Submission:
Inquiry into the opportunities to improve mental health outcomes for Queenslanders

February 2022

The Public Advocate
Influencing change to empower lives

Submission Summary

As the Public Advocate for Queensland, I am responsible for advocating for systemic reform to improve the lives of Queensland adults with impaired decision-making ability.

Mental health conditions present particular and unique issues for this cohort. People who have impaired decision-making ability due to an existing disability (for example an intellectual disability or acquired brain injury) are more likely than others to experience a mental health condition. In addition, people who experience a mental health condition may also experience impaired decision-making ability, be it temporary, fluctuating, or permanent.

The nature of mental health concerns affecting people with impaired decision-making ability often means that they require acute care for periods of time, provided in authorised mental health facilities rather than in the community.

The treatment and conditions experienced by people with impaired decision-making ability while in authorised mental health facilities has been of concern to myself and previous Public Advocates for a number of years.

In late 2021 I embarked on a systemic advocacy project concerning the services provided to acute mental health patients in authorised mental health services across Queensland. This project is being conducted in collaboration with Professor Neeraj Gill. Professor Gill, in addition to practicing as a psychiatrist at Gold Coast Health, is the clinical lead for mental health at the School of Medicine, Griffith University, a member of the Queensland Mental Health Review Tribunal, and a board member 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.

The project will be completed in June 2022 with the release of a report by my office.

This submission details the issues identified in the early stages of consultation associated with this project. Although the project has only recently begun, a wide range of issues have been identified and are presented for consideration by the Mental Health Select Committee.

The issues also identify areas where reforms need to be considered in order to improve the long-term outcomes for people who engage with the mental health system in Queensland.

They include:

- **Improving the system's first response to a mental health crisis presentation in the community** – which includes additional training for Queensland Ambulance Service officers, the availability of alternative crisis care pathways and improvements to information sharing amongst first responder services.
- **Improving the experience of mental health patients in emergency departments** – including diversionary options within departments to limit the escalation of conditions and providing evidence-based recovery approaches to urgent mental health care presentations, inclusive of referral and linking to responsive community treatment options.
- **Reviewing the locked ward policy employed at all authorised mental health facilities** – this policy is not aligned with the *Human Rights Act 2019* and actively discourages people with acute conditions to voluntarily seek treatment. Alternative programs and policies need to be considered that have achieved strong outcomes for patients. The Queensland Mental Health Commission (QMHC) released a report proposing locked ward alternatives in 2014,[7] with a follow up in 2017[8] and its recommendations remain relevant to this inquiry.
- **Improving the assessment and treatment of dual diagnosis patients (mental health condition and intellectual disability)**
- **Addressing the accountability and transparency of the Mental Health Review Tribunal** - this includes enhancing patient knowledge, awareness and understanding of tribunal proceedings,

the tribunal recording its proceedings in compliance with the *Recording of Evidence Act 1962*, improving patient access to information and legal representation to support their attendance at a tribunal hearing, and reviewing the requirements of clinical reports provided to the MHRT, to include information that focuses on the patient's recovery goals, and the supports required to achieve those goals.

- **Fully integrating the role of the Independent Patient Rights Adviser (IPRA) into the acute mental health system** – this includes ensuring the consistent application of policies in relation to IPRAs across authorised mental health services, improving IPRA access to relevant information to assist them in their role of supporting patients, and enhancing the relationship between IPRAs and treating teams.
- **Improvements to discharge planning by partnering with patients, their families, substitute decision-makers and support persons to develop individual discharge plans that;** clearly outline expectations of patients following their discharge, provide information to patients, families, substitute decision-makers, and support persons, about ongoing community treatment required. Discharge plans should also include information on how to link to services that will assist with discharge, work to prevent re-admission and promote better health outcomes for mental health patients and their families.

Introduction

Thank you for the opportunity to provide a submission to the Mental Health Select Committee, in response to the Parliamentary inquiry into opportunities to improve mental health outcomes for Queenslanders.

As the Public Advocate for Queensland, I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making capacity.[1]

There are a range of conditions that may affect a person's decision-making ability. These include intellectual disability, acquired brain injury, mental illness, neurological disorders (such as dementia) or problematic alcohol and drug use. While not all people with these conditions will experience impaired decision-making ability, it is likely that many may, 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 choices and decisions.

Not all people with a mental health condition will experience impaired decision-making ability, however it is likely that many will, and particularly those who require acute care to treat their condition. Members of 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 submission will primarily address the following terms of reference nominated for this inquiry:

> b) the current needs of and impacts on the mental health service system in Queensland;
> c) opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services (including alcohol and other drugs and suicide prevention)
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> a. across the care continuum from prevention, crisis response, harm reduction, treatment and recovery;
> b. across sectors, including Commonwealth funded primary care and private specialist services, state funded specialist mental health services and services funded by the NDIS.[2]

[1] *Guardianship and Administration Act 2000* (Qld) s 209.
[2] Mental Health Select Committee, Parliament of Queensland, Inquiry into the opportunities to improve mental health outcomes for Queenslanders, terms of reference, December 2021.

I will also make note of some additional issues for the Committee's consideration – primarily in relation to the interaction between the mental health and criminal justice systems.

Mental illness and people with impaired decision-making ability

The prevalence of mental ill health 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.[3]

Several studies also outline the challenges faced by clinicians when making psychiatric diagnoses in this population group, who often 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.

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.[4]

The Public Advocate's interest in the mental health system

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

Following the introduction of 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.

My ongoing interest and advocacy in this area has led to a systemic project currently being undertaken by the office in collaboration with Professor Neeraj Gill (School of Medicine, Griffith University, Clinical Lead, Mental Health, Griffith University-Gold Coast HHS, GP Liaison Psychiatrist, Gold Coast HHS).

The project is exploring the assessment, treatment, and care provided at facility based mental health services across Queensland. The scope of this project includes:

- initial responses to a mental health crisis in a community setting (including the interface between emergency services and hospital emergency departments);
- admission into an authorised mental health unit (including the admission of adults on voluntary and involuntary bases);
- treatment and care received in an authorised mental health unit (including the application process for the authorisation of specialist treatment such as Electroconvulsive Therapy (ECT) and non-ablative neurosurgery); and
- discharge into a community setting.

The findings of this project will be contained in a report that is due for completion by June 2022.

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[3] 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.

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

To date, a large range of stakeholder organisations have been consulted to provide input into the project. The views or opinions in this submission do not, however, necessarily reflect the views of the stakeholders who were consulted during the project (Attachment 1).

Using this input as a base from which to document a patient journey through the system, a series of issues have been identified, which form the basis of this submission.

I acknowledge that this submission does not cover all aspects associated with the delivery of mental health care services in Queensland, however I believe that the issues identified have implications for facility-based treatment and for other areas, including community based mental health care.

The issues

1.0 Pre-hospital admission – mental health crises in the community

This section highlights issues associated with a person presenting with a mental health crisis in the community and their consequent journey to a health facility.

1.1 Limited appropriate options to divert people away from emergency departments

When a person presents with a mental health crisis in the community, the first people they see are normally the police and paramedics, before being transported to an emergency department setting due to a lack of available alternative community-based treatment options.

The Queensland Ambulance Service (QAS) and the Queensland Police Service (QPS) have recently introduced co-responder programs, which provide opportunities to divert some patients who present with acute distress in the community away from emergency department settings. Anecdotally, both co-responder programs have been successful. The benefit of the co-responder program for QAS has been the ability to provide a health-based response as the first response in the community and to provide mental health interventions in homes. However, the ability to support patients is often limited given the capacity of community mental health teams and the limited resources available to provide ongoing support.

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 authorised mental health service from the emergency department. It has been identified that people with a dual diagnosis (for example, intellectual disability, acquired brain injury and substance abuse), as well those presenting with deliberate self-harm and suicidal ideations, make up a large proportion of this cohort of people.

In these situations, there are very few options available. Queensland Health has initiated the development of Safe Hubs in various areas across Queensland designed to provide support for people who do not require emergency care. However, these hubs 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, these safe hubs are not accessible 24 hours a day, with most only operational for a short period of time after hours.

Patients who do receive treatment in the 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 health 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, their reaction to which may lead to the increased possibility of the use of restraint and sedative practices.[5]

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. My office has been advised that the loss of the mental health service provider resulted from a loss in their 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.

Anecdotally, my office has also been informed by stakeholders that the Queensland Health introduced 1300 MH CALL potentially exacerbates issues for people with mental health issues in the community. Designed as a first point of contact to publicly provided mental health services, the call service operates like a triage service for people in the community experiencing mental health issues. While this service provides efficiencies for Queensland Health, it has limited the ability of community-based organisations to assist people to seek care. Prior to the introduction of the call service, community organisations were able to walk in to see community mental health teams with a consumer and provide support to consumers to tell their story, including relevant information to support appropriate assessment and treatment pathways. Now, the call service does not allow this to readily occur, which has created additional barriers for some seeking community mental health treatment, increasing the likelihood of an emergency department presentation.

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 and for those who are not "unwell" enough for admission and treatment in an authorised mental health service. There also needs to be established care pathways that encourage and enable people with mental illness to self-present for assessment and treatment in the early stages, as well as pathways that enable the primary health care sector to link patients to community services for ongoing support.

1.2 Use of Emergency Examination Authorities and waiting time in Emergency Departments for mental health presentations

Under the *Public Health Act 2005*, the QAS and QPS can make an emergency examination authority to transport a person experiencing a mental health crisis to an appropriate facility for assessment. The limited options available to both 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 type of care.

Anecdotally, my office has been informed of instances where emergency examination authorities have been used 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. However, my office has been told of instances where emergency examination authorities have not been accepted by the emergency department treating team, and patients are subsequently discharged back into the community without the provision of any treatment or referrals to ongoing support.

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 authorised mental health service, but who are not safe to be discharged back into their homes without ongoing treatment and support.

Long waiting times for those experiencing ill mental 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 results in the person leaving without receiving

[5] 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.

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.

1.3 Mental health training for first responders

Paramedics receive very little mental health training as part of their recognised tertiary training course. The Queensland Ambulance Service provides only two hours of mental health crisis training for all new recruits, which is very limited given the extensive number of mental health presentations seen 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 diagnosis (cognitive impairment combined with a mental health condition).

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

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

The QPS have spent a significant amount of time and money establishing databases and information systems to track patient information and monitor outcomes. However, information sharing across agencies continues to be a significant problem. A research project undertaken by the QPS illustrated a significant link between mental health and domestic and family violence, leading to homicide. 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 Queensland Health or their general practitioner. 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.

2.0 Emergency department admission, assessment, and treatment

2.1 Environment and impact on mental health consumers

The emergency department of a hospital can be a very threatening, highly stimulating, and triggering environment. Due to their response to this environment, the clinical presentation of a mental health patient can be very different to their presentation in the community. Consequently, the examination process employed for the person may be unduly influenced by the environment and has the potential for patients to be placed on involuntary treatment authorities (removing their rights in relation to their treatment and care) prematurely. For people with a dual diagnosis of cognitive impairment and a mental illness, this process may be exacerbated as their reactions to an emergency department environment can be quite severe.

The emergency department environment is also not perceived to be 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 the QPS. This escalates situations further and can sometimes have tragic outcomes for the person involved.

In this context, the health system needs to consider the provision of diversionary options for people presenting with a mental health condition that are calmer, less threatening, and culturally appropriate. 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 calming lounge room like space, which provides a much calmer and less

threatening environment. No referral is required to access this service, which provides an opportunity for people in acute mental distress to self-present.

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, QAS and QPS, although there is no option for a person to self-present to this service. Much like the Urgent Mental Health Care Centre in Adelaide, it was designed with the intent to provide 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 ward including a seclusion room in addition to short stay beds and chairs, which may not provide the calming, home like environment originally intended.

2.2 Differences in Hospital and Health Services across Queensland

Currently there are differences in emergency department processes employed across Hospital and Health Services in Queensland. This variation is illustrated in the 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, and others have separate emergency departments for people presenting with mental health concerns.

Independent Patient Rights Advisers (IPRAs)[6] endeavour to see patients shortly after their admission to an authorised mental health service or emergency department. It is the IPRA's role (under the *Mental Health Act 2016*) 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 communicate to the treating team the patient's views, wishes and preferences about their treatment and care. However, this process relies on a timely referral and/or patient flow information being shared that alerts IPRAs to the admission of a patient. A lack of these processes and sharing of patient flow information means that the IPRA's ability to provide timely services to those who need it most can be severely curtailed.

2.3 Patients' and families' right 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 authorised mental health service environments. However, there are problems implementing this provision of the Act in an emergency department setting. A complaint must be made by a patient and/or their support person in the first instance, and this must be dealt with in accordance with Hospital and Health Service policies. In situations where the complaint is not able to be resolved, a second opinion can be sought. The complaint process itself can take up to 28 days to be completed and then a second opinion another 7 days. As such, these timeframes are not conducive to the emergency department setting. Ryan's Rule[7] can be used in this instance; however, the prevalence of its use in this situation is not known.

3.0 Admission, assessment, and treatment in an authorised mental health unit

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

[6] The role of Independent Patient Rights Advisers (IPRAs) is explained further in section 3.4

[7] 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.

the incidence of patients absconding. There is strong evidence, however, of the detrimental effects that locked wards may have on patients, including; lowered self-esteem and autonomy, a sense of seclusion and confinement, and lower levels of satisfaction with services provided.[8]

Locked wards mean that patients who voluntarily admit themselves to an authorised mental health service (as well as those treated involuntarily) are detained, under current Queensland Health policy, in locked facilities. For patients presenting for the first time this comes as a significant shock. The locked ward environment is potentially a trigger for patients withdrawing consent for treatment, which subsequently can result in a treatment authority, which effects a transition from a voluntary to involuntary admission. This transition has significant implications for the treatment path for the patient, including the involvement of the Mental Health Review Tribunal (MHRT).

It is unclear what effect the existence of locked wards has 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 that enter an authorised service voluntarily do transfer to a treatment authority (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 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 coercive practices such as seclusion.[9]

The safewards model was initially implemented in seven health services across 18 wards in urban and regional Victoria 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.[10]

The Queensland Mental Health Commission has also addressed the issue of locked wards in Queensland with the release of an options paper in December 2014, *Moving towards a more recovery-orientate, least restrictive approach in acute mental health wards, including locked wards*.[11] Several reforms were recommended in this report as alternatives to locked wards, including recovery orientated practice approaches. A progress report was also published by the Commission in 2017 which noted that a trial of the safewards model of care was being undertaken in Central Queensland, Metro North, Metro South, and West Moreton Hospital and Health Services.[12] Implementation of the safewards program across the Hospital and Health Services 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 conducted on three of the five acute mental health wards implementing safewards in south-east Queensland which highlighted the challenges in changing mental health nursing practice in busy acute inpatient

[8] N. Gill, S. Parker, A. Amos, et al, "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.
[9] Gill, Parker, Amos et al p.55
[10] 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, 462, 2019
[11] 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.
[12] Queensland Mental Health Commission, *Implementation progress of the 2014 report, Options for reform: moving towards a more recovery orientated lease restrictive approach in acute mental health wards including locked wards*, May 2017.

wards, suggesting readiness of staff to engage, buy-in from management and adequate training that fits with the local context are important for successful implementation of safewards.[13]

3.2 Assessment and treatment of patients presenting with dual diagnosis

The perceived appropriateness of assessment and treatment practices is an issue for many stakeholders, particularly for patients who present with mental health symptoms with an additional background diagnosis and/or diverse cultural backgrounds (this cohort of people includes people with an intellectual disability, neurological impairment, a background of trauma, culturally and linguistically diverse and Aboriginal and Torres Strait Islander people). The assessment and treatment of this cohort 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., broken bone), but displays symptoms of a mental illness, the consultation liaison psychiatry team is called upon to consult and provide specialist support in the appropriate care and treatment of that patient's mental health. This does not generally occur in an authorised mental health service, meaning that intellectual disability or other neurological conditions are not considered as a component of 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.

3.3 Functions of the Mental Health Review Tribunal

When people are under a treatment authority in an authorised mental health service the Mental Health Review Tribunal 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 an individual as a component of their treatment and hears appeals regarding certain decisions made by treating teams or the service.

The previous Public Advocate identified a series of significant concerns related to the operation of the Mental Health Review Tribunal. These concerns, supported anecdotally by stakeholder interviews and a research paper released in 2020,[14] are detailed below.

a) Audio recording of Tribunal proceedings

The absence of formal recording of MHRT proceedings was a concern of the previous Public Advocate for some time, and is a focus of my 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 that 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 conducted 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.[15] 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*.[16]

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[13] 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.
[14] 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.
[15] Correspondence from the President of the Mental Health Review Tribunal to the Public Advocate, dated 15 July 2021.
[16] Correspondence from the President of the Mental Health Review Tribunal to the Public Advocate, dated 15 July 2021.

The MHRT advised the previous Public Advocate in July 2021 that there remain some outstanding issues to be resolved to record hearings, 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 is committed to a timely execution of the arrangement for recording under the Act.[17]

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.

b) 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 the tribunal hearing for support, however the independence of this support has been raised as a concern by some stakeholders. In some cases, an Independent Patient Rights Adviser (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.

c) Patient participation at hearings

Kitchen table discussions[18] involving patients with a lived experience of mental illness who have participated in Tribunal hearings have been conducted by the Mental Health Review Tribunal.

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 Mental Health Review Tribunal as a significant gap that impacts on a patient's participation at their hearing.

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

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

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 suggested to stakeholders their view that the tribunal had already come to a decision regarding their case based on the clinical report prepared and considered that their contribution would not make a 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 is felt that this would improve the tribunal's focus on their goals and where they are 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 the recovery goals of individuals relies on services existing and being available in the community, to ensure protective mechanisms are in place to support the patient's goal, without increasing any risks associated with removing the

[17] Correspondence from the President of the Mental Health Review Tribunal to the Public Advocate, dated 15 July 2021.
[18] 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.

treatment authority. 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.

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

A review of a Treatment Authority 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 Treatment Authority being put in place. This tight timeframe places additional pressure on already busy clinicians and 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 has also been identified as a factor limiting consideration of longer hearing times for patients.

e) 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 Authorised Mental Health Service, 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 to no support provided to the patient to understand the contents of the letter. In some instances, the Individual Patient Rights Adviser[9] may be aware of the patient's upcoming hearing and will therefore provide support, however, this is not always the case.

3.4 Role of the Independent Patient Rights Adviser (IPRA)

Independent Patient Rights Advisers (IPRAs) are positions created by 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.[19]

[19] Independent Patient Rights Advisers, Queensland Health, *Mental Health Act 2016* Fact sheet, p 1.

a) Initial referral to an Independent Patient Rights Adviser

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

The operation and referral to IPRA services will be determined by the Hospital and Health Service local policies and practices with variation 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, or by using patient flow information or bed management systems, depending upon the Hospital Health Service.

The work of IPRAs is primarily focused on assisting patients to understand their treatment and care, and assisting patients to communicate their views, wishes and preferences with the treating team about their treatment and care. 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.

b) 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 to the patient, 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".[20] 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.

c) 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 Mental Health Review Tribunal hearings and be provided with notices relating to the patient under the Act. An IPRA is often the main point of education and awareness of the role and rights of an NSP to patients. There is concern that if a patient has not engaged in IPRA services, they may not be aware of this right.

d) Patients 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 many patients' inability to engage a legal advocate without support from an IPRA, and the inconsistent approach across Hospital and Health Services to IPRAs accessing the Mental Health Review Tribunal hearings schedule.

A patient is only required to have notice of their upcoming hearing 7 days prior, however, the Mental Health Review Tribunal hearings schedule is issued 21 days beforehand and provided to the authorised mental health service. Most community legal centres require at least 7 days to review a case, therefore if the IPRA does not have access to this list when it is first issued to the authorised mental health service, or not within a timeframe that allows a patient to engage with legal representation, the ability for the patient to have legal representation is severely curtailed.

[20] *Mental Health Act 2016* (Qld) s.53

3.5 Communication between treating teams and patients

Communication between treating teams and patients has been identified as a major concern and source of complaints in authorised mental health services. 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 have reported spending significant amounts 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, as they maintain an independent role from the treating team, have spent significant time building rapport and relationships with patients, and are often 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.

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

Referrals from Queensland Health clinicians to advocates and lawyers to support clients with QCAT applications and representation are minimal across the mental health sector. Stakeholders have reported that the social work role in Queensland Health 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 Queensland Health.

Stakeholders report that in most cases a QCAT application is completed with very little thought to other options that could be considered to negate the need for the appointment of a substitute decision maker for the patient.

3.7 Community Visitors Program (Office of the Public Guardian)

The Office of the Public Guardian's adult community visitors independently monitor 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.[21]

Community visitors monitor the adequacy and appropriateness of services provided in authorised mental health services and can make announced and unannounced visits to ensure consumers are being care for, make inquiries, and lodge complaints for, or on behalf of, consumers.

Community Visitors also have the power to refer complaints to an external agency where appropriate. Community Visitors provide a report to the service provider following their visit outlining relevant issues that have been identified.[22]

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[21] *Public Guardian Act 2014* (Qld), Part 6, Division 1 Interpretation, s 39 p 36-37.
[22] *How Community Visitors advocate for adults, advocacy and rights protection for adults with a disability*, Office of the Public Guardian, fact sheet.

Community visitors can experience difficulties when conducting official visits of some authorised mental health facilities. These difficulties can be exacerbated by the level of contact and information sharing afforded to community visitors by IPRAs and treating teams.

Both IPRAs and community visitors exist to ensure that the 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 we ensure that these services are able to operate efficiently and effectively to achieve the outcomes sought under the *Mental Health* and *Public Guardian Acts*.

It appears that both services would benefit from the implementation of consistent policies across all authorised mental health services 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.

3.8 Other patient issues

Stakeholders from various organisations have also identified a range of additional issues encountered by patients when accessing treatment in authorised mental health services including:

- **Patients not understanding and/or having explained** to them the extent and nature of their treatment, not understanding what a treatment authority is and what that 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".[23]

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

[23] *Mental Health Act 2016* (Qld) s.53 & s.55

4.0 Discharge from authorised mental health services

4.1 Discharge plans

The Queensland mental health alcohol and other drugs clinical services developed a Comprehensive Care suite of documentation that is based upon the 2017 National Safety and Quality Health Service (NSQHS) standards and includes a "transfer of care" document. Patients should be provided with a copy of their transfer of care, which provides details regarding their obligations for further treatment in the community, as well as information about their accommodation if this is part of the treatment authority conditions. Accommodation conditions (if relevant) should also be communicated as part of the Mental Health Review Tribunal process.

Stakeholders have reported that patients can have limited involvement in planning for their ongoing care and recovery following discharge from an authorised mental health facility, which includes not being provided with relevant documentation like their transfer of care. As a result, some patients may not be aware of any follow up treatment that has been organised, or what their obligations are, particularly if they remain on a treatment authority 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 and can impact on their participation in the community as a whole.

4.2 Availability of appropriate support on discharge

The capacity and scope to provide immediate support to patients with complex mental health conditions has been identified 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 authorised mental health service.

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

In addition, stakeholders have reported resourcing issues impacting community mental health teams' capacity to deliver services directly to patients in their home environment. This may result in the delivery of services in outpatient clinic type settings and in some cases in emergency department settings, rather than directly in patient homes. This has the potential to jeopardise the provision of ongoing treatment and care in the community, and the building of therapeutic relationships in order to achieve positive outcomes for patients and their families.

Stakeholders have also reported 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 trust and rapport that was built with previous case managers. This is a cohort that frequently moves, frequently changes 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.

Additional issues for consideration

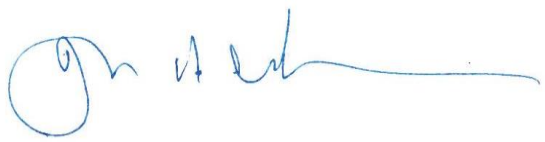
This submission also notes in passing the complex interplay that exists between Queensland's forensic disability service system and the Queensland mental health system. For instance, under the Mental Health Act, the Mental Health Court can make a Forensic Order (Mental Health) where a person is deemed to be of 'unsound mind' or unfit to stand trial (and other conditions are met). In addition, where a person's 'unsoundness of mind' or unfitness to stand trial is the result of their intellectual disability (and where the person does not require treatment for a mental illness), the Mental Health Court can make a Forensic Order (Disability). As the Ogloff et al report identified back in 2018, most of the people currently subject to Forensic Orders (Disability) – who currently number more than 100 – are managed by Authorised Mental Health Services, despite not having treatable mental illnesses. Only a very small number of people reside at the Forensic Disability Service (the state's only dedicated forensic disability service), under the oversight of the Director of Forensic Disability.

A series of reports have called for governance and operational reforms in this arena: see Ogloff, Ruffles and Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System* (unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, 2018); State of Queensland (Department of Communities, Disability Services and Seniors), *Section 157: Review of the operation of the* Forensic Disability Act 2011 *Final report*, 2018; Queensland Ombudsman, *The Forensic Disability Service report*, 2019. This submission echoes those reports' calls for reform.

Conclusion

Thank you for the opportunity to contribute to the inquiry into the opportunities to improve mental health outcomes for Queenslanders.

Yours sincerely



John Chesterman (Dr)

Public Advocate (Queensland)

Attachment **Stakeholder organisations consulted**

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 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 heath 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.