open manner.

Tribunal members recognise a person’s support network and this will be discussed at a hearing. The Tribunal is interested in what a person’s own safeguards would be if their ITO was revoked and how they would continue to manage their mental health recovery.
It is important the representation or support present at a hearing, takes the time to debrief with the person on the ITO after the hearing to ensure understanding. A person with lived experience said, “I didn’t understand what the decision meant at first, I was quite unwell at the time. I had to ask the two nurses beside me what it meant, and then they told me and I was ok with it”. If there is an undesired outcome then there is the risk that a person may feel further disempowered or that they have wasted their time. Discussion with a support is key to seeing the ITO as an ongoing process and being able to reflect on what was gained from the hearing. Referrals to representation may be necessary if a person is unhappy with the outcome.

**Statement of Reasons**
A person can request a Statement of Reasons that explains the decision that is made by the Tribunal. If the request is made within 7 days, the Statement of Reasons is provided by the MHRT within 21 days. An appeal can be lodged with the Mental Health Court if the patient disagrees with the decision of the Tribunal. Appeals must be lodged in writing within 60 days of receiving the written decision.

**YOU HAVE THE RIGHT TO REASONS**
Advance Health Directive

An Advance Health Directive (AHD) – sometimes called a living will – is a formal way to give instructions about your future health care. A person makes it when they are well and it comes into effect only if your health deteriorates and you lose capacity to make your own decisions.

A person with lived experience, who had been previously living outside of the state said, “my doctor didn’t even know what it was in Queensland. You have clinical staff who have no idea of the importance of the document”.

Current documents that are used in ITO and MHRT processes refer to Advance Health Directives. Based on the community feedback that informed this project, it appeared that most stakeholders were not aware of how Advance Health Directives would be relevant from a mental health perspective and that they were not commonly used.

Due to the new focus on Advance Health Directives in the upcoming legislation, this is a tool that could improve people’s capacity to determine their own treatment when they become unwell and increase a sense of self-determination.

Talk To Your Treating Team

A number of people with lived experience said that they did not feel like they could contribute to decisions around the type of treatment they received when on an ITO. This can be detrimental to a person’s sense of self-determination and recovery. The MHRT does not address the type of treatment a person receives, unless it is in regards to electro-convulsive therapy (ECT) or psychosurgery.

However, the ability of a person and treating team to work together can be a foundational element of recovery and impact on the Tribunal’s decision to revoke the ITO. This relationship can also impact the perception a person has of their ITO as well as the MHRT processes. People on ITOs were more likely to see the ITO as an element of their recovery if they trusted a member of their treating team.

“I knew everything I needed to know. I trusted my case manager. It definitely would have been different if I didn’t like my case manager”

(Person with lived experience)
All stakeholder groups identified that increased communication between the treating team and other relevant people improved experiences with MHRT processes and reduced misunderstandings.

It was clear that the more informed and supported the support persons were, the more they were able to assist the person on an ITO. Most community members saw this as a responsibility of the treating team.

“Clinicians should be sitting down more with patients. Families should be able to come and talk to the consultant”
(Health worker)

“Speak to the carer and find out what their needs are”
(Tribunal member)

YOU HAVE THE RIGHT TO HAVE A TREATMENT PLAN PREPARED FOR YOU AND HAVE YOUR AUTHORISED DOCTOR (TREATING PSYCHIATRIST) TALK TO YOU ABOUT YOUR TREATMENT UNDER THE PLAN WHEN AN ORDER IS MADE

YOU HAVE THE RIGHT TO PARTICIPATE IN DECISIONS ABOUT YOUR MENTAL HEALTH TREATMENT, INCLUDING THE DEVELOPMENT OF YOUR TREATMENT PLAN

YOU HAVE THE RIGHT TO BE TREATED AS REQUIRED UNDER YOUR TREATMENT PLAN WHILE YOU ARE RECEIVING TREATMENT

YOU HAVE THE RIGHT TO BE FULLY INFORMED ABOUT ANY CHANGES TO YOUR INVOLUNTARY STATUS AND REASONS FOR THIS

Recommendation

Community awareness and support of documents that represent the voice of the person including:
- Self Report and other formats
- Advance Health Directives
Key Issues

Representation at the Mental Health Review Tribunal
I started advocating for people and attending some of the hearings and understanding more. People seemed to me to be totally disempowered by the process. No one seemed to feel that the orders could be changed, no one seemed to be aiming for least restrictive. The biggest problem is the lack of representation, it was just horribly, manifestly unfair for these people.
Key Issues

Representation at the Mental Health Review Tribunal

Representation refers to a person’s voice being conveyed at a Mental Health Review Tribunal (MHRT) hearing. A person might be able to do this themselves, but they also have the right to have legal representation, an advocate or an allied person assist them in conveying their views. People on an involuntary treatment order (ITO) said the person they would choose to help them at a hearing would be “someone who can see things from my view” and “somebody that knows me and my needs”. Feedback indicates that people can feel intimidated due to an inequitable ratio of power and control when there are a number of members of the treating team present at a hearing but limited support for the individual.

“I wouldn’t talk purely because I didn’t think anything I would say would make them change their mind. I did talk, but there’s moments where I was like, I may as well not even say anything because they’ve already got a set mind. It’s up to the person writing the evidence [clinical report]”
(Person with lived experience)

Local Tribunal members reflected that a hearing was most effective when all relevant people were present and had an understanding of their role, including the treating team (psychiatrist, case manager, sometimes a doctor) and representation or supports external to the treating team. This provides contextual information to Tribunal members enabling them to have a more holistic understanding of the unique person’s situation and results in more informed decisions. Representation also assists a person on an ITO to engage in the process. The Tribunal will consider a person’s mental state, psychiatric history, social circumstances, response to treatment and willingness to continue treatment.

WHO ATTENDED THIS YEAR?
THERE WERE 1034 MATTERS

- PERSON ON ITO 321
- ALLIED PERSON/OTHER SUPPORT 139
- LAWYER 7
- ADVOCATE/AGENT 4
- CULTURAL SUPPORT 9
Being There – The Treating Team

Members of the treating team attend as witnesses to the clinical report. They are there to respond to questions about the treatment criteria and treatment issues. A psychiatrist becomes a statutory decision-maker with the power to detain people and take away their freedoms when they put a person on an ITO. Community members emphasised that if a psychiatrist has this power, then they should be present at the hearing to explain this to the person. The MHRT hearing is the way that a psychiatrist is held accountable to the broader community by reviewing whether the law is being applied appropriately.

The context of a hearing is unique to a regular psychiatrist appointment as it is aimed at facilitating all people’s voices. Challenges include a psychiatrist’s high workload and time constraints, particularly for those not based at the hospital where the hearings are held. Due to the seriousness of removing someone’s rights, it is hoped that engagement in these processes is prioritised.

A number of people on ITOs said that the hearing was transparent and direct and assisted a person to understand why they were receiving involuntary treatment. People with lived experience want others to recognise the impact that a removal of their rights can have on their recovery.

“Maybe I think that there should definitely be something like an ITO, but not taking your rights away so much. I think it’s a good thing in some senses, but I think they overdo it. Psychiatrists and people with power need to take it more seriously”

(Person with lived experience)

Persons from all groups who engaged with the project commented on the difficulty people on ITOs have in establishing relationships with members of the treating team due to high staff turnover in the public mental health system. As well, a person may or may not get along with their psychiatrist or case manager. Fatigue in retelling their story occurred when people had a change in psychiatrist or case manager. Reasons for changes in a member of the treating team should be explained to the person.

Those with consistent and/or positive relationships with their treating team reported better understanding of their rights and MHRT processes. Those people with lived experience who identified this also said that they felt their case managers thought it was an important process.

A person has the right to be aware of representation external to the treating team and this representation must be accessible.
YOU HAVE THE RIGHT TO BE TOLD BY YOUR AUTHORISED DOCTOR (TREATING PSYCHIATRIST) ABOUT THE ORDER, ITS CATEGORY (INPATIENT OR OUTPATIENT) AND THE REASONS FOR THE ORDER

TREATING TEAM ATTENDANCE

NURSE AND CASE MANAGER ........................................... 756
PSYCHIATRIST .......................................................... 167
REGISTRAR OR OTHER DOC ......................................... 109
INDIGENOUS MENTAL HEALTH WORKER ..................... 24
INDIGENOUS TRIBUNAL MEMBER ................................ 243

Who Can Be At A Hearing?

The person on the ITO

The person themselves is their own best representation. A person with lived experience said that being present at a hearing is important “because it’s about me I guess. I felt I wanted to have control over decisions to do with me”.

Another person said the best representation is “someone who knows the person; someone who knows their moral and legal rights; a consumer to be able to speak for themselves, utilise the team and show they are participating in their care – this shows the Tribunal they’ve progressed toward recovery”.

Limited decision making and self-determination can be associated with the process through which an ITO is implemented. A person with lived experience said “the problem isn’t in the ITO itself, it has a lot to do with the people who enforce it. I think it’s the people who were there, bad experiences aren’t to do with the ITO itself, it’s the people who are in charge or who you go to talk about it with”.

There were perceptions from people on ITOs that the more capable a person is at advocating for themselves, the more they may be challenged by those in positions of authority. It is important that a person’s capacity to ask questions and engage in their own recovery is supported. Local Tribunal members reflected that once a person realises that they will get the opportunity to speak they appear to find the MHRT process less intimidating and are more likely to contribute.

A person with lived experience said that being put on an ITO can impact the likelihood of a person seeking representation at their hearings, “it kicks their guts in, makes them feel guilty and shamed, how the hell do they get representation if someone is not listening to them because they think they have a mental illness?”. This emphasises the role of allied persons.
Allied Persons

An allied person is chosen by the person on an ITO and an application for an allied person is filled out. The allied person needs to then accept the nomination. In some cases, if the patient does not have the capacity to choose an allied person, the Administrator of the mental health service will nominate someone. A person can choose not to have an allied person.

The allied person must not be a paid carer of the person, or an employee of the health service. An allied person receives the same correspondence from the MHRT as the person on the ITO (except for the Self Report). Their role is to support the person on an ITO to put forward their views, wishes and interests.

When people accompany a person on an ITO to a hearing, but have not officially become allied persons, they are classified as support people. They may attend if the Tribunal agrees.

An allied person is likely to have an established relationship with the person on the ITO, as they have been through a process of being nominated. This report focuses on their role at a MHRT hearing where they can attend and help a person have their say.

There have been occasions, where confusion over roles and conflicts of interest have been detrimental to the running of the hearing as, “an allied person is supposed to say simply what the person wants not what is in their best interests” (Health worker).

For an MHRT hearing to be conducive to recovery, it is important that each person present knows their role and responsibilities at a hearing.

“If people choose to go, then representation is key: but the question is, is that representation informed?” (Health worker)

YOU HAVE THE RIGHT TO CHOOSE AN ALLIED PERSON AS A FORMAL SUPPORT PERSON TO HELP YOU REPRESENT YOUR VIEWS AT A HEARING
Support Persons: Carers, Family Members, Significant Others

There was particular interest expressed around MHRT processes and the rights and obligations of allied persons at the forum for support persons. This group can have the same feelings of confusion, disempowerment and helplessness in the face of complex systems. It is important they are aware of their rights, choices and supports within the mental health system as they must be supported in order to support a person on an ITO.

“You have to deal with the bureaucracy as a carer. I’ve seen some carers develop their own illnesses because of being a carer” (Carer)

“I went in but I didn’t have much to say” (Family member)

A person on an ITO may not feel confident speaking for themselves in a hearing, but is able to communicate their views to a support person who is then able to advocate for them. This group are often those with the closest relationships to the person. For this reason, they face some unique barriers in supporting and representing a person at a hearing. This is mainly founded in the conflict of interest between what a person may want represented at a hearing and what a loved one may believe is in their best interests. The role of an allied person is to represent the views of the person.

“Sometimes family members can’t support a person without putting in strict guidelines, ie don’t take drugs, and this would be against the person’s wishes” (Carer)

“It’s a mystery why I’m on it. You’ll find it similar in other people’s lives, it’s often family who want them on it… My family asked mental health to keep me on an ITO to protect me while they’re away. They did not discuss it. They decided it” (Person with lived experience)

When a person becomes unwell, they may decide that they don’t want to engage with or be represented by their regular support. This can be highly stressful for those supports and a difficult issue to navigate for health staff. The more communication there is between a treating team, community and health workers and a person’s natural support network, the more effectively these issues are managed. Respecting a person’s confidentiality can be balanced with the provision of information about rights, choices and supports in relation to ITOs and MHRT processes to support persons.
Service Providers

The most frequently selected option of who a person would choose to help them at a hearing was support workers. In order to represent a person’s voice at the hearing, a health or community worker may be the nominated allied person. If they are not, then the Tribunal must agree that they can attend.

The more familiar a service provider is with MHRT processes and rights, the more capable they will be in supporting a person on an ITO. People with lived experience identified the positives of having health or community workers support them: they assisted them to navigate the system; they had a better understanding of the processes than family members at times; they may be the most stable and significant people in a person’s life at the time; the person on an ITO trusted them and this increased their confidence to contribute in a hearing.

“I went with whoever I felt comfortable with. Either a family member or a worker from wherever I was staying. The worker was probably better because they understood it”
(Person with lived experience)

Advocate

Local Tribunal members highlighted the benefit of having an independent advocate present at the hearing. This refers to an advocate who was nominated as an allied person, “the other thing the advocate was good at, was that they had a good relationship, they were talking to each other, the advocate was asking the patient questions, the patient could see the advocate was doing a good thing for him”. Tribunal members highlighted that the advocate was able to add context, knowledge of broader community services and provide a platform for the person’s voice or encourage them to speak themselves.
Legal Representation

“You need a legal rep because they know what to say” (Person with lived experience)

Only 2.3% of hearings in Queensland had legal representation. In Cairns, only 0.7% of hearings had legal representation. A local Tribunal member said that legal representation was the most effective representation as, “lawyers who appear know the Act as a rule and therefore offer suggestions within the context of the Act. It’s about their understanding”. Other benefits of legal representation were that they discuss issues with their clients prior to the hearings so the person is well-informed and through doing this, prepare someone for what can be achieved in the hearing.

Legal representation in Queensland is a choice. Not all people will need or want legal representation. Health workers identified some issues with having a lawyer present at the hearing include the use of confusing jargon that the person on the ITO might not understand and creating a court like atmosphere where a person feels they have done something wrong. Other health workers said that lawyers who know their role in a MHRT hearing can be effective as translators of the jargon. Legal representation should be aware
Recommendation

Community legal services investigate funding for the provision of a Mental Health Legal Service in the Cairns region.

A health worker suggested that, “the role of the Tribunal should be to provide an outline or framework for lawyers if they haven’t been before, regardless of the capacity of the person”.

Legal representation is not readily accessible in the Cairns region for representing people at a MHRT hearing. The main barrier to securing legal representation was financial. Other barriers included people not being aware that it was a right, not being able to read or fill out forms and feeling that a lawyer would not represent their voice appropriately.

YOU HAVE THE RIGHT TO LEGAL REPRESENTATION

YOU HAVE THE RIGHT TO RECEIVE VISITS FROM YOUR OWN HEALTH PRACTITIONER OR LEGAL ADVISER AT ANY REASONABLE TIME
Interpreters (Language or Sign)

In this project, only one person on an ITO identified as being from a CALD background. This person identified communication barriers that arose from her own experience, particularly with CALD psychiatrists.

There were no deaf community members who were directly engaged with during the course of the project. Feedback from community workers who work with the deaf community highlighted a number of issues that need further exploration.

These included the need for interpreters to be available for deaf community members. A community worker said that there were “at least ten deaf Aboriginal and Torres Strait Islander persons who have been admitted to the Mental Health Unit”.

The majority of the inpatients at the MHU are involuntary patients. This suggests that there are a number of deaf Aboriginal and Torres Strait Islander people who are or have been on ITOs. It was highlighted that there are multiple barriers for people who are deaf and CALD and these people may need two interpreters.

There are current community concerns that a lack of availability of interpreters at all points in the process of being put on an ITO means that there is a compounded lack of understanding and disempowerment at MHRT hearings. As well, interpreters at hearings are often present via videolink or teleconference. Sometimes there is a delay in the videolink which is a barrier to communication.

YOU HAVE THE RIGHT TO AN INTERPRETER
Public Guardian or Enduring Power of Attorney

The role of Public Guardians and Enduring Power of Attorneys (EPOA) are completely separate from a person being put on an ITO. Feedback from the MHRT and Cairns community indicates that there is inconsistency around the notification, attendance and role of Public Guardians at MHRT hearings. There was little feedback on Enduring Power of Attorneys. Both of these roles can be identified in Advance Health Directives (refer to Preparing for the Mental Health Review Tribunal, pg. 33-44).

If a Public Guardian is appointed to make decisions concerning a person’s health, then decisions between the MHRT and Public Guardian can crossover. There needs to be consistency in notification and attendance for Guardians around MHRT hearings if it is relevant and appropriate. Guardians and EPOA can be nominated as allied persons, which means they would receive correspondence from the MHRT. It might be useful for a person to have their Guardian or EPOA present at their MHRT hearing.

A Public Guardian
is appointed by the Queensland Civil and Administrative Council (QCAT) to protect the rights and interests of adults who have an impaired capacity to make their own decisions. A Public Guardian can make certain personal and health care decisions on behalf of the person.

An Enduring Power of Attorney (EPOA)
is someone appointed by a person when they are well. This gives the EPOA the authority to make personal or financial decisions on behalf of the person if that person loses capacity to make those decisions.
Key Issues

Continuity Of Care
Continuity of Care

It is important that an involuntary treatment order (ITO) is perceived as an integral part of a person’s plan to move towards mental wellness. Like other parts of a person’s recovery, this is something that should be discussed and engaged with between the person and other relevant people in that person’s life. While a person may not have the final say about treatment when they are involuntary, as far as possible their preferences should influence their treatment.

Feedback suggested that a person on an ITO is unlikely to distinguish specific experiences with the Mental Health Review Tribunal (MHRT) from their experience on an ITO as a whole. It was emphasised by people with lived experience, that dignity and respect must be applied before, during and after the ITO.

When asked what system improvements people who have been on ITOs would recommend, the majority of people said the way in which they were put on an ITO. Some people also said that after they were taken off the ITO, they felt that it was used as a threat if they were not compliant. These experiences impact a person’s perception of the purpose of the ITO and MHRT.

“The way I got into the program, into the system itself. The cops put me in handcuffs. That wasn’t necessary. They could have said stuff like “we’re going to take you to the hospital, we’d much prefer you just come along, but if you don’t we’ll force you” – because I would have just gone”

(Person with lived experience)

“It might have been when I was released, they told me, I didn’t even know what it was at the time… I didn’t even know what an ITO was, only what it stood for and I didn’t like it…”

(Person with lived experience)
A person who becomes unwell to the extent of requiring the Mental Health Act is costly both for that person’s social and emotional wellbeing, and the community. The number of people on ITOs in Queensland has significantly increased over the years. It is possible that prevention and early intervention would better work to support people through times of unwellness and decrease the use of involuntary treatment.

For those who receive involuntary treatment, consistency of support after their ITO is revoked is essential to avoid as far as possible, the person being put on an ITO again.

Community and health workers, support persons and people with lived experience identified a number of occasions when the revocation of an ITO was not conducive to recovery. This has a significant impact on the person, as well as their support persons who are often left as their only continuity of care. The necessity of a stable and ongoing support network for a person who has their ITO revoked was emphasised by the community, “an issue is that clients become well, and the scaffolding is removed” (Health worker). A person also said having her ITO revoked, “left me feeling a failure and severely depressed without any help and recovery”.

**Patient Rights Adviser Role**

The Patient Rights Adviser role does not currently exist. It is a proposed role to be introduced in the Mental Health Act 2015 that is currently tabled in parliament. The purpose of this section of the report is to compile what community members said was needed in the community. Patient Rights Advisers could address these needs if the role is adequately resourced. If for some reason, Patient Rights Advisers are not introduced in the new legislation, these needs must still be addressed.

**Suggestions included:**

- Ensuring a person with lived experience and their support persons understand rights, choices and supports in regards to ITOs as soon as the process is initiated. This must be a specific role’s responsibility as it is currently shared between members of the treating team and MHU staff. There must be time for follow up allocated to assist understanding as people may not engage with information when they are unwell or overwhelmed.

“**The first time I realised I was on it was when I was at the hospital and I wanted to leave and they said I can’t because I’m on an ITO and I said what was that, and they said it means I’m a risk to everyone and myself. That’s the first time I’d heard of it**”
"Overall, people don’t understand at every level that they have the opportunity to advocate. You don’t have to take this lying down. By the time it’s gotten to MHRT, people have given up. It needs to start way back, when someone first goes to hospital, and they’re present all the way through”
(Carer)

Independent persons to be readily available to provide information around ITOs and MHRT processes, particularly regarding a person’s human rights, how the MHRT works to safeguard their rights and referrals to other sources of information if appropriate. This would also include assistance navigating the mental health system, options for representation and referrals to potential representation.

Community feedback clearly stated that the way information was perceived by a person was influenced by who was delivering it. If a person did not have a trusting relationship with the provider of the information then they were unlikely to believe the information would benefit them.

Independent persons to be readily available to provide information and assistance navigating the mental health system to a person’s external support people or stakeholders. This would focus on the rights and roles of these stakeholders and could include carers, family members, significant others, Public Guardians, Enduring Power of Attorneys, GPs, health and community workers, advocates, legal representation and other representation. Greater awareness among all stakeholders is likely to improve the attendance of and representation for people on ITOs at their hearings.

“They just made the hoops so hard to jump through. We try to call them and there seems like there’s something wrong with their phone. We go through the hospital and they ask “why are you calling us?” then they transfer us to someone else who tells us that they’re the wrong people to speak to as well”
(Carer)

Support for Tribunal members to be part of professional local networking meetings where agencies raise awareness about the services they provide. This provides Tribunal members with added context about what a person might currently be or could possibly be accessing.

Facilitation of general community awareness, education, engagement and health promotion around ITOs.
Other comments included that the proposed Patient Rights Adviser role should have lived experience, “because no one questions their abilities, whereas they question ours all the time”; “a lot of carer and consumer participation in building that role”; and that there needs to be Aboriginal and Torres Strait Islander Patient Rights Advisers. As well, the persons in the role should have adequate legal training and an extensive understanding of mental health legislation; work in and collaborate with consumer companions, community visitors and all relevant Queensland Health staff; and play a dual role in supporting people in the mental health system and providing feedback for system improvement based on the barriers identified by those people.

People must be able to access the people in these roles. If these services are not accessible then they will not improve people’s experiences when engaging with the MHRT. This means that there needs to be a team of Patient Rights Advisers. 100% of people asked thought a Patient Rights Adviser role would be useful and 91% indicated that the role should be independent from Queensland Health.

Other Supports

When a person is on an ITO, they have a psychiatrist and a case manager. When they are taken off an ITO, they may not have access to these supports any longer. This highlights the importance of an external support network.

“They need to put more support into the community sector. Because people start to get a little bit well and then get discharged, and there’s not enough community support there to pick them up and they get unwell again”

(Community worker)

The Tribunal recognises and is interested in a person’s support network as this is the scaffolding that can assist a person in their recovery. As well, people in this network will notice if a person is becoming increasingly isolated or vulnerable and may be at risk of becoming unwell. Potential roles of other stakeholder groups identified but not elaborated on in the previous body of the report include that of GPs, the police and broader community services.

Recommendation

The Patient Rights Adviser role should be independent from Queensland Health and resourced to provide support for all stakeholders in the process. This community engagement will require a team of personnel.
**GP Role**

An overwhelming number of community members from all groups identified the benefit of having a consistent health practitioner in a person’s life. This could increase a person’s feelings of choice over their health service, “I want to have a choice of mental health doctor and staff – you have a choice in all other places in society”. Some people experience financial barriers if their GP does not bulk bill.

While it is unlikely a GP would attend a MHRT hearing, they are at liberty to write a letter that can be submitted to the Tribunal members. This adds another dimension to the clinical report and any contribution the person has made. As well, it shows that a person has an alternative system in place to care for their health.

This is a promising avenue to improve continuity of care for people who are, have been or may be put on an ITO in the future. Exploration in this area could include:

- GPs able to readily access up to date information on mental health care
- Improving GPs knowledge of and access to resources around ITO and MHRT processes
- Use of the current eHealth system (an electronic summary of a person’s health records) could improve approved sharing of mental health history
- GPs identifying themselves as preferred mental health providers (some local GPs have identified mental health as an interest on Cairns Health Online. Allied health workers are also on this site)

The role of a GP would be effective on the basis that the person had an ongoing and trusting relationship with that GP.

**Police**

There was overwhelmingly positive feedback from community members who discussed local police. Community members felt that they are particularly good in the Cairns City area and make an effort to provide their staff with mental health training.

Some people with lived experience had had negative experiences with police. This included being handcuffed when being taken to the MHU for an assessment, despite not displaying any dangerous behaviour, and being put in the watch house and not having mental health contacted. This emphasises the importance of ongoing involvement of the police in community discussion and action around mental health.

Some suggestions to improve the role police have when engaging with people with lived experience were:

- Increased collaboration between police and service providers. This was in reference to these service providers contacting the police if they were
“A doctor actively listened to everything I said, and that’s so important”
(Person with lived experience)

“It would be good if they had a long term GP – because the public system psychiatrists and case managers will change all the time”
(Health worker)

“Mental Health is not the only go to. There’s GPs, there’s mental health plans. It’s like reading an encyclopaedia and having to make sense of everything”
(Carer)

“A better process would involve more continuity of practitioners”
(Lawyer)
concerned for a person’s safety. It was suggested that police could be provided with information regarding whether the person was seen to be a danger to themselves or others and this could influence their actions when visiting the person.

- Involvement of the police with mental health services networking and events generally to increase awareness.

Available services in the broader community

Local Tribunal members said that the support of service providers in Cairns can assist a person on an ITO in their social and emotional wellbeing, and through MHRT processes. Being on an ITO can impact the way people engage with other services in the community. Issues regarding available services in Cairns included:

- If a person is directed to or feeling pressured to engage with external community services to satisfy the treating team, this can create issues for voluntary services.

“\textit{The thing is when they said Service X is voluntary, it would be if you weren’t on an ITO – because it was Service X or the hospital. And you don’t want to go back to the hospital. So it was a choice, but not really}”

(Person with lived experience)

- There is stigma associated with experiencing mental health issues, particularly for people on ITOs, and this is compounded by the small population of the Cairns area and feelings of being identified in the community.

- Those people supporting persons on ITOs can experience burnout, particularly if they are positive and trusted supports and these people need to be supported too.

“When you’re a good worker in the right role, and everyone calls you – the police, the workers, people needing support – there are demands, reasonable and unreasonable, that can be huge. If you’re devoted and genuine, and dedicated to building a care system – there’s the enormity of that need”

(Person with lived experience)

- For a person on an ITO to progress through their recovery, there needs to be available and appropriate supports.

A lack of access to housing was brought up a number of times. Gaps in the system were highlighted by a person who is temporarily residing with parents and is not eligible for housing for this reason.
There is a need for outreach supports for a person who lives alone. A person with lived experience said, “most people get put on orders because they live alone. If they live with someone, then the authorities see them as being monitored in some way. There needs to be more support for those who live alone.”

- Community services need to be flexible when working alongside people on ITOs and consider the impact that the removal of one’s decision making and rights can have on a person, as well as their unique experience of mental health issues.

“(The person I care for) will say he’s a horrible person in the morning and will say no to everything, but he’s a different person in the afternoon and will be open to things. But services just can’t deal with that”

(Carer)

- Ensuring that the scaffolding that comes with an ITO is not removed when an ITO is revoked. Ways to reduce the number of people who go on and off ITOs a number of times is an area that could be explored. Carers said, “continuing contact. Having somebody. I really feel the ongoing care is the key” and “what needs to happen is that people are eased back into the community”. A person with lived experience said “it’s about knowing how to utilise your resources when you’re in need. What is your need?”.

A health worker highlighted the importance of establishing relationships in the community, “it’s about a person developing relationships with the appropriate services. That’s sustainable”. Feedback indicated that service providers should recognise that their role may include monitoring a person’s medication, but also involves supporting the person in their social and emotional wellbeing.

- More services are needed in rural areas. Community feedback suggests that people are kept on ITOs as there are not the necessary services available to support them.
Key Issues

Outside of Project Scope

Aboriginal and Torres Strait Islander People on Involuntary Treatment Orders

Mental Health and the Justice System
41% of all hearings in the Cairns region are for Aboriginal and Torres Strait Islander people, even though only approximately 18% of the population of the Cairns region are Aboriginal and Torres Strait Islander. 1

Due to time constraints and based on community feedback from a range of members of the Aboriginal and Torres Strait Islander community in the Cairns region, it was recognised that this project could not do justice to exploring the unique experiences and barriers for Aboriginal and Torres Strait Islander people on involuntary treatment orders (ITOs). The following issues were identified by Aboriginal and Torres Strait Islander community and health workers from eight Cairns and Yarrabah organisations, and Aboriginal and Torres Strait Islander Tribunal members, as areas for further exploration:

- The perception of some Aboriginal and Torres Strait Islander people on ITOs and the broader community that ITOs are permanent.

  “All the fellas that go to the reviews think that they’re on it forever. Their human rights have been taken off them because of a flick of a pen – why would they bother going?”

  “Once people are assessed and it is decided they need to be on the needle then I thought that was for life”

  “That’s all they can get their head around, they’re stuck on this ITO – it’s pissing them off. They need to have something to work toward. There needs to be hope. It’s helplessness. You’re sitting here in this dark hole and there’s no light at the end of the tunnel”
- Language barriers in every part of the system including a practitioner misinterpreting the Aboriginal and Torres Strait Islander person as well as Aboriginal and Torres Strait Islander persons not understanding language related to ITO and Mental Health Review Tribunal (MHRT) processes, including at the MHRT hearing.

“It’s really intimidating, especially if you’re disempowered... I think some of the people I work with, don’t really understand – even the ‘voluntary’ and the ‘involuntary’”

“I’ve been to a few (MHRT hearings) and I’ve got no idea what they’re talking about. And the language – I can’t understand it”

- Literacy barriers in reference to information provided to persons about their ITO and MHRT processes, as well as MHRT hearing documents including the notification letter, Self Report and clinical report.

- More support services needed in regional and remote locations for persons on ITOs and their support persons.

“We go to TI. They got their own case workers. The problem is they haven’t got the service supports. There are limited services up there”

- A need for access to more education, resources and training for community and health workers of ITOs and MHRT processes. These people were identified as the best sources of information to Aboriginal and Torres Strait Islander people on ITOs and their support network as they were able to translate the information in appropriate ways and language.

“I feel like a guinea pig. I don’t know how to help the person. The person looks at me for help, and I don’t know what to do. I don’t know my rights as a support worker”

“As Indigenous workers, we can translate it to and educate our clients”

- Culturally appropriate training and resources to be readily available and specific to diverse Aboriginal and Torres Strait Islander communities. There was particular distinction made between the uniqueness of experience that a person may have in Yarrabah, Cairns City, Cape communities and the Torres Strait Islands.

“Is it possible to do some brochures in lay terms and pictures? Then everyone on an ITO can get a brochure”
“Education. There needs to be a season of education. Educating carers, individuals, service providers. There needs to be an investment. People need to know how much it can be a benefit to you, to engage in these processes.”

“You could offend someone easily if you don’t know the protocol”

Community members provided feedback on appropriate ways to move forward. The majority of Aboriginal and Torres Strait Islander community members said that it was necessary for such a project to be driven and informed by Aboriginal and Torres Strait Islander people from and based in the community that was being explored.

“Cultural competence – they should understand more. The older case workers understand the family dynamics. Culture and family. They need to understand the family in different areas as people move around”

- Stigma associated with mental illness can deter a person and their supports from seeking help.

- The need for non-Indigenous persons engaging with Aboriginal and Torres Strait Islander people on ITOs to be culturally competent and consider the person in their context.

Recommendation

A project to explore the issues related to attendance and representation for Aboriginal and Torres Strait Islander people on ITOs, driven and informed by Aboriginal and Torres Strait Islander community members from and based in the community being explored. This would include recommendations for systemic reform.

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1 Australian Bureau of Statistics, 3238.0.55.001 Estimates of Aboriginal and Torres Strait Islander Australians, June 2011
Opportunities of improvements to MHRT processes for Aboriginal and Torres Strait Islander people on ITOs were identified in discussion with community members. These indicated that further exploration of systemic reform in this area could improve experiences and work to address the disproportionate number of Aboriginal and Torres Strait Islander people on ITOs in the Cairns region:

“I don’t know if it’s possible, but it could be good to set up a meeting so that the client has met the Tribunal members before their hearing, even just briefly”

“And there’s an issue with being stuck in front of a TV camera. All the reviews we have ever been to have had a videolink”

“Can it look different and still achieve what it needs to achieve?”

“One of the biggest issues is what we’re doing right now – a Western process of wellbeing. It needs to be looked at, cultural processes of wellbeing including going out bush, doing smoking processes”

“Prevention stuff – this is what will happen if you do this, then this will happen. Have a yarn about it. With your family, with your support worker”

“A big chunk of our work with people on ITOs is sitting down, educating, making a clear plan”
There are a high number of people on involuntary treatment orders (ITOs) who also have matters being dealt with under the Justice System. There is often confusion between processes to do with a person’s ITO and court proceedings. This sometimes results in a person on an ITO feeling as though their ITO is a form of punishment.

If a person on an ITO is charged with an offence, court proceedings are suspended. The Director of Mental Health is notified and requests a mental health examination and report from the person’s treating psychiatrist. This might be to determine if the person was of unsound mind at the time of committing the offence or is unfit to stand trial. A person may be put on a forensic order if they have a mental illness and have been charged with an offence.

During the consultation process, community members emphasised that people on forensic orders experience significant barriers to having their human rights satisfied and achieving wellness. Concerns included restrictions imposed on people that were not catered to the person’s unique circumstances and

Forensic Order
A forensic order is made by the Mental Health Court and authorises for a person who has committed an offence to be treated involuntarily by a mental health service. Like ITOs, forensic orders are reviewed by the Mental Health Review Tribunal (MHRT). When you are on a forensic order, you are automatically an inpatient but you may have limited community treatment (a form of leave from the mental health facility where you are an inpatient).

“set them up for failure” when in the community, and inadequate preparation for a person on a forensic order who is being released from jail or the Mental Health Unit which results in them becoming detained shortly afterwards. Community members felt that there was an assumption that persons in jail would be released into the Mental Health Unit which was sometimes not necessary.
The following issues were identified as areas for further exploration by community and health workers, legal representatives, and persons who are or have been on ITOs and had experience with the justice system at the same time:

- Persons waiting for psychiatric reports in custody for a period of up to 18 months when the legislated timeframe is 21 days

- Perceptions of people about forensic orders that, “it’s like prison, but if you’re in prison – you have a release date”

- Inconsistency in communication between health services, community services, legal representation and the justice system

  “A lawyer might be seeking notes from the hospital. They could fill out the right documentation and then the hospital says – we don’t really keep that many notes” (Lawyer)

- A lack of collaboration and recognition of shared responsibilities between the health and justice services

- There was positive feedback from some lawyers who have established relationships with mental health workers and work together to improve representation for a person. Lawyers require adequate information to be able to effectively represent and advocate for a person, such as provision of the clinical report

  “I work with mental health (to understand and represent someone). The aim is to assure their liberty” (Lawyer)

- Some persons who require psychiatric reports may not have these report requested. If a legal representative recognises that a psychiatric report is required at a later date then they are at a cost to the client. Community legal centres have limited funding to cover this cost

  “Lawyers need clinical reports to be able to advocate for the client. Lawyers need a signed authority form from the client. Then the lawyer might ask the court to order a psych report and the court’s response – why should we pay for it?” (Lawyer)

- Potential opportunities for more appropriate processes were identified for people on ITOs or forensic orders going through court proceedings, including the collaborative approach of the Murri Court

- Current legislative requirements can impact on the intent of the Mental Health Act
“When you read the Mental Health Act, it’s so clear – and in practice, it’s less clear. If a person on a Forensic Order takes drugs/alcohol then they’re detained for two weeks. It’s using it as a containment process/ control mechanism. This is not reasonable. Do we want to lock them up forever? Rights of liberty”

- Some people with lived experience said that they were taken to the watch house when they were unwell and mental health workers were not contacted
- Compounded vulnerability for persons with Acquired Brain Injuries or unrecognised Fetal Alcohol Spectrum Disorder
- Refusal of bail for people who do not have a residential address
- People who are unwell self-representing in court possibly because they are not aware that they can access legal representation or are unable to fill out the form themselves; or it is not available to them due to limited resources
- Literacy and language barriers

“The professional also misunderstands the language of the person and makes wrong assessments based on this. That’s a massive issue. A number of people have gone back to jail because of misunderstandings”

People on ITOs going through court proceedings and people on forensic orders are particularly vulnerable as they must navigate mental health system and justice system processes. These people are sometimes engaged with the disability system or other areas depending on their unique situation. Gaps between services and systems were brought up at a number of forums and in one on one meetings.

There are a number of changes in the proposed Mental Health Bill 2015. It may be beneficial to explore this area when the new mental health legislation is introduced so that identified gaps can be addressed during the period of change.

Recommendation

A project to explore the issues experienced by persons who are receiving involuntary treatment and also have matters being dealt with under the justice system including recommendations for systemic reform.
Recommendations
Recommendations

The following recommendations are based on feedback from community members in the Cairns area. A research project from a national perspective may inform further recommendations and improvements for positive systemic reform.

These recommendations aim to increase attendance and representation at the Mental Health Review Tribunal (MHRT) and in doing so, facilitate recovery by improving people’s understanding of their rights, choices and access to supports within the mental health system.

Recommendation

Increased and accessible training, education and information on people’s rights; mental health legislation; and MHRT processes for all stakeholders provided in ways that are relevant and effective to each group.

[refer to Project Outcomes, pg. 18]

People with lived experience.

- Information packs
- Information sheets and other diverse formats
- Self-advocacy and peer support training
- Consumer Companions
- General community discussion and awareness raising

Carers, family members and significant others (support persons)

- A central point of contact for information and referral to appropriate services

Staff working with people with lived experience at Queensland Health and other service providers (community and health workers)

- Compulsory training regarding mental health legislation and MHRT processes from a human rights perspective
Legal representatives (and others wanting to understand the role of legal representation at the MHRT)
- Webinars
- Mental Health Legal Service

Allied persons (this term may become nominees in the new legislation)
- Information packs and education forums

Aboriginal and Torres Strait Islander peoples
- Training, resources and educational forums from a cultural perspective and facilitated or informed by Indigenous people from the local area
- Pictorial resources

**Recommendation**

The MHRT must be adequately resourced to develop, disseminate and coordinate training, education and information resources to support all stakeholders in Queensland.

[refer to Project Outcomes, pg. 21]

**Recommendation**

The MHRT and the person on the ITO receive the clinical report at least seven days before the hearing date.

[refer to Preparing for the Mental Health Review Tribunal, pg. 38]

**Recommendation**

Community awareness and support of documents that represent the voice of the person including:
- Self Report and other formats
- Advance Health Directives

[refer to Preparing for the Mental Health Review Tribunal, pg. 44]
Recommendation

Community legal services investigate funding for the provision of a Mental Health Legal Service in the Cairns region.

[refer to Representation at the Mental Health Review Tribunal, pg. 54]

Recommendation

The Patient Rights Adviser role should be independent from Queensland Health and resourced to provide support for all stakeholders in the process. This community engagement will require a team of personnel.

[refer to Continuity Of Care, pg. 61]

Recommendation

A project to explore the issues related to attendance and representation for Aboriginal and Torres Strait Islander people on ITOs, driven and informed by Aboriginal and Torres Strait Islander community members from and based in the community being explored. This would include recommendations for systemic reform.

[refer to Aboriginal and Torres Strait Islander people on involuntary treatment orders, pg. 69]

Recommendation

A project to explore the issues experienced by persons who are receiving involuntary treatment and also have matters being dealt with under the justice system including recommendations for systemic reform.

[refer to Mental Health and the Justice System, pg.73]
**Visual Summary**

**QLD** has the lowest attendance at mental health review tribunals Australia wide: **39%**

**AND THE LOWEST** legal representation (2.3%)

**5x SELF REPORTS** received this year in Cairns: **1034 HEARINGS**

**THIS IS 0.0005%**

**41%** of hearings in the Cairns region are for Aboriginal or Torres Strait Islander which appears to be an overrepresentation of the population in the Cairns region: **18%**

A patient who attends their hearing is **10 TIMES** more likely to be revoked than those who don’t attend.

**TREATING TEAM ATTENDANCE**

- Nurse and Case Manager: **756**
- Psychiatrist: **167**
- Registrar or Other Doc: **109**
- Indigenous Mental Health Worker: **24**
- Indigenous Tribunal Member: **243**

**WHO ATTENDED THIS YEAR?**

- Person on ITO: **321**
- Allied Person/Other Support: **139**
- Lawyer: **7**
- Advocate/Agent: **4**
- Cultural Support: **9**

Wanted more info on their rights: **83% on an ITO**

**83%** on an ITO

**78**
Appendices

Resources

Self Report
Resources

Information on the Queensland Mental Health Review Tribunal (MHRT) and its processes:

- Queensland Mental Health Review Tribunal

  Resources include an interactive online guide to attending a hearing, DVDs, online
  AUSLAN videos, brochures and factsheets as well as resources specifically for Aboriginal
  and Torres Strait Islander people.

- Public Forms

  This includes all forms associated with MHRT processes.

- Self Report

  Refer to Preparing for the Mental Health Review Tribunal (pg. 33-44).

- Mental Health Court forms

  This includes all Queensland Court Forms. Find Mental Health Act 2000 (Qld) for a list of
  the forms associated with this legislation.

Information on mental health legislation:

- Mental Health Act 2000 (Qld) (Current as at 1 September 2015)
  [https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealthA00.pdf](https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealthA00.pdf)

  Queensland’s current mental health legislation.

- Queensland Parliament

  Two Bills (the Mental Health (Recovery Model) Bill 2015 and Mental Health Bill 2015)
  have been referred to the Health and Ambulance Services Committee for consideration.
  This site includes information on each Bill, background and prior consultation,
  submissions, and public hearings and briefings. Refer to this site for up to date information
  on changes to Queensland’s mental health legislation.
• Queensland Government Mental Health Resources
Resources include factsheets and posters about the Mental Health Act 2000 (Qld) and associated topics, as well as general information on mental health and wellbeing.

Information for legal representatives:
• Queensland Handbook for Practitioners on Legal Capacity
This resource provides practical guidance on the legal and ethical issues relevant to competency issues for elderly clients, clients with mental illness, intellectual or cognitive impairment.

Information on persons seeking advocacy, legal representation or support:
• Rights in Action
http://www.rightsinaction.org/
Rights in Action is a non-profit, community based organisation that provides strong independent advocacy for people with disabilities who are in vulnerable situations. Rights in Action is completely on the side of the person with a disability and will support them where needed. Advocates have had experience with the MHRT. Call on (07) 4031 7377 or email info@rightsinaction.org
• Capricorn Citizen Advocacy
  http://www.capricorncitizenadvocacy.org.au/1resources.htm
  This organisation is based around a trained community member (citizen) establishing an
  advocacy relationship with a person with a disability who is vulnerable and has significant
  unmet needs. Online resources include lists of books, publications, videos and DVDs that
  may be of interests to persons with lived experience and advocates.

• Aboriginal and Torres Strait Islander Legal Service (Qld) Ltd (ATSILS)
  http://www.atsils.org.au/
  ATSILS is a community based organisation that provides professional and culturally
  competent legal services for Aboriginal and Torres Strait Islander people across
  Queensland. ATSILS can provide legal assistance in advice, duty and casework matters
  including a free-call telephone advice service, referrals, and preliminary assistance (such
  as writing short letters and completing forms). Call the Cairns office on (07) 4046 6400 or
  the toll free line on 1800 012 255.

• Legal Aid
  Legal Aid gives legal help to financially disadvantaged people about criminal, family and
  civil law matters. There is a Legal Aid office in Cairns City. You can call Cairns on (07) 4048
  1133 or the Client Information Service Centre for free legal information on 1300 65 11 88.

• Queensland Advocacy Incorporated (QAI)
  http://www.qai.org.au/
  QAI is a free mental health legal advice and representation service. It provides free,
  independent legal assistance in mental health law across Queensland. People can call
  (07) 3844 4200 to make a telephone appointment. Other resources include factsheets on
  the Mental Health Act, advocacy and human rights.

• Queensland Public Law Clearing House Incorporated (QPILCH)
  QPILCH Mental Health Law Practice provides free legal advice and assistance to people
  with mental illness, or impacted by mental health law who cannot afford a private lawyer.
  This service is based in Brisbane but they provide advice over the phone on (07) 3846
  6317. Other resources include factsheets and referrals of where to go for help.
• Office of the Health Ombudsman
The Office of the Health Ombudsman receives complaints about health services. All information provided is treated confidentially, and reviewed fairly and impartially.

• Queensland Mental Health Commission (QMHC)
QMHC is a statutory body with the purpose of driving ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance abuse system. There are a number of resources on the QMHC site about action on mental health in general. This may be a good site to keep up to date with possible training and education opportunities when mental health legislation changes.

This is not an exhaustive list of resources relating to MHRT processes and mental health legislation.
Self Report to the Mental Health Review Tribunal

The Mental Health Review Tribunal protects the rights of people having involuntary treatment. Your treating team will prepare a clinical report BUT the Tribunal would also like to know your views. You may use this form to help you prepare a report for your Mental Health Review Tribunal hearing. The Tribunal will use this information in making their decision. You may post or fax this to the Tribunal or bring it with you to your hearing. You can give information to the Tribunal in other ways such as a letter, or by talking to the Tribunal at your hearing. You may like to include other information.

You only need to give information to the Tribunal if you want to.
If you have a support person you can ask them to help you fill out this form

<table>
<thead>
<tr>
<th>Your details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

Below are some suggestions of what you might like to tell the Tribunal:

- How you feel about being on an order
- The result you want from the Tribunal hearing
- Any comments about the doctor’s report
- How you feel about your treatment
- The people who support you and the ways they support you
- Your hopes and plans for the future
- How do you think/feel your life is going
You may also like to comment on the following. These are only suggestions

- How you are looking after yourself
- How you deal with life’s stresses and what you do
- What will it take to have control of yourself
- Where you live and if you are happy there
- How you occupy your time – paid/voluntary work; studying; hobbies; interests
- Any comments about the progress you have made
- Any other information you would like to tell the Tribunal

Please sign your report

Patient Signature

Date: / / 

Thank you for completing this form

Please return it to the Tribunal by one of the following methods:
Post to: MHRT, PO Box 15818, City East, Brisbane, QLD, 4002
Fax to: (07) 3234 1540
Bring this form with you to your hearing
Reference List

Mental Health Act 2000 (Qld) (Current as at 1 September 2015),

Queensland Mental Health Review Tribunal (MHRT),

NSW Mental Health Review Tribunal 2014/15 Annual Report,

Queensland Advocacy Incorporated (QAI),
http://www.qai.org.au/

Queensland Mental Health Review Tribunal (MHRT) 2014/2015 Annual Report,

Queensland Parliament: Mental Health (Recovery Model) Bill 2015 and Mental Health Bill 2015,

Queensland Public Interest Law Clearing House Incorporated (QPILCH),

Victoria Mental Health Tribunal 2014/2015 Annual Report,
The Partners in Recovery (PIR) initiative is funded by the Australian Government Department of Health.

phone: 07 4031 7377
email: info@rightsinaction.org