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From

Professor Neeraj S Gill
MBBS, MD, FRANZCP, DrPH
Consultant Psychiatrist, Gold Coast Health QLD
Professor, School of Medicine and Dentistry, Griffith University, Southport QLD
Email: [redacted]
Phone: [redacted]

To

Committee Secretary
Mental Health Select Committee
Parliament House
George Street
Brisbane Qld 400

Re: Individual submission to the Parliamentary Inquiry into the opportunities to improve mental health system outcomes for Queenslanders

I am a senior consultant psychiatrist, Gold Coast Hospital and Health Service (HHS) and Clinical Lead, mental health and Professor, School of Medicine and Dentistry, Griffith University, Southport QLD.
I am an elected director on the Board of the Royal Australian and New Zealand College of Psychiatrists (RANZCP).
I am a member of the Queensland Mental Health Review Tribunal.

I have previously worked as the Clinical Director, Mental Health, Darling Downs HHS (2010-2014) and Medical Director, Mental Health, Gold Coast Health (2015-2017). I acted as the Chief Psychiatrist, Queensland Health in 2017 and 2018.

I was awarded Doctor of Public Health (DrPH) degree in 2020 by the University of New South Wales, Sydney based on my doctoral thesis on 'human rights of people with mental disabilities'.

This is my individual submission. The views presented here are my own and may not represent the views of the above organisations where I hold employment/affiliation.

1. **Hospital centric-model – the need for better funding and greater focus on community based mental health**

Queensland mental health system is highly hospital centric. Large hospitals in metropolitan and regional towns are the centre of gravity of Queensland mental health system. Within hospitals, the focus is on Emergency Departments and Acute inpatient psychiatric units/wards. This is based on a traditional medical model, where unwell individuals are taken to hospitals, often through emergency departments, and admitted into inpatients wards for treatment. Current opinion and international evidence dissuade from this hospital focus and points towards the need for community based mental health care and with greater liaison with primary care sector.

> "*We need to shift the balance of mental health services from hospital-centered with community outreach when convenient for staff, to community-centered and mobile, with in-reach to hospital only when necessary.* (Rosen, Gill, & Salvador-Carulla, 2020).

Queensland mental health system has community psychiatry teams attached to the large hospitals. However, the community mental health services (MHS) have the following problems/shortcomings:

- Community MHS' are under-funded and under-staffed. According to one estimate, Qld Community MHS' require an addition of 3000 new staff inter-disciplinary service provider staff members.

- While a lip-service is paid to the importance of peer-support workforce and 'recovery-orientation', the proportion of peer-support workforce with lived experience of mental health issues is miniscule as compared to the clinicians in Qld MHS'. Most Acute Care Teams, Community Care Teams (CCT) and Mobile Intensive Rehabilitation Teams (MIRT) function without any peer support workers. It is notable that the peer-support workers need the strong and constant team support of expert clinical staff, so enhancements allowing employment of peer workers should be accompanied by enhancements ensuring adequate clinical staffing as well. In other words, peer workers should not be employed as a cost saving measure, at the expense of and while depleting clinical positions, as some MHS' elsewhere have tried to do.

- The case management model needs to be reviewed. In most of the Community MHS', highly skilled clinicians like mental health nurses, psychologists, social workers, occupational therapists provide generic case management (care-coordination) and do not utilise their professional skills (e.g. psychology, occupational therapy input) in this generic case management model.

- Many functions carried out by the highly qualified clinicians can be conducted by peer-support workers, which would then free-up the clinicians to provide more services based on their professional qualifications and expertise.

- The Community MHS's are often not mobile enough. The so-called community clinics often function as traditional sedentary 'out-patient clinics'. While currently there are restrictions on movements of clinicians due to COVID-19, even pre-COVID, many teams expected the service-users to turn up for appointments to the clinics and did not make home-visits as much as required. There is great merit in meeting service-users and their families/carers on their own turf and terms (Rosen, Gill, & Salvador-Carulla, 2020).

- Even the Acute Care Teams (ACTs) often do not reach out to the service-users in community as much as they should or can. While with some increase in funding and staffing, the ACT clinicians have been more mobile in recent years than say a decade

ago, many ACTs still have a culture of advising the concerned family/friends to bring the patient to the Emergency Department rather than clinicians volunteering to make home visit to assess the patient in the community.

Recommendation:

1. The MHS' need to shift the centre of gravity from hospital-centric to community-based care.
2. Community MHS' require significantly increased funding to employ additional clinical and peer-support staff.
3. The community MHS' should be more mobile. Bringing the patient to Emergency Department or directly to the acute inpatient unit should be the last resort when all viable active-response community-based options have been exhausted.

2. Integration and liaison with primary care sector, including the GP's

With rising burden of mental illness, the tertiary specialist mental health services on their own cannot meet the demands of communities for mental health care. Mental health care must be embedded into, and integrated with, primary care sector, as emphasised by the World Health Organization (World Health Organization, 2008). That is far from the case in Queensland. While some Hospital and Health Services (HHS') and Primary Health Networks (PHN's) have established joint plans for mental health care, those plans and strategies gather dust in the archives of bureaucratic ivory towers and hardly ever translate into practice on the ground. The reality is that State-funded HHS' and Commonwealth-funded PHN's and other services continue to work as Silo's with little convergence or synergy.

The Specialist MHS' and General Practitioners (GP) continue to have little communication. GP's often complain about difficulty getting their patients seen by specialist services due to high threshold for access into Community MHS'. GP's also complain about not receiving timely discharge summaries when their patients are discharged from acute inpatient units. The good old practice of calling the GP's to give a warm hand-over has all but ended.

Part of the problem is poor incentivising of mental health item numbers for GP's which of course is a Commonwealth issue. However, with better liaison and communication between MHS' and GP's, the GP's would be a lot more willing to treat patients with mental health issues. That would ultimately decrease the burden on community MHS'.

Recommendation:

4. Qld MHS' must invest in Primary Care Liaison and GP Liaison. This could be done through Primary Care/GP Liaison Teams, led by psychiatrists, and supported by psychiatry registrars, community mental health nurses and other clinicians. There are anecdotal examples of such services, which need better funding and operational support (Gill & Amos, 2013).

3. Social determinants of mental health – Whole of government and whole of community response

There is a long road that a person walks, before ending up with mental health system. We cannot improve the mental health outcomes for Queenslanders without addressing the social determinants of mental health. This requires a whole of government and whole of community approach, not just health response. Government policies in every field and at every step must be geared towards addressing social determinants of health (including mental health). There is international evidence that addressing social inequities and social determinants of health is possible and is the best way to improve health outcomes of the population (Marmot, 2015, 2016). This includes addressing the issues of homelessness, unemployment, education and social exclusion. This is especially important for Aboriginal and Torres Strait Islander peoples, rural population, Culturally and Linguistically Diverse (CALD) communities and other socio-economically deprived populations living on the fringes of the society.

Recommendation:

5. Queensland Government adopts a whole of government and whole of community response to address social determinants of health and to deal with social inequities.

4. Queensland Government's Locked Wards Policy – A draconian measure and step back in history

The Queensland Government issued a policy directive to lock all acute adult public mental health inpatient wards in 2013. Previously, MHS' had a discretion to lock the wards as and when needed based on acuity and safety issues. That clinical discretion was removed by the Campbell government in 2013, along with a whole lot of other so-called 'reforms' at the time. Despite criticism from professional bodies (Royal Australian and New Zealand College of Psychiatrists, 2013) and advocacy for an alternative (Queensland Mental Health Commission, 2014), the policy has been retained to this day. A blanket directive to treat all psychiatric inpatients in a locked environment without individualised consideration of safety is inconsistent with least restrictive recovery-oriented care. It is against the principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006), to which Australia is a signatory.

> *"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…" (United Nations, 2006. Art. 14)*

Contrary to these principles for minimising coercion and protecting the liberty and integrity of persons with disabilities, the locked door policy in Queensland acute mental health units directly leads to deprivation of liberty of patients who are assessed to require a 'voluntary admission' to an acute mental health unit in Queensland and have capacity to consent to treatment.

Queensland Health reported a reduction in 'absences without permission' from psychiatric inpatient wards after the introduction of the locked wards policy, however no in-depth analysis of the consequences of this policy has been conducted. It has been argued that patients returning late or not returning from approved leave is a more common event than

patients 'escaping' from mental health wards, yet all may be counted as 'absent without permission' events. A review of the international literature found little evidence of reduced absconding from locked wards. Disadvantages for inpatients of locked wards include lowered self-esteem and autonomy, and a sense of exclusion, confinement, and stigma. Locked wards are also associated with lower satisfaction with services and higher rates of medication refusal. On the other hand, there is significant international evidence that models of care like Safewards and having open door policies can improve the environment on inpatient units and may lead to less need for containment and restrictive practices. (Gill et al., 2021).

Queensland Mental Health Commission recommended again in 2017 that:

> *'The Commission is of the view that a decision to lock doors should be discretionary and based on local decision-making. Local decision-making should be supported by a statewide policy framework that takes a whole-of-ward approach to recovery-oriented, least restrictive practices.'* (Queensland Mental Health Commission., 2017)

Recommendation:

6. MHS' should be provided with a discretion to lock or not lock the wards as required, rather than a mandatory locked doors policy.

5. High and increasing rates of involuntary treatment under Mental Health Act 2016 (MHA 2016)

The Queensland Mental Health Act 2016 (MHA 2016), which replaced the Mental Health Act 2000 (MHA 2000), was intended to improve the human rights of patients, including by minimizing compulsory treatment (Queensland Health, 2017). Section 3(2) states that

> '*the main objects (of this Act) are to be achieved in a way that safeguards the rights of persons and is least restrictive of rights and liberties of a person who has a mental illness.'*

However, a recent study has found that compulsory treatment is on the rise in Queensland in spite of a number of mechanisms to promote less restrictive treatment in MHA 2016 (Gill,

Amos, et al., 2020). Causes of this unintended consequence of rise in compulsory treatment may include a lack of systematized and well-resourced voluntary alternatives, a paternalistic and restrictive culture in mental health services, and risk aversion in clinicians and society (Gill, Allan, Clark, & Rosen, 2020). Further systematic inquiry is required around the possible determinants of the rise of compulsory treatment and effective ways to reduce compulsory treatment and promote voluntary and less restrictive care. It is likely that despite introducing some less restrictive ways and supported decision-making provisions, the changes in Queensland legislation do not go far enough.

Recommendations:

7. An evaluation of the impact of Mental Health Act 2016 should be conducted.
8. Systematic research needs to be funded, to find out reasons behind increase in involuntary/compulsory treatment rates in Queensland MHS'.
9. Funding should be provided to operationalise less restrictive and voluntary alternatives.

6. Mental Health crisis response – hospital based locked model versus community-based welcoming model

A 'Crisis Stabilisation Facility' (CSF) has been built next to the Emergency Department in Robina Hospital. It is great to see injection of funding and resources into mental health, with inclusion of peer support workforce. There have been suggestions of similar crisis units elsewhere in the state.

I believe that this model is loosely based on 'Crisis Now' model from Phoenix, US, run by RI International. However, those crisis centres in US are peer/NGO-led and community-based.

On the Gold Coast, the crisis facility is:

- hospital-based
- locked facility
- with a seclusion room
- with nursing station behind glass doors ("fish-bowl")
- The peer-support worker to clinician ratio is low.

It is true that Emergency Department is not a calming facility for patients in mental health crisis, but there are many different models of providing crisis response in mental health. One school of thought is that rather than setting up a parallel psychiatric emergency centre without medical expertise, we can expand the mental health wing within a better-resourced ED setting. In addition, community-based, open, peer-NGO led facilities (supported by clinical staff) may be started, providing more humane and recovery-oriented care, at a fraction of the cost.

The Gold Coast/Queensland model does not improve community-based (outreach) services, does not make mental health services more mobile, is a restrictive locked facility and does not offer any more choice to the service-users (as there are no walk-ins allowed- patients can only be brought by police or Ambulance or referred from Emergency Department). On the contrary, South Australia has started Urgent Mental Health Care Centre model (https://www.umhcc.org.au/), which is a welcoming place for people experiencing mental health crisis. Each model has its pros and cons. Often, we evaluate our own models and give them a five-star rating. Crisis mental health support is a crucial service and hence, any expansion of the Gold Coast crisis model to other regions in Queensland must be preceded by independent evaluation of the Gold Coast model and comparative analysis of different models.

Recommendation:

10. There must be an independent evaluation of the Gold Coast Crisis Stabilisation Model.

11. Community-based, NGO-peer led open crisis stabilisation models should be tried and a comparative evaluation should be conducted between hospital-based, locked facilities with traditional medical-nursing model, versus community-based, open facilities with peer-NGO led model supported by clinical staff.

Conclusion

In summary, Qld Community mental health services are under-funded and need to be provided with funding for additional community mental health clinicians as well as peer support workers. The centre of gravity of Qld mental health system should shift from hospital-based to community-based services. The integration and liaison with primary care sector

including GP's must be strengthened. The inpatient psychiatric units must move towards open doors and recovery-oriented practices. The emphasis on involuntary/compulsory treatment must be reduced, through operationalisation of voluntary and less restrictive ways. The clinician-patient interaction should be based on a respectful therapeutic relationship and human connection, which is what people in acute mental health crisis as well as those with severe and persistent mental health conditions require. The society needs to be more accepting and inclusive of patients with mental health conditions.

This is a brief submission on a variety of issues. I would welcome an opportunity to provide further information to the Select Committee.

Acknowledgement:

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