ABBREVIATED CURRICULUM VITAE and STATEMENT

Name	**Professor Harry Waldron McConnell MD, FRCPC, FRANZCP**
Date of Birth	[redacted]
Current Address	PO Box 4833 ROBINA TOWN CENTRE QLD 4230 Australia
Telephone	[redacted]
Email	[redacted]
Basic Medical Qualifications	**MD:** Ohio State University, Columbus, OH, USA, 1978-1982 **B.Sc. with Great Distinction:** McGill University, Montreal, Canada
Medical Licensure	**Full Registration, General Medical Council (United Kingdom)** **Full Registration, Commonwealth of Pennsylvania, USA** **Specialist Registration (Psychiatry) Australian Health Practitioner Regulation Agency**
Specialist Qualifications Institute / Country / Year obtained	• **Board Certification, American Board of Disability Medicine/ Independent Medical Examiners, 2012 – present** • **Fellowship, International College of Psychosomatic Medicine, 2012** • **Fellowship, Royal Australia New Zealand College of Psychiatrists, Category III, Eminence and Seniority, 2010 – present** • **Section 12 certification (Mental Health):** (United Kingdom), 1997 • **Fellowship: FRCPC,** Fellow of the Royal College of Physicians of Canada (division of medicine) – examination, 1991, admitted to College as Fellow, 1992; specialist certification in Psychiatry (1991), specialist eligibility in Neurology (1994) • **Board Certification (USA)** in Medical Psychotherapy, 1994; • **Fellow and Diplomate**, American Board of Psychotherapy, 1994 **Board Certification (USA)** in Psychiatry - American Board of Neurology and Psychiatry, 1993 • **Board Certification (USA)** in Pain Medicine, 1989 • **Diplomate, American Academy of Pain Medicine,** 1989 • **USA Board Certification:** National Medical Board Examination, parts I, II, and III,1983
Current Positions	**Consultant Neuropsychiatrist and Director, Neurosciences, St Vincent's Hospital Brisbane,** **Professor of Neuropsychiatry and Neurodisability**, Griffith University School of Medicine **Clinical SubDean**, Griffith University/Gold Coast Health District **Clinical Coordinator, Student Elective and Selective Programmes**, Griffith University **Consultant Neuropsychiatrist**, Currumbin Clinic **Consultant Neuropsychiatrist,** Acquired Brain Injury Clinic, Northern Brain Injury Rehabilitation Services **Chair, South East Queensland Disability Advisory Council** **Member, Queensland Disability Advisory Council** **Member, Prescriptions Medicines Committee, Therapeutic Goods Administration (TGA)** **Member, Quality and Patient Safety Sub Committee, Uniting Care QLD Exec** **Member, St Vincent's Research Ethic Committee**

TRAINING

Basic Medical Training	**DOCTOR OF MEDICINE (MD)** **1978 – 1982 Ohio State University College of Medicine Columbus, Ohio** **UNDERGRADUATE EDUCATION** **1975 – 1978 McGill University, Montreal, Canada** Degree: B.Sc. "with great distinction", June 1982; Psychology Honours Program; Thesis: Attention and Dominance in Rhesus Monkey Social Structure
Specialist Training	**Psychiatry** Four years registrar training, University of Otago, 1986-91 **Neurology** Total seven years Clinical Neurology training including basic Registrar training at University of Otago, Senior

	Resident (Registrar) Position at Medical College of Pennsylvania., and Honorary Senior Registrar Position at King's College, University of London in Neurology, Institute Of Psychiatry and Institute of Epileptology. **Subspecialty Training** **Advanced Training in Epileptology**, Institute of Epileptology/ Centre for Epilepsy, Kings College London, 1995 – 1999 and through the Epilepsy Mini-Fellowship in Epileptology, Bowmann Gray School of Medicine, USA, 1994. **Pain and Disability Management** Fellowship, Pain Management focusing on health promotion, treatment and disability management, Shealy Institute, Springfield MO, USA, 1984 - 1985 Clinical Fellow, Shealy Pain and Health Rehabilitation Institute, Springfield, Missouri, USA. 1984 – 1995 **International Health and Disability** University of Arizona College of Medicine, Tucson, Arizona, USA, graduate-level course on International Health with a focus on disability and clinical care in developing countries, 1984 **Internal Medicine** University of New Mexico School of Medicine
Publications	I have authored and edited many peer reviewed articles, policy documents as well as influential guidelines and textbooks including: • BMJ Clinical Evidence, Issues 3 - 6. Barton S, Jones, G,. Cuervo-Amore LG, McConnell H, Patel A, Young C. editors. December 2001. London, BMJ Publishing Group (also Foreign Textbook editions and online and CD-ROM) • Taylor D, McConnell H, Duncan D, Kerwin R: The South London and Maudsley NHS Trust Prescribing Guidelines, Martin Dunitz, London, 6th edition, 2001 (also Foreign Textbook editions) and 5th edition, 1999. • McConnell H, Snyder P Psychiatric Co-Morbidity in Epilepsy: basic mechanisms, diagnosis and treatment, American Psychiatric Press,1998 • McConnell H, and Bianchine JR Cerebrospinal Fluid in Neurology and Psychiatry, Chapman and Hall/CNS Publications, London, England, 1994.
Statement	Having close family members with various neuropsychiatric conditions, I have worked over ten years in volunteer and paid capacities in Special Education and in the Special Olympics and recreational programmes for people with intellectual and neuropsychiatric disabilities prior to medical school. My primary clinical interest is in the care of people with neuropsychiatric disabilities. I have been a full time clinician, researcher and academic lecturer for over 25 years. I have worked in Centres of Excellence in Neuropsychiatry in the USA and UK and helped to establish key international guidelines in Neuropsychiatry through BMJ Clinical Evidence and the Maudsley Prescribing Guidelines. I have further worked with the World Health Organization, World Bank Institute and other key international agencies and advised to Ministers and Prime Ministers in several countries and states. I am one of a handful of psychiatrists with MO4 status for International Pre-eminence in Queensland Health and also Category III status for International Eminence with the Royal Australia New Zealand College of Psychiatrists. I am a member of the Australia New Zealand College of Mental Health, American Academy of Neurology, American Neuropsychiatry Association, Australia-New Zealand Association of Neurologists (associate), and European Academy of Neurology and am a Fellow of the RANZCP. Training in Psychology, Neurology and Psychiatry, I have a passion for integrated multidisciplinary approaches to Neuropsychiatry, currently establishing the Institute for the Clinical Advancement of Neurodiversity (I CAN!). I work closely with the Health and Disability Advocacy Clinic at St Vincent's Hospital, and several NDIS implementation groups and have recently set up a task force for integrated Health and Disability care in South East Queensland for people with complex disabilities. My clinical specialty focuses on people with complex neuropsychiatric conditions including developmental disorders, acquired brain inuries with multiple psychiatric co-morbidities. My work is predominantly Second Opinions and I get referrals nationally and internationally for complex case reviews. I see patients both in both the private and public sectors, including frequent use of telehealth consultations for national and international referral and for those living in remote and rural areas. I am active in research, supervising several High Degree students and teach medical and other health professional students on a regular basis. I also advise on health and disability policy issues to state and national Ministers and have advised to many governments (Australia, Papua New Guinea, USA, UK, Saudi Arabia) and international agencies e.g. the World Health Organization and World Bank.

Professor Harry McConnell

M.D. F.R.C.P.C F.R.A.N.Z.C.P

PROFESSOR OF NEUROPSYCHIATRY AND NEURODISABILITY

Health and DisAbility Services
PO Box 4833
Robina Town Centre QLD 4230

Email: [redacted]

Kathleen Dalladay, Acting Research Director

Health and Ambulance Services Committee

[redacted]

15 November 2015

Dear Ms Dalladay

Re: Submission to Health and Ambulance Services Committee on Mental Health Act

Thank you for your email of 11 November 2015 requesting a submission to the Committee. I am in general agreement with the changes proposed in the revised Act. The Act does make changes in decision-making processes for people with mental health conditions closer to the processes already in place for anyone with any health condition, unless a crime has been committed. This advances the issues of stigma within the public and within the profession towards people with mental illness.

However, in my opinion the Act should align more closely with the Guardianship Act, also currently under review. The definitions and decision-making processes could better be combined as a single Integrated Health and Disability Act. This would be less discriminatory towards people with mental illness and disabilities and issues such as decision-making processes, capacity and restrictive practices could better be aligned under a single bill. Unless a person has committed a crime, the decision-making processes should be the same regardless of whether they have a mental health condition.

I see no logical reason for the legislation dealing with restrictive practices to be so different in the two pieces of legislation. There is no clinical basis for the laws relating to restrictive practices to differ depending on one's funding and on whether one has a disability or a mental health condition. This makes at present for the confusing situation where a different set of laws apply to individuals once they enter the hospital with respect to restrictive practices. This becomes problematic for the consumer, their carers and the GPs and specialists looking after them in the community. The regulations should also not differ for individuals funded by the Department of Communities. The restrictive practice legislation arising from the Carter Inquiry needs to align with the restrictive practices used on any person regardless of whether they have a mental health condition or a disability.

The restrictive practice regulations also need to make a clear distinction on the use of chemical restrictive practices or seclusion on an emergency basis where the individual represents a potential danger to themselves or others, as opposed to chemical restraints or seclusion used in the ongoing treatment of a chronic illness. This is particularly important particularly with respect to the use of antipsychotics or seclusion rooms specifically. In an emergency situation, chemical restraint or the use of seclusion room may be the least restrictive clinical practice for the individual. The current training and protocols for 'Code Blacks' and similar situations in Queensland Health are inadequate. Queensland Health should follow well-established international protocols in this area such as those outlined in the Maudsley Prescribing Guidelines. The training and protocols should be uniform across the State. At Centres of Excellence in Psychiatry overseas, there are Acute Emergency teams consisting of a small number of highly trained and skilled individuals that respond to episodes of potential aggression in hospital with very specific well-defined protocols analogous to the Trauma Emergency Teams for episodes of trauma and Code Blue Teams for acute medical emergencies.

Mental Health Consumers deserve no less a standard of care than medical, surgical or trauma patients when faced with an emergency where there is a potential danger to themselves or to others.

The use of chemical restraint for an individual with a chronic illness and without a diagnosis for which that restraint is clinically indicated cannot be justified. This is a completely different clinical situation and the two forms of use of restraint need to be differentiated. Similarly the use of seclusion in the ongoing management of individuals with chronic conditions cannot be justified. These practices are unfortunately nonetheless common occurrences in Queensland.

There should be concordance with the restrictive practice legislation in both the Guardianship and Mental Health Acts irrespective of funding source or of disability co-morbidities. This would best be accomplished in a single Integrated Health and Disability Act, avoiding the confusion in this area.

Similarly, the definition of 'Capacity' should align between the Mental Health and Guardianship Acts. This also can produce unnecessary confusion to clinicians. There are currently many misunderstandings about the different applications of the Guardianship and Mental Health Acts in different clinical situations. This is unnecessary and is easily remedied by an alignment of the two Acts, or, a combining of the two Acts into a single Integrated Health and Disability Act where the same regulations and same definitions applied.

With respect to the issue of the of no longer requiring mandatory Psychiatrist reports for people with involuntary treatment orders subject to offenses, this does not, in my opinion, adequately protect the individual's rights. The individual should be entitled to a detailed mandatory Psychiatrist report and should also have the opportunity for a second opinion in such instances.

The issue of GPS tracking is contentious. In my opinion there should be a clear distinction between GPS tracking done for clinical purposes where there is consultation of the treatment team with the family, consumer and/or substitute decision maker and GPS tracking that is mandated by the Court. In the latter circumstance it is appropriate for the Chief Psychiatrist, a clinician, and the Mental Health Tribunal and to be able to make this determination.

The issues with respect to psychosurgery including Deep Brain Stimulation require a high degree of expertise and both community and consumer consultation. I believe there is a role for establishing a separate Neuroscience Advisory Panel, working with the Mental Health Tribunal. This would be analogous to the Psychosurgery Review Board in Victoria, but with a more general remit involving other advances in Neurosciences relating to Mental Health. Neuroscience is a rapidly expanding field and it's impact on psychiatric treatments in increasing exponentially. A Neuroscience Advisory Panel would advise not only on Deep Brain Stimulation, but also other new and experimental treatments, provision of immunotherapies for autoimmune encephalopathies, overlapping issues with Neurodisability, epilepsy, driving etc. Such a body should have a variety of specialists including ethicists, neurosurgeons, neurologists, neuropsychiatrists, psychologists, pharmacists, members of the community and consumer representatives. While the Psychosurgery Review Board in Victoria advises only on DBS, this Neuroscience Advisory Board would be involved not only in DBS treatments but more broadly in the implementation of the many advances in Neurosciences pertaining to Mental Health particularly the many new therapeutic modalities for voluntary or involuntary people with mental illness.

The issue of Advanced Care Directives (ACDs) is an important one. I strongly favour the use of ACDs and further propose that provision of ACDs should be offered to every patient at the point of discharge and be an essential part of the treatment plan and discharge planning process for all consumers.

I would be happy to come and discuss any if these issues with the Committee.

I also attach a copy of my cv.

Yours faithfully

Professor Harry McConnell