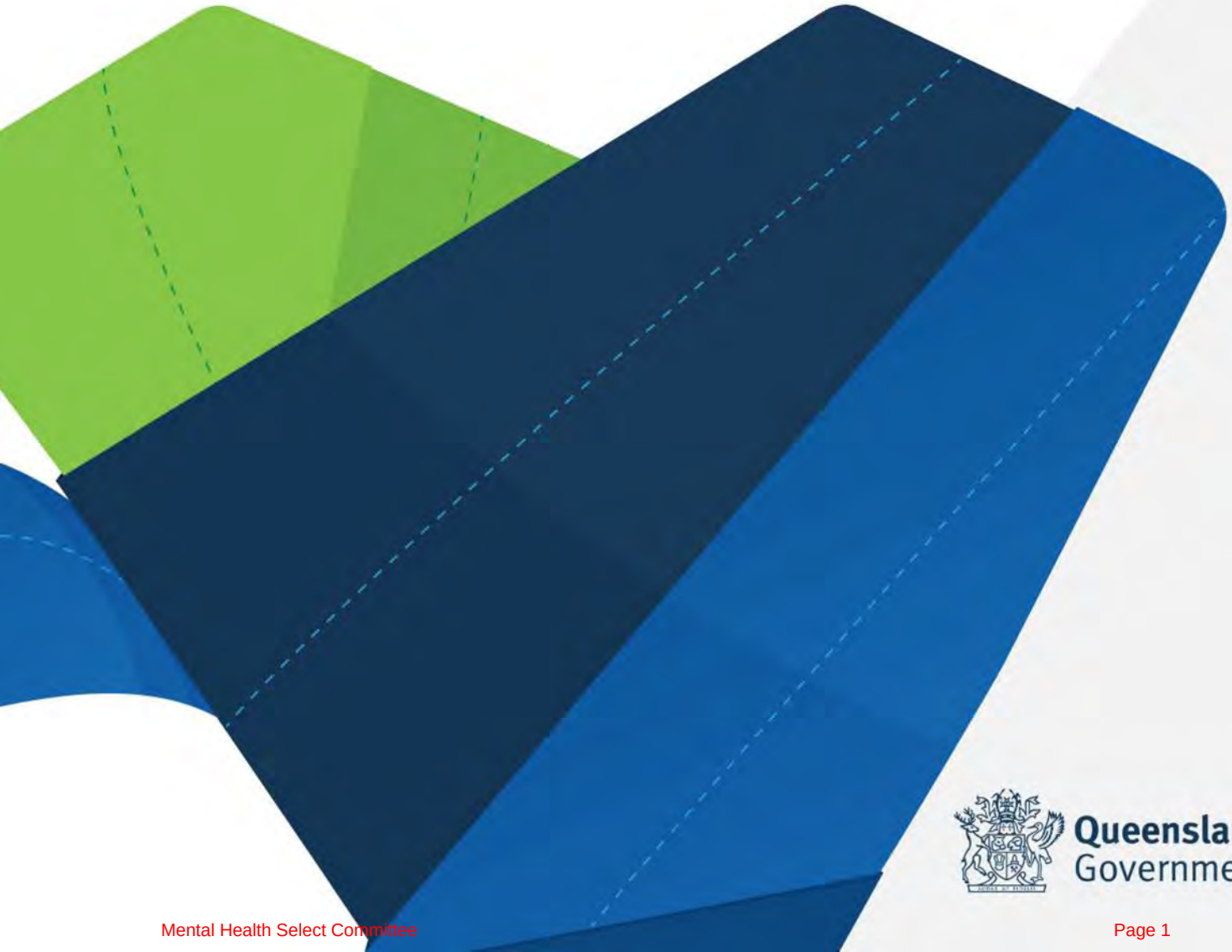
Queensland Health

Submission

Inquiry into the opportunities to improve mental health outcomes for Queenslanders



Queensland Government

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Executive summary

- Between 2016-2021, the Queensland Government invested more than $350 million in new funding for state-funded mental health alcohol and other drugs (MHAOD) services under Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services (Connecting care to recovery, available here).
- Despite this significant funding boost, the state-funded MHAOD system in Queensland is under pressure. It is faced with:
  - demand for treatment that has been increasing at a faster pace than population growth and workforce increases.
  - the lowest per capita expenditure and second lowest growth in per capita expenditure in Australia on mental health (MH) services.
  - the lowest number of available MH beds at 32.3 bed per 100,000 population in 2020-21 compared to other Australian jurisdictions
  - the lowest direct care Full Time Equivalent positions per 100,000 persons in Australia
  - significant workforce constraints including access to and retention of a skilled and capable workforce across a range of MH professions is a constant challenge
  - a shortfall in MHAOD capital when compared with need.
- Additionally, the COVID-19 pandemic has led to increased demand for MH services and furloughed staff who are close contacts, symptomatic, or tested positive; delays for some inpatients associated with access to and the operation of the National Disability Insurance Scheme (NDIS); and stigma associated with mental illness, substance use, and suicidality impact one's willingness to seek treatment and can lead to poorer physical and mental health outcomes.
- However, Queensland has strong foundations with key system enablers in place to support future growth and development. These include system planning and use of robust planning methodologies, capital planning, statewide and specialist services; a contemporary legislative framework for MH, system and service improvement mechanisms and governance, partnerships and collaboration including positive relationships at the HHS and Primary Health Network (PHN) level, and an expanding lived experience workforce.
- Contributing to the health equity for First Nations Queenslanders is vital. This includes approaches to making services more culturally capable and welcoming, increasing the proportion of Aboriginal and Torres Strait Islander people across the MHAOD workforce and continuing to build positive relationships with First Nations communities and organisations.
- Effective and appropriate inclusion, engagement and leadership of people with a lived experience of mental illness, problematic alcohol and other drug (AOD) use and suicide, and that of their families, carers, and supporters is critical in all aspects across policy, planning, program design and implementation, quality assurance, clinical review, and at the point of service.

- The state-funded MHAOD system exists within a broader system and should operate as a 'whole' and within a person centred framework to support the best outcomes for individuals, their families and carers.
- Housing, education, vocational training, policing, justice and social/community, employment and economic development are key areas that can impact on an individual's mental health and wellbeing and risk of mental illness.
- There are many opportunities to build on the existing foundations and develop person centred and recovery focused approaches that interface with and contribute to the broader system. These include:
  - suicide prevention
  - mental health crisis
  - perinatal and infant mental health
  - children and young people
  - people with eating disorders
  - alcohol and other drugs
  - dual disability
  - forensic mental health
  - older people.
- Effective leadership, multi-agency partnerships, collaborative models of service and care, embracing new technologies and innovations, a focus on continuing quality and service improvement must remain priorities as part of any development of the MHAOD service system.

1 Purpose

This submission provides information to the Select Committee to assist its consideration of potential responses to the key issues and matters identified through its Inquiry into opportunities to improve MH outcomes for Queenslanders.

Queensland Health's (QH) submission has been co-authored by the Department of Health (DoH), Hospital and Health Services (HHSs), and the Queensland Ambulance Service (QAS).

It builds on the QH written briefing and information provided at the public hearing on 20 January 2022.

The information provided identifies several current and future challenges facing the state-funded *treatment* system[1] and describes opportunities for further improvements, service development and growth in line with current Queensland Government policy which is informed by the best available evidence.

The QAS has provided additional information to augment this submission. This can be found at Appendix 1.

2 Key messages

- The Report on Government Services 2022 shows that between 2010-11 and 2019-20 there was a 52 per cent increase in per capita expenditure on public HHSs delivered by HHS in Queensland, while for MH services there was a five per cent increase per capita in expenditure over the same period.
- The state-funded MHAOD system in Queensland is under pressure but has strong foundations which will support its future growth and development.
- A Health Equity Strategy that is co-designed, co-owned as well as co-implemented is vital to address the high rates of mental health, problematic substance use and unacceptable suicide rates among First Nations People.
- The experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers is critical and leads to improvement of mental health services, reduction of negative community attitudes, and promotion of a better quality of life for consumers.
- While addressing the existing challenges within the state funded MHAOD system will help to improve mental health outcomes of Queenslanders, this needs to be supported by reform across the broader health system and across key aspects of the socio-economic determinants of health to prevent or reduce people's escalation into severe illness, problematic substance use and crisis.

[1] MH, AOD treatment, care and support for individuals, their families and carers delivered through HHS, NGOs inclusive of Aboriginal and Torres Strait Islander Community-Controlled Health Organisations (CCOs), and the QAS.

- Over nearly three decades, Queensland has been following the reform path set out in five successive National Mental Health Plans with a strong shift in the balance of investment from psychiatric hospitals to community-based services. Of 2.8 million episodes of service in 2020-21, 70 per cent were in the community. While in the last 10 years there has been a welcome shift to community-based beds (from 0 to 20 per cent now in the community), the total number of beds weighted by population has not grown and there is a shortage of inpatient beds, particularly for acute admission.
- People living with mental illness and problematic substance use experience significant stigma, including discrimination across health and other aspects of their social and community life which creates barriers to seeking treatment.
- Protection of human rights, safety, and high-quality care in a system where all participants are well informed are paramount. People subject to an order under *the Mental Health Act 2016* (MHA2016) receive 36 per cent of all episodes of care. There needs to be more partnerships between people with lived experience and clinicians to reduce or to eliminate the use of restrictive practices or coercion (seclusion, restraint, and the use of orders) and place a greater emphasis on voluntary care.
- Suicide prevention has been a significant priority in Queensland and there have been many innovative strategies implemented to tackle this, but suicide rates remain unacceptably high. It should continue to remain a priority.
- The workforce in Queensland MHAOD services strives daily to provide a high standard of care in the context of significant human and capital shortfalls and challenges.
- An increasing focus on delivering comprehensive care requires a shift in workforce practice and skill development. Working to full scope of practice within complementary multidisciplinary and partnership arrangements are required to meet an individual's needs.
- There needs to be a continuing recognition of the role and value of the lived experience (peer) workforce as part of the treatment and care team responding to the needs of individuals, their families and carers.
- Effective leadership is required to make the necessary improvements in the system. The focus needs to be on leadership at the state level to ensure the strategies are designed to meet the needs of the population, while allowing local leadership to adapt strategies to meet local priorities.
- As a result of the COVID-19 pandemic there has been a rise in the number of people with depression and anxiety which is disproportionately higher for women and young people. Like other natural disasters, the psychological effects can take a long time to present and that the call for psychological assistance will remain long after the physical effects have resolved.
- As mental disorders are more likely to emerge at a young age, early intervention and services beginning in early life are vital.
- Queensland Health continues to build on and adopt digital strategies to optimise services through better use of information.

3 Contributing to Health Equity for First Nations peoples

Aboriginal and Torres Strait Islander (First Nations) peoples are part of the oldest continuous culture in the world and make a significant and unique contribution to Queensland communities and culture. First Nations peoples are also part of the health workforce and Aboriginal and Torres Strait Islander service providers deliver MHAOD responses within social and emotional wellbeing frameworks and holistic cultural models of care.

In 2019, 4.6 per cent of Queensland's population identified as Aboriginal and/or Torres Strait Islander with 58 per cent of the population living in inner-regional and major cities, and 54 per cent under the age of 25 years. By 2031, the First Nations population is projected to grow to over 300,000 people with the greatest growth in the Brisbane region.

Aboriginal and Torres Strait Islander peoples continue to experience disparities and inequities accessing health services, their experiences with health and wellbeing services, and their overall health outcomes.

Aboriginal and Torres Strait Islander peoples experience higher levels of morbidity from mental illness, assault, psychological distress, and self-harm. Intentional injuries comprise around 5 per cent of the disease burden for First Nations peoples in Queensland, which is more than double the rate for non-indigenous Queenslanders. Mental illness is the leading burden of disease experienced by First Nations peoples in Queensland, contributing up to one-fifth of the total disease burden for First Nations Queenslanders.

As noted in QH's Written Briefing, according to the Australian Bureau of Statistics the average rate of death from suicide for Aboriginal and Torres Strait Islander Queenslanders (2016-2020) was 28.0 per 100,000, 1.9 times higher than for non-Indigenous Queenslanders (14.6 per 100,000) and above the national Aboriginal and Torres Strait Islander suicide rate (25.6 deaths per 100,000).

Around 20 per cent of Queensland's Aboriginal and Torres Strait Islander population live in remote or discrete communities. Despite large expenditures by all governments, outcomes and opportunities in communities remain behind the rest of the state. The Queensland Productivity Commission's report service delivery in remote and discrete Aboriginal and Torres Strait Islander communities (2017) (QPC report) found that socioeconomic determinants (education, income, overcrowding), racism and discrimination play a significant role in the health gap, along with behavioural and environmental risk factors and that Community Controlled Organisations (CCOs) provide effective, culturally appropriate and multidisciplinary models of comprehensive primary healthcare.

Aboriginal and Torres Strait Islander peoples are over-represented in Queensland's corrective services system and experience significant and increasing rates of imprisonment of around ten-times the non-Indigenous rate.

Making Tracks Together – Queensland's Aboriginal and Torres Strait Islander Health Equity Framework (Making Tracks Together) developed through a partnership between QH and the Queensland Aboriginal and Islander Health Council (QAIHC) was released in October 2021.

Making Tracks Together provides direction for HHSs, CCOs, and other healthcare service providers to deliver equitable, culturally safe, and clinically effective care.

The aim of the Making Tracks Together is to galvanise a renewed and shared agenda to improve Aboriginal and Torres Strait Islander peoples' health outcomes, experiences, and access to care across the health system. It also acknowledges that social and emotional wellbeing is the foundation for physical and MH for First Nations peoples. Caring for self, kin, community, and country is core to Aboriginal and Torres Strait Islander knowing, being and belonging. Good health and wellbeing are built upon deep and enduring social, emotional, and cultural connections between self and the whole community.

Making Tracks Together places Aboriginal and Torres Strait Islander peoples and voices at the centre of healthcare service design and delivery in Queensland. This agenda has been enacted in Queensland legislation through new provisions in the *Hospital and Health Board Act 2011* and Hospital and Health Regulation 2012 and is supported through a robust and considered public policy environment.

The Chief Aboriginal and Torres Strait Islander Health Officer has a key leadership role.

Within the DoH, the MHAOD Branch works closely with the Aboriginal and Torres Strait Islander Health Division in developing and implementing policies, planning, and commissioning of MHAOD, suicide prevention and social and emotional wellbeing services for First Nations peoples. The two areas jointly participate on a number of cross-government and national forums.

The Queensland Aboriginal and Torres Strait Islander Leadership in MHAOD (Leadership Group) is a group of Aboriginal and Torres Strait Islander MHAOD QH employees in strategic leadership positions across the state. The purpose of the Leadership Group is to provide leadership, expert advice relating to the needs of Aboriginal and Torres Strait Islander peoples and contribute to decision-making in the development of culturally secure and competent MHAOD services. Members are identified MHAOD leaders from HHSs and subject matter experts from a range of services including forensic mental health (FMH) and AOD.

Delivery of MHAOD, suicide prevention, social and emotional wellbeing services, program and projects for Aboriginal and Torres Strait Islander peoples and communities takes place through HHSs and CCOs.

Significant effort is taking place to address MHAOD and suicide prevention responses to Aboriginal and Torres Strait Islander peoples. This includes:

- Funding and working with QAIHC to deliver specific sector development and related work to improve the cultural safety of AOD service delivery across sectors.
- Engaging with Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (DSDSATIP) and partnering to align with efforts under Closing the Gap, Local Thriving Communities and supporting the renewed approach to Alcohol Management Plans.
- Invests in the Indigenous Mental Health Intervention Program (IMHIP) which is a culturally capable model of MH care and transitional support for Aboriginal and Torres Strait Islander peoples incarcerated in the Brisbane Women's and Woodford Correctional Centres.

Following extensive consultation with First Nations people to identify what resources are needed to support an Aboriginal and Torres Strait Islander person experiencing a suicidal crisis when presenting to a HHS, the following was identified:

- resources to support the delivery of culturally capable and welcoming services for Aboriginal and Torres Strait Islander people and their carers
- culturally welcoming emergency department (ED) service environments
- engagement with people and their care system during the provision of services.

The National Safety and Quality Health Service Standards (NSQHSS) User guide for Aboriginal and Torres Strait Islander Health calls for a welcoming healthcare environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people.

In 2020-21, eight HHSs were provided project funding for a partnership between ED, MHAOD services and the Aboriginal and Torres Strait Islander workforce to develop, test and evaluate culturally safe, engaging and welcoming environments for Aboriginal and Torres Strait Islander people experiencing a suicidal crisis.

Improvement activities within the ED setting include:

- Addressing the relevant information and translation needs of Aboriginal and Torres Strait Islander people relating to suicide risk.
- Training to support ED staff to be culturally capable and skilled in trauma-informed care, particularly the impacts of intergenerational trauma.
- Building positive relationships with the local Aboriginal and Torres Strait Islander community and organisations by working with them to identify and implement projects to improve patient experiences within the ED.
- Environmental improvements to enhance cultural sensitivity in the ED. For example, acknowledgements, displaying flags, signs, symbols and local artworks or artefacts, adapting the literature to make resources more appealing and acceptable, and sensory based activities.
- Increasing referral pathways and partnership with Aboriginal and Torres Strait Islander Health Services.

Through collaboration with key stakeholders, QH has developed the Cultural Information Gathering Tool, a culturally informed tool that identifies and collates Aboriginal and Torres Strait Islander cultural status and cultural information to guide culturally appropriate treatment. The tool and guide have recently been revised and are to be endorsed for use within the next two months.

The recent commitment by the Queensland Government as part of the 2020 State Election to establish a new ten bed residential AOD treatment service in Cairns, with complementary non-residential programs, includes a focus on ensuring the service is co-designed and culturally safe for Aboriginal and Torres Strait Islander young people and their families. The DoH has commissioned QAIHC to undertake appropriate community consultation to inform the model of service.

Recent revisions to the National Mental Health Services Planning Framework (NMHSPF) have focused on developing modelling specific to the needs of Aboriginal and Torres Strait

Islander peoples. As part of work to develop the Queensland Drug and Alcohol Service Planning Model (Q-DASPM) an Aboriginal and Torres Strait Islander expert advisory group was established with representation from CCO AOD treatment service providers to develop the Framework for the planning and commissioning of Aboriginal and Torres Strait Islander AOD treatment services in Queensland.

Under Action on Ice, QAIHC was commissioned to undertake two 'AOD-OUR-WAY' projects to support and build the capacity of Aboriginal and Torres Strait Islander services, communities, and families to respond to methamphetamine and other drug use. The first project provided tailored resources and training for the frontline workforce in community controlled and AOD treatment services. The second project developed a suite of age and culturally appropriate resources to support service providers, families, and young people.

Opportunities for improvement

Further work is required to ensure that Aboriginal and Torres Strait Islander people feel safe, respected, engaged, and confident to accept and receive clinical care across all healthcare settings.

Policy, planning, and service improvements for state funded MHAOD, suicide prevention and crisis responses are ongoing to embed strategic directions of Making Tracks Together.

Achieving health equity for First Nations peoples means focusing specific effort to address health differences and better meet the real and underlying needs of Aboriginal and Torres Strait Islander peoples across Queensland. Aboriginal and Torres Strait Islander peoples continue to experience differences in health that are avoidable, unfair, and remediable. Health equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. Health systems, including MHAOD services, play a significant role in addressing health inequities.

In accordance with requirements outlined in the Hospital and Health Boards Regulation 2012 each HHS is developing a Health Equity Strategy that is co-designed, co-owned, and co-implemented.

QH's future direction will also align with and contribute to the aims and targets of Making Tracks, the Queensland Government Reconciliation Action Plan 2018-2021 and the QH Aboriginal and Torres Strait Islander Strategy 2016-2021 as well as draw upon the findings of the Queensland Productivity Commission and other relevant policy, research, strategies and plans.

National strategic policy that will guide future directions includes the National Agreement on Closing the Gap (2020), *The fifth national mental health and suicide prevention plan* (Fifth Plan), National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023, National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* and the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026.*

Future directions will also be informed by The Gayaa Dhuwi (Proud Spirit) Declaration (Gayaa Dhuwi is Aboriginal and Torres Strait Islander social and emotional wellbeing, MH and suicide prevention national leadership body); and existing and ongoing consultation, participation and engagement with Aboriginal and Torres Strait Islander

community-controlled health organisations, QAIHC, First Nations individuals, their carers and family members with lived experience, the lived experience (peer) workforce, and Aboriginal and Torres Strait Islander leaders and communities.

As part of developing the new MHAOD plan, consultation has taken place to inform ongoing strategies to reduce health inequities, improve cultural quality and safety.

Priorities include:

- Procuring MHAOD and suicide prevention services from the Aboriginal and Torres Strait Islander community-controlled sector based on Aboriginal and Torres Strait Islander models of care.
- Embedding culturally capable approaches across the system by increasing Aboriginal and Torres Strait Islander representation across the workforce including in leadership positions.
- Improving culturally safe and quality treatment and care for Aboriginal and Torres Strait Islander people accessing mainstream MHAOD care.
- Improving pathways of care for Aboriginal and Torres Strait Islander people across health and related services.
- Improving mechanisms to empower and include the voice of First Nations peoples in policy, planning, design and delivery of services.
- Strengthening partnerships to redesign and better coordinate services at a statewide, regional and local level.
- Supporting communities with Alcohol Management Plans to access MHAOD services (social and emotional wellbeing treatment and support).
- Continuing delivery of the IMHIP youth project to provide in-reach and transitional support for Aboriginal and Torres Strait Island young people who experience detention.
- Improve culturally appropriate models of care for Aboriginal and Torres Strait Islander peoples involved in the criminal justice system.

4 Lived experience

The Australian Productivity Commission Inquiry into Mental Health (PC Report) pointed to system reform that puts people at the centre, and that governments need to include the perspectives of people with a lived experience of mental illness and their carers in policy development and planning activities.

As stated in the QH written briefing, QH is committed to the inclusion, engagement and leadership of people with a lived experience of mental illness, problematic AOD use, and suicide and that of their families, carers, and supporters in all aspects – across policy, planning, program design and implementation, quality assurance, clinical review and at the point of service.

The experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers is critical and leads to improvement of MHAOD services, reduction of negative community attitudes, and promotion of a better quality of life.

Connecting Care to Recovery promoted a greater inclusion of individuals, carers and lived experience. The implementation of initiatives in the Queensland Government's response to the Barrett Adolescent Centre Commission of Inquiry set a benchmark for how policy, planning, service development can take place alongside and be co-designed by people with lived experience and carer.

This continues participation in capital program governance groups to inform the design of new alcohol and other drug residential rehabilitation services in Rockhampton, Ipswich, Bundaberg and Cairns. QAIHC has also been commissioned to lead stakeholder engagement (including consultation with young people, families and communities) to inform the development of a culturally capable model of services for the new youth AOD residential and non-residential services in Cairns.

There is much scope for improvement across QH to further embed lived experience across QH. Supporting the engagement of people who use AOD presents unique complexities given the nature of substance use and diversity of the group of people with differing views and experiences. This requires further engagement with key stakeholders to refine how this can be accomplished.

Queensland has a proud history of engagement with people with a lived experience and carers. Queensland was an early adopter of the suite of lived experience surveys (see QH written briefing). Queensland has the highest mental health peer work in Australia (see section 5.2.5.2 – Lived experience (peer) workforce).

The active involvement of people with a lived experience and carers in the development, planning, delivery and evaluation of services is a hallmark of a quality MHAOD health system. QH is pursuing several initiatives across MHAOD treatment and care to embed lived experience. Many are featured in this document. One is the MHAOD Comprehensive Care Initiative: partnerships in care and communication which places the person at the centre of their care and recognises the critical importance of coordination between all members of the consumer's support network. This approach confirms the person with lived experience as an expert in their own experience and allows the opportunity for consumers and carers/families to participate in decisions regarding treatment and care.

QH is also working to ensure lived experience engagement as a key element in suicide prevention in healthcare. The voice of lived experience is integral to the delivery of safe and compassionate care of people in suicidal distress (see section 6.1 – Suicide prevention).

The leadership and direction from the newly established *Mental Health Lived Experience Peak Queensland* (auspiced by the Queensland Mental Health Commission (QMHC), in the initial stages of operation) is welcomed to further drive lived experience across QH.

5 Contributing to a person-centre system to improve mental health outcomes for Queenslanders

5.1 Overview

Both the QH and QMHC's written briefings emphasised there are a range of factors impacting MH outcomes and that MH and wellbeing takes place in a broader social, environmental and economic context.

The PC Report also highlighted the range of factors impacting mental health and the importance of a person-centred MH system being '*built outwards from the individual, to include community services and institutions, it also includes an individual's family, kinship group, friends and community. As such, healthcare is only one — albeit important — component of the mental health system*'.[2]

This broader system is reflected in the figure below (Figure 1) adapted from the PC Report.

Figure 1: Key components to building a person-centred mental health system as identified in the Australian Productivity Commission inquiry into mental health

[2] Productivity Commission, Australian Government (2020), Mental Health – Productivity Commission Inquiry Report, Volume 2 (No95, 30 June 2020) https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf , page 101.

Other Queensland Government agencies will be providing the Committee with submissions relevant to their respective roles and contributions in this broader system, noting that housing, education, vocational training, policing, justice, social/community, employment and economic development are key areas that can significantly impact on a Queenslander's MH and wellbeing and risk of mental illness.

QH's contribution to this person-centred system through the provision of specialist MHAOD treatment, care and support and more broadly through EDs along with other health responses, is significant.

The treatment and care are guided by comprehensive national and state policy which prioritises a whole of system approach. Governance mechanisms are established within the DoH and in the clinical and service delivery environment, along with ongoing efforts to continually improve, monitor as well as evaluate treatment and care. Important statewide mechanisms to support education, training, and research as well as specialist expertise in key areas are in place. MH has been integrated with AOD. There are increasing efforts to systematically address multimorbidity. Responding to crisis and driving comprehensive approaches to suicide prevention are a key focus. Shifting to a more digitally enabled service delivery environment is underway.

However, the capacity of this system is under significant pressure. Services (HHSs and NGOs) are faced with increasing demand and are managing in a constrained fiscal and workforce environment, exacerbated by managing the impacts of COVID-19. Quality and safety of treatment with efforts to introduce new and contemporary models of care are impacted by aged facilities in need of repair, refurbishment or complete redesign and new builds.

HHSs and NGOs report an increase in service demand, which has been compounded by the COVID-19 pandemic. While they have actively engaged in local efforts and solutions such as partnerships with other stakeholders to achieve more from each dollar spent the demand has outstripped capacity to provide treatment and care.

The challenges of attracting workforce across the state has also been raised consistently, particularly challenging for rural and regional Queensland. The travel restrictions due to the COVID-19 pandemic have further exposed the fragility of the available workforce. Once again, local solutions such as increasing numbers into graduation programs are being implemented to meet local need but there remains a concern about the availability of a skilled and competent workforce over the medium and longer term for this specialty.

While all HHSs are engaged in various planning processes, many identify a lack of joined up planning at the state and Commonwealth level with services at a local level funded from different sources, in turn leading to fragmentation and a lack of complementarity across the local service system. The introduction of the NDIS and inadequate resourcing at a local level to manage additional complexity associated with dual disability, workforce constraints, and stigma are areas further impacting capacity to meet demand and provide more comprehensive care.

It is important that the system operates as a 'whole'. For example, not being able to access community placements can mean a longer than required inpatient admission or stay in the ED or not having the right type of treatment/beds along an individual's treatment and recovery can impact their mental health/AOD outcomes.

The demands and challenges facing state-funded MHAOD treatment and care are being considered as part of the development of a new MHAOD plan to follow on from the current plan for state-funded MHAOD services - Connecting Care to Recovery.

The DoH (MHAOD Branch) has been undertaking significant planning and consultation to develop a new plan. To date, this has included extensive evidenced-based planning and comprehensive needs analysis, as well as significant consultations with more than 500 stakeholders across the state to inform development of strategies and priorities to be included in the plan. Stakeholders include HHS, NGOs, PHNs, the QMHC, Queensland Alliance for Mental Health (QAMH), Queensland Network of Alcohol and Drug Agencies (QNADA), QAIHC, specialist clinical groups, peer workers and Aboriginal and Torres Strait Islander leaders across HHS. People with lived experience of MHAOD and specific conditions including eating disorders, perinatal mental illness along with carers have also been consulted.

Planning and needs analysis informing and underpinning a new plan is based on the NMHSPF and the Q-DASPM. Additionally, utilisation data and a review of existing infrastructure and bed stock (see section 5.1.9 – MHAOD service need) is considered. This analysis has been further shared with each HHS to ensure local priorities, opportunities for new models and partnerships is considered. See the draft 'plan on a page' at Appendix 2 of this submission which shows high level principles and strategies that have been identified as part of the development to date of a new MHAOD plan.

The current state-funded MHAOD system is guided by a wide range of national and state-based policies, strategies and plans. Many of these were noted in the QH written briefing but importantly include:

- *Shifting minds: Queensland mental health alcohol and other drugs strategic plan 2018-2023* (Shifting minds).
- *Every life: the Queensland suicide prevention plan 2019-2029* (Every life).
- *Queensland Health System Outlook to 2026 for a sustainable health service* (QH System Outlook).
- *Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services* (Connecting care to recovery).
- *The fifth national mental health and suicide prevention plan* (Fifth Plan).
- the *National Drug Strategy 2018-2026* (NDS).

The PC Report, the National Suicide Prevention Adviser's Final Advice (NSPA Advice), and the final report of the Royal Commission into Victoria's Mental Health System (RCVMHS) point to, and in many cases restate, the issues and challenges facing the delivery of MHAOD, suicide prevention, and response across the broad health system in Australia. Many of these issues and challenges exist in Queensland.

5.1.1 Increasing service demand and system pressure

Demand for state-funded MH treatment has been increasing at a faster pace than population growth and workforce increase. More recently, Queensland has seen a growth in population, including interstate migration during COVID-19, experiencing the highest influx since 2004. In comparison with other states/territories has the greatest inflow to regional regions with future impact of an increasing population expected.

Over the past five years there has been an average annual increase of 2.1 per cent in the number of persons accessing this MH treatment and care, with more than 109,000 people accessing a service in 2020-21. This increase in demand creates additional pressure at the entry point into the state-funded treatment system.

HHS report increasing complexity of presentations to services. There is a significant increase in crisis driven referrals from EDs into MH treatment and care, Queensland Police Service (QPS) and QAS. The referrals from EDs nearly tripled from 2010-11 (14,091) to 2020-21 (44,792) with referrals from QAS and QPS doubling from 2010-11 (7,010) to 2020-21 (14,912).

While there have been increasing referrals to MH treatment and care, the number transitioning to ongoing care has only increased by 16 per cent and overall, the number of open services episodes increased by 19 per cent. This is indicating that service capacity, with current models and resource levels, is at its limit. It is also reflective of increasing demand for crisis driven responses (see section 6.2 – Mental Health Crisis).

While HHS MHAOD services have made significant improvements to treatment and care, with relatively consistent annual improvements across a range of patient safety, quality and national performance measures, there has been a recent decline in performance across some areas. This includes an increase in the rates of seclusion which may be a result of the negative impact of the increased pressures on service delivery and individuals experience.

5.1.2 Queensland has the lowest per capita expenditure on mental health

Historically, Queensland has had one of the lowest per capita expenditure on MH services in Australia, being below the national average for the past ten years.

The 2022 Report on Government Services, shows that in 2019-20, Queensland again had the lowest per capita expenditure in Australia. Nationally there was a ten per cent growth in per capita expenditure between 2010-11 and 2019-20, however, Queensland's investment grew at half the rate, with only a five per cent growth over the period, the second lowest level of growth in Australia.

In the February 2022 release of the Mental Health Services in Australia[3] report shows that at $246.90 spent per person, Queensland remains the lowest resourced of all the states and territories in 2019-20, being below the national average of $260.49 per person.

The Report on Government Services 2022 also shows that between 2010-11 and 2019-20 there was a 52 per cent increase in per capita expenditure on public health services delivered by HHSs in Queensland, while for publicly funded MH treatment, care and support, there was a five per cent increase per capita in expenditure over the same period.

[3] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Graph 1: Queensland per capita expenditure growth on overall public health compared to per capita expenditure growth on public mental health, 2010-11 to 2019-20

Source: Report on Government Services 2022, Part E, Section 13 Services for mental health: Released on 1 February 2022. Table 13A.6. Section 12 Public hospitals: Released on 1 February 2022. Table 12A.2. Percentage reflects change between 2010-11 and 2019-20 per capita spend.

5.1.3 Available beds

Queensland also remains under the national average of 35.2 for MH beds and continues to have the lowest number of available MH beds at 32.3 beds per 100,000 Queensland persons in 2020-21.

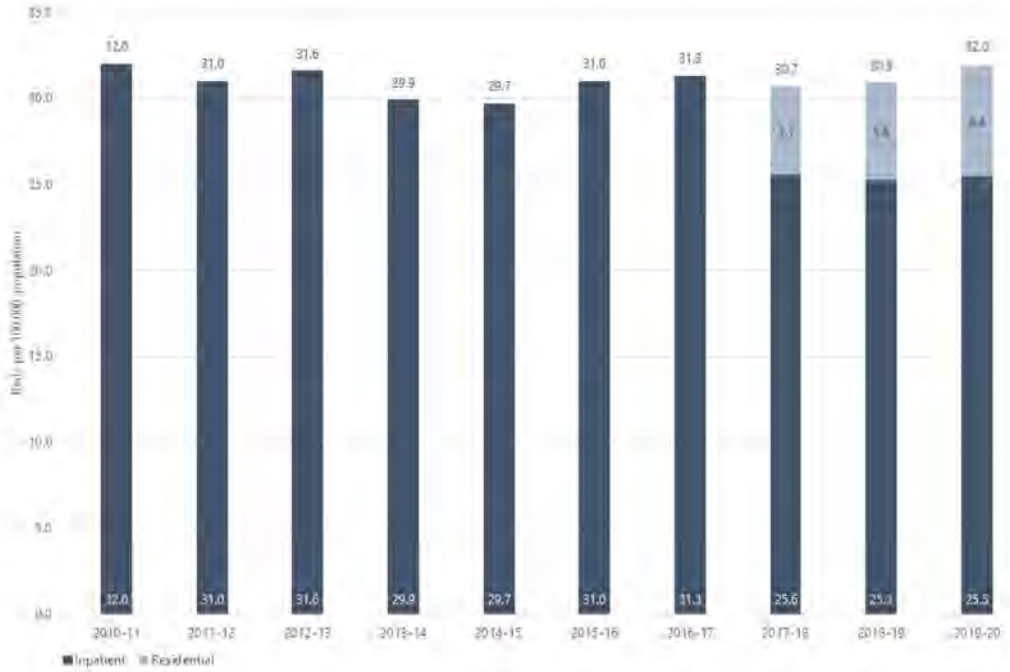
Overall bed numbers are made up of hospital beds (1,312 average available beds at a point in time) and 24-hour staffed residential MH beds (329 average available beds). Most of these beds (53 per cent) are in the acute admitted setting, 27 per cent are in extended admitted (including forensic and secure rehabilitation beds), and the remaining 20 per cent are in community residential services.

Queensland's MH beds per 100,000 persons has remained stable over the past decade, despite the increase in per capita expenditure on public HHSs. The graph below shows the beds and composition from 2010-11 through to 2019-20 (see Graph 2).

For inpatient hospital beds, Queensland remains below the national average of 27.5 public MH hospital beds per 100,000 population at 25.5. However, this is a slight increase from the 25.3 in 2018-19.

While there has been an increase in residential MH beds in 2019-20 of 6.4 beds per 100,000 population up from 5.6 in 2018-19, Queensland remains below the national average of 9.5 residential MH beds per 100,000.

Graph 2: Change in QH hospital and residential beds per 100,000 population, 2010-11 to 2019-20



Source: Report on Government Services 2022, Part E, Section 13 services for mental health: Table 13A. 14. Released on 1 February 2022

5.1.4 Workforce constraints

Workforce availability, retention and sustainability are significant issues impacting service delivery. HHSs and NGOs consistently report that access to and retaining a sufficiently skilled and capable workforce across a range of MH professions is a constant challenge. This issue is more pronounced in Queensland's regional and rural areas. Workforce issues are covered more fully in section 5.2.5 - Workforce.

Queensland has one of the lowest direct care Full Time Equivalents (FTE) per 100,000 persons for MH service provision in Australia, being below the national average for most of the last decade. The 2022 Report on Government Services shows that in 2019-20, Queensland had the third lowest direct care FTE per 100,000 persons in Australia. Overall, for HHS delivered MH services, there were 120.8 direct care FTE per 100,000 population in in 2020-21.

The shortfall in workforce FTE against planning framework projections (NMHSPF and Q-DASPM) is significant. A conservative estimate of more than 1,300 additional FTE is required to partly meet these shortfalls and deliver a balanced workforce across state-funded MHAOD treatment.

The evaluation of Connecting Care to Recovery identifies that while learnings from workforce projects were integrated into practices in some HHSs, a lack of recurrent workforce funding constrained capacity to embed practices across the system.

The evaluation found:

- the workforce continues to be under pressure, which is likely to increase without further investment.

- a significant focus on workforce development will be needed to address workforce pressures.
- the different remote, regional and urban workforce challenges and opportunities will need to be reflected in the activities supported under the next strategy.

5.1.5 Infrastructure is critical

Maintaining, renewing, and redeveloping existing infrastructure to ensure it is 'fit for purpose', along with development of new infrastructure is critical. Investment in MHAOD infrastructure supports quality, safe and contemporary MHAOD models of care and service delivery.

Successive state MH plans have aimed to address identified need for MH capital in response to major policy shifts (for example, de-institutionalisation in the 1990s), increased population growth and contemporary clinical practices and models of service. The Queensland Plan for Mental Health 2007–2017 (QPMH) identified a ten-year target of 40 MH inpatient beds per 100,000 total population. To meet this target, the 2007-08 State Budget committed dedicated funding to support 17 capital works projects across Queensland to expand the range of inpatient beds available and to upgrade existing inpatient services to meet contemporary standards.

Stage 1 (2007-2011) of QPMH delivered 263 re-conditioned and additional beds across Queensland. An additional 99 new Community Care Unit (CCU) beds were established in regional Queensland through a Commonwealth Government capital initiative. Other capital projects slated for Stage 2 of the QPMH were not progressed due to lack of committed capital and operational expenditure. In total, QPMH delivered 251 additional hospital and community based MH beds.

Despite the significant funding boost of more than $350 million in new investment over five years for initiatives under Connecting Care to Recovery from 2016-2021, there was no dedicated capital budget. Notwithstanding this, several mental health capital projects were progressed through other funding streams, capital planning processes and supported through recurrent operational funds under Connecting Care to Recovery. Three new regional Step-Up Step-Down (SUSD) units were announced in the 2016-17 State Budget. The 2017-18 State Budget also provided additional capital funding in response to the recommendations arising from the Barrett Adolescent Centre Commission of Inquiry Report, to establish a new Adolescent Extended Treatment Facility on a site at The Prince Charles Hospital campus, two new adolescent SUSD in Brisbane, and refurbishment of two adolescent day program spaces at Logan and the Gold Coast.

It should be noted, however, that of the 16 HHS acute units currently in use, nine units were initially designed or constructed in the 1990s. A number of these show significant problems of design, capacity and aging which affect patient care. Although there have been some small refurbishments and expansions, at least six require replacement to enable optimised contemporary care. The Cairns unit has already been demolished and is using temporary accommodation until a new unit can be completed in 2024. Three new ward developments (West Moreton, Cairns and Wide Bay) are in advanced stages of planning or construction. Two recent builds (Gold Coast University Hospital and Sunshine Coast University Hospital) are contemporary and provide an optimum environment for care.

Similarly, the two of the four secure mental health rehabilitation units (SMHRU) were designed in the 1990's and show problems of design, capacity and aging which affect contemporary care. The Ridley Unit located at the Baillie Henderson site is more than 40 years old. Community beds are more recent and due to the model of service, are less subject to wear and tear.

A lack of capital investment to support identified planning priorities, the longer lead in time required for capital projects and increasing demand for services have contributed to a plateauing of and shortfall in MHAOD capital when compared with need. While this is pronounced, it should be noted that investment in AOD services and infrastructure has lagged well behind mental health capital investment and requires significant attention.

The Victorian Government's response to the RCVMHS has committed just under $500 million for capital investment across a broad range of projects including digital services, more acute, sub-acute and forensic beds and community-based hubs. This includes a further $20 million committed to undertake coordinated and comprehensive service and capital planning across the MH system to guide future investment and may include upgrades to existing assets, new community service facilities and more new acute beds was also provided. Similarly, the New South Wales Government continues to invest in infrastructure for MH services as part of the $700 million Statewide Mental Health Infrastructure program announced in 2018-19 with more than $65 million allocated for 2021-22.

The time lag associated with capital investment across MHAOD in Queensland and inability to meet demand is already being felt and observed particularly in areas with the highest population growth (generally the southeast corner of Queensland) where demand for acute MH inpatient beds is exceeding inpatient capacity. Several capital initiatives identified in recent planning are directly focused on the need to reduce the rate of MH presentations to EDs and reduce avoidable inpatient admissions to MH acute units, such as short stay beds, SUSD facilities, and crisis support spaces. However, the rate of development and establishment of these types of services and facilities from planning to practical completion can take up to two or more years is outpaced by the increase in demand.

The DoH (MHAOD Branch) has undertaken planning to develop a capital pipeline which identifies key priorities (See section 5.2.1.2 – Capital planning). These include:

- adolescent, young adult and older persons acute beds
- secure mental health rehabilitation unit (SMRHU) beds
- additional CCU beds
- adult and youth SUSD beds
- adolescent day programs
- older persons sub-acute/extended treatment beds.

5.1.6 COVID-19 impacts

The impact of the COVID-19 pandemic, implementation of measures to stop its spread, along with the fluctuating nature of responding to new strains has resulted in significant increases in demand across state-funded MHAOD services. This demand has also been experienced across key human services agencies that augment and intersect with the treatment system,

for example, accommodation and housing; child safety; domestic and family violence support services; financial counselling; criminal justice and education.

State-funded MHAOD workforces have been significantly impacted. Like other parts of the community, staff have had to furlough due to being close contacts or symptomatic or have tested positive. This has placed an enormous stress on the remaining workforce, or the people being deployed into areas they normally wouldn't work in to maintain safe service delivery.

The social and economic impacts to date of COVID-19 on individuals, families and the community are still being realised. There is a high level of concern, based on international experience, that these impacts will coalesce and ultimately result in significant increases in mental ill health inclusive of problematic use of alcohol and other substances.

Work undertaken by the Queensland Centre for Mental Health Research (QCMHR) estimated a 11.4 per cent increase in the prevalence of major depressive disorder and 11.6 per cent increase in the prevalence of anxiety disorders in Australia for 2020 because of the pandemic (compared with a pre-COVID-19 baseline). Women and younger people were disproportionately affected.[4] There is ongoing work to identify trends for each state, and whether this trend will continue.

There is evidence of increased access to AOD and variable changes in other drug use patterns across the COVID-19 pandemic.[5] Online alcohol sales with home delivery options (including rapid delivery within 30 minutes to two hours) account for a growing share of the alcohol market in Australia, having increased by an average of 14 per cent annually over the last five years.[6] This type of supply raises concerns about access by young people, people who are already intoxicated or alcohol dependent and the potential for increased alcohol-related harms to self-and/or others[7].

The average number of referrals to public MH services both inpatient and community grew from 2,835 per week in 2019 to 2,930 in 2020 and 3,008 in 2021. Referrals for MH community treatment services increased by 12 per cent between 2019-20 and 2020-21, with referrals for adolescents (12 to 17 years old) increasing by approximately 20 per cent over this period. There have been notable increases in people presenting with eating disorders (there were almost 400 more referrals for eating issues for persons aged 12 to 17 years, a 97 per cent increase to 806 referrals in 2020-21), anxiety, alcohol and drug problems and adult and child and youth services are reporting significant and unmet demand pressures.

COVID-19 and measures to control its spread has also resulted in disruptions to AOD service delivery, most notably for residential treatment services who have had to reduce clients to

[4] For more information on worldwide effect refer to http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02143-7/fulltext. Australian data supplied by QCMHR in private communications.

[5] https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impact-of-covid-19-on-alcohol-and-other-drug-use

[6] S Colbert, L Thornton and R Richmond, 'Content analysis of websites selling alcohol online in Australia', Drug and Alcohol Review, 2020, 39(2): 162-169.

[7] Alcohol and Drug Foundation, 'Online alcohol delivery – cause for concern', 2020; and 'Retail During COVID-19', 2021

ensure safe social distancing, resulting in drop in treatment episodes.[8] However, this is at a time where there is increasing need. QH's Adis (24/7 Alcohol and Drug Support, formerly the Alcohol and Drug Information Service) reports an increasing rate of calls over the period of the COVID-19 pandemic responding to an average of 3,862 inbound calls per month from Queenslanders seeking support for their own or someone else's substance use in 2021-21.

HHSs report that after any period of lockdown or self-restriction on movements there is a surge of MH presentations. It is expected the MH and substance use effects of the pandemic will continue and demand for MHAOD treatment will continue to increase.

It is difficult to predict the ultimate course of the pandemic and the effects that it will have on MH, substance use and wellbeing. The increases in psychological distress in the community and suicidality in some contexts associated with the pandemic have not yet translated into higher suicide rates. Other increases such as sustained increased youth presentation and eating disorder presentations have been well documented. It is predicted that up to one in three people will suffer from Long COVID, a persistent physical illness with prominent symptoms like fatigue, depression and anxiety.[9]

The longer-term effects on cognition and emotion are not yet clear. Research is currently being undertaken to understand the relationship between COVID-19 and suicide, depression, anxiety, eating disorders and potential cognitive changes which will guide services in the future. There are also several studies that are underway nationally to assess the impact of COVID-19 on AOD use.

There are lessons that can be learnt from current responses – the rise of telehealth, the value of NGO supports, the capacity of MHAOD services to provide physical healthcare support, the changing nature of work and new approaches to care.

Evidence demonstrates that with all-natural disasters the psychological effects can take a long time to present and that the call for psychological assistance will remain long after the physical effects have resolved.

Information about the Queensland Government's COVID-19 support measures for community-based service providers and the Mental Health and Wellbeing Community Package is provided at Appendix 3.

5.1.7 Impacts of the introduction of the National Disability Insurance Scheme

Issues associated with the introduction of the NDIS and its impact on hospitals were canvassed in the QH submission to the Health and Environment Committee Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system (available here). Access to services, thin

[8] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/covid-19-impact

[9] For more information refer to https://www1.racgp.org.au/newsgp/clinical/what-causes-long-covid

markets, supply of specialist disability accommodation, providers relinquishing support and delay in discharging patients were identified as issues.

While the National Disability Insurance Agency (NDIA) has made improvements to the NDIS to better respond to the needs of people with psychosocial disability such as the introduction of complex care planners and the continued education of NDIS planners on psychosocial disability, issues remain.

HHSs have reported NDIS participants including those with psychosocial disability being relinquished by service providers to EDs and MH units due to issues with workforce particularly during the response to COVID-19. HHSs also report that hospital discharge processes have been delayed further by recent changes in the NDIA to centralise decision-making to increase the consistency of decisions.

If an individual with psychosocial disability cannot access appropriate assessments by practitioners with appropriate expertise, their disability may not be apparent. Gaining access to these assessments may be difficult for some groups e.g., those who are homeless, Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) backgrounds, and people living in rural and remote areas.

Even though there are now specialist NDIS planners for people with complex needs, not all people with psychosocial disability will gain access to these planners. This may be exacerbated in a rural and remote areas where the workforce may be thin. If a planner does not have sufficient understanding of psychosocial disability, the need for some supports may not be recognised.

For example, the NDIS funds Supported Independent Living (SIL) supports where they are 'reasonable and necessary' by the NDIA's decision-makers, based on evidence from private and public assessors. If the NDIA assesses level of supports as 1:3 care but the HHS is of the opinion the individual requires 1:1 supports for safe discharge and has provided relevant evidence, there will likely be delays in discharge until further evidence is provided. If the NDIA does not sufficiently recognise the psychosocial issues and therefore fund the level of supports assessed as needed by the HHS e.g., 1:1 supports, there is no other funding mechanism available. This can result in individuals not being discharged. In addition, even if SIL is funded, there is a thin market for SIL service providers particularly for people experiencing more complex behavioural issues. There are reports that in some MH units, delays of 6-12 months have occurred where there are no service providers available for individuals with complex mental health issues or transitioning from secure facilities or those with co-occurring mental illness and intellectual disability. An absence of sufficiently expert disability workers to in reach into hospital settings can lead to a deterioration in prospects of discharge.

In addition, an absence of trained disability support staff in the community can lead to a deterioration of community living and a heightened risk of extended admissions resulting in an individual's overall condition deteriorating.

Access to accommodation is also problematic. The NDIA will fund Specialist Disability Accommodation (SDA), including robust SDA (i.e., housing that has been designed to incorporate a reasonable level of physical access provision and be very resilient, reducing the likelihood of reactive maintenance and reducing the risk to the participant and the community) for those eligible. Even if eligibility can be proved, these individuals must also

obtain required SIL funding and availability of an appropriate dwelling before discharge can occur. SDA is available only for those with very high needs (estimated to be 6 per cent of NDIS participants but currently underused) so many individuals with psychosocial disability will not be eligible and will have a need for public housing. Lack of access to this may also delay discharge.

Gaining access to NDIS Medium Term Accommodation (MTA) so that an individual has somewhere to live while waiting for confirmed long term housing solution is also a concern for those with psychosocial disability. The NDIS only fund MTA for those awaiting disability related supports who have a confirmed long-term housing solution. This has the effect of penalising NDIS participants who cannot access long-term housing due to thin markets. MTA is usually funded for up to 90 days. While MTA is welcomed, access to the NDIS, eligibility for sufficient supports and permanent housing must all occur before MTA can be approved which may lead to significant inpatient delays in discharge.

People in rural and regional areas can also have difficulty accessing NDIS service providers across various areas of support and therefore difficulty in utilising packages.

HHS also report difficulties in appropriate supports being provided to an individual where criminogenic factors may be at play. While it is clear the NDIA will not fund supports that it considers relate to criminogenic factors, HHS may consider the causal factors of the behaviour are due to disability.

This distinction causes issues for many individuals using MH services including those who are subject to forensic orders (MH) and forensic orders (disability) or involved in the justice system. For these individuals who have been diverted away from the justice system to the MH system for 'treatment and care' there is also no funding for these types of supports. Failure in funding for these supports can delay discharge for these individuals. In addition, for those subject to forensic order (disability), MH units are not the appropriate place for rehabilitation and MH staff do not have the expertise or resources to support those individuals with intellectual disability to transition and remain safely to the community.

While the new NDIS Recovery Framework recognises the fluctuating nature of MH issues and psychosocial disability and the need for faster responses and quick plan changes, its implementation will be key to whether it leads to improved outcomes for those with psychosocial disability.

At the end of Quarter 1 2020-21, 10 per cent of participants in Queensland in the NDIS had a psychosocial disability. Modelling by the Productivity Commission during its inquiry into Disability Care and Support[10] predicted this to be 13.8 per cent. In addition, Quarter 1 2021-2022 rates of assessment of access for people with psychosocial disability was 55 per cent.

[10] As reported in *People with a Psychosocial disability in the NDIS Report – 30 June 2020*

5.1.8 Mental illness, substance misuse, and suicide is stigmatised

Stigma is one of the most common reasons for people not seeking treatment.

It has been reported that those living with mental illness experience significant stigma including discrimination across health and other aspects of their social and community life. Additionally, people perceiving their mental health experiences to be stigmatised can result in withdrawal from important life opportunities.

Stigma is experienced across a range of settings including health care, justice and welfare systems, friends, families and communities and creates barriers to seeking treatment, accessing employment, housing and community belonging. Stigma by health professionals toward people with mental illness including problematic substance use is associated with poorer physical health outcomes as physical conditions are often overlooked, not recognized or attributed to aspects of one's pre-existing illness or problematic substance use.

Negative community attitudes, misperceptions, stigma and discrimination have a real and significant impact, including reinforcing shame and creating barriers for people (and their families) seeking help. This is exacerbated for people with problematic substance use and amplified for marginalised groups, particularly for Aboriginal and Torres Strait Islander people who also experience discrimination and racism.

Efforts to reduce stigma for individuals in need of state-funded MHAOD treatment, care and support are required and should be multi-faceted to include population-based approaches, community level interventions with family and communities, interventions aimed at changing the behaviours of professional staff and address structural barriers across multiple systems. These include mass media campaigns, participation of people with lived experience as core practice in policy and program development and service delivery and workforce strategies including education, training, and complaints management.

The PC Report, The Fifth Plan and the RCVMHS report have all raised stigma as significant issues. The National Mental Health Commission (NMHC) is developing a National Stigma and Discrimination Reduction Strategy focusing on addressing stigma and discrimination across the MH and broader health system, financial services, insurance and the law, education and training, employment, social services, disability, income support and housing.

Across the HHSs, stigma reduction campaigns are led by MHAOD services. Several HHSs have taken on the Shatter the Stigma campaign following its development by Mackay HHS. This campaign takes many forms across the state, including promotion of stigma reduction by wearing a Shatter the Stigma shirt on an identified day and conducting awareness raising activities within the HHS and wider community. Wide Bay HHS has extended its program into an ongoing campaign aimed at reducing stigma. This includes staff training and awareness raising and Shatter the Stigma ambassadors across the HHS to promote stigma reduction and work toward change.

5.1.9 MHAOD service need – what the modelling and planning show

As stated previously, QH has undertaken extensive planning and needs analysis to inform a new plan state-funded MHAOD services to follow on from Connecting Care to Recovery.

Development of strategies and actions and is based on outputs from the NMHSPF and the Q-DASPM, current utilisation data and a review of existing infrastructure and bed stock and takes into consideration outcomes of gap analysis and consultation with key stakeholders and relevant State and National policy directions and priorities.

The NMHSPF has undergone significant revision with a new version (4) recently released. This revised model reflects updated epidemiology of disease burden, service demand and evidence. This has resulted in identification of specific service need for young people (18-24 years), eating disorders, First Nations and rural and regional issues. These changes are consistent with feedback from service providers and individuals and carers and align with what the demand data demonstrates from the time prior to and during COVID-19.

It is important to understand the NMHSPF provides a model of the *ideal* service system across all settings and providers, based on epidemiological data from Australia and international sources, contemporary best practice recommendations and expert opinion including people with lived experience and carers.

Modelling shows that Queensland is 61 per cent to NMHSPF projections for acute bed capacity. There are significant service gaps for children and adolescents (63 per cent to projections), young adults (8 per cent to projections), perinatal and infant mental health (8 per cent to projections), eating disorders (11 per cent to projections) and older people (40 per cent to projections). There is currently limited capacity across HHS to meet acute bed needs for these population groups.

For community bed-based services, Queensland is 45 per cent to updated NMHSPF resource projections. Significant service gaps are present for young people, including SUSD beds and youth MH residential rehabilitation. In addition, Queensland is 22 per cent to NMHSPF resource projections for older persons bed-based extended treatment.

Service gap analysis for MH community treatment identifies that Queensland requires more than 1,300 FTE to reach NMHSPF resource projections. Analysis of MH community support services (psychosocial supports) indicates that Queensland is currently 29.6 per cent to projections (it should be noted the PC Report identifies significant service gaps in provision of psychosocial support and recommended that all Governments ensure people have adequate support and for this to be included as part of a new National Mental Health and Suicide Prevention Agreement – see Section 7).

Forensic MH treatment modelling indicates that Queensland is 45 per cent to forensic resource projections for bed-based services and an estimated 65 per cent to projections for FTE for prison mental health treatment. For Community Forensic Outreach Services (CFOS), Queensland is 76 per cent to forensic resource projections.

AOD treatment in Queensland across the continuum is funded through a mixture of Commonwealth and State programs; it is estimated the State is responsible for funding 60 per cent of AOD treatment and harm reduction services in Queensland. As of 2021, an

estimated 65,000 people in Queensland aged 10 years and may meet criteria for AOD dependence and would be indicated for treatment and/or harm reduction services, with a further 525,000 people aged 10 years and over considered 'at risk' of problematic substance use and indicated brief AOD intervention. Of this population, it is estimated that over 350,000 people of all ages require an AOD treatment, harm reduction service or brief intervention funded through Queensland Health.

The estimated service gap for community based AOD bed-based services is also significant. By 2027, the Q-DASPM estimates that Queensland requires significantly more residential rehabilitation and community AOD withdrawal beds.

The new Q-DASPM (which differs from but can be used in a complementary way to the NMHSPF) was delivered in 2021 and is being applied to planning by the DoH for the first time.

Q-DASPM produces *whole of* Queensland resource estimates regardless of funder.

As such, QH has applied a weighting of approximately 60 per cent of total need[11] to enable an initial estimate of the gaps that fall within QH's remit. When measured against Q-DASPM estimates for state-funded AOD community bed-based services (for people aged 10 years and over), by 2027, QH will be 76 per cent to weighted estimates for residential rehabilitation beds and 34 per cent to weighted estimates for residential withdrawal beds.

For AOD community treatment services (for people aged 10 years and over), by 2027, QH is 45 per cent to weighted Q-DASPM community treatment FTE estimates. Of this, opioid treatment accounts for approximately 20 per cent of this FTE requirement.

AOD hospital inpatient beds in HHSs are primarily indicated for complicated withdrawal requiring medical care and can be delivered through hospital admission on medical wards or identified AOD withdrawal beds (e.g., the Hospital Alcohol and Drug Service unit which is a specialist 16-bed capacity unit that accepts referrals from across Queensland but primarily receives clients from the south-east corner). Analysis of the Q-DASPM indicates QH is currently 28 per cent to 2027 projections. The 60 per cent weighting is not applied in this case.

5.2 System enablers

5.2.1 Statewide planning

As stated in QH's written briefing, the DoH, through the MHAODB, has developed expertise in service and capital planning including the use of evidence-based planning methodologies including the NMHSPF and the Q-DASPM. A key aspect of maintaining this expertise is to provide support and advice to HHS to augment local HHS and PHN service planning. This

[11] Weighting derived from Ritter, Berends, Chalmers, Hull, Lancaster and Gomez, 2014, 'New Horizons: The review of alcohol and other drug treatment services in Australia', Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.

planning role is a crucial mechanism to support implementation of national and state policy, services development, and identification of priority MHAOD capital projects.

5.2.1.1 Service planning

Planning for state-funded MHAOD services aims to identify the needs and gaps, both current and projected using three main benchmarking resources – NMHSPF, Q-DASPM and the Mental Health and Addiction Portal (MHAP).

Application of these enables the provision of evidence-based advice to support:

- planning for state funded mental health alcohol and other drug services.
- supporting HHS Local Area Needs Analysis efforts.
- supporting HHS master planning activities.
- supporting Integrated Joint Regional Planning efforts between PHNs and HHSs.

The main outputs include:

- written reports, HHS profiles and regional level advice.
- activity projections.
- NMHSPF and Q-DASPM resource projections.
- stylised analysis of service gaps and needs.

To facilitate a comprehensive understanding of the service system for the state funded MHAOD sector, a range of existing data sources are utilised. While the primary planning tools utilised to establish service benchmarks and gaps are the NMHSPF and Q-DASPM, application of existing service use and population health data to develop a comprehensive evidence base to assess need.

Consideration is also given to several other important factors that influence resource estimations, including regional contexts and population demographics, current service configurations, staffing and infrastructure requirements, and HHS bed flow arrangements. Comprehensive consultation with HHSs and key sector stakeholders supports the application of planning tool outputs and needs analysis to identify priority actions and investments.

The NMHSPF is a world first, evidence-based framework designed to support users (Commonwealth, states and territories), PHNs and HHS to plan, coordinate, and identify resourcing requirements for MH treatment, care and support to meet a given population's need. QH has been an early adopter of this framework which has led to a strong foundation of planning and identification of need.

The NMHSPF provides a model of the *ideal* service system across all settings and providers, based on epidemiological data from Australia and international sources, contemporary best practice recommendations and expert opinion including people with lived experience and carers.

It uses an agreed national taxonomy of mental health services across the full spectrum of care from promotion and prevention, primary care services, and community support services through to the most intensive forms of specialised care and support services.

The NMHSPF model allows age specific modelling and estimation of resources across six age groups with separated modelling for 65+ years age: 0-4 years, 5-11 years, 12-17 years, 18-24 years, 25-64 years, 65+ years and 65+ years Behavioural and Psychological Symptoms of Dementia (BPSD). It can provide estimates of resource and activity demand per 100,000 population which can then be extrapolated to other population sizes, such as a particular state, HHS or PHN region.

Application of the NMHSPF to Queensland's service system promotes a common language and specifications for MH treatment services across the various age groups and provides a robust set of benchmarks to analyse unmet need.

NMHSPF contains modelling specific to rural and remote communities and Aboriginal and Torres Strait Islander peoples. However, the NMHSPF does not include specific modelling for components of the service system that are not MH specific or modelling for MH services for specific populations, including culturally diverse populations and forensic populations.

Development of the first iteration of the NMHSPF was a national project undertaken between 2011 and 2013 to progress a commitment under the Fourth National Mental Health Plan. It is an iterative model and will continue to be updated to reflect contemporary best practice and changes in epidemiology. More recently, the NMHSPF has undergone significant development, with a new version (v4) launched in December 2021 by the Commonwealth DoH, the Australian Institute of Health and Welfare, and University of the Queensland.

Several assumptions underpinning NMHSPF – Planning Support Tool (NMHSPF – PST) v4 differ significantly to previous versions of the NMHSPF, with new service elements also introduced for both bed-based and ambulatory mental health services.

An outline of the most significant changes include:

- Updated demand modelling for acute mental health beds.
- Inclusion of resource estimates for acute eating disorder beds.
- Service demand and resource estimates specific to Aboriginal and Torres Strait Islander populations.
- Service demand and resource estimates specific to regional and rural populations.
- Service demand and resource estimates specific to young people aged 18 to 24 years.
- General updates to epidemiological assumptions underpinning the NMHSPF.
- When applying the NMHSPF, it is important to be aware of the assumptions underpinning the model, and its application to unique circumstances.

Like with the NMHSPF, QH has promoted the importance of ensuring there are robust planning frameworks and tools in place to support AOD service planning including development of new capital. QH commissioned an update to an existing national framework, the DASPM resulting in the Q-DASPM (delivered in 2021). This process was undertaken in collaboration with key stakeholders including QNADA, QAIHC and service providers.

The Q-DASPM is a population-based model for drug and alcohol service planning; to estimate the need and demand for treatment; to use clinical evidence and expert consensus to specify optimal care packages; and to calculate the resources needed to provide these care packages. It includes four different drug types (alcohol, cannabis, methamphetamine, opioids) and covers five age groups (10-14, 15-19, 20-24, 25-64 and 65 plus years). The model

predicts AOD treatment demand through a complex series of calculations, combining databases that include population growth estimates, AOD epidemiology and prevalence such as the Global Burden of Disease, distribution of the severity of different substance use disorders and the successful treatment rate of various substances.

Q-DASPM includes the populations that will require either intensive interventions (community and bed-based treatments for the numbers of people estimated to meet diagnostic criteria for alcohol and other drug dependence) or brief interventions (the at-risk population that may be indicated for lower-level intensity treatment and support) and calculates the staffing and resources required to meet this demand (e.g., number of treatment beds, or clinical AOD nurses). Q-DASPM accounts for regional and/or remote locations by applying a loading within the care packages on non-direct clinical care.

As with all planning tools, there are limitations. The Q-DASPM does not include poly drug use epidemiology, co-morbidities or adjustments for treatment services provided to Aboriginal and/or Torres Strait Islander people. However, the companion Framework can be used as part of the planning process and the population projections of the Q-DASPM to better estimate demand and indicate AOD treatment service resources for Aboriginal and Torres Strait Islander peoples.

5.2.1.2 Capital planning

Maintaining, renewing, and redeveloping existing infrastructure to ensure that they are 'fit for purpose' to support contemporary MHAOD service delivery poses numerous challenges and risks. In addition, new infrastructure is required to keep pace with population growth and the associated increasing demand and to introduce new models of care.

Capital planning at the local and state level occurs through several pathways and departmental processes.

In AOD, state-funded community-bed based (residential) rehabilitation and withdrawal management is mainly delivered through the NGO providers and CCOs. In these cases, treatment is delivered out of capital owned by providers, or in some cases properties owned by HHSs and leased to providers or property owned and/or funded by the Commonwealth Government.

The DoH (MHAOD Branch) has developed a Capital Strategy which aligns to the Queensland Government's Project Assessment Framework (PAF) and the DoH's infrastructure strategy. Departmental capital planning processes currently include system-wide strategic planning for infrastructure, strategic asset management planning, master planning, the capital investment prioritisation process, capital budget bids for the State Budget submission, and oversight and assurance of capital investments through the Investment Assurance Committee.

The MHAOD Capital Strategy considers these interdependencies and, informed by NMHSPF and Q-DASPM analysis, identifies strategic partnerships and strategies to improve the status of MHAOD capital initiatives within the departmental planning and prioritisation process.

The intent of the MHAOD capital strategy is to:

- identify the current MHAOD bed stock to establish a baseline.

- utilise the NMHSPF and Q-DASPM to determine the projected service need for each bed type for each HHS and establish benchmarks.
- identify new infrastructure requirements based on gap analysis.
- identify capital priorities that support key priorities for the next five-year MHAOD plan.
- identify priority for refurbishment/maintenance requirements for MH and AOD facilities.

Service need and gap analysis is critical to the capital plan which is adjusted in line with new or planned beds, existing bed flow arrangements and any MHA2016 authorisation processes. Targets may be established to account for variability across individual HHSs and ensure equity. Information from this analysis, consideration of broader policy or priorities, departmental processes and pathways for investment prioritisation, all contribute to the development of the current prioritised MHAOD capital pipeline.

Long term proactive planning is vital to ensure that there is sufficient capital capacity to meet the increasing demand for services. MHAOD capital planning takes into consideration the significant time lag between increased demand, construction and commissioning of new units and the development and implementation of community-based programs.

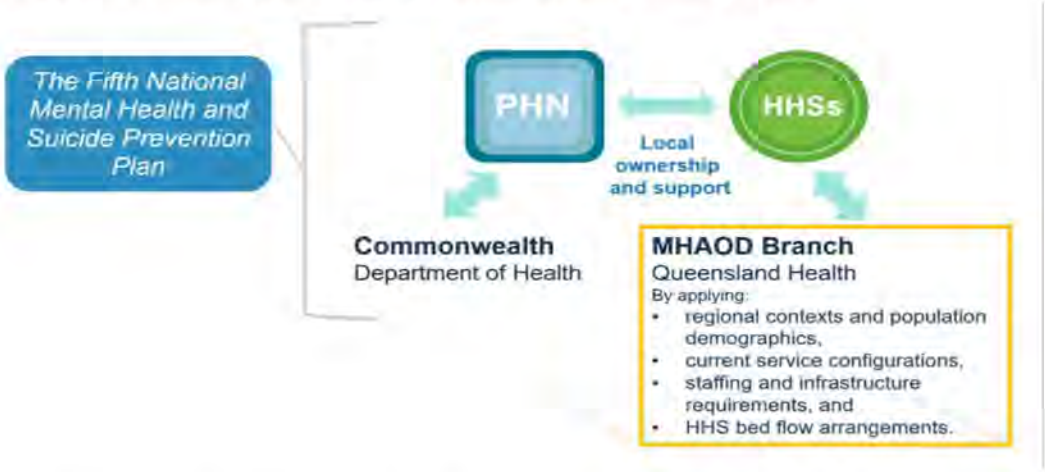
The MHAOD capital pipeline identifies as highest priority those projects that support the priorities determined from recent analysis and planning and includes more:

- adolescent, young adult and older persons acute beds
- SMHRU beds
- additional CCU beds
- adult and youth SUSD beds.
- adolescent day programs.
- older persons sub-acute/extended treatment beds.

5.2.2 Regional planning

Under the Fifth Plan, all Governments signed up to the commitment for PHNs and HHSs to work together to achieve integrated regional planning and service delivery. Central to this action is the development of joint regional mental health and suicide prevention plans using nationally developed tools such as the NMHSPF to guide evidence-based decision making about the right mix and level of services and workforce to meet local needs. Joint regional plans are supported by implementation strategies outlining governance, change management, priorities, milestones, and success monitoring. An iterative process to the development of joint regional plans is advocated with PHNs and HHSs starting with foundational plans and developing more comprehensive plans as the partnership and collaboration matures.

Figure 2: Framework supporting the PHN-HHS joint regional planning process



The DoH supports HHSs to work with their respective PHNs to develop joint regional mental health and suicide prevention plans. These include:

- support the HHSs to jointly develop joint regional plans with their PHNs (for some regions, we have developed workshops to facilitate this process and are members of the local steering committees)
- contribute relevant data to inform regional level understanding of service gaps, duplication and areas of highest need
- training and technical support for HHSs to use the NMHSPF.

Queensland has led the country with development of these plans supported by strong and collaborative relationships between HHS and PHNs. In Queensland, all PHNs and HHSs have completed foundation plans and are working to completion of comprehensive service development plans which are due 1 July 2022.

5.2.3 System and service improvement, excellence and innovation

5.2.3.1 Leadership and culture

'We can no longer assume to solve health systems issues by pretending or conspiring to imagine that they have Newtonian properties, and pipeline models should be seen for what they always were – idealistic, normative renderings of the world. Even though this makes our ambitions to improve healthcare infuriatingly more difficult, we must grapple with the world we actually inhabit, not the one we wish we did.'[12]

Improving the MH outcomes for Queenslanders requires a comprehensive and connected health system that must be robust and flexible enough to provide more effective,

[12] Braithwaite, J., Churruca, K., Long, J. C., Ellis, L. A. & Herkes, J. (2018.) When complexity science meets implementation science: a theoretical and empirical analysis of systems change. BMC Medicine, 16, 63.

sustainable, equitable, and cost-effective health care[13] for all Queenslanders. The experience and impact of COVID-19 has highlighted the significant challenges within the current system, requiring services to rapidly learn and respond to unforeseen challenges under extreme conditions and has added an urgency to the need for clinical improvement reform. Queensland is not alone in recognising this. Queensland has significant pockets of strength to build upon that will equip it to deal with these challenges.

Queensland is not immune to the challenges that are seen world-wide in system and service quality improvement and innovation, which include:

- Ensuring clinical practice keeps pace with evidence, noting the long delays that traditionally exist between new evidence and implementation of that evidence, impacted by external interest groups, limited stakeholder engagement, inadequate funding of infrastructure, workforce, expertise and technology, and cultures that are resistant to improvement and innovation.
- Traditional fragmentation and silos between clinical governance, research, education organisations, digital solutions, strategy and planning, the services delivering clinical services, clinicians, individuals with a lived experience, and the community.
- Recruiting and maintaining a suitably qualified and experienced multi-disciplinary workforce working at the top of their scope and including lived experience workforce.
- Outdated approaches to learning from critical incidents which can inadvertently contribute to limitations of learning and the perception of blame cultures.
- Access to and use of information and digital technologies that support clinical decision-making and planning at the individual, service and policy-level.

Complexity in our health services and systems has been under-appreciated, despite growing evidence for the challenges it presents to system and service safety, improvement, and innovation endeavours. Current approaches to improving healthcare safety and quality are not yielding the improvements required as they do not adequately incorporate our current understanding of complexity of healthcare. Seeing complex systems as essentially componential and linear, traditional approaches tend to overestimate the certainty with which we can understand causes of healthcare failures or predict outcomes of particular quality improvement initiatives.[14,15]

Complexity has been defined as '*a dynamic and constantly emerging set of processes and objects that not only interact with each other but come to be defined by those interactions*'.[16] The whole is therefore more than the sum of the parts. These emergent outcomes are difficult to predict. Therefore, teams must rapidly adapt to these emergent situations.

[13] Enticott, J., Melder, A., Johnson, A., Jones, A., Shaw, T., Keech, W., Buttery, J., & Teede, H. (2021). A Learning Health System Framework to Operationalize Health Data to Improve Quality Care: An Australian Perspective. Frontiers in Medicine, 8, 730021–730021. https://doi.org/10.3389/fmed.2021.730021

[14] Dekker, S. W., Hugh, T. B., Wachter, R., Pronovost, P., Dekker, S., Laursen, T., . . . Peled, H. (2010). Balancing no blame with accountability in patient safety. New England Journal of Medicine, 362(3), 275.

[15] Hirschhorn, L. (1997). A tale of two stories: Contrasting views of patient safety. Chicago, Ill.: National Patient Safety Foundation.

[16] Cohn, S., Clinch, M., Bunn, C. & Stronge, P. (2013). Entangled complexity: Why complex interventions are just not complicated enough. Journal of Health Services Research & Policy, 18, 40-43.

Resilient health care supports approaches that anticipate and respond to these emergent situations, proactively monitoring processes and learning from experiences. Leaders in the complex and high-risk area of healthcare must develop skills in balancing the need for both stability which is required to reliably deliver on complex tasks, and then flexibility to respond to emergent situations. Leaders must constantly monitor the need to balance these stability/flexibility tensions. Developing a culture that therefore supports engaging with multiple and broad perspectives on problems is essential. This requires an acknowledgement of unpredictability, recognition that teams in different settings will modify approaches to suit their context (self-organisation), encouraging connections, relationships, and adaptive capacity, and using conflict productively.[17]

The recognition that leadership and culture represent essential components of patient safety, quality improvement and innovation has been building over the past three decades, and prior to that in other industries. Repeated reviews internationally of failures of healthcare systems have highlighted the central role of leadership and culture, including cultures of blame that lay the ground for adverse incidents and the failure to learn and improve from those. There are links between higher rates of health care incidents and increased levels of staff absenteeism, poor retention and a culture lacking in a safety and quality focus, and the benefits of leadership at every level, including supporting bottom-up processes, reflection and learning, and sustained effort.[18] Sustained improvement in quality and safety is significantly reliant on changing workplace culture. Leadership and culture therefore must be a central priority.

In Australia, safety and quality improvement is guided by documents including the Fifth Plan, the NSQHSS 2nd Ed, 2017 and QH's System Outlook. The Australian Commission on Safety and Quality in Healthcare notes the importance of leadership commitment to driving and prioritising safety, and sharing that vision with others, building mutual trust, engaging workforce including in an awareness that things can go wrong, and supporting optimal learning from adverse events. The National Safety and Quality Health Service Standards sets the expectation that leadership at clinician, service and organizational level to support a culture of safety and quality improvement, inclusive of partnering with individuals and carers, including Aboriginal and Torres Strait Islander communities. The standards provide priorities and strategic direction, incorporating quality and safety priorities into business decision making, and ensuring governance of these processes.

Given Queensland's complex interconnected systems, leadership must ensure engagement of multiple stakeholders in the pursuit of continuous learning and improvement, including individuals with a lived experience, carers, clinicians, research, evaluation, digital capacity, strategy and planning expertise.

Leaders must set a culture of learning within organisations and systems, building a shared sense of purpose, and supporting systems thinking to connect all parts of our system and

[17] Greenhalgh, T. and C. Papoutsi (2019). "Spreading and scaling up innovation and improvement." BMJ 365: l2068.
[18] Short B, Marr C, Wright M. A new paradigm for mental-health quality and safety: are we ready? Australas Psychiatry. 2019 Feb;27(1):44-49. doi: 10.1177/1039856218797423. Epub 2018 Sep 24. PMID: 30244584.

drive advancements in quality in our complex systems. The learning culture must support collective learning and dialogue, and personal reflection.[19]

Leaders have a critical role in supporting cultural reform that prioritises learning, so that there exists a culture that supports individual clinicians, services and the system to learn rapidly, implement that learning and learn from the implementation. This will be considered further in section 5.2.3.2 - Quality, safety, data, research and evaluation, implementation. A Learning Health System ensures that '*science, informatics, incentives, and culture are aligned for ensuring continuous improvement and innovation; best practices are seamlessly embedded in the care process; patients and families are active participants in all elements; and new knowledge is captured as an integral by-product of the care experience*'.[20]

The broader range of quality and safety improvement activities currently being undertaken across MHAOD is described in section 5.2.3.2 - Quality, safety, data, research and evaluation, implementation. There are a range of activities currently being driven at a local HHS level and those supported by the DoH (MHAOD Branch) and it is intended a mechanism to build a quality and safety infrastructure and agreed clinical reform agenda across state funded MHAOD services is developed. This will include addressing issues of leadership and culture. This will aim to support both bottom-up process and agility to respond to emergent issues, in addition to alignment with system priorities.

There are currently a number of specific mechanisms that support leadership and broader engagement and development in safety and quality improvement. These include statewide clinical networks and collaboratives which focus on specific improvement priorities (e.g., physical health assessment, suicide prevention). Two examples are the:

- Mental Health Clinical Collaborative (with a predominant focus on physical healthcare and is leading Australia with a comprehensive smoking cessation program)
- Brief Breakthrough Collaborative for Comprehensive Care.

Each of these networks include a focus on mentoring and supporting the development of local leaders and increasing capacity in implementation science. Leadership and the development of a safety-oriented culture is also a key priority of the DoH (MHAOD Branch) supported Zero Suicide in Healthcare Multisite Collaborative. This Collaborative has reported opportunities for participating services to engage in collaborative problem solving, knowledge transfer, and sharing of resources. These activities have resulted in perceptions of clinicians of greater support by their services.

The MHAOD Quality Assurance Committee whose remit is to support the improvement of safety and quality of public mental health services, has identified the importance of restorative just culture (RJC) for state funded MHAOD service improvement. Consideration of how to implement RJC principles at a state level has been occurring at DoH (MHAOD Branch) level.

[19] Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. (2021). Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems. IHI White Paper. Boston: Institute for Healthcare Improvement.
[20] Ellis L, Sarkies M, Churruca K, Dammery G, Meulenbroeks I, Smith C, Pomare C, Mahmoud Z, Zurynski Y, Braithwaite J. (2022). The science of learning health systems: A scoping review of the empirical research. JMIR Medical Informatics. 02/01/2022:34907

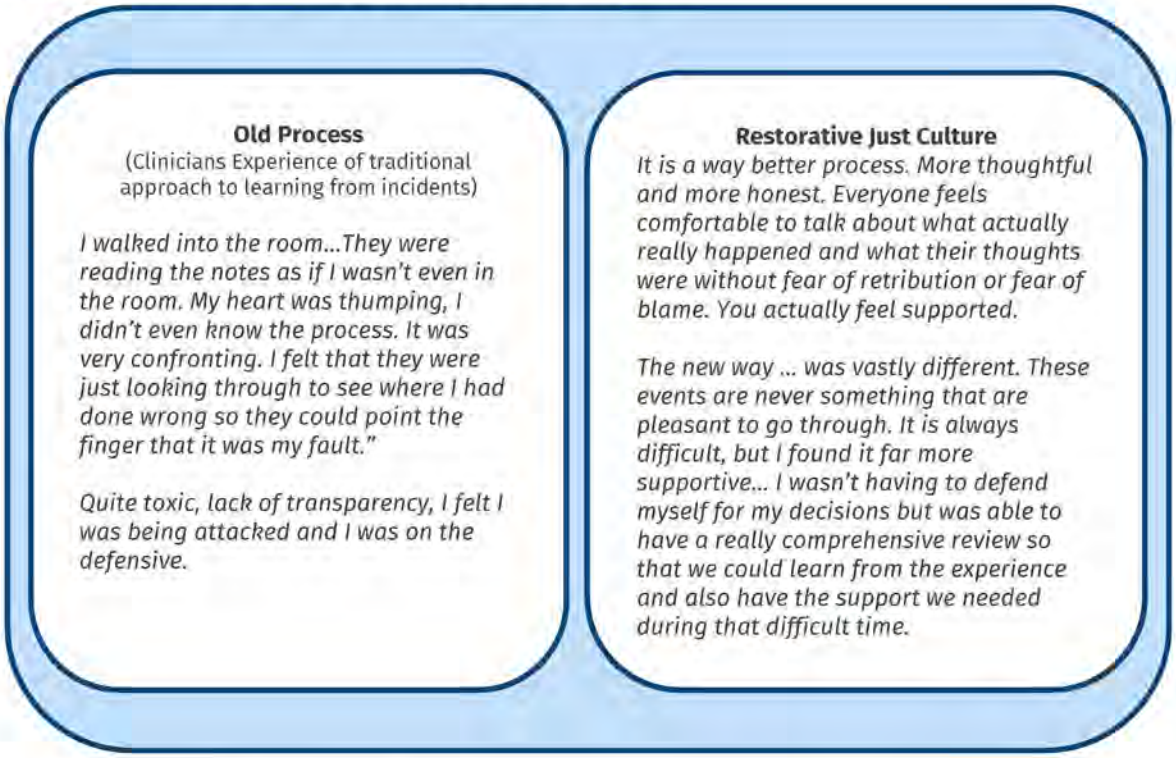
Cultural change is notoriously challenging to bring about. Sustaining it even more so. An example of a cultural change process within the state is the implementation of RJC in a MHAOD service.[21] RJC provides a mechanism to address complexity in healthcare. This approach recognises that adverse incidents, when they occur, are nearly always the result of the complex interplay of systems issues, and that cultures of blame, which are pervasive in healthcare systems worldwide, prevent the individual, service and system from learning and improving, and cause harm to those involved from the family to the clinicians and organisation. This prevents learning and improvement. RJC places focus on a forward-looking accountability that explores the impacts on and needs of all who have been harmed (including patients, families and clinicians). It empowers victims of harm and gives them a central role in the process. It results in non-punitive approaches that support learning, healing and quality improvement that more adequately address complexity, through the more forward-looking conversations that it promotes. Significant achievements have been demonstrated through this cultural change process including improvement in staff perceptions of just culture and second victim experiences, and increased alignment with Resilient healthcare principles. Further, significant improvements in the quality and strength of recommendations developed since the implementation of the framework, most notably on the domain of effectiveness/evaluation[22] have been seen. Given the significant harms that have been demonstrated by existing cultures, a greater level of support for implementation across the system is required.

Clinicians' perspectives on the new process have shown a profound change that supports both a healing and learning process (see Figure 3).

[21] K. Turner, N. J. Stapelberg, J. Sveticic and S. W. Dekker Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework Australian & New Zealand Journal of Psychiatry (2020) Vol. 0 Issue 0 Pages 0004867420918659 Accession Number: 32383403 DOI: 10.1177/0004867420918659

[22] K. Turner, J. Sveticic, D. Grice, M. Welch, C. King, J. Panther, C. Strivens, B. Whitfield, G. Norman, A. Almeida-Crasto, T. Darch, N.J.C. Stapelberg, S.Dekker Restorative justice significantly improves stakeholder inclusion, second victim experiences and quality of recommendations in incident responses (unpublish)

Figure 3: Changes in clinicians' experience when RJC is applied.



Opportunities for improvement

Further support for Leadership development and cultural change is required to achieve the cultural change necessary for service and system improvement.

Effective leadership is integral to the development and maintenance of an improvement focused service culture. Within a safety and quality reform agenda, investment in building the capability and engagement of statewide and service leaders, including clinical leaders, is critical if we are to support improvement efforts, achieve upskilling of staff and effectively promote a commitment to an agreed vision of continuous quality improvement within our health services.

At the statewide and HHS level, the capability to support safety and quality improvement in MHAOD services requires dedicated funding to enable embedded safety and quality improvement. Leadership at the HHS level includes strong service leaders, influential clinical leaders and lived experience leadership to advocate for the importance of safety and quality improvement as a key element of service delivery.

A number of evidence-based strategies can facilitate the development of leadership skills and provide opportunities for leaders/leadership teams to create and support a culture of responsibility, accountability, trust, empowerment and participation at all levels of the organisation. Leadership skills development needs to be resourced and would include a focus on all disciplines at all levels of the organisation and on the lived experience workforce with the objective of:

- developing a greater understanding of complexity and resilience.
- developing an understanding of the central role of culture in ensuring safe and effective care.

- developing skills for articulating a vision for high quality and compassionate care.
- developing skills in co-design and ensuring that consumer and family feedback is always heard, and that lived experience leadership is present at all levels of the organisation. This will require enhanced funding to support the expansion of the lived experience workforce.
- improving understanding and facilitation of continuous learning in organisations, supporting the transparency of data, a reporting culture and embedding implementation science methodologies.
- creating a shift from reliance on positional authority to approaches that facilitate relational approaches to harness conflict and enable cultures that allow for strong challenge.
- developing attitudes, knowledge and skills to bring together all stakeholders for an interconnected system supporting improved quality, more effective, efficient and safe care and that are better places to work.

Cultural change must be a priority as part of service improvement efforts. Supporting the understanding of implementation and maintenance of a RJC will require commitment of resources to support the development of a statewide framework, training, resourcing within services and ongoing support for the workforce.

5.2.3.2 Quality and safety, data, research and evaluation, implementation

Addressing Queensland's MHAOD needs requires a whole of system, cross-sectoral approach that can be flexibly implemented to meet the needs and priorities of local communities. Partnerships between people with lived experience, MHAOD service clinical leaders, researchers, PHN and NGO organisations and government agencies along with enhanced information technology and data analytics capacity are necessary to provide a connected continuum of care for individuals that is evidence-based and ensures seamless communication between agencies, ensuring continuity of care and minimising gaps and errors that place individuals at risk for harm.

At the centre of any health system is the wellbeing and safety of individuals, and their families and carers. Thus, all aspects of the system must be viewed through the lens of how they seek to protect and/or reduce risk of harm for service users and whether they facilitate or impede an individual's safety and psychosocial growth.

This section outlines key aspects of ensuring safe, efficient, and effective health care and issues that are currently faced within Queensland.

Safety and quality improvement are the foundation of efficient and effective healthcare in an environment of ever-increasing demands and complexity. There are links between higher rates of healthcare incidents and increased levels of staff absenteeism, poor retention and a culture lacking in a safety and quality focus.[23] There has been an increasing focus on safety and quality improvement across the world with various MH services internationally

[23] Short B, Marr C, Wright M. A new paradigm for mental-health quality and safety: are we ready? Australas Psychiatry. 2019 Feb;27(1):44-49. doi: 10.1177/1039856218797423. Epub 2018 Sep 24. PMID: 30244584

committed to embedding a structured safety and quality improvement framework to support business as usual across their service.

In Australia, safety and quality improvement is a targeted priority area under the Fifth Plan. The NSQHSS 2nd Ed, 2017 produced by the Australian Commission on Safety and Quality in Health Care provide a consistent national framework to assist improvement of service provision, identifying the essential elements of high-quality comprehensive care, as well as organisational functions integral to supporting the provision of care.

QH's System Outlook provides a framework for a coordinated, system-wide response to growing demand for health services based on three interrelated directions:

- transform health services to improve health outcomes.
- optimise the system making the best use of resources.
- grow the system to maintain access.

A focus on improvement of QH's MHAOD services through transformation and optimisation of service capability is critical.

Data and Information systems provide critical information for making care decisions and plans and for informing service and policy-development. However, these innovations and technologies require ongoing review and update to ensure that they are fit for purpose, that they work as intended and that there is a workforce that is trained and committed to using them. The utility and effectiveness of existing systems require review for functionality, relevance and a commitment to resourcing the capacity to analyse and report on health outcomes and evolving issues is needed. Some of these issues are further articulated in section 5.2.3.3 - Making Time to Care. To address this, QH (MHAOD Branch) finalising a framework for improving the experience and outcomes for individuals using state funded MHAOD services, through digital health innovations. The strategy will inform the planning, funding and delivery of MHAOD healthcare leading to better integrated information capability that delivers benefits to our consumes, service providers and workforce over the next five years.

Research, evaluation, and implementation are critical aspects of a well-functioning health system and are central to the delivery of safe, efficient and effective care. Best practice approaches to caring for people experiencing severe and complex or crisis MH and/or alcohol and drug issues require constant attention to the evolving evidence-base for assessment, diagnosis and treatments and interventions. Research and evaluation inform the development of clinical care pathways, service models and specific treatments and provides essential information about whether these approaches work in the ways in which they are intended.

In Australia, research and evaluation is often considered as disconnected or additive to delivery of health services and is typically under-funded when compared to other developed nations. Best practice assessment and treatment requires an ongoing commitment to careful and systematic integration of research and clinical practice. Thus, commitment to a statewide improvement framework that views the relationship between clinical care and research as bi-directional is critical to ensuring that Queenslanders receive best practice care tailored to their needs.

Delays between the identification of new evidence and its implementation into and across services are well recognised. They are driven by multiple factors including: external drivers (e.g., political pressures; vocal interest groups, level of stakeholder engagement, inadequate funding of infrastructure and technology); organisational barriers (e.g., a culture resistant to improvement and innovation; inadequate resources, inappropriate staff skill mix, staff engagement; individual professionals identity, and competencies); and the characteristics of the intervention itself (e.g., level of evidence, ease of use; appropriateness in the setting). Addressing these complexities is critical to success in realising improvements.[24]

Safety and quality improvement: The DoH (MHAOD Branch) supports HHSs with a range of clinical governance activities to promote quality and safe care in MHAOD treatment, care and support. The leadership and direction provided by the DoH aims to drive quality and safety priorities aligning with a clinical reform agenda and national and Queensland directions. These approaches are combined with bottom-up approaches by clinicians, and leaders in services, in collaboration with people with lived experience and carers, to identify critical areas of priority, examples of innovative practice and early adoption of best practices to support the system.

Safety and quality improvement is an enabler for the reform agenda and is currently a priority as part of the development of a new MHAOD plan.

Data and Information: The QH has an established information capability, including a statewide clinical electronic record, known as the Consumer Integrated Mental Health Addiction (CIMHA) application and the Mental Health and Addiction Portal (MHAP), which provides business intelligence capability to the sector. These systems support business intelligence for HHSs and the DoH (MHAOD Branch) in ongoing implementation of statewide clinical improvement initiatives and continuous quality improvement.

QH MHAOD services have a strong history in the use of performance data to inform change and support reform. This is underpinned by statewide frameworks, strategies and reporting. Routine performance data is accessible by HHSs at Executive and frontline service delivery level to monitor and explore opportunities for improvements.

Continued development of the infrastructure, capacity and culture that delivers mature, predictive analytics will support planning, resource utilisation and clinical service delivery in real time.

Research, Evaluation and Implementation: The provision of safe, efficient and effective care is the responsibility of all stakeholders, across all levels of the healthcare system. Adoption by healthcare systems of an improvement framework which includes all stakeholders, using a combination of effective top-down and bottom-up strategies, should be informed by the improvement science evidence-base. A range of statewide mechanisms exist to support collaborative health leadership and engage clinicians in continuous quality improvement in the delivery of consistent, safe and quality care. These mechanisms include statewide

[24] Lau, R., Stevenson, F., Ong, B. N., Dziedzic, K., Treweek, S., Eldridge, S., Everitt, H., Kennedy, A., Qureshi, N., Rogers, A., Peacock, R., & Murray, E. (2016). Achieving change in primary care-causes of the evidence to practice gap: Systematic reviews of reviews. Implementation Science: IS, 11(1), 40–40. https://doi.org/10.1186/s13012-016-0396-4

clinical networks and collaboratives which focus on specific improvement priorities (e.g., physical health assessment, suicide prevention).

A significant challenge and opportunity exist in supporting sufficient structure so expertise may be adequately translated to clinical improvement, strategic policy and service planning activities. While the QH has established a sound framework to support safety and quality improvement in MHAOD services, further work and resources are required to align efforts and enhance service and clinician capability in reliable and valid approaches to safety, quality improvement, digital readiness and the embedding of research, evaluation and implementation science as core functions of the health system.

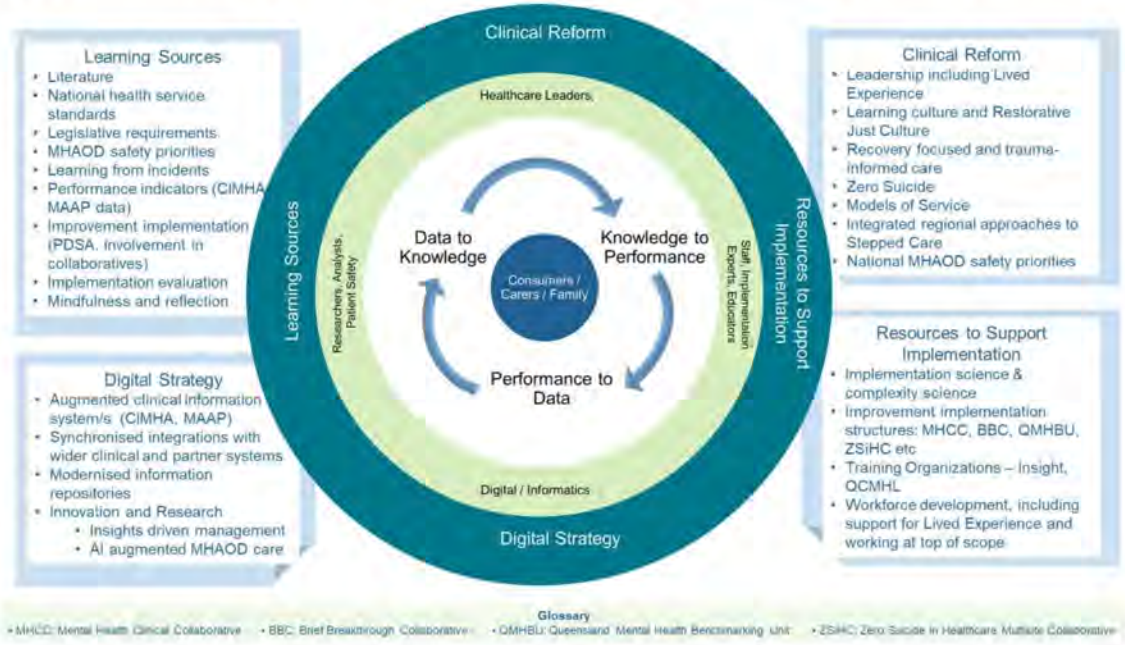
Opportunities for improvement

To guide and optimise safety and quality improvement efforts by HHS leaders and frontline clinicians, state funded MHAOD services require a clear and achievable framework to drive safety and quality activity across the state. The DoH (MHAOD Branch) aims to provide a mechanism to build a quality and safety infrastructure and agreed clinical reform agenda across state funded MHAOD services.

This safety and quality improvement program aims to enhance the capability of QH to ensure a learning culture to build the capacity that places service quality, improvement, innovation and excellence as a central priority of health care that supports services to undertake safety and quality improvement initiatives in MHOAD services. The aim is to meet the NSQHSS using an evidence informed safety and quality improvement framework, that supports rapid translation of innovation and best practice.

While a process to develop a safety and quality improvement framework will require engagement with multiple stakeholders, the following figure (Figure 4) articulates in a preliminary way, the important priorities, processes and connections that might exist in any future framework.

Figure 4: Elements of safety and quality improvement and innovation in state-funded MHAOD services



The enhancement of system and service capability in quality and safety improvement is required. A statewide Framework for quality and safety improvement requires a shared vision of clinical reform agendas (a framework), leadership, staff and service capability and digital capability.

The current range of mechanisms and funded services that drive safety, quality and improvement would benefit from harnessing all efforts, streamlining approaches to the priorities that align with clinical reform agendas as well as shares knowledge, skill and experiences across the state. The bringing together and sharing of knowledge, insights, and opportunities from these various statewide and HHS led groups will support a consistent approach in safety and quality improvement across Queensland MHAOD services. Importantly all these components work together in an interconnected way, as a learning health system.

The challenge for state funded MHAOD services is to harness the improvement capacity already available within the system, and to bring together the expertise, the passion, the time and the funding required to build a culture and practice which is supportive of change and continuous healthcare improvement.

- Individuals, families and carers at the centre

  The centre of any future model would be individuals, families and carers and all aspects of the system are viewed through the lens of how they seek to protect and/or reduce risk of harm for service users and improve experiences and outcomes.

- Learning drives the clinical reform agenda

  A structured consideration of the sources of learning for an organisation has been considered in the literature.[25] Within the state funded MHAOD service context, these sources would include:

  - published literature
  - grey Literature
  - involvement in collaboratives
  - feedback including from individuals and carers
  - relevant national standards
  - national MHAOD safety priorities
  - Chief Psychiatrist policies
  - learning from incidents
  - learning from data (CIMHA; MHAP) including from evaluation of implementation
  - mindfulness and reflection.
- The clinical reform agenda

  Top-down and bottom-up improvement efforts are required across a range of clinical quality and safety improvement areas. The statewide MHAOD safety and quality improvement program will guide action by the DoH (MHAOD Branch) to support evidence-based improvement initiatives required for health care reform across the priority areas outlined in the draft MHAOD Plan and in keeping with the draft national MHAOD safety priorities, for consideration for adoption by QH, and in alignment with current clinician led reform agendas.

  - Supporting leadership development including lived experience in quality, safety and improvement.
  - Building support for a cultural change in state funded MHAOD services and consistent commitment to healthcare improvement.
  - Ensuring a culture that encompasses recovery principles, trauma informed care, least restrictive practices, partnerships, co-design, and RJC.
  - Models of Service that are refined based on evidence, informed by the learning process, include consideration of integrated regional approaches, use stepped care models, and are linked with the Digital strategy.
  - The National MHAOD Safety Priorities are outlined in Box 1.

[25] Edwards, M. T. (2017). An Organizational Learning Framework for Patient Safety. American Journal of Medical Quality, 32(2), 148–155. https://doi.org/10.1177/1062860616632295

Box 1: National MHAOD safety priorities

Priorities for reform have been identified through extensive consultation with consumers, clinicians and service leaders. These priorities underpin and inform existing, planned and proposed safety and quality improvement initiatives which will drive clinical reform by mental health alcohol and other drug services, which include:

1. Partnering for improved safety
   a. Enabling consumer led care, supporting informed choice
   b. Implementing the Australian Commission on Safety and Quality in Health Care Comprehensive care standard across HHS mental health alcohol and other drug services
      i. Continuing the integration of care across mental health alcohol and other drug services through a shared electronic health record and use of comparative data
      ii. Consolidating implementation of Comprehensive Care: Partnerships in Care and Communication
      iii. Enhancing prevention-oriented risk management capability and practice
   c. Building mental health alcohol and other drug services service capability to identify and manage multimorbidity across physical and mental health, alcohol and other drug and intellectual and developmental disability co-morbidities
2. Enhancing responses to deterioration
   a. Implementing the National Safety and Quality Health Service Standards Recognising and responding to acute detericration standard across mental health alcohol and other drug services
   b. Enhancing approaches to prevention and care of deterioration, including relapse, and the crisis support system
   c. Promoting stepped care models linking across primary care and specialist mental health alcohol and other drug service providers
3. Providing trauma-informed care
   a. Enhancing service responses to trauma
   b. Identifying domestic and family violence and targeted service responses
   c. Reducing restrictive practices
   d. Improving care for people with a personality disorder
4. Improving medication safety
   a. Improving quality and safety of medication management, including prescribing, dispensing, administration practices and the monitoring of adverse medication incidents
   b. Supporting prevention and treatment of opioid dependence, through opioid stewardship and expanded treatment availability
5. Reducing suicide and self-harm
   a. Continued implementation of the Zero Suicide in Healthcare framework and crisis system reform initiatives
6. Increasing the safety of transitions

- Resources to support implementation
  - Development of expertise in implementation science and complexity science
  - Collaboratives - Mental Health Clinical Collaborative, Brief Breakthrough Collaborative, Zero Suicide in Healthcare Multisite Collaborative
  - Queensland Mental Health Benchmarking Unit
  - Training Organizations – Insight, QCMHL
  - Investing in workforce development, including support for lived experience workforce and working at top of scope.
- Digital strategy

  Improved integrated information technology including the provision of evidence based stepped care e-health approaches; effective utilisation of routinely collected data including individuals and carer experiences and outcomes; technological solutions to assist with planning and assessing progress and outcomes of care at the individual and service level.

- Continual improvement cycle

  Embedded in the framework is the reciprocal and bi-directional relationship between data, knowledge and performance. The knowledge obtained by the human resources (leadership, clinician, people with a lived experience, researcher) and established data and information systems. The knowledge drawn from these various sources then results in recommendations and translation of knowledge into practice. This approach contributes to a reduction in the lag between evidence generation and implementation and requires ongoing input with fidelity and accuracy to ensure that meaning can be made, and that practice and policy evolves with the evidence.

  This safety and quality improvement initiative aims to set the direction for a sustainable approach to MHAOD service safety and quality improvement into the future which will transform health services to improve health outcomes, optimise the system to make the best use of resources and grow the system to maintain access in an environment of rapid demand increase. Additional resources are required to support the elements outlined above and to enhance the capacity of DoH (MHAOD Branch) and HHSs to advance excellence in safety and quality across the healthcare system.

5.2.3.3 Making time for care

Clinical documentation of care and data collection are critical to health care safety and quality, to track planning, provision and progress of care, legislative requirements, and supporting funding. Information driven decision making can support improvements in safe and quality care with routine clinical data informing research and evaluation to expand our evidence base and improve practices.

Accurate and meaningful information increases our capacity to understand what works for whom and under what circumstances, thus enabling clinicians to develop evidence-based care plans tailored to individual needs; service providers to explore factors associated with intervention effects across groups of people with a lived experience, improving service planning processes; and policymakers to develop priorities, pathways and standards for clinical care.

Electronic health records have led to improvements in quality and safety, diagnostic accuracy, improved continuity of care across settings, support for visibility of key performance measures and support for guideline-based care. Despite this, there are unintended consequences of electronic health information systems including increased documentation time, with this burden itself being associated with negative impacts including errors, poor quality of documentation, reduced time with individuals receiving services, workforce retention issues and clinician burnout.[26]

[26] Moy, A., Schwartz, J. M., Elias, J., Imran, S., Lucas, E., Cato, K. D., & Rossetti, S. C. (2020). Time-motion examination of electronic health record utilization and clinician workflows indicate frequent task switching and documentation burden. AMIA Annual Symposium Proceedings, 2020, 886–895

Clinical information gathering and documentation offers a particular challenge in busy clinical contexts. If it is not time and cost-effective and easy to understand there is likely to be limited effort with gaps and errors in recording.

Technical assistance is needed for regular and accurate information collection practices[27] and to ensure that data collected can be analysed and reported in reliable, timely and meaningful ways. Data collected must clearly match the needs of clinicians and individuals receiving services, as well as policymakers.

Accurate information assists service providers and funders to adapt and pivot priorities to address increasing complexity and adverse events (e.g., natural disasters, COVID-19). Therefore, system reform must include strategies to minimise administrative burden and support the healthcare workforce to gather key clinical information accurately and record in a timely manner.

In doing so, this requires recognition that this burden is occurring in the context of increasing demand for mental health services and in the face of inadequate staffing and resources. There is also a disconnect between data requirements and clinical care provision, so that clinicians either perceive that the information collected does not assist effective care and/or they are unclear how and why data is collected and used. This impacts staff wellbeing, increasing demands, creating frustration and concern and reducing job satisfaction. They have been implicated as significant contributors to staff burnout. For example, the PC Report noted that health professionals providing MH services often experience stigma, stress, burnout and high turnover, this is undesirable not only for health professionals and providers but because it adversely affects the quality of care received by individuals.

A nuanced understanding of these issues will support more comprehensive efforts to address them, including:

- inadequate levels of staff and their training.
- clinical documentation structure including design, number and recommendations for use of forms.
- MHA2016 compliance requirements.
- fragmented flow of information in CIMHA and cumbersome functionality.
- lack of opportunities for input from other sources such as lived experience input.
- fear of blame and risk aversive documentation practices.
- lack of ability to connect information across settings both within the public health system and externally.
- lack of funding support to deliver a comprehensive program of enhancements to infrastructure to keep pace with service reforms, technology advances and digital innovations.

[27] Blanke, A., & Walzer, N. (2013). Measuring community development: what have we learned? Community Development (Columbus, Ohio), 44(5), 534–550. https://doi.org/10.1080/15575330.2013.852595

Such improvement efforts will require change management/implementation expertise that accounts for resistance to change that is considered a threat to clinical autonomy.

In line with the importance of a continuous improvement approach, there have been repeated reviews and updates of the clinical documentation suite of forms and CIMHA since 2008. Recent benefits have been achieved in reducing the number of electronic medical records and in moving HHS alcohol and other services into CIMHA, providing a significant improvement in patient safety, with greater transparency to support continuity of care, clinical handover, reduced duplication, greater support for the best practice of more integrated approaches to co-occurring AOD and other MH issues. The review and update of forms to improve the delivery of comprehensive care importantly have come with training and change management strategies based on evidence-based implementation science (Brief Breakthrough Collaboratives focusing on elements of comprehensive care such as Formulation and Care Planning) and including engagement of lived experience, clinicians, and service leaders and utilised routinely collected data in a data driven improvement approach. However, clinician concerns about this issue remain an enduring theme.

Other current advantages of CIMHA include the availability of clinical plans that can be accessed by police and ambulance at times of crisis for an individual. This access provides a great opportunity to improve the safety of the individuals and others, and support for person-centred, individualised responses at times of crisis. However, there are challenges regarding the governance and currency of the plans, particularly for individuals whose care has been closed to the MH service. There are also concerns regarding the alignment of those plans with the reality of the resources available to ambulance and police at those times of crisis. Further work in this area is required.

There are advanced plans underway for secure transfer of electronic forms from CIMHA, specifically Transfer of Care, Care Plans and QH letter Template into General Practice Software. This is an important activity to support efficient and safe transitions of care, and support for regional connected responses to the care system with a focus on primary care.

CIMHA contains a wealth of data that can be mined to support service improvement efforts and system improvement priorities. The DoH (MHAOD Branch) continues to improve access to performance reports, including the national performance indicators through mechanisms such as the Mental Health and Addiction Portal (MHAP). MHAP is a business intelligence solution that provides the foundation for improved reporting, analysis and access to mental health alcohol and other drug data through leveraging a data warehouse to collate, integrate and transform disparate data from multiple source systems. For users, MHAP enhances and creates efficiencies in creation, delivery and accessibility of MHAOD related data and analytics, creates a secure platform for access to a broad range of information that is utilised for service evaluation and planning, performance monitoring and investigation and to support clinical and business processes.

Importantly, linkages between the DoH (MHAOD Branch), frontline clinicians and mental health and AOD services through data and Key Performance Indicators (KPI) reporting enable the joint identification of clinical priorities, interpretation to support improvement efforts along with their evaluation and refinement.

Increased capacity in the system to support analysis of routinely collected data ensuring its value for clinicians, individuals with a lived experience and service leaders would support

further improvement efforts as well as link documentation being made by clinicians to important clinical outcomes.

A recent example of this was the work of the Formulation Brief Breakthrough Collaborative with DoH (MHAOD Branch). The initiative developed word searches of routinely collected data and efficiently evaluate the impact of these improvement efforts of teams without further burden on clinicians. It also had the added advantage of highlighting the benefits of flow of information in CIMHA and use of appropriate forms for clinical assessments. In addition, the DoH (MHAOD Branch) provided a video that highlighted the benefits of the flow of information in CIMHA and current CIMHA functionality with the aim of reducing duplication of efforts by clinicians.

This highlights that a great deal of untapped information in CIMHA could be used to enhance clinical outcomes and support clinician engagement, however these processes require adequate resourcing.

Opportunities for improvement

It is paramount that within Queensland a strategic and linked up approach to advancing streamlined, fit-for-purpose clinical documentation and mechanisms for data sharing is embedded and supported within a comprehensive framework. Documentation burden is multifaceted and complex. Bringing about change is always challenging and that challenge in this area is often under-recognised. Solutions necessarily span workforce, planning and funding, clinical governance expectations, digital capability, individuals with a lived experience and clinician expectations, leadership and culture.

- Leadership, culture, co-design, collaboration

  Given the span of possible solutions, a systems level response must include representatives from across the DoH (MHAOD Branch), lived experience and clinician representatives, leadership from HHSs in any co-designed solutions. Given the themes of defensive, risk averse documentation practices, a RCJ (see section 5.2.3.1 – Leadership and culture) can support this.

- Learning

  Given the importance of avoiding oversimplification and ensuring a more nuanced clarification of these issues, a broad range of sources of learning are required to inform any iterative solutions, including literature review, review of quality and safety standards, reaching out to other jurisdictions; contact with exemplar organisations; and feedback from individuals, carers, clinicians and leaders.

  The mental health sentinel event review (*When mental health care meets risk: a Queensland sentinel events review into homicide and public sector mental health services*[28]) was a driver of recent reviews into documentation and remains an important driver. This and other incident reviews have been conducted within a limited Safety I

[28] QH (2016) When Mental Health Care Meets Risk: A Queensland sentinel events review into homicide and public sector mental services: Final Report. Available from https://www.health.qld.gov.au/__data/assets/pdf_file/0026/443735/sentinel-events-2016.pdf

approach, rather than Safety II or using Resilient Healthcare principles. While these drivers represent important considerations that can drive improvement, they are incomplete and may result in unintended consequences where the impacts of the designed solutions may be inadequately anticipated (e.g., lack of adequate consideration of critical issues that impact documentation burden such as thoroughness and efficiency trade-offs, understanding demand and capacity mismatches, understanding misalignments such as clinician/information system misalignment, and the range of potential solutions and the possible impacts of those proposed solutions).

A significant contribution to learning and the design of solutions in this area is human factors and ergonomics (HFE), recognising this as an under-utilised but evidence-based approach to design of health information systems including electronic medical records. HFE is the use of knowledge about human functioning (e.g., physical, sensory, emotional, and intellectual) and limitations to inform system design. Usability in this *context "goes beyond the features of the interface (e.g., legibility of texts, layout or prompting) to address the compatibility of a system behaviour [sic] with users' needs. This approach considers human-machine mismatches as one basis of human errors and emphasizes the importance of user-centric design to guarantee the overall performance and safety of a system."* [29]

- Digital innovation

  Funding and implementation of the Digital Information Strategy (DIS) will support many of these efforts. The DIS describes a future which will transform the approach to care delivery with greater participation of individuals receiving services enabled by contemporary digital innovations (see section 5.2.3.4 – Digital capacity and information technology).

  This transformation will be delivered utilising a horizon-based approach delivering incremental capability over time. Investment will be utilized to optimize QH's existing digital footprint while deploying advanced features in a managed way.

  – Horizon One (1-2 years) will establish the foundation and deliver pre-requisite optimisation enhancements.
  – Horizon two (Years 3-4) will support optimisation through advanced clinical information capabilities and transformation via modern individual service user engagements channels.
  – Horizon three (Years 5+) will continue transformation via individual self-care and collaboration and grow the system via intelligent decision support capabilities.

  The delivery of these identified outcomes is critical to align initiatives to existing priorities and investments within the wider QH system to optimise cost and effort and realise synergies across the health eco-system.

[29] Pelayo, & Ong, M. (2015). Human Factors and Ergonomics in the Design of Health Information Technology: Trends and Progress in 2014. Yearbook of Medical Informatics, 24(1), 75–78. https://doi.org/10.15265/IY-2015-033

Adopting the solutions described and delivering on the digital capability requires wider support and investment from QH, its partners and other participants.

5.2.3.4 Digital capacity and information technology

Historically, there has been a siloed approach to the development and implementation of information technology capability across the state-funded health system, driven by both DoH and local HHS priorities. The statewide CIMHA went live in 2008. Some statewide capabilities (i.e., The Viewer) are available universally whereas others such as ieMR and RIVer are delivered to portions but not all areas of QH. This approach has led to clinical risks, inefficiencies and duplication of effort, impacting on appropriate information sharing to support patient safety, continuity of care and the achievement of a personalised and integrated health system across MHAOD and physical healthcare.

In 2021, to better understand and address the challenges in information sharing and optimal service delivery, the DoH (MHAOD Branch) developed the MHAOD Healthcare DIS, and the Digital Information Investment, Solutions and Delivery Framework (Roadmap). Aligned to the Digital Health Strategic Vision for Queensland 2026, and incorporating learnings from the findings of the RCVMHS and the PC Report, implementation of the DIS will seek to 'advance healthcare and outcomes for Queenslanders with mental health and substance issues, through digital health innovations and integrated information'. The aim is to clarify and strengthen the alignment of information priorities, infrastructure between MHAOD and the broader QH information and digital ecosystems to address risks, issues along with inefficiencies associated with the current state.

To inform the development of DIS and Roadmap, over 200 stakeholders were consulted across reference, technical and focus groups incorporating perspectives from individual users of state-funded MHAOD services, their families and carers, HHSs, clinical and non-clinical workforce and information management, QAS, QPS, Queensland Corrective Services, NGOs, eHealth Queensland, and Clinical Excellence Queensland. Lived experience consultation strongly informed the future vision. Individuals, their families and carers articulated the desired use of digital innovation to improve their service experience in order to create a single point of access and information for self-management to support information sharing across the sector to reduce the need to retell their story and experiences again and again.

QH MHAOD program has a well-established information capability which supports service delivery across public MHAOD services. This includes a statewide MHAOD electronic record capability, known as the CIMHA application; the Mental Health and Addiction Portal (MHAP) which provides business intelligence capability to the sector, and substantial data holdings and information management expertise.

QH also have dedicated resources across the state (clinicians with specialist skills in information technology) who provide training, support and education to clinicians and service managers in the areas of digital information literacy, quality improvement and integration of digital information in clinical care and management. This supports a culture of data-informed practice enabling service development and better outcomes for individuals, their families and carers.

Opportunities for improvement

Appropriate investment to support implementation of the DIS and Roadmap will provide opportunities to capitalise on integration and use of existing data sets across multiple sectors. These data sets have the capacity to deliver substantial insights to drive improved policy, decision making and clinical/business processes. In partnership with universities and research institutions, the application of data and analytics will be more closely anchored to solving the most challenging problems within the sector to address integration of capability across policy, planning, clinical governance and to develop information literacy across the workforce.

The future state will:

- Transform services through collaboration, information sharing and use:
  - providing self-service access to individuals health data and relevant self-care information as and when they need it.
  - empowering people to be partners in their self-care by providing opportunities to collaborate while encouraging active participation on their health outcomes.
  - better coordination across the care continuum by enabling access to relevant clinical insights at the point of care and during service encounters with other government and non-government services.
- Optimise services through better use of resources:
  - enhancing information exchange for safety and efficiency by reducing the administrative burden and potential for human error.
  - providing streamlined information access and task automation to deliver information that is available in a timely manner, relevant to specific needs and leverages technology enabled efficiencies.
  - providing advanced decision support capabilities to clinicians, service partners and individuals for improved care-related decisions.
- Grow effective, efficient and safe services that meet evolving needs of people with a lived experience and community through a sustainable foundation:
  - enhancing information exchange and equity of access with broader service partners to address individuals or communities with unique needs and challenges (e.g., rural and remote areas).
  - setting evidence-based priorities for service growth needs by having advanced business intelligence tools and augmented data holdings to support decisions on MHAOD models of care.
  - managing sustainability and alignment with strategic directions of the information capability via flexible, modern information technologies and infrastructure, which can deliver functionality in an agile manner and can scale to meet evolving system needs and expectations.

The future state acknowledges the digital infrastructure and access limitations across some Queensland communities and the adoption of digital technologies and innovations augments existing approaches to service delivery, but to further enhance and grow how and where state-funded MHAOD services can be accessed.

5.2.4 Legislative framework for mental health

The capacity to deliver involuntary treatment is a necessary pillar of the MH system. More than half of acute admissions to acute MH in-patient units are involuntary and although the involuntary order may not be required for ongoing care, it is a major mechanism to protect people from harm to themselves and/or others. Whilst voluntary treatment is the gold standard, it is not always possible to do so. From a human rights standpoint there is a tension between ensuring the protection of a person's right to health and care and their right to be free of unnecessary restrictions or impositions. All countries have some form of laws which address these issues (MH acts). In the last eight years all Australian jurisdictions (except Norfolk Island which has recently come under Queensland's administrative control) have revised their MH acts with particular regard to human rights and the capacity of a person to consent to treatment.

There has been increasing recognition of the need to reduce or eliminate the use of restrictive practices or coercion (seclusion, restraint and the use of orders) worldwide.[30] For more than 15 years, QH has been an active participant and leader in national programs such as Towards the Elimination of Restrictive Practice which have had considerable success in changing practice and outcomes.[31]

There is a need for a strong regulatory system to ensure the rights of people are protected and that they receive high quality care. Ensuring individuals, their families and supporters are aware of their rights, that they have support to understand what is happening, be involved in decisions about their care, be able to ask questions and seek review is vital.

The *Queensland Mental Health Act 2016*

The MHA2016 establishes the regulatory framework for the involuntary treatment, care and protection of people who have a mental illness and who do not have capacity to consent to be treated.

In addition to the MHA2016, the legislative framework that supports MH treatment and care in Queensland also includes a range of other pieces of legislation including the *Human Rights Act 2019*, *Hospital and Health Boards Act 2011*, *Guardianship and Administration Act 2000*, *Public Health Act 2005*, and the *Forensic Disability Act 2011*.

The MHA2016 commenced in March 2017 following a comprehensive review, including extensive lived experience, community and partner consultation of the former legislation (the repealed Mental Health Act 2000) which had been in place for more than 10 years. The MHA2016 introduced several key reforms to Queensland, in particular to improve patient rights.

In 2019, the Implementation Evaluation Report found that implementation of the MHA2016 was generally effective, operating as intended with less restrictive ways and patient rights

[30] World Psychiatric Association Position Statement: Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care 2020 https://www.wpanet.org/_files/ugd/e172f3_635a89af889c471683c29fcd981db0aa.pdf
[31] John A Allan, Gary D Hanson, Nicole L Schroder, Anna J O'Mahony, Australian Roxanne M P Foster, Grant E Sara, Six years of national mental health seclusion data: The Australian experience. Australasian Psychiatry, 2017 vol. 25, 3: pp. 277-281

focused treatment and care. Three themes for further consideration were targeted: training and education, monitoring outcomes, and improved data analysis.

The evaluation of Connecting Care to Recovery focused on enhancements made to the Court Liaison Service, the right of certain patients to have free legal representation before the Mental Health Review Tribunal and the establishment of Independent Patient Rights Advisers (IPRAs) across all HHSs. Overall, it was found that processes to support patient rights have been improved and suggested further measures to support understanding of human rights in the Magistrates court, expansions to IPRAs and a focus on initiatives to reduce restrictive practices.

Office of the Chief Psychiatrist

The Office of the Chief Psychiatrist (OCP) is cognisant of the need to ensure that regulatory frameworks support evidence-informed clinical practices and that any regulatory impact is the minimum necessary to achieve the intended policy outcome. The system relies upon the good work of HHS MHA2016 Administrators to liaise between clinicians and the OCP and for all staff to be trained in using MHA2016 to support human rights of individuals and their families. Increasing patient numbers and staffing limitations have brought stresses similar to the rest of the system.

The regulatory reform agenda within OCP reflects the complexities associated with mental health legislative framework, as it interacts with multiple other pieces of legislation both within Queensland and nationally. To be responsive to the needs of individuals receiving services, clinicians, and the community, OCP maintains a comprehensive regulatory review and monitoring register which permits consideration of any legislative barriers or changes in national or international standards. To date multiple improvements to MHA2016 have been identified and after consultation have progressed successfully through the legislative process.

There are several important ongoing issues all related to human rights and quality of clinical services described below.

Least restrictive practices

The MHA2016 requires treatment and care to be provided in a way that is least restrictive.

Despite this national focus on least restriction of individual rights and liberties being a critical strategy in trauma-informed care, the evaluation of Connecting Care to Recovery identified an increase in the use of restrictive interventions since commencement of the MHA2016.

In the four years to 2019-20 there has been 12 per cent increase in Treatment Authorities made which outstrips population growth. Following a more than 40 per cent drop in the rate of seclusion in the previous 8 years there has been a rise in seclusion since 2017-18, although this is not uniform across the state. This may be unrelated to the legislation, including potential increase in complexity and acuity of conditions which meet the threshold for involuntary treatment, lack of suitable community placements, increased demand for beds meaning only the most acutely sick people are admitted and an increased requirement for, and awareness of, reporting of coercive events. Working towards eliminating restrictive interventions remains major focus of quality improvement work by OCP and HHSs.

Locked acute adult mental health inpatient units and discretionary locking framework

Since December 2013, adult acute MH inpatient units in Queensland have operated under a locked wards policy, following a critical incident involving an absent patient. The policy intended to protect the safety of patients and the community and reduce rates of patient absence without approval.

Since implementation of the policy, concerns continue to be raised by HHSs, the QMHC, the Public Guardian, the Public Advocate and lived experience and carer representatives who have highlighted human rights concerns. A similar locked ward policy has been in place in New South Wales for more than 15 years and Victoria introduced a discretionary locking wards policy shortly after the Queensland's policy.

HHSs have implemented a range of evidence-based, recovery-oriented strategies to ensure the safety and security of inpatient MH facilities, such as Safe Wards, and more responsive leave arrangements while working towards a least restrictive model of care. This has resulted in a significant overall reduction in inpatient absent without approval events over recent years (e.g., in 2021 the rate was 3.4 per 1,000 involuntary patient days well below the target of 4.1).

Rather than individuals absconding from an inpatient unit, failure to return from leave accounts for most reported inpatient absences across the state.

Following on from the considerable improvement in understanding of the issues and results, in consultation with HHSs, people with a lived experience, and key external stakeholders, the Chief Psychiatrist is considering options for a return to discretionary locking of adult acute MH inpatient units.

In July 2021, the Chief Psychiatrist granted an exemption to the locked wards policy for Gold Coast MH and Specialist Services to pilot a framework for discretionary locking at an eight-bed short stay inpatient unit (Waratah Unit). This has recently been extended to take account of the implications that the COVID-19 pandemic. A review of the pilot will inform further options for a proposed discretionary framework.

Indefinite nature of forensic orders

The Mental Health Court determines whether a person charged with a serious offence is of unsound mind or unfit for trial. If a person is found of unsound mind or permanently unfit for trial, the Court may make a forensic order or a treatment support order and must do so if temporarily unfit for trial.

People on forensic or treatment support orders can then be admitted to hospital or receive care in the community depending on levels of risk identified. As the person is completely diverted from the criminal justice system to the health system these orders do not have defined durations but can be revoked by the Mental Health Court or Mental Health Review Tribunal.

There is a concern that a person may be placed on an order and detained when the charges are unproven, and the facts not tested. In all other jurisdictions, other than Queensland and Western Australia, they have a 'special hearing' process to test charges against a person should they be found unfit for trial. Although this potentially applies to only a small number of cases, the absence of a special hearings' framework has been raised by stakeholders as a potential human rights issue for the legislative framework in Queensland.

Comprehensive consultation with legal, people with a lived experience, advocacy and victim support stakeholders on the MH and criminal justice frameworks is required and a discussion paper for wide consultation is being prepared.

MHA2016 and people with intellectual or cognitive disability

The MHA2016 enables people with intellectual or cognitive disability to be diverted from the criminal justice system if they were unsound of mind at the time of allegedly committing an offence or unfit for trial due to their intellectual or cognitive disability (similar to people experiencing mental illness).

There are two primary types of forensic order that can be made – a forensic order (mental health) and a forensic order (disability).

There are more than 110 people subject to forensic order (disability). The majority of people on a forensic order (disability) are managed by QH authorised MH services (AMHSs), mainly residing in the community with support packages provided by the NDIS. There is a 10 bed Forensic Disability Service (FDS) which offers care and rehabilitation managed by the Department of Seniors, Disability Services, and Aboriginal and Torres Strait Islander Partnerships (DSDSATSIP).

Stakeholders have raised the following concerns about the application of the MHA2016 and people with an intellectual and cognitive disability:

- The restrictive practices framework which applies under the MHA2016 differs from the framework applied to NDIS-funded service providers, resulting in patients being made subject to multiple frameworks at the same time.
- Persons on a forensic order (mental health) may have a treatment support order which operates as a 'step down' or less restrictive order than a forensic order made by the Court but there is no equivalent order for a person on a forensic order (disability).
- Similarly, there is no ability to transfer a person out of custody for the sole basis that they require care for an intellectual or cognitive disability—even if the person would otherwise have been detained in an AMHS or the FDS.
- The accountability for the legislative requirements of a forensic order (disability) sits with AMHSs but responsibility for care and service delivery primarily sits with NDIS service providers.

Careful consideration of the rights and service implications for persons with an intellectual or cognitive disability requires collaboration with all stakeholders including the DSDSATSIP and QH, the Commonwealth Government, NDIS, lived experience, carer, advocacy, and legal groups (for clinical implications see section 6.8 – Forensic MH).

National mutual recognition

In Australian, MH orders made under the legislation of one jurisdiction may not have effect in other jurisdictions. This can create significant problems for continuity of care, restrict freedom of movement and causes confusion for individuals with a lived experience, carers, and clinicians.

A person without care may become significantly unwell or long-term inpatients may be detained away from family and other supports.

Under the Fifth Plan a national legislative scheme was agreed as the preferred mechanism to facilitate the mutual recognition of civil involuntary treatment orders. Queensland is leading this national project. The Chief Psychiatrist independently represents Queensland on an interjurisdictional project steering committee which is responsible for providing expert advice to inform development of the model legislation in 2022.

Opportunities for improvement

Involuntary treatment and MH legislation gives rise to issues of capacity, supported or substituted decision-making, risk and a person's right to treatment.[32] The nature of these issues and the times at which involuntary treatment may be required can result in diverse and opposing views about MH legislation. This affects some of the most vulnerable people in the community, so continuous review, engagement, consultation, and consideration of any potential effects on human rights and clinical outcomes are required.

- Continued emphasis on Human Rights
  - As noted in the QH written briefing, MHA2016 is compatible with the Human Rights Act 2019. However, this is a dynamic process and future concerns raised by the Human Rights Commission as a result of their investigation of complaints, changes to other Acts or through case law may require changes. An example of this is a current proposal to strengthen MHA2016 in relation to human rights and capacity to consent to ECT to be absolutely sure that the best stance on human rights is taken. There will be other issues and the system must remain responsive to ensure human rights and a workable system.
  - Globally, the United Nations Convention on the Rights of Persons with Disabilities (2006) applies specifically to people with MHAOD problems. There is international and national debate about the value of mental health acts, whether we should legislate to promote MH and wellbeing rather than concentrating on just the treatment of mental illness. Society's attitudes are changing in regard to guardianship, substitute or assisted decision making and rights to control one's own treatment. The principles of open disclosure, full consultation and co-design will affect the way we respond to these debates in legislation.
  - Australia is a party to international treaties on Human Rights. In 2017, the Commonwealth Government ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Now that OPCAT is operative, all governments must consider the implications of international scrutiny of human rights of mental health and drug and alcohol services through regular inspections.
  - Training for advanced skills in understanding human rights for clinicians and administrators and increased awareness for people with a lived experience, their families and carers is an ongoing issue. For example, many individuals and their

[32] McSherry B. (2014) Mental health laws: where to from here? Monash University Law Review (40) 1 http://classic.austlii.edu.au/au/journals/MonashULawRw/2014/10.html

families are unaware of their right to seek a second opinion and the way information is conveyed could be reconsidered.

  - Many of the changes made to support human rights such as IPRAs, court liaison, increased legal representation should be continuously reviewed and expanded where appropriate.
  - Future directions such as digital capacity and clinical practice improvement offer additional opportunities to strengthen human rights by streamlining processes and giving a clear view of what happens in treatment.

- Least restrictive practices
  - Evidence suggests involvement of people with a lived experience and carers in governance and innovation can be vital to finding alternatives to coercion. Involvement at all levels and codesign are key. They should be part of good practice and clinical improvement. For example, establishing partnerships with people who have a lived experience, their carers, clinicians, HHSs, OCP, and QMHC to identify lessons from a lived experience perspective and address practical issues experienced by clinicians in supporting less restrictive options in AMHSs. Evaluation of these initiatives to determine their effectiveness and value would identify future investment priorities. Such a program aligns with the QH System Outlook.
  - Maintenance of high-quality support for clinicians, individuals, families, and carers. This is a core ongoing function which requires increasing consideration of changes in clinical practice, communications, the digital strategy, and level of people with a lived experience involvement on the legislative framework to identify new opportunities.
- Discretionary locking framework for acute adult wards
  - The current trial once evaluated should inform a statewide policy approach which addresses the balance between human rights and safety concerns. Other considerations include capital improvements to existing units and the provision of alternative placements for people at risk.
- MHA2016 and persons with intellectual or cognitive disability
  - The intersection of different Acts, funding sources, multiple policy sources and paucity of specialist services for people under a forensic order (disability) or at risk of entering the forensic system needs a systematic approach. Legislative change to produce better alignment may be needed to underpin a more integrated service system.
- Forensic MH
  - Queensland has one of the more innovative and patient focussed forensic MH legislative and court systems because of its emphasis on diversion from the criminal justice system towards a health treatment system. It is a great example of how legislation supports outcomes for people with a lived experience. As discussed in section 6.8 – Forensic MH, there are considerable pressures on courts, prisons, and services in general. Besides the issues of already discussed, issues about court and tribunal procedures, transfer of patients, place of treatment and human rights and equity of treatment will arise that are likely to require legislative consideration.

- National mutual recognition
  - The next step is to look at forensic orders in a similar way across jurisdictions. Given the siloed nature of each jurisdiction's MH acts, this model of interstate cooperation should be considered for other legislative changes which affect all jurisdictions and address confusion about different interpretation of rights and service variability across jurisdictions.
- Engagement with the broader system including legislation
  - Continuous improvement in services and changes to legislation across government but particularly in relation to justice, youth justice, corrections, police, child safety, education and housing require a sophisticated approach to interagency engagement to consider how human rights and codesign are optimised.

5.2.5 Workforce

5.2.5.1 Recruitment, retention, and sustainability

These are a number of workforce challenges impacting provision of MHAOD treatment, care and support including:

- stigma associated with MHAOD careers.
- exacerbation of workforce pressures by attrition due to an ageing and/ or fatigued workforce.
- insufficient developed and articulated pipelines for new entry workers, including vocational and tertiary training, mentoring and supervision, and recruitment pathways.
- shortfalls identified across MHAOD specialised work streams and settings in a context of overarching shortages of skilled workers across the sector.
- inequitable workforce distribution across geography, culture, service type and setting.
- cultural safety needs of higher representation of Aboriginal and Torres Strait Islander and CALD groups presenting with severe and persistent issues.
- ensuring an appropriate mix of clinical and non-clinical multi-disciplinary team members and optimising scope of practice of multi-disciplinary team members.

In the last five years, the expansion of opportunities within the NDIS sector has led to increased competition for workers, especially allied health professionals. More recently, COVID-19 restrictions on interstate and overseas movement have impacted significantly on recruitment to HHS training rotations and vacancies, particularly in rural and remote settings.

At a local level, diversion of clinical staff to COVID-19 prevention and treatment services and HHS budget over runs have limited capacity to attract and recruit new graduates to MHAOD services.

In 2020, Queensland ranked fifth among States and Territories for the number of registered psychiatrists, psychologists, and MH nurses and fourth for MH occupational therapists per 100,000 population.

In addition, it is estimated that AOD treatment and care services are currently meeting 28 per cent of need and the demand is predicted to rise to a treatment population of 147,151 persons by 2025-26, an increase of 10.7 per cent from 2019-20.

Of particular concern is the projected loss due to retirement within 10 years of 2019 of 47 per cent of MH and 57 per cent of AOD registered nurses and 37 per cent of enrolled nurses, with this impact increased in rural and remote areas. The five-year projected losses of 20 per cent of MH and 26 per cent of AOD registered nurses require urgent recruitment of entry level graduates to maintain supply of this skilled workforce. Other workstreams predicted to exit the industry in significant numbers by 2029 include 38 per cent of psychiatrists, 37 per cent of psychologists, and 33 per cent of occupational therapists.

While integration of lived experience (peer) workforce into multidisciplinary teams and their career pathways have seen significant enhancements in recent years, the available FTE is not adequate to provide a full range of support services to individuals.

Similarly, recent advances in Aboriginal and Torres Strait Islander Health Worker career pathways and requirement for all HHSs to achieve health equity will take some time to improve on the current available FTE positions. There is also under-occupation of available FTE due to ongoing recruitment difficulties of qualified Aboriginal and Torres Strait Islander Health Workers.

Recruitment and retention of newly qualified AOD workers is a priority in the current context of significant shortfalls in services to meet demand and would benefit from a range of strategies, including 'grow your own workforce', transition programs and pathways to AOD.

The state-funded NGO workforce not captured within the workforce data provided in the written briefing includes significant numbers of lived experience (peer) and psychosocial support workers providing psychosocial support services and AOD supports.

Lived experience (peer) workers comprise 21.5 per cent (117) of the 543 NGO MH workforce which also delivers SUSD (109 residential care staff) and crisis services in partnership with QH staff.

Allied health professionals are under-represented in HHS MH services. The lower numbers of allied health staff employed in HHS MH services potentially impacts on the outcomes. While the majority of QH employed psychologists work in MHAOD services, the number of psychologists is still less than the recommended targets in the NMHPF within many services. Of the remaining QH allied health workforce within HHS MHAOD services:

- 20 per cent (246) are social workers
- 4 per cent (20.5) speech therapists and audiologists
- 3.5 per cent (20) dietitians
- 20 per cent (7.5) exercise physiologists
- less than 1 per cent (9.3) pharmacists.

Apart from social workers, the remaining allied health staff are also maldistributed across HHS MHAOD services. The lack of dedicated allied health staff constrains the capacity of services to deliver clinical interventions to reduce the significant co-morbidities associated with long term mental health illness and treatment modalities.

A further identified issue is that the current case management focus in HHS MHAOD multi-disciplinary teams acts as a disincentive for the recruitment of allied health practitioners. Many report that under this model, their capacity to operate at the top of their scope of practice is hindered and they become deskilled as they are undertaking a range of tasks that could appropriately be transitioned to staff with less specific clinical and support skills.

Models that support Nurse Practitioners, nurses and allied health professionals operating to the top of their scope and license such as the Allied Health Brief Therapies Clinic (Box 2) offer individuals opportunities to access and receive best practice evidence-based care that has been demonstrated to result in positive treatment outcomes, avoid ED presentations and reduce episodes of hospitalisation.

Box 2: Exemplar – Supporting scope of practice improving individual and workforce outcomes

Allied Health Brief Therapies Clinics

The Allied Health Brief Therapies Clinics (AHBTC) project was funded under Connecting Care to Recovery and was established as a collaborative between West Moreton HHS, Metro South HHS and Darling Downs HHS.

The AHBTCs provide a service model to enhance allied health workforce capability and scope of practice where clinicians undertake brief therapeutic interventions, working collaboratively with individuals at risk of suicide and their families and carers to deliver accessible, effective and timely services at a time of distress or crisis.

The evaluation showed the clinics complemented services at the HHS and showed significant improvement in psychological distress for the consumers attending. The findings pointed to a significant reduction in ED usage following Clinic intervention. The immediacy of care provided to consumers through AHBT Clinics ensures that individuals are supported during their highest period of risk. Addressing the initial suicidal ideation or crisis within three business days of referral serves to keep consumers actively engaged, reducing the potential for further escalation. Allied health staff noted the clinics helped them refine and develop new skills and deliver in line with scope of practice. The model provides prompt treatment and support and allows safe transition from one service provider to another.

The clinic design has applicability to other areas across HHS. The program received a QH Award for Excellence in 2019 for connecting healthcare.

An increasing focus on delivering comprehensive care requires a shift in workforce practice and skill development as it involves all aspects of service delivery and requires co-ordination across agencies. The involvement of multiple providers emphasises the importance of a shared understanding of an individual's needs, assessment processes and care plan.

Several workforce initiatives which have the capacity to inform recruitment and retention of the workforce and provide guidance for future action are outlined at Appendix 4.

Opportunities for improvement

The current shortfall in capacity to deliver state-funded MHAOD services in response to unmet and increasing demands on an already stretched system requires recruitment of an

expanded workforce integrated with enhanced service planning, capital infrastructure and skill development opportunities.

New workforce positions informed by indicative staffing profiles in the NMHSPF and QDASPM are required to minimise the significant existing and looming shortfalls across workstreams such as psychiatry, nursing, allied health, lived experience (peer) and culturally representative workers; deliver project coordination and skills training and support uptake of digital technologies and information systems. While recruitment of early career staff is essential to maintain the pipeline, there is an ongoing need to ensure capability lift through recruitment and retention of a more experienced workforce.

Workforce recruitment, retention and sustainability in the current competitive environment requires a multi-pronged approach including career awareness and promotion, attractive career pathways and incentives to employment, workforce skills development, and a focus on staff wellbeing and support.

Examples of areas for further effort include:

- partnerships with entry level training providers across schools, vocational and tertiary settings to embed MHAOD modules in pre-service training.
- incentives to uptake of MHAOD careers for priority workstreams.
- support for staff to gain minimum qualifications e.g., scholarships, grants and placements, with including consistent lived experience (peer) and multicultural support worker training.
- dedicated coordination of Aboriginal and Torres Strait Islander, CALD and lived experience (peer) workers.
- 'Grow Your Own' recruitment statewide but also with a focus on areas of need, such as rural and remote and niche services.
- incentives for experienced health and human services professionals to gain MHAOD skills.
- enhanced skills development training opportunities for MHAOD staff, partners and lived experience and carer representatives and dedicated training, mentoring and supervision strategy, positions and HHS staff backfill.
- dedicated resources for staff wellbeing and support linked to QH employee wellbeing programs.
- building dedicated training posts into new services and reconsidering training capacity as existing services expand.
- clear career pathways and leadership opportunities (including development and training), especially for priority workstreams.
- exploration of new and emerging workforce positions and shifts in practice and credentialling e.g., allied health assistants, lived experience (peer) care coordination, Rural Generalist MHAOD advanced skills.
- dedicated allied health workforce and models to deliver evidence based clinical interventions to individuals reduce the significant co-morbidities associated with long term MH illness and treatment modalities.

- a shift from case coordination activities to alternate models and interventions for mental health practitioners that utilise the full scope of practice of the professions.
- leverage of workforce incentives across State and Commonwealth Government programs, such as:
  - scholarships for priority population groups, employment, and relocation support.
  - access to MBS rebates, training through specialist colleges, special conditions visas.

5.2.5.2 Lived experience (peer) workforce

Development of the MHAOD lived experience (peer) workforce is one of the substantial reforms to have emerged to MH service delivery over the past two decades in Australia and Queensland. Lived experience (peer) work is recognised as a unique and separate discipline offering a valuable contribution to delivery of MH services to individuals with a lived experience.

The MH lived experience (peer) workforce employed in HHSs are part of a multidisciplinary team. They work across all settings within HHSs and draw on their own personal experiences of MH and recovery or supporting another person through these experiences.

There are also significant numbers of lived experience (peer) and psychosocial support workers providing community mental health psychosocial support services and AOD supports delivered by NGOs. Lived experience (peer) workers comprise 21.5 per cent (117) of the 543 NGO MH workforce which also delivers SUSD (109 residential care staff) and crisis services in partnership with HHS staff.

The lived experience (peer) workforce consists of two distinct categories – 'peer worker' and 'carer peer worker'. The National Lived Experience (Peer) Workforce Development Guidelines (National Guidelines) describes a peer worker as someone who has a 'personal experience of mental health challenges, service use, period of healing/personal recovery'. A carer peer worker is described as someone who has an 'experience of supporting someone through mental health challenges, service use, periods of healing/personal recovery'.

For AOD, lived experience (peer) workers make a unique contribution in the treatment, care, and planning of services for people with problematic substance. Compared to other peer workforce, people with lived experiences of AOD encounter unique barriers and challenges particularly regarding stigma and discrimination and a lack of understanding of the nature of substance use including from within healthcare settings. As a person with lived experience explains *"It was difficult going - because the local doctor looks at you like, "Well, just get off it." They don't understand... that it is a disease. They just think, just stop using it. Well, it's not that easy."*

People with a lived experience of problematic substance use and their loved ones represent a diverse range of people as evidenced in the Peer Peak Scoping Project commissioned and funded by the DoH in 2020. The project undertaken by QNADA surveyed 401 people who use drugs in Queensland and found a heterogenous group with a broad range of views and need. The report suggested a focus on population specific engagement, particularly for marginalised groups of people who use drugs, including people from CALD backgrounds and Aboriginal and Torres Strait Islander people.

Other unique barriers for people with lived experience of problematic substance use arise from the illicit nature of some substances and associated complexities. This includes a fear of repercussions from identifying as a person engaged in an illicit act and for those with a related criminal history, barriers to employment. Specific strategies are required to engage and support people with lived experiences of problematic substance use to address these unique issues.

Employment of people with a lived experience enriches provision of MHAOD treatment, care and support. The Fifth Plan noted that 'peer workers or workers with a lived experience of mental illness, play an important role in building recovery-oriented approaches to care'. Integration of lived experience (peer) workers into service delivery delivers a reduction in hospital admission rates and stigma; improved social inclusion; and an increased sense of hope for individuals, carers and their families.

However, the rapid expansion of the lived experience (peer) workforce has given rise to numerous challenges. At the national level it has been noted that the expansion of the role in Australia appears ad hoc and lacks structured workforce development.

In Queensland the integration of the lived experience (peer) workforce into multidisciplinary teams has seen significant improvements in recent years, including the development of career pathways. As stated in the QH written briefing, the lived experience (peer) workforce accounts for two per cent of all FTE MH positions – average of 7 FTE per 1,000 direct care FTE. While this figure is well above the national average, it falls short of resource projections under the NMHSPF.

Lived experience (peer) workers are employed in 13 of the 16 HHSs. There are now more than 140 FTE staff employed across the state in a range of peer and carer roles, comprising two per cent of the MH workforce. Despite Queensland's geographically diverse population this workforce is predominantly employed in HHSs within the south-east Queensland region.

For MH programs being delivered NGOs as part of state funded MH treatment and support, there are approximately 21.5 per cent (117 staff) delivering psychosocial support services and other care across SUSD and crisis support services.

While improvements have been made in increasing the lived experience (peer) workforce into adult MH services more support and development is needed within the infant, child, and youth MH space across the continuum particularly in the youth peer workforce space.

Many lived experience (peer) workers are at significant disadvantage, arising from their lived experience in their preparedness for and ability to access minimum qualifications and many who participate in training experience difficulty in gaining appropriate placements and subsequent employment.

Currently, training and development for the lived experience (peer) workforce and skill development of other workers in maximising integration of their role into multidisciplinary teams has not been included in MHAOD training. In addition, there are limited options for more experienced lived experience (peer) workers to train and participate in mentoring and supervision of newly employed workers.

The evaluation of Connecting Care to Recovery noted that there needed to be a renewed focus on lived experience (peer) workforce planning and that the lived experience (peer) workforce should be expanded and developed. This includes a need to focus on the formal

development for the workforce including supervision skills development and training. Recruitment of the workforce continues to be an issue and there needs to be consideration of improvements to on-the-job training and development of the lived experience (peer) workers.

To address variations in employment of lived experience (peer) workers across the state and to improve understanding of the roles and responsibilities within HHS MH services, the QH MH Framework Peer Workforce Support and Development 2019 was developed and implemented.

This Framework includes:

- peer work values
- employment principles
- workforce support
- professional development
- scope of practice
- role descriptions.

In 2021, the NMHC launched the National Guidelines. These guidelines are designed to place lived experience (peer) work at the centre of MH reform and include the lived experience workforce as a vital component of quality, recovery focused MH services.

DoH (MHAOD Branch) recognises the value of the lived experience (peer) workforce and the need to include the voice of their leaders in decision making. The QH Lived Experience Workforce Leadership Group provides leadership and expert advice from a lived experience perspective and promotes the MH lived experience (peer) workforce. This Leadership Group will be engaged in the development of future directions for the lived experience (peer) workforce in QH.

The current QH Framework needs to adapt to the rapidly changing landscape of lived experience (peer) work and will be updated to align with the new National Guidelines.

The current shortfall in the lived experience (peer) FTE against the NMHSPF and their low visibility at two per cent of the MH and less than one per cent of the AOD workforces limits their ability to meet the support needs of all individuals and fulfill their potential to contribute fully as integrated multidisciplinary team members.

Expanding the lived experience (peer) workforce is essential to enhance and improve the outcomes of people with a lived experience.

Opportunities for improvement

Priorities identified for consideration to enhance and expand the lived experience (peer) workforce include:

- recognising the role and value of the lived experience (peer) workforce including educating other health professionals about their role and value and the outcomes for people with a lived experience.
- enhancing and integrating lived experience support across state-funded MHAOD services.
- improving professional development for lived experience (peer) workers.

- enhancement of mentoring support and supervision.
- ensuring there is appropriate support for individuals with complex/specific needs, including the addition of Aboriginal and Torres Strait Islander and youth lived experience (peer) workers.
- development of a peer workforce for people experiencing problematic substance use.

5.2.5.3 Regional, rural and remote workforce

Queensland's decentralised population impacts directly on health equity with gaps in access to local MHAOD services and issues in recruitment of specialised MHAOD staff, especially in rural and remote areas. Populations in regional areas are increasing due to interstate migration from southern states, exacerbating severe workforce shortages across allied and medical health.[33, 34] Current workforce arrangements are insufficient to address MH issues in remote and very remote settings.

National and State data indicate that mental illness is a key issue in remote and very remote settings with some issues more prevalent compared to metropolitan areas. A 2019 Australian Institute of Health and Welfare report notes the burden of disease in remote and very remote areas is 1.4 times that for major cities, particularly for suicide and self-inflicted injuries.[35] The 2018-19 Queensland Preventative Health Survey findings indicate that mental or behavioural problems are higher for the socio-economically disadvantaged who are over-represented in remote and very remote populations; spinal and brain injuries among Aboriginal and Torres Strait Islander adults are higher in very remote areas; and adults in remote areas were 35 and 36 per cent more likely to exceed the lifetime risk guidelines and single occasion risk for alcohol consumption than those in major cities.[36]

Remote and very remote settings have a high proportion of Aboriginal and Torres Strait Islander peoples and regional areas have substantial CALD populations whose members are vulnerable to mental illness.[37, 38] Aboriginal and Torres Strait Islander people are over-represented among individuals using QH MH services compared to their proportion of the population. Refugees and asylum seekers are particularly vulnerable to self-harm and suicidal behaviours, with self-harm among asylum seekers higher than in the general population and among prisoners.

Across Australia in 2019-20, expenditure on Medicare subsidised MH specific services per capita dropped sharply with increasing remoteness. People in remote and very remote communities receive 36 per cent and 17 per cent of the per capita expenditure received by

[33] Queensland State Development – 2021 located at https://www.statedevelopment.qld.gov.au/regions/queensland
[34] National Rural health Alliance. Fact Sheet: Mental health in rural and remote Australia. Canberra, ACT; July 2021.
[35] National 2020 data. Accessed at: https://www.aihw.gov.au/reports/australias-health/burden-of-disease
[36] Queensland Health. Queensland preventative health survey. Queensland survey analytic system (QSAS) detailed results. Available: https://www.health.qld.gov.au/research-reports/ population-health/preventive-health-surveys/detailed-data. Accessed 14 July 2020 as in:
The health of Queenslanders 2020. Report of the Chief Health Officer Queensland Published by the State of Queensland (Queensland Health) November 2020.
[37] Multicultural Australia. Humanitarian Settlement Program New Arrivals Report 2018 – 2021 (FY) accessed at: Report (refugeehealthnetworkqld.org.au)
[38] Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/jun-2016

people in major cities.[39] Across remote and very remote Queensland, workforce shortages and wide variations in specialist MH support due to lack of sustainable models of service provision and environmental and geographical factors all contribute to poorer access to services and increasing disadvantage in more remote areas.

While general practitioner services are the most accessed services, in remote and very remote areas they reduce to a half and a quarter of the rate in major cities with psychiatry and psychology services even less available compared with major cities. This limits timely access to services such as Better Access MH supports which require medical practitioner referral to allied health providers.

The lack of immediate access to more specialised MH services in outer regional, rural and remote areas place pressure on general practitioners, nurse practitioners and allied health providers to provide vital frontline and extended MH services including addiction. Advanced training and specialised professional support are essential to develop experience in responding to a wide range of MHAOD conditions.

Table 1: Australian Distribution of MH clinical professionals per 100,000 population 2019-20

Profession	Major cities	Inner regional	Outer regional	Remote	Very remote
Psychiatrist	16.5	6.9	5.5	6.7	2.6
Psychologist	109.6	64.6	47.4	42.2	31.1
MH Nurse	96.1	85.7	56.8	56.2	34.8

Access to psychiatrists in rural and remote Queensland is limited and often reliant on fly-in fly-out (FIFO) or drive in drive out (DIDO) specialists. This is not ideal for mental illness which is episodic in nature and can involve crises requiring urgent professional contact. If visiting psychiatry is inconsistent or unreliable, limited follow up between visits may impact patient care, treatment choices and outcomes.

In Queensland, psychologists and nurses are the most common MHAOD professionals, with low numbers of psychiatrists and MH occupational therapists. Nurses (predominately registered nurses (RNs)) and allied health practitioners comprise 46 and 22 per cent respectively of public funded MHAOD workforce.

[39] Australian Government. (2021). Mental Health Services in Australia. Australian Institute of Health and Welfare. Canberra. Accessed at: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Table 2: Queensland MH professionals – headcount, FTE, and FTE per 100,000 population, 2020

Profession	Headcount	FTE	FTE per 100,000 pop
Psychologist	6,040	5,299.2	102.04
MH Nursing (RN+EN)	5,038	4,735.5	91.18
Psychiatrist	797	783.5	15.09
MH Cccupational Therapist	555	512.9	9.88
AOD Nursing (RN)	354	332.4	6.40

The distribution of MHAOD professionals across Queensland is affected by geography and level of specialisation. As shown in Table 3, 94 per cent of the most common professionals are in urban metropolitan (74 per cent) and regional centres (20 per cent) with sharp drops as rurality and remoteness increase.

Professionals in rural and remote areas must develop strong mentoring and referral linkages with specialised services to offset professional isolation while dealing with lack of access to human services such as education and employment opportunities for themselves and family members.

Table 3: Distribution of Queensland's MHAOD workforce by Modified Monash Model (MMM) areas of geographical remoteness

Workstream	Modified Monash Model Category							
	Urban/ Metro-politan	Regional	Large Rural Towns	Medium Rural Town	Small Rural Town	Communities		Total
						Remote	Very Remote	
	MMM1	MMM2	MMM3	MMM4	MMM5	MMM6	MMM7	
Psychologists	4,702	1,031	84	103	81	11	28	6,040
MH Nursing (RN)	2,979	1,045	70	82	44	17	41	4,278
Psychiatrists	646	138	4	1	1	1	6	797
Occupational Therapists (MH)	377	138	8	20	6	3	3	555
Drug and Alcohol Nursing (RN)	230	91	5	2	16	2	8	354
Total workforce in each MMM	**8,934**	**2,443**	**171**	**208**	**148**	**34**	**86**	**12,024**
Total workforce % MMM	**74.30**	**20.32**	**1.42**	**1.73**	**1.23**	**0.28**	**0.72**	**100**

MH medical workforce recruitment and retention in regional, rural and remote areas across Queensland is a key issue, as is the need to deliver care more flexibly to take account of the state's dispersed service system. Junior doctors and trainees from a rural background or a positive experience in regional, rural or remote areas are more likely to practice in these areas once trained.[40]

COVID-19 restrictions on interstate and overseas movement impacted significantly on recruitment to HHS training rotations and vacancies, particularly international medical and allied health graduates in RR settings. Queensland's low ranking among States and Territories for registered MH professionals per 100,000 population makes attracting and maintaining adequate levels of psychiatrists, psychologists and MH nurses and MH occupational therapists into rural and remote areas even more difficult.

Cultural safety considerations contribute significantly to reduced access to MHAOD services, even when there is higher need. Each year, around 1,800 refugees settle in Queensland with clusters in regional areas of Toowoomba, Townsville and Cairns.[41] South Sea Islander populations are concentrated in coastal areas such as Mackay. Aboriginal and Torres Strait Islander people comprise 4.5 per cent of the population with the largest numbers in Brisbane (70,723 or 11 per cent), highest proportion in the Torres Strait Indigenous Region (82 per cent) and rural and remote areas exceeding 4.5 per cent. This distribution has implications for the diversity of the workforce and culturally representative staff are an important factor in encouraging people to access services.

People from CALD backgrounds are reluctant to voluntarily access hospital and community-based MH services. This is not related to lower levels of need, but to difficulties in understanding and accessing services and lack of culturally safe and appropriate services. They typically have higher needs by the time they present to public MH services, often presenting late in the onset of mental illness and are over-represented in involuntary treatment.

Across HHSs covering western rural and remote areas of Queensland, cultural workers are employed at lower percentages than in larger centres and far below their representation as users of these services.

[40] Medical Deans Australia and New Zealand, National Data Report 2020: 2015–2019 data from final year students at Australian medical schools, Medical Deans Australia and New Zealand website, 2020 in National Medical Workforce Strategy.

[41] Multicultural Australia. Humanitarian Settlement Program New Arrivals Report 2018 – 2021 (FY) accessed at https://www.refugeehealthnetworkqld.org.au/

Table 4: 2016 Census percentage comparison of Aboriginal and Torres Strait Islander population compared to and MH cultural workers compared to individuals using MHAOD services 2021, by HHS.

HHS	Total Population	Aboriginal and Torres Strait Islander Population	% Aboriginal and Torres Strait Islander	% MH consumers July-Dec 2021	% Cultural Workers July – Dec 2021
Cairns	252,833	29,731	11.8	25.4	32.7
Central Qld	219,752	14,567	8.6	19.5	14.1
Central West	10,722	854	8.0	18.4	6.1
Children's Health Qld	NA	NA	NA	12.9	7.2
Darling Downs	279,734	16,148	5.8	15.5	9.0
Gold Coast	591,570	10,614	1.8	5.6	5.1
Mackay	173,892	9,499	5.5	15.2	20.2
Metro North	981,358	22,389	2.3	9.8	17.1
Metro South	1,119,503	25,873	2.3	8.3	9.7
North West	28,428	8,699	30.6	57.2	9.3
South West	24,678	3,297	13.4	29.4	3.1
Sunshine Coast	407,638	8,994	2.2	7.1	15.5
Torres and Cape	26,514	18,548	70.0	73.5	34.4
Townsville	239,484	20,926	8.7	25.8	37.9
West Moreton	278,544	13,013	4.7	18	19.2
Wide Bay	214,227	10,008	4.7	13.6	14.5
Statewide	**4,848,877**	**213,160**	**4.4**	**14.1**	**19.5**

*Percentage of MH workers identifying as Aboriginal and Torres Strait Islander service providers, mainly Health Workers.

Opportunities for improvement

Further expansion and enhancement to scale up QH's current initiatives in rural and remote locations is required. Enhanced recruitment and retention of priority workstreams and service types:

- communications strategy to clearly articulate career pathways and opportunities.
- recruitment strategy to target trainees, new graduates and experienced workers.
- expand range of multidisciplinary team positions linked to optimal/ full scope of practice including Mental Health Nurse Practitioners.
- cultural safety focus with enhanced peer, Indigenous and CALD workers.
- Grow Your Own approaches –community members, scholarships, staff rotations.
- flexible working arrangements offered (e.g., shared positions, hybrid FIFO/DIDO, cross agency).
- investment in rural and remote training pathways that support the growth, sustainability and value generated by the rural and remote workforce and spread of rural generalist service models that deliver accessible, safe, effective and efficient health services for rural and remote consumers, e.g., the Allied Health Rural Generalist Pathway and Rural Nurse Generalist with advanced specialty in mental health.
- support for an incentive program for allied health practitioners in rural and remote areas in line with medical practitioners such as the Commonwealth Government Practice Incentives Program and HELP debt reduction scheme.

Increased capacity and flexibility of MHAOD service delivery and responses including:

- analysis of current services against planning frameworks and evidence-informed care.
- engagement of consumers and carers in service planning and delivery and policy design.
- training, mentoring and supervision strategy to improve regional, remote and very remote skillset with focus on capability and competency to participate in therapeutic models of care.
- mix of delivery modalities - continuity of care close to home, outreach, digital technology and virtual care.
- agility to work across stepped care models to deliver a wide range of needs.
- Communities of Practice and research across service and geographic boundaries.
- support for enhanced access to MBS rebates for a wider range of allied health staff.
- investigate opportunities for regional commissioning to jointly plan and fund evidence-based regional, remote and very remote community responses utilising pooled government funding.

5.2.6 Partnership, collaboration and comprehensive care across the continuum

Partnerships, collaboration, coordination and integration is consistent with *My health, Queensland's future: Advancing health 2026*. HHSs have emphasised the need for more effective collaboration, coordination, and integration across and between programs, services and providers. Connecting Care to Recovery also recognised the need for effective partnerships with other health and social service sectors to holistically meet the needs of individuals, their families and carers experiencing MH, AOD issues.

The MHAOD system's scale and complexity presents multiple challenges. The findings of the PC Report, and other recent strategic reviews of the MHAOD system, all identify the persistent, systemic issues affecting the accessibility and affordability of MH services. It is known that poor coordination, collaboration and integration in the service system not only results in increasing the complexity of the service system for individuals, families and carers but also results in inconsistent access to care and an inefficient distribution of financial and human resources. The NMHC's *Report of the National Review of Mental Health Programmes and Services* highlighted the lack of integration and coordination leading to individuals navigating a *'complex and fragmented service system...a patchwork'*.[42]

While lack of integration and coordination features across health and social systems more broadly and is not unique to the MHAOD treatment and care, people who live with mental illness or substance misuse are at much greater risk of poorer physical health, social and economic disadvantage and have lower life expectancy.

[42] This report can be accessed from https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/national-reports/2014-Contributing-Lives-Review

As stated previously, in line with the requirement of the Fifth Plan HHSs and PHNs across Queensland have been working to develop joint regional plans, with the support of the DoH (MHAOD Branch). The development of these plans enables Commonwealth and state funded providers of MHAOD to work together to identify local needs and local solutions, supporting local partnerships and collaboration.

There are many examples across the state where providers have come together either in formal or informal partnerships to improve care across the continuum. Examples of this include the QAS MH Co-Responder Program (described in the QH written briefing) and the Dialectic Behavioural Therapy Education Program highlighted in Box 3. In addition to HHS partnering with NGOs and primary care, it is essential that HHS collaborate with other parts of the public health system as individuals seeking care often have touch points with many parts of the health system and can have co-morbidities highly associated with mental illness and substance use.

Box 3: Dialectic Behavioural Therapy Education Program – an example of formal partnership to support workforce development and improved outcomes

Dialectic Behavioural Therapy Education Programme

In response to an identified local capacity and access need Brisbane South PHN, NGOs and Metro South HHS aligned funding to implement an education programme to enhance the competence of the NGO staff, primary care, and HHS in DBT interventions.

This programme increases opportunities for the person seeking help to receive an evidence-based intervention in the primary care and NGO setting. This increases the opportunity that an individual learns techniques and coping strategies that may will reduce the risk for further deterioration of an individual's mental health. This training has been adapted to meet the specific needs of populations groups such as Aboriginal and Torres Islander peoples.

It is highly valued, oversubscribed and currently being researched for its effectiveness on improving staff competence in delivering the interventions and to ascertain the benefits for the individuals who receive the interventions.

5.2.7 Statewide services

QH has established several statewide and specialist clinical, training and education, research and sector support services. These statewide services are critical system enablers of safety, equity and innovation in healthcare, as well as workforce and community development and support across sectors.

HHS MHAOD services provide treatment and care to consumers with a range of MHAOD and co-morbid issues. However, it is recognised there are a range of other issues where specialist advice and expertise are important to adjunct treatment and care responses.

This includes for individuals with CALD backgrounds, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Plus (LGBTIQ+) needs, history of torture and trauma, intellectual and developmental disability and forensic issues. These issues can increase the complexity of diagnosis, treatment and follow up care.

Situating expertise in a statewide or specialist clinical service enables access to appropriate best evidence care to individuals, equity of care to consumers and support to all HHSs. This contributes to the sustainability and efficiency of MHAOD services. The advice and support to HHSs can be provided face to face or via technology as required. These services also offer

training for those staff who wish to sub specialise and provide education and "communities of practice" for all staff to increase their knowledge and skills. Although generally focused on HHSs, these statewide and specialist services are also available to provide advice to GPs and other service providers who require their support. These include the Queensland Centre for Infant and Perinatal MH, the Statewide MH Intellectual Disability Service, the Queensland FMH Service (QFMHS), the Queensland Children's Hospital Gender Clinic, QH Eating Disorders Service and the Queensland Transcultural MH Centre.

QH statewide services that deliver workforce development, training and support, as well as research, contribute to service delivery improvements, sector and workforce development and support engagement within statewide, regional and local MHAOD service networks. These services include the Queensland Centre for MH Learning, Insight and Dovetail (specialists in AOD) and the Queensland Centre for MH Research. These training providers are also an important mechanism to support implementation of and training in key state priorities, such as, youth justice and domestic and family violence.

The work and expertise of these statewide and specialist services also contribute to the development of policy and planning in response to new evidence and emerging clinical practice, research and evaluation and their connection through supporting the workforce to statewide, regional and local needs and examples of good models of care and practice.

6 Recovery focused health care

6.1 Suicide prevention

Suicide is a critical priority for the healthcare system. Suicide is the leading cause of death in those aged 15 to 44 years, and one of the leading causes in other age groups, with over-representation by Aboriginal and Torres Strait Islander peoples, rural and regional populations, the LGBTIQ+ community, males, and high rates in the elderly.

Suicide Prevention has been a significant priority in Queensland and Australia for many years.

A strong focus in the Australian context has been on population-based efforts such as Living is for Everyone (LIFE) Strategy in Australia.[43] These strategies take a blended approach, combining universal interventions (targeted at the whole of population level) with 'selective' interventions targeted to broad groups who may have higher risk, but have not yet self-harmed, and 'indicated' interventions that target individuals who have demonstrated risk (e.g., through recent self-harm or expressed suicidal ideation).[44] More recently, all-of- community multiagency responses to suicide have been articulated through the Lifespan approach, which combines nine strategies, each underpinned by evidence for

[43] Refer to LIFE-framework-web.pdf (lifeinmind.org.au)

[44] Hawton, K., & Pirkis, J. (2017). Suicide is a complex problem that requires a range of prevention initiatives and methods of evaluation. British Journal of Psychiatry, 210(6), 381-383. doi:10.1192/bjp.bp.116.197459

suicide prevention in a community-led approach, which includes health, education, frontline services, business including media and the community. Such frameworks interact with the public healthcare system through strategies to support evidence-based treatment for suicidality and support for emergency and follow up care for suicidal crisis, for example, for those being discharged from EDs following suicide attempts and suicidality.

Public healthcare systems have, however, traditionally focused on identifying mental illness in those presenting with suicidality, and in addition to assessing for level of risk and focusing efforts on treating the mental illness and intervening with those assessed as high risk. There has been recognition of the limitations of that approach, with evidence over many years demonstrating that we cannot predict who will go on to die by suicide, and that categorical assessments of risk (high, medium, and low) should not be used to predict risk, or to decide on what resources those individuals require for care.

This realisation has led to a paradigm shift in suicide prevention efforts in health care systems. A growing number of health services have adopted a systems approach to suicide prevention, which recognises that many people who die by suicide do not necessarily have a severe or enduring mental illness, that most of those who die by suicide were not identified as high risk in recent contacts, and that suicide specific interventions (such as safety planning and non-clinical support) are essential components of a pathway of care.

The Zero Suicide Framework (ZSF) is an example of a systems approach to suicide prevention in a healthcare setting and was adopted early by Gold Coast Mental Health and Specialist Services (GCMHSS) in late 2015. Subsequently, 12 HHSs have been working to implement Zero Suicide in Healthcare (ZSiH) with the support of the DoH (MHAODB).

The ZSF has shown great promise when implemented with high fidelity, including a data driven continuous improvement and evaluation process, which demonstrated a 35 per cent reduction in re-admissions for suicide attempts when someone is placed on the Pathway.[45, 46]

The challenge with paradigm shifts is that they are at risk of resulting in pendulum swings, in which the focus of care swings from one approach to determining service priority and focus (e.g., diagnosis and risk) to a new focus (e.g., suicide specific and non-clinical care), potentially disregarding the previous approach entirely. Rather, a balanced approach is needed that incorporates new paradigms within the effective aspects of existing ones. It is important to avoid the risk of a pendulum swing in the Queensland healthcare system i.e., an increasing focus on planning and funding non-clinical support, and the potential for unintended consequences of shifting the focus away from the equally important clinical aspects of care or not addressing the impacts of the new paradigm on the clinical healthcare system. Responding to the risk and impact of suicide across the Queensland community is

[45] N. J. C. Stapelberg, J. Sveticic, I. Hughes, A. Almeida-Crasto, T. Gaee-Atefi, N. Gill, et al.Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses Br J Psychiatry 2020 Pages 1-10DOI: 10.1192/bjp.2020.190

[46] Turner, K., Sveticic, J., Almeida-Crasto, A., Gaee-Atefi, T., Green, V., Grice, D., Kelly, P., Krishnaiah, R., Lindsay, L., Mayahle, B., Patist, C., Van Engelen, H., Walker, S., Welch, M., Woerwag-Mehta, S. & Stapelberg, N. J. 2021. Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework. Australian & New Zealand Journal of Psychiatry, 55, 241-253.

not an either/or decision when considering where it is best to put resources and funding. Rather, it requires a careful balance addressing all issues.

Tensions and paradox are common features of the complex system within which we work in healthcare. It is important when these exist, that we hold on to those tensions and address all aspects. These tensions and paradox exist at multiple levels in suicide prevention efforts, at an individual clinician level, service level and system strategy and planning level.[47]

At an individual clinician level, there was a need to adapt current approaches. The pre-existing paradigm focused on identification of mental illness and high-risk individuals. However, as mentioned there is a realisation that the majority of those who die by suicide were not deemed high risk and many did not have severe mental illness. This has been described in the literature in other contexts as the Paradox of Prevention[48] which recognises that the majority of the burden of a condition (i.e., suicides) will come from those at lower risk, due to the sheer weight of numbers of people who present with lower risk. This recognition has led to the more population-based systems approach of the ZSF within the healthcare setting, with a focus on moving away from prediction approaches to providing suicide specific interventions (e.g., safety planning, counselling on access to lethal means, and rapid follow up aftercare in the community) irrespective of the diagnosis or risk category for those presenting with suicide attempts or suicide crisis. However, there remain individuals, for example those who present with severe mental illness and/or with high lethality attempts who have been proven to have very high rates of suicide[49] and therefore require a particularly strong clinical focus on diagnosis, formulation, treatment of mental illness and clinical aftercare. All individuals on the Suicide Prevention Pathway, a core aspect of the ZSF, also require at least a degree of clinical aftercare to ensure best practice in clinical handover of care. Therefore, it is vital that at an individual clinician level, a focus is retained on both best evidence in individualised diagnosis, formulation, clinical treatment, and clinical handover while embracing best practice in suicide specific care, and the benefits of standardised pathways of care regardless of diagnosis, holding on to the tensions and paradox.

At a service level, the Paradox of Prevention has had enormous implications in terms of the numbers of consumers who are now "in scope" for at least brief interventions and brief clinical follow up. When these pathways of care are implemented with fidelity (with good outcomes) these individuals are now getting the care they require, but significant strain is placed on state funded MHAOD services delivered by HHSs in order to achieve the needed fidelity, safety and quality required. Despite the best intentions of staff, increasing suicide presentations, particularly following on from the COVID-19 pandemic, have led to the inability to maintain fidelity to best practice for the care pathway. The increased burden of care carried by services implementing these best practices has not been funded. Services must also maintain a focus on the importance of the component of the Pathway that provides suicide specific interventions, while also reinforcing, and providing training and

[47] Turner K, Sveticic J, Pisani A, O'Connor N, Burke K, Woerwag-Mehta, S and Stapelberg, N (unpublished – cited with permission of the authors) Tensions and Paradox in Suicide Prevention.
[48] Rose, G. 1981. 'Strategy of prevention: lessons from cardiovascular disease'. British Medical Journal, 282, 1847-1851.
[49] Runeson B, Tidemalm D, Dahlin M, Lichtenstein P, Långström N. Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. BMJ. 2010 Jul 13;341:c3222.

ongoing supervision for best practice clinical care, that maintains focus on comprehensive care, formulation, diagnosis, treatment of mental illness and substance use disorders.

At a system strategy and planning level, there is a risk of underestimating complexity, and there must be recognition of the tensions and paradox described above. Funding must be directed to support all care required. Upstream interventions to address the social determinants of suicide are vital, as are a range of clinical and non-clinical early intervention solutions for preventing crises and the non-clinical supports for aftercare. Additionally, a focus must be maintained on the clinical aspects of suicide prevention as already described with resources and funding to support this. Further, as a key planning methodology to support service development and appropriate resourcing, it is critical the NMHSPF is revised to take account of and recognise suicide and crisis, in addition to the shift in paradigm impacting activity in services and increases seen with those presentations associated with the pandemic. Therefore, given the limited buckets of funds, there is a risk that funding may inadequately serve those with severe and complex mental illness.

Suicide is a complex and challenging issue with no single solution to reduce suicide or its impact. Therefore, suicide prevention requires a whole-of-government, cross-sectoral approach to planning, strategic policy development and service delivery.

As outlined in QH's written briefing, the work undertaken to align with Every life and the opportunities for HHSs and others to intervene in those at risk of suicide through the provision of a comprehensive range of safe, high quality health services. This includes primary care, crisis services, clinical treatment and psychosocial support.

Zero Suicide in Healthcare Multi-Site Collaborative

Within QH, the ZSiH Multi-Site Collaborative is a system-wide collaboration between HHSs, coordinated and supported by the MHAODB, and as outlined in the Written Briefing is guided by seven elements of the ZSiH Framework spanning leadership, workforce training and support, a pathway of care that includes elements of identification of those at risk, engagement, and evidence-based treatment, with a data-driven continuous improvement approach.

Nine HHSs have a small amount of recurrent funding to support project and clinical leadership of improvement initiatives aligned to the Framework, while three others have been supported through non-recurrent funding (total investment $6.8 million over five years). Evaluation of this work has demonstrated reported improvements in problem solving, knowledge transfer and sharing of resources, more consistent clinical processes, and the perception of support by both clinicians and leaders.

Furthermore, a 35 per cent reduction in people re-presenting to the health service with a suicide attempt following an earlier suicide attempt has been demonstrated by the Gold Coast HHS following implementation of their Suicide Prevention Pathway.[50]

[50] K. Turner, N. J. Stapelberg, J. Sveticic and S. W. Dekker Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework Aust N Z J Psychiatry 2020 Vol. 54 Issue 6 Pages 571-581

Importantly, the approach taken to achieve these outcomes within the MH service took an all of health service approach, rather than the addition of a specific 'team' for the pathway, recognising that all staff within a MHAOD service are involved in suicide prevention efforts. A significant focus and commitment have been made by services to upskill all staff through training and ongoing supervision and a data driven improvement processes. This has resulted in large numbers of consumers benefiting from the pathway. For example, utilising this all of service approach resulted in, 7,445 consumers at the Gold Coast being placed on the pathway between December 2016 and March 2021, with a doubling of monthly average numbers over four years.

There have been and remain critics of the Zero Suicide terminology, with concerns that it would worsen blame cultures that exist in healthcare. Gold Coast was able to demonstrate that cultures can improve rather than worsen with the introduction of the ZSiH Framework, but this was in the context of a significant simultaneous focus within the service of adopting a RJC which included overt support for staff who do this challenging work and were being asked to 'aspire to zero'. There was a particular focus on support for staff and families following deaths of consumers from suicide. Given the challenges that exist in bringing about change in complex systems, it is of note that there was rapid adoption of the ZSiH Framework in this busy service, with high fidelity to elements. It has been argued that the adoption of a RJC is a vital accompaniment to any suicide prevention efforts, but particularly when using the language of zero, and was a vital ingredient to its success.

Early evidence indicates that funded clinical leadership and project support within HHSs, supported by multi-site collaborative service improvement methodology, promotes change in clinical care practices and consumer outcomes. Additional investment would facilitate expanding the reach of the collaborative across the state, while supporting existing sites to sustain early gains and improvements. It is essential to consider this investment as part of broader service system enhancements, as the Suicide Prevention Pathway enables consumer access to other service elements, such as crisis care, aftercare and support for carers, in addition to ongoing clinical care for those who require it.

Targeted strategies across the lifespan

Specific Child and Youth adaptations have been made to the ZSF within Queensland with the development of GenZ Suicide Prevention resources within Children's Health Queensland for use across HHSs.

Specific adaptations to cater for the older persons population has not yet occurred in Queensland but remains an area of future focus which will require funding support for the development of specific pathways of care, resources and training. Older males have some of the highest rates of suicide and need to remain a priority area. It has been identified that for older adults, physical illnesses and disabilities are a prominent feature that can impact risk and therefore must be addressed. Additionally, there is some evidence to suggest that there may be opportunities to intervene with older persons in general healthcare settings who may be at risk of suicide, support within primary care, assistance with navigating to specialist services when required and in accessing appropriate treatment and carer support.

It has been suggested that a navigator role may assist with these pathways. This requires further exploration.[51]

Carer support

Informal and unpaid carers, who are usually family or friends, of a person experiencing a suicidal crisis are integral to their loved one's support system providing a range of emotional and practical support essential to their wellbeing. Carers often report high emotional distress, challenges with their relationships, engage in fewer social activities, and feel lonely and isolated. Caring for someone experiencing suicidality has a profound impact on a carer's emotional, social and financial state.

Supporting people caring for a loved one experiencing a suicidal crisis is critical to increasing the confidence and capacity of carers to maintain their own wellbeing while providing care and support to their loved one.

The implementation and evaluation of 'Crossing Paths', a new model of care to enhance support for people caring for a loved one experiencing a suicidal crisis has was described in the written briefing. See Box 4 for carers' reported experiences.

Box 4: Carers experiences of Crossing Paths

"My partner receives a lot of care from various organisations, and it was really humbling for someone to reach out to me personally and say, "how are you going?" The first time I hear from time I heard from them it actually moved me to tears"

"It as little practical ideas to keep my daughter safe that was a big thing... It was little things, but they were big to me and helped in a lot of ways"

"You go from totally overwhelmed, wanting to sit in a corner and don't know what to do; to: 'there's a path out, I've got this'. I can sit in the park with a coffee, unload and come home, pick up my load and keep going."

I am able to deal with things better. I don't have a meltdown and burst into tears because I feel isolated. I feel calmer myself and I feel lighter... I'm happier and I can do things with a different attitude, I'm more capable... I wish this was around years ago before we got to the stage that we did".

Aftercare – non-clinical community-based psychosocial support

As described in the QH written briefing, in the 2019 State Budget, $7.6 million over four years was allocated for the provision of non-clinical aftercare services to support people following a suicide attempt through The Way Back Support Service[52] which provides psychosocial, one-on-one aftercare support for up to three months for people who present to a referring hospital following a suicide attempt or suicidal crisis. Non-recurrent funding is supporting 10 The Way Back Support Services across the state, and while the evaluation is due in December 2022, the mid-term national evaluation indicates clients are experiencing

[51] McKay R, Pond D, Wand A. Towards Zero Suicide for older adults: implications of healthcare service use for implementation. Australasian Psychiatry. December 2021. doi:10.1177/10398562211054039
[52] The Way Back Support Service was developed by Beyond Blue.

significantly reduced psychological distress and suicidal ideation between their first and last assessment.

Quotes from individuals who have accessed The Way Back Support Service are provided in Box 5.[53]

Box 5: Individual's experience of The Way Back Support Service

> *"I'm still getting 'me' back but with The Way Back I can be a better person. She said she was always there if I ever need to go back – I haven't yet, which is good, but good to know that it's there"*
>
> *"She helped me realise that I am at risk. And when I am at risk, what the tools are to help me find my way back. It's given me a better chance to find my own direction nowadays even after the program end. We have tough days, but there are skills you can learn and things you can do that help you get through the day without being so severe.*

In four of the seven bilaterally funded The Way Back Support Services, demand for aftercare is outstripping supply, with several of the larger services experiencing up to double the demand than predicted and funded. However, it is likely that this represents only a small percentage of those who attempt suicide.

Given that a previous suicide attempt is a significant risk factor for future suicide, it is imperative that aftercare is offered universally to people who have attempted suicide.

Workforce development and support

The health workforce needs to be equipped with the attitudes, skills and knowledge to recognise and appropriately respond to a person experiencing a suicidal crisis. Consistent training and workforce development provides a common approach and language for providers of suicide related care. To ensure training and skills development opportunities are available and meeting workforce needs, a workforce development strategy is being progressed. The strategy will be consistent with the new QH Suicide Prevention Practice Guideline.

The Queensland Centre for MH Learning currently provides training to staff on a range of suicide risk assessment and management courses, targeting ED staff and the MHAOD services workforce, and other clinical staff.

New training options are being developed to support clinical teams to provide care to people at risk, such as the redesign of the Suicide Risk Assessment and Management in the ED setting (SRAM-ED) program.

Additional training enhancements are required including extending suicide prevention training to MHAOD NGOs and improving workforce capability for clinical leaders to support staff delivering suicide care.

A number of HHSs have initiated programs to support staff, including following critical incidents including the loss of a consumer to suicide. It is well recognised that staff can

[53] Unpublished The Way Back Support Services Interim Evaluation report

suffer significant and long lasting negative psychological impacts when clinical incidents occur, and there are a range of evidence-based interventions that can assist. Some are being implemented and consideration of further actions is being undertaken, although no specific funding for this work exists.

Opportunities for improvement

Although a great deal of important work has been occurring as described, there are a range of issues that need to be addressed going forward, to ensure progress continues:

- Given the imperative of an all of community, multiagency and whole-of-government response to suicide prevention, regional approaches to planning and delivery of service including exploration of opportunities for joint commissioning between HHSs and PHNs should be supported. These approaches will support addressing gaps and reducing duplication, support of both clinical and non-clinical interventions, shared training and tools, improved safe handovers of care, and responding earlier to prevent suicide crisis as well as responding adequately to those in crisis. This will be further explored in section 6.2 – MH crisis.
- Given the early success of the ZSiH work, there is a need for funding to support the expansion of this to other services and the ongoing sustained support for existing services.
- The Way Back Support Services are currently over-subscribed and are providing services to consumers from a limited number of health services. Additional support for enhancing existing services, and scaling up to include other services, is required.
- The Carer Support initiative is a promising pilot addressing a critical gap, and consideration should be given to further scaling up this type of support across other services in the state, dependent on evaluation.
- An ongoing focus on best practice in clinical assessment, diagnosis, formulation, and evidence-based treatment is required. This should include addressing multimorbidity across physical and MH, including AOD, which often increase the risk of suicide, with a particular focus within state-funded MHAOD and primary care services, on:
  - depression, including sub-types
  - substance use disorders
  - chronic physical disorders including pain.
- A focus on diagnosis and evidence-based treatment of depression, including sub-types, within state-funded MHAOD and primary care services.
- Enhancement of funding of Acute Care Teams in HHS MHAOD services to enable the adoption of these best practices in Suicide Prevention to reduce suicides and suicide attempts.
- Ongoing support for workforce development will require both statewide resourcing for ongoing refinement and delivery of training in line with best evidence base, and local resourcing for flexible delivery of training and ongoing supervision and support to embed changes in practice.
- Support and funding for the planned MHAOD Digital Information Strategy which can enhance options for e-Health, including stepped care approaches to care; facilitate improved safe clinical handovers; facilitate shared care plans and safety plans; and

improve access to timely data to enable improved and efficient data driven continuous improvement and evaluation.

- Support leadership and cultural change through transformation to a RJC. This will include development of a strategy and associated training and support at both a state and service level.

6.2 Mental health crisis

Demand for MH crisis care has increased over the last decade, placing significant pressure on emergency services (i.e., QAS and QPS) EDs, and state funded MHAOD services. In the past five years alone, ambulance calls for MH emergencies has grown more than 15 per cent and ED MH presentations have increased 20 per cent, and referrals to specialised MH services has grown by 20 per cent.

Demand increases prior to the pandemic have been further exacerbated due to the impact of COVID-19 on MH, with demand from young people having been particularly impacted with this covered more specifically in section 6.4 – Child and youth.

Increasing demand and resourcing constraints have seen the MH service system reorient over time to focus on crisis responses, limiting the resources available to provide optimal therapeutic and aftercare support. This includes limiting a range of supports that have demonstrated the ability to prevent emerging MH crisis, reduce the likelihood of relapse and potentially reduce loss of life. With increasing demand, together with pre-existing gaps between NMHSPF recommended community MH services staffing levels and current resources, existing acute care teams, intended to provide home and community-based care, have become increasingly hospital-based and limited in the outreach care they can provide. Lack of outreach capacity in turn results in more people in crisis presenting to EDs or defaulting to non-MH interventions such as those provided by ambulance or police.

It is widely acknowledged, by service providers and people with lived experience alike, that EDs and hospitals are not ideal locations for many people who are experiencing a MH crisis. There is evidence that reliance on EDs and police, is less effective and more expensive than community-based MH crisis intervention models of care.[54] People in crisis and their families often describe frustration trying to access and navigate the MH care system when in crisis, and present to the ED in crisis because they believe they do not have access to better options of support. People who present to EDs with a MH issue often report the ED as unwelcoming, overcrowded and over-stimulating, wait longer to be seen than other patients, have longer stays in the ED and are more likely to leave before their treatment is completed. The high stimulus environment can lead to escalation of distress and use of restrictive

[54] Shore, S., & Sternbach, K. (2016). Behavioural Health Crisis Services: A Component of the Continuum of Care. Retrieved from: https://www.texasstateofmind.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf

practices.[55,56] Individuals in Queensland with lived experience of MH crisis have themselves strongly voiced the need for more sophisticated responses (see Box 6).[57]

Box 6: Young person's experience of ED during a suicidal crisis

> *"Emergency departments are a horrible environment at the best of times, let alone when you are in extreme emotional distress. Suicide is the leading cause of death for young people. This is a crisis, this is an emergency. We as a society, and as a system CAN and MUST do better."*

It is recognised that when provided with the right support and within the right setting, many people can move through a MH crisis without the need for ED or inpatient care. Some people will require inpatient care and access to inpatient MH beds in Queensland remains a significant concern with a large gap between NMHSPF recommendations and existing bed stock.

While the NMHSPF is an important tool for identifying, planning and resourcing a wide range of state-funded specialised MH services, it has been recognised that the framework does not adequately address the delivery of care to people experiencing MH and suicidal crisis, many of whom do not have an underlying severe mental illness and does not, at this point, encompass a range of innovations that have been emerging locally and internationally to improve crisis care.

There is growing consensus internationally that we need MH crisis reform to move away from siloed, piecemeal responses which maintain fragmented, highly variable and frequently costly responses, to focus on the whole crisis system of care.[58, 59, 60] Focusing on access to beds, co-responder models, and solutions within the ED are important but will be insufficient to solve the complex demands of crisis response – which requires system reform to ensure a connected continuum of care.

Rather, a regional response which constitutes a coordinated network of services is needed to meet the needs of those in crisis, including a continuum of care that prevents and intervenes prior to crisis, provides early intervention, coordinated crisis response, and supports recovery and relapse prevention following crisis. Important core principles need to be shared across these service elements.

[55] Clarke, Dusome, D., & Hughes, L. (2007). Emergency department from the mental health clients perspective. International Journal of Mental Health Nursing, 16(2), 126–131. https://doi.org/10.1111/j.1447-0349.2007.00455.x
[56] Australasian College for Emergency Medicine. (2018a). Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions. Melbourne: ACEM
[57] Queensland Centre for Mental Health Research. (2020). Partners in Prevention – Understanding and enhancing first responses to suicide crisis situations: Perspectives from lived experience. Retrieved via https://qcmhr.org/resources/partners-in-prevention-reports-understanding-and-enhancing-first-responses-to-suicide crisis situations/
[58] Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. Rockville, MD: SAMHSASuicide prevention
[59] Fitton, S., & Reagan, E. (2018). Behavioral Health Crisis Services – Models and Issues. Health Management Associates. Accessed via https://www.healthmanagement.com.
[60] Paton, F., Wright, K., Ayre, N., Dare, C., Johnson, S., Lloyd-Evans, B., Meader, N. (2016). Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. Health Technology Assessment (Winchester, England), 20(3). https://doi.org/10.3310/hta20030

Shifting Minds includes a focus on improving our response to MH crisis, including alternatives to EDs, expanding co-responder models, responding to consumers presenting with self-harm, assertive follow up following ED presentations and admissions, enhancing workforce capacity including trauma-informed care, a well-integrated peer workforce, least restrictive practice, and whole of system improvements.

The Fifth Plan outlines eight priority areas, many of which have an impact on the whole MH system. Of importance is the development of a regional integrated system of crisis response.

Recent innovations have been trialled in Queensland in a limited range of locations, with promising results, with the aim of expanding the range of MH crisis care options available, reducing demand on EDs, improving access to and co-ordination of care, and improving consumer experiences and outcomes (refer to QH's written briefing for more information). Many of these innovations feature embedding lived experience workforce into the models of service.

Box 7: Lived experience vision statements for QH's crisis system reform governance

The lived experience representatives on QH's crisis system reform governance structure have developed six vision statements for Queensland's mental health crisis service system.

- People in crisis are fully supported and receive crisis care until it is determined by all parties involved that the risk has been eliminated, and every precaution taken to prevent a person rebounding into crisis and ending their life.
- All people who present in a mental health crisis are treated equally, with respect, in a safe non-judgmental environment, regardless of their diagnosis or number of presentations.
- Carers and families are considered, included, and valued for their perspective by staff. Their rights are always recognised and respected.
- Carers and families are supported during the time the person they care for is in crisis, and throughout that person's recovery.
- The hospital stands by its promise to do no harm, and to provide a safe environment while delivering compassionate care to all people who present in crisis, regardless of their mental health diagnosis.
- Our services can effectively and efficiently support the differing needs of people in a mental health crisis or while in recovery, through a caring holistic person led approach.

Crisis support spaces, the Crisis Stabilisation Facility (CSF), QAS MH Liaison Service, QAS MH Co-Responder (MH-CORE), MH Liaison Service (MHLS), MH Liaison Service (Police Communications Centre), Police-MH Co-Responder Models and the MH Intervention Program (MHIP) have all been described in the QH written briefing.

Evaluation of these initiatives is progressing.

In terms of a crisis support space there is evidence of improved the reported experiences of individuals.

Box 8: Individuals' experiences of a crisis support service

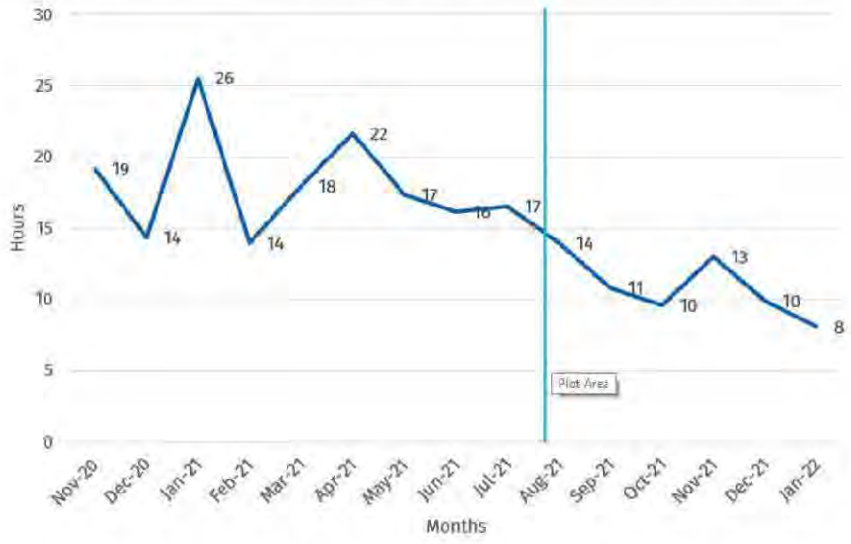
An individual presenting in crisis in the context of workplace distress spent time with a Peer Worker who assisted her working through her options to resolve her crisis. She reported this had a significant impact on helping to resolve her crisis. She returned two months later to thanks the peer worker for the help they had given her, saying that she had told her friends about The Space and encouraged them to seek help there if they ever needed it.

An individual was referred to the crisis support space over the weekend. We spent about 2-3 hours engaging her through board games and playing music that she enjoyed. At the end of the session, she reported that she was initially planning to ring the ambulance as she was not coping with her suicidal thoughts. However, she decided to try coming to the crisis support space and found that the space helped distract her from her suicidal thoughts. She was encouraged to present to the crisis support space in the future if she is in a similar situation.

In this example, the crisis support space is effective at redirecting individuals away from ED and also providing people with a space to distract and regulate themselves in a crisis.

The CSF on the Gold Coast, a stand-alone alterative to the ED, is demonstrating significant reductions in length of stay in the ED of individuals who were admitted to MH beds (see Graph 3), reduction in total hours of all people attending for MH care in EDs (see Graph 4), and people's improved experience.

Graph 3: Reduction in average length of stay (hours) in EDs since the Gold Coast CSF commenced (August 2021) for individuals admitted to MH beds, November 2020 to January 2022



Graph 4: Reduction in total hours of all people attending for MH care in EDs since Gold Coast CSF commenced, September 2021

Box 9: Individuals' experience of the Gold Coast CSF

> *"I have been admitted in many different hospitals before with my mental health and the crisis centre was the most amazing place I have ever been. Never have I felt so safe and listened to and taken care of. Knowing that I have the crisis centre there for me if I even need it puts my mind at ease"*
>
> *"The feeling of peace as I walked in and how caring and calm everyone one. It felt like I was not judged and actually understood"*
>
> *"Feeling safe to embrace the emotions that I was feeling without any judgment. I felt like I was somewhere that wanted the best for me, instead of just treating me like a number/person".*

Box 10: Experience of Advanced Peer Workers at the Gold Coast CSF

> *"Following peer engagements, consumers have provided positive feedback by saying things along the lines of "I've never had a conversation like that before." Many consumers have commented that peer support throughout the course of their stay in CSU helps them so much in clarifying how to move forward in their life and recovery, building hope that recovery is not only possible but probable with the right supports and referral pathways in place."*
>
> *"For consumers that have had previous negative interactions with mental health service delivery in the past, the CSU provides the opportunity to build new and positive associations. ... the existence of a positive environment encourages consumers to reach out for support and continue to engage with services, leading to better outcomes."*

In terms of the QAS liaison and co-responder initiatives, evaluation is also progressing. The QAS is one of the largest ambulance services in the world, responding to over 1.3 million, time critical events, such as trauma, injury and medical related emergencies a year; with 13 per cent of these emergencies being for a MH crisis. The QAS has seen an upward trend

for calls for MH emergencies to Triple Zero (000) of between 15 per cent and 20 per cent per annum for the past five years.

During October 2021, following active intervention by the MHLS clinicians, an ambulance attendance was avoided (and possible subsequent transport to hospital for further interventions) for 306 people who called Triple Zero (000) with a MH emergency. QAS has access to CIMHA, although the currency and the alignment of plans with the reality of the context is sometimes problematic, particularly for consumers who are closed to MH services.

The QAS MH Co-Responder (MH CORE) can facilitate access to appropriate follow up and referrals. Between 60 and 70 per cent of the time the consumer avoids hospital presentation by identifying and implementing appropriate treatment pathways for people experiencing a MH crisis. A further investigation of the QAS MH CORE (in conjunction with the QPS MH response programs) is currently underway, examining the qualitative and quantitative outcomes of the programs.

The MH Liaison Service - Police Communications Centre (MHLS-PCC) embedded MH consultation-liaison role since 2015, it has been positively evaluated, won a QPS award for excellence (2016, Customer Focus) and was identified in the 2020 National Productivity Commission Report as a case study demonstrating innovative practice that should be considered by other States and Territories. The MHLS-PCC service co-locates experienced MH clinicians from the QFMHS within the Brisbane Police Communication Centre (BPCC). Information sharing is supported through a Memorandum of Understanding (MOU) MH Collaboration (2017) that ensures best practice in balancing confidentiality and service collaboration. It currently operates until 11pm, 7 days a week.

The Police MH co-responder model is a Queensland multidisciplinary secondary response to MH situations, in which health services and police officers work together as a response unit in selected HHSs.

Other initiatives not outlined in the QH written briefing include:

- *Mental Health Lounge:* Opening in 2020, the Logan Hospital MH Lounge provides a dedicated waiting area and consultation rooms for people seeking MH support adjacent to the hospital's ED. Designed with MH consumers in mind, consumers can access the lounge following medical triage with care provided by a team of medical, nursing, allied health and peer support staff.
- *Short Stay Pathways/Units:* The above Crisis Stabilisation Facility includes a 72 hour "Short Stay Unit". A "Short Stay Pathway" allows for uplifting of existing beds with increased allied health, peer worker and community follow up capacity to ensure that increased engagement, comprehensive care, interventions, and rapid community follow up occurs. This has been demonstrated in Queensland to have a significant positive impact on reducing both length of stay, but also improving outcomes including reduced readmission rates compared to a matched cohort. This enhancement of existing beds provides an immediate response to the critical need to address lack of acute MH beds across the state.
- *Hospital in the Home:* Hospital in the Home or Home-based Assertive Treatment Teams are services that offer intensive specialised support in the home as an alternative to inpatient care. This care is designed for consumers who are suitable to receive care, treatment, and support in their own home. These services allow consumers to remain

connected to family and routine while receiving high intensity care. The ability of a MH service to provide Crisis Response and Home-based Treatment Teams is a core recommendation from the National Confidential Inquiry in Suicide and Homicide in the UK (National Confidential Inquiry into Suicide and Homicide, 2001) to provide evidence based, safer care. Apart from a few examples of home-based treatment, this has not yet been a focus of funding in Queensland.

- *Adult MH Centres:* Queensland Government initiatives have been complemented by Commonwealth investments in adult MH care that seek to improve access and coordination, with a focus on people who do not require state funded specialised MH services but do require additional MH support that cannot be provided through general practice alone. This includes a proposal to establish Adult MH Centres under co-funding arrangements with states and territories. These centres are intended to provide after-hours crisis support capacity.

Opportunities for improvement

Current investment is insufficient to allow existing acute care teams to continue responding to growing demand while also providing an optimal level of crisis and aftercare including home and community outreach. Current investment is also insufficient to allow expansion in innovations that may reduce demand and improve consumer's experience of care and outcomes.

While additional investment in these areas is recommended, it is recognised that poorly coordinated services are a significant problem, and that siloed investment can lead to increasingly fragmented service systems. It is essential that crisis care services are well coordinated both across QH and with other health care providers. For this reason, QH will progress a statewide framework to guide and evaluate state and local crisis care reforms and future investments.

As outlined above, the Fifth Plan highlighted the importance of the development of a regional integrated system of crisis response. In addition, there are frameworks and literature from international sites which provide further compelling advice for the need for more connected networks of response. The Crisis Services Task Force of the National Action Alliance for Suicide Prevention (Action Alliance) argued strongly that a piecemeal approach was unacceptable, and all core elements were required in order to save lives in a cost-effective way noting a shift towards using data in real time, 24/7 mobile response, residential crisis stabilisation and underpinned by core principles including recovery orientation, trauma-informed, Zero Suicide principles, strong commitment to safety and collaboration with law enforcement. Southern Arizona Crisis System depicted the crisis system to include crisis prevention, early intervention, crisis response, and post-crisis services and supports. Similarly, the *Crisis Care Concordat: Improving outcomes for people experiencing MH crisis*, developed and signed by multiple stakeholders involved in MH crisis in the United Kingdom, focused on access and support before a crisis, urgent and emergency access to crisis care, quality of treatment and care when in crisis and recovery and staying well.

Therefore, taking into consideration these models and policy framework, together with strong feedback from HHSs some of whom have already engaged in significant co-design regarding a framework, while a Queensland statewide framework will require further

consultation and co-design, essential elements that can drive direction can be summarised as follows:

- Regional Leadership Network Using a Data Driven Improvement Approach

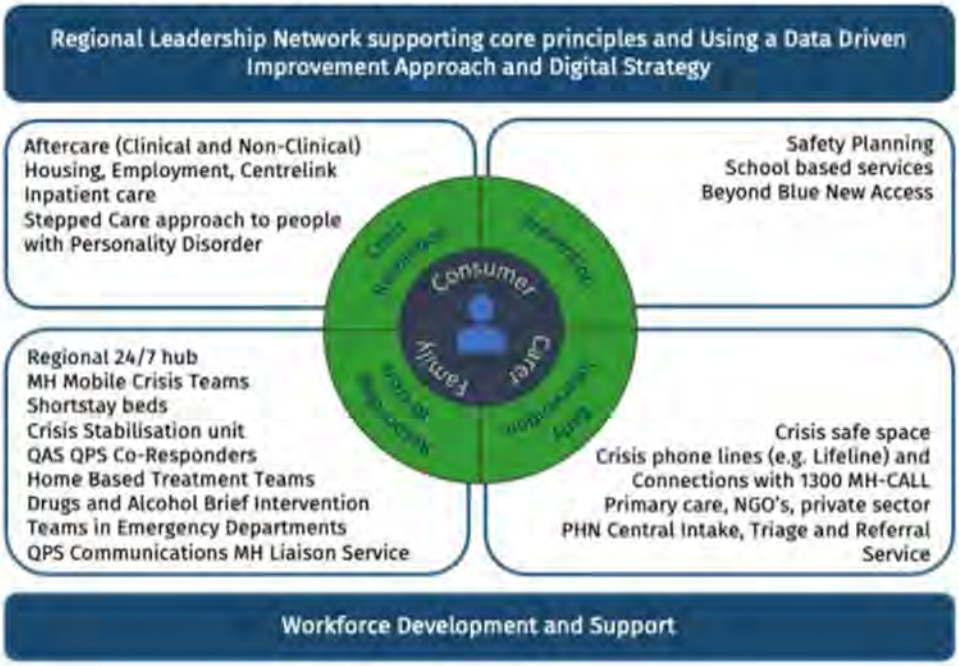
  A strategic approach to transforming MH crisis care across Queensland would include a multiagency coordinated and integrated network of care that is co-designed, recovery oriented, trauma-informed, utilising a framework that conceptualises crisis in terms of prevention, early intervention, responding to crisis and crisis resolution. It would address whole of life considerations, and the unique needs of priority groups:

  – Each region would develop a local leadership coalition, inclusive of lived experience leadership, coordinating a network for responding at a regional level and leading the development of a comprehensive continuum of care available to meet the needs of people who experience MH crisis. Gaps would be identified, reduce duplication, and support clarity to the community to navigate pathways of care. Alignment of all groups to underlying core principles would support this, for example, recovery orientation, trauma informed, lived experience and involvement of families, Zero Suicide principles within a healthcare setting, all-of-community approach to suicide prevention (e.g., Lifespan approach), least restrictive practices, integrated MH, AOD and physical health care, comprehensive care, culturally safe, responding to diversity, and a RJC.
  – A Digital strategy that supports shared electronic systems to enhance communication and shared care planning with consumers across the network or services; advanced data analytics; available data to support evaluation and real time responding to crisis.

- Continuum of Care

  A joint mapping exercise of relevant stakeholders in the region to be undertaken as a joint activity led by the HHS and PHN. Components of a continuum of care are indicated in Figure 5 below, ensuring that the consumer gets the right care at the right time and place.

Figure 5: Components of continuum of care for MH crisis services



- Workforce development and support

  Workforce development would be supported by statewide education providers who also respond to the identified regional workforce needs and support localised adaptations to meet regional needs.

- Addressing current limitations

  Addressing the current limitations in the system will require attention to the following priority areas:

  – Development of a statewide crisis reform strategy and support for regional planning to align with this, and partner with the Commonwealth Government to ensure appropriate interface between state-funded specialised MH services and proposed new community Adult MH Centres.
  – Enhance resources available to acute care teams to enable optimal care and follow up, including home and community outreach, acute mobile response, and home-based treatment, and expand the role of peer workers in EDs, home and community outreach.
  – Enhancing Drug and Alcohol Brief Intervention Teams providing services to EDs.
  – Establish additional crisis stabilisation services in areas with highest ED demand as alternatives to EDs, and crisis support spaces in all major hospitals or in accessible community locations close by, with extended operating hours as an adjunct to EDs.
  – Enhancing Drug and Alcohol Brief Intervention Teams providing services to EDs.
  – Establish crisis care co-ordination roles to improve co-ordination and follow-up care for people presenting to emergency and acute care teams in crisis.
  – Enhancement of the Police Communications MH Liaison Service (e.g., expanding operating hours, referral pathways, improved links to the broader crisis system).

- Enhanced MH Services funding to provide a stepped care approach to care for people with Personality Disorder, to enable the provision of brief interventions for people presenting in crisis, group work and individual therapy.
- Enhanced funding to provide short stay pathways within acute inpatient units maximise the use of existing MH beds, provide more intensive evidence-based interventions and peer workforces support for those people requiring brief crisis admission given infrastructure delays to building new beds.

6.3 Perinatal and infant mental health

During the first 1,000 days (conception to two years of age), a developing child is at their most adaptable but also their most vulnerable. The early years (up to the first 2,000 days) are crucial for an infant's physical and neurological development, and sets the foundation for life-long learning, MH and wellbeing. During this time of rapid growth, relationships with parents and other caregivers are critical. Persistent difficulties in early relationships can have pervasive effects on many aspects of a child's development (cognitive, psychological and physical), with long term costs to themselves, their families, communities and society. Research indicates intervening in the first three years of an infant's life is an effective way to ensure healthy brain development and associated social and emotional growth with health and wellbeing.

Perinatal MH is the MH and emotional wellbeing of parents, from conception until two years after the end of pregnancy. Perinatal mental illness covers a range of emotional and MH disorders from mild and transient to severe and disabling. Both mothers and fathers/non-birthing partners can experience perinatal MH difficulties and can benefit from support and treatment.

Infant MH describes the emotional wellbeing of infants and young children from conception to three years of age. It relates to an infant or young child's ability to: experience, express and manage emotions; form close and secure relationships with parents and care givers; and explore their environment and learn about the world. Critical to infant MH is the relationship between the infant/young child and their parent or primary caregiver.

The perinatal period is a time of significant change in which pre-existing MH and/or the impact of adverse childhood experiences (ACES) such as abuse, family breakdown, parental substance use or incarceration, can be exacerbated and existing stressors (e.g., mental illness, family violence, gender identity issues) can further accelerate, resulting in rapid deterioration of the health of the new parent and their relationships. These issues are further compounded when the perinatal period is accompanied by factors such as social disadvantage, geographic isolation, and First Nations status.

The MH and wellbeing of parents is critically important to the emotional and physical development of their baby. The impact of unaddressed MH problems through the perinatal period are far reaching, impacting the parent/s and the infant/child in the present with these following impacts transmitted across generations. Parents with mental illness report a reduced quality of life and are at increased risk for suicide and infants of parents with untreated/poorly managed mental illness have greater life-long risk of physical, substance use and MH disorders. Maternal suicide continues to be the leading cause of death in women during pregnancy and the first twelve months postpartum.

When untreated or undertreated, mental illness in the perinatal period is associated with significant costs in addition to increased morbidity and mortality for women and poorer outcomes for children and families.

National and international research supports the cost effectiveness of early interventions in the perinatal period. Most notably, gains in quality adjusted life years lead to reduction in negative long-term outcomes for women and families, reducing exposure to adverse childhood experiences for infants and improving the global burden on health care services, both immediate and long term.

For instance, Deloitte estimated the cost to Australia of loss of productivity associated with maternal perinatal depression was $86.59 million and the burden of disease associated with 16,575 disability adjusted life years.[61] In 2019, an Australian report funded by peak not-for-profit perinatal organisations estimated the annual economic impact of perinatal depression and anxiety (PNDA) disorders to be $877 million, with health costs (comprising of primary, community health services and hospital care) estimated at $277 million.[62] Economic costs secondary to reduced productivity in the workplaces and absenteeism were $643 million and a further $7 million for the social and emotional impacts for the infant with increased childhood diagnosis such as MH and developmental issues. This does not factor in the additional economic costs and increased prevalence of other mental illness in the perinatal period, nor reduced access to health care and supports, escalating intimate partner violence and MH issues during the COVID-19 pandemic. The latest research suggests an increased prevalence of PNDA and negative impact on women's MH throughout the pandemic.[63]

PNDA are prevalent disorders affecting 1 in 5 mothers and 1 in 8 partners or fathers. In addition, parents during the perinatal period are also at risk of emergent, relapse or ongoing impacts of other common mental illnesses. Post-traumatic stress disorder (PTSD), obsessional compulsive disorder, substance use disorders, eating disorder, personality disorder, bipolar affective disorder and psychotic disorders also have equally negative consequences on parental wellbeing and infant attachment.[64]

Additionally, approximately 15 per cent of infants and young children experience clinically significant MH issues.[65] Investment in early intervention and specialist MH services to support the wellbeing, MH and development of infants and young children from conception to five-years, and their families also offers significant benefits not only for these consumers but also in the longer-term. If problems are identified and treated early, this may lead to reductions in demand for MH treatment and support during later childhood, adolescence or

[61] Deloitte Access Economics (2012) The cost of perinatal depression in Australia Final Report. Post and Antenatal Depression Association. https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-economics-perinatal-depression-australia-cost-071112.pdf

[62] PwC Consulting Australia. 2019. The cost of perinatal depression and anxiety in Australia, https://panda.r.worldssl.net/images/uploads/Cost-of-PNDA-in-Australia_-Final-Report-061119-compressed.pdf

[63] Iyengar U, Jaiprakash B, Haitsuka H, Kim S. One Year Into the Pandemic: A Systematic Review of Perinatal Mental Health Outcomes During COVID-19. Front Psychiatry. 2021;12:674194. Published 2021 Jun 24. doi:10.3389/fpsyt.2021.674194, and Florence Thibaut, Patricia J. M. van Wijngaarden-Cremers. Women's Mental Health in the Time of Covid-19 Pandemic. Front. Glob. Womens Health. 2020. https://doi.org/10.3389/fgwh.2020.588372

[64] Refer to https://www.panda.org.au/prevalence-of-mental-illness-in-the-perinatal-period

[65] The Australian National Workforce for Child Mental Health (Emerging Minds)

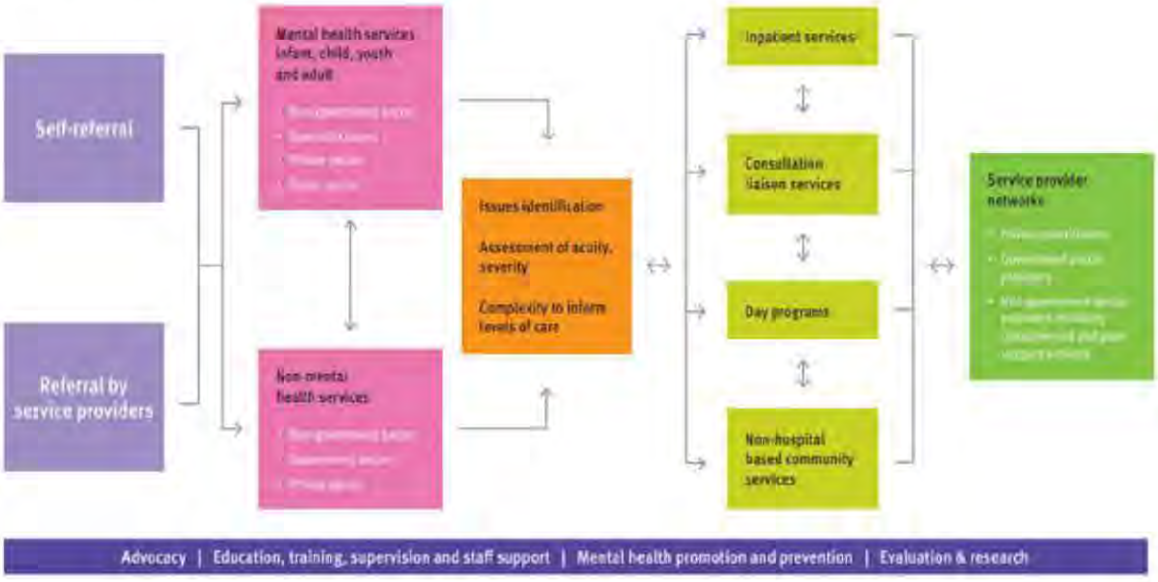
as adults. Better outcomes for individuals and families contributes to enhanced social and economic benefits.

State-funded specialist perinatal and infant mental health (PIMH) services are offered within the context of the broader continuum, including MH care and support for new parents and their infants provided through maternity services, private midwifery/obstetrics, general practice and child health, primary and secondary care (for example, through general practice, private midwifery/obstetric providers, child health and early education). The differing funding and program approaches, noting these are State, Commonwealth, private and NGO services adds complexity to the service delivery environment.

The treatment framework to support an integrated system of care across the continuum (refer to Figure 6 below) developed by the Queensland Centre for Perinatal and Infant Mental Health (QCPIMH), provides assessment and tailored perinatal interventions including mother-infant attachment work.

This continuity of care model leverages PIMH staff embedded in HHS and includes strong links with primary care, maternity care, child health, adult MH and services with expertise in infant and child MH and development to provide holistic care and improve early recovery.

Figure 6: PIMH service model



PIMH has been recognised as an important issue for several years in Queensland. Under the *Queensland Plan for MH 2007 – 2017*, the Queensland Government invested $0.97 million to establish the QCPIMH, a hub of expertise in PIMH to provide co-case management, consultation, liaison, and support to state funded MH services and the broader community sector. QCPIMH centrally coordinates service development in collaboration with the DoH, HHSs and the broader continuum of health services.

Under Connecting Care to Recovery, more than $31 million over five years has been invested for enhancements to the continuum of specialist PIMH treatment care and support across the state. This included establishment of Queensland's first public mother-baby MH unit, the four-bed statewide Lavender Mother and Baby Unit at Gold Coast University Hospital, enhanced community-based care across the state through new PIMH specialist positions; the

Together in Mind PIMH Day Program; the e-PIMH telepsychiatry service; and community support funding delivered by NGOs, for example Peach Tree Perinatal Wellness and the Early Social Emotional Wellbeing infant service.

The evaluation of Connecting Care to Recovery found that while previous funding for statewide services has enhanced the reach of services to target cohorts (including perinatal), this has not been sufficient to meet increasing demand across the state.

Responding to demand for specialist mother-baby perinatal MH beds and identified need for enhanced dedicated perinatal and infant community MH services and sufficient levels of investment are imperative to further strengthening and enhance the existing PIMH service continuum.

Current levels of State-funded PIMH services, particularly specialist mother-baby MH beds (for the mother when she requires acute MH inpatient treatment) and specialist community treatment, are not sufficient to meet this demand.

HHSs report:

- Increased perinatal MH referrals to HHS, precipitated by the COVID-19 pandemic – for example a 20 per cent increase in referrals to Metro North HHS between December 2020 and January 2021.
- Significant increase in demand for specialist mother baby MH beds – referrals to the statewide Lavender Mother and Baby Unit located on the Gold Coast more than doubled over 2020.
- Increased demand for PIMH telepsychiatry services.

Opportunities for improvement

Continuing to enhance the integrated continuum of care for PIMH services will support more mothers, fathers and their infants and young children to access timely and appropriate specialist care within acute, sub-acute and community settings.

It is also important to ensure that service responses respond to the unique needs of Aboriginal and Torres Strait Islander women and their infants and women and families from CALD backgrounds.

Delivery of appropriate maternity care for people with PIMH disorders requires integrated consultation-liaison/outpatient services within maternity care as well as specialist PIMH community teams and inpatient PIMH care. Consideration of opportunities to provide preconception advice and support, and support in the context of perinatal loss, is also important in this continuum of care.

There is an urgent and critical need for additional mother-baby MH inpatient beds to support new mothers in accessing appropriate inpatient care and support co-location of mother and baby when acute inpatient care is required. The Mater has already undertaken extensive planning to develop additional public and private mother/baby beds leveraging existing capital.

Increasing community-based perinatal MH clinicians and infant MH clinical positions to address increased demands and identified needs, enhance access for more mothers, fathers, their infants and families. Specialised infant MH treatment to families works to build and strengthen secure attachment relationships, manage and understand the infants' emotional

experiences, with a recovery-orientated focus on the trajectory of infant development, emotional wellbeing and social connections.

Strengthening the capacity of the existing telepsychiatry service (provided through the QCPIMH) to enhance clinical consultation to regional and remote HHSs who do not have capacity to support specialist PIMH positions, and where additional consultant psychiatry coverage is required.

Additional statewide capacity to support training, research and evaluation activities is required to strengthen workforce capability across the continuum of care. This is across the health sector, and other 'family touchpoint' sectors (i.e., early childhood educators and carers, Child Safety Services) to have skills in the areas of women's and family MH to identify MH issues early and refer to specialist PIMH care as appropriate. It is important that staff along these important touchpoints have the skills to provide parenting and parent-infant relationship interventions as required.

Inclusion of lived experience (peer) support within models of care and links to appropriate peer-led services is also an important component of contemporary models, including building the evidence base through evaluation and research.

Support for fathers, partners, secondary carers and other family members is integral within services. This includes strengthening opportunities across existing PIMH programs including Together in Mind Day Program fathers' session, SMS for parents, and peer-led services.

These enhancements will augment and positively impact on the capacity of the PIMH continuum of care to support other State and Commonwealth initiatives to identify and treat perinatal and infant MH issues early and effectively.

6.4 Child and youth

Achieving good MH outcomes for children, young people and their families requires a range of well connected, adequately resourced service elements which address a spectrum of needs from prevention and early intervention through to treatment and continuing care. QH provides specialist MHAOD services for children, young people and their families experiencing severe and complex MH issues and problematic substance use.

For children and young people, severe and complex MH issues are indicated through significant or persistent levels of emotional distress, behavioural disturbance and/or functioning impairment. Young people engaged in MH services frequently have cooccurring problematic substance use.

Mental ill-health is the leading cause of disability in people aged 10 to 24 years and accounts for almost 50 per cent of the burden of disease in people aged 16 to 24 years. It has been estimated that 15 per cent of children and young people aged four to 17 years had a mental illness in the previous 12 months. However, this reported prevalence is likely to be higher due to MH problems in children often going unnoticed, and the tendency of adolescents to not seek help. Young adults experience higher rates of mental illness than the rest of the adult population and around three-quarters of adult MH disorders emerge by 25 years of age.

There has been a rise in mental ill health in Australian youth. For example, Mission Australia in their National Survey of young people aged 15 to 19 years have shown a steady increase in the prevalence of clinical anxiety and depression.[66] Between 2012 and 2020, there has been a 44 per cent rise in young people reporting high scores of psychological distress (indicative of likely to have a mental disorder such as anxiety or depression) increasing from 18.8 per cent to 26.8 per cent. Young females are disproportionately affected, a finding which was first reported in 2014. There are many proposed reasons for the rise in MH problems in young people (i.e., social media, family breakdown, drug and alcohol use, increase educational pressures etc) and there is not widely accepted and plausible explanation. Importantly, the rise in MH problems preceded the pandemic, was occurring before the proliferation of social media and varies from country to country.

Between 2017 and 2021 there was a 29 per cent increase in referrals to state-funded community child and youth MH services across Queensland. Notably, the highest increase was seen for female adolescents aged between 13 to 17 years with a 57 per cent increase in referrals. Additionally, referrals for children and young people with eating issues have increased by 92 per cent between 2018-19 to 2020-21.

HHSs advise there has also been a rise in presentations of children and young people with complex comorbidities (e.g., neurodevelopmental disorders and AOD issues) and increasing levels of complexities in MH presentations across the continuum of state-funded child and youth MH services which require intense and specialist level services. Due to HHS services being at capacity, these presentations risk not been seen in a timely manner. Additionally, Metro South HHS advises that a significant number of referrals (82 per cent) are not accepted, noting these referrals are not always appropriate for MH treatment or do not meet the threshold of entry when assessed against other priority referrals.

There has also been a significant increase in the number of crisis presentations to both EDs and HHS child and youth MH services:

- Analysis of QH 2019-20 data shows that 19.2 per cent of all suicide and self-harm ED presentations were young people aged between 12 and 17 years.
- CIMHA data shows that for zero to 18-year-olds, presenting problems identified as 'suicidal issues' have increased by 32 per cent between 2019 and 2020.

Increased presentations have been precipitated by the COVID-19 pandemic, with greater demand overall, increasing anxiety-based issues and family pressures. However, it is also recognised that there have been ongoing trends of increasing pressure for several years pre-pandemic and across Australia.

Managing risk and crisis presentations has increasingly become a function for EDs and state-funded community child and youth MH services. The ED often serves as a crucial site of care including risk assessment, intervention and facilitating further treatment for children

[66] Tiller, E., Greenland, N., Christie, R., Kos, A., Brennan, N., & Di Nicola, K. (2021). Youth Survey Report 2021. Sydney, NSW: Mission Australia. Available at https://www.missionaustralia.com.au/what-we-do/research-impact-policy-advocacy/youth-survey

and young people presenting in crisis. However, many EDs do not have specialist child and youth MH staff available out of hours.

Box 31: Exemplar of child and youth mental health service reform

Child and Youth Mental Health Service Acute Response Team (CYMHS ART) in Metro South was set up in response to the increasing Child and Youth presentations to the Emergency Department.

The introduction of CYMHS ART increased the available clinical workforce and extended the hours of operations 7:00 am to 9:00 pm Monday to Friday across two EDs. Alongside this, the service developed and expanded post-presentation follow-up support, as well as pre-emptive support with the aim to avoid unnecessary ED presentations by increasing support to the young person and their family when and where it is needed.

Results to date show increased numbers of young people supported at home avoiding hospital admission, reduced length of stay in the ED and a reduction in the number of Emergency Examination orders brought into ED.

Feedback from families has been very positive with family members reporting:

"The extra support helping my daughter also helps me gain a better perspective and understanding on how to help. Feeling grateful for these services!"

"Relapse was avoided. Brief family interventions were helpful to reconnect with my son".

Additionally, the onset of AOD use often occurs in adolescence, which is a time characterised by increased independence, experimentation, and risk-taking behaviours. Service demand analysis (including the Q-DASPM) identifies a significant unmet need for core youth AOD treatment in Queensland including, intake and screening and brief intervention and counselling, particularly for areas in south-east Queensland.

For young people who experience problematic substance use, particularly in early adolescence, there are often a set of associated complex psychological, social, developmental, and other environmental factors requiring multi-strategic responses. A 2019 report on the needs and characteristics of 508 young people aged 12 to 25 years utilising state-funded youth AOD treatment on a nominal day in 2017 found high rates of family conflict, unemployment, and school disengagement amongst all young people, with high rates of reported trauma and concurrent MH problems.[67] Inhalant use is a key example of this complexity which represents a serious risk of harm to young people using inhalants and disproportionality affects younger more disadvantaged and marginalised groups in society, including for Aboriginal and Torres Strait Islander young people.

Effective intervention for young people experiencing problematic substance use supported by mechanisms for addressing the social and cultural determinants of health can have long term health benefits for individuals as well as socio-economic benefits for communities.

Children with a disability (including neurodevelopmental disorders such as Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder) or a chronic illness are at significantly

[67] Hallam, K. T., Davis, C., Landmann, O., & Kutin, J. (2019). ThYNC-Q, The Youth Needs Census – Queensland: Needs and Characteristics of Young People in the Youth Alcohol and Other Drug System in 2017. Brisbane: Dovetail

higher risk of having MH issues than children without a disability. Those with an intellectual disability are up to four times more likely to have a diagnosable mental illness. In addition to the disability itself, the mental illness has an impact on school participation, relationships, family functioning and long-term outlook, as the MH problems may persist throughout the life course.

While the NDIS delivers disability supports for children and young people with a disability, the clinical MH treatment remains the responsibility of the MH system. The recovery-focused and time-limited model of care provided by child and youth MH services is not optimal where there is complex disability and MH/behavioural presentations. HHSs report cases where some of these children and young people have experienced a deterioration and escalation of behavioural disturbance, resulting in acute MH inpatient management.

Many children and young people exposed to trauma, engaged in the child protection and/or youth justice system, and impacted by an array of other social determinants such as poverty, homelessness, and domestic and family violence, often face broader disadvantage across multiple life domains. These can result in poorer outcomes for physical health and MH into adulthood, increased risk of disengagement from education and the workforce and increased vulnerability to serious risk of harm from the emergence of problematic substance use. Development of multi-agency tailored therapeutic responses to support these vulnerable young people and their families across agencies will support reduced impacts on related systems such as EDs and provide holistic, comprehensive wrap-around care and responses.

State-funded child and youth MHAOD treatment and support is provided in the context of a broad continuum of primary and secondary health, MH and wellbeing and family support services including other state funded initiatives such as the Department of Education's Student Wellbeing Package and the Commonwealth Government initiatives such as the NDIS and headspace.

Between 2016-2021, the Queensland Government invested $87 million under Connecting Care to Recovery to enhance a range of sub-specialist services which have provided valuable stepped care and sub-acute services to strengthen the continuum of care for children and young people in Queensland.

The current continuum of state-funded MH services for children and young people (see Figure 7 below) includes community based child and youth MH treatment, acute inpatient MH beds, Jacaranda Place-the Queensland Adolescent Extended Treatment Centre, community bed-based services (Youth Residential Rehabilitation and Youth SUSD services), and a range of specialised services including Perinatal and Infant MH services, Assertive Mobile Youth Outreach services, forensic services, Evolve Therapeutic services (funded by the Department of Children, Youth Justice and Multicultural Affairs), Adolescent Day Programs and the Ed-LinQ program.

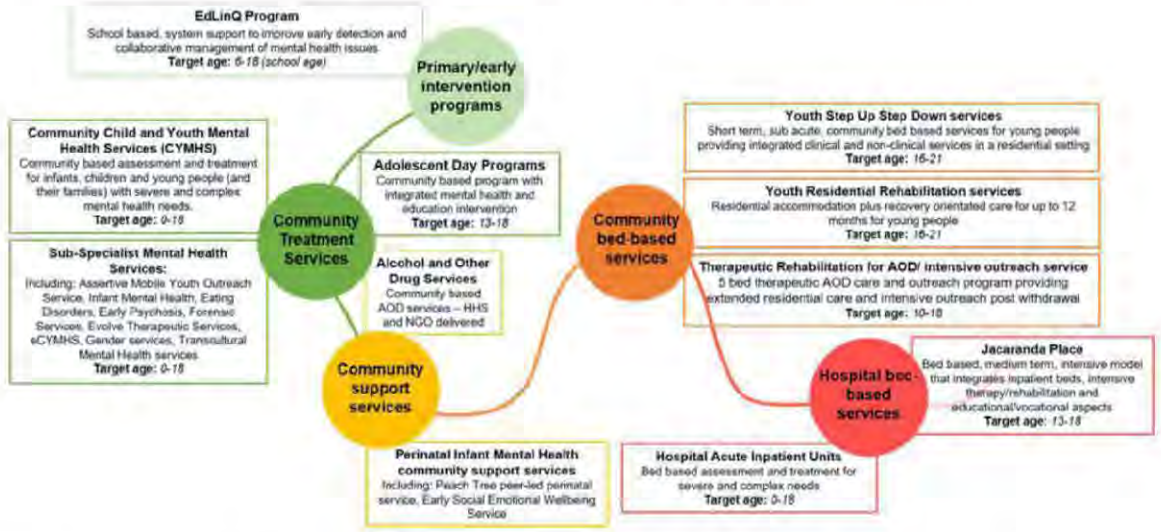
State-funded AOD treatment and harm reduction for young people (aged up to 25 years) is also delivered through HHSs and NGOs. AOD services for young people are culturally, age and developmentally appropriate and family inclusive. Given the range of needs of young people engaged in AOD treatment, services work with other agencies and across sectors to provide comprehensive and integrated care.

The QH statewide service Dovetail assists AOD treatment and related MH and youth providers with advice about the complex treatment needs of young people, assists providers in improving their responses to AOD and can work with service systems and communities to better respond to young people, their families and community experiencing problematic substance use.

Existing community bed-based youth alcohol and other drug treatment providers offering withdrawal management and rehabilitation for those up to 18 years including intensive structured treatment and care is available on a statewide basis at South Brisbane. This also includes pre- and post-residential care for young people and their families through intensive outreach.

To address gaps in intensive rehabilitation options for young people experiencing problematic substance use and associated complexities, the Queensland Government is expanding community bed-based rehabilitation service options including a new alcohol and other drug treatment service for North Queensland, based in Cairns. The new service includes residential and non-residential programs inclusive of culturally safe and specifically tailored programs for Aboriginal and Torres Strait Islander young people and their families.

Figure 7: Broad overview of state-funded perinatal, infant, child and youth MHAOD services



The years between 16 and 24 are an important transition point in a person's life, particularly noting many people in this age group are leaving school and moving on to tertiary education and/or work.

Many people experience mental ill-health or problematic substance use during this period which can negatively affect a person's ability to participate economically and socially and disrupt their transition from education to work. Seeking help for MHAOD problems is not easy and can be especially difficult for young people. The experience and impact of mental ill-health during this life stage can derail key developmental milestones and significantly increase the risk of poor health, social, education and employment outcomes. The human

and economic impact can last for decades, through what should be prime years of productivity and economic participation.

The onset of AOD use often occurs in adolescence which is a time characterised increased independence, experimentation, and risk-taking behaviours, occurring in the context of high rates of family conflict, unemployment, past school disengagement and high rates of reported trauma and concurrent MH problems. Older adolescents and young adults also have the potential to be exposed to greater risk of harms from substance use through increased likelihood of being in settings where drug use is more prevalent (i.e., entertainment settings like nightclubs or festivals) interest and access to new and emerging drugs in these settings, peer groups, and online environments. A 2022 Australian study found that at music festivals 'higher-risk drug behaviours was common, particularly amongst males and those using drugs for the first time'. [68]

The timing of first onset in adolescence and early adulthood means that MHAOD issues have a significant social and economic impact and warrants consideration as a priority. It is at this age and stage in life that young people are:

- engaged in education that will be formative in their social connections and future pathways to employment.
- experiencing major life transitions including moving between levels of education, from education to employment, and away from their families or caregivers into independent living arrangements.
- developing and navigating new social connections and interpersonal relationships.

It is imperative that where possible, models of service that seek to reduce transition points between services should be developed and accessible. There is added complexity that needs to be carefully managed as the young person moves between child and youth MHAOD to adult MHAOD services.

An independent review completed by Health Outcomes International (HOI) as part of the Government response to Recommendation 5 of the BAC COI final report reviewed service alignment and transition arrangements for young people with severe and complex mental illness transitioning from adolescent to adult MH services in Queensland.[69]

The HOI report included the recommendation to improve service alignment and transition arrangements, and to establish specific Youth MH Teams that include support needs of young people in terms of problematic AOD use, education, employment, housing, disability services etc. These teams would provide assertive, community assessment, treatment and

[68] Healey, A., Siefried, K.J., Harrod, M.E., Franklin, E., Peacock, A., Barratt, M.J. and Brett, J. (2022), Correlates of higher-risk drug-related behaviours at music festivals in New South Wales, Australia. Drug Alcohol Rev. https://doi.org/10.1111/dar.13404

[69] HOI, Review of the alignment and transition arrangements between adolescent and adult mental health services in Queensland, 2017, https://researchnow-admin.flinders.edu.au/ws/portalfiles/portal/16751527/rec_5_final_report.pdf

clinical care including psychosocial support, linkages with other services, specialist AOD treatment as required, and outreach components to facilitate engagement.

HHSs report that young people who are patients struggle to advocate within the adult MHAOD system, there is generally a higher threshold for access to state-funded MHAOD services, with the focus geared towards an adult individual. As young people develop through adolescence into young adulthood, additional supports may be required to assist them traverse developmental milestones, engage in social, educational/vocational opportunities, and support continued engagement of their families and carers as appropriate. This is in addition to the need to support youth-friendly services that promote engagement.

Youth specific services has been recognised in the revised NMHSPF which has better modelled services specific to younger people. As a result, resource estimates targeted to young adulted aged 18 to 24 years includes specific young adult acute MH beds. Enhancing access to specialist acute young adult care supports developmentally appropriate care in an acute setting that is informed and responsive to the needs and diversity of this cohort to promote ongoing care and recovery. Young people (aged 16 to 25) have the highest prevalence of mental illness and the effects of mental illness on this group can be devastating.

Supporting additional adolescent and young adult beds and additional complementary community treatment services, are estimated to return an additional 29,300 to 52,860 quality-adjusted life years per year, an addition of $46-86 million in labour income.

As outlined previously, there has been an overwhelming increase in presentations to the state-funded MHAOD system, with eligibility thresholds for ongoing care and treatment are narrowing in response. This has resulted in clinics having reduced capacity to offer ongoing treatment required due to meeting these demand pressures.

Similarly, headspace centres, designed to provide services for young people aged 12 to 25 years with mild to moderate mental ill-health, are reporting both increasing demand and increasing proportion of high-risk and complex presentations.[70] The headspace model experiences ongoing challenges (e.g., workforce and lack of clinical oversight impeding on ability to provide specialist MH care and pharmacological interventions[71]), with subsequent impact on provision of effective treatment[72] for young people with mild to moderate MH concerns. This in turn places additional pressures on state-funded MH services to respond to

[70] Orygen, The National Centre of Excellence in Youth Mental Health and headspace, National Youth Mental Health Foundation. Submission to the Productivity Commission's Inquiry into Mental Health. 2019.
[71] Rickwood, D. J., Telford, N. R., Parker, A. G., Tanti, C. J., & McGorry, P. D. (2014). headspace - Australia's innovation in youth mental health: who are the clients and why are they presenting? Med J Aust, 200(2), 108-111. doi:10.5694/mja13.11235
[72] Iorfino, F., Carpenter, J. S., Cross, S. P., Crouse, J., Davenport, T. A., Hermens, D. F., . . . Hickie, I. B. (2021). Social and occupational outcomes for young people who attend early intervention mental health services: a longitudinal study. Med J Aust. doi:10.5694/mja2.51308

risk and crisis presentations, or some young people falling through the gaps with no adequate service option available.

Young people with emerging MH issues may have difficulty accessing an appropriate treatment response across the continuum. If left untreated, their MH may deteriorate and result in presentation in crisis to EDs and/or State-funded MHAOD services.

QH currently provides a range of bed-based and community treatment for young people (16 up to 25 years). This includes community-based treatment via child and youth (0 to 18 years) and adult MH services (18 + years), community bed-based treatment and support with Jacaranda Place - the Queensland Adolescent Extended Treatment Centre (0 to 18 years with up-reach to 21 years as developmentally appropriate) and Youth SUSD Services and Youth Residential Rehabilitation Services (16 to 21 years). A few child and youth MH services target young people up to the transitional period from adolescence to the traditional adult cut off point 18 years.

A small number of HHSs provide specialist MH treatment for young people. However, these are generally focused on a small number of diagnostic groups. For example, Gold Coast host a young adult inpatient unit, and several HHSs including Metro North and Townsville have early psychosis services for (age 18 to 25). These have generally been developed from existing resources to meet a clinical need.

State-funded specialist AOD treatment and harm reduction for young people (aged up to 25 years) is provided through HHS and NGOs funded through service agreements with the DoH.

Examples of youth specific AOD treatment and harm reduction delivered through HHSs include the Hothouse Program at Metro North HHS and the LADDERS program at Metro South HHS. NGOs deliver specialist AOD capacity in youth services (where young people with multiple issues are engaged) and for specific cohorts including young people identifying as LGBTIQ+ and for Aboriginal and Torres Strait Islander young people. Young people aged 18 to 25 years account for the majority (67 per cent) of all children and young people accessing these specialist youth AOD treatment services, as identified in a 2019 Queensland youth treatment census.[73] Young people aged 18 and over may also access existing adult community bed-based rehabilitation and withdrawal management services.

As part of the 2020 State Election, the Queensland Government committed to delivering a new youth AOD residential treatment service based in Cairns to help meet the needs of young people in Far North Queensland, inclusive of Aboriginal and Torres Strait Islander young people.

QH's statewide service Dovetail provides clinical advice and professional support for workers, services and communities who engage with young people affected by AOD use.

Recently, QH in partnership with the Children's Hospital Foundation, have funded a two-year pilot of Orygen Digital's Moderated Online Social Therapy (MOST) platform in Queensland (Q-MOST). Q-MOST is being rolled out to seven HHSs and other relevant stakeholders such as headspace. The Q-MOST pilot will deliver an evidence-based clinician-moderated online

[73] Hallam, K. T., Davis, C., Landmann, O., & Kutin, J. (2019). ThYNC-Q. The Youth Needs Census – Queensland: Needs and Characteristics of Young People in the Youth Alcohol and Other Drug System in 2017. Brisbane: Dovetail

platform offering young people aged 12 to 25 years, online personalised therapy programs, moderated social networking and evidence-based tools to adjunct face-to-face clinical care. This pilot has recently commenced and will be evaluated by the Queensland Centre for MH Research.

Opportunities for improvement

The evaluation of Connecting Care to Recovery outlined that while new investment enhanced the reach of services to target cohorts including children and young people, the enhancements were not sufficient to meet increasing demand across the state.

Noting the increase in demand on state funded MHAOD service system for children and young people, particularly the increase in crisis presentations for adolescents, there is reduced capacity to provide comprehensive assessment, treatment and care for the younger cohort and their families. Other service options outside the state funded MHAOD system such as private practitioners, headspace also report their books are closed and long waiting lists. This in turn places additional stress on state funded MHAOD services.

Recent evidence, supported through consultations and extensive service needs analysis, highlights a need to grow the range and volume of child and youth services along the continuum to respond to increasing MH presentations, increasing levels of complexities in presentations, and young people and their families presenting in crisis and with suicidality.

This enhancement is required across community treatment, including access to specialist eating disorder (refer to section 6.5 – Eating disorders), forensic (refer to section 6.8.2 – Child and youth forensic MH), day programs, community support services including growth of the youth peer and carer peer sectors, community bed-based such as youth residentials and youth SUSD services, and hospital bed-based services.

Additional capital is required to support increased numbers of adolescent acute beds, recognising the need to increase the availability of specialist inpatient MH care (at the right time and closer to home) to assist adolescents, with their families and carers, to recover their health, wellbeing and developmental potential (refer to section 5.2.1.2 – Capital planning).

There is a need to strengthen integration and multi-agency approaches for highly vulnerable cohorts of children and young people who are within the remit of multiple agencies requiring a coordinated response.

There is a critical need to augment the existing AOD treatment system to address service gaps and enhancing system capacity to engage and support "hard to engage" cohorts such as young people involved in the youth justice system, child protection system and Aboriginal and Torres Strait Islander young people.

This could include expanding community-based AOD treatment, trialling new models of specialist youth AOD treatment, including e-health and building the capacity and supporting state-funded child and youth MH services to respond more to the needs of adolescents with co-morbid substance misuse issues.

Evidence identifies the need for AOD treatment and care that is flexible, family inclusive, developmentally responsive, and provides integrated and collaborative treatment and support to reduce substance related harms for these vulnerable young people. While Queensland is expanding the availability of intensive community residential and

non-residential AOD treatment for young people in Cairns and surrounding regions, there continues to be limited services, models of care and collaborative partnerships tailored to meet the needs of vulnerable young people their families and communities, experiencing problematic substance use and associated problems.

Noting onset of illness is generally between 15 and 19 years of age, it is important to continue to consider the role of specialist services that are youth friendly and inclusive, and provide care and treatment, with a focus on emerging diagnostic groups, for example, early psychosis services, borderline personality disorders, substance use disorders and severe treatment refractory depression.

To both address demand for increasing presentations of young people with severe and complex MHAOD issues, and to support youth-focused and specialist youth treatment and care, consideration should be given to establishing discrete young person-beds and additional complementary community treatment services.

This will support provision of evidence-based treatments and care which address the specific MHAOD needs of the young person in the context of their important life stage. Interfacing with other care and support provided by other agencies including vocational and educational support, youth peer support, care coordination and liaison, family and support network services and housing is also critical.

In addition to the above it is also important to grow treatment and care responses in areas of identified unmet need for young people across Queensland and as part of local and regional service systems and implement sustainable strategies to attract, recruit and retain the workforce and develop MHAOD skills and experience (see also section 5.2.5 - Workforce).

Tailoring responses for priority groups including young people in rural and remote areas and Aboriginal and Torres Strait Islander young people, families and communities is essential.

6.5 Eating disorders

Eating disorders are a group of mental illnesses typically characterised by problems associated with disordered eating or body weight control, and a severe concern with body weight or shape and may include overeating or insufficient food intake. Eating disorders are one of the 12 leading causes of hospitalisation costs due to mental illness in Australia and the total social and economic costs of eating disorders in Australia has been estimated at $69.7 billion.

Eating Disorders are serious MH conditions, estimated to affect four per cent of the population and are associated with considerable psychological distress, serious medical complications, potential of lifetime prevalence and higher mortality risks. Along with substance use disorders, they have the highest mortality rate of all psychiatric disorders. The mortality rate for people with anorexia nervosa is the highest of all psychiatric illnesses, and over 12 times higher than that compared to the annual death rates from all causes in females aged 15 to 25 years of age.

Research shows that adolescents are at greatest risk, with the average age of onset for an eating disorder between 12 and 25 years. Of concern is the increasing rate of younger children presenting with early signs of disordered eating behaviours. Eating disorders in

childhood and adolescents disrupt developmental trajectories including physical health and growth, social engagement and development, educational learning and achievement.

There has been nationwide recognition of the increase in new presentations during COVID-19 of eating disorders and people relapsing with eating disorders across both the public and private sectors. There is also some evidence pointing towards an increase in the acuity and severity of presentations. Initial Australian research indicates the COVID-19 pandemic has negatively impacted individuals experiencing eating disorders with an increase in restriction, binge eating, purging and exercise behaviours in those with eating disorders.

In Queensland, data captured between 2019-2020 (during the COVID-19 pandemic) indicated an overall increase rate of eating disorders diagnoses presentations of more than 25 per cent, the rate being higher in the younger age group between 13-25 years. HHSs are reporting extreme surges in presentations for eating disorders along with private hospital and private practitioners, many of whom have long wait lists or closed their books. This has in turn, placed additional stress on state-funded HHS and NGO services.

In 2020, QH facilitated two targeted Eating Disorders consultations with clinical experts and people with a lived experience of an eating disorder, their families and carers.

These consultations acknowledged that while under immense pressure, the existing system provided a solid foundation for future growth. People with a lived experience supported the appropriateness of the current system of service responses. However, there was agreement among service providers and, consumers, carers and families that there are not enough resources in the system for specialist care (as evidenced by increasing waitlists and people not receiving timely assessment and treatment) and limited specialist eating disorder services outside the South East corner of Queensland.

The need to expand the continuum of care with in-reach models, access to supports directly into people's homes and explore new and innovative models of care was identified along with services needing to provide a seamless care experience when transitioning between services (e.g., inpatient and community, from child and youth MH services to adult MH services, extended inpatient residential care such as offered through Wandi Nerida located on the Sunshine Coast).

QH funds treatment and care for children, young people and adults with eating disorders across Queensland. Bed-based and community treatment is delivered by HHSs. Treatment and psychosocial supports are also provided by a specialist NGO - Eating Disorders Queensland (EDQ) (for individuals 16 years and over).

The state-funded services system for eating disorder comprises the following specialist components:

1. The Queensland Eating Disorders Service (QuEDS) which provides:
   - consultation-liaison support and advice to HHSs statewide, who support individuals with and eating disorder in inpatient and community settings.
   - education and training to HHS and research
   - a day program (available to individuals across the State)
   - an assessment clinic and individual treatment (for individuals in Metro North HHS)

   - an intake service (for individuals across the State to be assessed for entry into the five-bed specialist inpatient unit at the Royal Brisbane and Women's Hospital (RBWH)).
2. Eating Disorders Hubs (Gold Coast, Sunshine Coast and Cairns). These hubs provide specialist consultation-liaison eating disorders support to general medical and MH inpatient services, referral pathways, case coordination and workforce development at the local level.
3. Inpatient care provided through HHS MH and other general medical wards.
4. Community based assessment, treatment and care provided by state-funded child and youth, and adult MH services and other community-based health services.
5. A five-bed specialist eating disorder unit for statewide referrals located at the RBWH.
6. Treatment and support including peer and carer programs provided by EDQ.
7. The Child and Youth MH Eating Disorders Program Team (CYMHEDP) operating from Children's Health Queensland HHS (based at Greenslopes) which provides:
   - direct clinical services to children and young people within the Children's Health Queensland HHS catchment residing in the Greater Brisbane area
   - consultation-liaison support to some HHSs that provide treatment and care to children and young people with eating disorders
   - education and training to some HHSs and research
   - a day program, offering an intense program for people experiencing complex issues, which have not been responsive to community-based treatment. This service is based in Chermside with capacity for statewide scope.

This system sits alongside private hospital and private practitioners who also treat and care for individuals experiencing eating disorders.

The Queensland Government invested a total of $10.1 million over five years commencing in 2016-17 for eating disorders under Connecting Care to Recovery. This investment continued to develop hubs of specialist eating disorder expertise across major HHS catchments in Queensland to augment QuEDS in South-east Queensland Brisbane and Sunshine Coast HHS and one in Cairns and Hinterland HHS for North Queensland.

Enhancements were made to specialist child and youth treatment including establishment of a specific day program from 2020-21 and incorporate both local (Greater Brisbane) and statewide components. Carer and peer support provided by EDQ was also enhanced.

In response to the immediate and emerging impacts of COVID-19 QH provided EDQ with over $150,000 to support its existing program of service delivery and purchase necessary equipment to deliver services via telehealth.

Opportunities for improvement

Two major findings of the evaluation report on Connecting Care to Recovery relating to eating disorders was the need for more specialist training to be made available and for more equitable access to statewide services such as QuEDS across the State.

Opportunities to further develop and build on Queensland's strong foundation for responding to children, young people and adults with eating disorders include:

- Improving care navigation and transition pathways.

- Boosting capacity of specialist inpatient treatment for eating disorders across the State.
- Increasing access to specialist support in regional locations care across the age spectrum.
- Developing new and emerging, evidence informed models of care and support such as Hospital in the Home and parent meal support at home to strengthen the continuum of care for both consumers and carers.
- Expand the workforce and training.
- Focusing on earlier detection and care and expansion of evidence informed treatment modalities to meet variable levels of needs.

6.6 Alcohol and other drugs

As stated in QH's written briefing, AOD use is common and people use legal and illegal substances for a variety of reasons and in a range of ways (which may be across a spectrum from occasional use to dependent use and different patterns of consumption including drug type, frequency, quantity and method of use).

In 2019, 20 per cent of Queenslanders aged 14 years and over reportedly drank alcohol at levels that exceeded lifetime risk guidelines and 29 per cent at levels that exceed single occasion risk. These figures were higher than the national average. One in six or almost 17 per cent of Queenslanders reported using an illicit drug in the preceding 12 months. Cannabis was the most commonly used illicit drug.

There are also common patterns of co-occurring MH conditions and problematic AOD use. In populations of people in metro areas who regularly use illicit substances between 50 – 60 per cent report they had experienced a MH problem in the last six months (predominantly depression, anxiety and post-traumatic stress disorder).

The negative impacts of problematic AOD use can be substantial and affect individuals, families, communities as well as service systems and workers. Harms associated with problematic AOD use can be short or long term and include intoxication and overdose, accident, injury, illness and death, chronic dependence, as well as personal and social harms (including loss of relationships, education, employment and income). Alcohol use is one of the leading causes of preventable injury and early death in Queensland and is a leading contributor to the burden of disease.

Problematic substance use is highly associated with marginalisation, discrimination, racism and/or socio-economic disadvantage. Some of the population groups at risk of greater harms (within the context of other social determinants of health) include children and young people, people with MH and other co-morbidities (including persistent pain), people who inject drugs, women, people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples and people at risk of or experiencing homelessness. There are high rates of problematic substance use in people involved in the criminal justice system. Trauma and stressful life events and transitions including from custody back to the community are also times of vulnerability for problematic AOD use.

The status of some substances as illegal and their personal use and possession a criminal offence, can have real and significant impacts for people who engage in illicit drug use

including through creating barriers to treatment and recovery and the potential for further harms from involvement in criminal justice settings.

While use of more than one drug (known as poly-drug use) is the norm (and excluding diversion interventions for cannabis), alcohol and methamphetamine are the drugs for which most people engage in treatment. New psychoactive substances are increasingly available (including through online purchasing) with often unknown chemical constituents, adulterants and purity and pose a risk particularly for young people. Common and legal products such as aerosol deodorants are involved in outbreaks of inhalant use.

Queensland has some of the largest increases in rates of unintentional drug-induced deaths for different drug types. This includes pharmaceutical opioids, other pharmaceuticals (such as benzodiazepines) and increasingly stimulant drugs.

In 2020-21 the Queensland Needle and Syringe Program (inclusive of sites across HHS, NGO providers and private pharmacies) distributed a total of 11,535,515 syringes from 20 primary sites, 117 secondary sites, 70 dispensing machines and 843 pharmacies.

QH's Adis provides telephone support and a website for anyone concerned about their own or someone else's substance use. Adis has seen ongoing increases in call volume and in 2020-21 responded to an average of 3,862 inbound calls per month from Queenslanders seeking support for their own or someone else's substance use; with an average of 13,319 new users (monthly) to the Adis website (www.adis.health.qld.gov.au) during the same period.

Queensland has the second highest ratio of opioid treatment clients to prescribers in Australia. In 2020 there were approximately 7,000 people receiving treatment for opioid dependence, with about half through public prescribers and most receiving their medications via private pharmacies.

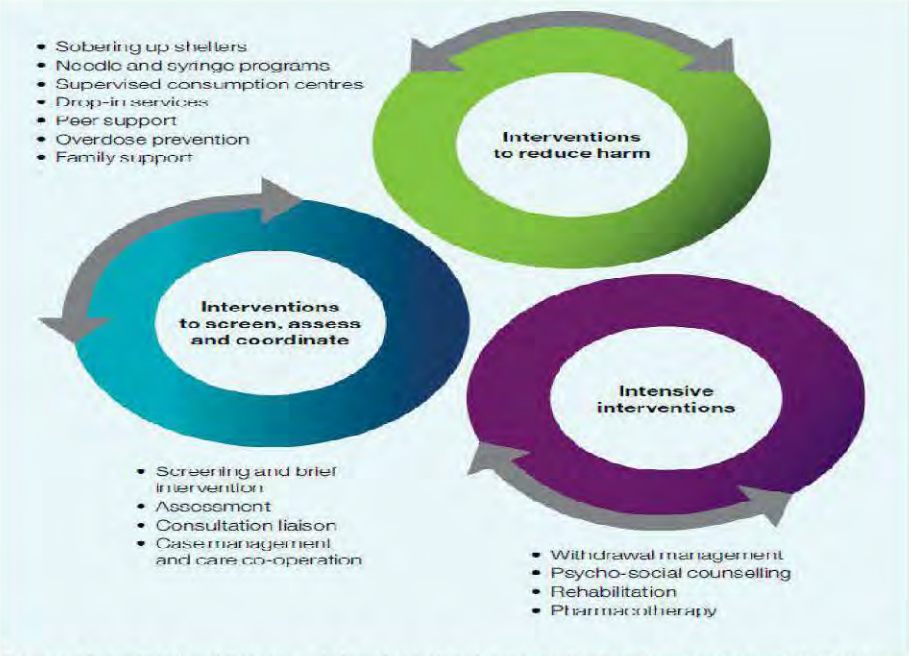
Diagnosis and treatment of chronic Hepatitis C is also increasing within those accessing AOD services with highly effective medicines and enhanced diagnosis pathways now available. Barriers to successful Hepatitis C treatment have included diagnosis burden and lack of cultural safety. A positive diagnosis of Hepatis C carries with it significant stigma. People with a diagnosis often report a history of negative interactions with health care practitioners if they disclose their positive status which, in turn, further decreases treatment potential.

To prevent and reduce problematic AOD use and harms and support positive outcomes and recovery, Queenslanders need access to effective and efficient AOD treatment and care delivered through coordinated care and connected systems.

Treatment is generally more effective if initiated early. Some people will require different intensity of treatment and care at different stages or across their lifetime, while others may seek peer support (through mutual aid services like Smart Recovery or Alcoholic Anonymous) or recover without the need for formal intervention.

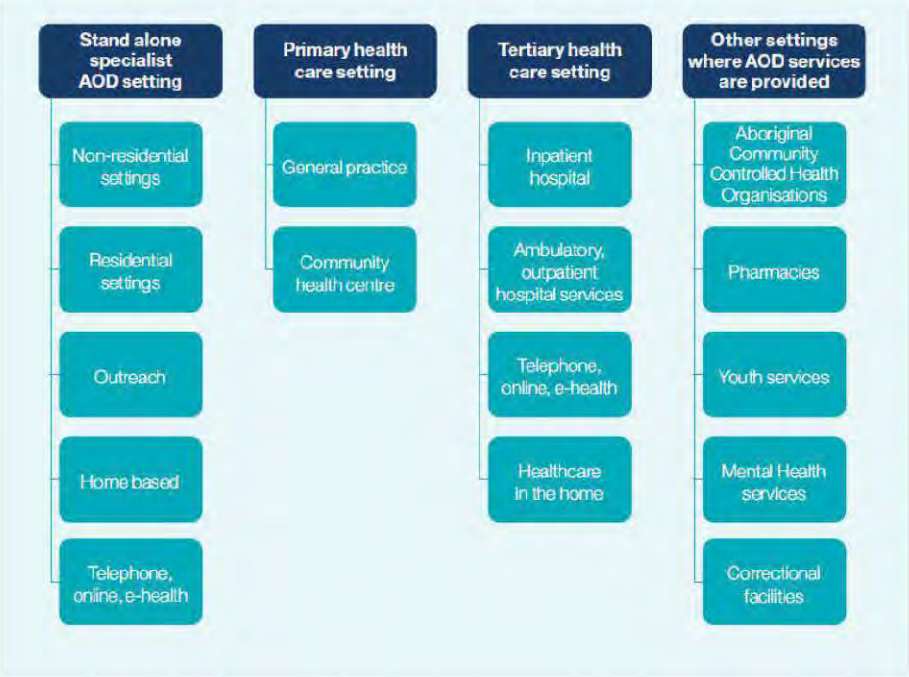
Queensland's state-funded MHAOD treatment and harm reduction services play a vital role in providing specialist care for people with moderate-to-severe problematic substance use and dependence (and their families) and those at greater risk of harms. The private and primary healthcare sectors play a part and people typically require care across a number of settings and treatment types which vary in duration, intensity and specialty (see Figure 8 and 9).

Figure 8: The alcohol, tobacco and other drug treatment service system



Sourced from National Framework for alcohol, tobacco and other drug treatment 2019-2029.

Figure 9: Different alcohol, tobacco and other drug treatment settings



Sourced from National Framework for alcohol, tobacco and other drug treatment 2019-2029.

Analysis of need identifies a lack of sufficient volume and type of treatment and harm reduction options across Queensland and in some regions very limited to no options for care. The gap in MHAOD prevention in Queensland, universal and targeted, is also acknowledged.

There has been significant reform and service development to increase and improve treatment and AOD outcomes for Queenslanders and their families.

As noted in the QH written briefing, work to improve integrated and collaborative MH and AOD policy, planning and service delivery across HHS and NGOs is progressing recognising the intersections within health and across these systems of care. This includes increasing recognition of problematic AOD use and dependence as a health issue and the importance of continuing to establish comprehensive care processes, digital strategies and information sharing and consistency, quality, and safety.

There has been significant collaboration nationally and across Queensland to develop and implement the National Framework for Alcohol, Tobacco and Other Drug Treatment and the National Quality Framework for Drug and Alcohol Treatment Services. The DoH also commissioned the development of Q-DASPM to support improved population-based planning. This was developed with support of a cross-sectoral advisory group and expert working groups of service providers and key stakeholders. An Aboriginal and Torres Strait Islander expert working group developed the Q-DASPM companion Framework for the planning and commissioning of Aboriginal and Torres Strait Islander AOD treatment services in Queensland.

There has also been increased investment in AOD treatment in recent years. This includes new investment of $10 million per annum recurrent under Connecting Care to Recovery for more treatment and family support delivered by NGO and recurrent funding to support the statewide Alcohol and Drug Clinical Advisory Service hosted by Metro North HHS.

Additionally, $105.5 million over five years was committed to implement a suite of supply, demand and harm reduction initiatives under Action on ice: The Queensland Government's plan to address use and harms caused by crystal methamphetamine. Significantly this included investment of approximately $17 million capital and $4 million per annum operational to establish a new, purpose-built, adult 42-bed residential rehabilitation and withdrawal service in Rockhampton (the first of its kind in Queensland that commenced operation in 2021); and approximately $4 million per annum to support families impacted by AOD use (through Family Drug Support and the Breakthrough for Families program and family recovery units in Logan); as well as $6 million per annum to support targeted services responses across Queensland through HHS and workforce development through QH's statewide AOD training and education service Insight and support for youth providers, Dovetail.

To support implementing recommendations of the 2017 Drug and Specialist Court Review,[74] $1 million per annum has been invested for the AOD health treatment component of the re-established Queensland Drug and Alcohol Court in Brisbane (delivered through Metro South HHS) and $650,000 per annum to establish the statewide Tele-D telephone service for health interventions delivered for people referred from the Police and Court Diversion program (through Adis), as well as $763,000 funding for establishing and enhancing

[74] Available from: https://www.courts.qld.gov.au/courts/drug-court/drug-and-specialist-courts-review

dedicated AOD treatment delivered by HHS and NGO providers for new CourtLink services in south-east Queensland.

Under the 2016 Queensland Parole System Review,[75] $20 million over five years from 2017-18 with $8 million recurrent from 2022-23 was committed for QH and Queensland Corrective Services to implement opioid substitution treatment across all Queensland Correctional Centres. Implementation planning for the final stage of delivery of this program is underway.

More recently as part of a 2020 State Election commitment the Queensland Government committed $51 million of capital funding to establish a 28-bed adult AOD residential treatment service in Bundaberg, a 45-bed adult service in Ipswich, and a 10-bed youth residential AOD treatment service in Cairns.

Also of note is the current work of the QMHC in finalising a new whole-of-government AOD Plan following comprehensive consultation across the State, to which activity by QH will contribute; as well as the cross-sectoral work to develop a new Queensland AOD Treatment Service Delivery Framework (in draft) and the Queensland AOD Treatment and Harm Reduction Outcomes Framework. All AOD activity in Queensland also aligns with and delivers on the National Drug Strategy 2017-2026 and its sub-strategies.

As stated previously, detailed planning and policy work confirm the need to continue to grow the volume and range of AOD responses to meet identified gaps and population needs, improve quality, safety and connectedness of AOD treatment within health and other systems of care and enhance responses to reduce AOD-related harms.

This is within the context of the existing policy approach to provide and improve connected, collaborative and comprehensive MHAOD care, given high rates of co-morbid mental illness and substance use disorders. A range of strategies support this, from policy and funding, planning and commissioning of services, data and information sharing, formal and informal arrangements, sector and workforce development and support. It is acknowledged this also takes place in a broader context of other supply and demand and harm reduction approaches.

Key identified AOD treatment, harm reduction and support priorities include (but are not limited to):

- Increasing the range of withdrawal management and care across regions to support access to suitable and appropriate care to meet people's AOD withdrawal needs, including outpatient and home-based support, residential bed-based care and hospital bed-based services as required.
- Increasing availability of tailored models of treatment and care that parents and guardians with children in their care can access, including flexible hours, residential services where parents can reside with their children and non-residential community options that provide for both parents and children, and can be more flexible in the provision of treatment and care.

[75] Available from: https://parolereview.premiers.qld.gov.au/

- Enhancing and establishing tailored treatment and care options for women, including residential services and community treatment group programs for women as well as women and their children, and promoting and tailoring phone and online services available to women.
- Expanding access to AOD treatment, harm reduction and care for children and young people, particularly in the context of early intervention, to help prevent problematic use, dependence or further harms.
- Enhancing the delivery of culturally safe and holistic models of care for Aboriginal and Torres Strait Islander people, their families and communities that support First Nations leadership and are established in line with the principles and objectives of Making Tracks, Local Thriving Communities and Closing the Gap strategies.
- Working across public, private and primary healthcare to improve access to treatment of opioid dependence and harm reduction including improving access to prescribing, medication dispensing and strategies to reduce overdose (such as access to naloxone, including take home) and harms associated with injecting (through enhancing Needle and Syringe Programs and establishing them in correctional settings) and continued rollout of Opiate Substitution in prisons.
- Improving access to brief and early intervention including delivery by phone and online and to support system connectedness for people seeking to engage in treatment through Adis.
- Models for regional, rural and remote regions need to be tailored for access and effectiveness and to support the workforce, including through MHAOD treatment and care, generalist healthcare and Aboriginal and Torres Strait Islander healthcare services; with a focus on regions with limited services and including using digital (phone and online) services client, workforce support and improving out-of-hours service access.
- Supporting the development and implementation of evidence-based and collaborative responses to reducing AOD related harms and improving safety including public health early warning systems and drug checking health services.
- Ensuring AOD responses as part of crisis system and suicide prevention reforms including more integrated MH and AOD treatment and care through ambulance services and in EDs, with options to expand Drug and Alcohol Brief Intervention Teams in other hospitals.
- Reducing stigma and discrimination.
- Attracting, recruiting and retaining the workforce, including addressing workforce supply challenges across the State and in rural and remote areas, Aboriginal and Torres Strait Islander health and peer workforce, and access to medical addiction specialty.
- Improving the participation and engagement of people with lived experience of AOD.
- Continuing collaborative work and strengthening capacity and effective mechanisms for the DoH, HHS, and other commissioners and key stakeholders to support joint regional planning for MH and AOD treatment care across Queensland.

6.7 Dual disability

In 2009, there were approximately 400,000 people with lived experience of intellectual and developmental disability (IDD) in Australia, which equates to approximately 80,000 Queenslanders (assuming even distribution across states). The number of Aboriginal and Torres Strait Islander people with disability in Queensland is unknown, although it is estimated to be over one third of the total Aboriginal and Torres Strait Islander population which was 220,000 in the 2016 census.

People with IDD have a significantly higher rate of mental illness, including psychosis, than the general population. Complicating this issue is the fact that mental illness can present as behavioural disturbance in people with IDD.

HHSs report that in a number of cases, individuals with IDD or cognitive impairment (e.g., acquired brain injury) present to their services when service providers or families are unable to manage behaviours. While mental ill-health may cause or contribute to behavioural changes, HHSs report that this is not always the case. Even when mental ill-health is a contributory factor, admission to hospital is often not the best solution.

Despite this, and in the absence of any other inpatient environments more suited to manage behavioural disturbance in people with IDD, individuals are admitted to MH units. This is not necessarily in the best interest of an individual with intellectual disability. Managing challenging behaviour is not the core business of state funded MHAOD units and there exists a lack of specialist expertise and resources to provide appropriate management for these individuals which in turn, may cause increased distress to the individual. Further, these individuals with IDD who are admitted to MH units, often face delays or have difficulty accessing NDIS supports. For example, HHSs report that the NDIS may try to label some challenging behaviours as due to MH and will therefore not be eligible for behaviour support funding.

This may more often be the case in those individuals with mild IDD. For some of these individuals, there may be a co-occurring MH issue, such as schizophrenia. However, once the mental illness has been treated, and residual challenging behaviours are assessed as related to the IDD itself, providing sufficient evidence of the functional impact of the mild IDD to satisfy NDIS criteria may be difficult.

People subject to a forensic order (disability) are a significant sub-group who may have unnecessarily long hospital stays. This group can also be (inappropriately) admitted to QH MH units when it is assessed there is a lack of appropriate community supports or community supports are insufficient.

This situation is compounded because there are some gaps in support for this group as the NDIA will not fund supports considered to be responsibility of the justice system. Currently, there is no funding source for some of these supports and individuals may then be admitted to MH units which is often not the appropriate place for someone who requires specialist disability supports.

In recognition of the need for support and expertise to assist with treatment and support for people with ID, Queensland Health has established the Specialist Mental Health Intellectual Disability Service (SMHIDS) – previously the Specialist Disability Assessment and Outreach Team, a statewide sub-specialist MH service. SMHIDS assists QH MH services by providing

assessment and management advice in relation to individuals who have an IDD and complex clinical needs (mental illness and/or challenging behaviours) to achieve better outcomes. SMHIDS is located at West Moreton HHS and assists all HHSs and DSDSATSIP in relation to Restrictive Practice approvals.

SMHIDS has also commenced the ECHO project which involves monthly tele-mentoring clinics which enables clinicians to present, discuss and obtain advice on a case study with the SMHIDS team and other colleagues.

QH also funded and commissioned the Mater Intellectual Disability and Autism Service (MIDAS) to undertake an in-reach project to provide targeted support, including the assessment and/or provision of management advice for individuals with IDD, who were an inpatient or outpatient in QH MH services and identified as complex. The project began on 1 January 2019 to run initially for six months. This was extended to nine, then 12 then finally 18 months duration, completing on 30 June 2020.

Referrals were received from 13 of the 16 HHSs and 135 assessments were completed. There were 61 cases of IDD without Autism Spectrum Disorder (ASD), 34 cases of ASD with comorbid IDD and 21 individuals with ASD but no IDD. Overall, the individuals identified as complex by the HHS typically had mild and moderate IDD, or for those on the spectrum, Level 2 Autism.

Approximately half of the individuals referred to MIDAS were already NDIS participants and 34 per cent were in the process of applying to the NDIS (e.g., collecting evidence to submit in their application). At least four individuals had failed attempts to apply to become NDIS participants prior to MIDAS referral. MIDAS assessments were detailed and performed by clinicians with sub-specialty expertise. Following assessment by MIDAS, an additional 31 individuals (23 per cent) of the total sample gained access to NDIS, including those four applicants who had previously been denied access. Twenty-two individuals had SIL funding at the time of MIDAS referral. This number increased to 34 clients following MIDAS assessment, with most new SIL funding for the more expensive categories (SIL for 2 Complex).

This illustrates the potential value of subspecialty MH expertise for individuals with IDD that the HHSs identify as complex.

The MIDAS project also delivered education on IDD MH and NDIS access to MH staff across HHSs. MIDAS has also been awarded an NDIS ILC Grant to build capacity in mainstream health and MHAOD services, the Enhancing Access to Services for Your Health (EASY Health) project. This project will develop and evaluate education in this area for MHAOD services using two Queensland MHAOD services as pilot sites. The two HHSs and DoH (MHAOD Branch) are members of the Advisory committee of the MIDAS EASY Health project. These resources will be available on the Queensland Centre for MH Learning website for access by all QH MH clinicians.

6.8 Forensic mental health

6.8.1 Adult forensic mental health

Forensic MH treatment and care is established internationally, and within Australia, and involves assessing and managing risk associated with mental disorder for people within a variety of criminal justice and health settings. These services span the criminal justice system including services for people in contact with police, services in courts, watch houses, prisons, the community and inpatient services.

In Queensland, specialist forensic MH services provide a range of supports for several groups of people including those:

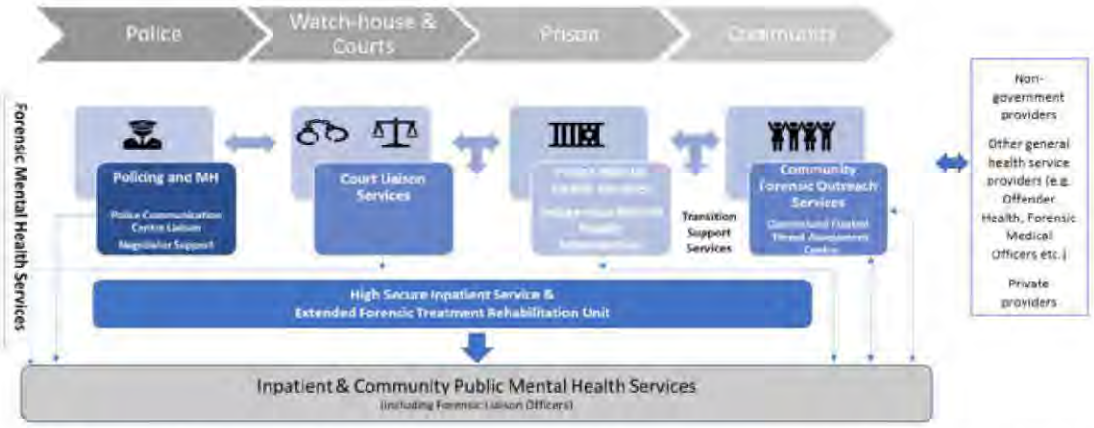
- whose mental illness is treated under a forensic order or treatment support order
- with mental illness in contact with the justice system (i.e., through gaol, community-based corrections, and courts)
- with mental illness whose behaviour is such that they are at risk of contact with the criminal justice system.

Treatment and care are either provided by HHS through MHAOD services or through specialist Forensic Mental Health Services (FMHSs). Treating responsibility for individuals on forensic orders and treatment support orders is held by HHS (community and inpatient MH services) who manage other individuals also considered to be higher risk and provide services to consumers from forensic settings (such as classified patients).

Services delivered by QH and operating across the health and justice systems include:

- Court Liaison Services (CLS)
- Community Forensic Outreach Services (CFOS)
- the High Security Inpatient Service (HSIS)
- Extended Forensic Treatment and Rehabilitation Unit (EFTRU)
- Prison Mental Health Services (PMHS)
- the Indigenous Mental Health Intervention Program (IMHIP)
- Policing and Mental Health services (Queensland Fixated Threat Assessment Centre (QFTAC))
- Police Communications Centre Mental Health Liaison Service (PCC MHLS)
- Mental Health Support of Police Negotiators.

Figure 10: The components of the Queensland FMH system – interfaces with the criminal justice system and state-funded MH services



Specialist FMHSs are not located in every HHS and arrangements are in place through larger HHS to deliver these specialist responses. The QFMHS hosted through Metro North HHS provides statewide program coordination and works with the DoH (MHAOD Branch) and HHS to support integration of services, consistency of standards, quality and safety activities, model of service development and oversight, training and development, clinical leadership, service planning and development, departmental and interdepartmental liaison.

Further information is available at Appendix 5.

The prison population provides evidence of the need for forensic treatment and care. In Australia, it was estimated that 43 per cent of people in custody had experienced a mental illness in the last 12 months and 55 per cent had experienced a substance use disorder. The situation is worse for Aboriginal and Torres Strait Islander people. A study funded by the Queensland Government identified a 12-month prevalence of any mental disorder to be 75 per cent among Aboriginal and Torres Strait Islander people. While the direct costs of managing people with a mental disorder in the criminal justice system are difficult to determine, the recent PC Report estimated approximately 15 per cent ($2.4 billion) of expenditure on the criminal justice system nationally was attributable to mental-ill health in 2017-18.

The last 10 years has seen an almost doubling of the prison population in Queensland from a daily count of 5,079 in 2012 to a peak of more than 10,000 in 2021. These numbers are significant. It is also important to understand that the flow of individuals into and out of custody has increased with resultant impacts on the delivery of MHAOD treatment - initial assessments, release planning and the challenges of ensuring continuity of care.

It is not only the prison population which has experienced growth in the last decade. The number of consumers managed on a forensic order or treatment support order (either as inpatients or in community) has increased from 629 in 2009 to 991 in 2020. The largest rates of increase have been in the forensic order (disability).

The When Mental Health Care Meets Risk noted that Queensland's High Secure bed numbers were low. In 2017, an unpublished comparison ranked Queensland as one of the lowest in the country (1.84 per 100,000 compared to a national average of 2.56 per 100,000). This creates challenges in access to appropriate care for those whose risks cannot be managed in

less restrictive settings, and for services otherwise required to provide care to these individuals.

In addition to increased service demand, care for people receiving FMHSs is further complicated by a range of factors including:

- High rates of co-occurring mental disorders and general and chronic physical health conditions, as well as social disadvantage such as homelessness, poor education, and high rates of trauma.
- Disruption in social supports and continuity of care through justice processes.
- Relative lack of diversional processes and court alternatives for individuals.
- The high-risk period for morbidity and mortality post release from custody, and lack of available support resources in areas such as housing.
- Ongoing over-representation of Aboriginal and Torres Strait Islander people throughout justice settings and in FMHSs – and the associated need for culturally appropriate models of service delivery.
- Lack of AOD service provision into custodial settings – this also produces challenges for linked up service delivery at release back into the community.
- A gap in facilitating access to appropriate inpatient MH care when required for people in custodial settings.
- The lack of Commonwealth funded programs (including access to Medicare funded health care) in custody. This further exacerbates the 'missing middle' phenomenon described in the PC Report for this population group.
- The relative lack of specialised therapeutic interventions for problem behaviours (such as sexual offending) available in the community for those with mental illness (funded by Queensland Corrective Services). These are generally funded and delivered through other Government agencies or are available only infrequently (mostly Brisbane-based) in the private sector which is financially out of reach for many consumers.
- Workforce challenges including:
  - accessing and coordinating specialised training for the forensic MH workforce
  - recruitment and retention, particularly within certain disciplines such as health workers (qualification requirements) and psychology (working for state funded MHAOD services not seen as competitive, particularly for those with specialist skills)
  - the reduction in specialist training options within university settings (presenting specific difficulties in preserving the skill-base of this sub-specialty workforce and build on the broader workforce challenges that exist across the MHAOD health system).
- Ensuring consistency and quality of service provision across HHSs providing FMHSs.
- The requirement to work across multiple internal and external stakeholder groups to support effective service provision, in addition to working across multiple pieces of intersecting legislation.
- While there remains a stigma around mental illness itself, those who have mental illness and engage in offending behaviour are 'doubly stigmatised'. This can mean that people:
  - with mental illness are further stigmatised in justice settings

  - with offending behaviour are stigmatised in MH settings.
- Despite vulnerabilities, this population group is not always well understood by the general public and media; they also tend not to be popular politically.

Opportunities for improvements

The development of Queensland's FMHSs have been informed by several policy documents, frameworks and reviews including *Queensland Forensic Mental Health Policy 2002* and the *Forensic Mental Health Strategic Framework 2011*, the *Review of Queensland Forensic Mental Health Services 2002: the promoting balance in the forensic mental health system report* and the When Mental Health Care Meets Risk.

Queensland faces challenges in providing FMHSs across a vast geographical area and 16 HHSs, including coordination and consistency, implementing standard models of service across different locations, following the consumer journey, working across several governments and NGOs, and workforce development in the context of specialist service provision.

Ensuring Queensland's FMHSs operate as an integrated system, are well planned, and operate to a consistent quality standard is a priority. Development of a policy and contemporary strategy in consultation with HHS and specialist FMHSs to provide clarity about how the service system integrates and how it is best supported will assist with addressing some of the challenges identified.

Further development and investment in High Security Inpatient Services (HSIS) to meet the needs of Queensland's population and address risk due to lack of availability of both acute and rehabilitation HSIS beds. Resourcing also needs to consider the complexities of this patient group beyond standard inpatient models of staffing. Any expansion of the HSIS needs to be accompanied by a clear model of service including accessible and transparent processes for referral, admission, and discharge given the interface and patient flow between the HSIS and HHSs around Queensland.

The MHA2016 provides for people in custody who require inpatient MH treatment to receive such treatment in AMHS inpatient units as Classified Patients. This provision is consistent with the principle of equivalent care for those in custody and the Right to Health Care enshrined in the *Human Rights Act 2019*. There remains an unmet need for classified patient beds and meeting the demand now and into the future is a priority. While there is a variety of opinions about how best to meet this challenge, the prevailing view is that no one solution will resolve the challenge and there needs to be a variety of approaches.

In Queensland, over a five-year period (2017-2021), while approximately 60 per cent of recommendations for a Classified Patient admission resulted in an inpatient episode (n= 1,222), approximately 31 per cent did not receive an admission for inpatient care and were judged to have significant treatment needs that could not be adequately met within the justice system for an extended period (n=627).

The unmet MH need for a significant number of people in custody presents challenges for Queenslanders and for service systems including Queensland Corrective Services and MHAOD services. People released from custody with untreated mental illness have an increased risk of reoffending and re-imprisonment compared with those without mental illness. Early detection and intervention to treat mental illness and substance use disorders

for individuals at risk of coming into custody and in prisons is imperative to improve outcomes and reduce offending.

Significant further enhancement is required and improving health and social outcomes for individuals with mental disorder, their families and communities and would yield economic benefits for Queensland.

A range of other initiatives can contribute to service and system improvement. These include:

- Early intervention approaches and diversionary programs such as the Police Communications Centre – MH Liaison Service and co-responder models.
- Additional services to divert more people with mental illness who contact the criminal justice system into MH care and treatment and supports to reduce their risk of reoffending, including accommodation and housing, supported employment as per the PC Report.
- In addition to enhancements to AMHS capacity and HSIS bed capacity the development of a specialised acute assessment unit has been proposed to assist with classified patient demand. The availability of a unit that had physical, relational, and procedural security sufficient to manage high risk and complex patients could complement existing inpatient capacity but could require further planning and development of the model of service delivery. Initial proposals have included that it would particularly focus on the group of people who are not appropriate for admission to the HSIS but present a risk management challenge that is beyond the capacity of the AMHSs. Such a unit would necessarily be in a hospital setting and would require capital investment and recurrent operating budget. It would function to provide initial treatment, stabilisation, and development of a treatment plan linking to either HSIS, AMHSs, back to correctional centres, or the community depending on the individual's needs and custodial status. In this way it would not replace the existing treatment pathway options but would supplement them to better ensure appropriate placement while maintaining continuity of care and timely access to treatment.
- Expanded provision of transitional MH care which not only provides better health and criminal justice outcomes but reduces classified patient demand. This can include assistance with obtaining post-release accommodation, linkage with non-government support agencies or the NDIS and actively supports linkage to NGOs in the community.

For Aboriginal and Torres Strait Islander people, it is essential that treatment, care, and support is culturally appropriate reflecting Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing and promoting access across the continuum of custody and community. Currently, the IMHIP is available in three south-east Queensland correctional facilities. It provides a model of social and emotional wellbeing, and MH care that is led and staffed by Aboriginal and Torres Strait Islander clinicians and health workers. Its service provision is complementary to and works in collaboration with PMHS and has been recognised both at a state and national level as an innovative and leading program in this area.

Expansion of these sorts of programs to include correctional centres in the northern and central areas of Queensland where the proportion of Aboriginal and Torres Strait Islander people in the custodial population is highest is required. It is also important that identified

positions work at the front end of the justice system to support early engagement and identification of needs and that non-indigenous clinicians are supported to develop cultural capability.

PMHS provide an in-reach model of MH care into the state's major correctional centres, providing in centre treatment, facilitating access to inpatient care as required and proving transitional support. There are also a small number of psychology specific roles, however there is far more scope to introduce discipline specific roles and programs with greater resourcing. Current resourcing has not kept pace with the growth in prisoner numbers and demand for service provision proving a barrier to access of equitable level of care to those in the community and negatively impact transition to the community for this vulnerable group.

There is a need to expand MH service delivery to correctional centres both in terms of human resources and models of service, which would also provide an opportunity for a review of the PMHS model of service in line with recent reports, such as the PC Report, best practice evidence, and opportunities for partnership in prevention-based activities such as psychoeducation, group based coping skills, and trauma informed care frameworks. There is also a gap in the provision of specialist AOD treatment. This is a priority given the prevalence of substance use disorders in correctional settings and the implications for adequate linking to ongoing treatment and services on release to the community.

Increased numbers have put pressure on existing health infrastructure in correctional facilities which, in turn, impacts health service access and service delivery. There is a need to quantify access needs; maximise opportunities within existing infrastructure; and identify additional infrastructure requirements (built and digital) for effective service delivery.

The CFOS is a core component of the MH treatment response to the management of individuals in the community who present a risk to others. Effective risk management and reduction is central to ongoing recovery. This principle has led to several recent initiatives in line with recommendations from the report When Mental Health Care meets Risk including significant work undertaken to support improved risk assessment and management processes in Queensland's MH system, some of which have also added to the scope and function of CFOSs. There is a need for ongoing service development given both population growth and evolving patterns of need and demand across geographical regions and within the population group.

The relative lack of forensic intervention services (addressing behaviours such as sexual offending, stalking, fire-setting, threats, and general violence) which are accessible to individuals is a significant challenge. Resourcing is required to develop and implement a forensic intervention model of service within CFOS, in addition to resourcing of the core existing functions of CFOS to address the significant growth in the Queensland population that has occurred in the last 15 years, and to ensure equity of access and coordination of services for the Western Corridor and Central Queensland.

CLSs operate on the premise of facilitating access to MH assessment and treatment and promoting due process for those with mental illness before the courts. These services grew in scope and function with the introduction of the MHA2016, however challenges remain in meeting service demand: in specific geographic areas; due to the evolving nature of stakeholder expectations and referral patterns; and the complexity of the client cohort and those with disability.

There is a need to support service expansion in areas where challenges of geography are impacting equitable service provision (such as the Cape and Torres Strait) and areas where service provision is currently limited (Western Corridor).

Addressing the growing number of referrals and waitlists for Fitness for Trial and Unsoundness of Mind assessments/reports for the magistrates' courts require a multi-faceted approach including addressing the lack of alternative court processes and diversion options outside of the functions of the MHA2016, and adequate resourcing and NGO partnerships to support meaningful onward referral for people with mental illness before the courts. Additionally, in recognition of the transient nature of contact with this cohort and the more proactive approach required for those with psychosocial disability, more streamlined processes are required, for example, with federally funded entities such as the NDIS.

Workforce Development in FMH is a critical priority area and is constantly evolving requiring an up-to-date specialist skill set in addition to foundation experience in MH. This presents unique challenges in recruitment and workforce sustainability, as well as access to training and ongoing development (particularly in regional areas). These workforce development needs require a consistent and sustained approach tailored to models of service delivery and will benefit from ongoing skill development of the FMH workforce including ongoing development opportunities for staff of FMHSs and collaboration with industry partners. Opportunities for relevant student groups to gain exposure to FMH as a career option, promotion of FMH and develop translatable skill sets within the existing MH workforce are key strategies. Provision of professional development opportunities for Forensic Liaison Officers (FLOs) as a means of capacity building across MH services should also take place.

There are many valuable partnerships operating between MH services and police across the state. Several key statewide initiatives are a collaboration between police and FMHSs including QFTAC, Police Communications Centre MH Liaison Service, and the MH Support of Police Negotiators program. These programs are however vulnerable to competing demands within the QPS. There is a need to build on existing relationships and structures to establish a collaborative governance structure between QPS and QH oversighting the operation of programs at the service delivery level as well as at a strategic systems level. These structures are to oversight the development of jointly owned models of service.

FLOs are a key link between FMHS and general MH services more broadly; they have a core function in enhancing the risk management capacity of MH services across the state. It has been several years since these roles were introduced and their operation has been influenced by several changes in the health landscape, including the increased number of patients on forensic orders, forensic order (disability) and treatment support orders (which are not evenly distributed around the state creating disproportionate workloads both for FLOs and their respective MH service, as well as creating accompanying risk). There is a need for continued recognition of the need for FLO roles, role clarity and definition, support for ongoing development, and a renewed assessment of resourcing need. This can be facilitated through the development of a FLO Model of Service (MOS) in the context of demand/resourcing need to be in line with MOS responsibilities, policy-based responsibilities and population need (e.g., number of forensic orders). The FLO roles should also be supported by the workforce development strategy outlined above.

6.8.2 Child and youth forensic mental health

The forensic child and youth MH (Forensic CYMHS) services target population are children and adolescents generally aged 10 to 18 years who are in contact with the youth justice system, or at high risk of contact (e.g., problematic sexualised behaviour or violence). This cohort are amongst the most marginalised and disadvantaged young people in the State as identified by Queensland Youth Justice data from 2017–18:

- 31 per cent had a parent that has been held in adult custody
- 58 per cent had a diagnosed or suspected MH or behavioural disorder
- 17 per cent had a diagnosed or suspected disability
- 52 per cent were totally disengaged from education, employment and training
- Almost 1 in 5 were homeless or had unsuitable accommodation
- 51 per cent had some involvement with the Child Protection system
- 80 per cent reported using at least one drug or volatile substance
- 63 per cent had experienced or been affected by domestic and family violence.

In Queensland, Aboriginal and Torres Strait Islander children account for seven per cent of the total population of 10 to 17-year-olds, but in 2018–19, they made up 45 per cent of young offenders. Moreover, Aboriginal and/or Torres Strait Islander young people account for 71 per cent of the population in Youth Detention Centres in Queensland.

Youth justice reforms, policy and planning frequently occur in a politically sensitive environment with high public scrutiny requiring rapid responses. Consequently, these important developments have often occurred somewhat independently of consideration for forensic MH service capacity, impacts and resourcing and resulted in a workforce ill equipped to meet demand.

Noting Forensic CYMHS are a small and developing sub-specialty with a requirement for highly specific skills, there is a comparatively small specialist workforce within the north Queensland locations (80 per cent of Forensic CYMHS workforce is located in South East Queensland). Recent work undertaken by the Youth Crime Taskforce has identified a small subset of juvenile offenders (approximately 10 per cent or 300) are serious recidivist offenders and responsible for almost half of charged offences by children. The geographical distribution of this sub-group has been identified as more prevalent in northern areas of the state as seriousness increases, and this does not align well with the current FMHS capacity.

The high rates of problematic substance use in young people engaged within the criminal justice system are well documented. The high rates of alcohol and substance use disorders in young people who are engaged with the criminal justice system is well established and substance misuse has been identified as a key risk factor for recidivism for 62 per cent of the young people on supervised Youth Justice orders.

A multi-disciplinary collaboration to embed and evaluate a model of social and emotional wellbeing care for Aboriginal and Torres Strait Islander young people (10 to 17 years) who experience detention at Brisbane and West Moreton Youth Detention Centres commenced in June 2020. This pilot could inform further expansion/development of the model to other areas of the state.

QH, through HHSs currently provide MHAOD services to and about children and young people (generally aged 10 to 17 years) in contact with the youth justice system. This occurs via an outreach model from three Forensic CYMHS hubs (Brisbane, Townsville and Cairns) that deliver assessments and interventions for young people in three main settings:

- Courts: Magistrates are provided with specialist, MH and forensic assessments (e.g., fitness for trial and/or soundness of mind), screening and advice.
- Youth Detention Centres (Brisbane Youth Detention Centre in Wacol, West Moreton Youth Detention Centre in Wacol and Cleveland Youth Detention Centre in Townsville): comprehensive MH assessment, treatment and transition planning.
- Community settings:
  - Specialist assessment, crisis and risk-management planning and consultation liaison services to CYMHS and youth justice services. May include interagency intervention planning and strategies to enhance service provision, crisis and risk-management plan development.
  - QH is a key partner in the Department of Children, Youth Justice and Multicultural Affairs pilot Specialist Multi Agency Response Team (SMART) initiative which supports collaborative development of an Action Plan for young people at high risk of reoffending and operates in seven sites in Greater Brisbane, West Moreton, Gold Coast, Townsville and Cairns.
  - Assessment and support of escalating numbers of children held in police watchhouses due to capacity issues at youth detention centres (above 30 per day in January 2022). Children held for more than five days frequently experience a deterioration in their MH requiring assessment and support.

Opportunities for improvement

Appropriately skilled, MH services available at the right time and in sufficient numbers to identify and respond to the MH needs of the youth justice cohort can assist in:

- Reduce risks associated with inadequate identification and treatment of MH issues among young people in contact with the youth justice system.
- Provide significant social and economic benefits for Queensland through reduced offending behaviour and improved outcomes for young people in contact with the youth justice system.

As outlined, current Forensic CYMHS provide assessment, treatment within detention, however treatment options within the community are lacking and do not meet demand both for those within the Youth Justice system and more broadly. Further reiterated within the work of the Taskforce, there is a need for collaborative, multi-agency responses, further highlighting the need to increase overall workforce capacity, particularly within north Queensland.

As forensic assessments require specific training and supervision to ensure accurate administration and interpretation of validated risk assessment measures, skilled formulation to ensure risk management and care planning meets the needs of consumer, families, potential victims and the general community, there is a role for a specific training function to support expansion of workforce capacity.

The availability of specialist AOD treatment and support services for young people is limited (refer to section 6.4 – Child and youth) and therefore improving capacity of current forensic child and youth MH service staff is warranted.

Work needs to continue to support emerging, evidence-based responses to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander children, young people, and their families, with anticipated positive outcomes for First Nations young people.

6.9 Older people

Services for older people experiencing MH and problematic substance use are part of a complex system of services delivered by a range of providers including the HHSs (state-funded specialist treatment and rehabilitation), Commonwealth funded programs (PHNs, NDIS, residential aged care, dementia services and veteran affairs), the private sector and non-government organisations (psychosocial disability support).

The Royal Commission into Aged Care Quality and Safety pointed to the need for better integration of MH services across disability, aged care, home and community care and further investment and effort to build specialist services. Queensland's older population (65 years and older and 50 years old for Aboriginal and Torres Strait Islander persons) is expected to grow by 43 per cent between 2016 and 2026 up from 713,653 to 1,022,984 representing serious challenges for the provision of health services into the future.

HHSs provide specialised assessment, clinical treatment, and rehabilitation across inpatient, outpatient and community settings focused on servicing older people experiencing severe mental illness and behavioural disturbances, and for those who may fall under the provisions of the MHA2016. These services are delivered in general (adult) or specialised older person services, geriatric medicine, hospital in the home or in specific dementia management services. Dementia and mental illness are highly correlated with approximately half of people with dementia experiencing psychotic or depressive symptom during their illness with behavioural and personality changes expected.

Some groups of older Queenslanders have specific needs including Aboriginal and Torres Strait Islander persons, people living in rural and remote areas, and people from CALD backgrounds.

Opportunities for improvement

Analysis undertaken through planning processes shows that there is significant need, and the current level and range of service responses is not sufficient to meet this need.

Priority focus areas identified for consideration include:

- More beds across inpatient acute, sub-acute and non-acute extended treatment services.
- Additional capacity to provide consultation liaison services for residential aged care and community treatment.
- Focusing on building a specialist older person workforce.
- Continuing to build and strengthen partnerships with geriatric medicine and aged care.

- Developing new models of care that improve quality and safety of services in residential aged care and home care.

7 National mental health and suicide prevention agreement

Queensland has been working alongside other States and Territories and the Commonwealth since May 2021 to develop and finalise a new National Mental Health and Suicide Prevention Agreement.

This follows the National Federation Reform Committee (NFRC) agreement to collaborate on systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer-focussed and compassionate MH and suicide prevention system to benefit all Australians. A media statement regarding the NFRC meeting on 11 December 2020 is here.

The PC Report recommended development of a new National Mental Health and Suicide Prevention Agreement and for this to address psychosocial support responsibility (provision and funding of), as well as specify minimum funding commitment by both levels of government to support expansion of mental healthcare and psychosocial supports.

Appendices

Appendix 1: Queensland Ambulance Service Response

The QAS is the legislated provider of pre-hospital emergency health care across Queensland. The QAS is one of the largest ambulance services in the world, responding to over 1.3 million, time critical events, such as trauma, injury, and medical related emergencies a year; with 13 per cent of these emergencies being for a MH crisis.

The QAS support the needs of the community by providing pre-hospital ambulance response services throughout the state 24 hours a day. The QAS are an integral part of the primary health care sector in Queensland, and as such have a unique view of the health care landscape of Queensland, including the MH of the state.

Calls to Triple Zero (000) for people experiencing a MH crisis equates to about 1 in 12 jobs most days for the QAS, usually the second most frequent call for service, after falls. In 2020 over 59,000 people called Triple Zero (000) experiencing a MH emergency, this was a 15 per cent increase from the previous years. The QAS has seen an upward trend for calls for a MH emergency to Triple Zero (000) of between 15 per cent and 20 per cent for the past five years.

The QAS sees MH crisis situation, as any situation where a person feels that they are unable to cope with the stressors of life, leading to distress and suffering, requiring alleviation or care. This does not necessarily meet the criteria for a mental illness/disorder, characterised by a clinically significant disturbance in cognition, emotion regulation or behavioural dysfunction requiring medical or hospital-based interventions.

The QAS sees itself emerging as an essential player in the development of the MH sector. Given the important role the QAS plays in the provision of responses to people experiencing a MH crisis. The QAS's broad definition of MH crisis and legislative response requirements provide a unique view of the MH landscape, particularly the crisis support needs of the community. This information is invaluable for service development and planning throughout public health, private, non-government, primary health and tertiary services sectors.

QAS and MH Crisis

MH conditions in people calling Triple Zero (000) are identified by emergency medical dispatchers (EMDs) through the Medical Priority Dispatch System (MPDS). MPDS is a standardised call taking process whereby a series of scripted questions are asked to enable a quick and precise categorisation the medical needs of the calls, to get the right care to the right patient at the right time. This is not a medical triage, but a medical dispatching tool to ensure that a person receives the most appropriate pre-hospital care. A MH emergency is classified as a code MPDS 25.

These calls are for a broad range of situations including high risk situations; an exacerbation of an existing MH condition; a suicide crisis; significant life events; domestic violence; drug and alcohol use/issues; and aberrant type behaviours. MH crisis situations presenting to the QAS are often a complex interplay of physical, social and psychological factors.

Often calls to Triple Zero (000) for people experiencing a MH crisis are once the emergency has escalated to a crisis point. Paramedics are often first on scene to a death by suicide or are having to provide lifesaving interventions for people who are actively engaging in behaviours intended to end their own life or misadventures which are risky or life threatening. These people are sometimes not mentally ill, rather demonstrating poor MH, often with the addition of drugs or alcohol, high levels of distress or poor resilience/coping strategies in response to stressors or perhaps there is a biological basis for the behaviour. The clinical complexities and co-morbid or high-risk confounding risks defines the MH crisis incidents attended to by the QAS.

Calls to Triple Zero (000) come from individuals, families or carers, other health care providers, non-government sector, police, and GPs. For many people experiencing a MH crisis, Triple Zero (000) will be their first step to accessing support and assistance from the health care sector or the 'last resort' once all other avenues have been exhausted.

These situations are as unique and heterogeneous as the individuals who are experiencing them. At the end of the day, like all other callers to Triple Zero (000), the person is probably having the 'worst day of their life.'

A review of the presenting problems identified in the Triple Zero (000) calls, as determined by the Medical Priority Dispatch System reveals the most common problems for people experiencing MH crisis is a suicide crisis. This includes:

- threatening suicide or self-harm – e.g., expressing through behaviours or words an intent to end one's own life or harm self
- suicide ideation / suicide crisis - e.g., sending a text message to another person expressing hopelessness, helplessness or risks to self
- suicide attempts – e.g., actively engaging in acts to end one's own life.

Aggression and emotional dysregulation were the second most common problems identified. Aggressive incidents often involved the police, who work in collaboration with the QAS to manage a person's behaviours. The police are concerned the presentation indicate the person is experiencing compromised MH, a medical condition, or acute intoxication with substances, which required a medical assessment/ treatment rather than a legal intervention.

Emotional dysregulation includes people who are experiencing distress, stress, or a severe reaction to a stressor. This encompasses many presentations, including people who are suffering from a grief reaction, an accumulation of stress, or circumstances where they do not have the coping strategies, capacity, resilience or resources to cope with the circumstances they find themselves in. Anxiety and stress are also a common reason for people calling Triple Zero (000) in an emergency.

These broad categories of presentation do not necessarily mean the person is experiencing a mental illness requiring a medical intervention, although they do require some relief or alleviation of their current distress and symptoms.

People with an existing mental illness experiencing an acute exacerbation of symptoms also require a QAS response. This can be identified by families, carers, service providers or other professionals. The QAS also responds to people who are under the MHA2016 and require transportation.

The MPDS description of abnormal behaviour, encompasses those unusual behaviours that require further assessment, but may not necessarily pose an immediate risk to someone's life is also a common call for service for the QAS. These are usually reported to Triple Zero (000) from third parties or members of the public and require a response as a MH emergency.

Paramedics are skilled and experienced in situational risk assessment and will assess a person experiencing a MH crisis appropriately and attempt to ascertain the cause of the presenting signs and symptoms and exclude and/or manage causes of abnormal behaviour where possible.

Paramedics are generalist health care providers with training in a broad range of conditions/problems including trauma, health and crisis management. The nature of the work of the QAS for call takers, Emergency Medical Dispatcher (EMDs) and paramedics on road is defined by extreme time pressures and restraint, on average, EMDs gather the required location and demographic information about a person in crisis in three minutes and paramedics have approximately 20 minutes to assess a of the situation and make a clinical assessment and treatment plan on scene. Not uncommonly, they are working with limited information about the patient, history and collateral.

QAS MH Response Program

The assessment and care of people experiencing a MH crisis prove a challenge for EMDs, paramedics on scene and into the ED. These often-complex presentations require an understanding of the collateral history, precipitating factors and risk features which may not be immediately available in an acute emergency assessment. To support paramedics and EMDs in their assessment and decision making around people experiencing MH crisis situations, along with improved education and training, the MH Liaison Service (MHLS) in the Operations Centre is available state-wide 24 hours a day and QAS MH Co-responders (MH CORE) in selected areas.

- **MH Liaison Service (MHLS)**

The MHLS involves a Senior MH Clinician working in the Brisbane Operations centre to provide information, advice and assistance to EMDs, supervisors, managers, paramedics statewide, in an effort to support the timely and appropriate dispatch of resources to people in a MH crisis, and to assist attending paramedics' clinical decision making on scene.

The MHLS can provide direct clinical support to patients experiencing a MH crisis via telemedicine including, de-escalation; risk assessment and management; advice, information, and psycho education regarding symptom management; and guidance around appropriate referral options.

In October 2021, after an active intervention the clinicians were able to avoid an ambulance attendance (and possible subsequent transport to hospital for further interventions) for 306 people who called Triple Zero (000) in a MH emergency. Additionally, the Clinicians provided real time risk assessment and management for 406 calls from people who were expressing ideas of ending their own life by suicide, including 3 who were actively engaging in a behaviour to end their own life.

The clinicians have access to QH clinical data bases, including CIMHA, and can provide timely information regarding a person's MH history, treatment plans, management plans and other

pertinent information, which will help and support the clinical decision making. The Clinicians will use this information, to assess the needs of the person experiencing a MH crisis and provide the most appropriate management and treatment plans, considering resources outside of the hospital system if available.

The service relies on the information and data from CIMHA to provide timely and appropriate health care to people experiencing a MH emergency. The quality of the utility of the information provided on CIMHA is imperative to the QAS. The collaboration between the QAS and DoH (MHAOD Branch) is pivotal in providing this service.

Box 12: Clinician experience – making the move to the QAS MHLS

I have recently changed jobs from being a Senior MH Nurse in a busy city hospital Emergency Department to the QAS MH Liaison Service (MHLS). The first thing I noticed when I started in this role is how busy the service is and, how acute the jobs can be.

Working in an Emergency Department for three years I truly thought I was at the forefront of MH, but I think it is in this role we are truly at the 'pointy end' of acuity and risk.

I used to have to triage in the ED, the MHLS feels like you must work at an even faster level and, ensure all necessary information is available for the crews who will be attending, especially if there is any risk.

The people who call Triple Zero (000) in an emergency have complex needs and are often in very acute circumstances. Speaking to patients and family members in the MHLS can be confronting. I have been on the phone to a mother as her child was assaulting her, a young female who was cutting herself, and talked to someone while they stood on a bridge to name a few.

The MHLS is involved in hundreds of incidents/scenes every week, providing our input and expertise. I feel very honoured to have contact with paramedics who attend our jobs, which are sometimes risky or with many unknown elements to contend with.

Triple Zero (000) call takers and Operation Centre Supervisors who work side by side with us, I know, value the input into MH jobs. We are also an ear for them to debrief, or a colleague to assist them with their decision making related to QAS patients experiencing a MH crisis.

In the time since I joined the team, I have seen the volume of calls increase from paramedics on scene which I take as a compliment to the service we are providing; in that they are using our service to allow us all to provide an even more cohesive level of care to the patients we work with.

Caoidha - QAS MH Liaison Service Clinical Nurse Consultant, 2022

- **QAS MH Co-Responder (QAS MH CORE) Program**

A second major investment by the QAS into how people with a MH crisis are responded to is the QAS MH Co-responder Program (MH CORE).

The QAS MH CORE pairs a senior Queensland Health MH Clinician working alongside a QAS paramedic within specific areas (as of 2021: Gold Coast, West Moreton, Metro South, Metro North, Sunshine Coast, Cairns and Townsville). The collaboration between the QAS and participating HHSs has seen a pivot in how MH services are delivered from hospital-based emergency response, to seeing people in their own homes.

The service aims to be a first and health response to people who are experiencing a MH crisis in the community, consistent with the views and wishes of consumers and carers in the MH sector. The QAS MH CORE provides timely and thorough physical health, mental state, and risk assessment with management/treatment plans, for people in their own home, using

their own resources and supports. The QAS MH CORE can facilitate access to appropriate follow up and referrals, and between 60 and 70 per cent of the time keeping the person away from hospital, while also identifying and implementing appropriate treatment pathways for people experiencing a MH crisis. This model of care has immense benefits for consumers and people experiencing a MH crisis.

While the QAS MH CORE does not affect demand for QAS services, as regardless of the presence the program the QAS would need to respond to all received requests for attendance, the efficiencies and potential cost savings across the health care system can be identified. Potential direct savings for the QAS occur due to the timely dispatch of clinically appropriate resources to persons experiencing a MH crisis. Being a first and only response crew to people experiencing a MH crisis, providing specialised MH care, allows acute ambulance crews to respond to the next emergency within the community and therefore increasing the QAS's resource capacity.

The capacity release savings associated with the QAS MH CORE model are further enhanced by savings to the emergency health system that result from providing targeted assessment and treatment to people experiencing a MH crisis, in their own environment and, potentially, removing the need for transportation to hospital. Additional downstream savings to the broader health system may also be considered. This includes cost avoidance savings aligned with the diversion away from ED presentations to more targeted care, which is informed by and aligned with existing management plans, where relevant or more appropriate care/treatment alternatives.

The success of the QAS MH CORE in providing high quality outcomes for people experiencing a MH crisis, as well as for creating efficiencies throughout the health system as a whole, has been acknowledged through with the expansion of the program from three pilot sites in 2019 to recurrent funding for 17 additional sites throughout the state by 2024.

As the program develops and expands throughout the state there is potential for further development and enhancement of the service through: the development of the program in regional areas; the development of shared definitions and operating procedures; further collaboration with stakeholders; improved dispatch processes and streamlining/refinement of the reporting requirements of the MH clinicians to increase the capacity of the program service delivery.

The QAS MH CORE demonstrates the importance of outreaching MH crisis responses to people in their own environment and empowering them to utilise their own resources to manage the crisis. There is considerable recognition of the importance of a timely and appropriate response to people experiencing a MH crisis, and how if this is done effectively, can support a person out of crisis and significantly contribute to their recovery journey.

Box 13: A day in the life of a QAS MH CO-Responder Clinician

Since July 2019, the QAS has trialled pairing a senior MH clinician from the local MH team with a paramedic to respond to people experiencing a MH crisis situation in selected areas in South East Queensland. I have the privilege of working with the skilled and dedicated professionals out of the Beenleigh Ambulance Station.

No two days are alike, they all start the same way, but you never know what the afternoon and night will bring. After arriving at station for our shift, my partner and I perform our vehicle and equipment checks and then we begin the task of scanning jobs looking for appropriate MH cases.

These include incidents involving self-harm/threats of suicide, emotional crisis/bereavement, anxiety/low mood/depression and acute psychosis. These are jobs which the co-responder can effectively assess, providing appropriate treatment and referral pathways, in most cases out of the hospital environment.

The QAS MH Co-responder can spend time to support people through their difficulties and free up other crews to attend other jobs. We perform the same assessment and referrals as performed in the ED however, we do this in the patient's home environment, reducing the time required for transportation and ED waiting/ramp time. This results in a much improved and efficient experience of service for the patient.

The MH assessment, including a mental state examination, can take anywhere between 20 minutes to one hour depending upon the complexities of the case. The MH clinician and paramedic conducts a risk assessment and makes a plan accordingly, often involving supportive counselling and community supports via non-government organisations, our 1300 MHCALL (1300 642 255) service or even simply to follow-up with a phone call from the MH clinicians.

This is the great thing about being part of the Metro South HHS, that we can arrange local and appropriate follow up for people as required. We attend a huge variety of cases and below is an example of how this joint role of MH clinician and paramedic is effectively meeting the needs of the patient and saving resources for both first responders and emergency staff.

Paul – QAS MH Co-Responder, Clinical Nurse Consultant, 2021

Appropriate Alternatives to EDs

The QAS responds to people in a MH crisis who are demonstrating a complex clinical, social and health conditions, some impacted by drugs and/or alcohol, or in distress, or unable to cope. Many people in MH crisis, attended by the QAS do not meet the criteria or are diagnosed by paramedics on scene for a mental illness, but do have high care needs and, at times, require complex social interventions, care or a safe environment.

It also needs to be acknowledged that people experiencing a MH crisis, may also require a further assessment of their physiological condition, to ensure that there is no underlying biological basis for their behaviour in a hospital ED.

This may include:

- effects of any deliberate self-harm
- delirium/neurological changes

- illnesses/infection
- head injury
- endocrine conditions
- toxicological conditions
- effects of drugs and or alcohol

The QAS advocates that the needs of the person being responded to are paramount and all health needs requiring assessment, which cannot be conducted in the pre-hospital setting, are conducted appropriately. It is imperative that a person in a MH crisis, who requires a physiological examination, receives an appropriate medical assessment. Sometimes a hospital ED is the most appropriate place for a person who is experiencing a MH crisis.

It is well recognised and acknowledged by the QAS that EDs are not equipped to meet the needs of people experiencing a MH crisis, especially those experiencing complex social and emotional problems, or poor MH. Although often an ED is the only option available 24 hours a day. An ED is the most similar model of care to that of the QAS in that they are not specialist services, they are available to everyone without discrimination or prohibitive inclusion and exclusion criteria.

In Queensland the public, private and non-government MH system is a complex network of specialist providers, each providing specified programs and services to people with MH conditions. A broad array of public and privately funded new boutique services are now available to Queenslanders within the health system and in the community. A lot of these services are led by peer workers or people with a lived experience of MH conditions or by specialist providers with expertise in a particular area of MH care. These important development within the MH sector will contribute to improving outcomes for people with MH conditions in the community.

Although, when a person is experiencing a MH crisis, which is a feature of many MH conditions, many of these resources are not available or there are a broad range of barriers which a restricting access, meaning the ED is the only available option.

These barriers can include:

- limited access because of restricted/infrequent operating hours (e.g., business hours of operation or part time hours)
- extensive (prohibitive) inclusion and exclusion criteria (most notable being age restrictions – with few services available for young people and children aged 18 years or young people in crisis)
  - Access or assessment criteria for inclusion (e.g., enduring mental illness diagnosis for ongoing MH care)
- being at the capacity of available resources (e.g., 'no beds')
- lack of resources for social resources and/or welfare crises
- few resources are available 24 hours for people experiencing reactive MH crises such as:
  - carer fatigue

  - distress
  - grief
  - shock
  - victims of crime
  - significant life events
  - suicidality
- few resources are available 24 hours for people experience co-morbid alcohol and drug or intellectual disability and MH crisis
- private sector providers can be risk adverse or not available to people experiencing a MH crisis.

Summary

The QAS has a unique view of the health sector, seeing people experiencing health care needs in their own environment, or while going about their everyday life. This includes people experiencing a MH crisis situation.

The QAS broad definition of MH crisis and legislative response requirements provide a unique view of the MH landscape, particularly the crisis support needs of the community. This information is invaluable for service development and planning throughout the public health, private, non-government, primary health, and tertiary services sectors.

The QAS considers MH crisis as a broad range of conditions, including risk to self or others, poor decision-making capacities/capabilities, distress, and abnormal behaviours. These presentations are marked by distress, which includes an inability to cope and the requirement for alleviation of the presenting symptoms.

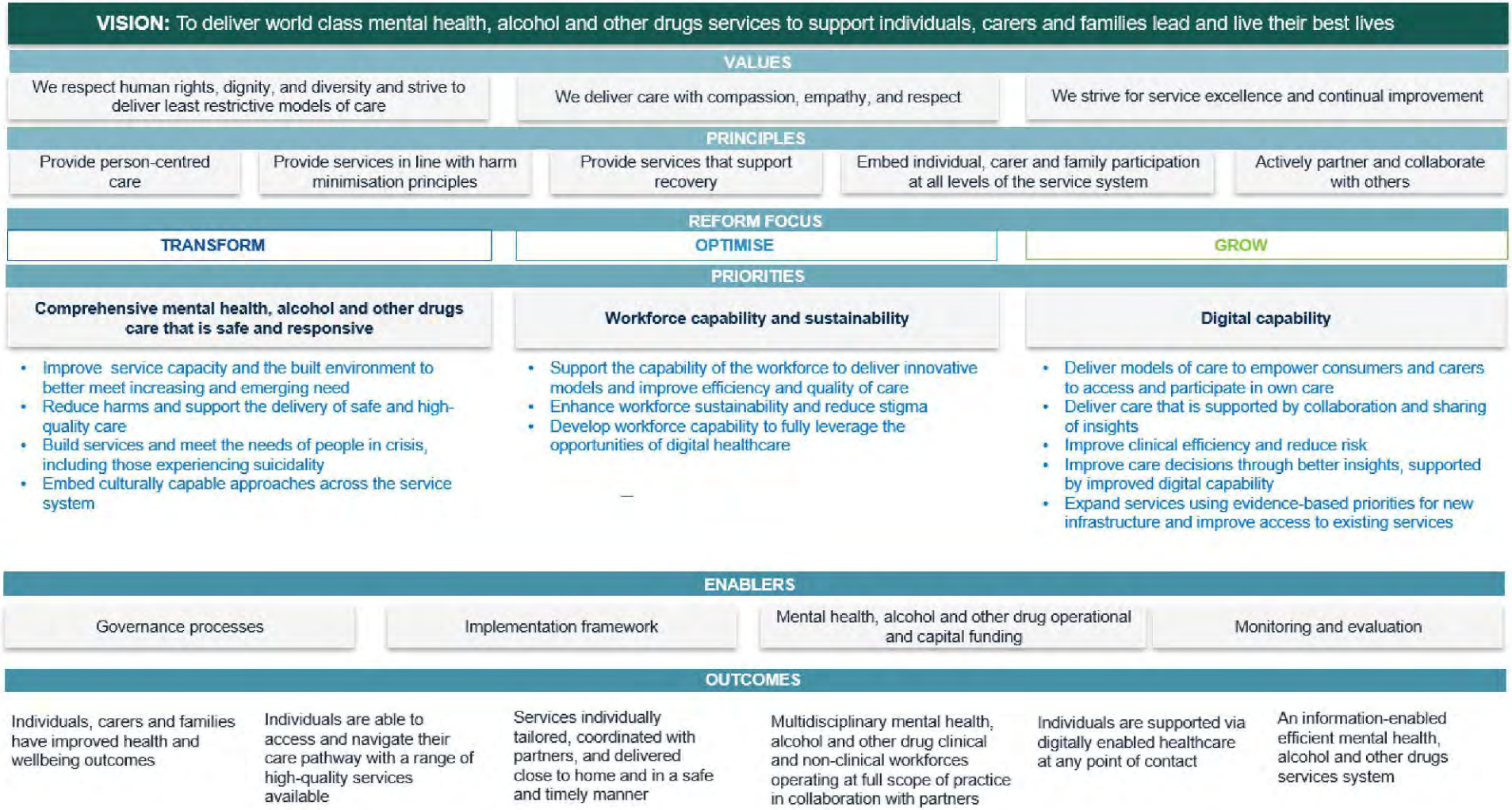
The QAS responds to all people in crisis and does not discriminate on age, geographical location, intellectual capacity, drug and alcohol intoxication or MH status. The service is available 24 hours a day and is often the first step in accessing health services, or a last resort once all other avenues have been exhausted.

The QAS also has a strong appetite to utilise appropriate alternate pathways to ED; although these pathways must be inclusive, available, safe, and suitable for the types of MH crises the QAS attends daily.

The QAS has developed the MH Response Program which aims to work within the broader MH sector create a better everyday life for people experiencing a MH crisis. By providing timely and appropriate ambulance/health responses, the focus is to deliver people the best opportunity for positive MH and well-being and to lives with meaning and purpose. The MHLS and the QAS MH CORE are two major initiatives of the QAS MH Response Program.

The QAS has demonstrated a willingness and capability to pivot and adapt their delivery of service to new and innovative systems of care, to provide the best possible outcomes for all patients. The QAS is poised to embrace new models of care for how people experiencing a MH crisis are cared as demonstrated by the implementation of the QAS MH CORE.

Appendix 2: Draft plan on a page – high level principles and strategies



Appendix 3: Queensland Government COVID-19 support packages

On 14 April 2020 the Queensland Premier and Minister for Trade and the Minister for Health and Ambulance Services announced the $28 million COVID-19 Grant Fund: Immediate Support Measures for community-based providers delivering public health services to boost their organisational capacity and, in turn the health system's capacity, to respond to COVID-19. The final allocation was $30.33 million, reflecting the volume of high-quality service models proposed across the NGO sector in Queensland.

MH services and support were the highest cohort allocation under the grant fund with 89 grants awarded, totalling $12.6 million, comprising:

- Forty-one direct allocations totalling $2.6 million as an immediate response to enhance a suite of existing MH services:
  - Individual Recovery Support Program
  - Group Based Peer Recovery Support Program
  - Individual Recovery Support Program – At risk of Homelessness Program
  - Individual Recovery Support – Transition from Correctional Facilities Program
  - Multicultural/Refugee and Asylum Seeker Response
  - Eating Disorders Service.
- A further 48 grants totalling $10 million were allocated to successful applications under the Request for Proposal. These fell into three categories:
  - new service offering – 18 grants totalling $3.8 million
  - organisation support (e.g., information technology/infrastructure enhancements) – 17 grants totalling $4.4 million
  - enhancement of existing service as outlined in grant proposals – 13 grants totalling $1.8 million.

On 20 August 2020, the Premier and Minister for Trade announced $46.5 million over two years to support a Mental Health and Wellbeing Community Package (the Package), as part of the Queensland Government's Economic Recovery Strategy. The package comprises six targeted evidence-based initiatives designed to mitigate the immediate and longer-term MH impacts of the COVID-19 pandemic. Localised MH community treatment and support services were directed to areas where services have experienced greater demand – where local economies are dependent on construction, tourism and related service industries have been impacted. This has included:

- bolstering community MHAOD treatment and support responses across high priority areas
- localised MH initiatives through grants to up to 45 rural councils
- boosting capacity of existing NGO AOD residential rehabilitation services
- enhancing specialist MH responses for people in quarantine
- expanding the MH co-responder service between QH and the QAS to the Sunshine Coast
- online MH therapy programs for young people.

Appendix 4: QH initiatives to support rural and remote workforce issues

The following QH initiatives are designed to respond to rural and remote workforce issues these are inclusive but not necessarily specific to the MHAOD workforce.

The QH Office of Rural and Remote Health operates:

- A Clinical Support Unit which supports safe and quality rural and remote health care.
- The Pathways to Rural and Remote Orientation and Training (PaRROT) program - provides flexible modes of training for QH professionals working in rural and remote settings.
- Statewide Rural and Remote Clinical Network through which clinicians and network members engage in planning, priority setting and advises the Minister for Health and Ambulance Services, DoH and HHSs.
- The Rural and Remote Health Advisory Committee which includes key stakeholders across the health care system to advise the Queensland Government and QH to provide strategic leadership and direction.

Other QH initiatives include:

- the annual medical recruitment campaigns to recruit resident medical officers and registrars for positions in HHSs across the state.
- Queensland Rural Generalist Pathway to create rural generalist specialities to address skills shortfalls across regional, rural and remote locations.
- incentives to attract professionals to regional, rural and remote areas such as:
  - relocation and accommodation support to medical and other recruits to transition to regional, rural and remote areas
  - professional development and remoteness allowances for medical and health professionals
  - right to private practice
  - access to MBS services for QH employed medical officers such as State/Commonwealth Private Practice Joint Agreements which facilitate private patient choice in the public health sector which are fundamental to recruit and retain a skilled workforce and ensure access to enhanced GP services in regional, rural and remote communities.

Appendix 5: Queensland Health Forensic Service

Services delivered by Queensland Health and operating across the health and justice systems include: Court Liaison Services (CLS), Community Forensic Outreach Services (CFOS), the High Security Inpatient Service (HSIS), Extended Forensic Treatment and Rehabilitation Unit (EFTRU) Prison Mental Health Services (PMHS), the Indigenous Mental Health Intervention Program (IMHIP), and Policing and Mental Health services (Queensland Fixated Threat Assessment Centre (QFTAC), Police Communications Centre Mental Health Liaison Service (PCC MHLS), and Mental Health Support of Police Negotiators).

FMHS Components	Location	Coverage	Description
CFOS	Metro North	CQ, WB, SC, MN, MS, WM, DD, GC, SW	CFOS provides a consultation liaison service to mental health services in relation to the risk assessment and management of consumers who have been in, or are at risk of, contact with the justice system
	Townsville	TSV, NW, MKY	
	Cairns	C&H, Torres & Cape	
CLS	Metro North	SC, MN, MS, WM, DD, GC, SW (Psychiatry to WB)	Court Liaison Services provide mental health assessment and referral within watch-house environments, and assessment of fitness for trial and unsoundness of mind within magistrates' court settings
	Wide Bay	WB	
	Central QLD	CQ, CW	
	Mackay	Mackay	
	Townsville	TSV (Psychiatry to MKY and NW)	
	North West	NW	
	Cairns & Hinterland	Cairns, Hinterland, Cape	
PMHS	West Moreton	Arthur Gorrie CC, Wolston CC, Brisbane CC, Brisbane Women's CC, Southern Qld CC, Numinbah CC, Palen Creek CC, Woodford CC, Borallon CC	Prison Mental Health Services provide in-reach mental health services to major correctional centres across Queensland
	Wide bay	Maryborough CC	
	Central QLD	Capricornia CC	
	Townsville	Townsville Men's CC, Townsville Women's CC	

FMHS Components	Location	Coverage	Description
	Cairns	Lotus Glen CC	
HSIS (EFTRU)	West Moreton	Statewide	The Statewide High Security Inpatient Service (HSIS) provides specialist inpatient mental health and rehabilitation for those individuals assessed as presenting a higher level of risk either through the mental health court or on referral as a classified patient
QFTAC	Metro North	Statewide	Mental Health clinicians' partner with QPS to assess and respond to referrals of fixated individuals or those at risk of grievance fuelled violence
PCCMHLS	Metro North	Statewide	The PCCMHLS places clinicians in the police communications centre to provide relevant MH information to assist in the safe resolution of MH crises identified through 000 emergency calls to police
IMHIP	Metro North	Woodford CC, Brisbane Women's CC, Southern QLD CC	The Indigenous Mental Health Intervention Program is an Aboriginal and Torres Strait Islander developed, led, and staffed model based on concepts of social and emotional wellbeing, providing services for Aboriginal and Torres Strait Islander people in custody.