OFFICE OF THE HEALTH OMBUDSMAN

11 February 2022

PRIVATE AND CONFIDENTIAL
The Honourable Joe Kelly MP
Chair
Mental Health Select Committee
Parliament House
George Street
BRISBANE QLD 4000

By email: mhsc@parliament.qld.gov.au

Dear Mr Kelly

Submission in response to the Mental Health Select Committee's Inquiry into the opportunities to improve mental health outcomes for Queenslanders

The Office of the Health Ombudsman (OHO) receives complaints about health services and health service practitioners. The specific objectives of the *Health Ombudsman Act 2013* are to protect the health and safety of the public, to promote professional, safe and competent practice by health practitioners, and to promote high standards of service delivery by health service organisations. This includes the role of managing complaints arising from the delivery of mental health services in both the public health system and by private facilities and practitioners.

The OHO also plays an important role in providing information to people who contact the OHO about how they can make complaints about mental health services, whether to the OHO or to the health service provider directly.

Due to the broad nature of the OHO's jurisdiction over all health service complaints and health service providers, it is not possible to easily identify what proportion of complaints to the OHO involve concerns about mental health services or mental health practitioners. It would also not be meaningful to provide exact data on the numbers or proportions of complaints/enquiries on particular types of issues raised about mental health services and practitioners because the weight of overall complaint numbers may mask important issues. For example, some frequently raised issues describe legitimate concerns that may not warrant a regulatory response, while some far less common issues raised in complaints are indicative of serious safety and quality issues which are of particular concern to the OHO.

Complaints about the provision of mental health services provide a vital window into a person's experience as a consumer in the mental health system. I am able to make the following comments on some of the key themes identified in mental health complaints and enquiries received by the

Level 12, 400 George Street, Brisbane
PO Box 13281 George Street, Brisbane Qld 4003
www.oho.qld.gov.au

OHO that may be of interest to the Select Committee when conducting the Inquiry (the MHSC Inquiry). For ease, I have noted where these themes respond to the Inquiry's specific terms of reference (TOR).

Access to mental health services in a crisis

A key theme noted in Appendix 5 to the written briefing for the MHSC Inquiry relates to challenges in responding to consumers experiencing mental health crisis and suicide distress. This theme is responsive to TORs (b), (c), (d), (f), and (g).

In the public briefing to the MHSC Inquiry on 20 January 2022, the Chief Psychiatrist noted "Presentations to emergency departments with a self-harm or suicide ideation diagnosis increased on average by 14 per cent each year between 2016-17 and 2020-21".

The OHO frequently receives complaints from mental health consumers or their families where there is a crisis situation and specialist mental health care is either not available (either generally, or at that particular time/location) or not provided by the relevant public hospital emergency department. This has resulted in situations where consumers who are actively self-harming or are at risk of suicide are discharged or redirected from emergency departments. There are unfortunately times where this has had devastating consequences for the consumer and their loved ones.

In making this comment, I note that there is no indication that this lack of crisis care is in any way deliberate or negligent, but may instead be impacted by issues such as resourcing, availability of services location and other system issues. This theme is consistent with issues identified in other mental health inquiries such as the Productivity Commission's recent mental health inquiry and the need for a range of service responses to consumers experiencing mental health crises and suicide distress.

The OHO also regularly receives contacts from mental health consumers who are experiencing crisis. These crises often do not describe a typical health emergency situation, but are no less critical to those consumers. The ability of the public mental health system to respond to these situations, and the delivery of mental health crisis response functions through emergency departments, would appear to be particular challenges.

Discharge arrangements and coordination of care

An examination of themes raised in complaints to the OHO indicates that there is a need for greater integration of services in settings that deal with consumers with high support needs or vulnerabilities, particularly those who may have diminished capacity for complex decisions or those with complex mental health conditions. As the public briefing for the MHSC Inquiry notes, "Access to GPs and general support services, described as primary mental health care, in a stepped model of mental health care is critical. Without this early intervention and care coordination to assist individuals and their families we risk issues, crises and conditions worsening and escalating." This theme appears to relate to TORs (b), (c), (d), (f), (g), and (h).

It is also apparent there is a need for greater integration of services provided in the public mental health system, and the integration between public mental health care and private mental health care so that services across the board are able to wrap around the consumer and provide a joined up response. This need is apparent in the transitions (in both directions) between emergency (crisis) care and ongoing mental health care, which may traverse the public and private systems. At times, concerns are also raised about a perceived lack of specific follow up after engaging with

mental health services in a crisis situation, and other complaints report that consumers are unable to obtain urgent appointments with their regular mental health care providers for intervention or follow up care.

Finally, the issue of coordination of care across health care disciplines is also relevant. This concern relates to the need to coordinate both physical and mental health care needs and to proactively address the high rate of poor physical health outcomes experienced by mental health consumers as identified in the *Equally Well Consensus Statement* and associated strategies.[1]Although this is rarely raised as a specific issue of complaint, this is an observation made from OHO's experience of managing complaints about mental health and physical health issues in Queensland since its establishment. The commitments made by state and federal governments to the Equally Well strategy recognise the challenges for mental health consumers in navigating multiple systems to meet their physical and mental health needs.

The level of support that the current system is able to provide seems to rely heavily on consumers remaining engaged with one specific general practitioner who can assist to coordinate care. On this note, a recently-observed trend of increasing numbers of general practitioners ending treating relationships due to challenges presented by the consumer's behaviour may pose particular risks for mental health consumers and point to the need for both education and supports for general practitioners in responding to the needs of mental health consumers as well as coordination of care with mental health services.

Service availability

Although there are not a significant number of complaints received specifically about mental health service availability in regional areas of Queensland, the complaints received indicate that the availability of mental health services across all areas of Queensland is inconsistent and causes challenges for Queenslanders trying to access support. The challenge of accessing appropriate and timely mental health services is not limited to rural and regional areas, as complaints are also received about difficulties in obtaining appointments or accessing both public and private mental health services in metropolitan areas. This theme responds to TORs (b), (c), (d), (e), and (f).

The issue of service availability may also be an issue of concern for consumers with dual diagnoses who require multiple types of specialist and psychiatric services whilst seeking to remain close to family or otherwise comfortable settings.

Given the known challenges for mental health consumers in making complaints, it is almost certain that the number of concerns raised with the OHO would underrepresent this issue of service access and availability for consumers seeking mental health services (as would also be the case with most of the themes raised in this submission).

Concerns about personal and sexual safety in mental health facilities

Specific mention should be made of concerns around personal safety in mental health facilities. This theme relates to TORs (b), (c), (d), (e), (f), (g), (h) and (i).

Complaints are regularly received by the OHO about use of excessive force by security officers or practitioners, and the trauma associated with these incidents for mental health consumers. While recognising the challenging circumstances that are often associated with these incidents, these complaints point to the need to consider the nature of the training provided to security officers, the environments in which these incidents occur and approaches to de-escalation and less restrictive

[1] https://www.equallywell.org.au/#

practices. The use of body worn cameras is important evidence in considering allegations as well as understanding the context of the incident and experience of the mental health consumer. Regardless of whether the use of force was considered reasonable or not in the particular circumstances, it is critical that mental health services provide a trauma informed response and debriefing for the consumer and provider appropriate follow up care for any injuries incurred.

Of particular concern are the complaints about physical or sexual assaults, harassment or sexual activity between patients receiving mental health inpatient treatment. OHO has received some truly distressing complaints about sexual assaults in mental health inpatient environments, particularly of young women. These assaults are occurring in an environment where they have the right to feel safe and secure and be receiving appropriate care and supervision. This is an issue that is not unique to Queensland and has received particular attention in Victoria through the Royal Commission into Victoria's Mental Health System[2] and the 'Right to be Safe' report[3] produced in my former role as the Mental Health Complaints Commissioner in Victoria. Queensland's Health's '*Sexual health and safety guidelines – mental health, alcohol and other drug services*' (2016)[4] appropriately identifies the key risks in respect to sexual safety for mental health consumers and guidelines for services to prevent and respond to these incidents. The complaints received by OHO about sexual safety incidents and sexual assaults indicate that further attention is warranted to address these significant issues.

Some of the alleged sexual assaults reported to OHO have been directly linked to the environment in which these young women are being placed, with shared-gender wards being the most common environment. Under the National Safety and Quality Health Service Standards 2021 all health services are required to 'actively manage and improve the safety and quality of health care for patients' and provide 'a safe environment for the delivery of care'[5]. For mental health consumers, the provision of a safe environment requires particular attention to the known risks and vulnerabilities of individual consumers, taking into account factors such as age, gender and trauma backgrounds.

I will be exploring ways in which the OHO can work with key stakeholders to use the critical insights gained from these complaints to strengthen the safe provision of mental health services and will be seeking to engage with key stakeholders and mental health services to address this significant issue.

In relation to my jurisdiction over registered practitioners in mental health service environments, the issue of boundary violations (i.e. consensual sexual or non-sexual relationships) between practitioners and patients is one which unfortunately continues to occur and these are managed with due seriousness by the OHO and by Ahpra and the relevant National Board.

Other common issues seen in complaints

Complaints provide a vital window into consumers' lived experiences of mental health services, as well as the experiences of their families and carers. This section relates primarily to TOR (d) in that these are matters that rise directly from those lived experiences.

[2] https://finalreport.rcvmhs.vic.gov.au/download-report/; s10.7.1 Addressing sexual and gender-based violence in acute inpatient settings, pp632-635
[3] https://www.mhcc.vic.gov.au/ensuring-sexual-safety-acute-mental-health-inpatient-units
[4] https://www.health.qld.gov.au/__data/assets/pdf_file/0030/426828/qh-gdl-434.pdf
[5] Australian Commission on Quality and Safety in Health Care, *National Safety and Quality Health Service Standards Second edition – 2021*, pp 7 & 12 https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition

Common issues frequently raised in mental health complaints received by the OHO include concerns relating to:

- Medication, including side effects, dosage (including failures to consider relevant information from family members, as well as concerns about dosages up to levels that cause sedation), objections to mandated treatment (particularly injections) under the *Mental Health Act 2016* (MHA), and the impacts of medication being suddenly changed.
- Concerns about the use of the MHA raised by patients, along with concerns raised about the lack of use of the MHA when it is perceived as needed by family members or carers;
- Information disclosures, including failure to provide sufficient information to nominated persons or family members, but also privacy breaches where information is provided without the patient's consent;
- Inadequate assessments of risk, including failures to conduct assessments, perceptions of assessments being rushed, or failures to take into account relevant information (including the safety of family members);
- The use of electro-convulsive therapy, including authorities to administer, side effects and number of treatment cycles;
- Concerns about diagnosis, including challenges to the veracity of information provided by others that led to a diagnosis, or disagreement between practitioners about diagnosis;
- Concerns about discharge arrangements, particularly premature discharge or the inadequate coordination of services post-discharge;
- Lack of specialised services to support children and young people, particularly those with complex needs.

Many of these common issues raised in mental health complaints have an underlying theme of the consumer not understanding or feeling at the centre of their care and treatment, or family and carers not feeling included in the assessment of risks and in decision making and planning.

Information and education about the *Mental Health Act 2016*

As the primary avenue to complain about health services in Queensland, the OHO receives a significant number of enquiries from consumers confused about where they should go to complain about their treatment under the application of the MHA. It is apparent that more could be done to educate consumers and their families or friends about the MHA, its application and the MHA safeguards which they can access. Calls are frequently received by the OHO from people who are seeking information or support which under the MHA framework should have already been provided. The OHO will be continuing to engage with mental health services and Patient Rights Advisors on ways in which these issues could be addressed in both individual cases and more generally by mental health services.

Complaints from particularly vulnerable groups

It is well established, both in Queensland and in other jurisdictions, that mental health consumers are less likely to complain about challenges encountered in the mental health system. The OHO does not always obtain sufficient data from complainants to enable detailed demographic analysis of mental health complaints to be provided but it is reasonable to assume that there are many more concerns that have not been raised with the office. It is also reasonable to assume that

particular population groups may require proactive engagement and additional support to make a complaint.

For this reason, the OHO is presently taking steps to provide improve the accessibility and delivery of complaint services to mental health consumers, including by providing more supportive and tailored services. The OHO is committed to learning from feedback and to continually adapt our services to ensure that the concerns of all Queenslanders are able to be heard and addressed.

The OHO provides a dedicated phone line for complaints from prisoners, which is one of the population cohorts that research suggests is at greater risk of poor mental health. A notable number of complaints are received from prisoners about access to mental health treatment in prison, even in circumstances where the prisoner has self-identified that support is needed and requested this support through prisoner health care processes. Other concerns commonly raised include issues of continuity of care and medication for those prisoners who were undergoing treatment for mental illness before they were incarcerated. From the issues raised by prisoners to OHO, it would appear that there are often significant delays with obtaining information from general practitioners or hospitals and re-commencing treatment. These are issues that the OHO will continue to address through our complaints resolution processes and raise in our regular engagement with the Office of Prisoner Health and Wellbeing.

The key role of complaints in improving service safety and quality

Complaints and notifications to the OHO are a key mechanism for identifying issues of safety and quality within service systems. Complaints by consumers, families and carers provide vital insights into what may not be working in the system and identifying opportunities for improvement. In particular, the ability to refer matters to external agencies under s92 of the *Health Ombudsman Act 2013* ensures that the results of hospital and health service investigations are shared with the OHO. In addition to driving the response to that particular complaint or notification, these outcomes also inform the OHO's systemic work.

I intend for the OHO to undertake further work to look at ways in which we can share learnings from complaint trends with relevant agencies to promote improvements to service safety and quality.

Additionally, I will be exploring opportunities to engage with key stakeholders in the mental health sector on ways in which mental health consumers, particularly those in vulnerable and high risk population groups, can be supported to make complaints either directly to services, through other existing oversight and advocacy mechanisms such as community visitors, or to the OHO.

Increases in complaint numbers

The written briefing for the MHSC Inquiry notes that increasing demand on mental health services is impacting on the capacity for care to be delivered. As the number of complaints can be expected to grow proportionate to this increasing demand, there are undoubtedly also corresponding impacts on the capacity for a robust and accessible complaints framework to be delivered equitably across Queensland.

The written briefing for the MHSC Inquiry also notes the impact of COVID-19 on the mental health and wellbeing of Queenslanders, resulting in increased demand across public mental health and other drugs service. However, it is simply too soon to say whether COVID-19 has had an impact on overall complaint numbers in relation to the same services. This may never be able to be determined, given that complaints about mental health services are often split between complaints

about individual mental health practitioners, complaints about mental health facilities, and complaints about perceived failures of general health facilities (such as emergency departments) to appropriately deal with mental health concerns. It is certainly not impossible to assume that at least some of the increase in complaints received by the OHO in the current financial year is attributable to the unique circumstances created by COVID-19.

Conclusion

As a general comment, the issues that are apparent through the OHO's complaints data are not unique to Queensland. These themes reflect many of the themes identified in the recent Productivity Commission Inquiry Report into Mental Health,[6] as well as other reports into the mental health sector. In particular, the themes discussed in this letter of access to mental health care, the delivery of mental health care for consumers in crisis, and coordination of services are particularly notable as being common issues which all mental health systems need to better respond to.

The importance of the complaints framework in the mental health system cannot be underestimated. As noted in the Productivity Commission report, complaints can resolve issues both for the individual, and address systemic concerns.[7] Further, the impacts of making a complaint and not receiving appropriate responses can further damage mental health.[8] It is therefore vital that Queensland has a robust, accessible and efficient complaints framework.

Fortunately, in Queensland we have the advantage of having the OHO as the single point of entry to the health care complaints system, making it relatively easy for people to determine who to complain to. However, there are also challenges inherent in this approach, and specific attention and tailored approaches are required to ensure that complaints about mental health services are given due attention and consideration alongside the greater volume of complaints about general health services. We are committed to building on the strengths of OHO's model to continue to improve the accessibility and responsiveness of our complaints processes, and to protect and promote the health and safety of Queenslanders who are accessing mental health services in accordance with OHO's legislative functions.

I trust this information is of assistance to the Committee. Should further information be required I will be pleased to assist.

Yours sincerely

Dr Lynne Coulson Barr OAM
Health Ombudsman

[6] https://www.pc.gov.au/inquiries/completed/mental-health/report.
[7] p1114
[8] p1115