Question on Notice
No. 606
Asked on 21 April 2006

DR DOUGLAS asked the Minister for Health (MR ROBERTSON)-

QUESTION:

What progress has the Mental Health Sentinel Events Implementation Secretariat made in relation to the nine key recommendations of *The Queensland Review of Fatal Mental Health Sentinel Events*, released in March 2005 and, in particular, for my electorate of Gaven?

ANSWER:

Implementation of the nine key recommendations of the Report of the Queensland Review of Fatal Mental Health Sentinel Events is a long term process that commenced in July 2005 and is planned to continue until 2008-09. $4.6 million (non-recurrent) and $530,000 (recurrent) has been allocated for implementation of all nine key recommendations. This is in addition to the large injection of funds for additional mental health clinical staff that were announced by the Premier and myself in late 2005.

The Mental Health Sentinel Events Implementation Secretariat has established a site on the Queensland Health internet site so that members of the public can access information on this important project. The link is:
http://www.health.qld.gov.au/mental_hlth/publications/Achieving_Balance.pdf

A series of updates will be posted on the site containing the most recent information about statewide implementation of each of the nine key recommendations. The first and second updates were issued in October 2005 and March 2006 and I attach these for the Member's information.

Of particular interest to the electorate of Gaven are the funds that have been provided to increase patient safety in the mental health inpatient wards of the Gold Coast Hospital at the Southport and Robina campuses (in response to key recommendation 6). All mental health inpatient units in Queensland were asked to undertake a safety audit to identify items, for example plumbing fixtures and door handles, that may represent potential hanging points or were otherwise considered to pose a safety risk for patients. A total of $790,546 (non-recurrent) was allocated to mental health services around the state in 2005-06. Of this, $232,600 (non-recurrent) was transferred to the Gold Coast Health Service District to address identified patient safety issues in the mental health inpatient units at Southport and Robina.

In response to key recommendation 9, funds have been distributed to all Queensland Health mental health services to provide additional training for clinical staff in the administration of the *Mental Health Act 2000*. As the Member would be aware, this Act provides for the involuntary assessment and treatment and the protection of persons having a mental illness, while at the same time safeguarding their rights. A *Mental Health Act 2000* online training system has been developed as part of the Clinician Development Program (CDP). Over $30,000 (non-recurrent) was transferred to the Gold Coast Health Service District in March 2006 to enable all authorised doctors, psychiatrists and mental health practitioners to complete this online training to ensure that their continued authorisation to perform functions under the *Mental Health Act 2000* is appropriate.

ATTACHMENT 1

Achieving Balance

Implementation of the Report of the
Queensland Review of Fatal Mental Health Sentinel Events

Update No. 1 - October 2005

1. Background

It is well known that serious mental disorders have an associated high rate of mortality through suicide despite optimal care. Rates of death by suicide of 10% of people with schizophrenia and 15% of people with bipolar affective disorder are generally accepted as existing in developed countries worldwide. A recent comprehensive review of studies of suicide and mental disorders estimated that the suicide rate for individuals with serious mental illness is 7 to 10 times that in the general population.

Rates of homicide are also higher than in the general population. Australian data indicate that while around 3% of people have a serious mental illness, 5% of homicides are committed by people who are considered to be mentally ill.

Despite these facts, fatal sentinel events involving people with a serious mental illness are still very uncommon. For example data from the Australian Institute of Criminology's National Homicide Monitoring Program indicates that on average there were 2 homicides per year in Queensland committed by people considered to be mentally ill over the 14-year period 1989-90 to 2002-03. Over that same period the total number of people committing homicide in Queensland averaged 74 per year.

Nevertheless sentinel events involving people with serious mental illness, particularly homicides and police shootings of people with mental illness, often evoke considerable concern in the general community. This concern has on occasion resulted in criticism of the community based model of mental health care that has been the focus of mental health reform, and suggestions that deinstitutionalisation has failed.

2. The Review

With these issues in mind, in February 2004 the Director-General of Queensland Health established a committee to undertake the Queensland Review of Fatal Mental Health Sentinel Events. The task of the Review was to investigate certain deaths involving people with serious mental illness that occurred in a two year period (1 January 2002 to 31 December 2003), and to determine if there were systemic issues in mental health services that needed to be addressed. The 45 deaths that were examined included suicides and unexpected deaths of people receiving mental health assessment or treatment in acute inpatient units or emergency departments, homicides where the offender had a mental illness, and people with mental illness who were shot by police.

3. The Report

Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events was submitted to the Director-General in March 2005. The Report highlights many significant issues facing mental health services including the increasing level of acuity of mental health patients with high levels of co-morbid drug and alcohol abuse, and low numbers of skilled staff particularly in inpatient units and in high growth, low socio-economic districts.

The Report makes it clear that not every case of suicide or homicide represents a failure of clinical care or of the mental health system. In some instances the intrinsic severity of the condition, the discouragement arising from sometimes unrelenting symptoms, combined with an inability to provide constant long term 24 hour supervision, can lead to an unexpected fatal outcome. On the other hand in some cases a series of decisions which may have appeared reasonable at the time turn out in retrospect to have been errors of judgement. It is the latter group the Review was concerned with, highlighting systemic issues which appear to be common to the cases investigated.

The Report concluded the extent and direction of mental health service reform in Queensland was appropriate, but there are issues that should be addressed to increase the quality and safety of services.

4. Recommendations

The Report outlines 60 recommendations and nine key recommendations addressing the following issues:

- standardisation of processes around assessment, treatment, searching, leave and discharge planning and inpatient observations
- communication and information management
- management of drug and alcohol problems
- management of mental health presentations in emergency departments
- support of general practitioners in managing patients with mental illness
- inpatient environment and means to suicide
- immediate response to and investigation of sentinel events
- administration of the *Mental Health Act 2000*
- staffing and bed resources and education and training.

Implementation of the nine key recommendations was approved by the Queensland Health Board of Management in June 2005. The key recommendations are reproduced in full on page 3 of this update.

5. Implementation

Implementation of the nine key recommendations began in July 2005 and is expected to continue until December 2009.

An overarching steering committee is being established, and will be chaired by the Director of Mental Health, Dr Aaron Groves. A Sentinel Events Implementation Secretariat has been

established to provide support to the Steering Committee and also assist with implementation activities. The Secretariat consists of the following members:

- Glenys Powell, Principal Project Officer,
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- Helene Dyer, Senior Research Officer, Ph: 3131 6929
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- Vanessa Lidgard, Administration Officer, Ph: 3131 6928
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6. Further Information

The *Summary Report of the Queensland Review of Fatal Mental Health Sentinel Events* will be posted on the Queensland Health internet site and the QHEPS Mental Health Unit site. For further information regarding the implementation of the key recommendations of *Achieving Balance*, please do not hesitate to contact any member of the Secretariat on the contact details listed above.

Key Recommendations

Achieving Balance: Report of the
Queensland Review of Fatal Mental Health Sentinel Events, March 2005

Key recommendation 1	Develop core state-wide standardised processes for mental health assessment, risk assessment and treatment accompanied by appropriate education and training. Particular attention should be given to addressing non-compliance with treatment.
Key recommendation 2	Give high priority to developing an information system to ensure the access of emergency department and mental health staff across health service districts to timely, accurate clinical information.
Key recommendation 3	Increase integration of mental health services and alcohol, tobacco and other drug services. *(Note: Wording as amended in March 2006).*
Key recommendation 4	Explore alternative models for the delivery of emergency mental health assessment and treatment to clients with mental health problems currently presenting to emergency departments.
Key recommendation 5	Develop models for continuing support of general practitioners when patients with major mental illness are discharged from mental health services to their care.
Key recommendation 6	Remove potential means of suicide wherever possible by implementing searching procedures in accordance with the *Mental Health Act 2000* and correcting potential structural factors in all inpatient mental health units and their immediate

	environment.
Key recommendation 7	Establish an ongoing process for monitoring the results of analyses of mental health sentinel events at the corporate level to determine trends and communicate these to the services.
Key recommendation 8	Accelerate the implementation of the *10 Year Mental Health Strategy for Queensland, 1996* in relation to staffing and bed resources. Particular emphasis should be given to recruitment and retention of clinical staff and provision of acute inpatient beds, complemented by access to additional secure beds and supported accommodation, in areas of high morbidity and high growth.
Key recommendation 9	Provide standardised competency based training for staff who perform functions under the *Mental Health Act 2000* with particular emphasis on management of forensic order patients (including persons of special notification), and liaise with the Mental Health Review Tribunal regarding the conditions of limited community treatment for patients under the *Mental Health Act 2000.*

Achieving Balance

Implementation of the Report of the
Queensland Review of Fatal Mental Health Sentinel Events

Update No. 2 - March 2006

Restructure

As part of the restructure of Queensland Health Corporate Office, the Mental Health Sentinel Events Implementation Secretariat has been transferred from Mental Health Branch to the Patient Safety Centre and is located in Block 7, Royal Brisbane and Women's Hospital Campus.

The Patient Safety Centre (PSC) is one of six centres within the Reform and Development Unit of Queensland Health.

The PSC works in partnership with Health Service Districts, in particular Patient Safety Officers, to coordinate and support statewide and local patient safety programs.

The PSC is committed to reducing preventable patient harm by:

- raising risk awareness and promoting a culture of safety
- integrating and building on programs currently in place
- building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach
- providing patient safety tools for consistent use across the State
- building a central resource centre that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state wide implementation
- creating networks for discussion and shared learning.

Implementation Progress

Implementation of the nine Key Recommendations began in July 2005 (see page 4 of this update for the full list of Key Recommendations). Listed below is a summary of the main achievements and activities to date:-

KR1: Standardisation of core processes for assessment and treatment

- Amanda Kivic joined the Mental Health Sentinel Events Secretariat in January 2006 to progress Key Rec 1.
- A network of mental health staff with responsibility for clinical documentation portfolio has been established.
- Districts requested to provide all current relevant documentation used by mental health services to the Secretariat for analysis.

KR2: Mental Health Enterprise Integrated Information System

- The development of detailed functional specifications is now complete.
- A Request for Information (RFI) process is underway. The object of this is to confirm there are no suitable applications available on the market and determine the cost to develop a solution.
- Discussions are continuing with key stakeholders on the best way to interface the system with existing systems such as EDIS and HBCIS.
- Forums showcasing the key features of the specifications will be held with senior clinicians and managers on 14 March 2006.

KR3: Mental health services and ATODS

- Final meeting of the interim committee for *Key Recommendation 3* was held in Dec 2005. Decision made to recommend to the Director-General that Key Recommendation 3 be amended to align with the Forster Review recommendation for: *increasing integration of mental health and alcohol, tobacco and other drugs services to improve outcomes for people with a dual diagnosis*.
- Approval by the Director-General pending.
- First meeting of the Steering Committee for Key Recommendation 3 is scheduled for 9 March 2006.

KR4: Alternative models for emergency care for clients with mental health problems

- Queensland participating on the AHMAC Emergency Mental Health Access Policy Group, and is contributing to mapping baseline information in all jurisdictions to determine how systems are currently operating.
- Mapping includes Emergency Departments and community access points. Results to be put to the AHMAC National Working Group on Mental Health in May 2006.

KR5: Support for GPs in management of mental health clients

- Secretariat scoping literature and current related projects.

KR6: Remove potential means of suicide in inpatient units

- Bids received in 2005 from District Mental Health Services to rectify identified mental health inpatient structural safety issues.
- Director of Mental Health approved funds totalling $756,496.17 which were transferred to the services in late 2005.

KR7: Establish ongoing process for monitoring mental health sentinel events

- Patient Safety Centre has circulated draft revised Queensland Health Incident Management Policy for comment by 28 February 2006. Proposed definition of mental health sentinel event altered to be consistent with national definition.

KR8: Resources and education

- Announcement of additional funds for mental health services by the Minister for Health and the Premier on 11th and 25th October 2005.
- Departmental approval received in August 2005 for the establishment of a Queensland Centre for Mental Health Learning.
- Calls for expressions of interest for the Strategic Advisory Board and Expert Reference Groups of the Centre for Mental Health Learning - with closing date of 7 April 2006. For relevant forms go to the following link: http://qheps.health.qld.gov.au/hssb/mhu/mhwp/htm/qcmhl.htm

KR9: Mental Health Act 2000 competencies

- The *Mental Health Act 2000* Online Training System (OTS) went live on 1 July 2005.
- Funding approved by Director of Mental Health for 5 hours overtime for all authorised mental health practitioners and authorised doctors to complete modules of the OTS.
- Consultations between Mental Health Branch and authorised mental health services took place in late 2005 regarding Limited Community Treatment and Limited Community Treatment Review Committee.

Further Information

The Overarching Steering Committee has met twice - in November 2005 and March 2006.

The *Summary Report of the Queensland Review of Fatal Mental Health Sentinel Events* is posted on the Queensland Health internet site at the following address: http://www.health.qld.gov.au/mental_hlth/publications/Achieving_Balance.pdf.

A site has been established on QHEPS that provides further information regarding *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events, March 2005.* The site can be found at the following address: http://qheps.health.qld.gov.au/hssb/mhu/act_and_rights/sentinel/index.htm

The site includes information on the following:

- Establishment of the Queensland Review of Fatal Mental Health Sentinel Events including terms of reference, methodology and definition of mental health sentinel events that were examined
- *Summary Report of the Queensland Review of Fatal Mental Health Sentinel Events*
- Key recommendations from *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events, March 2005*
- Membership and Terms of Reference of the Overarching Steering Committee for the implementation of *Achieving Balance*
- Implementation progress of the recommendations from the Queensland Review of Fatal Mental Health Sentinel Events
- Updates
- Links
- Secretariat

New contact details for secretariat members

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For further information regarding the implementation of the key recommendations of *Achieving Balance: The Queensland Review of Fatal Mental Health Sentinel Events, March 2005*, please do not hesitate to contact the Secretariat on the details listed above.

Key Recommendations

Achieving Balance: Report of the
Queensland Review of Fatal Mental Health Sentinel Events, March 2005

Key recommendation 1	Develop core state-wide standardised processes for mental health assessment, risk assessment and treatment accompanied by appropriate education and training. Particular attention should be given to addressing non-compliance with treatment.
Key recommendation 2	Give high priority to developing an information system to ensure the access of emergency department and mental health staff across health service districts to timely, accurate clinical information.
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Key recommendation 6	Remove potential means of suicide wherever possible by implementing searching procedures in accordance with the *Mental Health Act 2000* and correcting potential structural factors in all inpatient mental health units and their immediate environment.
Key recommendation 7	Establish an ongoing process for monitoring the results of analyses of mental health sentinel events at the corporate level to determine trends and communicate these to the services.
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