Better Pathways:

Improving Queensland's delivery of acute mental health services

August 2022

The Public Advocate

Influencing change to empower lives

Acknowledgement of Country
The Public Advocate and staff acknowledge Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as the Traditional Owners and custodians of the land on which we live. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging

Acknowledgement of Lived Experience
We acknowledge the experiential expertise of adults with impaired decision-making ability, whose rights we seek in our work to promote and protect.

Authorship
This report has been drafted by staff at the Office of the Public Advocate in collaboration with Professor Neeraj Gill, who was contracted by the Office to work on this project.

Public availability
This report is available online at www.publicadvocate.qld.gov.au. Alternatively, you may contact our office to access a hard copy.

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Interpreter service
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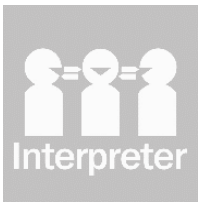


Recent Public Advocate systemic advocacy publications (available at www.publicadvocate.qld.gov.au)

- Adult safeguarding in Queensland, Volume 1. Identifying the gaps
- A discussion of section 216 of the Queensland Criminal Code: a call to review the criminalization of sexual relationships involving people with 'an impairment of the mind'
- Elder abuse: Joint issues paper (co-publication with the Queensland Law Society)
- Improving the regulation of restrictive practices in Queensland: a way forward

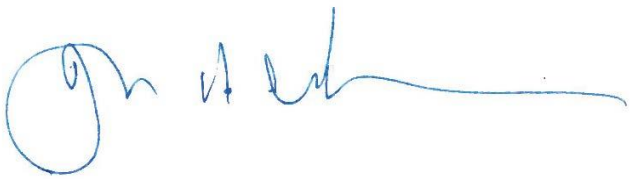
Foreword

It is a hallmark of a society that values all its citizens that targeted, timely, and high-quality mental health services are available to all who need them. And it is fair to say that our need for such services is, for a range of reasons, greater now than it has been before. In addition to other factors that affect a person's mental health, the past two years have seen extraordinary additional stresses placed on the mental health of Queenslanders, with the Covid-19 pandemic and major flooding incidents testing the resilience of all who have been affected. We know that we in Queensland have much to do to improve and broaden the mental health services that we offer; whether that be services for people in acute situations, better early intervention, improved community-based support, and indeed in the myriad ways we can prevent the deterioration in people's mental health.

Testimony to the widespread agreement on this point, a matter of weeks after the research for this report began, the Queensland Parliament established the Mental Health Select Committee to inquire into 'opportunities to improve mental health outcomes for Queenslanders'. That Committee's final report was delivered in June 2022. Rather than supplanting the need for this report, the Mental Health Select Committee's report can, and I hope will, be read in tandem with this one. Where the Committee concentrated on making reform recommendations that will lead to a broad improvement in the mental health of Queenslanders, this report concentrates on identifying improvements to the public acute mental health system and focusses on this particular area in far greater depth than the Committee could, given its very broad terms of reference. To the extent that there is overlap, the two reports can be seen as complementary (indeed this report makes particular reference, in its recommendations, to instances where the Mental Health Select Committee has made similar reform calls). Moreover, I am hopeful that the reforms recommended here are able to be implemented as part of the Queensland Government's mental health reform agenda, which is due for release soon.

The production of this report has been a joint undertaking; it has been researched and written by staff members in this office in close collaboration with consultant psychiatrist Professor Neeraj Gill. I want to thank Professor Gill for this collaboration, which has enabled staff in this office to draw on his clinical (and other) expertise. I also want to acknowledge and thank Sandra Smith, who led the office's involvement in the project, along with Tracey Martell, who provided extensive editing and collegial support. I also want to thank the key stakeholders who provided valuable comments on the penultimate draft of this report (but who of course are not responsible for any errors in the report).

This report makes 21 very carefully considered, and feasible, reform recommendations. I look forward to working with the various parties to whom those recommendations are addressed in seeing them realised.



John Chesterman (Dr)
Public Advocate

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Acronyms

ABS	Australian Bureau of Statistics
ACT	Acute Care Team
ASBD	Acute Severe Behavioural Disturbance
AHD	Advanced Health Directive
AIHW	Australian Institute of Health and Welfare
AMHS	Authorised Mental Health Service
ATS	Australasian Triage Scale
CCT	Continuing Care Team
CCU	Community Care Unit
CIMHA	Consumer Integrated Mental Health and Addiction (application)
CRPD	Convention on the Rights of Persons with Disabilities
DIDO	Drive-in Drive-out
DJAG	Department of Justice and Attorney-General
DSDSATSIP	Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
EA	Examination Authority
ECT	Electro-convulsive Therapy
EEA	Emergency Examination Authority
EEO	Emergency Examination Order
FIFO	Fly-in Fly-out
FO	Forensic Order
FTE	Full time equivalent
GP	General Practitioner
HHB	Hospital and Health Board
HSCE	Health Service Chief Executive
ICCPR	United National International Covenant on Civil and Political Rights
IPRA	Independent Patient Rights Adviser
MHAODB	Mental Health Alcohol and Other Drugs Branch
MHRT	Mental Health Review Tribunal
MIDAS	Mater Intellectual Disability and Autism Service
MIRT	Mobile Intensive Rehabilitation Team
NDIS	National Disability Insurance Scheme
NSP	Nominated Support Person
NSQHS	National Safety and Quality Health Service
NTS	National Triage Scale
OPCAT	Optional Protocol to the Convention against torture and other cruel, inhuman or degrading treatment or punishment
OPMH	Older Persons Mental Health
PHN	Primary Health Network
QAS	Queensland Ambulance Service
QCAT	Queensland Civil and Administrative Tribunal
QH	Queensland Health
QPRIME	Queensland Police Records and Information Management Exchange
QPS	Queensland Police Service
QUM	Quality Use of Medicines
SAMHSA	Substance Abuse and Mental Health Services Administration
SMHIDS	Statewide Mental Health Intellectual Disability Service
SHA	Statutory Health Attorney
SUSD	Step-up Step-down
TA	Treatment Authority
TSO	Treatment Support Order
WHO	World Health Organisation

Executive Summary

Mental illness is common, with one in every two Queenslanders experiencing some type of mental illness during their lifetime, and almost one in five experiencing mental illness in any one year. Among the estimated 17% of Queenslanders who will experience a mental illness annually, approximately 3% will experience a severe mental illness, 5% a moderate mental illness and 9% a mild mental illness.[1]

State funded hospital inpatient acute services are funded to provide care to Queenslanders who experience the most severe forms of mental illness and behavioral disturbances, including those who may fall under the provisions of the *Mental Health Act 2016* (Qld).

The principal intent of Queensland's *Mental Health Act*, when revised in 2016, was to improve the human rights protections afforded to people receiving mental health assessments, treatment, and care under the Act, as well as limiting the number of people subject to compulsory or involuntary treatment.[2]

The objective of this report has been to identify issues impacting adults with impaired decision-making ability and a mental illness at various stages of their journey through the public acute mental health system. To achieve this, stakeholders with extensive expertise in the assessment, treatment, and care of people with an acute mental illness were consulted across metropolitan and regional areas of Queensland. In addition, people with a lived experience of mental illness shared their stories and provided valuable insights on their experiences of the system.

This report has been prepared by the Public Advocate in collaboration with Professor Neeraj Gill, who contributed his extensive clinical and academic expertise in mental health, human rights, mental health law and the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, as a practising psychiatrist and academic.

Issues have been identified across multiple stages of a patient's journey through the public acute mental health system.

The issues highlight the need for systemic changes to improve:

- The response to people experiencing a mental health crisis in the community;
- The experience of mental health patients in emergency department settings;
- The experiences of voluntary and involuntary patients admitted to inpatient Authorised Mental Health Services, addressing, in particular, the locked ward policy, restrictive practices, and the assessment and treatment of dual disability patients;
- The accountability and transparency of the Mental Health Review Tribunal;
- Independent system safeguards and protections, inclusive of Independent Patient Rights Advisers and community visitors;
- Discharge planning processes, to facilitate the increased involvement of patients, families, and supporters;
- Data collection and reporting to monitor the system; and
- The development of Disability Service Plans by Hospital and Health Services that include specific mental health-based strategies.

Twenty-one recommendations have been made that are consistent with the protection of human rights in acute care settings and the associated delivery of positive outcomes for adults with impaired decision-making ability. Several of the recommendations are consistent with recommendations made by the Queensland government's Mental Health Select Committee following its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'.

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[1] Queensland Health, '*Written briefing, inquiry into the opportunities to improve mental health outcomes for Queenslanders*,' <https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/a220114%20-%20Queensland%20Health%20-%20Written%20brief.pdf> 2022, p.5.

[2] *Mental Health Act 2016* (Qld) s 4.

Recommendations

Supporting the delivery of effective community mental health crisis responses

Recommendation 1

Queensland Health should extend Acute Care Teams to deliver 24-hour outreach services in the community, providing short-term clinical crisis interventions and onward referral to people experiencing a mental health crisis.

Recommendation 2

The Queensland Government should extend the co-responder program, in a format that is appropriate to each particular region, so that it is available to all Queenslanders.

This recommendation is consistent with recommendations 28 and 30 of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

Recommendation 3

The Queensland Government should extend Queensland Health's Crisis Support Spaces program to provide:

a. a 7 day a week service, with opening hours consistent with peak periods for mental health presentations at hospital emergency departments;
b. referral via General Practitioners, the Queensland Ambulance Service or patient self-presentation;
c. home-like, safe, and calming environments to enhance the patient care experience; and
d. best practice crisis and stabilisation services, delivered by a combined peer lived experience and clinical workforce.

This recommendation is consistent with recommendations 29 and 30 of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

Recommendation 4

The Queensland Ambulance and Police Services should extend mental health crisis training for first responders to include training on responses for people presenting with a dual disability such as a mental illness and an intellectual disability or cognitive impairment.

Improving the experiences of mental health patients in emergency departments

Recommendation 5

Hospital and Health Services should engage people with lived experience to co-design spaces in emergency departments for patients presenting with a mental illness. These areas need to be quiet, calm, and facilitate a trauma-informed therapeutic approach to care.

This recommendation is consistent with recommendations 4 and 21 (in relation to co-design) of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

Recommendation 6

Hospital and Health Services should provide people with a mental illness with appropriate access to a peer lived experience worker in emergency departments.

Recommendation 7

Hospital and Health Services should expand their Aboriginal and Torres Strait Islander mental health workforce, enabling improved access for Aboriginal and Torres Strait Islander people who present to emergency departments or who are admitted into inpatient Authorised Mental Health Services.

This recommendation is consistent with recommendation 57 of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

Recommendation 8

The Chief Psychiatrist should amend the 'management of complaints and a right to second opinion' policy to ensure that patients receiving treatment under the *Mental Health Act 2016* get support to understand the services they are receiving and are provided with timely access to a peer lived experience worker.

This recommendation is consistent with recommendation 54 (expansion of the lived experience workforce) of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

Improving the experience of mental health patients admitted to inpatient Authorised Mental Health Services

Recommendation 9

The Chief Psychiatrist should prioritise the abolition of the locked ward policy for all inpatient Authorised Mental Health Services across Queensland and replace it with a discretionary locking of wards policy.

Recommendation 10

The Chief Psychiatrist should develop a policy directing all inpatient Authorised Mental Health Services to prepare and distribute an information package for voluntary patients, aligned with:

a. the Australian Charter of Healthcare Rights;
b. the National Safety and Quality Health Service Standards; and
c. the National Standards for Mental Health Services.

Under this policy all voluntary patients should receive the support and information necessary for them to understand their rights when receiving treatment and care.

Recommendation 11

The Chief Psychiatrist should undertake a review of the use of restrictive practices in inpatient Authorised Mental Health Services and develop a strategy to reduce or eliminate their use, in conjunction with ensuring safe working environments for staff. The review and strategy should consider, among other things:

a. the introduction of the Safewards model;
b. ward design features that reduce the use of seclusion and physical restraint, and;

c. the effectiveness of the Psychotropic Prescribing Guideline for people with intellectual or developmental disability.

Recommendation 12

The Queensland Government should fund a specific service to provide assessment, treatment and care of patients with a dual disability (such as a mental illness and an intellectual disability, dementia or acquired brain injury). This service should:

a. provide expert consultation services for the assessment and treatment of mental health patients with a dual disability;
b. be accessible to mental health practitioners across all Hospital and Health Services, including in regional and remote areas; and,
c. operate as a centre of excellence for people with a dual disability.

This recommendation is consistent with recommendation 9(a) of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

The Mental Health Review Tribunal

Recommendation 13

The Mental Health Review Tribunal should:

a. prioritise the electronic recording of all tribunal proceedings in accordance with the *Recording of Evidence Act 1962*;
b. develop a policy detailing a consistent approach to the attendance of support persons at Mental Health Review Tribunal hearings, including Individual Patient Rights Advisers for those patients who do not have an identified support person; and,
c. continue to regularly review and, where necessary, revise all written information provided to patients, their families and support persons explaining the role and functions of the tribunal and the outcomes of tribunal hearings. All information needs to be easily understood by people who are acutely unwell, have a dual disability, or are from a culturally and linguistically diverse background.

Recommendation 14

Inpatient Authorised Mental Health Services should develop guidelines to facilitate the timely sharing of Mental Health Review Tribunal hearing lists with Independent Patient Rights Advisers so that patients can be supported to engage a legal advocate if desired.

System safeguards and protections

Recommendation 15

The Chief Psychiatrist should develop, in collaboration with Hospital and Health Services, a set of minimum standards to guide the referral of mental health patients to Independent Patient Rights Advisers. The standards should apply to all areas of patient presentation, including in emergency departments and Queensland Health's Crisis Support Spaces. They should also include scope for appropriate variations in regional, rural and remote areas.

Recommendation 16

Queensland Health should expand the Independent Patient Rights Adviser service to be available after business hours and on weekends to accommodate the significant proportion of patients presenting to emergency departments at these times.

Recommendation 17

The Chief Psychiatrist and the Public Guardian should develop a memorandum of understanding between the Independent Patient Rights Adviser service and the Community Visitors Program that acknowledges the separate roles and responsibilities of each service in safeguarding the rights of patients and provides for collaboration and reporting relationships between the two services.

Recommendation 18

The Queensland Government should expand the role of the Inspector of Detention Services so that their duties include inspections of inpatient Authorised Mental Health Services where involuntary patients are detained. Alternatively, an OPCAT-compliant inspection mechanism should be established for all Authorised Mental Health Services where involuntary patients are detained.

Discharge planning processes – Inpatient Authorised Mental Health Services

Recommendation 19

Hospital and Health Services should improve the discharge planning process for mental health patients by:

a. engaging with patients, their caregivers, support persons and relevant substitute decision-makers in all decisions regarding the patient's ongoing treatment and care; and,
b. improving the accessibility and relevance of information provided to General Practitioners when a patient is discharged from an Authorised Mental Health Service.

This recommendation is consistent with recommendation 3 of the Queensland Parliament Mental Health Select Committee's report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' (June 2022).

Improving data collection and reporting

Recommendation 20

The Chief Psychiatrist should develop mechanisms to collect and report annually on data associated with the operation of Authorised Mental Health Services including:

a. the number of patients who enter an inpatient Authorised Mental Health Service voluntarily (via their own consent or through the operation of an Advance Health Directive);
b. the number of patients who enter an inpatient Authorised Mental Health Service under substitute consent provided by:
    - a personal guardian,
    - an attorney appointed under an enduring power of attorney or Advance Health Directive; or,
    - a statutory health attorney; and
c. the number of patients whose status changes from voluntary to involuntary during their stay in an inpatient Authorised Mental Health Service.

Disability service plans

Recommendation 21

All Hospital and Health Services should develop disability service plans, and incorporate into those plans specific mental health strategies that include (but are not limited to):

a. involving people with lived experience of mental illness in the co-design of spaces for mental health patients in emergency departments;
b. providing people with appropriate information and support to understand their rights as a mental health patient; and,
c. facilitating the involvement of patients, families, caregivers and support persons (to the extent desired by the patient), or relevant substitute decision-makers, in decisions regarding admission, treatment, care and discharge.

1.0 Introduction

1.1 Mental Health

The World Health Organisation (WHO) defines mental health as 'a state of well-being in which the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.[3] Conversely, mental illness (also referred to as ill mental health) is defined as a 'clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities'.[4]

Mental illness is common, with one in every two Queenslanders experiencing some type of mental illness during their lifetime, and almost one in five experiencing mental illness in any one year. The severity of mental illness can range from mild to severe. Among the estimated 17% of Queenslanders who will experience a mental illness annually, approximately 3% will experience a severe mental illness, 5% a moderate mental illness and 9% a mild mental illness.[5]

For at least the last decade, emergency departments have been recognised as a key entry point for people needing to access assessment and treatment for a mental illness. Mental health related presentations to Queensland public emergency departments accounted for between 3.8% - 4.0% of all presentations from 2010 – 2020, increasing slightly to 4.1% in 2019/2020. It is suggested that the change recorded in 2019/20 is attributable to the effect of the COVID-19 pandemic on mental health. However, these statistics also highlight the relevance of this issue prior to COVID-19.[6]

During 2019/2020, 55.3% of mental health related emergency department presentations in Queensland arrived by ambulance, 8.4% by police or correctional services and 36.3% by other modes of transport.

In the same year, 16% of mental health related presentations in Queensland were triaged as an emergency (patient to be seen within 10 minutes of presentation), 54.2% as urgent (patient to be seen within 30 minutes) and 22.8% as semi-urgent (patients to be seen within 60 minutes).[7] Furthermore, in the same period 39.3% of mental health related presentations were admitted to hospital from the emergency department and 1.8% were referred to another hospital for admission.[8]

While these figures do not reflect the number of people with ill mental health who were provided with alternative treatment to divert them away from emergency department settings, it does highlight the high volume of people with ill mental health being transported to emergency departments by ambulance services, and the proportion who are subsequently admitted to hospital for ongoing assessment, treatment, and care.

State funded hospital inpatient acute services have always been an essential part of the Queensland mental health system for people requiring assessment and treatment of an acute mental illness. These services are funded to provide care to Queenslanders who experience the most severe forms of mental illness and behavioral disturbances, including those who may fall under the provisions of the *Mental Health Act 2016* (Qld).

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[3] World Health Organisation, *Mental health: strengthening our response*, 2018, <http://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>.
[4] Australian Government, Mental Health Commission, '*The fifth National Mental Health and Suicide Prevention Plan 2017-2022*,' National mental health strategy, August 2017, p.67.
[5] Queensland Health, *Written briefing, inquiry into the opportunities to improve mental health outcomes for Queenslanders*, <https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/a220114%20-%20Queensland%20Health%20-%20Written%20brief.pdf> 2022, p.5.
[6] Australian Institute of Health and Welfare, *Mental health services in Australia: Services provided in public hospital emergency departments,* 01 Feb 2022.
[7] Australian Government, *Report on government services, chapter 11, Public Hospitals*, p.14, 2016, rogs-2016-volumee-chapter11.pdf.
[8] Australian Institute of Health and Welfare, *Mental health services in Australia: Services provided in public hospital emergency departments,* 01 Feb 2022.

One of the main intentions of Queensland's *Mental Health Act*, when revised in 2016, was to improve the human rights protections afforded to people receiving mental health assessments, treatment, and care under the Act, as well as limiting the number of people subject to compulsory or involuntary treatment.[9]

Since that time, and aligned with growing community concern regarding mental health, there have been a number of reviews and strategies developed at a state and national level.

Late in 2021, the Queensland government initiated a parliamentary inquiry, conducted by the Mental Health Select Committee, into 'opportunities to improve mental health outcomes for Queenslanders'. This inquiry (to which the Public Advocate provided written and oral submissions) made available a platform from which to explore issues impacting the delivery of mental health services across the continuum of care, to highlight the strengths and limitations of the current system. The report detailing the findings of the inquiry was tabled in the Queensland Parliament on 6 June 2022, including 57 recommendations to the Queensland government.[10] This report has been followed by a commitment by the Queensland Government to the development of a dedicated mental health funding stream in its 2022-23 financial year budget.[11]

This report complements the inquiry's report, with a focus on one component of the mental health care system in Queensland – the public acute mental health system.

It explores issues impacting adults with impaired decision-making ability who have been admitted to an inpatient Authorised Mental Health Service (AMHS) as:

- an involuntary patient under the *Mental Health Act;*
- a voluntary patient with the consent of a substitute decision-maker or statutory health attorney (SHA); or,
- a voluntary patient who has consented to their own admission.

This report also considers those adults who have not been admitted to an inpatient AMHS, however are receiving treatment and care from a Queensland Health Acute Care Team (ACT).

1.2 The Public Advocate

The Public Advocate is established under chapter 9 of the *Guardianship and Administration Act 2000* (Qld) to promote and protect the rights and interests of Queensland adults with impaired decision-making ability[12] through systemic advocacy.

Section 209 of the *Guardianship and Administration Act* states that the functions of the Public Advocate are:

a) promoting and protecting the rights of adults with impaired capacity (the adults) for a matter;
b) promoting the protection of the adults from neglect, exploitation, or abuse;
c) encouraging the development of programs to help the adults to reach the greatest practicable degree of autonomy;
d) promoting the provision of services and facilities for the adults;
e) monitoring and reviewing the delivery of services and facilities to the adults.

[9] *Mental Health Act 2016* (Qld) s 4.
[10] Mental Health Select Committee, *Inquiry into the opportunities to improve mental health outcomes for Queenslanders*, Parliamentary Committees, Report No. 1, 57th Parliament, June 2022, pp.x – xviii.
[11] Queensland Government, 2022-23 Budget, *Investing in our health*, <Investing In Our Health - Queensland Budget 2022-23> 22 June 2022.
[12] People with impaired decision-making ability encompass a broad and diverse group. Conditions that may affect a person's decision-making ability include intellectual disability, acquired brain injury, mental illness, neurological disorders (such as dementia) or alcohol and drug misuse. While not all people with these conditions will experience impaired decision-making ability, many will at some point in their lives. For some, impaired decision-making ability may be episodic or temporary, requiring intensive supports at specific times, while others may require lifelong support with decision-making and communicating their choices and decisions.

The operation of Queensland's public acute mental health system has been of concern to Public Advocates in Queensland for several years, particularly in relation to the assessment, treatment, and care of adults with impaired decision-making ability.

Following the introduction of amendments to the *Mental Health Act 2016*, the previous Public Advocate noted critical issues in the Office of the Chief Psychiatrist's annual reports, specifically in relation to involuntary treatment and its impacts on the human rights of individuals at a time when they are at their most vulnerable.

Not all people with a mental illness will experience impaired decision-making ability, however it is likely that many will, and particularly those who require acute care and treatment. People in this cohort may have impaired decision-making ability because of an intellectual disability, acquired brain injury or dementia and develop a mental illness during their life or, alternatively, they may have a mental illness that affects their decision-making ability, either temporarily or permanently.

This report reflects the Public Advocate's ongoing interest and advocacy in this area. It details the findings of a systemic project, undertaken by the Public Advocate in collaboration with Professor Neeraj Gill (Health Research Institute, University of Canberra and School of Medicine, Griffith University).

2.0 This report

2.1 Scope

This report focusses on the admission, assessment, treatment, and care provided to adults with an acute mental illness in the Queensland public mental health system.

Noting the complexities in the Queensland public mental health system, which provides a broad range of services, some of which involve significant interface with other systems and organisations, the scope of the project informing this report has included:

- the initial response to a mental health crisis in a community setting (including the interface between emergency services and hospital emergency departments);
- assessment and treatment in the community by an ACT (funded by Queensland Health);
- admission into an inpatient AMHS (including the admission of adults on a voluntary and involuntary basis);
- treatment and care received in an inpatient AMHS; and,
- discharge into a community setting.

The overall objective of the project was to identify and explore issues impacting adults with impaired decision-making ability at various stages of their journey through the public acute mental health system. This report details the issues associated with the patient pathway and journey through this system. It concludes with a series of recommendations that are consistent with the protection of human rights in acute care settings and the associated delivery of positive outcomes for adults with impaired decision-making ability.

Throughout this report, the word patient or consumer is used interchangeably, referring to a person who is receiving assessment, treatment, and care in the emergency department, as an inpatient of an AMHS or in the community by an ACT.

2.1.1 Relationship to the Mental Health Select Committee 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'

As noted, on 6 June 2022 the Mental Health Select Committee delivered its final report to the Queensland government. Among 57 recommendations, the committee called for:

- a significant injection of new expenditure to expand a broad range of existing services;
- provisions to improve the sharing of patient data and records within the system;
- a focus on improved rural and regional service provision; and,
- a public education campaign to improve community awareness of mental health issues.

The report also encourages the government to include people with lived experience of mental illness in the design and delivery of mental health services.

While the Queensland Government is yet to release a response to this report and its recommendations, a significant commitment has been made (21 June 2022) to the funding of the mental health system in the 2022-23 financial year budget.[13]

The Public Advocate commenced this project prior to the establishment of the Mental Health Select Committee by the Legislative Assembly on 2 December 2021. While this report can be seen as complementary to the Committee's report, it also provides recommendations that arise from a deeper exploration of the Queensland public acute mental health system than the Mental Health Select Committee was able to undertake.

[13] Queensland Government, 2022-23 Budget, *Investing in our health*, <Investing In Our Health - Queensland Budget 2022-23> 22 June 2022.

2.2 Mental illness and people with impaired decision-making ability

Statistical data on the prevalence of mental illness amongst people with impaired decision-making ability is not readily available. However, there have been many studies that have reported on the prevalence of mental illness in population cohorts that include adults with impaired decision-making ability.

According to the Australian Bureau of Statistics (ABS), in 2018, 19.1% of the population in Queensland lived with disability, and of all people with disability in Australia, 23.2% reported a mental or behavioural disorder as their main condition. The most common mental and behavioural disorders include:

- psychosis and mood disorders (7.5%);
- intellectual and development disorders (6.5%); and,
- neurotic, stress related and somatoform disorders (6.1%).[14]

Further to this, in 2018, 5.1% of the population in Queensland were persons with psychosocial disability. Nationally, 85.5% of people with psychosocial disability also reported having one or more other impairments or restrictions. Of the 1.1 million people nationally with psychosocial disability, 63% also had physical disability, 38.3% intellectual disability and 33.2% sensory disability.[15]

The prevalence of mental illness in Australian adults with intellectual disabilities has been reported in several studies, with most indicating an over-representation of this cohort, particularly in relation to psychiatric disorders and conditions like schizophrenia.[16]

The rates of mental illness among people with intellectual disability are at least 2.5 times higher than that of the general population.[17]

Several studies outline the challenges faced by clinicians when making psychiatric diagnoses for people who have intellectual disability and present with communication and cognitive impairments. This may result in an underrepresentation of the true prevalence of mental health diagnosis in adults with intellectual disability.[18] Accurate assessment, subsequent diagnosis, and analysis of how the presenting mental disorder impacts on a person, are fundamental pre-requisites for appropriate treatment and ongoing management of people with intellectual disability and mental ill health.[19]

The relationship of traumatic brain injury to major psychiatric disorders is also well documented. People with a traumatic brain injury have a higher incidence of mental disorders when compared to the general population. In addition to psychiatric disorders, the presence of other neuropsychiatric problems including aggression, behavioural dysfunction, substance abuse and increased risk of suicide is common with traumatic brain injury, which increases the complexity of providing appropriate treatment and care for this population group.[20]

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[14] Australian Bureau of statistics, *Disability, Ageing and Carers, Australia: Summary of Findings, 2018*, Disability, Ageing and Carers, Australia: Summary of Findings, 2018, <http:www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release>.

[15] Australian Bureau of Statistics, *Psychosocial disability*, 2020, <http://www.abs.gov.au/articles/psychosocial-disability>.

[16] J. Torr, Intellectual Disability and Mental Ill health: A view of Australian Research, *Journal of Mental Health Research in Intellectual Disabilities*, Vol.6, 2013, pp.159-178.

[17] J. Troller, C. Salomon, C. Franklin, Prescribing psychotropic drugs to adults with an intellectual disability, *Australian Prescriber*, Vol.39, 2016, pp.126–130.

[18] P. White, D. Chant, N. Edwards, C. Townsend & G. Waghorn, Prevalence of intellectual disability and comorbid mental illness in an Australian community sample, *Australian and New Zealand Journal of Psychiatry*, Vol.35, 2005, pp.395-400.

[19] P. White, p.399.

[20] R. Reeves & R. Panguluri, Neuropsychiatric Complications of Traumatic Brain Injury, *Journal of psychosocial nursing mental health*, Vol.49, no 3, 2011, pp.42-50.

3.0 Approach taken to inform this report

3.1 Stakeholder engagement and published sources

To inform this report, a wide range of stakeholder organisations and agencies were consulted (see Appendix 1). The views or opinions in this report do not, however, necessarily reflect the views of all stakeholders consulted.

This report also draws on information and data from a range of other sources including research papers, annual reports, statistical data, project and policy papers and submissions to the Mental Health Select Committee associated with the 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'.[21]

3.2 Collaboration

In addition to engaging with a wide range of stakeholders, the Public Advocate has collaborated with Professor Neeraj Gill on this project. Professor Gill is a practicing psychiatrist on the Gold Coast, Professor at the Health Research Institute, University of Canberra and the School of Medicine, Griffith University, a member of the Queensland Mental Health Review Tribunal (MHRT), and a Board Director of the Royal Australian and New Zealand College of Psychiatrists. He has published several academic papers with a focus on human rights, mental health law, and the emotional and social wellbeing of Aboriginal and Torres Strait Islander people.

3.3 Structure

To appropriately identify and explore the issues associated with the public acute mental health care system in Queensland, a patient's journey through the system was identified and then mapped to form the basis of this report. We follow a patient from their initial time of crisis in the community through to their presentation to an emergency department, admission into an inpatient AMHS, and subsequent discharge into the community. This includes the assessment, admission, treatment, care, and discharge of patients presenting with a mental illness, and services provided both in emergency departments and in inpatient AMHSs.

At each stage of the process, critical issues have been identified by stakeholders, highlighting the impact the operation of the public acute mental health system has on patients.

[21] Mental Health Select Committee, *Inquiry into the opportunities to improve mental health outcomes for Queenslanders*, Queensland Parliament, December 2021.

4.0 Background

4.1 The Queensland public acute mental health system

Public mental health services in Queensland are delivered by 16 Hospital and Health Services (HHSs) across the state. HHSs are independent statutory bodies, which means that the delivery of services is governed by a Hospital and Health Board (HHB) and managed by a Health Service Chief Executive (HSCE).

Queensland Health (QH) is responsible for the overall management of Queensland's public health system at a statewide level, including strategic policy, system planning, funding, monitoring, and promoting improvements in the quality and safety of all health services.

The Mental Health Alcohol and Other Drugs Branch (MHAODB) sits within QH's Clinical Excellence division and supports the statewide development, delivery, and enhancement of clinical and non-clinical services in mental health and alcohol and other drugs treatment. The position of Chief Psychiatrist is established within this branch and is responsible for exercising statutory responsibilities for the purpose of the administration of the *Mental Health Act,* and for consultation and specialist advice regarding the clinical care and treatment of people with mental illness.[22]

There are 18 public sector AMHSs (excluding children's health) across 15 regional HHSs (see appendix 2).[23] This includes approximately 1500 beds in total, with around 800 of those beds being acute beds (approximately 53% of all beds available)[24]. In 2020-21 there were 32.3 mental health beds per 100,000 persons in Queensland across hospital and community residential services. This includes forensic and secure rehabilitation beds (approx. 405 beds) and community residential services (approx. 300 beds).[25]

Inpatient AMHSs provide treatment to patients who are not able to be treated in the community. Patients receiving assessment, treatment and care in an inpatient AMHS can enter a facility voluntarily or involuntarily under a treatment authority (TA), forensic order (FO) or treatment support order (TSO) issued under the *Mental Health Act*.

4.2 Relevant statistics

4.2.1 Emergency Department presentations

During 2019-20 65,802[26] people with mental illness presented to a Queensland hospital emergency department. Of these, 55.3% were transported by ambulance, 8.4% by police or correctional services and 36.3% by other means (e.g., private vehicle).

Just over 1 in 3 (25,883 or 39.3%) were admitted to an inpatient Authorised Mental Health Service following assessment.[27]

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[22] Clinical Excellence Queensland | Queensland Health, *< http://clinicalexcellence.qld.gov.au/about-us/what-we-do/mental-health-alcohol-and-other-drugs-branch>*.
[23] Queensland Health, *Schedule of authorised mental health services and administrators*, 3 September 2021.
[24] Mental Health Select Committee, *Public briefing – inquiry into the opportunities to improve mental health outcomes for Queenslanders,* transcript of proceedings, Thursday 20 January 2022, Brisbane, p.19.
[25] Queensland Health, *Written briefing, inquiry into the opportunities to improve mental health outcomes for Queenslanders,* 2022, p17.
[26] Australian Institute of Health and Welfare, *Mental Health Services Australia: Services provided in public hospital emergency departments,* 2019-2020.
[27] Australian Institute of Health and Welfare, *Mental Health Services Australia: Services provided in public hospital emergency departments,* 2019-2020.

4.2.2 Admissions to Inpatient Authorised Mental Health Services

Persons admitted to an inpatient AMHS can be admitted as a voluntary or involuntary patient. Both voluntary and involuntary patients receive assessment, treatment, and care in the same facility.

Under the *Mental Health Act*, an involuntary patient means:

(a) a person subject to any of the following—
(i) an examination authority;
(ii) a recommendation for assessment;
(iii) a treatment authority;
(iv) a forensic order;
(v) a treatment support order;
(vi) a judicial order; or
(b) a person detained in an authorised mental health service or public sector health service facility under section 36; or
(c) a person from another state detained in an authorised mental health service under section 368(4).[28]

The *Australian Institute of Health and Welfare, Mental Health Services* report provides details of the percentage of involuntary separations[29] in acute mental health facilities.

In Queensland, the percentage of involuntary separations from acute facilities (specialised mental health inpatient units) were recorded as follows:

- 2017-2018 – 53.9%;
- 2018-2019 – 42.3%; and,
- 2019-2020 – 46.5%.[30]

It is recognised that some patients in inpatient AMHSs have lengthy admissions (up to or beyond 12 months for a select few as reported by stakeholders), such that they may not be included in the above separation data. However, this data does highlight that involuntary patients in Queensland acute facilities accounted for between 42 – 54% of separations between 2017 and 2020.

4.2.3 Inpatient Treatment Authorities

The Chief Psychiatrist is required to report on information relating to the administration of the *Mental Health Act*, including specific data for each AMHS.[31]

This information is detailed in the Chief Psychiatrist's annual report. It provides a summary of statistical data for each AMHS and details how key legislative provisions have been applied. A range of key statistics included in the Chief Psychiatrist's annual report are highlighted in sections 4.2.3 to 4.2.5.

In 2020/2021 there were 8,805 inpatient TAs made across 18 public AMHSs in Queensland, representing 98% of all TAs issued (the remaining 199 or 2% were issued as community TAs).[32] The previous year reflected similar figures, with 8,832 inpatient TAs made in comparison to 204 community TAs (98% inpatient TAs).[33] These figures reflect the high percentage of initial TAs made in the inpatient setting in comparison to in the community.

[28] *Mental Health Act 2016* (Qld) s 11.
[29] The Queensland Health Data Dictionary defines a separation as the process by which an admitted patient completes an episode of care. This occurs when a patient is discharged, is transferred to another facility, absconds, or dies whilst in care.
[30] Australian Institute of Health and Welfare, *Mental Health Services Australia: National KPI data set, 2017 – 2020.*
[31] *Mental Health Act 2016* (Qld) s 307.
[32] Queensland Health, *Chief Psychiatrist Annual Report 2020-21*, p.19.
[33] Queensland Health, *Chief Psychiatrist Annual Report 2019-20*, p.19.

4.2.4 Restrictive practices

National seclusion and restraint data from state and territory mental health services has been collected since 2011 following endorsement of the need to collect data by the Australian Health Minister's Advisory Council and the Australian Institute of Health and Welfare (AIHW). This has enabled reporting on key aspects of mental health reform in Queensland. However, this data does not provide information about 'when' or 'why' restrictive practices are being used, nor does it provide information about the individual personal characteristics of those who restrictive practices have been applied to.

Seclusion, physical and mechanical restraint is recorded nationally, however, Queensland did not start reporting on physical restraint until 2017-18.

- **Seclusion**

The *Mental Health Act* provides that:

(1) Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.
(2) However, seclusion does not include -
    (a) Confinement of a person in a high security unit, or in another authorised mental health service approved by the chief psychiatrist for the purposes of this part, if the confinement is –
        i. for a period, approved by the administrator of the service, of not more than 10 hours between 8 p.m. and 8 a.m.; and
        ii. for security purposes; or
    (b) Confinement that is authorised under a law other than this part.[34]

Seclusion rates in Queensland (events per 1000 bed days) initially decreased following the introduction of the amended *Mental Health Act* in 2016 (from 8.0 to 6.1), however have increased annually since 2018/19, spiking to 10.0 in 2019/2020, before dropping slightly to 9.2 in 2020/2021.[35] In comparison to the national figures, Queensland's seclusion rate has been higher every financial year since 2015-16, except for 2017-18, which was slightly lower (6.1 versus 6.9 nationally).[36]

- **Physical restraint**

The *Mental Health Act* provides that:

(1) Physical restraint, of a patient, is the use by a person of his or her body to restrict the patient's movement.
(2) However, physical restraint of a patient does not include –
    (a) the giving of physical support or assistance reasonably necessary –
        i. to enable the patient to carry out daily living activities; or
        ii. to redirect the patient because the patient is disoriented; or
    (b) physical restraint of the patient that is authorised under a law other than this part; or
    (c) physical restraint of the patient that is required in urgent circumstances.[37]

Physical restraint in Queensland was not reported prior to 2017/18. Like seclusion rates, the use of physical restraint (events per 1000 bed days) has been increasing annually since 2017/2018 and reached 15.20 In 2020/21.[38] In comparison to national data, however, Queensland recorded lower physical restraint rates in 2017/18 and 2018/19 and only slightly higher than the national rate in 2019/20 (11.5 versus 11.0 nationally).[39]

[34] *Mental Health Act 2016* (Qld) s 254.
[35] Queensland Health, *Chief Psychiatrist Annual Report 2020/21,* p.30.
[36] Australian Institute of Health and Welfare, *Mental Health Services Australia: National KPI data set,* 2015/16 – 2019/20.
[37] *Mental Health Act 2016* (Qld) s 268.
[38] Queensland Health, *Chief Psychiatrist Annual Report 2020/21,* p.36.
[39] Australian Institute of Health and Welfare, *Mental Health Services Australia: National KPI data set, 2017/18 – 2019/20.*

- **Mechanical restraint**

The *Mental Health Act* provides that:

(1) Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement.
(2) However, mechanical restraint does not include –
    (a) the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury; or
    (b) restraint of a person that is authorised or permitted under a law other than this part.[40]

The mechanical restraint rate in Queensland (events per 1000 bed days) has been consistently low between the years 2015-16 to 2020-21, ranging from 0.1 – 0.2, in comparison to the national average which ranges from 0.5 – 1.7.[41]

4.2.5 Electroconvulsive therapy

In Queensland, Electroconvulsive therapy (ECT) may only be performed in an AMHS with the informed consent of a person, or with the approval of the Mental Health Review Tribunal (MHRT).[42]

Between 2017 and 2021, the number of applications submitted to the MHRT for the provision of ECT ranged from 527 to 658. In the same period, the percentage of applications approved by the MHRT ranged from 58% to 77%.[43]

4.3 The legislative environment

Laws govern aspects of the assessment, treatment, and care of patients with mental illness in Queensland. There are several laws (Acts), which are relevant in the acute care mental health environment including:

- The *Anti-Discrimination Act 1991* (Qld);
- The *Guardianship and Administration Act 2000* (Qld);
- The *Health Ombudsman Act 2013* (Qld);
- The *Human Rights Act 2019* (Qld);
- The *Hospital and Health Boards Act 2011* (Qld);
- The *Mental Health Act 2016* (Qld);
- The *Powers of Attorney Act 1998* (Qld);
- The *Public Health Act 2005* (Qld); and,
- The *Public Guardian Act 2014 (Qld*.

The United Nations Convention on the Rights of Persons with Disabilities[44](CRPD) is an international treaty, which embeds the rights of persons with disabilities into international law. It specifically mentions inclusion of mental disabilities in its first article. The CRPD was ratified by Australia in July 2008 and entered into force on 16 August 2008. Australia's legal system is dualist, such that international conventions (like the CRPD) do not become a part of Australian law until they are incorporated into domestic legislation. This differs to a monist legal system whereby international conventions become part of domestic law once ratified.[45]

[40] *Mental Health Act 2016* (Qld) s 244.
[41] Australian Institute of Health and Welfare, *Mental Health Services Australia: Restrictive practices in mental health care,* 2015/16 – 2020/21.
[42] *Mental Health Act 2016* (Qld) s 236.
[43] Queensland Government, *Mental Health Review Tribunal Annual Report*, 2017-2018, p.20, 2018-2019, p.21, 2019-2020, p.17, 2020-2021, p.19.
[44] United Nations, *Convention on the rights of persons with disabilities, adopted on 13 December 2006, GA Res 61/106, UN Doc A/Res/61/106,* 2006 (entered into force 3 May 2008), <http://www.un.org/development/desa/disabilities/convetion-on-the-rights-of-persons-with-disabilities.html>.
[45] Series, L, *Disability and human rights, Routledge Handbook of Disability Studies*, 2nd edition, Routledge, New York, 2019.

The CRPD provides a framework for all signatory nations to follow to ensure the rights of persons with disabilities are met. In Australia, the CRPD is implemented through legislation, policy, and programs.[46]

The Health Ombudsman Act 2013 (Qld) and the *Hospital and Health Boards Act 2011* (Qld) both protect the rights of patients in the QH system, however the *Mental Health Act 2016* (Qld) provides for the unique elements germane to the treatment of mental illness, such as involuntary treatment, that are not provided for in other mainstream legislation.

The *Human Rights Act 2019* (Qld) also promotes and protects the rights of all Queenslanders, regardless of their status. Likewise, the *Anti-discrimination Act 1991* (Qld) provides protections for all Queenslanders from unfair discrimination, which includes the provision of health services. The *Guardianship and Administration Act 2000* (Qld), and the *Powers of Attorney Act 1998* (Qld), establish the powers of guardians, administrators, and attorneys, who can provide consent for assessment and treatment on behalf of a person with a mental illness who has impaired decision-making ability.

The information below summarises the relationship between each Act and the mental health system.

4.3.1 Mental Health Act 2016 (Qld)

As noted, the regulatory framework for the involuntary treatment and protection of a person with a mental illness in Queensland is governed by the *Mental Health Act*. It is the principal piece of legislation associated with the operation of Queensland's acute mental health care system.

The Act commenced on 5 March 2017, replacing the previous *Mental Health Act 2000* (Qld). The Act established the position of Chief Psychiatrist, whose function it is to protect the rights of patients in an AMHS and develop policies and guidelines for staff working in these facilities.

AMHSs are declared by the Chief Psychiatrist under the Act and provide treatment and care for involuntary and voluntary patients with a mental illness.

The MHRT is an independent decision-making body also established under the Act. Its role includes the review of TAs, FOs, and TSOs made under the Act to determine their appropriateness. Under the Act, the MHRT has the power to confirm or revoke an authority or order, approve limited community treatment, change the category of an authority or order from inpatient to community (and vice versa), and decide whether a person is fit for trial. The MHRT can also approve examination authorities (EAs), ECT, and the transfer of forensic patients in and out of Queensland.[47]

Independent Patient Rights Advisers (IPRAs) are also established positions under the Act. Their key function is to provide patients and their support persons with information about their rights when receiving treatment and care under the Act. This includes supporting people who may be in an inpatient AMHS and being treated under an inpatient TA, or a person who is living in the community and is being treated under a community TA.

4.3.2 Human Rights Act 2019 (Qld)

Queensland's *Human Rights Act* protects 23 human rights and freedoms of all Queenslanders. The Act requires public entities (such as hospitals and AMHSs) to act in a way compatible with human rights. It also includes, as one of its 23 rights, the right to health services, which states that 'every person has the right to access health services without discrimination, and a person must not be refused emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment to the person'.[48]

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[46] Australian Government, Department of Social Services, *Disability and Carers*, March 2022, <http://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/government-international/international-participation-in-disability-issues>.
[47] Queensland Health, *Mental Health Act 2016 fact sheet, Mental Health Review Tribunal*, p.2.
[48] *Human Rights Act 2019* (Qld) s 37.

4.3.3 Public Health Act 2005 (Qld)

The Public Health Act provides basic safeguards to protect public health by preventing, reducing, or controlling risks. Under the Act, an ambulance or police officer can make an emergency examination authority (EEA). This authority allows officers to detain and transport a person to a treatment or care place (public sector health service facility) if they believe a person's behaviour indicates they are at immediate risk of serious harm, the risk appears to be because of a major disturbance in the person's mental capacity, and the person appears to require urgent examination, or treatment and care for the disturbance.[49]

4.3.4 Public Guardian Act 2014 (Qld)

In addition to establishing the various roles and responsibilities of the Public Guardian as a substitute decision-maker of last resort for people with impaired decision-making ability, this Act also establishes additional safeguards and protections that apply to several facilities, including AMHSs.

The safeguards include the role of community visitors (adult) who are appointed by the Public Guardian. Community visitors have both inquiry and complaint functions and are required under the Act to visit particular sites and report back to the Public Guardian. Their main function is to protect the rights and interests of consumers at these visitable sites.

Inquiry functions of community visitors include their ability to inquire into:

> (a) the adequacy of services for the assessment, treatment, and support of consumers at the visitable site;
> (b) the appropriateness and standard of services for the accommodation, health, and wellbeing of consumers at the site;
> (c) the extent to which consumers at the site receive services in the way least restrictive of their rights;
> (d) the adequacy of information given to consumers at the site about their rights;
> (e) the accessibility and effectiveness of procedures for complaints about services for consumers at the site; and
> (f) at the request of the public guardian, another matter about the visitable site or consumers at the site.

Complaint functions of community visitors include their ability to:

> (a) inquire into, and seek to resolve, complaints; and
> (b) identify and make appropriate and timely referrals of unresolved complaints to appropriate entities for further investigation or resolution.[50]

4.3.5 Anti-Discrimination Act 1991 (Qld)

The *Anti-Discrimination Act* promotes equality of opportunity for all Queenslanders with protections from unfair discrimination. The Act prohibits discrimination based on attributes including; 'gender, relationship status, pregnancy, parental status, breastfeeding, age, race, **impairment** (*emphasis added*), religious beliefs or religious activity, political belief or activity, trade union activity, lawful sexual activity, gender identity, sexuality, and family responsibilities'.[51]

4.3.6 Guardianship and Administration Act 2000 (Qld)

Under the *Guardianship and Administration Act*, the Queensland Civil and Administrative Tribunal (QCAT) can appoint administrators or guardians to make decisions on behalf of an adult with impaired decision-making ability. Administrators can make financial and legal decisions related to financial matters, and guardians can make personal and health care decisions.

[49] *Public Health Act 2005* (Qld) s 157B.
[50] *Public Guardian Act 2014* (Qld) s 41.
[51] *Anti-Discrimination Act 1991* (Qld) s 6.

Under the Act, administrators and guardians must apply and promote the following principles when performing a function or exercising a power (that is, making decisions on behalf of an adult) including:

1 Presumption of capacity
2 Same human rights and fundamental freedoms
3 Empowering adults to exercise human rights and fundamental freedoms
4 Maintenance of adult's existing supportive relationships
5 Maintenance of adult's cultural and linguistic environment and values
6 Respect for privacy
7 Liberty and security
8 Maximising an adult's participation in decision-making
9 Performance of functions and exercise of power
(a) in a way that promotes and safeguards the adult's rights, interests and opportunities and
(b) in the way that is least restrictive of the adult's rights, interests and opportunities.
10 Structured decision-making, so as to (a) recognise and persevere, to the greatest extent practicable, the adult's right to make the adult's own decision, and (b) if possible, support the adult to make a decision.[52]

4.3.7 Powers of Attorney Act 1998 (Qld)

The *Powers of Attorney Act* provides for the appointment of an attorney, who is a person authorised to make particular decisions for another person, which can include providing consent for a person's admission to an inpatient AMHS.

The Act describes the obligations and powers of different types of attorneys, including those appointed under general and enduring powers of attorney (EPoA), attorneys appointed under advance health directives (AHDs), and statutory health attorneys (SHAs).

4.4 Policies and procedures

4.4.1 Chief Psychiatrist policies

Under the *Mental Health Act,* the Chief Psychiatrist is required to develop mandatory policies for all staff performing functions under the Act, including mental health service administrators, authorised doctors and authorised mental health practitioners.

Current policies in place cover the following:

- patient rights and support;
- examination and assessment;
- treatment and care;
- courts, forensic patients and people in custody;
- seclusion and restraint;
- transport, movement and patient absence;
- Mental Health Review Tribunal; and,
- administration of the Act.

In addition, the Queensland Government's *Policy and Practice guideline for Hospital and Health Service Chief Executives – Securing adult acute mental health inpatient units* requires that the main entry and exit doors to all acute mental health inpatient units be locked on and from 15 December 2013. Under this policy:

> … voluntary patients, visitors, persons who are not involuntary patients or involuntary patients who have a valid basis for departing from the unit (including a leave entitlement) should be allowed to move freely in and out of the units (and through any exit or entry doors which are otherwise locked),

[52] *Guardianship and Administration Act 2000* (Qld) s 11B.

> subject to all appropriate steps being taken to ensure that persons who do not fall into one of these categories do not depart from the unit. [53]

4.4.2 Hospital and Health service procedures

The *Hospital and Health Boards Act 2011* provides legislated principles for public AMHSs.

These principles, amongst other things, prescribe the development of a patient complaint system in AMHSs that has a focus on dealing with complaints quickly and transparently.

The principles support the National Safety and Quality Health Service Standards, and more specifically the clinical governance standard, which require all health services to have complaint management systems that encourage and support reporting and timely resolution of complaints.

The Chief Psychiatrist's *Management of complaints and right to a second opinion policy* outlines the process for managing complaints for those patients who are receiving treatment and care under the *Mental Health Act*. This policy specifically states that complaints must be received, acknowledged, and assessed in accordance with individual HHS procedures in the first instance.

Section 2 of the policy states:

> *The Act provides patients and 'interested persons' a right to request a second opinion about a patient's treatment and care.* [54]

The policy further explains that when assessing any complaint, regard must be given to section 2 of the policy, however, this section only applies when an AMHS has not been able to resolve the complaint in the first instance.

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[53] Queensland Health, *Mental Health Act 2016* Chief Psychiatrist policies – *Policy and practice guideline for Hospital and Health Service Chief Executives – Securing adult acute mental health inpatient units,* pp.384–386. <http://www.health.qld.gov.au/__data/assets/pdf_file/0027/977040/CPP_All.pdf>.

[54] Queensland Health, *Mental Health Act 2016* Chief Psychiatrist policy – *Management of complaints and right to a second opinion,* 2020, p.3.

5.0 Issues and obstacles

5.1 Access to state funded acute mental health services

This section highlights issues associated with a person presenting with a mental health crisis in the community and their subsequent journey to access appropriate care.

5.1.1 Limited appropriate options to divert people away from emergency departments

Stakeholders have raised concerns with the Public Advocate that current mental health services to support people presenting with a mental health crisis in Queensland are hospital centric. When a person in the community is in crisis, police and/or paramedics are often called as a first response, and while this may be appropriate for some people who can be managed in the community, in many cases transportation to a hospital emergency department due to a lack of alternative and available community-based crisis assessment and treatment options is required.

In 2019/2020, 55.3% of mental health related emergency department presentations in Queensland public hospitals arrived by ambulance, air ambulance or helicopter rescue services. This is in comparison to only 35.5% of the total emergency department presentations arriving via these modes of transport.

While it is recognised that the total number of emergency department presentations are significantly larger than those associated with mental health related presentations (n = 1,606,395 and n = 65,802 respectively), the figures do demonstrate the high proportion of mental health related cases the QAS transport to Queensland public emergency departments for assessment and treatment. [55]

5.1.2 Existing diversionary options

5.1.2.1 Co-responder programs

Funding from the Queensland Government has enabled collaboration between HHSs, the QAS and the Queensland Police Service (QPS) to implement co-responder programs, which provide opportunities to divert some people who present with acute mental distress in the community away from emergency department settings. Co-responder programs partner mental health professionals with ambulance and police officers to enhance interactions in crisis situations, reduce the need for hospitalisation, and increase the diversion of people with behavioural concerns away from the criminal justice system.

The West Moreton mental health QPS co-responder program commenced in March 2017 and was evaluated following its initial 16-week implementation phase. This evaluation demonstrated key successes, including a significant reduction in the need for a person's presentation to an emergency department, and admission to a facility in the days following the crisis event. When a mental health nurse (co-responder) worked alongside police attending a mental health crisis situation, 28.7% of people were transported to the emergency department, 4.1% were taken into police custody and 67.2% remained at the scene, which in this case was predominantly their home.[56]

People who remained at home (67.2%) were referred to a range of organisations for ongoing support, however the evaluation was not able to ascertain whether the referral for ongoing support

[55] Australian Institute of Health and Welfare (AIHW), *Mental Health services in Australia: Services provided in public hospital emergency departments*, 2019-20.
[56] T. Meehan, J. Brack, Y. Mansfield & T. Stedman, Do police-mental health co-responder programmes reduce emergency department presentations or simply delay the inevitable?, *Australian Psychiatry*, Vol. 27 (1), 2019, pp.18-20.

was actioned by either the individual or the organisation receiving the referral. What was identified, however, was that in the two weeks following intervention by the co-responder team, only 12.2% of people who were treated in the community presented to the emergency department. [57]

The mental health co-responder program implemented in Cairns has also been evaluated to identify what elements were essential in establishing the program, and what challenges were faced during the implementation phase. The evaluation involved interviewing a range of stakeholders from QH mental health services, QPS, organisations delivering mental health social services, and mental health consumer advocacy representatives.

The following were identified as essential elements to the program:

- co-responder team characteristics,
- collaborative project governance,
- senior and executive level support, and
- co-location.[58]

The perceived challenges identified in implementing the co-responder program included:

- client confidentiality,
- lack of an evaluation plan, and
- resource priorities.[59]

Stakeholders have advised the Public Advocate that one of the many benefits of the co-responder program, for the QAS in particular, has been the ability to provide a health-based response as the first response in the community and to provide mental health interventions in residential homes.

However, the ability for ongoing support beyond what first responders can deliver is often limited by the capacity of community mental health teams and the resources available to provide the ongoing support required.

In regional areas, this issue is exacerbated. The QAS have implemented co-responder programs in areas including the Gold Coast, West Moreton, Sunshine Coast, Metro South, Metro North, Cairns and Townsville, which anecdotally have relieved some pressures associated with mental health related emergency department presentations in these areas. The QAS do intend to expand this model to other regional and outer regional areas, however at this stage, a gap in service remains.

Additional issues also arise for those people who are assessed as being too unwell to remain in their home or other living arrangements (particularly if mental health triggers remain) but who are deemed not unwell enough to be admitted to an inpatient AMHS from the emergency department. Stakeholders have reported people with a dual disability and/or dual diagnosis (for example, intellectual disability, acquired brain injury and substance abuse), as well as those presenting with self-harm and suicidal ideations, make up a large proportion of this cohort.

5.1.2.2 Queensland Health's Crisis Support Spaces program

QH has initiated the development of crisis support spaces in various locations across Queensland, which are intended to provide support for people with mental illness who do not require emergency care. However, these spaces do not operate with centralised and consistent policies or practices, meaning that they may not be available to all patients with mental health issues who have been diverted from emergency department settings. In addition, the spaces are often not accessible when required (e.g. when mental health presentations at emergency departments peak), with most only operational for a short period of time after-hours; and they are not available at all in most outer regional areas across Queensland.

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[57] T. Meehan, J. Brack, Y. Mansfield & T. Stedman, 2019, pp.18-20.
[58] J. Robertson, M. Fitts, J. Petrucci, D. McKay, G. Hubble & A. Clough, Cairns Mental Health Co-Responder Project: Essential elements and challenges to programme implementation, *International Journal of Mental Health Nursing,* Vol. 29, 2020, pp.450-459.
[59] J. Robertson, M. Fitts, J. Petrucci, D. McKay, G. Hubble & A. Clough, 2020, pp.450-459.

Primary Health Networks (PHNs) are also funded to deliver mental health safe hubs that are intended to provide afterhours safe spaces for people to access support during times of distress. Similar to those operated by QH, these hubs do not provide 24-hour services and are not available in many outer regional areas.

5.1.2.3 Community mental health and social health services

Patients who do receive treatment in an emergency department may also require referral to community-based health or other social health services. It is well recognised that the peak time for mental health patient presentations in the emergency department is after hours, yet most community mental health services and social services are only open Monday to Friday, during normal business hours. This can lead to delays in accessing appropriate services to support patients. It also places additional pressures on emergency departments, which can lead to lengthy waiting times for patients until a bed or alternative service is found. This can have significant consequences for mental health patients, but even more so for those patients with impaired decision-making ability, including waiting without treatment in noisy, overcrowded conditions. The reaction of people to this type of environment and the frustrations it presents may lead to the increased possibility of the use of seclusion, restraint and sedative practices.[60]

In 2019/2020, the triage categories allocated to mental health related emergency department presentations in Qld were;

- Category 1 - Immediate – 0% (immediate);
- Category 2 - Emergency – 16% (within 10 minutes);
- Category 3 - Urgent – 54% (within 30 minutes);
- Category 4 - Semi Urgent – 23% (within 60 minutes); and,
- Category 5 - Non-Urgent – 6% (within 120 minutes).

This data highlights a significant proportion of people presenting with mental health related illness (semi and non-urgent) who could benefit from referral to community-based health or other social health services, to maintain their mental health and wellbeing in the community.[61] Triage of emergency department mental health-related presentations is discussed further in section 5.2.1 of this report.

5.1.2.4 Queensland Police referrals service

A Queensland Police referrals service has been established specifically to support vulnerable people in the community rather than in emergency departments, however it no longer includes a state-wide mental health service provider. The Public Advocate has been advised that the loss of the mental health service provider resulted from a loss in its funding source and the inability to manage the volume of work being referred to their service in the absence of such funding. Referrals to mental health services are also restricted in rural and remote areas where community-based services are either at capacity or not available.

5.1.2.5 Queensland Health 1300 MH CALL

QH 1300 MH CALL is a state-wide telehealth mental health triage service that provides support, information, advice, and onward referral to callers. The service is available 24 hours a day, 7 days a week and links callers to the nearest and most appropriate Queensland public mental health service.

It was introduced by QH to provide a first point of contact for people experiencing a mental health crisis in the community.

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[60] M. Duggan, B. Harris, WK. Chislett & R. Calder, *Nowhere else to go: why Australia's health system results in people with mental illness getting 'stuck' in emergency departments*, Mitchell Institute, Victoria University, 2020.
[61] Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia: Services provided in public emergency hospitals,* 2019-20.

5.1.2.6 Queensland Health Acute Care Teams (ACTs) and the QH 1300 MH CALL service

ACTs are a critical component of QH's response to address mental health crisis presentations in the community. Noting that variations do exist across HHSs, a brief overview of the history of ACTs is provided below.

Introduced prior to the state-wide call service (1300 MH CALL), the ACT model of care was to provide a multidisciplinary mental health service to people with acute care needs in the community. This included the provision of an outreach clinical response for people experiencing a mental health crisis in their home and/or the community, or those recently discharged from an emergency department. The outreach response provided by ACTs was never a 7 day/24-hour service however it did allow for extended hours of operation, and a 7-day service in some HHSs.

In terms of community outreach, the service provided a short-term clinical crisis intervention, for those who required it, to be delivered in a person's home for a period of up to 2 weeks, which occasionally extended to 4-5 weeks.

Stakeholders have indicated, however, that the significant increase in mental health presentations over the past decade has meant that the service response from this team has changed, with most follow up of patients now occurring over the telephone, with limited face-to-face clinical intervention being provided.

The 1300 MH Call service was introduced by QH to supplement and improve the efficiency of ACTs. This service triages incoming calls and refers requests directly to ACTs. Its introduction has provided a significant service improvement, allowing for GPs and members of the community to contact one central number to refer or seek assistance for someone experiencing mental ill health or in crisis, regardless of where they are located across Queensland.

While the 1300 MH Call is a 24 hour, 7 days a week service that is staffed by qualified clinicians who provide a triage service over the phone and onward referral, the intended outreach service provided by ACTs is not a 24-hour service.

Stakeholders have informed the Public Advocate that the call service, although achieving some efficiencies, has created additional barriers that increase the likelihood of emergency department presentations.

Stakeholders have noted that the call service restricts face-to-face access with community mental health services by a person in crisis, as the only way they can now access any QH mental health service is by calling the 1300 MH CALL. This has also limited the way in which community-based organisations are able to assist people to seek care. Previously, they could accompany a person to visit community mental health services and help them to provide the details necessary to access appropriate care and treatment – now that is not possible and emergency department presentations are consequently more likely.

It was also noted that while the introduction of QH 1300 MH CALL has enabled GPs to refer patients to a mental health service using only one number, extended waiting times associated with the call intake service continue to exist as they did under the previous model, where contact was made with ACT members directly. This creates difficulties for GPs given the limited time allocated for GP patient appointments under the Medicare rebate schemes (15-minute appointment slots).

The Central Queensland HHS has implemented a supplementary service, where GPs can continue to contact an ACT medical officer directly to get advice on treatment pathways for patients presenting with acute mental health disturbances in the community, however this service is only offered during business hours.

The new call service has also not alleviated the gap in the provision of an outreach acute mental health response in the community after hours.

Stakeholder reports, coupled with statistical data available for mental health presentations, indicates that emergency departments are more likely to see people in crisis during hours that are outside of normal business hours (including on the weekend). Thus, when a call is made to QH 1300 MH Call that is outside of ACT operational hours, there is no other option but for the person to present to an emergency department if they require assessment.

During 2019-20, the busiest time for mental health related emergency department presentations in Queensland public hospitals was recorded to be between 10.00 a.m. and 9.59 p.m. on weekdays. On weekends (from Friday 2.00 p.m. – Sunday 11.59 p.m.) this pattern differs slightly with the busiest times recorded between 2.00 p.m. and 01.59 a.m.[62]

Overall, this information points to the need to establish optimal care pathways that;

- are responsive to the needs of people prior to a crisis evolving;
- cater for people who are not 'unwell' enough for admission and treatment in an inpatient AMHS but require ongoing support in the community;
- encourage and enable people with mental illness to self-present for assessment and treatment in the early stages of an illness;
- enable the primary health care sector to link patients to community services for ongoing support in a timely and efficient manner; and,
- are available at times when mental health presentations to emergency department settings generally occur.

In establishing these care pathways, it will be necessary to review the ACT model of service. A stakeholder has informed the Public Advocate that a review of the model of service was to take place prior to the COVID-19 pandemic, however this has been delayed.

In addition, support services that are easily accessible and can provide timely advice to GPs on managing patients in the community who present with mental health disturbances are needed.

There is also a need to provide safe places such as those operational under the QH Crisis Support Spaces program that can facilitate the above-mentioned care pathways.

The Substance Abuse and Mental Health Services Administration (SAMHSA) agency, which is based in the United States Department of Health and Human Services and leads public health campaigns to advance the behavioural health of the US population, have recently developed National Guidelines for Behavioural Health Crisis Care which detail best practice for crisis receiving and stabilisation services.[63] In establishing and implementing additional services across Queensland, these guidelines may be a valuable resource.

5.1.3 Use of Emergency Examination Authorities and waiting time in emergency departments for mental health related presentations

Following changes to the *Mental Health Act* 2000 (Qld), Emergency Examination Orders (EEOs) by police officers and ambulance officers[64] were removed and subsequently renamed EEAs and included in the *Public Health Act*.

Under the *Public Health Act*, the QAS and QPS can make an EEA to transport a person experiencing a mental health crisis to an appropriate facility for examination. The limited options available to both the QAS and QPS to refer patients in significant distress for ongoing support in the community (noted above), may potentially be leading to the overuse of these type of authorities to ensure that people receive at least some form of care.

[62] Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia: Services provided in public emergency hospitals,* 2019-20.
[63] United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioural Health Crisis care Best Practice Toolkit*, Rockville, 2020.
[64] *Mental Health Act 2000* (Qld) s 33.

Under the Act, an ambulance or police officer may detain and transport a person if they believe:

(a) a person's behaviour, including, for example, the way in which the person is communicating, indicates the person is at immediate risk of serious harm;
Example — a person is threatening to commit suicide; and
(b) the risk appears to be the result of a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication, or another reason; and
(c) the person appears to require urgent examination, or treatment and care, for the disturbance.[65]

When a patient arrives at an appropriate facility (e.g., emergency department), treatment teams examine patients admitted under the *Mental Health Act,* to decide about whether to recommend an assessment or not.

Under the Act, a doctor or authorised mental health practitioner may, after examining a person, make a recommendation for an assessment of the person if they are satisfied that:

(a) the treatment criteria may apply to the person; and
(b) there appears to be no less restrictive way for the person to receive treatment and care for the person's mental illness.[66]

Under the Act, treatment criteria are described in his way:

(1) The treatment criteria for a person are all of the following
(a) the person has a mental illness;
(b) the person does not have capacity to consent to be treated for the illness;
(c) because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in
(i) imminent serious harm to the person or others; or
(ii) the person suffering serious mental or physical deterioration.

(2) For subsection (1)(b), the person's own consent only is relevant.
(3) Subsection (2) applies despite the *Guardianship and Administration Act 2000*, the *Powers of Attorney Act 1998,* or any other law.[67]

EEAs provide first responders with enhanced powers and decision-making abilities when responding to a mental health crisis in the community. The criteria for an EEA under the *Public Health Act* are broad, including mental disturbances associated with conditions including intoxication, disability, injury, illness, or any other reason, which could extend to people with acute medical conditions such as delirium, and those who may be heavily influenced by alcohol and/or drugs.

Under the *Mental Health Act*, however, the recommendation for assessment criteria are very specific. A person must meet the treatment criteria, which states that the person must have a mental illness.

While there is a difference between a person having 'a mental illness', and a person with 'a major disturbance in their mental capacity', EEAs are often used by first responders to transport patients to emergency departments in the absence of other options being available to provide the level of specialist examination required to determine if a mental illness exists.

In the emergency department, a treating team has three options when responding to an EEA:

- to examine the person and decide whether the EEA is required or not;
- to request the involvement of the mental health service for further examination, which may be the ACT in this instance; or,
- to start a recommendation for an assessment without the involvement of the mental health service.

[65] *Public Health Act 2005* (Qld) s 157B.
[66] *Mental Health Act 2016* (Qld) s 39.
[67] *Mental Health Act 2016* (Qld) s 12.

Stakeholders have reported that in some circumstances all people subject to EEAs are referred to a mental health service for an examination. This presents resourcing challenges for these services, however it is recognised that some emergency department staff may not be fully equipped to provide the level of examination required, particularly in outer regional areas.

Anecdotally, stakeholders have also noted instances where EEAs have been used by first responders to ensure patients are examined in the emergency department in a timely fashion, or to ensure that patients who require examination do not leave the emergency department without appropriate care. The Public Advocate has also been made aware of instances where EEAs have not been accepted by emergency department treating teams, and patients are subsequently discharged back into the community.

This anecdotal evidence emphasises the gap in services that exists for those patients who may not require emergency department care and/or admission into an inpatient AMHS but do require ongoing treatment and support when discharged back in the community.

In a study published in 2022, data was collected from the Queensland Police Records and Information Management Exchange (QPRIME) and Director of Mental Health (QH) annual reports from 2002/2003 to March 2017 to determine rates of EEOs issued by the QAS and QPS across Queensland. Results from this study showed:

- an approximately 15% rise per year in EEOs, however discrepancies in data between the QPRIME system and the Director of Mental Health's annual reports were noted, with approximately 27% less EEOs reported in QH annual reports; and,
- EEOs made by the QPS (60%) were greater in number than those made by the QAS (40%)[68]

This study further explored data for one large metropolitan Queensland region (population of 720,000 equating to 14.7% of Queensland's total population) over the same period to understand the impact of the changes in the legislation, specifically when an EEO under the *Mental Health Act 2000* (Qld) was replaced by an EEA under the *Public Health Act 2005*. Analysis of this data showed:

- a loss of information on reporting of EEAs during implementation of the new legislation (particularly from 5 March 2017 to 30 June 2017);
- discrepancies between QPRIME reporting of EEO data and the Director of Mental Health's annual reporting of EEO data (27% not declared in annual reports) between 2009-2010 and 5 March 2017; and,
- a significant increase in discrepancies between QPRIME and the Chief Psychiatrist's annual reporting of EEA data from 5 March 2017 to 2019-2020. Even though QPS and QAS data for EEAs were not separated in the Chief Psychiatrist's annual reports, QPRIME data recorded 6,887 QPS registered EEAs in comparison to a combined total of EEAs (QPS and QAS) of 1,803 reported in annual reports.

The findings of this study highlight that the majority (84%) of QPS registered EEAs issued under the *Public Health Act* were not publicly reported, which exposes a gap in crucial information available to the public following changes in legislation.[69]

Looking again at overall figures, in 2019/2020, 23,883 (38%) mental health related presentations to Queensland public emergency departments resulted in an admission to hospital, compared to 39,919 people (62%) who were not admitted.[70] These figures may indicate that a number of people brought to hospital emergency departments by emergency services could have been diverted from the hospital system in the first instance if appropriate services had been available in the community.

[68] A. Clough, A. Evans, K. Grant, V. Graham, J. Catterall, R. Lakeman, J. Gilroy, G. Pratt, J. Petrucci & R. Stone, Recent amendments to Queensland legislation make mental health presentations to hospital emergency departments more difficult to scrutinise, *Australasian College for Emergency Medicine*, Vol.34, 2022, pp.130-133.
[69] Clough, p.132.
[70] Australian Institute of Health and Welfare (AIHW), *Mental Health Services in Australia*, 2019-20.

In addition, many mental health presentations settle in acuity, for example, the effects of acute drug or alcohol intoxication wear off, and sometimes the crisis is stabilised, and patients can be discharged back into the community with adequate support and follow-up plans in place.

However, stakeholders have advised the Public Advocate that, on some occasions, people presenting to emergency departments are discharged without adequate follow-up and support, which points to the need to strengthen services provided in the community mental health and social sectors.

Long waiting times for those experiencing mental ill health in emergency departments have also been highlighted as a concern by many stakeholders. Waiting times of between 10 – 21 hours have been reported, which in many cases result in the person leaving without receiving an appropriate assessment, reducing their trust in the medical system. In some cases, this can lead to people disengaging from the medical system completely, including the primary health care sector.

5.1.4 Mental health training for first responders

QAS officers do not receive extensive mental health training as part of their recognised tertiary training course. The QAS provides two hours of mental health crisis training for all new recruits, which is very limited given the extensive number of mental health presentations officers respond to in the community. Additionally, it does not appear that any type of extensive training is provided in relation to the treatment of people presenting with a dual disability such as a cognitive impairment combined with a mental illness.

QPS officers are also not trained to deliver a health or medically based response to a mental health crisis, yet one of the main access points for people seeking mental health assistance is contact with either the QAS or QPS.

Anecdotally, stakeholders suggest that there has been an increase in the knowledge of QAS and QPS officers following the introduction of mental health liaison and co-responder programs within their services, which does represent a positive development in this area.

5.1.5 Lack of integrated information systems to facilitate appropriate and coordinated crisis responses

The QPS have allocated significant resources to establishing databases and information systems to track information and monitor outcomes in relation to mental health crises they respond to in the community. However, information sharing across agencies continues to be a significant problem.

In May 2015, a state-wide clinical review to examine fatal mental health events in Queensland was announced by the Minister for Health and Minister for Ambulance Services, establishing the Mental Health Sentinel Events Clinical Review (the Review).[71] An independent Mental Health Sentinel Events Review Committee (the Review Committee) was appointed to conduct the review under the provisions of the *Hospital and Health Boards Act 2011*.

Findings from the review illustrated a significant link between mental health and domestic and family violence leading to homicide. In addition, other findings from the review included:

- the identification of co-occurring dual diagnosis and dual disability conditions (substance misuse, personality disorders, intellectual disability, development disorder, cognitive impairment, acquired brain injury) which increased the complexity of cases. Unfortunately, in these cases mental health treatment plans for these people rarely addressed these matters; and,
- the identification of fragmented storing of clinical information, which was inconsistent across HHSs. This included clinical alerts of a person's risk status (on the Consumer Integrated Mental

[71] C. Dick (Minister for Health and Minister for Ambulance Services), *Clinical review to examine serious mental health events, Media statement,* The Queensland Cabinet and Ministerial Directory, Brisbane, 8 May 2015.

Health and Addictions (CIMHA) application) not being easily visible, or the review dates for the alert having expired.[72]

In addition, when background information regarding perpetrators of homicide was investigated, it was found that most were registered as having a mental health condition in records held by either QH or their general practitioner (GP). This information was not shared with police, however, or at least was not accessible at the time of their initial intervention with the person, prior to a homicide event.

While privacy considerations must inform any reform here, timely shared information is required for a crisis response to be appropriately coordinated, and this requires systems that are integrated and accessible to all services involved.

5.2 Emergency department admission, assessment, and treatment

5.2.1 Triage of emergency department mental health-related presentations

As highlighted above, several stakeholders have raised the issue of long waiting times for patients presenting with mental ill health in Queensland public emergency departments.

The National Triage Scale (NTS) was developed by the Australasian College for Emergency Medicine and was implemented in 1993. In the late 1990s it underwent revision and was renamed the Australasian Triage Scale (ATS). It is based on adult psychological predictors such as airway, breathing, circulation and disability.[73] The scale is recommended by the Australian Council on Healthcare Standards and is used as a performance indicator in emergency medicine.[74]

Prior to its revision, it was identified that the NTS did not include patients presenting with a mental illness and consequently no guidelines were available to assist emergency nurses when triaging patients with mental illness. The Mental Health Triage Scale (MHTS) was consequently developed as an adjunct to the NTS and was validated against the following criteria:

- acceptance by emergency nursing staff;
- reduced waiting and transit times;
- service delivery;
- fewer patients did not wait;
- support for the urgency categories by liaison psychiatry medical staff;
- continued use of the scale at 2 years follow-up; and,
- impact on other emergency patients.[75]

The Australian College for Emergency Medicine has guidelines on the implementation of the ATS in emergency departments.[76] The guidelines do provide some clinical descriptors for ATS categories 1 – 5, that relate to behavioural/psychiatric presentations including:

- Category 1 (immediate) – severe behavioural disorder with immediate threat of dangerous violence.
- Category 2 (within 10 minutes) – violent or aggressive, immediate threat to self or others, requires or has required restraint and severe agitation or aggression.

[72] Queensland Health, *When mental health care meets risks: A Queensland sentinel events review into homicide and public sector mental health services Final Report,* April 2016.
[73] M. Ebrahimi, A. Heydari, R. Mazlom & A, Mirhaghi, The reliability of the Australasian Triage Scale: a meta-analysis, *World Journal of Emergency Medicine*, Vol.6, No. 2, 2015, pp.94-99.
[74] S. Whitby, S. Ieraci, D. Johnson & M. Mohsin, *Analysis of the process of triage; the use and outcome of the National Triage Scale,* Liverpool Health Service, 1997 and Australian Council on Healthcare Standards and the Australasian College for Emergency Medicine*, Clinical indicators. A users' manual*, Version 1. Melbourne: ACHS Care Evaluation Program, 1996.
[75] D. Smart, C. Pollard & B. Walpole*,* Mental health triage in emergency medicine*, Australian and New Zealand Journal of Psychiatry*, Vol.33, 1999, pp.57-66.
[76] Australian College for Emergency Medicine, *Guidelines on the implementation of the Australasian Triage Scale in Emergency Departments,* Version 4, July 2016, pp.5-8.

- Category 3 (within 30 minutes) – very distressed, risk of self-harm, acutely psychotic or thought disordered, situational crisis, deliberate self-harm, agitated/withdrawn and potentially aggressive.
- Category 4 (within 60 minutes) – semi-urgent mental health problem, under observation and/or no immediate risk to self or others.
- Category 5 (within 120 minutes) – known patient with chronic symptoms, social crisis, and clinically well patient.

The Australian Department of Health has published on its website the Emergency Triage Education Kit, which is the national standard for education associated with triaging in emergency departments. Designed to provide a consistent approach for use of the ATS, this program includes 12 individual learning units, including the mental health triage tool. This tool provides additional information including typical presentation (observed/reported) and general management principles to consider.[77]

What is not known, however, is to what extent the Emergency Triage Education Kit and the mental health triage tool are utilised in Queensland public emergency departments, and whether any resources are allocated to the ongoing support and training of staff in the use of such tools.

A Delphi study to derive a tool for mental health triage in emergency departments identified further work was needed in defining statements that are subject to possible individual interpretation (for example, continuing self-harm and exhibiting safeguarding concerns), as well as statements that appear at different levels of severity (extreme, severe, and moderate). [78]

In addition, another study investigated the perspectives of emergency department staff on triaging of mental health related presentations. This study included emergency department staff across all of Australia, and while it only included a small number of nurses (3) and doctors (3) in Queensland, the representative sample from Queensland was nursing (21%) and doctors (15%).

The findings of this study have implications for education, policy, and practice in triaging mental health related presentations in emergency departments, and include:

- environmental factors (physical structure, time pressures imposed on triage assessment, activity level and triage workload);
- policy, education, and training resources to support triage decision-making;
- staff factors (knowledge and experience about psychiatric conditions and accuracy of triage decision and attitudes towards mental illness); and,
- patient factors (police as mode of transport to emergency department), behavioural (aggression and violence were strong indicators for urgency) and clinical condition (e.g., mood).[79]

This information underscores the complexity associated with triaging mental health presentations in emergency departments and may point to the need for individual HHSs to review the operationalisation of existing triage processes in use. This includes ensuring appropriate resources are allocated to emergency department staff to support ongoing education and training in triaging of mental health related presentations.

[77] The Department of Health, *Emergency Triage Education Kit, 2013*, <Department of Health | Emergency Triage Education Kit>
[78] A. Mackway-Jones & K. Mackway-Jones, An Expert Delphi study to derive a tool for mental health triage in emergency departments, *Emergency Medicine Journal*, Vol.37, 2020, pp.738-743.
[79] M. Gerdtz, T. Weiland, G. Jelinek, C. Mackinlay & N. Hill, Perspectives of emergency department staff on the triage of mental health-related presentations: Implications for education, policy and practice, *Emergency Medicine Australasia*, Vol.24, 2012, pp.492-500.

5.2.2 The impact of the emergency department environment on mental health consumers

The emergency department of a hospital can be a very threatening, highly stimulating, and triggering environment. In response to this environment, the clinical presentation of a patient with a mental illness can be very different to their presentation in the community.

Consequently, the examination process employed for a person may be unduly influenced by the environment and has the potential for patients to be placed on involuntary TAs (adversely affecting their rights in relation to their treatment and care) prematurely. For people with a dual disability of cognitive impairment and mental illness, this process may be exacerbated, as their reactions to an emergency department environment can be quite severe.

Stakeholders have also raised concerns about emergency department environments not being a culturally appropriate or safe place. Many Aboriginal and Torres Strait Islander people have experienced significant intergenerational trauma and hold a strong fear of police. In situations where an Aboriginal or Torres Strait Islander person (or any person for that matter) exhibits escalating behaviours due to the emergency department environment, the automatic response is a code black, which alerts security and, sometimes, the QPS. This escalates situations further and can sometimes have tragic outcomes for the person involved.

Stakeholders have indicated that while QH HHSs do have dedicated Aboriginal and Torres Strait Islander liaison services that assist Aboriginal and Torres Strait Islander patients and their families with their journey to, during and after their hospital admission, the extent to which these services have the capacity to provide support to mental health patients in the emergency department and inpatient setting has been raised as a concern. Some HHSs provide an extended service that includes part hours on a weekend, and beyond standard working hours during the week, however this is not consistent across HHSs. In addition, stakeholders have not only identified capacity as a concern, but also the mental health skills of the workforce to be able to deliver services in these environments.

Stakeholders have reported that emergency departments in regional areas do not have dedicated areas to safely assess and manage patients with behavioural disturbances. In addition, emergency departments in regional areas cater for all age groups with a wide range of presentations (e.g., youth, perinatal, adult, and older persons) in one area, which adds complexity to this issue.

In this context, the health system needs to consider the provision of diversionary options for people presenting with a mental illness that are calmer, less threatening, and culturally appropriate, including access to mental health trained Aboriginal and Torres Strait Islander liaison services.

Diversionary options like this have been trialled in other jurisdictions, including South Australia. The Urgent Mental Health Care Centre in Adelaide is a peer-led recovery and clinical support model that provides an evidence-based recovery approach for people presenting with mental illness. This service is provided in a lounge room like space, which provides a much calmer and less threatening environment. No referral is required to access this service, providing an opportunity for people in acute mental distress to self-present to a place other than an emergency department.

In Queensland, a crisis stabilisation unit was opened at Robina Hospital on the Gold Coast in 2021 to divert patients in acute mental health crises away from emergency departments. The unit is an extension of the mental health services offered on the Gold Coast, and accepts admissions via the emergency department, the QAS and QPS, although there is no option for a person to self-present.

Much like the Urgent Mental Health Care Centre in Adelaide, the service was designed with the intent of providing a comfortable, therapeutic, and home like environment, and includes a lived experience workforce (peer workers). However, stakeholders have noted that the unit has moved away from its original intent and is now a locked unit including a seclusion room in addition to short stay chairs where a patient may have to remain for up to 12 hours, which may not provide the calming, home-like environment originally intended.

Overall, this information points to the need to engage people with a lived experience of mental illness in the experience-based co-design of appropriate environmental spaces in emergency departments.

Experience-based co-design is an approach to improving healthcare services which borrows from participatory design and user experience design to bring about quality improvements in healthcare. [80]

This information also points to the need to expand Aboriginal and Torres Strait Islander liaison services to enable these services to be provided in emergency departments and inpatient AMHSs, by staff who have received mental health training specific to their role.

5.2.3 Patients with dual disability

Stakeholders have informed the Public Advocate that AMHSs are not funded to cater for the needs of mental health patients with intellectual disability, and that people with an intellectual disability are not the target population for Queensland Health AMHSs.

Generally, people with an intellectual disability are supported by disability service providers, however, in instances where a person experiences an acute behavioural disturbance on the background of an intellectual disability, the emergency department is usually where the person presents. This can often result in admission to an inpatient AMHS which is not adequately resourced or equipped to appropriately assess and manage the needs of people with an intellectual disability.

Similarly, stakeholders have informed the Public Advocate that specific services addressing the needs of people with a dual disability (for example a mental illness combined with dementia or an acquired brain injury) are lacking.

5.2.4 Differences in Hospital and Health Services across Queensland

Currently there are differences in emergency department processes employed across HHSs in Queensland. This variation is evidenced in the type of support provided to patients, and the way in which patients are triaged and managed.

Some emergency departments are inclusive, with all patients treated in the one setting, while others have separate emergency departments for people presenting with mental illness. For example, Royal Brisbane and Women's Hospital, a metropolitan hospital based in Brisbane, has a dedicated Psychiatric Emergency Centre, which is separate to the main emergency department.

Access to specialist mental health services in emergency departments, such as ACTs, also varies across the state. While ACT staff are available for emergency department referrals in all metropolitan areas on a 24/7 basis, the situation in regional areas is very different. ACTs in regional locations (e.g., Rockhampton, Cairns, Townsville, and Mount Isa) do have a physical presence onsite however operate as an outreach service via telephone for outer regional emergency departments in places like Gladstone, Emerald, Biloela, Winton and Longreach. In addition, not all ACTs in regional areas are funded to provide a 24-hour service.

Independent Patient Rights Advisers (IPRAs)[81] endeavour to see patients shortly after their admission to an emergency department or AMHS.

It is the IPRA's role (under the *Mental Health Act*) to ensure a patient and/or their support person are advised of the patient's rights, to support the patient and/or their support person, and to

[80] S. Donetto, P. Pierri, V. Tsianakas & G. Robert, Experience-based Co-design and Healthcare Improvement: Realizing Participatory Design in the Public Sector, *The Design Journal*, Vol.18:2, 2015, pp.227-248.
[81] The role of Independent Patient Rights Advisers (IPRAs) is explained further in section 5.3.8.

communicate to the treating team the patient's views, wishes and preferences about their treatment and care.[82]

IPRAs are located in every HHS across Queensland, however, in regional areas, there is extensive travel involved for IPRAs to support patients. While IPRAs are employed by individual HHSs, the geographical area that they cover is in accordance with the AMHSs, which cover a larger geographical area in the case of regional HHSs. For example, the Central Qld AMHS also covers the Central West HHS, Cairns also covers Torres and Cape HHS, Townsville also covers the North West HHS and Darling Downs also covers South West HHS. IPRAs are generally based at, or near hospital sites (larger hospitals in regional areas) and provide telephone services to remote locations within their geographical area. Some IPRAs provide site visits (scheduled blocks of time, 1 – 2 times per year) to more remote sites to enable face-to-face contact with these services. Essentially, all mental health consumers, regardless of their location, can access the services of an IPRA, however the mode of delivery of the IPRA service differs depending on the geographical location of the consumer.

The effective operation of the IPRA service also relies on a timely referral and/or patient flow information being shared by other hospital staff. A lack of these processes and sharing of patient flow information across inpatient AMHSs, which has been reported by several stakeholders, means that an IPRA's ability to provide timely services to those who need it most can be severely curtailed.

5.2.5 Patient and family rights to question assessment recommendations in emergency department settings

The *Mental Health Act* provides the ability for patients and/or their families to request a second opinion in relation to treatment options, both in emergency departments and inpatient AMHS environments.[83] However, stakeholders have reported there are problems implementing this provision of the Act in an emergency department setting. Section 290 (Second opinion about treatment and care) of the Act states:

> (1) This section applies if an authorised mental health service has been unable to resolve a complaint about the provision or treatment and care to a patient. [84]

In accordance with the Chief Psychiatrist Policy 'Management of complaints and right to a second opinion':

> Complaints **must** be received, acknowledged, and assessed in accordance with the established HHS procedures or, for a private sector AMHS, in accordance with the hospital's complaints management procedures.[85]

In essence, a complaint can be made by a patient and/or their support person, however, the complaint must be addressed in accordance with HHS policies in the first instance. In situations where the complaint is not able to be resolved by an AMHS (in accordance with the relevant HHS policy), a second opinion can be sought if the patient is being treated under the Act. The HHS complaint process itself can take up to 28 days to be completed and then a second opinion can take another 7 days to be provided. These timeframes are not conducive to emergency department settings.

Ryan's Rule[86] can also be used by patients and/or their supporters, however, the prevalence of its use in this situation is not known. Anecdotally, stakeholders have indicated that Ryan's Rule is often used, however it is generally not fit for purpose in cases involving assessment recommendations

[82] *Mental Health Act 2016* (Qld) s 294.
[83] *Mental Health Act 2016* (Qld) s 290.
[84] *Mental Health Act 2016* (Qld) s 290.
[85] Queensland Health, *Mental Health Act 2016* Chief Psychiatrist Policy, *Management of complaints and right to a second opinion,* April 2020, p.2.
[86] Ryan's Rule was developed by Queensland Health following the death of Ryan Saunders in hospital under difficult circumstances. The rule means that patients, families, guardians and/or carers can request a clinical review (second opinion) if they have concerns about their health condition deteriorating, or if they feel their concerns regarding their condition are not being heard.

made in emergency department settings. Stakeholders have noted that, since its inception and over time, the intent of Ryan's Rule appears to have changed. Initially, application of the rule saw greater involvement of specialist staff, however now general medical and nursing staff tend to undertake the review.

Stakeholders have also noted that the use of second opinions in regional areas is more problematic given the limited number of psychiatric staff able to be called upon who are not involved with the patient. The independence of the second opinion in these circumstances has been questioned by several stakeholders.

Stakeholders did indicate, however, that significantly improved outcomes are achieved in situations where patients have access to the time and support they require to understand the circumstances of their admission under the *Mental Health Act*, their rights, and the treatment and care they are to receive, reducing the likelihood of complaints.

This information reinforces the importance of providing patients access to an IPRA in emergency department and inpatient settings. It also points to the need for clinical staff and the lived experience workforce to provide information to patients about their legal status and rights more transparently and proactively.

5.2.6 The role of the lived experience workforce

The National Mental Health Commission developed the National Lived Experience (Peer) Workforce Development Guidelines under Action 29 of the Fifth National Mental Health and Suicide Prevention Plan.[87] A suite of four documents has been published to accompany the guidelines to act as a resource for employers to support the development of a lived experience workforce within organisations.

The lived experience roles document (one of a suite of four) provides a practical guide to designing and developing lived experience positions within organisations and includes a list of common lived experience position titles and tasks.

In accordance with this document, lived experience/peer workers use their personal lived experience to understand the impact that mental illness, service use, and recovery has on an individual, and in their role, enables them to provide individual support to people accessing services, including identifying and developing personal goals for recovery and assessing other needs such as housing, financial coaching, and counselling.[88]

There has been significant research done that recognises the value of a lived experience workforce including:

- improving the outcomes for people using mental health services that are measurable from a clinical and recovery perspective;[89] and,
- support provided by people with a lived experience can be as effective on symptom reduction and service satisfaction as clinical care provided by mental health professionals.[90]

This information reinforces the benefits of providing patients access to a lived experience workforce in addition to access to IPRAs, as well as the suitability and appropriateness of the use of the lived experience workforce for mental health patients in understanding the services they use.

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[87] National Mental Health Commission, *Lived Experience Workforce Guidelines*, <http.www.mentalhealthcommission.gov.au/lived-experience-workforces/peer-experience-workfoce-guidelines>.
[88] L. Byrne, L. Wang, H. Roennfeldt, M Chapman, L. Darwin, C. Castles, L. Craze & M. Saunders, *National Lived Experience Development Guidelines: Lived Experience Roles,* National Mental Health Commission, 2021, p.31.
[89] G. Resnick & R. Rosenheck, Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence, and empowerment, *Psychiatric Services,* Vol.59, 2008, pp.1307-1314.
[90] K. Davies, M. Gray & L. Butcher, Lean on me: The potential for peer support in a non-government Australian mental health service, *Asia Pacific Journal of Social Work and Development* (Routledge), Vol.24, 2011, pp.109-121.

5.3 Admission, assessment, and treatment in an inpatient Authorised Mental Health Service

This section highlights issues associated with a person's stay in an inpatient AMHS as a voluntary or involuntary mental health patient.

5.3.1 Locked Ward policy

In 2013, the Queensland Government implemented a policy to lock all acute public inpatient mental health wards to prevent harm resulting from involuntary patients absconding without permission. Despite this direction, there is limited international evidence that locked wards reduce the incidence of patients absconding. There is strong evidence, however, related to the detrimental effects that locked wards may have on patients, including lower self-esteem and feelings of autonomy, a sense of seclusion and confinement, and lower levels of satisfaction with services provided.[91]

Locked wards mean that patients who voluntarily admit themselves to an inpatient AMHS, as well as those treated involuntarily under the Act, are managed in locked facilities. For patients needing acute care for the first time, this comes as a significant shock.

Stakeholders have described locked wards to the Public Advocate as being misleading, meaning that once you are inside the system, regardless of whether you are a voluntary or involuntary patient, you are treated the same. Stakeholders have also reported consumers viewing this as an abuse of power, not treating people as individuals but grouping them together and making presumptions about behaviour, which further stigmatises people with mental illness. Some stakeholders have noted that locked wards are the outcome of an efficiency driven system, rather than a system that focusses on the individual needs of people, and that the use of locked wards breaches basic human rights.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD)[92] was ratified by Australia in 2008. The CRPD requires that all persons with disabilities have the right to equal recognition before the law, the right to liberty (article 14) and the right to physical and mental integrity on an equal basis with others.

Specifically, article 14 of the CRPD states:

> Parties shall ensure that persons with disabilities, on an equal basis with others:
> a) Enjoy the right to liberty and security of person;
> b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty. 93

The locked ward policy employed by QH does appear to breach this requirement especially in relation to patients who are admitted voluntarily. The locked ward environment is potentially a trigger for patients to withdraw consent for treatment, which subsequently can result in a TA, effecting a transition from a voluntary to an involuntary admission. This transition has significant implications for the treatment path of the patient, including the involvement of the MHRT.

The use of locked wards in Queensland inpatient AMHSs may also be considered an unlawful deprivation of liberty under the *Human Rights Act 2019* (Qld).[94] A person is deprived of their liberty if they are physically detained without their consent. Voluntary patients who are admitted to inpatient AMHSs and are free to leave at any time are not deprived of their liberty. Stakeholders, however, have noted that voluntary patients, admitted to inpatient AMHSs, are not aware that

[91] N. Gill, S. Parker, A. Amos, R. Lakeman, M. Emeleus, L. Brophy, S. Kisely, Opening the doors: critically examining the locked wards policy for public mental health inpatient units in Queensland, Australia, *Australian & New Zealand Journal of Psychiatry,* Vol.55, no. 9, 2021, pp.844-848.
[92] United Nations, *Convention on the Rights of Persons with Disabilities*, United Nations, 61/106, New York, 2006.
[93] United Nations, 2006, Article 14.
[94] *Human Rights Act 2019* (Qld) s 29.

they are being admitted into a locked ward environment providing them with the same conditions as those who are admitted involuntarily.

Stakeholders have noted that the Chief Psychiatrist's policy and practice guideline for securing adult acute mental health inpatient units specifically states:

> voluntary patients, visitors, persons who are not involuntary patients or involuntary patients who have a valid basis for departing from the unit (including a leave entitlement) should be allowed to move freely in and out of the units (and through any exit or entry doors which are otherwise locked), subject to all appropriate steps being taken to ensure that persons who do not fall into one of these do not depart from the unit.[95]

In practice, however, stakeholders have noted that the ability of a voluntary patient to leave the ward of their own free will is severely curtailed.

It is unclear what effect the existence of locked wards has had on the rate of involuntary mental health treatment in Queensland. It does appear, however, based on annual reports from the Office of the Chief Psychiatrist (2017-2021), that a proportion of patients who enter an authorised service voluntarily do transfer to a TA (involuntary) at some time during their stay as an inpatient.

Examples of alternatives to locked wards in mental health facilities that have been used or trialled in other jurisdictions include the safewards model and the six core strategies program.

The safewards program includes ten interventions aimed at; improving communication between staff and patients, the provision of de-escalation strategies, the use of positive language, and distraction and sensory modulation to manage anger. The six core strategies program emphasises the importance of clear leadership and collaborative care with patients and their carers, which subsequently can reduce the use of coercive practices such as seclusion.[96]

The safewards model originated in the United Kingdom as a new model to reduce conflict and containment on psychiatric wards.[97] The model was implemented in seven health services across 18 wards in urban and regional Victoria (Australia) in 2015. A study was conducted following its implementation, with results including staff reports of;

- a reduction in the physical and verbal aggression displayed by patients which led to them feeling safer on the wards;
- improved connections with patients;
- being better able to use recovery-orientated care practices; and,
- being able to build more equal relationships with patients.[98]

The positive findings of this study were suggested to be attributed to the following two key activities that were unique to this Victorian study:

- interactive training delivered to staff prior to the commencement of the 12-week trial, including locally developed training materials in addition to the original UK safewards training material; and,
- fidelity monitoring of the trial being extended beyond the trial period, for 12 months.[99]

[95] Queensland Health, *Chief Psychiatrist Policies, Mental Health Act 2016*, December 2021, p. 384.
[96] L. Bowers, J. Alexander, H. Bilgin, et al, Safewards: The empirical basis of the model and a critical appraisal, *Journal of Psychiatric and Mental Health Nursing*, Vol.21, 2014, pp.354-364.
[97] L. Bowers, Safewards: a new model of conflict and containment on psychiatric wards, Vol.21, 2014, pp.499-508.
[98] J. Fletcher, B. Hamilton, SA. Kinner, L. Brophy, Safewards impact in Inpatient Mental Health Units in Victoria Australia: Staff Perspectives, *Frontiers in psychiatry*, Vol.10, article 462, 2019.
[99] J.Fletcher, M. Spittal, L. Brophy, H. Tibble, S. Kinner, S. Elsom & B. Hamilton, Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement, *International Journal of Mental Health Nursing,* Vol.26, 2017, pp.461-471.

This suggests that consideration needs to be given to the following:

- appropriate training of staff prior to the implementation of a new model of care;
- training that takes an interactive approach;
- the development of training materials that are site specific to ensure the local context is accommodated for; and,
- adequate resources being allocated for implementation that allow for all three phases of implementation fidelity to be monitored (that is: before, during and after implementation).

The Queensland Mental Health Commission has also addressed the issue of locked wards with the release of an options paper in December 2014, *Moving towards a more recovery-orientated, least restrictive approach in acute mental health wards, including locked wards*.[100] The report was based on a study funded by the Commission and undertaken by the University of Melbourne. This study included the perspectives of people with lived experience as well as staff with experience of acute mental health wards.[101]

Several reforms were recommended in the options paper as alternatives to locked wards, including recovery orientated practice approaches.

A follow up progress report was published by the Commission in 2017, which noted that a trial of the safewards model of care (noted above) was being undertaken in Central Queensland, Metro North, Metro South, and West Moreton HHSs.[102] Implementation of the safewards program across HHSs included training for staff, engagement of safeward 'champions', and the development of a project team at each site to support implementation. A qualitative study was consequently conducted to evaluate the program in three of the five wards in which it was implemented. This evaluation highlighted the challenges in changing mental health nursing practice in busy acute inpatient wards, suggesting the readiness of staff to engage, buy-in from management and adequate training that fits with the local context are important for successful implementation.[103]

An exemption to the locked ward policy was granted for Gold Coast mental health and specialist services by the Chief Psychiatrist in 2021, which enabled the service to trial discretionary locking of an eight-bed short stay inpatient unit. The Public Advocate has been advised that this trial is currently undergoing an internal review, and, to date, no results are publicly available. However, it is noted in the 2022 QH submission to the Queensland Parliament's Mental Health Select Committee 'Inquiry into opportunities to improve mental health outcomes for Queenslanders', that this review will inform further options for a proposed discretionary locking of wards framework.[104]

5.3.2 Involuntary treatment

The Office of the Chief Psychiatrist has been reporting on involuntary assessments (entry pathway and outcomes) annually since the introduction of the *Mental Health Act*.

These reports detail the;

- number of patients recommended for an assessment preceded by an examination authority (EA);
- number of patients recommended for an assessment preceded by an emergency examination authority (EEA); and,
- number of patients who receive a 'recommendation alone' for an assessment (not preceded by any type of EA).

[100] Queensland Mental Health Commission, *Options for reform: Moving towards a more recovery orientated least restrictive approach in acute mental health wards, including locked wards*, December 2014.
[101] J. Fletcher, B. Hamilton, S. Kinner, G. Sutherland, K. King, J. Tellez, C. Harvey & L. Brophy, Working towards least restrictive environments in acute mental health wards in the context of locked door policy and practice, *International Journal of Mental Health Nursing,* Vol.28, 2019, pp.538-550.
[102] Queensland Mental Health Commission, *Implementation progress of the 2014 report, Options for reform: moving towards a more recovery orientated least restrictive approach in acute mental health wards including locked wards*, May 2017, p.2.
[103] N. Higgins, T. Meehan, N. Dart, M. Kilshaw & L. Fawcett, Implementation of the Safewards model in public mental health facilities: A qualitative evaluation of staff perceptions, *International Journal of Nursing Studies,* Vol.88, 2018, pp.114-120.
[104] Queensland Health, *Submission inquiry into the opportunities to improve mental health outcomes for Queenslanders*, Mental Health Select Committee, submission No. 50, p.56.

The number of TAs, TSOs and FOs made are also tabled in annual reports.

The 'recommendation alone' category includes people who present voluntarily who are then assessed for a TA. This would also include people who are considered voluntary patients under an advance health directive, or those admitted to an inpatient AMHS with the consent of an attorney, guardian, or statutory health attorney (SHA) as per the least restrictive approach outlined in the Act (further information provided below).

The Chief Psychiatrist's annual reports do not provide a breakdown of the type of patients that fall under the 'recommendation alone' category, making it difficult to understand the percentage of patients who are voluntary under the consent of a substitute decision-maker versus the percentage of patients who are voluntary under their own consent.

The annual reports between 2017/18 and 2020/21 demonstrate, however, that patients in the 'recommendation alone' category represent between 78 and 83% of all patients assessed for a TA. This compares to only 16-21% of patients assessed following an EEA and 1-2% following an EA.[105]

The Chief Psychiatrist's annual reports also provide information on the number of treatment authorities issued following an assessment. Numbers provided are not broken down to reflect the number of TAs made for those patients in the 'recommendation alone' category (i.e., not preceded by an EA or EEA). However, the numbers reported do reflect that, out of the total number of assessments undertaken, the percentage of assessments that result in a TA being made were 65% (2017/2018), 63% (2018/2019), and 63% (2019/2020) respectively.[106]

This could effectively mean that a significant proportion of patients presenting to an inpatient AMHS voluntarily (either presenting on their own accord, or with consent being provided by a substitute decision-maker under the least restrictive approach) are potentially losing this status and becoming involuntary patients soon after admission.

The questions raised by analysis of this data highlight a need for:

- A review of data collection and reporting processes associated with involuntary assessment and treatment pathways, to include reporting on voluntary patients entering services either via self-consent or with the consent of a substitute decision-maker.
- Further investigation of the movement of patients from voluntary to involuntary status soon after being admitted to an inpatient AMHS.

5.3.2.1 Other issues

Chief Psychiatrist annual reports also provide numbers of initial TAs made (inpatient and community). Initial TAs made in inpatient settings are significantly higher than those in community settings, and this has been consistent from 2017/2018 to 2020/2021, sitting at 98%.[107]

Stakeholders in some regional areas also indicated that a significant proportion of patients admitted under TAs (involuntarily) to inpatient AMHSs are those who are known to the service and experience a relapse. This may be indicative of a lack of available and appropriate community services and/or a lack of support being provided to GPs to adequately manage people with complex mental health presentations in the community.

Often patients with complex needs require active case management and significant supports to attend GP appointments for regular treatment, including monthly depot injections. Many GP practices, and particularly those in regional areas, where resources are already stretched to meet patient demand, cannot provide these types of intensive services to mental health patients. This points to the need for a review of the remuneration of mental health care item numbers for GPs under Medicare, which is an Australian Government issue.

[105] Queensland Health, *Chief Psychiatrist Annual Report*, 2017-2018, p.15, 2018-2019, p.19, 2019-2020, p.13, 2020 – 2021, p.13.
[106] Queensland Health, *Chief Psychiatrist Annual Report*, 2017-2018, p.15, 2018-2019, p.19, 2019-2020, p.13, 2020 – 2021, p.13.
[107] Queensland Health, *Chief Psychiatrist Annual Report*, 2017-2018, p.17, 2018-2019, p.25, 2019-2020, p.19, 2020 – 2021, p.19.

5.3.3 Least restrictive approach

The *Mental Health Act* defines a 'less restrictive way' as follows:

> (1) For this Act, there is a less restrictive way for a person to receive treatment and care for the person's mental illness if, instead of receiving involuntary treatment and care, the person is able to receive the treatment and care that is reasonably necessary for the person's mental illness in 1 of the following ways –
>
> (a) if the person is a minor—with the consent of the minor's parent;
> (b) if the person has made an advance health directive—under the advance health directive;
> (c) if a personal guardian has been appointed for the person—with the consent of the personal guardian;
> (d) if an attorney has been appointed by the person—with the consent of the attorney;
> (e) otherwise—with the consent of the person's statutory health attorney.[108]

Stakeholders have indicated that the number of mental health patients who have an advance health directive (AHD) in Queensland is very low. Further, stakeholders have advised that staff use of the Consumer Integrated Mental Health and Addiction Application (CIMHA) to record AHDs and appointed substitute decision-makers is very inconsistent, which may lead to situations where mental health patients are not afforded the opportunity to be treated under a less restrictive approach in some circumstances.

The Queensland Health Chief Psychiatrist policy: *Patient records*[109] clearly states that AMHS administrators must ensure that CIMHA data entry relevant to the assessment, treatment, and care of patients under the Act is accurate and up to date, including the patient's status under the Act, and the existence of any AHDs and documents relating to the appointment of an attorney. In addition, the policy states that AMHS administrators must ensure that all relevant staff are trained and competent in the use of CIMHA.

The Public Advocate notes that an evaluation of the implementation of the *Mental Health Act* was undertaken by QH, and a report released in April 2019.[110] This report notes the existence of a module to record AHDs and appointed substitute decision-makers in CIMHA, and the delivery of training to mental health service staff across Queensland to support its implementation.[111] Further to this, the Chief Psychiatrist's annual report 2018-19 details activities that were commenced to address findings from the evaluation of the implementation of the Act including:

- the development of a handbook to support consistent information system data entry and administrative processes;
- a review of Chief Psychiatrist policies and practice guidelines; and
- further exploration of opportunities for benchmarking and evaluation of the implementation of the Act in 2020-21.[112]

While these actions are noted, it does appear that further evaluation and activities to improve practices that support the less restrictive approach provisions under the Act are required.

Several stakeholders have also raised significant concerns regarding the use of a person's statutory health attorney in providing consent for treatment on behalf of a person with a mental illness.

[108] *Mental Health Act 2016* (Qld) s13.
[109] Queensland Health, *Mental Health Act 2016 Chief Psychiatrist Policy: Patient records*, April 2020, p.4.
[110] Queensland Health, *Evaluation of the Mental Health Act 2016 implementation | Evaluation Report*, April 2019.
[111] Queensland Health, *Evaluation of the Mental Health Act 2016,* p.8.
[112] Queensland Health, *Chief Psychiatrist Annual Report* 2018-19, p.8.

The Queensland Health, Chief Psychiatrist policy[113] states:

> if a person is accompanied by a support person, the doctor or authorised mental health practitioner may ask the person if their relationship with the person enables him or her to act as a statutory health attorney for the person. A statutory health attorney can only make decisions for a person without capacity if the person does not have an AHD, or a personal guardian or attorney for the relevant matters.

In addition, the policy states:

> A statutory health attorney is not appointed by the person. Therefore, consideration should be given to treating the person as an inpatient under a Treatment Authority and the extensive oversight and protections afforded by the Act, rather than providing inpatient treatment and care with consent of a statutory health attorney. The decision to treat a patient under a Treatment Authority or with the consent of a statutory health attorney in these circumstances should be made on a case-by-case basis. In making this decision, the authorised doctor must have regard to:
>
> - the person's treatment needs, and
> - the person's views, wishes and preferences.
>
> If the person is to be treated as an inpatient with consent of a statutory health attorney, the authorised doctor should ensure frequent review of this arrangement to reconsider the mechanisms to use, having regard to the person's circumstances. As a minimum, the treatment and care of the person must be reviewed by a Clinical Director at or around fourteen (14) days after admission. The Clinical Director may determine if the person should remain as an inpatient or if treatment in the community would be more appropriate. A decision about further review timeframe must also be made.

The policy clearly notes that an SHA is not someone who is appointed by the person, which moves away from the principle of making decisions that consider a person's wishes and preferences. Using an SHA to consent for a person to receive treatment in an inpatient AMHS also means that other independent safeguards are not provided for the person, including the involvement of the MHRT. While it is recognised that some additional safeguard mechanisms have been included in the policy, namely a review by a clinical director 14 days after admission, the extent to which these safeguards are operationalised and reviewed to monitor their effectiveness in upholding a human rights framework is not known.

An analysis of SHA provisions in a mental health treatment context against the UN CRPD article 12 (equal recognition before the law) found the following incompatibilities:

- using a SHA to consent on behalf of a person does not respect the rights, will and preferences of the person;
- a SHA could be a spouse or any adult who has provided care for the person, including a relative or friend, and such, is not free of conflict of interest; and
- using a SHA removes the oversight function of the mental health review tribunal, which in turn eliminates safeguards and monitoring by a competent authority.[114]

This role of a statutory health attorney in consenting to a person's admission to an inpatient AMHS (as opposed to medical treatment) may require further consideration as a component of a broader review of substitute decision-making legislation, policy, and practice.

5.3.4 Use of restrictive practices

Stakeholders have indicated that the use of restrictive practices in inpatient AMHSs is of concern, however, of greater concern is the under-reporting of complaints by patients regarding the use of such practices. Stakeholders noted the reticence of some mental health patients to raise complaints about restrictive practices, fearing retribution, including the perceived possibility of not being discharged from the facility.

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[113] Queensland Health, *Mental Health Act 2016 Chief Psychiatrist Policy-Treatment criteria, assessment of capacity, less restrictive way and advance health directives*, May 2020, p.12.
[114] N. Gill, & K. Turner, How the statutory health attorney provision in Mental Health Act 2016 (Qld) is incompatible with human rights, *Australian Psychiatry*, Vol.29, 2021, pp.72-74.

The use of seclusion has been raised by some stakeholders as a particular issue, indicating that practices in some HHSs are not aligned with Chief Psychiatrist policies, such as the policy on seclusion which provides:

> The following principles must be applied in the use of seclusion:
>
> - maintaining the safety, wellbeing and dignity of the patient is essential,
> - protecting the safety and wellbeing of staff is essential,
> - seclusion should only be used for the minimum period of time necessary, and
> - all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.[115]

Data on Queensland rates of seclusion (inclusive of all age groups in acute hospital settings) are provided in the Chief Psychiatrist's annual report. A review of this data indicates an increase in the seclusion rate (measured as number of events per 1,000 bed days) from 6.1 (2017-18) to 7.2 (2018-19), and a larger increase to 10 in 2019-20. In 2020-21, the seclusion rate remained high at 9.2. When comparing this to the national average[116], Queensland's seclusion rates remained higher than the national average for the years 2018-19 (7.2) and 2019-20 (8.1).

Stakeholders note that the cohort of people admitted to inpatient AMHSs has changed over the last decade, with an increase in males presenting with psychotic disorders and drug dependencies. It is recognised that this change may contribute to an increase in seclusion rates, however the concerns expressed by stakeholders in relation to seclusion practices, coupled with rates of seclusion that are above the national average, does indicate a need for a review of the operationalisation of the Chief Psychiatrist's restrictive practice policies in this area.

In this regard, in May 2015 the National Mental Health Commission released a position paper on seclusion, restraint and restrictive practices in mental health services[117] which provides examples of evidence-based interventions deemed as valuable in reducing the use of seclusion and restraint.

This document references the Substance Abuse and Mental Health Services Administration (SAMHSA) roadmap to seclusion and restraint free mental health services[118] and outlines the following six core strategies:[119]

- 'Leadership towards change' – outlining a philosophy of care that targets seclusion and restraint reductions;
- 'Consumer roles in inpatient settings' – having an inclusive approach which involves consumers, carers and other advocates in seclusion and restraint reduction initiatives;
- 'Using data to inform practice' – using data in an empirical, non-punitive way to review, analyse and monitor patterns of seclusion and restraint;
- 'Workforce' – developing procedures, practices and education that promote mental health recovery;
- 'Use of seclusion and restraint reduction tools' – using assessments and other resources to develop individual aggression prevention approaches; and,
- 'Debriefing techniques' – analysing why seclusion and restraint events occurred and evaluating the impacts on individuals with lived experience, families and carers and service providers.

Specific design features of inpatient wards have also been proven to reduce the use of seclusion and restraint as well as supporting better health outcomes and consumer experiences. Design features that can reduce the use of seclusion and restraint include:

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[115] Queensland Health, *Mental Health Act 2016* Chief Psychiatrist Policy: Seclusion, December 2021, p.3.
[116] Australian Institute of Health and Welfare, *Mental Health services Australia, National KPI dataset*, 2018-19 – 2019-20.
[117] Australian Government National Mental Health Commission, *A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services,* May 2015.
[118] Substance Abuse and Mental Health Services Administration, *Roadmap to Seclusion and Restraint Free Mental Health Services,* Rockville, 2005.
[119] K. Huckshorn, Reducing seclusion & restraint use in mental health settings: Core strategies for prevention, *Journal of Psychosocial Nursing and Mental Health Services,* Vol.42, 2004, pp.22-33.

- a beneficial physical environment (e.g., simple aesthetic improvements such as warm colours, rugs, and plants, as well as natural lighting, increased privacy, large balconies, and access to modern home electronics);
- sensory and/or comfort rooms; and,
- private, uncrowded, and calm spaces.[120]

5.3.4.1 Other issues

The use of chemical restraint is not regulated under the *Mental Health Act*. Furthermore, differences in understanding what chemical restraint is and the role it plays in the care of patients with an acute mental illness has been noted.[121]

Stakeholders have informed the Public Advocate that what is referred to as chemical restraint in legal terms is referred to as Acute Behavioural Disturbance Management (ABDM) by mental health clinicians.

A guideline developed by the Australian and New Zealand College of Anaesthetists, and endorsed by the Australasian College for Emergency Medicine, College of Intensive Care Medicine and Royal Australian and New Zealand College of Psychiatrists, for safe care of patients sedated in health care facilities for acute behavioural disturbance, provides the following definition:

> **Behavioural disturbance** is defined as the combined physical actions made by an individual which are in excess of those considered contextually appropriate and are judged to have the potential to result in significant harm to the individual themselves, other individuals, or property. Acute behavioural disturbance is characterised by a rapid onset and severe intensity. The aetiology is commonly a mental disorder, physical illness, or intoxication with alcohol and/or other substances. Often the behaviour is considered not to be under the voluntary or legally competent control of the individual.[122]

QH has developed two guidelines regarding ABDM in the emergency department setting[123] and inpatient AMHSs.[124] Both of these guidelines, while not mandatory, provide clinicians with best practice guidance on sedation for the purposes of ABDM.

The guideline for managing patients with Acute Severe Behavioural Disturbance (ASBD) in emergency departments also provides guidance on other aspects of behavioural management including assessment, use of de-escalation techniques, legal requirements, and documentation, however, the pharmacological aspect is focussed only on sedation. Similarly, the pharmacological guidance provided in the guideline on management of ABDM in Queensland acute mental health inpatient services is also directed toward sedation.

Under the Act, it is an offence to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition. The Act further states that treatment and care for a medical condition includes preventing imminent serious harm to the patient or others.[125]

The Chief Psychiatrist's 'clinical need for medication' policy outlines:

> AMHSs are responsible for the quality use of medicines (QUM) under the National Strategy of QUM, within the National Medicines Policy. [126]

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[120] S. Oostermeijer, C. Brasier, C. Harvey, B. Hamilton, C. Roper, A. Martel, J. Fletcher & L. Brophy, Design features that reduce the use of seclusion and restraint in mental health facilities: a rapid systematic review, *BMJ open*, Vol.11, 2021.
[121] E. Muir-Cochrane, A wicked problem: Chemical restraint: towards a definition, *International Journal of Mental Health Nursing,* Vol.29, 2020, pp.1272–1274.
[122] Australian and New Zealand College of Anaesthetists, *Guideline for safe care for patients sedated in health care facilities for acute behavioural disturbance,* September 2019, pp. 3.
[123] Queensland Health, *Management of patients with Acute Severe Behavioural Disturbance in Emergency Departments,* version 4.0, October 2021.
[124] Queensland Health, *Pharmacological management of acute behavioural disturbance management (ABDM) in Queensland Mental Health Alcohol and Other Drugs (MHAOD) Inpatient Services (adults and older adults) guideline,* Version 3.0, September 2021.
[125] *Mental Health Act 2016* (Qld) s 272.
[126] Queensland Health, *Mental Health Act 2016 Chief Psychiatrist Policy:* clinical need for medication, April 2020, p.1.

QUM involves:

- a considered selection of treatment options,
    - medicines, whether prescribed, recommended, and/or self-selected should be used only when appropriate, with non-medicinal alternatives considered as needed;
- appropriate choice of medicine when medicine is required; and,
- safe and effective use of medicines.[127]

In addition, AMHSs must comply with the National Safety and Quality Health Service Standards, which includes medication safety.

The Public Advocate has heard from people with a lived experience of mental illness about their experiences of the public acute mental health system, which included their concerns regarding:

- the administration of medication;
- the information provided to them about their medication; and,
- the difficulties they encountered when communicating their wishes and preferences regarding the medication prescribed to them.

Given this information, it appears appropriate that consideration be given to reviewing all clinical practice guidelines for the appropriate use of psychotropic medications in mental health settings, that extend beyond the purposes of ABDM. This should include, but not be limited to, reviewing the Psychotropic Guideline for people with intellectual or developmental disability.

During discussions, stakeholders also identified that the approach of security staff when responding to patients with escalating behaviours in inpatient AMHSs was of concern. Some stakeholders observed that, in some HHSs, the restraint practices employed by security staff are not necessarily the most appropriate or recognised best practice, including the use of the 'knee to neck move', which not only has implications for all patients, but additional implications for patients who have a background of trauma.

5.3.5 Sexual safety in inpatient mental health facilities

The QH *Sexual health and safety guidelines, Mental health, alcohol and other drug service,* provides information for mental health and alcohol and drug treatment services to:

- highlight sexual health as an important part of the provision of holistic care for clients;
- improve recognition of factors impacting on the sexual safety of clients;
- identify and appropriately respond to sexual safety risks;
- appropriately respond to allegations of sexual assault;
- establish a service culture which promotes sexual health and sexual safety; and,
- facilitate development of local processes and procedures related to sexual health and sexual safety, which meet the needs of clients accessing the Service. [128]

Section 9 of these guidelines focuses on preventing incidents, which includes the conduct of early identification checks of sexual safety risks using a risk assessment approach and mitigating risks for those who are identified as vulnerable. The guideline identifies that the design of the service environment is an important element in the promotion of sexual safety. It does, however, acknowledge that many of the considerations recommended may not be able to be applied in all existing mental health services, but should be considered when developing or upgrading services in the future.[129]

Stakeholders have raised the design of mental health ward environments as a significant issue potentially impacting on the sexual safety of patients. Stakeholders noted that many ward environments have four bed bays with one single toilet, and very few options to provide

[127] Queensland Health, *Mental Health Act 2016* Chief Psychiatrist Policy: clinical need for medication, p.1.
[128] Queensland Health, *Sexual health and safety guidelines, Mental health, alcohol and other drug services, 2016, Document Number #QH-GDL-434:2016,* p.1.
[129] Queensland Health, *Sexual health and safety guidelines, Mental health, alcohol and other drug services,* pp.9-13.

appropriate inpatient accommodation that is gender specific. In addition, it was noted that the significant change in the cohort of people admitted into mental health facilities over the last decade (e.g., an increase in males with psychotic disorders and drug dependencies), has made shared gender wards more difficult to manage.

Stakeholders report that females in shared gender wards often lock the door to their room as they do not feel safe. Some larger metropolitan mental health facilities have worked to minimise this environmental design issue by establishing wards that are 'largely female', by accommodating females in older persons mental health and other specialised wards, or only admitting females to metropolitan hospitals that have upgraded facilities to accommodate gender specific wards. While this has provided options in metropolitan areas, it is likely that facilities operating in regional areas do not have the same options available.

The Health Ombudsman has informed the Public Advocate that several complaints and notifications have been made about alleged sexual assault cases in Queensland inpatient AMHSs over recent years. The themes identified in these matters raise significant concerns as to the level of patient safety offered in these units, as reported in the Health Ombudsman's submission to the Mental Health Select Committee's 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'.[130] Stakeholders believe that there may be other instances that are not reported by patients who do not feel safe disclosing sexual assault concerns or complaints for fear of retribution.

A sexual safety project was conducted by the Victorian Mental Health Complaints Commissioner which culminated in *'The right to be safe*: *Ensuring sexual safety in acute mental health inpatient units: Sexual Safety project report.'*[131] The overarching recommendation of the project was for the development of a comprehensive sexual safety strategy to plan, coordinate and monitor actions to prevent and respond to breaches of sexual safety. While this project was undertaken in Victoria and was based on the analysis of complaints made to the Mental Health Complaints Commissioner, it may be beneficial for learnings from this project to be reviewed against the QH *Sexual health and safety guidelines, Mental health, alcohol and other drug services* to determine if such learnings are applicable in Queensland inpatient AMHSs.

5.3.6 Assessment and treatment of patients presenting with dual disability

The perceived appropriateness of assessment and treatment practices employed by treating teams has been raised as an issue by many stakeholders, particularly for patients who present with mental health symptoms and have an additional disability and/or diverse cultural background. This cohort of people includes, but is not limited to, people with an intellectual disability, neurological impairment, a background of trauma, culturally and linguistically diverse background, and Aboriginal and Torres Strait Islander people. Stakeholders have commented that the assessment and treatment of this diverse group of patients is generally provided through one lens only, that being the *Mental Health Act*.

In other acute health care environments, if a patient presents with a stroke, or other physical condition (e.g., a broken bone), and displays symptoms of a mental illness, the consultation liaison psychiatry team is regularly called to consult and provide specialist support regarding the appropriate care and treatment of that patient's mental health. This does not generally occur in an inpatient AMHS, meaning that intellectual disability or other neurological conditions may not be considered when formulating a treatment plan. This can potentially have significant outcomes for the patient, particularly if medication prescribed for a mental illness exacerbates other conditions like, for example, autism or epilepsy.

Stakeholders have indicated that there is potentially a cultural stigma associated with physicians consulting in inpatient AMHSs, which in some cases has led to psychiatrists having a very high threshold prior to initiating a referral, and sometimes only referring when an acute physical concern

[130] Office of the Health Ombudsman, *Submission Inquiry into the opportunities to improve mental health outcomes for Queenslanders,* Mental Health Select Committee, Submission No. 138, February 2022, p.3.
[131] Victorian Government, *The right to be safe: Ensuring sexual safety in acute mental health inpatient units: sexual safety project report,* Mental Health Complaints Commissioner, March 2018, p.2.

(e.g., renal failure or a broken bone) is identified, and requires immediate review by a treating physician.

In 2007, Edwards and colleagues examined Queensland psychiatrists' attitudes and perceptions of adults with intellectual disability and found the following:

- the majority of psychiatrists involved in the study had treated patients with an intellectual disability, with only 17% (n=30) not having seen adults with an intellectual disability in the previous 6 months;
- the majority of psychiatrists (71%) had assessed adults with intellectual disability in the public sector (11% as inpatients and 38% as outpatients);
- 88% of psychiatrists reported having not received training relating to the mental health needs of adults with intellectual disability in the last 12 months;
- 75% of psychiatrists agreed that antipsychotics were overused to control aggression;
- 68% agreed that adults with dual diagnosis receive a relatively poor standard of psychiatric care;
- 70% agreed that psychiatric treatment of these adults is usually symptomatic, rather than diagnosis based;
- 81% agreed that adults with dual diagnosis are exploited by other patients during inpatient admission;
- only 35% agreed that psychiatrists receive sufficient training in behavioural management of adults with dual diagnosis;
- 85% agreed specialised psychiatric units for adults with dual diagnosis would provide a higher standard of care; and,
- 58% of psychiatrists agreed they would prefer not to treat adults with an intellectual disability.[132]

Prior to the introduction of the National Disability Insurance Scheme (NDIS), the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP) provided support to AMHSs on the assessment and management of patients with intellectual disability presenting with a mental illness. Following the introduction of the NDIS, the Mater Intellectual Disability and Autism Service (MIDAS) was funded by QH for a short period to provide specialist support to fill the gap previously provided by DSDSATSIP. Now, a state-wide Mental Health Intellectual Disability Service (SMHIDS) operates out of the West Moreton HHS. This service commenced project ECHO (a virtual knowledge sharing model) to provide monthly tele-monitoring clinics enabling clinicians to present clinical cases to the SMHIDS team and other colleagues for discussion and advice.

Stakeholders have indicated that while this service has been instrumental in providing specialist support, it has an extremely large area to cover in the provision of such support.

Overall, this information highlights the need for further investigation of specialist mental health services for people with a dual disability.

5.3.7 Functions of the Mental Health Review Tribunal

When people are under a TA in an inpatient AMHS, the MHRT reviews their involuntary status at set times and decides whether the person should continue to be treated under the Act. The Tribunal is also responsible for deciding whether certain types of invasive treatments can be undertaken on a person as part of their treatment and hears appeals regarding certain decisions made by treating teams or the service.

Previous Public Advocates have identified a series of significant concerns related to the operation of the MHRT. These concerns, supported anecdotally by stakeholder interviews and a research paper released in 2020,[133] are detailed below.

[132] N. Edwards, N. Lennox, & P. White, Queensland psychiatrists' attitudes and perceptions of adults with intellectual disability, *Journal or Intellectual Disability Research*, Vol.50, part 1, 2001, pp.75-81.
[133] S. Boyle & T. Walsh, 'Procedural fairness in mental health review tribunals: the views of patient advocates,' *Psychiatry, Psychology and Law*, Vol.28, no. 2, 2020, pp.163-184.

5.3.7.1 Audio recording of Tribunal proceedings

The absence of formal recording of MHRT proceedings has been of concern for some time and is a focus of the Public Advocate's ongoing systemic advocacy. The recording of proceedings is a fundamental requirement of justice. In a jurisdiction which has the power to detain people indefinitely in a mental health facility, or authorise certain types of invasive involuntary treatment, it is critical that all proceedings are recorded to ensure fairness of process and accountability.

During 2019-20 the MHRT announced it was initiating an Audio Recording Project and would be conducting a trial of electronic audio recording of proceedings. The MHRT undertook consultation about the project and commenced the trial of recording early in the 2020-21 financial year, including sourcing appropriate software and equipment to conduct the recording, and identifying file storage solutions.[134] The MHRT also developed policies and procedures to support implementation of electronic audio recordings, and commenced discussions with the Department of Justice and Attorney-General (DJAG) for an arrangement for recording under the *Recording of Evidence Act 1962.*[135]

The MHRT advised the previous Public Advocate in July 2021 that there remained some outstanding questions to be resolved, including; who will be lawfully permitted to receive a record of proceedings; when typed transcripts of proceedings may be required; the fees for obtaining recordings and transcripts; and whether and how those fees may be waived. Further, the MHRT advised that, once these matters are resolved, it was committed to a timely execution of the arrangement for recording under the Act.[136]

To date, it appears that the plan to require audio recordings has been stalled for a variety of reasons. Action is required in this area as a priority.

5.3.7.2 Patient representation at hearings

Patients are limited as to who they can take to support them in a tribunal hearing. If a patient does not have a family member or nominated support person, a member of the treating team can sit in on a tribunal hearing for support, however the independence of this support has been raised as a concern by some stakeholders. In some cases, an IPRA can attend a tribunal hearing to support the patient, however this needs to be cleared and approved by the tribunal panel. It appears that there is no clear standard approach taken to approving an IPRA's presence at tribunal hearings across Queensland. The criteria for the approval of persons to support the patient seem to differ and appear, based on the observations of stakeholders, to be dependent upon the dynamic between the service provider and the tribunal panel rather than guidelines and policy.

5.3.7.3 Patient participation at hearings

Kitchen table discussions[137] involving patients with lived experience of mental illness who have participated in tribunal hearings have been conducted by the MHRT.

During engagement with stakeholders, it was noted that these discussions identified a patient's lack of understanding and/or not having knowledge of the role and functions of the MHRT as a significant gap impacting on a patient's participation at their hearing.

Patients also reported that they do not attend their hearing due to reasons including:

- A perception that their views are not taken into consideration by the tribunal when making decisions.
- The long travel times associated with attending a hearing if they are on a community-based treatment order, and particularly if travelling from regional and/or remote areas.

[134] Correspondence from the President of the Mental Health Review Tribunal to the Public Advocate, dated 15 July 2021.
[135] Correspondence from the President of the Mental Health Review Tribunal to the Public Advocate, dated 15 July 2021.
[136] Correspondence from the President of the Mental Health Review Tribunal to the Public Advocate, dated 15 July 2021.
[137] Kitchen table discussions are an empowering way for consumers to lead consultation in their community. They provide an opportunity for community members to have their say in a safe and supportive environment.

An option, known as a self-report, is provided for patients not attending a hearing however it is not perceived by patients as a document valued by the tribunal.

In addition, several patients have told stakeholders that, in their opinion, the tribunal had already come to a decision regarding their case based on the clinical report. Therefore, they felt their contribution would make little difference to the outcome of the hearing.

In terms of improvements, patients have suggested that additional information be included in tribunal documents outlining their recovery goals. It was felt that this would improve the tribunal's focus on their goals and where they were heading, rather than focussing on what has occurred in the past.

Based on stakeholder interviews, the tribunal also appears to be supportive of this type of focus. It has been noted, however, that looking at options to meet recovery goals relies on services being accessible in the community, to ensure protective mechanisms are in place to support the patient's goals, without increasing any risks associated with removing the TA. A lack of this community support has been identified as a contributing factor to some tribunal decisions regarding the continuum of care provided to patients.

5.3.7.4 Length of time for hearing and the impacts on people with complex presentations (including dual disability)

A review of a TA is allocated 30 minutes at a tribunal hearing, a very tight timeframe, particularly for patients who are appearing for the first time. If any flexibility in the time allocated for the hearing is to be considered by the tribunal (e.g., complex matters) the tribunal requires this information within the first 7 days of the TA being put in place. This tight timeframe places additional pressure on already busy clinicians and consequently this option is often not sought.

Additionally, the MHRT generates patient hearing lists 21 days prior to the 28-day hearing requirement, yet the clinical reports required from the treating clinician are not submitted to the tribunal until 7 days prior to the hearing. So, while the clinical report may outline some of the complexities and the need for a longer hearing, the two dates do not align, which makes it difficult for the tribunal to allocate additional time to a hearing. Resources allocated to the MHRT for hearings have also been identified as a factor limiting consideration of longer hearing times for patients.

5.3.7.5 Communication with patients attending tribunal hearings

Communication has also been raised as a significant issue for patients attending tribunal hearings. Concerns have been raised about the method by which patients receive information from the tribunal, as well as the clarity of the information explaining the tribunal process and what is expected of them.

As a matter of course, the MHRT sends a letter to the patient's home address advising them of their upcoming tribunal hearing (this is regardless of whether they are an inpatient or in the community). If they are an inpatient, a letter is also sent to the inpatient AMHS, which is then responsible for providing the correspondence to the patient. Stakeholders have reported instances where patients find the letter placed on their bed, with little or no support provided to understand the contents of the letter. In some instances, the IPRA may be aware of the patient's upcoming hearing and will therefore provide support, however this is not always the case.

Communication with patients with an intellectual disability and co-occurring mental disorder also needs to be considered in this context. The Department of Developmental Disability Neuropsychiatry at the University of New South Wales developed a guide for providers on accessible mental health services for people with an intellectual disability. This guide includes suggestions regarding providing information to a person with an intellectual disability, which

includes using easy-to-understand language or using augmentative and alternative communication where appropriate.[138]

This information highlights the importance for services to be aware of the needs of the individual people they are communicating with, to ensure that communication is accessible and appropriate to the person themselves, their family, and other networks of support.

5.3.8 Role of the Independent Patient Rights Adviser

IPRAs are positions created under the *Mental Health Act*.

The key functions IPRAs perform include:

a) ensuring patients and their support persons are advised of the patient's rights under the *Act,*
b) support patients and their support persons to communicate to health practitioners the patient's views, wishes and preferences about their treatment and care,
c) work collaboratively with community visitors under the *Public Guardian Act 2014,*
d) consult with clinicians and the Chief Psychiatrist on the rights of patients under the *Mental Health Act 2016, Guardianship and Administration Act 2000* and *Powers of Attorney Act 1998,*
e) advise the patient and their support persons of the patient's rights at Mental Health Review Tribunal Hearings,
f) help the patient engage a representative for their hearings if requested to do so,
g) work collaboratively with the patient's personal guardian or attorney to further the patient's interests, and
h) advise the patient of the benefits of an advance health directive or an enduring power of attorney.[139]

5.3.8.1 Initial referral to an Independent Patient Rights Adviser

Engaging an IPRA to assist a patient on admission to an inpatient AMHS should be a simple and efficient process, aligned with the objectives of the *Mental Health Act*.

However, the operation of, and referral to, IPRA services is determined by the individual policies and practices of each HHS, with significant variations noted across the state.

Referrals may be received and communicated to the IPRA in a variety of ways including:

- direct referrals from the treating clinical team;
- direct referrals from patients and or support persons; or,
- by using patient flow information or bed management systems.

The work of IPRAs is primarily focused on assisting patients to understand their treatment and care and communicate their views, wishes and preferences to the treating team. This can include things like; facilitating lines of communication with the treating team, assisting patients to put together a list of questions that they have about their treatment and care, and assisting patients to discuss their questions and/or concerns about their treatment and care with the treating team.

[138] Department of Developmental Disability Neuropsychiatry, Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers, prepared by J. Trollor & A. Ching, School of Psychiatry, UNSW Medicine, University of New South Wales, 2014.
[139] Independent Patient Rights Advisers, Queensland Health, *Mental Health Act 2016* Fact sheet, p1.

5.3.8.2 Provision of education to patients

Statutory guidelines associated with the *Mental Health Act* state that 'an authorised doctor must, as soon as practicable, examine the patient and decide the nature and extent of the treatment and care to be provided'. In deciding the treatment and care to be provided, the authorised doctor must; 'discuss the treatment and care to be provided with the patient, and have regard to the views, wishes and preferences of the patient, to the extent they can be expressed, including in an advance health directive'.[140] Stakeholders have raised concerns about the lack of education provided by treating clinicians to patients about their treatment and care. In many instances, they report that IPRAs are providing this type of education.

5.3.8.3 Nominating a support person

Under the Act, a patient may appoint a Nominated Support Person (NSP), which is a formally appointed person who can; discuss confidential treatment and care matters with the treating team, support or represent a person at MHRT hearings and be provided with notices relating to the patient under the Act.[141] An IPRA is often the main point of education and awareness of the role and rights of an NSP to patients. There is concern amongst stakeholders that if a patient has not engaged with IPRA services, they may not be aware of this right.

5.3.8.4 Patient access to legal advocates for tribunal hearings

A significant issue raised by stakeholders is the capacity for patients to access legal advocates to assist with tribunal hearings. This stems from the limited number of legal advocates who are available to assist, coupled with the inability of many patients to engage a legal advocate without support from an IPRA, which is hampered by the inconsistent approach across HHSs to IPRAs accessing the MHRT hearings schedule.

A patient is only required to have notice of their upcoming hearing 7 days prior, however, the MHRT hearings schedule is issued 21 days beforehand and provided to the AMHS. Most community legal centres require at least 7 days to review a case. Therefore, if an IPRA does not have access to the hearings schedule when it is first issued or within the first week of it being issued to the inpatient AMHS, the ability of a patient to engage with legal representation is severely curtailed.

5.3.9 Communication between treating teams and patients

Communication between treating teams and patients has been identified by stakeholders as a major concern and source of complaints in inpatient AMHSs. Complaints include treating teams not communicating the intention, purpose, and benefit of treatment (e.g., medication), and not explaining to the patient the specific order they are on and what this means for them. Patients (via stakeholders) often report being told they are being treated under the Act however this does not provide them with information about the order they are being treated under, or what it means. IPRAs report a need to spend a significant amount of time providing education to patients about their order and their treatment plans.

Concerns have consequently been raised about the delegation of patient education from treating clinicians to IPRAs. This also raises secondary issues for IPRAs. After having spent significant time building rapport and relationships with patients as a person independent of the treating team, they are being put in situations where they are expected to deliver the 'not so good' news about a patient's treatment in the absence of this being delivered by treating teams.

5.3.10 Support for patients attending the Queensland Civil and Administrative Tribunal (QCAT)

Referrals from QH clinicians to advocates and lawyers to support clients with QCAT applications (for the appointment of a formal guardian to act as a substitute decision-maker for certain matters)

[140] *Mental Health Act 2016* (Qld) s 53.
[141] *Mental Health Act 2016* (Qld) s 224.

and representation are minimal across the mental health sector. Stakeholders have reported that the social work role in QH facilities is generally tasked with coordinating an application to QCAT, and while many social workers do engage with community legal centres for support in this area, it is not the standard approach taken across QH.

Stakeholders report that in many cases a QCAT application is completed with limited consideration given to other options that could negate the need for the appointment of a substitute decision-maker for the patient.

5.3.11 Community Visitors Program (Office of the Public Guardian)

The Office of the Public Guardian's adult community visitors program independently monitors different types of accommodation called 'visitable sites' where vulnerable adults live. A visitable site is defined under the *Public Guardian Act 2014* as:

> (a) an authorised mental health service under the *Mental Health Act 2016* that provides inpatient services; or
> (b) the forensic disability service; or
> (c) premises, other than a private dwelling house, at which a funded adult participant lives and receives services or supports that—
> (i) are paid for wholly or partly from funding under the national disability insurance scheme; and
> (ii) are provided under the adult's participant's plan; and
> (iii) are provided by a registered NDIS provider that is registered under the National Disability Insurance Scheme Act 2013 (Cwlth), section 73E to provide a relevant class of supports; and
> (iv) are within the relevant class of supports; or
> (d) a place, other than a private dwelling house, that is prescribed under a regulation.[142]

Community visitors monitor the adequacy and appropriateness of services provided in an inpatient AMHS and can make announced and unannounced visits to ensure consumers are being cared for appropriately, as well as making inquiries, and lodging complaints for, or on behalf of, consumers.[143]

Community visitors also retain the power to refer complaints to an external agency where appropriate. Community visitors provide a report to the service provider following their visit outlining any relevant issues that have been identified.[144] They are also permitted to share this report with various other agencies, including the Public Advocate.[145]

Community visitors can experience difficulties when conducting official visits at some inpatient AMHSs. These difficulties can be exacerbated by the level of contact and information sharing afforded to them by IPRAs and clinical treating teams.

Both IPRAs and community visitors exist to ensure that the public acute mental health system includes appropriate safeguards and protections for people in situations where their human rights are being severely restricted. It is vital that these services are able to operate efficiently and effectively to achieve the outcomes sought under the *Mental Health Act* and *Public Guardian Act*.

It appears that both services would benefit from the implementation of consistent policies across all AMHSs in Queensland. Policies need to provide for appropriate levels of access, interaction and information sharing, communication, and escalation procedures to ensure that safeguards and protections for vulnerable patients are maintained and issues can be addressed.

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[142] *Public Guardian Act 2014* (Qld) s 39.
[143] Office of the Public Guardian Queensland, *The role of Community Visitors in Authorised Mental Health Services*, Fact sheet, p.1 <https://www.publicguardian.qld.gov.au/__data/assets/pdf_file/0009/579384/OPG_Factsheet_The-role-of-Community-Visitors-in-an-Authorised-Mental-Health-Service.pdf>
[144] Office of the Public Guardian Queensland, *How Community Visitors advocate for adults, advocacy and rights protection for adults with a disability*, Fact sheet, p.1 <https://www.publicguardian.qld.gov.au/__data/assets/pdf_file/0003/572349/OPG-Factsheet_Community-Visitor-Program-Adult.pdf>.
[145] *Public Guardian Act 2020* (Qld), ss 47, p42.

5.3.12 Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

The United Nations International Covenant on Civil and Political Rights (ICCPR) was ratified by Australia in 1980 and the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) in 1989. The Optional protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment[146] (OPCAT) builds on the foundation of both the ICCPR and CAT, with a focus on prevention rather than reaction, and cooperation instead of condemnation.

OPCAT entered into force in 2006, was signed by the Australian Government in 2009 and ratified in December 2017.

The objective of OPCAT is to establish a system whereby regular visits are undertaken by independent bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhumane, or degrading treatment or punishment.[147]

Article 4 states that visits can be to any place where persons are or may be deprived of their liberty, whether by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence. Furthermore, it defines deprivation of liberty for the purposes of OPCAT as 'any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative, or other authority'.[148]

The implementation of OPCAT in Australia is at the discretion of the Commonwealth Government, which allows local conditions to be considered.

The Commonwealth has suggested that, in the first instance, arrangements be put in place to ensure OPCAT compliance at the following places of detention:

- adult prisons
- juvenile detention facilities (excluding residential secure facilities)
- police lock-up or police station cells (where individuals are held for equal to, or greater than, 24 hours)
- closed facilities or units where people may be involuntarily detained by law for mental health assessment or treatment (where people are held for equal to, or greater than, 24 hours, such as a locked ward or residential institution)
- closed forensic disability facilities or units where people may be involuntarily detained by law for care (where people are held for equal to, or greater than, 24 hours), such as a Disability Forensic Assessment and Treatment Service
- immigration detention centres
- military detention facilities.[149]

In Queensland, the *Inspector of Detention Services Bill 2021* was introduced into parliament in October 2021. At the time of preparing this report, the Bill is being considered by the Queensland Parliament.

While not specifically mentioning OPCAT, the Bill includes the following:

> (1) The main purpose of this Act is to promote the improvement of detention services and places of detention with a focus on—
>
> (a) promoting and upholding the humane treatment of detainees, including humane conditions of their detention; and

[146] United Nations, *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,* United Nations, New York, 2002.
[147] United Nations, 2002, Article 1.
[148] United Nations, 2002, Article 4.
[149] Commonwealth Ombudsmen, *Implementation of the Optional Protocol to the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (OPCAT): Baseline Assessment of Australia's OPCAT Readiness,* Report No. 3, 2019, p. 8.

(b) preventing detainees from being subjected to harm, including torture and cruel, inhumane, or degrading treatment.

(2) The main purpose is to be achieved by providing a framework for—
(a) the review of detention services and inspection of places of detention; and
(b) independent and transparent reporting.[150]

Places of detention are defined under the Act and include:

(a) a community corrections centre;
(b) a prison;
(c) a watch-house;
(d) a work camp;
(e) a youth detention centre.[151]

Queensland public inpatient mental health units have been identified as places of detention for OPCAT purposes by the Commonwealth, however, the *Inspector of Detention Services Bill* does not include inpatient mental health facilities as places of detention.

Noting the above, it will be important that the role of the Inspector of Detention Services be expanded to include inspections of inpatient authorised mental health facilities in the future, or that an alternative OPCAT-compliant inspection mechanism be established.

5.3.13 Other patient issues

Stakeholders from various organisations have also identified a range of additional issues encountered by patients when accessing treatment in inpatient AMHSs.

These include:

- **Patients not understanding and/or having explained** to them the extent and nature of their treatment, not understanding what a TA is and what it means for them, and not understanding why they are being held in a locked ward. In essence, a common concern is that patients do not understand, or have not had explained to them, the 'nature and effect of the Treatment Authority'.[152]

- **Patients not being provided with timely and accurate information** about the treatment and care they are receiving. Often medication is changed, and patients are not aware of the change, do not understand why the change has been made, or the purpose of the change.

- **Patients not understanding their treatment plan, and/or not knowing what their treatment plan is**. Patients are provided with a written notice (which is required under the Act), but they often don't understand that this notice pertains to their treatment, and, secondary to this, they don't understand the content included in the notice. Patients reportedly either throw the notice away, and/or carry it around without understanding that the letter/notice is about their treatment. This serves as an example of the issues faced when providing information to adults with impaired decision-making ability, who are unwell, and who are not provided with the support required to make sense of their situation and treatment plan.

- **Patients indicating their views and preferences are not being considered** and reporting frustrations about not being heard by treating teams and other staff members.

- **Patients and their support persons suggesting that support persons are not involved in any decision-making**. Often (according to those stakeholders consulted for this project) the support person is not involved in any aspect of decision-making for the patient, and is only informed of the final decision, with the presumption that the role of the support person is to communicate

[150] *Inspector of Detention Services Bill 2021* (Qld) s 1.
[151] *Inspector of Detention Services Bill 2021* (Qld) s 5.
[152] *Mental Health Act 2016* (Qld) ss 53, 55.

and/or explain to the patient the decision, rather than supporting the patient to be involved in the decision-making process to the greatest extent possible.

5.4 Discharge from inpatient Authorised Mental Health Services

5.4.1 Discharge plans

The Queensland MHAODB has developed a comprehensive care suite of documentation that is based upon the 2017 National Safety and Quality Health Service (NSQHS) standards. This includes a 'transfer of care' document for patients discharged from inpatient AMHSs. Each service is obligated to provide patients with a copy of their transfer of care document, which provides details regarding their obligations for further treatment in the community, as well as information about their accommodation if this is part of their TA conditions. Accommodation conditions (if relevant) should also be communicated as part of the MHRT process when transferring from an inpatient TA to a community TA.

Stakeholders have reported that patients can have limited involvement in planning for their ongoing care and recovery following discharge from an inpatient AMHS, which includes not being provided with relevant documentation like their transfer of care document. As a result, some patients may not be aware of any follow up treatment that has been organised for them, or what their obligations are, particularly if they remain on a TA in the community. A lack of patient involvement in discharge planning does not encourage a patient's compliance with any community treatment that may be required to improve their health and wellbeing, can impact on their participation in the community as a whole, and may result in them having to return to an inpatient AMHS after relapsing.

5.4.2 Availability of appropriate support on discharge

The capacity and scope of community services to provide immediate support to patients with a mental illness who have complex needs has been identified by stakeholders as a significant issue associated with patient discharge. It may lead to patients either being discharged into the community without adequate supports (which places them at risk of deterioration) or lengthening the time they remain in an inpatient AMHS.

If patients do remain in a facility, this has the potential to place significant pressure on a facility's capacity to accept new patients.

Stakeholders have also reported resourcing issues impacting the capacity of community mental health teams to deliver services directly to mental health consumers in their home environment. This may result in the delivery of services in outpatient clinic type settings and, in some cases, emergency department settings. This has the potential to jeopardise the provision of ongoing treatment and care in the community, and the building of therapeutic relationships that can achieve positive outcomes for mental health consumers and their families.

Stakeholders note that pressure is sometimes placed on families to take on additional care responsibilities for their loved ones on discharge, and many families find this expectation is not sustainable over the longer term.

The availability of suitable accommodation in the community has also been identified as a significant issue that impacts on the delivery of appropriate supports on discharge. Stakeholders have described situations where mental health consumers gain access to emergency accommodation and are provided with support to engage with community mental health services in their geographical area. However, on moving to permanent accommodation, resulting in a change in address and often a change in geographical location, they are no longer eligible for these services. Stakeholders have reported consumers experiencing feelings of being 'bounced around' between services, having to tell their story all over again, which in some cases means re-living previous traumatic experiences, as well as experiencing a loss of the trust and rapport built

with previous case managers. This is a cohort of people who frequently move, frequently change phone numbers, and often will not answer a phone call if they do not know who it is, which makes follow up difficult when community mental health services rely on telephone contact to link with consumers. Stakeholders also note that where community organisations are listed as alternative contacts for consumers, very little effort is made to connect with the consumer themselves.

In regional areas, suitable accommodation has also been identified by stakeholders as a significant barrier to facilitating a safe discharge for patients. Availability of specialist accommodation to accommodate individual mental health needs is much lower in regional areas in comparison to metropolitan areas. Stakeholders note the impact this has on patients, which includes extended stays in the inpatient setting, which in some cases can lead to the patient developing a dependence on the ward environment, which is not a desirable outcome. In addition, the availability of services in regional areas to provide specialist mental health support is much more limited than in metropolitan areas.

The AIHW has been publishing data on the number of supported mental health housing places in states and territories since 2002-2003. Supported mental health housing places are defined as – 'housing places targeted to people affected by mental illness or psychiatric disability. These are places that are provided by the public housing authority, under a formal partnership agreement with the relevant state or territory health authority'.[153]

In Queensland, the number of supported housing places per 100,000 population (available at 30 June 2020) is significantly lower in comparison with other states. In 2019-20, Queensland supported housing places per 100,000 population was 0.3, in comparison to NSW (23.4), Victoria (9.5), Western Australia (51.1), South Australia (20.9), Tasmania (5.2), ACT (0) and Northern Territory (25.3).[154]

It must be noted that from 2018-2019 onwards, Queensland data for supported housing places per 100,000 population reflects changes resulting from the transition of clients to the NDIS. Supported housing places data for NSW also reflects the transition to alternative support arrangements (including NDIS). From 2017-2018, the ACT made several changes to its supported housing program which resulted in this jurisdiction reporting zero places.

[153] Australian Institute of Health and Welfare, *Mental Health services in Australia: Specialised mental health care facilities*, 2019-20.
[154] Australian Institute of Health and Welfare, *Mental Health services in Australia: Specialised mental health care facilities*, 2019-20.

6.0 Lived Experience

The Public Advocate extends his thanks to those people who have been willing to share their story in the hope of raising awareness of the issues they have encountered when seeking help at one of the most vulnerable times of their lives.

It is acknowledged that the following experiences cannot be viewed as ones that are shared by all people with a lived experience of mental illness. They are, however, personal experiences of some who have shared their story in the hope of bringing to life some of the issues that have been identified in this report.

The names of individuals who shared their experiences have been changed for privacy reasons.

Case study: Jake's story

Jake received a mental health diagnosis at the age of 21. Following his diagnosis, Jake 'bounced' in and out of an inpatient AMHS for an extended period – sometimes staying for two weeks and sometimes for as long as three months.

When he was in the inpatient service, Jake was prescribed medication under a treatment plan however he didn't really understand the treatment. He was provided with some pamphlets to increase his awareness of how his condition was being treated but he also found these difficult to understand.

His medication made him feel unwell (cloudy and unable to think clearly) however when he did try to talk about this to his treatment team, he did not feel that they listened to him.

In the periods when he was not in the inpatient AMHS Jake spent most of his time at home, sitting and watching television and not connecting with others socially.

With the support of his family, Jake was eventually linked to a community mental health service where he commenced telehealth consultations with a psychiatrist. When he spoke to this specialist about the side effects of his medication his dose was reduced, and he started to feel better. He didn't need to go back into the inpatient AMHS after this time.

Jake also started to visit a community organisation for adults with mental illness, where he was offered a few hours work each week. This quickly grew and he was soon working full time. As his confidence grew, Jake lost weight and became fitter. With this confidence, he enrolled in further education, something he would never even have thought about five years ago.

Jake's reflections

- *'I felt traumatised, not cared for and not listened to'*
- *'I was not listened to, so my attitude hardened, and I stopped seeking help'*
- *'I didn't understand, - I felt sad and helpless'*
- *'Feeling not cared for doesn't help you move forward in life'*
- *'It was a confusing experience - when you don't know what to think it is hard to look after yourself'*
- *'On the ward, patients talk to each other and say the same things – nobody listens, they just tell us to take our medication'*

Case study: Monica's story

Monica has lived with extreme family distress and trauma throughout her life, leading to her experiencing significant mental health concerns.

She first connected with the acute mental health care system in her early 20s, when a neighbour called emergency services, concerned about her behaviour. Monica was assessed at the emergency department and consequently involuntarily admitted to the AMHS located at the hospital in the regional town where she lived.

Her first experience was traumatic. When she became frustrated and agitated with the specialist allocated to treat her, she was transferred to a high security unit, where she was prescribed medication and had little contact or communication with other patients or staff.

Following that first experience, Monica 'bounced' in and out of the service, sometimes on a monthly basis. Each time she felt that her experience was the same.

The routine involved seeing a psychiatrist every few days, taking medication, eating meals, sleeping and not much else. The ward where Monica spent most of her time cared for between 30 and 40 patients monitored by only 3 or 4 staff, so communication and other activities were minimal.

Sometime later, Monica moved to a metropolitan area where she continued to experience mental health concerns. When she presented to an emergency department with symptoms, she was prescribed medication and discharged. Unfortunately, she overdosed on this medication and needed to go back to the emergency department. However, she did not feel like the emergency department or the AMHS could help her, so she did not stay.

The hospital referred her to a community based residential service where she initially stayed for 3 weeks but could then return voluntarily when her mental health problems escalated.

The relative stability she achieved during this period saw her find a community organisation that assisted her to put her life back together – helping her to find a place to live and employment.

Monica's GP provides ongoing medical care, and she is now linked with a psychologist in the community who she sees on a regular basis.

Monica's reflections

- *'I didn't understand why I was in hospital - nobody explained things to me in a language I understood'*
- *'The psychiatrist was not relating to what I was saying'*
- *'I felt ignored, like I didn't exist as a person, like I was just another number'*
- *'The system made me feel unsafe and didn't allow me to speak up'*
- *'Staff existed in a different dimension; I would try to start a conversation when the nurse arrived but would only ever get a one-word response before they would go again'*
- *'I was so doped up on medication I couldn't keep my eyes open'*
- *'Medication was their tool - it made it easier for them'*
- *'There is no human face to the system. They are just like robots and make you fit into their system and their routine. Nothing in the system is carried out with you. You are just managed to meet their system needs'*

Monica feels that the acute mental health care system could benefit from:

- A greater focus on assisting patients to find external supports so that, when discharged, they can be connected to accommodation and organisations that can help them to build the structure, routine and social skills needed to re-build their lives.
- Additional consultation with patients in relation to their treatment program, including consideration of alternative medications or courses of treatment if available and appropriate.
- The availability of peer support workers in the AMHS – someone with lived experience who is available to listen and work through some of the critical issues for patients.
- Additional time taken by treating teams to better explain the course of treatment to improve patient understanding.

Case study: Jody's story

Jody experienced significant mental ill health early in her life, attempting suicide for the first time when she was 13 years of age. In her teens, Jody was diagnosed with bipolar and schizoaffective disorder.

Following her diagnosis, Jody has bounced from one crisis to another, often being transported to hospital by the ambulance service. She has been in and out of hospital more times than she can recall.

In a period when Jody was well, she managed to sustain stable accommodation, but when she experienced suicidal thoughts her ability to manage her tenancy declined and she was asked to leave. A regular pattern has followed, with Jody either in an inpatient AMHS receiving acute care, or couch surfing while trying to find and sustain secure accommodation on her own.

When Jody did seek help voluntarily, she was often discharged from the emergency department within 2-3 hours. When admitted to an inpatient AMHS, taking medication was the only treatment she received. As an inpatient, she felt her voice was not heard, she did not feel respected and felt something less than human. For Jody, this made being a patient in an inpatient AMHS a frustrating experience and her primary goal was to leave.

Jody's reflections

- *'Hospital has nothing to offer someone with complex mental health conditions'*
- *'Staff need to listen and understand that people are not reacting for no reason - something bad has happened to them'*
- *'Community was the best support for me'*
- *'Length of stay should be based on an assessment of the individual's needs'*
- *'I felt angry when no one listened - then I just shut down'*
- *'There are always different staff at the hospital, so they don't get to know you as a person'*
- *'The social workers look for accommodation but there is no follow through after that'*

Jody feels that the acute mental health care system could benefit from:

- Listening to patients with compassion.
- Including goal setting in a patient's acute hospital care plan that includes the patient.
- Linking a patient's inpatient AMHS care plan to appropriate levels of community care on discharge.
- Providing a safe place in the community for patients experiencing mental health symptoms to access 24/7.
- An increased focus on understanding individual patient needs and providing ongoing follow up in the community, including stable housing and ongoing access to psychology and psychiatric care.

Case study: Peter's story

Peter experienced significant abuse and psychological trauma throughout his childhood years. He is the youngest of nine siblings and was offered little opportunity to establish non-familial or peer-based friendships.

Throughout his schooling, Peter experienced constant bullying from other students. He transitioned to university, however left in his second year so that he could work to financially support his family. At that time Peter was the only sibling living at home and was responsible for caring for his elderly parents, one of whom was receiving palliative care and the other who had been diagnosed with bipolar disorder.

Peter began his first relationship in his early 20s, which was not supported by his family due to differences in religious backgrounds. He was asked to leave home and lost contact with his family.

Peter married soon after. However, persistent negative beliefs overwhelmed his sense of self and a paranoia towards others became a constant thinking pattern. This contributed to Peter losing his job, which left him feeling hopeless and convinced he would never be able to support his family again.

Peter turned to his GP for help and was admitted to an inpatient AMHS for 3 months. During his admission, Peter saw a psychologist for the first time, who provided him with a booklet on bipolar disorder, asking if he recognised himself in it. Peter doesn't recall receiving a diagnosis of bipolar disorder while in the inpatient AMHS.

He was discharged with nowhere to go, and this was the beginning of a long period of homelessness. He moved interstate and continued to live on the street. Eventually, Peter found support through a community agency which offered him short term accommodation and connected him with primary health care and a community mental health service, which assisted him to find stable housing and transitional employment.

However, Peter's marriage broke down and his mental health fluctuated. He made multiple suicide attempts but was not admitted to an inpatient AMHS for any length of time. Peter's wife also filed a domestic violence order (DVO) against him, which meant that he could no longer see his two children. It was at this time that Peter first discovered his bipolar diagnosis, as it was listed in the court papers compiled by the hospital psychologist.

In time, Peter, with support from a community organisation, found employment and started some study. He also connected with a psychologist who helped him develop strategies to manage his mental health, and a psychiatrist who diagnosed him with post-traumatic stress disorder, borderline personality disorder, depression, and anxiety.

Peter now understands his paranoia can trigger long periods of distress.

Peter's reflections

- *'Hospital is not a place to find safety or support'*
- *'All I remember is a very young woman at hospital asking me why I had come back and telling me there is nothing they can do for me here'*
- *'GPs and the hospital put me on medication and then just upped the dosage each visit, and nothing changed for me'*

Peter feels that the acute mental health care system could benefit from:

- Providing patients with the time, encouragement and support they need by walking beside them throughout their journey.

7.0 The community interface

The Public Advocate acknowledges that adults with impaired decision-making ability who have a mental illness may access inpatient, outpatient, and community mental health services, delivered across government, non-government and private sectors. Access to community mental health services that meet the needs of people outside of a hospital setting are essential and have dominated the 2021/22 Queensland Mental Health Select Committee 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'.

There will, however, always be situations where inpatient mental health services are required, particularly for those people with severe mental illness who are assessed as being at significant risk to themselves or others and are not able to receive the treatment they require in a community setting. Adults with impaired decision-making ability and a mental illness may be more likely to fall into this cohort of people at some point in their lives.

In this context, the focus of this project has been to explore issues associated with the assessment and treatment of patients admitted to inpatient AMHSs, while also briefly addressing issues surrounding the immediate access to, and discharge from these facilities.

The interface between inpatient and community mental health services cannot be ignored and the Public Advocate acknowledges that this interface can have an impact on the effectiveness and efficiency of each sector in delivering services that meet the needs of Queenslanders with a mental illness.

While this report only briefly covers the community response, it should be noted that the delivery of effective long-term community mental health services plays an important role in identifying and managing possible situations of relapse and deterioration of mental health patients, which may reduce the need for a crisis response, and subsequent admission for inpatient treatment.

A study which analysed the complexity of the healthcare ecosystem to develop a framework to inform the future design, development, sustaining and monitoring of community health services delivered a number of recommendations for the future of community psychiatry and mental health services. One recommendation was the need to shift the centre of gravity of mental health services from 'hospital-centric services with occasional outreach, to community-centred services and facilities, with in-reach to hospital when needed, on a safety or urgent organic assessment basis'.[155]

7.1 Community based mental health services

Mental health services in Queensland are delivered under funding provided by state, Commonwealth, and private arrangements. While there may be some overlap in the type and scope of services delivered, in broad terms, there is a clear delineation between the scope of these services, depending on their funding source.

7.1.1 State funded services

State funded mental health services in Queensland are provided by sixteen HHSs operating in geographic areas across the state. The focus of these services is to provide care to Queenslanders who experience moderate to severe forms of mental illness and behavioral disturbances, including those who may fall under the provisions of the *Mental Health Act 2016.*[156]

In addition to acute bed-based services and facilities, QH deliver a range of community mental health services including;

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[155] A. Rosen, N. Gill & L. Salvador-Carulla, The future of community psychiatry and community mental health services, *Current Opinion Psychiatry*, Vol.33, 2020, pp.375–390.
[156] Queensland Government, Queensland Health (24 September 2020), *Queensland Mental Health Services*, <http://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/services>.

- initial assessment and triage (ACTs),
- community bed-based services (step-up/ step down-units, complex care units); and,
- community treatment services (continuing care teams, mobile intensive rehabilitation teams, early psychosis teams, transitional housing teams, homeless outreach teams, older persons mental health teams and child and youth mental health teams).

Assessment and triage services are delivered by ACTs, which provide 24-hour specialist mental health support (as part of the QH 1300 MH CALL service). They are the first point of contact for people when accessing public mental health services (both inpatient and community). These teams do have the scope to provide community outreach to patients by providing initial assessments in a person's home as an alternative to the person attending an emergency department, however, the extent to which this arrangement is operationalised has been identified as an issue by stakeholders. In addition, the ACT outreach response can also provide short term intensive home-based follow up for 2-4 weeks, e.g., daily, or alternate day home visits in addition to regular phone support, as an alternative to acute inpatient ward admission. However, the extent to which this arrangement is operationalised, given outreach ACT services are not funded 24 hours, coupled with the increase in mental health presentations and subsequent workload for ACTs, has also been raised by stakeholders as a concern.

Community bed-based services include:

- Step up/step down (SUSD) units, which are in the community and provide 24-hour residential services for adults aged 18 – 65 years who are experiencing severe and complex mental illness. These units provide services to support people who are either transitioning out of hospital (step down) and require additional support to settle back into the community, or who require additional support to prevent an admission into hospital (step up). Step up/step down units provide short term recovery orientated services for up to 28 days.
- Community care units (CCU) that provide medium to long term mental health care and rehabilitation services in a residential setting for people aged 18 – 65 years who require support to transition to independent living in the community.

Community treatment services include;

- Continuing care teams (CCTs) which provide ongoing care management for patients with long term persistent mental illness. Staff employed in CCTs are mental health practitioners, with professional backgrounds including social work, psychology, nursing, and occupational therapy. However, the role of the teams is generic care management rather than discipline specific interventions.
- Mobile intensive rehabilitation teams (MIRTs) who provide support to patients in the community up to 2 – 3 times per week. The scope of these teams enables a greater emphasis on community visits and mental health rehabilitation.
- The older persons mental health (OPMH) teams, which provide specialist assessment and treatment for people over the age of 65 years who experience severe and complex mental health problems. These teams are based in the community and tend to provide most of their services in a person's home and/or their community.
- Resource teams, which provide specialist services to support consumers, carers, staff, non-government agencies and other government departments to navigate the public mental health system. Specialist services provided include; dual diagnosis and case management, treatment planning and complex care coordination, forensic liaison, multicultural mental health, primary care liaison and links with other service providers such as the NDIS, clinical advice and interventions, and education and training.

In addition to the state funded services described above, a suite of additional mental health community support services are funded by QH and delivered through non-government organisations. Designed as wraparound support services, they provide non-clinical recovery focused interventions that are delivered on a one-to-one, peer-to-peer, or group basis in the community.

Many HHSs have also established consumer and carer services that include a lived experience workforce (peer recovery support workers, consumer and carer consultants), who provide support to consumers and carers to be actively involved in recovery from illness. The delivery of these services differs slightly across individual HHSs, however most provide services across the continuum of care from inpatient to continuing care teams in the community. In Queensland, the lived experience workforce accounts for two percent of all full-time equivalent (FTE) positions in the mental health and other drugs workforce.

It was noted by QH in its briefing to the 2022 Mental Health Select Committee 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' that the total peer-based workforce across Queensland remains small (12.9 consumer workforce FTE positions and 4.4 worker FTE positions per 1,000 direct care FTE in Queensland).[157]

7.1.2 Issues in access arrangements – metropolitan versus regional Queensland

Access to mental health services in outer regional areas across Queensland differs to access in metropolitan areas. For example, not all 1300 MH CALL and ACTs in outer regional areas provide 24-hour services, which has been identified by some stakeholders as a significant gap for these communities when needing to access mental health services outside of normal business hours.

Regional areas also do not have the same level of access to step-up, step-down services as metropolitan areas, as these types of facilities are available only on a very limited scale.

Access to specialist treatment services such as ECT has also been identified as an issue by some stakeholders, particularly for those living in outer regional areas. People receiving ECT in the community in metropolitan and inner regional areas can receive this treatment as a day procedure, in an AMHS. However, people living in outer regional areas are required to travel to inner regional areas and be admitted to an inpatient AMHS to receive ECT. The travel required to access ECT treatment means at least an overnight stay for these patients, which can result in further difficulties when beds are not available.

The mental health workforce in regional and remote areas has also been identified as an ongoing issue, with significant shortages in people to fill specialist mental health positions like psychiatrists, psychologists, and mental health nurses. Stakeholders note that access to psychiatrists in rural and remote areas is extremely limited and relies on fly in fly out (FIFO) or drive in drive out (DIDO) service delivery models. While it has been recognised that using different service delivery models in regional and remote areas is important to ensure there is some provision of specialist care, these service models rely on well-established primary health care services in local regions, that are culturally responsive to the needs of the population. In addition, the long-term sustainability of FIFO and DIDO services also relies on the ongoing education, mentorship, and shared care arrangements between local and specialist services to strengthen the delivery of local services.[158]

The QH submission to the Mental Health Select Committee 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders' provided details of the distribution of the MHAOD workforce by areas of geographical remoteness.

In 2020, the FTE, MHAOD workforce across Queensland comprised:

- Psychiatrist (783.5);
- Psychologist (5,299.2);
- Mental health nursing staff (4,735.5);
- Mental health Occupational Therapist (512.9); and,
- Alcohol and other drug nursing staff (332.4).

[157] Queensland Health, *Written briefing: Inquiry into the opportunities to improve mental health outcomes for Queenslanders,* 2022, p.18.
[158] R. Hussain, M. Maple, SV Hunter, V Mapedzahama, & P. Reddy, The Fly-in-Fly-out and Drive-in-Drive-out model of health care service provision for rural and remote Australia: benefits and disadvantages, *Rural and Remote Health*, Vol.15, (online), 2015, <http://www.rrh.org.au>.

The distribution of the MHAOD workforce varies across geographical regions, with more professionals in urban metropolitan regions. There is a significant difference in the number of psychiatrist professionals in urban/metropolitan regions (646) in comparison to regional (138), large rural towns (4), medium rural towns (1), small rural towns (1), remote communities (1) and very remote communities (6). Stakeholders have indicated it is often the case that psychiatrists based in regional centres will travel to rural and remote areas to provide a service, however this is not reflected in the numbers of psychiatrists who are based in rural and remote areas. The psychology, mental health nursing, occupational therapy and drug and alcohol nursing professions display a similar pattern. In all professions, the workforce in very remote communities is slightly higher than in remote communities, however this may be attributable to the more accepted use of the FIFO and DIDO service delivery model in these locations.[159]

7.1.3 Commonwealth funded services

PHNs were established by the Commonwealth Government in 2015 following a review of Medicare Locals, the predecessor to primary health networks.[160] In Queensland there are seven PHNs, tasked with integrating the care of patients across the entire health system to improve outcomes across six priority areas, including mental health.

Following the 2020/2021 Productivity Commission inquiry into mental health,[161] PHNs received funding to establish 'Head to Health' centres and a network of community mental health-based services. These centres aim to address key gaps identified in the mental health system, including helping people who have complex conditions that exclude them from accessing primary care services, but whose conditions are not severe enough to warrant access to state or territory public community mental health services. Some PHNs in Queensland have also established 'safe places' (a community-based model of care supporting people experiencing mental distress) and introduced mental health service navigators who provide information about mental health, suicide prevention and alcohol and other drug treatment services.

People living in outer regional areas have very limited access to these types of services and assistance continues to be most often sought in a hospital emergency department, if at all.

GP services are central to primary care and play a significant role in the coordination of services for people with complex care needs, as well as providing a gateway for access to specialist health (including mental health) services. Funding of GPs is primarily through commonwealth rebates (Medicare Benefits Scheme) and patient co-payments.[162]

GPs play a vital role in the long-term management of people with mental illness living in the community. Stakeholders have reported difficulties faced by GPs including; limited or inadequate sharing of patient treatment information by community mental health teams when patients remain under the care of community mental health teams, poor Medicare incentives for the provision of mental health care, and lack of access to specialist support. In regional areas, stakeholders have reported limited skill sets of GPs in some areas to manage people with complex mental health needs, in addition to the decreasing number of GPs willing to take on the long-term management of people with complex mental health needs in the community.

Allied health professionals, including psychologists, social workers and occupational therapists, do provide support to GPs with the delivery of primary mental health services under the Better Access to Mental Health Scheme, funded by the Commonwealth Government. In relation to this program, stakeholders have identified a gap in the availability of psychologists to provide services in metropolitan areas, and an even larger gap in regional and outer regional areas across Queensland.

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[159] Queensland Health, '*Submission: inquiry into the opportunities to improve mental health outcomes for Queenslanders*,' 2022, p.68.
[160] M. Booth, G. Hill, M. J. Moore, D. Dalla, M. G. Moore, & A. Messenger, 'The new Australian Primary Health Networks: how will they integrate public and primary care, *Public health research & practice*, Vol.26, no 1, 2016, e2611603.
[161] Australian Government Productivity Commission, '*Productivity Commission Inquiry Report Mental Health,* Vol.1, No. 95, June 2020.
[162] H. Swerissen & S. Duckett, *Mapping primary care in Australia*, Grattan Institute, July 2018.

PHNs do include GP liaison teams that provide support to GPs to access specialists, including referral pathways to QH. These do not include, however, specialist psychiatry liaison services. Some HHSs, such as the Gold Coast HHS, have set up GP psychiatry liaison teams who provide professional clinical support to GPs managing people with complex mental health needs in the community. However, such services have very limited staff and resourcing.

In some regional areas, such as the Central Queensland HHS, resources have been allocated to support GPs in managing mental health patients presenting with acute symptoms. In addition to 1300 MH CALL (based in Rockhampton), which provides a 24-hour intake service, GPs can contact a medical officer from the ACT between 9 a.m. – 3 p.m., Monday to Friday. This service has been designed as a specialist support service for GPs, to provide timely advice on the assessment and management of mental health patients in acute distress. Anecdotally, stakeholders have reported that there have been strong outcomes for mental health consumers, GPs, and emergency departments within the area as a direct result of this service.

PHNs in some regional areas have also established GP psychiatric support lines, which provide GPs with access to psychiatrists for advice on managing mental health patients in the community. While this is not an urgent support line, it does provide GPs with specialist support for the ongoing treatment of people with complex mental health needs who are not connected to state funded mental health community psychiatry teams.

As noted above, the Australian Productivity Commission conducted an inquiry (2020) into the effect of mental health on people's ability to participate and prosper in the community and workplace, and the effects it has more generally on the economy and productivity. Several recommendations were made following this inquiry, one of which was that the Australian Government should introduce a Medicare item for GPs and paediatricians covering the obtaining of advice from a psychiatrist about a patient under their care (recommendation 10.[163] This reform would help strengthen psychiatrist-GP liaison through the provision of additional funding.

The Prevention Compassion Care National Mental Health and Suicide Prevention Plan was developed by the Australian Government in 2021 as a significant step towards long-term system reforms in mental health and suicide prevention. This plan, as part of the reform, was based on recommendations from the Productivity Commission Report on Mental Health, the National Suicide Prevention Adviser's Final Advice, and the Royal Commission into Victoria's Mental Health System.[164]

Recommendation 10 of the Productivity Commission report[165] was supported in part by the Australian Government, with the following response noted:

> The Government will consider future changes to the MBS through the Better Access evaluation.[166]

Strengthening the relationship between psychiatrists and GPs in the primary care sector has been shown to be an effective approach in improving the mental health of Australians. There are various models which have been shown to deliver strengthened relationships in the sector including: consultation liaison, collaborative care, stepped care and matched care.[167]

Several studies have also detailed the strong association between mental health disorders and chronic physical diseases such as cancer, heart disease, stroke, diabetes, and chronic obstructive pulmonary disease.[168] This emphasises the important role that GPs play in managing chronic health conditions for patients with mental illness. Continuity of care for patients transitioning from inpatient and/or community mental health services, who require long term management of chronic health

[163] Productivity Commission, *Mental Health Productivity Commission Inquiry Report,* Vol.1, No. 95, 30 June 2020, p.69.
[164] Australian Government , *Prevention Compassion Care National Mental Health and Suicide Prevention Plan,* 2021, p.2.
[165] Productivity Commission, *Mental Health Productivity Commission Inquiry Report,* p.69.
[166] Australian Government, *Prevention Compassion Care National Mental Health and Suicide Prevention plan,*' p. 27.
[167] Suetani S, Sardinha S, Gill N. Improving the mental health of Australians: A renewed call for primary care psychiatry. *Australas Psychiatry*. 2022 May 20:10398562221104418. doi: 10.1177/10398562221104418. Epub ahead of print. PMID: 35595564.
[168] L. Dare, P. Bruand, D. Gerard, B. Marin, V. Lameyre, F. Boumediene & P. Preux, 'Co-morbidities of mental disorders and chronic physical diseases in developing and emerging countries: a meta-analysis,' *BMC Public Health*, Vol.19:304, 2019.

conditions, is dependent upon effective collaboration between health professionals in primary care and state government services. Such collaboration has been shown to improve patient outcomes with cost savings, increased access to health services, increased attendance at scheduled appointments, increased satisfaction, and increased awareness of local health services.[169]

[169] T. Street, K. Somoray, G. Richards & S. Lacey, 'Continuity of care for patients with chronic conditions from rural and remote Australia: A systematic review,' *Australian Journal Rural Health*, Vol.27, 2019, pp.196-202.

8.0 Conclusion

This report has highlighted the range of issues people with acute mental illness encounter in seeking assistance, and receiving assessment and treatment, when:

- experiencing a mental health crisis in the community;
- undergoing assessment and treatment in the emergency department and an inpatient AMHS; and,
- re-entering the community after being discharged from an inpatient AMHS.

It has also highlighted some of the issues faced by the workforce who assist, assess, treat and care for people with an acute mental illness.

Issues have been identified through consultation with stakeholders who have expertise in responding to mental health crises in the community, and who provide assessment, treatment and care in emergency department and inpatient settings in metropolitan and regional areas across Queensland.

This report has also incorporated the views and opinions of stakeholders who have significant interface with acute care patients, including legal representatives, the MHRT, the Office of the Public Guardian, and non-government community mental health services.

Of equal importance, people with a lived experience of mental illness were consulted, and while the views and opinions of these individuals cannot be seen as the collective view of all people with lived experience of mental illness, their views and opinions have provided real life stories highlighting some of the issues raised by stakeholders.

The report makes 21 reform recommendations to the Queensland government, many of which are consistent with or complement the recent Mental Health Select Committee report on its 'Inquiry into the opportunities to improve mental health outcomes for Queenslanders'.

The recommendations will improve the delivery of public acute mental health services in a way that is consistent with the protection of the human rights of people needing acute mental health care and treatment.

The Queensland Audit Office's forward plan 2022 - 25 currently includes an audit of the 'effective delivery of mental health services'. The Public Advocate will be requesting that the Audit Office consider including a review on the progress of the recommendations made in this report in this audit, which is due to be tabled in the Queensland Parliament during 2024 - 25.

Appendix 1

Stakeholder engagement

ORGANISATION	CONTENT EXPERT AREA
LawRight	legal representation of patients at MHRT.
Aged and Disability Advocacy (ADA) Law	legal representation of patients at MHRT.
Queensland Health, Individual Patient Rights Advisers (IPRAs)	Mental health clinical expertise, including mental health systems, *Mental Health Act* and implementation of Chief Psychiatrist's guidelines, and interface with patients with a lived experience of mental health.
Queensland Mental Health Commission (QMHC)	Mental health clinical expertise, policy, and reform.
Office of the Public Guardian (OPG)	Interface with patients with a lived experience of mental ill health.
Queensland Ambulance Service (QAS)	Clinical expertise – health response to mental health crises.
Queensland Police Service (QPS)	Response to mental health crises in the community.
Queensland Advocacy Incorporated (QAI)	Legal representation of patients at MHRT.
Mental Health Review Tribunal (MHRT)	Interface with patients with a lived experience, expert in Mental Health Review Tribunal operational processes.
Queensland University of Technology (QUT) – law school	Researcher, mental health, human rights.
STRIDE for better mental health	Clinical expert mental health practice, interface with patients with a lived experience.
Canefields Club house	Community organisation – psychosocial rehabilitation support for adults with mental illness to support engagement with meaningful activities in the community.
Queensland Alliance for Mental Health (QAMH)	Expertise – mental health policy and reform options (community), advocacy, interface with organisations delivering mental health services in the community.
Royal Australian and New Zealand College of Psychiatrists	Training, education and representing psychiatrists in Australia and New Zealand.
Office of the Health Ombudsman	Expertise in investigation and management of complaints.
Mental Health Lived Experience Peak Queensland (MHLEPQ)	Mental health consumer representative peak organisation for Queensland providing policy advice and system advocacy.

Central Queensland Mental Health Services	Expertise in the provision of mental health services in inner and outer regional areas of Queensland.
Gold Coast Mental Health Services	Expertise in the provision of mental health services in metropolitan areas.
Royal Brisbane and Women's Mental Health Services	Expertise in the provision of mental health services in metropolitan areas
Sunshine Coast Mental Health Services	Expertise in the provision of mental health services in metropolitan areas

Appendix 2

Schedule of Queensland Health public sector authorised mental health services and corresponding inpatient facilities catering for adults >18yrs

Queensland Health public sector authorised mental health service[170]	**Inpatient facilities**
Bayside Authorised Mental Health Service	Redland Hospital inpatient and specialist health units Daintree Psychogeriatric inpatient unit
Cairns Network Authorised Mental Health Service	Cairns Hospital inpatient and specialist health units
Central Queensland Network Authorised Mental Health Service	Rockhampton Hospital inpatient and specialist health units
Darling Downs Network Authorised Mental Health Service	Toowoomba Hospital inpatient and specialist health units Baillie Henderson Hospital inpatient and specialist units (excluding the intellectual disability beds)
Gold Coast Authorised Mental Health Service	Gold Coast University Hospital inpatient and specialist units Robina Hospital inpatient and specialist health units
Logan Beaudesert Authorised Mental Health Service	Logan Hospital inpatient and specialist health units
Mackay Authorised Mental Health Service	Mackay Base Hospital inpatient and specialist health units
Princess Alexandra Hospital Authorised Mental Health Service	Princess Alexandra Hospital inpatient and specialist health units Mater Misericordia Hospital (Adult and Mothers) inpatient and specialist health units
Princess Alexandra Hospital High Security Program Authorised Mental Health Service	Princess Alexandra Hospital Secure Unit
Redcliffe Caboolture Authorised Mental Health Service	Caboolture Hospital inpatient and specialist health units Redcliffe Hospital inpatient and specialist health units

[170] Queensland Health, *'Schedule of authorised mental health services and administrators,'* April 2022.

	Cooinda House, Psychogeriatric inpatient unit
Royal Brisbane and Women's Hospital Authorised Mental Health Service	Royal Brisbane and Women's Hospital inpatient and specialist health units Surgical Treatment and Rehabilitation Service (STARS) inpatient specialist health units
Sunshine Coast Authorised Mental Health Service	Nambour Hospital inpatient and specialist health units Sunshine Coast University Hospital Gympie Hospital
The Park-Centre for Mental Health Authorised Mental Health Service	The Park-Centre for Mental Health inpatient and specialist health units The Park High Security Program
The Prince Charles Hospital Authorised Mental Health Service	The Prince Charles Hospital inpatient and specialist health units
Townsville Network Authorised Mental Health Service	Townsville Hospital inpatient and specialist health units Pandanaus Special Care Unit (psycho-geriatric Residential Aged Care beds in Charters Towers) Mount Isa Base Hospital Department of Emergency Medicine
West Moreton Authorised Mental Health Service	Ipswich Hospital inpatient and specialist health units
Wide Bay Authorised Mental Health Service	Bundaberg Hospital inpatient and specialist health units Hervey Bay Hospital inpatient and specialist health units Maryborough Hospital inpatient and specialist health units