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

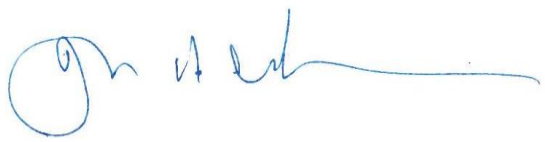
This submission also notes in passing the complex interplay that exists between Queensland's forensic disability service system and the Queensland mental health system. For instance, under the Mental Health Act, the Mental Health Court can make a Forensic Order (Mental Health) where a person is deemed 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.