From the Deputy President

Section 420 and less restrictive way

Section 420 applies to certain TA reviews from 5 March 2018. The section applies to the third review of a TA, that is, the second six monthly periodic review excluding any Applicant or Tribunal initiated reviews which have occurred before then. The administrator of the patient's treating service must give the Tribunal a report about whether the appointment of a personal guardian for the person may result in there being a less restrictive way for the person to receive treatment and care for the person's mental illness (section 420(1)(a)), and the Tribunal must consider that issue. The Chief Psychiatrist has issued a summary about the requirements of s420 to treating teams.

The clinical report template for TAs has been modified to include a section which clinicians can complete to satisfy section 420(1)(a), with the aim of avoiding adjournments because a separate report has not been provided in time. S420(1)(a) places the requirement to 'give the tribunal a report' on the administrator (or delegate, likely including the treating psychiatrist) and there is not an express requirement that the report be in writing. Whilst addressing the issue in writing in the clinical report may provide a patient with more time to consider the view expressed there, it is open to the tribunal to obtain a report orally at the hearing where the patient is present to hear it. Further, it may be that the Tribunal can obtain sufficient evidence from other parts of the clinical report, or from a combination of all sources of information before it, for the Tribunal to satisfy itself as to whether or not there is a less restrictive way. Should the Tribunal not be able to satisfy itself on that question, it may be necessary to adjourn.

You will note the requirement exists only for this particular review and is not an ongoing obligation.

For the purposes of section 420, personal guardian means a guardian appointment for a health matter by QCAT under the *Guardianship and Administration Act 2000* (**GAA**). A personal guardian may, in accordance with the GAA, make healthcare decisions for a patient and provide consent to receive treatment and care (subject to any conditions on the guardian's appointment). A guardian can be a person known to the patient or may be the Public Guardian. Often there are situations where a patient requires treatment and care for a mental illness but does not have capacity to provide consent. Rather than involuntary treatment, a personal guardian may be able to provide consent for the treatment.

In considering whether a personal guardian may result in a less restrictive way, the Tribunal may seek evidence from the treating team about a range of matters, including:

- whether the patient already has a personal guardian appointed by QCAT; or who would be a suitable appointment as guardian for the patient
- the types of healthcare decisions that would need to be made for the patient
- whether the treating team is aware of a person who may be able to be appointed as personal guardian or whether it would need to be the Public Guardian
- whether the possible appointed guardian would be prepared to make the required decisions
- whether any information is known about the views of a possible guardian and whether those views are in the best interests of the patient and in accordance with best medical practice.
- Whether the appointment of a person close to the patient to this role may have an impact on the quality of that personal relationship
- Whether the strict statutory review schedule for those subject to involuntary treatment under the Act in gives a patient more rights (and is less restrictive) than a patient may have under an appointment of a personal guardian by QCAT which is not reviewable in that way and relies on a review being initiated.

S420(1)(b provides that the Tribunal must consider whether such an appointment will result in a less restrictive way of the patient receiving treatment. I recommend that Tribunal panels record their deliberations on this issue and the considerations they took into account in the hearing notes to demonstrate this.

Learning and Development Committee

A Learning and Development Committee has been appointed and I would like to thank Helen Ridley, Jo Loftus, Fiona Meagher and Pat Hall for agreeing to participate. I will chair the committee, and the members may change annually to give others an opportunity to be involved. Initially the Committee will establish its role, or terms of reference, and will as a priority consider the course content and delivery method for the Forensic Specialisation course. It will look at continuing professional development, and have a role in the induction program for new members. In the meantime, the Tribunal has developed a Learning and Development Framework (attached) and I welcome your feedback on that document. Of course I am always happy to have members suggestions about continuing professional development so please email me if you have some ideas.

Section 199

Section 199 applies, for example, where a person on a treatment authority may be incarcerated at the time of the hearing. Section 199(2) provides that, in making a decision about the patient's treatment in the community, the decision must be made without regard to whether the patient is in custody under another Act. *As the explanatory notes for the section say: ".. a person on a treatment authority on an inpatient category may be lawfully held in custody, as the custodial status takes precedence. These provisions are subject to the classified patient provisions in chapter 3.'*

The result achieved by this section is different to that achieved by providing that the person in prison is community category, and including conditions about attendance at an AMHS post release. The effect of making the category of the person in prison 'inpatient' is that their discharge address from prison will be the AMHS, where they will be assessed. This is the place to which the prison must release them. Where a patient is made community whilst in prison, with, for example, a condition that they attend at an AMHS with 48 hours of release from prison for assessment, the discharge address can be anywhere, and a patient may not necessarily prioritise the AMHS visit in their first two days of freedom. This means the patient is placed in the position of breaching their LCT/conditions almost immediately.

The Act provides a direct pathway, which is therefore the preferable pathway, for the person who is in prison and for whom the Tribunal has sufficient concerns as to want them assessed by a clinician in an AMHS before returning to the community. This decision is always predicated on the Tribunal's thinking about the need for such an assessment or monitoring. If the Tribunal is satisfied that the person in prison can safely be returned to community living without an assessment by the treating team, then the category of community is appropriate.

Treatment Support Order to Treatment Authority

A member contacted me this week indicating she was to consider an application by a treating team for revocation of a TSO and making of a TA. This was the first one I had heard of but these applications will no doubt increase, particularly as some treating teams have made it clear they see the TSO as a 'step down' towards a 'step out' of the involuntary mental health system.

The important issue is that the TA can only be made on the recommendation of an authorised psychiatrist who considers that the treatment criteria apply and that there is no less restrictive way for the person to receive treatment and care for their mental illness: section 483(2) (a) and (b). If the Tribunal makes a TA, the decision must include the category of the TA (remembering there is a default position of community category unless certain circumstances apply), the AMHS responsible for the person, any limited community treatment and conditions

Acknowledgement of the traditional custodians

A few members have expressed concerns that they have been requested to make the acknowledgement of traditional custodians at hearings for indigenous patients only. Please feel free to make that acknowledgement before every hearing. The suggestion was to introduce it at indigenous hearings initially in order not to place further pressure on members by making it 'compulsory' at every hearing. The ideal is that it is done at every Tribunal hearing.