

When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services

Final Report

April 2016

When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services.

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Foreword

This report is the final publication of the Mental Health Sentinel Events Review Committee (the Review Committee). It demonstrates a commitment to help make forensic and general clinical mental health services as effective and high quality as possible. This report includes a review of the implementation of *Achieving Balance: Report of the Queensland review of fatal mental health sentinel events: A review of systemic issues within Queensland Mental Health Services 2002–2003*, the previous report on sentinel events in Queensland, and builds on important earlier work in all Australian governments.

Safety and quality in mental health care are of major importance to Australians and their representatives. Latest statistics estimate 45 per cent of Australians will experience a mental health disorder at some point in their lifetime and 20 per cent will experience a mental health disorder in any 12 month period¹. A recent review has estimated two to three per cent of Australians have severe mental health disorders, based on diagnosis, intensity and duration of symptoms². As knowledge about mental illness and mental health care grows, there are increasing expectations that our health system will achieve better standards of identification and quality of care for our mentally ill consumers.

The Review Committee was established to review recent fatal events involving people with mental health issues in Queensland. For its part in reviewing these fatal mental health events, or sentinel events, the Review Committee aimed to provide expertise and leadership in public mental health care and forensic mental health care that balanced best practice care with operational practicality. This report provides high level guidance for clinicians, administrators, and policymakers on opportunities to improve the identification and quality of care for our severely mentally ill consumers while simultaneously considering public safety.

At the outset, the Review Committee wishes to acknowledge the tragic nature of the events leading to the Mental Health Sentinel Events Review. Whilst the role of the Review Committee is to review these events objectively, the Review Committee acknowledges the suffering of victims, their families and communities, the impacts upon treating teams and family members of the perpetrators and the long term consequences for the perpetrators themselves.

Given the very low rates of homicide, it is not possible to reliably predict who will or will not engage in such an event. Rather, we must consider and address known risk factors to help identify consumers at high levels of risk for violence in order to help reduce violent acts overall, and in so doing also reduce the likelihood that a homicide will occur.

The Review Committee was impressed by the level of commitment to mental health care demonstrated by mental health staff with whom we met across the state. Such a commitment was also evident in the work we reviewed. The Review Committee wishes to thank the many organisations and individuals who have contributed towards the

¹ AIHW 2015

² AIHW 2015

Mental Health Sentinel Events Review 2016, including the Office of the State Coroner, the Queensland Mental Health Commission, the Queensland Police Service, Office for Women and Domestic Violence, families of victims, carer and consumer organisations, the Mental Health Alcohol and Other Drugs Branch, and Hospital and Health Services throughout Queensland, and the many individuals with whom we met and communicated.

The Review Committee would sincerely like to thank the support of the Review Team throughout the Review, including Jackie Bartlett, Joanna Cull, Jenene Tull, [REDACTED], [REDACTED], Judith Piccone, Suzie Lewis, Lauren Davis and Janet Martin. Their tireless efforts ensured the Review and this report completed the tasks set out in the Terms of Reference.

We must remember that the primary purpose of the health-care sector is to look after the unwell. This includes the seriously mentally ill person who, as a result of their mental illness, is at high risk for violence or who commits grave offences.

We commend this report to you.



Associate Professor Peter Burnett
Co-Chair, Sentinel Events Review Committee

15 / 04 / 2016



Professor James Ogloff AM
Co-Chair, Sentinel Events Review Committee

15 / 04 / 2016

Executive summary

Increasing media coverage has speculated on the role of mental illness in fatalities involving homicide or attempted homicide in Queensland and other parts of Australia. Since January 2013, there have been a number of high profile mental health fatal sentinel events reported in Queensland involving persons with a known or suspected mental illness. At the same time, a number of fatalities occurred as a consequence of police use of force interventions.

Contrary to media speculation and angst experienced by others, evidence does not support the perception that events of this nature are increasing. Since the last review, *Achieving Balance: Report of the Queensland review of fatal mental health sentinel events. A review of systemic issues within Queensland Mental Health Services 2002–2003* (Achieving Balance), Queensland has maintained a low incident rate of homicide, including homicides committed by people with mental illnesses. For the period 2003–04 to 2011–12, these rates were decreasing in both total number of events and the number in which a person with a mental illness was involved. Unfortunately, the overall homicide data for the period covered by the review were not available at the time of the review but given the relatively consistent pattern of homicide offences over the short-term, it would be unusual for the data to deviate from the most recently available data from 2011–12.

Whilst the number of homicides involving individuals with a mental illness is very low, the impacts of these events and of fatalities as a consequence of police use of force interventions are devastating for victims, families, the community and the perpetrators. It represents the worst possible outcome of severe mental illness and warrants investigation as a mechanism for continuous service development.

In May 2015, the Minister for Health and Minister for Ambulance Services announced the establishment of a state-wide clinical review to examine recent fatal mental health events in Queensland.

The Mental Health Sentinel Events Clinical Review 2016 (the Review) was conducted pursuant to the clinical review provisions of Part 6 Division 3 of the *Hospital and Health Boards Act 2011* (HHB Act 2011). The review was undertaken by an independent Mental Health Sentinel Events Review Committee (the Review Committee) appointed to assess the standard and quality of clinical assessment, treatment and care provided by public mental health services and make findings and recommendations on systemic matters to inform strategic directions, policy and clinical practice, with a view to improving the care of people with mental illness and minimising or preventing the recurrence of such events.

The role of the Review was to:

- examine the sentinel events and consider the standard and quality of clinical assessment, treatment and care provided to the person receiving a public mental health service
- consider the recommendations of the Achieving Balance report, and the extent to which the recommendations have been implemented, and related outcomes achieved for public sector mental health services
- make findings and recommendations on systemic matters relating to the sentinel events to inform strategic directions, policy and clinical practice, with a view to improving the care of people with mental illness, and to minimise or prevent the recurrence of such events.

The Clinical Review process involved:

1. examination of documentation relating to individual matters, including clinical files and electronic records, independent external clinical reports, and internal and external incident review or investigation reports
2. examination of relevant local and state-wide policies, guidelines and protocols relating to the treatment and care of people with mental illness, and safety and quality in mental health service delivery
3. undertaking site visits and inspections of selected mental health services
4. consultation with key stakeholders including consumer and carer representatives, health service providers, relevant statutory entities (e.g. Director of Mental Health, Mental Health Review Tribunal), departmental officers, other government agencies, and community organisations.

The Review Committee examined all matters that fell into the scope of the review and occurred over a period of 28 months from 1 January 2013 to 30 April 2015. The Review Committee considered all 24 homicides or attempted homicides and five fatalities as a consequence of police use of force interventions over the review period. This review was conducted by an examination of all of the documentation contained within the consumer's files, both in electronic and hard copy form.

Because the Review was intended to focus on systemic issues, the Review was conducted with a strong focus on consultation and actively engaged with peak representative bodies, government agencies with functions directly relevant to the review and Hospital and Health Services in Queensland. Families and carers of individuals whose sentinel events were included in the Review were invited to provide submissions.

The Review Committee also conducted a literature review on the relationship between mental illness and violence with a focus on acts of homicide involving consumers and assessing risk for violence among people with mental illness. Overall the literature is clear that the ability to predict who will commit serious acts of violence is limited; however, it is possible with standardised tools, such as the Historical Clinical Risk Management-20 (HCR-20), to identify the group of individuals that includes those who are more likely to engage in violent behaviour, broadly speaking. Even with the use of best-practice tools and practices, it is not possible to say with certainty whether any events could have been avoided.

Robust research, including work conducted in Australia, confirms that the vast majority of people with serious mental illnesses (i.e. more than 90%) do not engage in acts of violence that lead to criminal convictions. Nonetheless, the literature identifies there is a modest but statistically and clinically significant link between serious mental illness (e.g. psychosis) and violence, such that people with schizophrenia are from three to five times more likely to engage in violence compared to people in the community who do not have such illnesses. Moreover, international and Australia research shows that up to 10 per cent of men and 20 per cent of women who commit homicide have a psychotic illness. A number of factors have been found to increase the likelihood that someone with serious mental illness will engage in acts of violence, including, for example, substance misuse, personality dysfunction, antisocial attitudes, instability in major areas of life, active symptoms of mental illness, lack of compliance with medication and with treatment orders. These risk factors should be accounted for when assessing and treating people with these illnesses.

The focus of the review was to make findings and recommendations on systemic matters to inform strategic directions policy and clinical practice, with a view to improving the care of people with a mental illness and to the greatest extent possible minimising or preventing the recurrence of these events.

Overall the Review found that Queensland has made genuine efforts and significant progress in implementing the Achieving Balance recommendations including consumer data consolidation and availability and improved governance and guidance. Rates of homicide have reduced and are consistent with national values. Some key performance indicators have improved. Health and Hospital Services (HHSs) have implemented standardised processes for mental health assessment, risk screening and treatment, which has been accompanied by appropriate education and training. Alcohol and other drugs services are being integrated with mental health services. Queensland Health and the HHSs have a solid core to their mental health services, both forensic and non-forensic.

In conducting the Review, the Review Committee identified a high level of commitment to the service and professionalism by HHS staff members and by all persons with whom the Review Committee consulted. Nonetheless, given the focus of the Review on service development, a number of areas were identified where improvements can be made.

Key themes identified in this Review were generally consistent with previous reports commissioned in Queensland and Australia and are fundamental to the provision of quality mental health care and support to persons with severe mental illness. These are histories of violence and aggression amongst most consumers who perpetrated homicide; the crimes committed were predominantly against family members or other persons known to the perpetrator; issues with an episodic focus on clinical assessment and treatment; a lack of comprehensive risk assessments; breakdown in information sharing between services and a lack of information sharing between the service and family members/ carers.

The Review Committee concluded that overall the cases reviewed were isolated occurrences and did not identify any widespread patient safety issues. The review of cases, however, identified short comings in the risk assessments and treatment for the consumer. Opportunities were missed in each case that could have identified and addressed in the treatment plans the risk of violence. The Review has made eleven key findings and 63 recommendations, outlined in detail at pages 53 to 77 of this report.

In arriving at the findings and recommendations, the Review Committee was aware the examination had a narrow scope and was undertaken with the benefit of hindsight. Each case involved a consumer with complexity. The findings should be interpreted in context of the challenge of complex consumers who pose a high risk of violence, rather than as a general representation of the quality and standard of forensic mental health service provision in Queensland.

The following key findings and ensuing recommendations provide opportunities for service improvement.

1. State-wide forensic mental health service model

The structure of the existing state-wide forensic mental health service system is decentralised and fragmented. While the components of a forensic mental health service are present in Queensland (e.g. inpatient units, community-based services, prison mental health services, court liaison services, and policing and mental health services), these service components are located administratively in six separate Hospital and Health Services (HHS). There is effectively no unified forensic mental health service with a clear governance structure and service delivery model. This impedes effective governance, responsive service delivery, management of forensic consumers, and the delivery of a consistent and integrated service.

The Review found a wide variation in the Hospital and Health Services' perceptions of the various elements of forensic mental health services including the usefulness of the assessments undertaken and recommendations made by Community Forensic Outreach Services (CFOS). Concerns were raised about the availability of resources within a HHS to fulfil some clinical recommendations made by CFOS. It was the perception of some HHS staff that some CFOS staff often appeared to have inadequate knowledge of the structure and resources of the HHS, resulting in impractical recommendations. Some reports provided by CFOS services were not reviewed and signed by senior forensic staff which limited their usefulness to the HHS, and also reduced the authority of their recommendations. Conversely, concerns were expressed by some forensic mental health staff that HHS clinicians have inadequate knowledge and understanding of risk assessment and management and that the resources committed to the Forensic Liaison Officers (FLO) are sometimes diverted to activities beyond their remit.

The reporting and monitoring requirements for the large number of consumers on forensic orders in Queensland currently does not differentiate between consumers based on the severity of the acts they have committed or the level of risk for violence that they pose. Many consumers on forensic orders do not pose an elevated risk and do not require the intensive monitoring requirements currently mandated.

Recommendations

- 1 Develop an integrated state-wide forensic mental health service with a governance structure independent of Hospital and Health Services that enables the effective operation and maintenance of an integrated service across Queensland.
- 2 The position of Director of a state-wide forensic mental health service (SFMHS) is to have state-wide oversight of the integrated SFMHS, which provides and supports independence, governance, integrated standards and consistent practices.
- 3 Establish quarterly meetings between the Director of the state-wide forensic mental health services and Hospital and Health Services mental health service senior executives to improve quality, efficacy and integration of services.
- 4 State-wide forensic mental health services are provided to consumers assessed as being at a high risk of violence in addition to consumers on forensic orders under the *Mental Health Act 2000*.

- 5 The role and function of the Forensic Liaison Officer positions located within mental health services be quarantined for undertaking assessments and management of forensic mental health consumers and other consumers who pose a high risk of violence.
- 6 Develop collaborative and effective relationships between forensic mental health services and Hospital and Health Services (HHS) mental health services staff and obtain knowledge of the models of mental health service delivery and available services/resources within the HHS region, by ensuring that identified Community Forensic Outreach Services teams are attached to specific HHSs, thus ensuring teams and clinicians assigned gain an increased understanding of the HHS necessary to provide tailored support to that specific HHS mental health service.
- 7 Upon completion of an assessment and prior to the finalisation of the recommendations state-wide forensic mental health services staff are to discuss their findings with the Hospital and Health Services (HHS) mental health service clinicians responsible for the consumer's care to enhance the validity of the recommendations and to help ensure that they reflect the availability of resources and services in the HHS.
- 8 Develop a categorisation system to differentiate lower risk from higher risk consumers on forensic orders and adjust the treatment and monitoring requirements accordingly.
- 9 Consider the engagement model of Mental Health Intervention Coordinators with the Queensland Police Service in responding to potential mental health crisis situations as a component of the service delivery model for state-wide forensic mental health services.

2 Family engagement

Insufficient engagement with families was identified, including poor communication during all phases of care (assessment, treatment and discharge planning), and specifically, no documented evidence of information provided to families/carers about the consumers' risk to others in the eight cases in which the consumer was receiving active current treatment.

In a few cases, inadequate risk management contingency plans were developed in circumstances where an increased risk or known threats were foreseeable.

For some of the cases too much responsibility was placed on the consumer's family/carer to help manage the consumer's relapse symptoms, with little evidence of mental health services staff working with families to inform them of the relationship between mental illness and violence or to provide strategies to assist in managing violent behaviour and addressing the family members'/carers' need for safety and protection.

Despite evidence of previous history of domestic violence or threats to intimate partners, family members, children and parents, these risks were either not identified from collateral information provided by the family, or if known, strategies to manage them were not shared with the family, and often not specifically noted in clinical file material.

People at risk of violence by consumers tend to minimise, deny or be naïve about the risks that they may face even when they may have been threatened. Clinicians need to be aware of this and specifically address these matters.

Recommendations

- 10 The comprehensive assessments conducted by clinicians must be informed by collateral information obtained from families/carers. Prompts on obtaining this information are to be added to the State-wide Standardised Suite of Clinical Documentation and, where no collateral is provided, the efforts made to contact and obtain the information are to be documented and audited.
- 11 Engagement with families is to occur at initial contact with the consumer and throughout the consumer's episode of care, consistent with the *National Standards for Mental Health Services 2010* and reflective of a tripartite model involving the consumer, clinician and the family/carer.
- 12 Families/carers are to be informed of potential risks to their safety, provided with support and strategies on how to mitigate risks, and given clear advice on how to maintain their own safety in crisis and ongoing situations, including information about available support including support external to mental health services.
- 13 Prompts are to be included in comprehensive assessment, risk assessment and treatment planning as well as reminder included within staff training to ask about safety of family members, including ensuring that clinicians ask difficult questions about safety and risk.
- 14 Educate mental health services staff on information sharing legislation, particularly the approval to release information to family and other parties.
- 15 Revise the Mental Health Alcohol and Other Drugs Branch information sharing booklet to include information about providing advice and supporting families who may be at risk.
- 16 Identify opportunities to build mental health services staff knowledge on information sharing into the *Mental Health Act 2016* implementation process.

3 The consumer journey

3.1 Comprehensive mental health assessment

Mental health assessments and management plans for many new consumers or consumers re-presenting after a break of service were not sufficiently comprehensive to provide for appropriate mental health care or, where necessary, enable accurate risk assessment and formulation.

The review revealed that in many instances mental health assessments did not adequately consider longitudinal information as part of the assessment and development of care plans. Rather services were often limited to the presentation of the current episode of mental illness.

Of the materials reviewed it appeared that many consumers did not receive comprehensive formal assessment and the instruments of assessment from the State-wide Standardised Suite of Clinical Documentation were incomplete or not utilised.

Recommendations

- 17 Mental health services need to undertake a comprehensive mental health assessment for all new consumers accepted into treatment.
- 18 Mental health services need to undertake a comprehensive mental health assessment for any persons who frequently present to emergency departments or are frequently referred by other services, regardless of whether the consumer is admitted to the service. Frequency is defined as presenting on three or more separate occasions within a three month period.
- 19 In emergency situations the minimum standard for an assessment includes:
 - identification of presenting problem
 - consideration of previous mental health history and contacts
 - mental state examination
 - risk screen
 - identification of any relevant co-occurring conditions
 - collateral information.
- 20 Comprehensive mental health assessments should, insofar as possible, be a longitudinal assessment informed by a consideration of historical, contextual and current factors.
- 21 Mental health services should ensure appropriate training, supervision and auditing of comprehensive mental health assessments.

3.2 Violence risk assessment and management

While there was widespread use of risk screening, there was little evidence of more comprehensive risk assessments being conducted even when the consumer had a history of violence that was known to the mental health service. It was unclear from the evidence which practices triggered the engagement of specialist input and in some high risk cases there was no evidence of specialist input. Very few cases employed any validated risk assessment measure apart from the standard risk assessment screening form.

Consistent with the findings regarding comprehensive mental health assessments, risk screening, risk assessments and management plans did not contain evidence of a consideration of the consumer's previous history of violence.

There was a lack of evidence of matching appropriately skilled and experienced clinicians and providing suitable services for the treatment and care and ongoing monitoring of plans that are commensurate with the identified risk and complexity of the consumer.

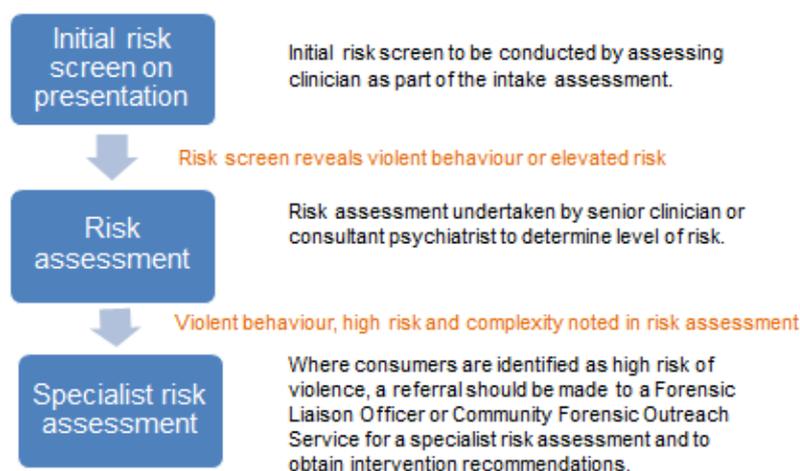
The lack of evidence of senior staff involvement in the provision of treatment, management and supervision of high risk consumers has resulted in unclear escalation processes for assessing and managing risk.

There has been limited access to, and uptake of, specialist forensic mental health advice and support, including coordination, supervision and leadership, for generalist clinicians managing forensic consumers or other consumers who pose a high risk of violence.

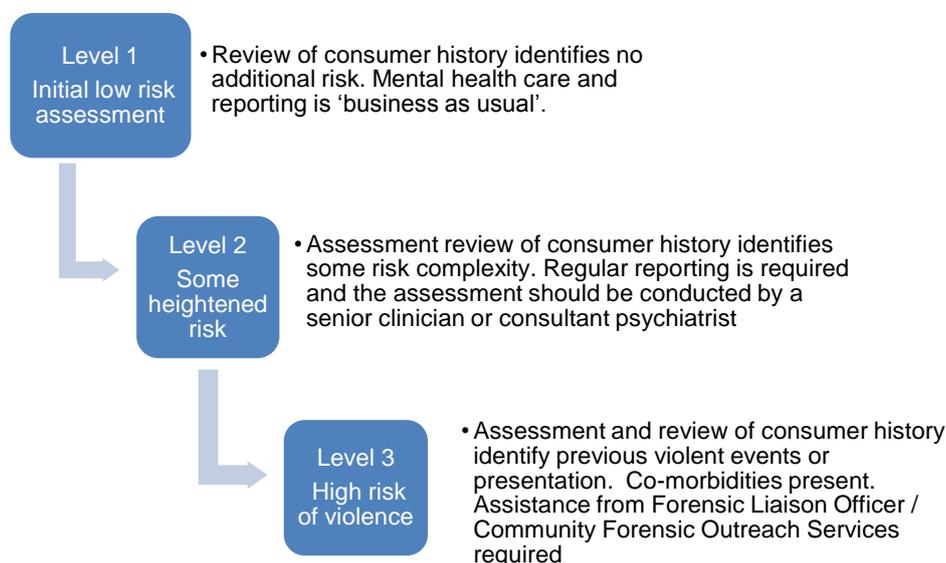
Recommendations

22 Implement the following three level violence risk assessment:

Risk Assessment Framework



23 The level of services required to address the consumer's level of risk should be commensurate with the level of risk identified for the consumer.



24 Consultant psychiatrists, and other senior clinical staff, are required to actively review and be involved in the development of management plans that expressly address violence risk factors for all consumers rated as Risk Level 3.

25 Forensic Liaison Officer positions should be quarantined from non-forensic mental health, or management of consumers at high risk for violence, service demands in order to maintain role, presence and expertise. Refer to Recommendation 5.

3.3 Formulation and treatment planning

Treatment planning did not appear to be consistently informed and formulated by:

- comprehensive mental health assessments
- violence risk assessments including Community Forensic Outreach Services recommendations, historical and contextual information
- longitudinal assessment, treatment and competencies
- recovery oriented care, in particular plans made in collaboration with consumers.

Recommendations

- 26 Formulations require a longitudinal perspective and should include information about mental illness, the relationship between mental illness and risk factors for violence, and the impact of risk of violence.
- 27 Management plans are to be informed by issues identified in the risk assessment and include proposals to address these issues including referrals to relevant agencies that can provide services that are outside of the scope of mental health services.
- 28 All consumers must have a completed care review and summary plan within six weeks of being accepted into the mental health service. A Recovery Plan should also be developed at this time, or explanation for its delay.
- 29 Undertake the 91 day Clinical Reviews in accordance with the *National Standards for Mental Health Services 2010* with a separate system of more comprehensive review to be developed by Hospital and Health Services for complex and high risk consumers.
- 30 Include within the State-wide Standardised Suite of Clinical Documentation a mechanism to trigger a comprehensive ad hoc review where indicated.
- 31 Clinical reviews to include an assessment of the effectiveness of the previous care plans and include strategies to mitigate and reduce the level of risk and stabilise behaviour.
- 32 Community Forensic Outreach Services' reports to be noted by a consultant psychiatrist and resulting changes to the management plan documented in the clinical file.

3.4 Therapeutic relationship

There was variable evidence of active engagement with consumers in their treatment and care to support recovery. Many occasions were observed of mental health services performing more passive monitoring roles such as medication compliance.

Recommendations

- 33 Mental health services should accelerate training of clinicians to work in collaborative, recovery-oriented practice with consumers, including those with a history of violence and/or forensic issues. For such consumers, clinicians may require more sophisticated training in application of the recovery model and techniques for addressing difficult issues, and specifically for managing risk of violence.
- 34 Training in more specialised applications of the recovery model and techniques to manage risk of violence should include input from consumers and forensic specialists.

- 35 Regular audits of case files should be undertaken ensuring evidence of consumer engagement is being documented, and shortfalls addressed in supervision and line management.

4 Consumers with co-morbid conditions

Review of case profiles repeatedly identified co-occurring or dual diagnosis conditions (substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury) which serve to increase the complexity of the case and may increase the risk of engaging in violent behaviours. Unfortunately, there was little systematic review of such conditions and the treatment plans rarely addressed these matters.

Recommendations

- 36 Greater consideration by clinicians is required during the comprehensive mental health assessment for the identification of dual diagnosis and co-occurring conditions (substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury) to ensure referral pathways are initiated.
- 37 Greater attention should be paid to the presence, and need for treatment, of co-morbid alcohol and other drug use and the implications of the substance misuse on consumer's mental health and risk of violence.
- 38 Greater attention should be paid to the presence of, and need for interventions for, co-morbid personality vulnerability and personality disorders and the implications of these conditions on consumer's mental health and risk of violence.
- 39 As part of the development of a formulation that includes mental health and risk of violence considerations, the role of any co-morbid or co-occurring conditions should be considered and incorporated.
- 40 Treatment plans should address and provide for the integrated management of complex consumers. Where required services fall outside the remit of mental health services, appropriate referrals should be made and, insofar as possible, the provision of external services should be monitored.
- 41 Multi-service case conferences would be beneficial to coordinating service efforts for consumers with co-morbid conditions, or those who repeatedly present to the mental health services.
- 42 Investigate ways to renew the functions of service integrated care coordinators for complex consumers, including those with mental health and dual disability, in consultation with the National Disability Insurance Scheme.
- 43 Investigate further mechanisms for managing particularly complex mental health consumers (i.e. those with any two of: substance misuse, personality disorder, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury, history of violence or offending) employing a whole of government approach.

5 Clinical systems and information

Clinical information is currently stored in a fragmented way and is inconsistent across the Hospital and Health Service. There is inconsistent access to reports, particularly *Mental Health Act 2000* related, and other longitudinal information. There is a lack of the systematic method for recording, storing, access and retrieval of clinical information within the Consumer Integrated Mental Health Application (CIMHA) relating to a consumer's risk which is used to inform assessment, management and review. CIMHA alerts indicating risk status are not easily visible and review dates had expired.

Recommendations

- 44 Use one consistent integrated state-wide clinical information system for mental health information. As Hospital and Health Services use the Consumer Integrated Mental Health Application (CIMHA), its continued use should be considered, however it is acknowledged that comment on Queensland Health information technology systems is out of scope of the Review.
- 45 Provide one area within the Consumer Integrated Mental Health Application for the storage of all information relating to a consumer's risk assessment, management and ongoing reporting. In addition to Mental Health Review Tribunal Reports, establish a clinical note category with a heading such as 'forensic reports' or similar to include all information relating to a consumer's history of aggression, criminal history, Community Forensic Outreach Service report, and Mental Health Court reports and risk assessment and management plans.

6 Building competencies and capabilities

Most of the cases reviewed demonstrated a lack of integration between assessments and treatment plans and an absence of effective escalation processes in the face of deteriorating mental health. Insufficient attention was paid to considerations of risk for violence and such matters were typically not considered in formulations, treatment plans, and interventions. This suggests issues with generalist clinicians' awareness, competency and capability and could reflect gaps in their supervision, education and training in mental health assessment, risk assessment, specialist forensic assessment, treatment planning and delivery.

Recommendations

- 46 Consistent with the recommended phased model of risk assessment and management, all clinicians require training in principles of risk assessment of people with mental illnesses. This knowledge is necessary to complete the risk assessment screening required for all consumers. Senior clinicians require training in risk assessment and management necessary to enable them to undertake the level two risk assessments using and interpreting validated risk assessment measures.
- 47 Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumers' needs rather than being passively identified in documents.

- 48 Provide training and supervision specific to identification of risk factors of violence to ensure appropriate escalation processes are included where indicated.
- 49 Provide training and supervision specific to recovery principles, and the dignity of risk (i.e. the realisation that all people including consumers carry with them some degree of risk and the important factor is how they manage that risk), to ensure treatment plans assist with firstly stabilising the consumer's presentation and working towards recovery which includes addressing violence risk factors.
- 50 Provide training on consumer confidentiality and release of information so that information sharing between the forensic mental health services, other service providers and family/carers allows for open discourse on risk and discovery of important factors to be considered in care planning.
- 51 Provide training and implementation support for the *Queensland Health dual diagnosis clinical guidelines and dual diagnosis clinical toolkit* to ensure all the consumer's needs for treatment and management are integrated and the necessary referral pathways engaged.
- 52 Implement a program of auditing skill acquisition for all relevant staff through review of documentation and other evidence to ensure necessary competencies have been transferred and evident in practice.
- 53 Explore opportunities to develop training and relationships with Primary Health Networks in relation to the assessment and management of risk of violence to others. Mental health services should develop better collaboration with domestic violence services in the management of family violence.

7 Support services and linkages with other agencies

A lack of awareness and utilisation of available services to support people at risk either as perpetrators or victims of violence was evident. Consultation, collaboration and information sharing between mental health services and community supports requires improvement to support consumers, private mental health service providers, non-government organisations, health workers, Victim Support Services, domestic violence services and the Queensland Police Service.

Recommendation

- 54 Given the disproportionate number of victims of homicide who were family members, there is an urgent need to enhance the awareness and capacity of the role of Victim Support Services to work with families who have experienced violence. This could be achieved by making the service more visible to Queensland clinicians, consumers, and the broader community, via an awareness campaign.
- 55 Consider the role that Victim Support Services could play in supporting consumers, family members, and others who have been victimised or are vulnerable to victimisation. Information about the service should be readily available at all points of contact with Queensland Health (e.g. emergency departments and outpatient units). This may result in an increase in the workload for the service, and this needs to be managed accordingly.

56 Undertake exploration to identify other government/non-government organisations/community-based services to support people at risk either as perpetrator or victim of violence, and to establish inter-disciplinary links so as to maximise service delivery to the families/carers of consumers.

8 Mental health literacy and access

Over the past twenty years, there have been improvements in mental health literacy within Queensland as in the rest of Australia; these have enhanced the community's general knowledge on prevention and early intervention for those with or at risk of a mental illness. However, the Review identified a number of incidents where access to and engagement with mental health services, or non-specialised services such as Primary Health Networks, general practitioners, nurse practitioners, Victim Support Services, domestic violence support, was lacking.

Recommendation

57 A whole of government strategy aimed at enhancing mental health literacy and access to support services with a focus on referral pathways and access to public mental health services would have beneficial effects for the management of all cases within scope of the Review.

9. The Queensland Police Service

No findings have been made regarding the provision of mental health services to those who died as a result of police use of force intervention (Category 4 cases). Examination of the information provided identified that in each case the victim either had no involvement with Queensland mental health services or where they did, there were no immediate concern regarding the appropriateness and competency of the mental health treatment provided.

Our review of those matters did not raise particular concerns about any way in which mental health services could have been provided in a manner to reduce the likelihood of the death of the individuals.

Consistent with other findings of the Review, opportunities for improvement were identified in information sharing and collaboration as well as in level of specialist forensic mental health support.

Recommendations

58 Establish communication protocols between mental health services and the Queensland Police Service to advise of changes in care status (including discharge from care) for those consumers who were brought to emergency departments by the Queensland Police Service.

- 59 Update training in mental health for Queensland Police Services to include de-escalation techniques for persons presenting in mental health crisis, understanding the difference between mental illness and being affected by substance use and knowledge of criteria for detaining a person involuntarily under mental health legislation.
- 60 Retain the co-responder model where mental health clinicians are available within the Police Communications Centre to provide support and access to necessary information to assist in managing police matters where the individual appears to be affected by mental illness. The services should be expanded to offer 24-hour coverage, as required.

10. Aboriginal and Torres Strait Islander peoples mental health and social and emotional wellbeing

Aboriginal and Torres Strait Islander peoples were not over-represented within the events reviewed. The Review Committee did not identify any specific findings in relation to the provision of mental health care for these individuals and is therefore not able to provide any systemic recommendations. This of course does not mean that there are not important considerations for mental health services for Aboriginal and Torres Strait Islander people, rather that they are not over-represented in the cases reviewed and, therefore, do not warrant specific comment within the scope of the present review.

During the course of consultation, information was provided to the Review Committee relating to [REDACTED]

[REDACTED]

[REDACTED] the Review Committee concluded that the important information obtained should be recorded for further consideration by Queensland Health.

Considerations

Queensland Health to learn from positive models introduced by Indigenous Health Organisations and engage in real collaboration on the planning for and implementation of services to meet the social and emotional wellbeing and also mental health needs for Aboriginal and Torres Strait Islander peoples³.

Consider models of co-locating within a community health services hub, a service within a community which provides support and advice across all forms of social and emotional wellbeing including housing, employment, health, mental health, and community support within targeted areas where there is high levels of social economic disadvantage and separation from family and support. Models considered would need to be attuned to the cultural requirements and different needs and available resources within regional, remote and urban areas. Consideration also needs to be given to increasing mental health literacy

³ Both Aboriginal and Torres Strait Islander peoples and Indigenous peoples are used in this document due to the two terms being used interchangeably in the literature, other reports and data.

among Aboriginal and Torres Strait Islander communities to help enhance access when services may be required.

11. Mental health quality assurance

Overall, the clinical documentation reviewed by the Review Committee was often considered poor due to being incomplete or lacked the necessary detail within mandatory fields. At times it was difficult to determine the qualifications of the staff member completing the forms (in hard copy), or whether the contents and formulation had been reviewed and endorsed by a more senior clinician.

The Hospital and Health Services (HHS) policies, protocols and procedures reviewed demonstrate that the Achieving Balance recommendations and Queensland Health guidelines had been adopted locally. However, examination of the materials within consumers' files indicated local processes and policies had not been consistently translated into standard practice.

Likewise, there were inconsistencies and gaps in processes across HHS and some disconnect when consumers were transferring between services.

Recommendations

- 61 Create a state-wide mental health Quality Assurance Committee to oversee the safety and quality of mental health services through formal assessment and evaluation processes.
- 62 Include within the remit of a Quality Assurance Committee the review of homicides and other serious acts of violence committed by or on consumers of public mental health services.
- 63 Include within the remit of a Quality Assurance Committee an oversight role in monitoring the regularity and suitability of care reviews and summaries of consumers identified as at a Category 3 risk of violence.

2. Review process

2.1 Background and purpose

Increasing media coverage has speculated on the role of mental illness in fatalities involving homicide or attempted homicide in Queensland and other parts of Australia. Since January 2013, there have been a number of high profile mental health fatal sentinel events reported in Queensland involving persons with a known or suspected mental illness. At the same time a number of fatalities had occurred as a consequence of police use of force interventions.

Contrary to media speculation, evidence does not support the perception that events of this nature are increasing. The last systematic review of sentinel events in Queensland in 2005⁴ acknowledged the rarity of these occurrences, and there does not appear to have been an increase in the frequency or rate of such events over the past decade. Regardless of the very small numbers involved, homicide or the unexpected death of a person with a mental illness represents the worst possible outcome of severe mental illness and warrants investigation.

On 8 May 2015, the Queensland Minister for Health and Minister for Ambulance Services announced the establishment of a Clinical Review to examine mental health sentinel events relating to homicide and fatalities resulting from police use of force interventions. As ten years have passed since the *Achieving Balance: Report of the Queensland review of fatal mental health sentinel events. A review of systemic issues within Queensland Mental Health Services (Achieving Balance)*, it was also deemed timely to undertake a follow up review on the implementation and efficacy of the report's recommendations.

The Mental Health Sentinel Events Clinical Review 2016 (the Review) was conducted pursuant to the clinical review provisions of Part 6 Division 3 of the *Hospital and Health Boards Act 2011* (HHB Act 2011). The review was undertaken by an independent Mental Health Sentinel Events Review Committee (the Review Committee) appointed to assess the standard and quality of clinical assessment, treatment and care provided by public mental health services and make findings and recommendations on systemic matters to inform strategic directions, policy and clinical practice, with a view to improving the care of people with mental illness and minimizing or preventing the recurrence of such events⁵.

2.2 The mental health sentinel events review committee

The Review Committee comprised of five members appointed by the Director-General, Queensland Health under Section 125 of the HHB Act 2011. Jointly, the membership covered professional backgrounds of psychiatry, law and psychology, mental health nursing, patient safety and a person with a lived experience of mental illness. To ensure community confidence and the integrity of the Review process, membership was independent of Queensland Health. The work of the Review Committee was supported by a dedicated project team (the Review Team). For a description of members and their expertise see Appendix 1.

⁴ *Achieving Balance: 2002–2003*

⁵ Sentinel Mental Health Events Terms of Reference Clauses 1.1, 3.3 and 3.4

2.3 Terms of reference and operational guidelines

Development of the terms of reference

The terms of reference (TOR) were developed by the Mental Health Alcohol and Other Drugs Branch (MHAODB) in consultation with the Queensland Police Service (QPS), Office of the State Coroner (Coroner's Office), the Queensland Mental Health Commission (QMHC), Victim Support Service (VSS) and the Department of Communities, Child Safety and Disability Services.

The TOR were endorsed by the Premier and the Minister for Arts and the Minister for Health and Minister for Ambulance Services in early September 2015 and were approved by the Director-General of Queensland Health on 14 September 2015.

Scope of the Review

To examine the following types of sentinel events that occurred in the period 1 January 2013 to 30 April 2015 where:

1. a person receiving a public mental health service is involved in an event which could reasonably result in their being charged with murder or attempted murder (Category 1)
2. a person is admitted or referred to a public mental health service within two months of an event which could reasonably result in their being charged with murder or attempted murder (Category 2)
3. a person receiving a public mental health service is a victim of a homicide (Category 3)
4. a person with a known or suspected mental illness dies as a result of police use of force interventions (Category 4).

The role of the Review Committee was to:

- examine the sentinel events and consider the standard and quality of clinical assessment, treatment and care provided to the person receiving a public mental health service
- consider the recommendations of the report *Achieving Balance*, and the extent to which the recommendations have been implemented, and related outcomes achieved for public sector mental health services
- make findings and recommendations on systemic matters relating to the sentinel events to inform strategic directions, policy and clinical practice, with a view to improving the care of people with mental illness, and to minimise or prevent the recurrence of such events.

The Clinical Review process involved:

1. examination of documentation relating to individual matters, including clinical files and electronic records, independent external clinical reports, and internal and external incident review or investigation reports
2. examination of relevant local and state-wide policies, guidelines and protocols relating to the treatment and care of people with mental illness, and safety and quality in mental health service delivery
3. undertaking site visits and inspections of selected mental health services

4. consultation with key stakeholders including consumer and carer representatives, health service providers, relevant statutory entities (e.g. Director of Mental Health, Mental Health Review Tribunal), departmental officers, other government agencies, and community organisations.

The instrument of appointment for the clinical reviewers, which also serve as the terms of reference, is set out at Appendix 2.

Development of operational guidelines

The Review Committee established operational guidelines for the Review, with three scope clarifications to the TOR (Appendix 3).

1. Inclusion of those events where a person was 'referred to' a public mental health service within two months of the event as delays to an admission would inadvertently exclude such cases from the Review.
2. Specified only those Achieving Balance recommendations relevant to the scope of the current Review would be considered.
3. Inclusion of events which could reasonably have resulted in a charge of murder or attempted murder but the matter was not pursued due to the death of the alleged perpetrator.

2.4 Review method

2.4.1 Identification of sentinel events

Through the examination of mental health records by the Review Team, an initial 17 Category 1, 2 and 3 events were identified as clearly within the scope of the Review and were confirmed by the Review Committee in October 2015.

An additional nine Category 1, 2 and 3 events were identified by the Review Team as potentially falling within the scope of which seven events were confirmed by the Review Committee resulting in a total of 24 Category 1, 2 and 3 sentinel events.

After consultation with and obtaining information from the QPS and the Coroner's Office, five events within scope for Category 4 (police use of force interventions) were identified and confirmed by the Review Committee in November 2015.

In total 29 sentinel events (cases) were identified as within scope of the Review.

2.4.2 Collection of sentinel event clinical data

Requests for information were issued to the Chief Executive of Hospital and Health Services (HHS) which had provided a mental health service to individuals involved in a sentinel event.

The information requested was for clinical files, electronic records, internal and external incident review and/or investigation reports for

- a four-year period prior to the event for Categories 1 and 3
- the period from the date of the event to November 2015 for events falling within Category 2. Where an individual in a Category 2 event had a previous contact with a mental health service within two years of the incident these records were also requested.

Hard copy and electronic versions (in secure format) of all records were provided to Review Committee members.

2.4.3 Review framework

The purpose of the Review was to assess demonstrated compliance with accepted standards of clinical assessment and care and to identify system challenges in assessing and managing the risk of violence within mental health service delivery in Queensland.

The Review Committee developed a review methodology that was based on current evidence, established mental health approaches and practice wisdom. The methodology used was:

- Step 1 – undertake a high-level focused review of the cases via the use of broad open-ended questions. This was undertaken to identify any commonalities between the cases, from a system perspective. Questions developed covered aspects of assessment, treatment and care documented in the consumer's files
- Step 2 – examine reports from the Coroner's Office and the QPS to assess if the management of the individual was appropriate
- Step 3 – identify any recurrent commonality between the cases
- Step 4 – develop themes arising from the multiple sources of information
- Step 5 – validate evidence to determine whether the theme was supported
- Step 6 – develop recommendations that address the evidence within each theme.

The themes were then tested against the recommendations from Achieving Balance and the evidence discovered relating to their implementation.

2.4.4 Review case summaries

Consumer materials were reviewed by Review Committee members out of session and discussed during the meetings held in October and November 2015.

One Review Committee member assumed responsibility for summarising the consumer materials to help identify the common themes and presented these for discussion to the Review Committee at the meeting held in November 2015. Summaries of the second identified group of consumers were considered at the meeting in December 2015.

Where a perceived conflict of interest such as a connection with a HHS or an association with the care of a consumer or their family/carer, could occur the relevant Review Committee member excused themselves from that discussion.

2.4.5 Identification of themes

Themes were first identified from review of the voluminous consumer materials and summaries and discussed at the meeting in November 2015. These themes were used to structure stakeholder consultation and HHS visits undertaken in December 2015 and January 2016. These themes are discussed in Section 5.

Information gathered from consultation with stakeholders and HHSs was presented at the January 2016 meeting, noting in particular any evidence that either supported or did not support any particular themes, and also any further themes/findings identified.

Final themes and findings were considered at the meeting held in February 2016. Evidence collected from all sources was tested against each theme to identify potential solutions based on best practice, sourced from literature and incorporated successes achieved within the mental health services themselves. These solutions were broadened into systemic and clinical recommendations.

2.5 Consultation

The Review Committee consulted widely to ensure stakeholder views, concerns and feedback were appropriately reflected when making its findings and associated recommendations. Stakeholders identified for consultation at the meetings held in October and November 2015 were impacted families, peak bodies with roles representing relevant interest groups and agencies with functions directly relevant to the Review. Appendix 4 contains the list of consultations undertaken and Appendix 5 contains the list of verbal and written submissions to the Review.

2.5.1 Stakeholder organisations

Each invitation for consultation contained targeted key concepts to open the consultation process, with each stakeholder invited to raise their own topics and matters of interest. The Review Committee met with and sought advice and input from the following stakeholder organisations:

- Queensland Mental Health Commission (QMHC)
- Office of the State Coroner (Coroner's Office)
- Queensland Police Service (QPS)
- State-wide Forensic Mental Health Service (SFMHS)
- Office for Women and Domestic Violence Reform, Department of Communities, Child Safety and Disability Services
- Victims Support Service (VSS)
- Mental Health Carers Arafmi Queensland (Arafmi Queensland Inc.).
- The Voice for Mental Health

A Co-Chair and at least one other Review Committee member attended each consultation. A Review Team member also attended each consultation to take minutes.

2.5.2 Families and carers of individuals whose sentinel events were included in the review

Given the sensitivity of the matter under review and not wishing to cause further distress to family members and/or carers a two stage process was developed. The names and contact details of families/carers were sourced from the relevant Consumer Integrated Mental Health Application (CIMHA) record.

The process was:

- Stage 1 – a letter briefly describing the purpose of the Review was sent to the identified persons inviting expressions of interest to provide submissions.

- Stage 2 – For persons expressing an interest, a second letter was sent with further details on the scope and purpose of the Review and advising of suitable methods for providing a submission, including both written and oral options.

Two responses were received expressing interest in providing a submission from the initial twenty letters sent. One submission was received in response to the second letter in Stage 2.

2.5.3 Hospital and Health Service site visits

The decision to undertake site visits and inspections of selected mental health services was based on consideration of the size and representativeness of the mental health services (major city, regional, rural and remote), and the number of sentinel events that had occurred within the HHS area.

Six HHS site visits were conducted and included in Appendix 4.

Similar to the stakeholder consultation process, each invitation specified the particular issues on which the Review Committee was seeking comment. Minutes from each site visit, along with any documentation provided were reviewed following the methodological process outlined in Section 2.4.3.

All further themes or findings resulting from site visits were then considered with the evidence gathered from the review of the clinical records. Where themes or findings were found to lack robust support from the evidence, the Review Committee determined whether they remained a theme (and therefore require recommendations), or were reframed as ‘observations’.

Similar to the stakeholder consultations, a Co-Chair and at least one other Review Committee member attended each HHS site visit. A Review Team member also attended each site visit to take minutes.

2.6 Out of scope considerations

- Departments of Emergency Medicine (DEM) practices and processes - however, those services provided by a mental health service within a DEM such as intake assessments were considered within scope.
- Child and Youth Mental Health Services – the Review focussed on the provision of adult mental health services [REDACTED]
- Mental Health Service Inpatient Units – as no sentinel events involved a consumer who was an inpatient, these services were not directly reviewed. Commentary has been included where inpatient policies and protocols could have directly impacted upon the quality of care and treatment of the consumer.

3. Review context

3.1 Recommendations from Achieving Balance and their implementation

In March 2005, the Achieving Balance report was published. The Achieving Balance report made sixty recommendations and nine key recommendations on systemic matters to inform Queensland Health strategic decisions, policy decisions and clinical practice with a view to improving mental health service systems and reducing sentinel events in Queensland.

The Mental Health Alcohol Other Drugs Branch (MHAODB) identified that these recommendations were implemented by Queensland Health between 2005 and 2011. The *Interim Report: Mental Health Sentinel Events Review* dated 30 October 2015 (see Appendix 6 for Part B of this report) formally reported the implementation of the nine key recommendations. These nine key recommendations, the key achievements and current activity are outlined below.

The first key recommendation recommended by the Achieving Balance report was a *standardised process for mental health assessment, risk assessment and treatment*. To achieve this, a state-wide standardised suite of clinical documentation (SSCD) was implemented in 2008 which includes forms to assist clinicians in the mental health assessment, risk assessment and treatment planning for consumers, including processes in relation to the management of non-compliance with treatment. A review of the core forms and clinical supervision guidelines is planned for 2015–16.

The next key recommendation was to have *an integrated information system*. This led to the development of the CIMHA, which integrated three different existing applications (19 separate mental health data bases), which was implemented in November 2008. CIMHA contains information regarding consumer demographics, alerts, diagnosis, relevant third parties, referrals and service episode information, interventions, clinical outcome measures, electronic clinical documentation, and is an electronic register for the *Mental Health Act 2000* (MHA 2000). CIMHA and the Viewer (read-only) are regularly upgraded to improve functionality and compliance with the requirements of the MHA 2000 legislation.

The Achieving Balance report also recommended *integrated responsibility for mental health and drug and alcohol treatment*. This resulted in the development of the *Queensland Health policy for service delivery for people with a dual diagnosis* in September 2008. In addition, the *Queensland Plan for Mental Health 2007-2017* (QPMH 2007–17) established 10 Dual Diagnosis Coordinators, and one state-wide Coordinator, to provide consultation, advice, support and leadership for staff within mental health and also alcohol and other drugs services working with individuals with a dual diagnosis. Additionally, the Mental Health Directorate and the Alcohol and Other Drugs Treatment Strategy Unit amalgamated in 2010 to become the now MHAODB. A review of the *Queensland Health dual diagnosis clinical guidelines and dual diagnosis clinical toolkit* is currently being undertaken as well as the development of an alcohol and other drugs (AOD) model of service including standardised AOD performance indicators and outcome measures.

Alternative models for delivery of emergency mental health assessment and treatment by emergency departments was another key recommendation. The publication of the *Clinical Services Capability Framework version 3.0* in January 2011 standardised practices regarding mental health presentations in emergency departments. An Emergency Department suicide prevention project is in progress and due for completion by July 2016. Additionally, in 2015 a commitment was made by the Minister for Health and Minister for Ambulance Services to provide specialised training and resource packages, tailored for emergency department staff regarding how to recognise and respond to people at risk of suicide.

The Achieving Balance report also recommended *models to support general practitioners*. The MHAODB noted that HHSs are responsible for the implementation of clinical services to meet the needs of people within their region. The intent of all models of service is that strong partnerships are initiated with other local health and mental health service providers, including primary care and non-clinical sector services.

Another Achieving Balance report key recommendation was the *removal of potential means of suicide within inpatient units*. Funding was provided to the then 14 district mental health services for environmental amendments and all projects were completed by 31 December 2006. Clinical practice and other guidelines were also developed by the MHAODB to assist inpatient units in managing suicide risk in their services. A review of the guidelines for managing ligature risks in mental health services is underway and the development of a guideline around creating a safe environment in mental health inpatient services is due for completion in 2016.

Ongoing monitoring of sentinel events was another key recommendation. The *Mental Health Act 2000 Resource Guide 2015* (MHA 2000 Resource Guide) requires that all clinical incidents involving forensic patients be reported to the Director of Mental Health or Delegate without delay. On 18 June 2013 the Director-General issued a Health Service Directive Patient Safety under the HHB Act 2011 for reporting Severity Assessment Code (SAC) 1 clinical incidents. This outlines the reporting requirements for HHSs to Patient Safety and Quality Improvement Service (PSQIS) for all SAC 1 incidents including analyses of these events. Current policies require that HHSs provide copies of root cause analyses to the Director of Mental Health, but not other forms of critical reviews. Meetings between the MHAODB and the PSQIS have commenced with a view to being involved in reviewing the analyses of all SAC 1 incidents. Additionally, the MHAODB has reported they will liaise with the Australian Institute for Suicide Prevention and Research (AISRAP) regarding their capacity to provide a timely analysis of mental health clinical issues relating to suspected suicides in Queensland to inform state-wide quality and safety initiatives.

The Achieving Balance report also recommended *accelerating the implementation of the 10 Year Mental Health Strategy for Queensland, 1996 in relation to staffing and bed resources*. The *Ten-year Mental Health Strategy 1996* was fully implemented and following this, the QPMH 2007–17 was developed. The Queensland Government reports implementing the QPMH 2007–17 between July 2007 and June 2011, with record investments in mental health.

The final key recommendation from the Achieving Balance report was *competency based training regarding staff with Mental Health Act 2000 functions especially with respect to forensic patients and liaison with the Mental Health Review Tribunal regarding the conditions of limited community treatment for patients under the Mental Health Act 2000*. An online

training system for the MHA 2000 has been developed by the MHAODB. A new e-learning package released in November 2013 provides an interactive scenario-based program, which includes a formal assessment for each scenario. For forensic patients, the MHA 2000 Resource Guide and its appendices outlining both the *Forensic patient management policy and procedures* and the *Policy and practice guidelines for the care of disability forensic patients* provides clear guidelines for dealing with non-compliance with conditions of limited community treatment. For patients on an involuntary treatment order the MHA 2000 Resource Guide sets out the legislative and policy requirements where a patient is non-compliant with their treatment plan. The online MHA 2000 training system and the MHA 2000 Resource Guide is regularly updated and available to clinicians (including those at private authorised mental health services) on an ongoing basis.

“At every contact (in person or via phone) the mental health clinician must document that the client’s risk has been assessed, and that there is a plan in place to manage the identified risk issues”
 - Current HHS Guideline

On 2 December 2015, the Review Committee wrote to HHSs requesting them to provide advice regarding the extent to which recommendations from Achieving Balance relevant to the scope of this Review had been achieved by their HHS. Responses received along with a sample of local policies, procedures and protocols were reviewed by the Committee.

A summary of the HHSs’ implementation of the Achieving Balance recommendations identifies that:

- HHSs have implemented standardised processes for mental health assessment, risk assessment and treatment of mental health consumers, which are supported by appropriate education and training. The policies, protocols and procedures are documented at differing levels of detail and focus depending on the local practices and priorities.
- CIMHA is generally used as the core system for mental health consumer information, especially in community based mental health services. Some DEMs have read only access to CIMHA with other sources of information being the Viewer and the Integrated electronic Medical Record (leMR) for inpatient mental health services.
- The level of integration of alcohol and other drugs services and mental health services in the HHSs varies across the HHSs. There is general acknowledgment that the rate of comorbidity with dual diagnosis is high. There was evidence that local level policies, procedures and protocols are in the process of being updated and refined to ensure there is consideration of these issues in delivering a service that meets the needs of these consumers.
- All staff are encouraged to undertake the authorised mental health practitioner online training. It is noted that to become an authorised doctor, staff must complete the MHA 2000 online training program.

3.2 Queensland mental health service system 2015–2016

3.2.1 National system for mental health services

Mental health services in Australia are provided by a composite of state and federally funded agencies. The federal government has taken the lead in national health reform initiatives and

also funds a range of services for Australians living with a mental illness including general practitioners, private psychiatrists and Better Access allied health practitioners. State governments have generally had responsibility for inpatient, emergency department and community services, including psychiatric disability services.

The National Mental Health Strategy comprises the National Mental Health Policy and the National Mental Health Plans which to date have covered the period 1993–2014 when the *Fourth National Mental Health Plan* lapsed. Consultation and engagement is underway in developing a Fifth National Mental Health Plan. The goal of these strategies and plans is to develop programs and services to better meet the mental health needs of Australians. The *National Safety and Quality Health Service Standards 2012* and the *National Standards for Mental Health Services 2010* guide the implementation of safe and quality mental health services.

The *Roadmap for National Mental Health Reform 2012–2022* endorsed by the Council of Australian Governments (COAG) in December 2012 reaffirmed the commitment to mental health reform as an ongoing national priority.

Additional to constraints in growth funding, the potential challenges and opportunities ahead include:

- the National Disability Insurance Scheme (NDIS) – persons with a psychiatric disability who have significant and permanent functional impairment may be eligible to access funding
- the introduction of activity-based funding for mental health inpatient services, where funding is supplied to states based on values for activities provided as opposed to block funding for services. This funding model is now used in most other areas of public hospital funding.

3.2.2 Queensland Health

Public sector health services can be stratified into the following distinct categories:

- Primary health care services: First level health care provided by a range of health care professionals supported by integrated referral systems. It includes health promotion, illness prevention, care of the sick, advocacy and community development.
- Secondary health care services: Health care services provided by health professionals who generally do not have first contact with patients. It includes elective and emergency treatment in hospital and non-hospital settings.
- Tertiary health care services: Specialised consultative health care, usually for inpatients and those referred from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment.
- Health care provision can also be subdivided into the following core areas:
 - Ambulatory services: Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. It also refers to care provided to patients of community based (non-hospital) health care services.
 - Acute services: Health care in which a patient is treated for an acute illness; treatment of injuries or trauma; or recovery from surgery. Acute care is usually provided in hospitals by specialised personnel.

- Sub- and non-acute services: sub- and non-acute episodes of care are those that do not meet the definitions for acute care.
- Mental health: mental health services in Queensland are provided in acute settings (on a voluntary and, in accordance with the MHA 2000, involuntary basis) and in community based residential and non-residential settings. The services can be subdivided into child and youth, adult and older persons' mental health services.

The HHB Act 2011 outlines the functions and powers of the system manager (Department of Health) and the functions and powers of the service providers (HHS). This devolves the responsibility of the provision of public health services from the Department of Health to the HHS.

3.2.3 Mental Health Alcohol and Other Drugs Branch

As a systems manager the MHAODB:

- supports the state-wide development, delivery and enhancement of safe, quality, evidence-based clinical and non-clinical services for mental health and alcohol and other drugs treatment
- supports the development of new programs and service delivery initiatives
- facilitates strong cross sectoral and intergovernmental relations with government and non-government partners at the state and national level.

3.2.4 Office of the Chief Psychiatrist

The function of the Office of the Chief Psychiatrist is to:

- improve outcomes and the recovery of those seeking mental health and alcohol and other drugs treatment through leadership, high-level advice and direction in relation to clinical service provision.

The Chief Psychiatrist as the Director of Mental Health is responsible for:

- exercising the statutory responsibilities for the purpose of the administration of the MHA 2000
- protecting the rights of involuntary consumers
- exercising powers in relation to people with mental illness who are, or have been, subject to criminal justice system processes.

Under the current legislation, the Director of Mental Health is responsible for issuing policies to ensure the appropriate administration of the MHA 2000. To meet these requirements, the Director of Mental Health has issued the MHA 2000 Resources Guide which contains policies relating to the provision of mental health services.

3.2.5 Hospital and Health Services

Under the HHB Act 2011, HHSs are responsible for the delivery of public hospital and health services. Governed by independent Boards, HHSs are accountable, through the Board chair, to the Minister for Health for local performance, delivery of local priorities and the provision of health care that meets national standards.

The *Clinical Services Capability Framework for public and licensed private health facilities v3.2* specifies minimum support services, staff profile, safety standards and other requirements for HHSs and licenced private acute hospital services to ensure patient health care services are delivered safely and in the most appropriate clinical setting / service.

Service agreements between the Department of Health and HHSs require mental health services to maintain accreditation against both the *National Safety and Quality Health Services Standards 2012* and the *National Standards for Mental Health Services 2010*.

3.3 Queensland mental health services

3.3.1 Mental health plans

The QPMH 2007–17 outlines the Queensland Government’s plan to reform and improve mental health services. In September 2014, the Queensland Mental Health Commission released *the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (the Strategic Plan) which commits the Department of Health to develop the new *Queensland Health Mental Health, Drug and Alcohol Services Plan 2016–2021* (Services Plan). The Services Plan, when released, will take into account current national directions, state government priorities, the principles and directions established in the Strategic Plan, and relevant quality and service standards.

3.3.2 The *Mental Health Act 2000* and the Queensland forensic mental health service system

The purpose of the MHA 2000 is to provide for the involuntary assessment and treatment, and the protection, of persons (whether adults or minors) who have mental illnesses while at the same time:

- safeguarding their rights and freedoms
- balancing their rights and freedoms with the rights and freedoms of other persons.

The MHA 2000 establishes specialised processes in relation to involuntary patients with a mental illness who are charged with a criminal offence. These processes enable expert examination of the person, as well as their detention in a mental health service if necessary.

The forensic mental health system refers to the components, both in the health system and the justice system, which respond to people with a mental illness who have been charged with an indictable offence.

Queensland Parliament passed the *Mental Health Act 2016* (MHA 2016) in February 2016 with an expected commencement date in November 2016. Processes are underway for the mental health system to make the changes as required by the new Act with oversight from an Inter-Departmental Executive Committee for activities that affect other government agencies and a mental health implementation committee for implementation activities within Queensland Health.

While there are many similarities between the two Acts, the MHA 2016 provides improved and simplified practices, as well as strengthening the role of family and support persons, including:

- the introduction of a treatment support order which is a less intensive order for forensic consumers with options to receive treatment within an inpatient setting with limited community treatment or even the community setting. This order has less stringent oversight compared to forensic orders
- the Mental Health Review Tribunal will now have the option of making a treatment support order as a step down from a forensic order
- an increased role of support persons to include the ability to discuss confidential information about the consumer with the treating team and to receive all notices given to the consumer
- doctors must discuss treatment and care with family/carers unless specific exemptions apply
- the enabling of information to be disclosed to assist identifying persons who may have a mental health defence.

3.3.3 Coverage of mental health services

All HHSs across Queensland provide specialist mental health services. In 2014–15, expenditure on both ambulatory and inpatient mental health services by HHSs was \$734.7M of which 50 per cent was on ambulatory care. For the three-year period 2012–13 to 2014–15, average available beds in general acute inpatient care (i.e. services principally targeting the general adult population aged 18–64 years) increased slightly from 13.3 beds per 100,000 catchment population to 13.7, demonstrating availability is increasing at a greater rate than population growth. Average community full time equivalent (FTE) staff numbers in general care for the same three-year period shows variability across the years and between HHSs with no clear trends. Some of the changes in FTE are due to clinicians moving across target population categories to match demand for services such as older persons or child and youth.

The *Mental health services in Australia* report by the Australian Institute of Health and Welfare (AIHW) demonstrates that Queensland mental health services have experienced significant growth in service demand in recent years. For example, community mental health contacts increased from 883,458 in 2009–10 to 1,605,851 in 2013–14. In the same period, public hospital separations with specialised psychiatric care grew from 28,903 to 34,874. However, it is noted that there was a decrease in the number of employed full-time psychiatrists from 784 in 2009 to 588 in 2013.

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Authorised Mental Health Services (AMHSs) are health services authorised under the MHA 2000 to provide involuntary examination, assessment, treatment and care for persons with mental illness. AMHSs include both public and private sector health services. There are AMHSs provided by all HHSs in Queensland. In most instances, AMHSs comprise inpatient and community components. Inpatient facilities are generally based in metropolitan and regional centres, while community components are established in rural and remote locations as well as major centres. In addition, section 15 of the MHA 2000 provides that a public hospital may be an AMHS for the purpose of a person's examination or assessment under the MHA 2000 if there is no AMHS readily accessible for example in remote or rural areas of the state.

Civil involuntary provisions may apply to a person who is believed to represent a risk to their own safety or that of others, or is likely to suffer serious mental or physical deterioration due to their illness.

Forensic provisions provide for the diversion of people with a mental illness and/or intellectual or cognitive disability who are charged with an indictable offence from court or custody to the mental health system, as well as decisions about criminal responsibility where the person has mental illness. The MHA 2000 also provides for information orders for victims of mentally ill offenders and non-contact provisions for family members, victims of crime and other interested persons, as well as provisions addressing community safety.

Classified patient provisions provide for the secure management of a person brought to an AMHS from court or custody for assessment and/or treatment of a mental illness.

Approximately 24,200 people have an open patient record at a public mental health service on any given day. Involuntary patients comprise approximately 21 per cent of the total number of people receiving public mental health services.

A total of 9,055 involuntary assessments were conducted following a request for assessment and recommendation for assessment during the 2014–15 reporting period, representing an 11 per cent increase from the previous year. Of these assessments, 64 per cent resulted in an involuntary treatment order (ITO) being made and 36 per cent did not result in an ITO being made before the end of the assessment period.

The total number of patients receiving involuntary treatment as at 30 June 2015 was 4,924, which represents a 6 per cent increase from the previous reporting period. Of these, 83 per cent (4,100) were subject to an ITO, 16 per cent (781) were subject to a forensic order and 1 per cent (43) were classified patients.

When a person who is subject to an ITO or a forensic order is charged with an offence, the provisions under Chapter 7, Part 2 of the MHA 2000 apply. These provisions aim to ensure that due consideration is given to issues of culpability and fitness for trial. Chapter 7, Part 2 provisions applied to 1,267 patients in the 2014–15 reporting period. This figure represents a 17 per cent increase from the previous reporting period.

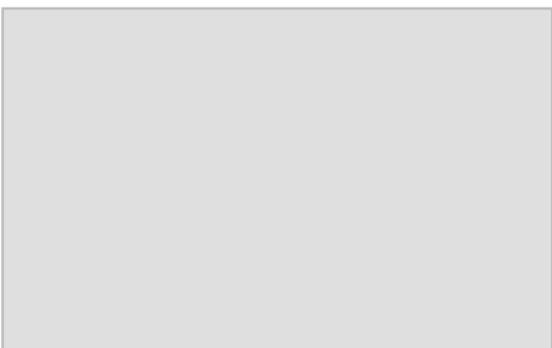
3.4 Protocols and procedures between Queensland Health and the Queensland Police Service

Good collaborative relationships exist between mental health services and the QPS. The Mental Health Intervention Coordinators (MHIC) program was introduced in response to the Achieving Balance report. This program involves coordinators established within the Queensland Ambulance Service (QAS), the QPS and mental health services. The MHIC's role is to act as a point of liaison, examine opportunities for enhanced interagency collaboration, share relevant service information, provide training, and discuss appropriate management for specific consumers including if required meetings to develop individual management plans either with the consumer, or with their consent.

A Crisis Intervention Plan (CIP) is developed for those consumers deemed to be at risk and who may require the QAS or the QPS intervention. This CIP is developed by the mental health services in consultation with the consumer for use by the QAS and or the QPS to

manage or resolve a mental health crisis when required. It includes the consumer's preferred way of being treated and supported in a crisis situation.

The Memorandum of Understanding (MOU) between the QPS and Queensland Health articulates the model of collaboration and highlights information sharing provisions including when and where this information can be shared. The MOU is currently under review with an expected released date of mid-2016. The MOU will incorporate amendments to mental health legislation passed in February 2016 which further enhance the sharing of relevant information.



A pilot of a new model of collaboration was introduced in December 2015 which co-locates a mental health clinician within the Police Communications Centre (PCC) for some hours of the week. The QPS has an inspector, with experience in crisis negotiation, monitor all police contacts ongoing in the state. The aim of this pilot model was to provide immediate mental health advice and information to the

QPS staff called out to an incident. For incidents that are identified by the QPS as potentially involving a person in a mental health crisis, the police inspector provides information to the mental health service staff members, who in turn, reviews information within CIMHA for any records and relays relevant information to the QPS police inspector and in turn to police staff in transit or at the scene. Where the person is not known to mental health services and phone advice is not adequate to manage the situation, an agreement has been made, where practicable, for a senior mental health clinician to attend the scene with the QPS.

The model provides mental health coverage for five evening shifts per week. Queensland Health is currently evaluating the model, including the spread of hours of mental health cover.

A co-responder model similar to the Police, Ambulance and Clinical Early Response (PACER)⁶ model in Victoria has been established in one HHS, is under trial in a second, and planned for a third later in 2016. This model involves a QPS officer and a mental health clinician, such as the MHIC, attending an incident involving a person with a known or suspected mental illness as a secondary responder. Though the model has not been formally evaluated by either the QPS or Queensland Health, anecdotal feedback points to safer and improved cost effective response to managing and resolving mental health crisis. This has been attributed to an improvement in shared language and understanding of mental ill health, enhancement of the QPS understanding of the MHA 2000 in relation to the involuntary assessment and treatment of a person with a mental illness, and also the roles of primary through to tertiary services and referral opportunities.

⁶ See http://www.acilallen.com.au/cms_files/acgpacerevaluation2012.pdf

3.5 Principles and practice of contemporary mental health care

Australia's model for care and treatment of mental illness complies with the International Standards. The *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* identifies fundamentally all mental health consumers be accorded basic rights and be treated with respect and humanity⁷. This includes, as far as practicable, that the consumer live and be treated within the community. These principles are subject to the competing public safety considerations, that is

“such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety order, health or morals of the fundamental rights and freedoms of others.”⁸

Provision of services

State based services deliver the major part of care for people with serious mental illness, with a component delivered by non-government organisations (NGO) and by private mental health facilities. In all states and territories, services are predominantly community-based, though hospital services continue to be an important component, and are the largest single item in mental health budgets. Most mental health inpatient units are mainstreamed and located within acute hospitals, although a few stand-alone units still exist. Inpatient stays in general acute units are generally for short periods to treat an acute presentation, often with considerable pressure placed on bed availability. Community services provide continuing care, assertive outreach, crisis assessment and management and support to primary care. These services are sometimes delivered by separate teams and other times by integrated ones. Some longer-term non-acute care is provided by public services, but much is provided by NGO's and other private providers.

Most services, and indeed the *National Mental Health Standards 2010*, embrace the concept of recovery in name at least, but levels of true consumer engagement, let alone consumer leadership, vary widely. Development of a consumer peer workforce is also patchy in the state services, but better in the NGO's. Clinicians working with people with severe illness may forget that a significant number, 30 to 50 per cent recover fully or partially in regard to both symptoms and functioning⁹, (this figure is higher if the broader consumer definition is used).

Recovery and risk

It may appear that there is a contradiction between the recovery concept of risk taking and the clinical concept of risk management; however, advances in recovery within a forensic framework shows that just as recovery assists consumers to manage their mental illnesses, so too must they manage any propensity for violence and aggression¹⁰. The recovery notion is for a mental health service consumer to take constructive risks to achieve the level of autonomy and independent decision-making enjoyed by other citizens; this known as the

⁷ Butler review pg 3

⁸ United nations, united nations principles for the protection of persons with mental illness and the improvement of mental health care [1], GA Res 46/119

⁹ Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006)

¹⁰ Drennan, G., & Alred, D. (Eds.). (2013)

dignity of risk¹¹. Autonomy cannot be achieved if a person commits acts of aggression or violence that will result in incarceration or detention of one form or another. A careful balance is to be struck between supporting a person to undertake positive risks in making choices and ensuring clinical risk is identified and managed in a manner consistent with the duty of care. The consumer and mental health services working collaboratively to manage such risks is in fact consistent with the aim of recovery.

Comprehensive and integrated care requires a collaborative partnership between consumers, clinicians and family/carers, and encompasses vocation, social activity, psychological wellbeing and engagement with the community as well as symptomatic recovery. Such care begins from the premise that symptomatic recovery is not the only, or even the main aim, rather the development of the recovery goals is led by the consumer. There may be times when the clinician, and/or the family/carer, differ from the consumer about the priority or nature of the goals; this can be particularly problematic if the consumer is unwell. Fine judgement is needed by clinicians to manage their duty of care to both the consumer and others while avoiding a retreat into a paternalistic way of behaving.

Stigma

Stigma associated with mental illness is identified as a significant barrier for persons to seek appropriate help and engage with mental health services. This stigma is made all the worse by the mistaken belief that all people with serious mental illness are at risk for violence. Mental health policy is increasingly focused on reducing this stigma alongside efforts to increase mental health literacy within the Australian community.

There has been considerable progress in reducing the stigma of mental illness in Australia in the last 25 years, spurred initially by the *Report of the National inquiry concerning the human rights of people with mental illness Volume 1 and 2*¹² and *First National Mental Health Plan*, the growing voice of the consumer movement, public disclosures by many leading people, and the work of organisations like beyondblue and headspace. It is true that the reduction in stigma has been greater for the high prevalence disorders such as anxiety and depression, more than for the psychotic illnesses suffered by most of those in this report. Stigma relating to violence and mental illness remains high.

¹¹ Parsons, C. (2008)

¹² Australian Human Rights Commission, 1993

4. Literature review and homicide data

4.1 Literature review

In this section of the report, we will discuss the relationship between mental illness and violence, followed by an overview of the prevalence of homicide including homicide committed by people with serious mental illness, violence risk assessment and the management of people with mental illness at risk for violence.

4.1.1 The relationship between mental illness and violence

It is very important to emphasise from the outset that the vast majority of people with serious mental illnesses, including schizophrenia, do not engage in violence and, of course, it is very rare that any person with a mental illness commits murder. Tragically, there is still an unacceptable level of stigma and misunderstanding of mental illness – including the mistaken belief that people with mental illness are violent.

Australian studies that have investigated the relationship between mental illness and schizophrenia, show, for example, that 90 per cent of people with schizophrenia do not commit a violent crime and more than three quarters do not engage in any type of offending behaviour¹³.

While it is the case that the majority of people with schizophrenia, and other forms of serious mental illness, do not engage in violent offending, there is now good evidence to show that people with schizophrenia are significantly more likely than other people in the community to engage in crime, violence and homicide¹⁴. The relationship that has been found is modest but clinically significant (i.e. people with schizophrenia have been found to be three to five times more likely than others to engage in violent offending).

A recent study investigated the prevalence of offending in a sample of more than 4,000 people with schizophrenia identified in five year blocks from 1975 to 2005 compared to a matched community control group¹⁵. As noted previously, the majority had no violent outcomes. However, when considering violent offences collectively (e.g. assault, robbery, indecent assault, rape, attempted murder, murder), almost one-quarter of people with schizophrenia (24.6%) were charged with such offence compared with fewer than ten per cent (8.6%) in the community sample. Thus, people with schizophrenia were approximately five times more likely than the comparison group to be convicted of a violent offence.

It is important to increase our understanding of the relationship between offending and mental illness in order to be able to treat consumers with serious mental illness and to help provide them with services that are likely to ameliorate both their symptoms but other social disadvantages and complex factors that can lead to offending and violence¹⁶. Research has found that the negative social factors associated with serious forms of mental illness overlap entirely with the negative social factors that increase the probability of being convicted of a

¹³ Short, T., Thomas, S., Mullen, P. & Oglloff, J. R. P. (2013); Wallace C, Mullen PE, Burgess P. (2004)

¹⁴ Douglas KS, Guy LS, Hart SD (2009); Fazel S, Gulati G, Linsell L, Geddes JR, Grann M. (2009)

¹⁵ Short, T., Thomas, S., Mullen, P. & Oglloff, J. R. P. (2013).

¹⁶ Oglloff, J. R. P. (2009)

criminal offence¹⁷. Those people with a psychotic illness who have backgrounds characterised by social and family disruption and disadvantage together with abuse, conduct disorder, substance misuse and educational failure are significantly more likely to offend than those with a psychotic disorder who do not have such disturbances in their backgrounds. Of course, most people with a psychotic illness do not come from such disadvantaged backgrounds, but more do than would be expected by chance¹⁸.

Studies in Victoria and Western Australian have found that offending precedes diagnosis in most cases where people with schizophrenia offend (60–73% of cases). It may well be that the offending reflected in part the influence of prodromal features of schizophrenia. Schizophrenia usually starts with a prodromal phase when symptoms are vague and easy to miss and are often similar to common adolescent behaviour and to other mental problems such as depression or anxiety disorders. These symptoms may not seem unusual for teenagers or young adults and schizophrenia is rarely diagnosed at this time. In particular, many if not most are not seen by a psychiatrist or psychologist until they have a psychotic episode that brings them into contact with the mental health system.

Research has identified differences between offenders with psychotic disorders and those with similar illnesses who do not offend. Offenders with mental illnesses:

- are less likely to accept from mental health professionals either advice or attempts at control
- are less compliant in all respects
- are likely to function better inter-personally and socially, where non-offenders are more disabled and withdrawn
- have a greater ability to source and a greater avidity for drugs, particularly stimulants
- are more likely to have anti-social attitudes
- have the potential for a fuller recovery in terms of social and interpersonal function than the more withdrawn, passive and self-absorbed non-offenders
- are not more likely to be more difficult to manage and support than non-offenders¹⁹.

Research has identified that the patterns of the association between mental illness and offending differ from case to case²⁰. Generally speaking, there are three general categories of people with mental illness who offend; understanding the general mentally disordered offender type will enable clinicians in general psychiatric services to provide appropriate treatment:

1 Consumers who offend because of their mental illness

This group is the smallest of the three groups. Their offences occur as a direct result of the mental illness. Typically, the illnesses that are present in people who fall into this category are psychosis or serious affective disorders accompanied by psychosis. Their mental illness is both a necessary and sufficient explanation for their offence. They only offend when they are acutely unwell and the offence behaviour is a product of their mental illness (e.g. acting on delusions or hallucinations). In Queensland, they may be found not criminally responsible due to being of unsound mind.

¹⁷ Mullen PE. (2006)

¹⁸ Mullen PE. (2006)

¹⁹ Justice Health (2016)

²⁰ Ogloff, J. R. P. (2009)

2 Consumers who offend as a result of the sequelae of mental illness

The second general group is comprised of those whose mental illnesses are a necessary but not sufficient explanation for their offending. It is by far the largest group of psychiatric consumers who offend. As is typical for many consumers with serious mental illnesses, these consumers begin to spiral downward socially as a result of their mental illnesses. They can become estranged from family and pro-social support networks. Their lives become unstable; housing, basic needs, and their need for non-judgmental personal support may go unmet. They may end up being accepted by groups of people who are themselves unstable. They often resort to engaging in illicit substance misuse. These social factors contribute to their resultant offending. While their mental illness may be a catalyst in the course of events that lead to the offending, the mental illness itself is not the direct cause of the offending. Had they not had a mental illness, they likely would not have begun offending. However, by the time they develop offending behaviour, their lives have become so disorganised and their maladaptive coping and survival strategies have become so entrenched as to make the reversal of these processes difficult over the long-term. Psychiatric treatment, while a necessary starting point, will not be sufficient alone to eliminate the offending behaviour.

3 Consumers who offend despite their mental illness

The final group includes those who would offend irrespective of whether they have a mental illness. Although not as large a group as the one above, many more consumers who offend fall into this category than into the first. The fact that they have a mental illness is neither a necessary or sufficient explanation for their offending. Consumers in this group are typically characterised by early onset antisocial and illegal behaviour. They differ from other mentally ill offenders by having a pervasive and stable pattern of offending regardless of their mental state²¹. This behaviour almost always precedes the onset of mental illness. While people with a psychopathic or antisocial/dissocial personality disorder will be included in this group, most of the people in the group will not be so disordered. It is important to acknowledge, though, that the broad range of people that may fall into this group, including the psychopaths, may well develop psychiatric illnesses. We must avoid the tendency to deny this group proper services or to acknowledge their mental illnesses. These consumers' mental illnesses may well exacerbate their offending or lead to unusual offending; however, even when they are asymptomatic they may continue to offend.

These broad categories of relationship need to be kept in mind when considering the potential benefits of mental health and other interventions.

4.1.2 Homicide and mental illness

Homicides in Australia are a relatively rare event with a rate in the national population of 1.1 per 100,000²². Queensland's homicide rate matches this rate at 1.1 per 100,000. Internationally, Australia has very low rates and is comparable to similar Western Nations

²¹ Hodgins S, Muller-Isberner R. (2004)

²² AIC Homicide data

such as, New Zealand (0.9), Canada (1.6), United Kingdom (1.0), France (1.0), and Germany (0.8), but much lower than the USA (3.8)²³. Trends in homicide rates in Australia are decreasing with Queensland having a greater rate of reduction as identified above in section 4.1.1.

Within the Australian rate, eight per cent (8%) or 0.09 per 100,000 are committed by a perpetrator with a known mental illness²⁴. Compared to severe mental illness occurrence of two to three per cent (2–3%) within the community, perpetrators with a mental illness are over-represented within the offender population. This over-representation of severely mentally ill persons was also observed in the findings of *Achieving Balance and Tracking Tragedy: a systemic look at suicides and homicides amongst mental health inpatients* (Tracking Tragedy). A concerning trend emerging is the percentage of homicides committed by a mentally ill offender increasing from five per cent (5%) in 2002 to eight per cent (8%) in 2012, or three times the occurrence of serious mental illness in the Australian population at the same time as homicide and offending rates are decreasing. This value still lies within the internationally observed range.

Research in Victoria investigating the rate of schizophrenia among people who commit homicide revealed that those with schizophrenia, who formed 0.7 per cent of the general population, were responsible for almost nine per cent (9%) of the homicides²⁵. This represents a relative risk of 13 times. Among women who commit homicide, one quarter were found to have schizophrenia²⁶. In addition, many other homicide perpetrators have other, less serious forms, of mental illness.

In the above research, approximately half of the men with schizophrenia who committed homicide had been diagnosed with the disorder prior to the murder, but the other half were only diagnosed immediately following the murder or sometime thereafter. For women, all but one had been diagnosed prior to the homicide. It is the case that a significant proportion of homicide offenders with a schizophrenia disorder are first diagnosed following the homicide. These people may have committed homicide during their first episode of active psychosis or they may not have come to the attention of mental health services in the past²⁷.

Regardless of the rarity of these events, a sentinel event involving a mentally ill consumer attracts high public attention. Community concerns re-emerge on public safety and the appropriateness of community care for the severely mentally ill. Some of this stems from the persisting stigma about mentally ill persons and low general mental health literacy. Programs such as beyondblue and headspace, have made impacts on improving community knowledge of these conditions.

Demographic characteristics of the perpetrators with mental illnesses who commit homicide in Australia²⁸ are predominantly male (86%) with most victims known to the perpetrator as either a member of their family (45%) or otherwise acquainted (39%). Only 16 per cent of victims are strangers to the perpetrator, compared to the national value of 11 per cent of all

²³ United Nations Office on Drugs and Crime (UNODC), (homicide statistics 2013)

²⁴ Presence of a mental illness is defined as the offender having a history of psychiatric conditions or as agreed upon by a judge at trial and includes Intellectual Disability, Depression and Mental Illness.

²⁵ Bennett, D. J., Ogloff, J.R.P., Mullen, P.E., Thomas, S.D.M., Wallace, C., Short, T., (2011)

²⁶ Bennett, D. J., Ogloff, J. R. P., Mullen, P. E., Thomas, S. D. (2012)

²⁷ Large M, Smith G, Nielssen O. (2009); Nielssen O, Large M. (2009)

²⁸ AIC Homicide data 2003-2004 to 2011-2012

homicides being strangers to perpetrators²⁹. These results are consistent with the findings of *Achieving Balance and Tracking Tragedy*, and consistent with international reviews which identified predominantly victims of these offences were known to the perpetrator³⁰.

4.1.3 The assessment of risk for violence among people with mental illness

As noted, research in Victoria shows that eight per cent (8%) of consumers with schizophrenia obtain a conviction for a violent offence at some point in their lives – and that this rate rises to more than 25 per cent for consumers who have both schizophrenia and a substance misuse disorder. Additionally, the prevalence of aggressive behaviour and violence among psychiatric inpatients is very high³¹. Although violence and aggression are by no means new phenomena, it has only been in the last 20–25 years that valid violence risk assessment instruments have been developed. This research was spawned by a revealing book published in 1981 that indicated that psychologists and psychiatrists were more likely to be wrong than right when predicting which consumers would be violent over time³². As with other areas of decision making in psychology and medicine, it was revealed that unstructured clinical judgments of violence risk and aggression had very low levels of accuracy³³. Vast improvements in the accuracy of violence risk prediction have since occurred with current research showing that structured risk assessment approaches provide a level of accuracy that far exceeds chance.

It is the case that between five and ten per cent (5–10%) of all homicides and more than five per cent (5%) of serious crimes of violence are committed by those with a schizophrenic syndrome. Because serious violence and particularly homicide are uncommon events, the annual risk of a person with schizophrenia committing a homicide is approximately 1 in 10,000 and for a crime of violence about 1 in 150³⁴. Though fear inducing behaviours occur quite frequently among people with serious mental illnesses, the incidence of actual violence is still very low³⁵.

Given their particularly low base-rate of occurrence, attempting to predict who will commit serious acts of violence or murder will inevitably be inaccurate and will result in an over-identification of risk in those who will never engage in such violence.

An alternative to falsely believing that we can predict who will engage in serious violence or homicide with a high degree of accuracy is to manage consumers who present with a high level of risk in a way that helps reduce the likelihood that those who might otherwise engage in serious violence or homicide will do so. Among people with serious mental illness, advances in violence risk assessment show that it is possible to identify, for example, the 10 per cent of the consumer group who will perpetrate 90 per cent of all the future fear inducing and violent acts. In this 10 per cent may be included nearly all of the far smaller number who will commit potentially lethal or seriously injurious acts. In effectively identifying the 10 per cent and managing them appropriately then the risks to the community of damage, including

²⁹ Bryant, W., & Cussen, T. (2015)

³⁰ Safety First Report, 2001

³¹ Ogloff, J. R. P. & Daffern, M. (2006)

³² Monahan, J. (1981)

³³ Grove, W., & Meehl, P. (1996)

³⁴ Mullen PE (2006).

³⁵ Short et al. *supra* note 9; Douglas et al.; Fazel et al. *supra* note 10.

the small chance of serious damage, will be reduced³⁶. Effectively identifying and managing all consumers in the high risk group will lower the overall risk to the community while minimising the deprivation of liberty of those in the lower risk groups. This risk group management approach is not perfect and does not increase the ability to identify a particular individual who may commit a serious act, but it does allow effective management of those at higher risk.

Protections afforded by the mental health act ensure that people will not have their liberty unduly restricted based solely on the fear for what they might do. In practice this obliges us in most clinical situations not to resort to increased coercion, let alone preventive detention, but to focus attention on greater support and more active follow up and assertive treatment in the community with the possibility of rapid admission, as required, during exacerbations of symptoms or social conflict.

Major risk factors

While there are a range of factors that have been associated with violence, among the most salient factors are severe mental illness, substance misuse, and antisocial/dissocial personality disorder (psychopathy). As discussed previously, severe mental illness is a risk factor for violence that is made worse with substance misuse.

The association between drugs, violence, and crime is well documented and there has been a considerable amount of research conducted in Australia³⁷. Both alcohol and other drugs have been associated with a significant increased risk of engaging in violent behaviour, including violent offences. Co-occurring mental illness and substance misuse has been associated with increased risk for violence. For example, in ongoing research in Australia with both inpatients and those in the community, consumers with a dual diagnosis were found to be more likely to re-offend and the severity of violence was likely to be higher in those who have a dual diagnosis; they also had worse outcomes in mental health services³⁸.

In addition to studying the relationship between major mental illnesses and violence, considerable research has been conducted to determine the links between personality disorders and violence. Psychopathy, although very rare, is one such personality disorder that has received considerable attention. Psychopathy is characterised by serious deficits in the person's ability to interact effectively with others, lack of remorse or guilt, pathological lying, callousness and lack of empathy, poor behavioural controls, impulsivity, narcissism, and early behavioural problems. Although Antisocial Personality Disorder is sometimes used interchangeably with psychopathy or Dissocial Personality Disorder, psychopathy is a much narrower construct³⁹.

In addition to the most salient risk factors, a range of environmental and lifestyle factors have been found to relate to violence risk (e.g. education, employment, relationships, compliance with orders, trauma, childhood adversity, etc.).

More recent advances in risk assessment have included the identification of an expanded range of predictor variables relevant to violence. Most important among these are those

³⁶ Douglas K, Ogloff J, Nicholls T, Grant I (1999)

³⁷ Butler, T., Levy, M., Dolan, K., & Kaldor, J. (2003)

³⁸ Ibid.; Ogloff, J. R. P., Talevski, D., Lemphers, A., Simmons, M., & Wood, M. (2015); Ogloff, J. R. P. Lemphers, A., & Dwyer, C. (2004)

³⁹ Ogloff, J. R. P. (2006)

variables that are subject to change (i.e. they can change over time and they can be influenced by treatment or other intervention). Generally speaking, risk assessment variables can be classed as "static" or historical (i.e. those that cannot be changed such as the incidence of past violence) and "dynamic" (i.e. those that can change over time, sometimes rapidly). These historic variables generally could not change over time. For example, if one began being violent as a young person, that fact will not change over time. Dynamic variables, in contrast, are subject to change over time, sometimes rapidly. These variables include such things as state of mind, situational factors, attitudes, plans, support, etc⁴⁰.

Effective risk assessment must take into account both static and dynamic variables; however, risk management generally requires an understanding of the dynamic risk variables. Contemporary approaches to risk assessment and management take into account both static and dynamic variables, thus considering an individual's past, present, and future risk factors that might affect the likelihood of him or her becoming violent.

Risk assessment measures

Beyond individual risk factors, a number of violence risk assessment instruments have been developed and validated in the past 20 years. Structured professional judgment (SPJ) is a model of decision-making that underlies many of the successful risk assessment measures⁴¹. The SPJ model provides guidelines for assessing violence risk in a systematic and structured manner, based on empirically supported risk factors, while at the same time permitting professional flexibility to consider unique characteristics of individual cases.

SPJ risk assessment guidelines also reflect recent conceptual developments within the field of violence risk assessment that stress the importance of attending to other features of risk, such as imminence, duration, severity, targets, nature, and management. Under the SPJ model, statements about the future are made (1) in relative terms based on comparison to others in similar circumstances, (2) without affixing numerical probability levels, (3) in general descriptive, action-facilitating categories (low, moderate, high risk) that are (4) tied to and defined in part by the degree of anticipated interventions deemed necessary in order to prevent violence, and which are (5) based on the presence of violence risk factors in a present case (whether few or many).

The Historical Clinical Risk Management-20 (HCR-20)

To bridge the gap between research on violence risk assessment and clinical practice, the *Historical Clinical Risk Management-20* (HCR-20), currently in version 3, has been developed and validated⁴². The "HCR-20" was named for the measure's 10 historical, 5 clinical, and 5 risk variables.

⁴⁰ Douglas, K. & Skeem, J.L. (2005)

⁴¹ Douglas, K. S., & Ogloff, J. R. P., & Hart, S. D. (2003)

⁴² Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013)

The HCR-20^{V3}

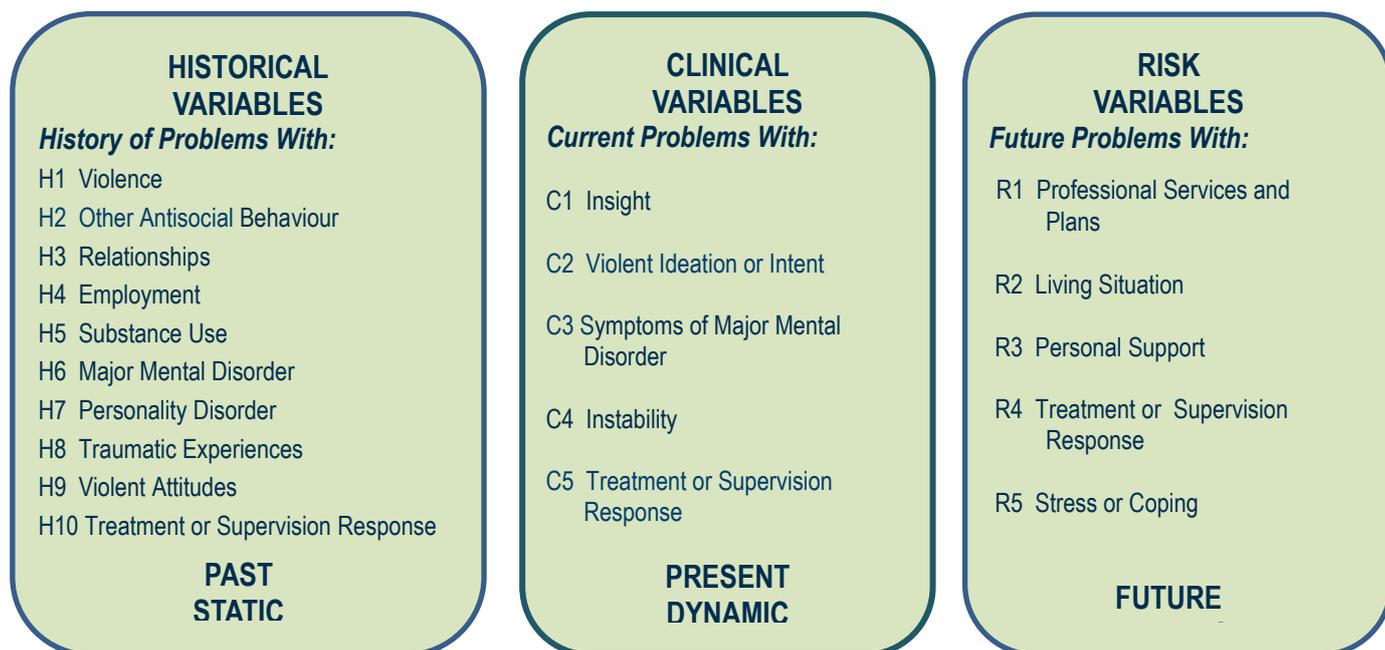


Figure 1 Diagram of Historical Clinical Risk Management-20 Version 3

The HCR-20 represents a blend of historical/static variables (i.e. those that are not subject to change over time) and dynamic variables (i.e. those that do change over time). The H scale focuses on past, mainly static risk factors, the C on current aspects of mental status and attitudes, and the R on future situational features that relate to the likelihood that an individual's level of risk can be managed.

There is a large body of empirical evidence that the HCR-20 is a valid measure of violence risk for use with forensic and non-forensic populations. The research has shown that higher scores on the HCR-20 relate to a greater incidence and frequency of violence than should lower scores. Research studies within civil psychiatric, forensic psychiatric, general population inmates, mentally disordered inmates, and young offenders, conducted in Canada, Sweden, the Netherlands, Scotland, Germany, England and the United States, have found that HCR-20 scores relate to violence⁴³.

As mentioned previously, the purpose of risk assessment, and indeed the role of most mental health professionals who work with clients or consumers at risk for violence, is to manage the individual's level of risk. As such, a companion manual was published to accompany the HCR-20⁴⁴. In addition to providing some foundation chapters, including one that explores the ethical and legal issues associated with violence risk prediction, chapters are provided to inform clinicians about strategies for managing each of the risk factors from the HCR-20 that are amenable to change (i.e. the C and R scale items).

Research shows that providing staff with training on the HCR-20, followed by supervision on a number of cases (typically between five and ten), ensures a high level of reliability in the administration and scoring of the measure⁴⁵.

⁴³ Douglas, K. S., & Reeves, K. (2010).

⁴⁴ Douglas, K. S., Webster, C. D., Hart, S. D., & Ogloff, J. R. P. (2001).

⁴⁵ Douglas, K. S., & Reeves, K. (2010)

Additional risk measurement instruments

Given the advances in the risk assessment literature, researchers and clinicians have developed a number of assessment tools that assess an individual's level of risk for engaging in some specific types of violence. Perhaps most relevant to mental health services are the *Short-Term Assessment of Risk and Treatability (START)*⁴⁶, for use in inpatient units and community mental health services.

4.1.4 Managing people with mental illness, including those who engage in violent offending

Australia's model for care and treatment of mental illness complies with the International Standards. The *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* identifies fundamentally all mental health consumers be accorded basic rights and be treated with respect and humanity⁴⁷. This includes, as far as practicable, that the consumer live and be treated within the community. These principles are subject to the competing public safety considerations, for example, "such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety order, health or morals of the fundamental rights and freedoms of others."⁴⁸

As noted previously, when discussing the three different ways in which mental illness relates to violence, the treatment of active symptoms is a necessary, though not always sufficient, method to avoid reoccurrence of violent behaviours. This is a recovery oriented focussed treatment methodology using a staged approach to integrate the consumer successfully into the community. Care must be taken to identify risk factors associated with ongoing violence so that those factors can be addressed, either by mental health services or other agencies, in order to help reduce the likelihood that further violence will occur. For some consumers this could be a quite lengthy process. There will remain a small percentage of consumers who will be unable to return into the community and require long-term or, very rarely, permanent care.

The remediation of symptoms and ongoing wellbeing consumers is and must remain the primary goal of mental health services, nonetheless, where known violence or characteristics of violence and offending are present, violence risk reduction must also be a focus of these treatments and recovery plan. Without adequate management of these behaviours, the consumer's recovery is not sustained, with negative impacts on their family and associates as well as reduction in the community's confidence in mental health care. Apart from the damage done to others as a result of consumers' violent actions, the consumer has to live with the consequences of those behaviours for the rest of their lives. In our experience, the vast majority of consumers who have committed murder, including the killing of family members, are greatly affected by remorse for the rest of their lives.

Increased risk of violence occurs where there is substance misuse and co-morbidities. The goals of any treatment plan to be effective must address all components of the consumer's vulnerabilities to assist with recovery and the reduction of violent behaviours.

⁴⁶ Webster, C. D. (2004)

⁴⁷ Butler review

⁴⁸ United Nations, United Nations principles for the protection of persons with mental illness and the improvement of mental health care [1], GA Res 46/119

“The mental health community has to start by accepting that violent and antisocial behaviours are amongst the potential complications of having a schizophrenic syndrome... as long as the problem of violence is minimised or dismissed as ‘non-illness related’, there can be no progress in reducing risk”.⁴⁹

Risk assessments themselves are not a panacea for reducing the occurrence of violent offending behaviours. Rather, they are a necessary element in helping to identify factors related to increased risk that should be addressed in an attempt to help reduce the likelihood of violent behaviour from occurring⁵⁰. As Mullen and Ogloff have noted⁵¹

“We are not now and probably never will be in a position to be able to determine with certainty who will or will not engage in a violent act. Relying on a range of empirically supported risk factors, though, we can make a reasoned determination of the extent to which those we are assessing share the factors that have been found in others to relate to an increased level of risk.”

Contemporary best practice in violence risk assessment requires that validated risk assessment measures and approaches are a reliable way of escalating and highlighting high risk individuals, bringing attention to the need for active treatment and monitoring⁵². For each of the Category 1 cases considered in this review, these high risk alarms were generally not evident in the clinical assessments and risk screenings/assessments when there was evidence they should have been identified and included in the treatment plans. The possibility of an effective intervention, and subsequent avoidance of even one of these events cannot be ignored.

Australia has implemented a deinstitutionalised model for the care and treatment of mentally ill consumers. This model of service is governed by the *National Standards for Mental Health Services 2010*. The levels of services provided in the health and community settings since removing the institutional model have received ongoing significant criticism⁵³, including lack of beds, resources, training and practices, with reports including cases of failure where these restricted services and lack of follow up have resulted in cases of suicide, management of mental illness through incarceration for criminal offences and the event category of this report, homicide.

Over the past decade, Australian governments, including the Queensland Government, have committed to addressing recommendations of reports into mental health services from the levels of service (*Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*) and reviews into sentinel events such as *Achieving Balance and Promoting Balance in the Forensic Mental Health System: Review of the Mental Health Act 2000* (the Butler Review) in the forensic mental health system 2006. Nationally these responses include the development and commitment to the National Mental Health Plan (in its fifth iteration). Queensland Health engaged and implemented the *Achieving Balance* recommendations. The primary focus of these responses and action plans has been for the improved care, wellbeing and hopefully recovery of people with a mental illness.

⁴⁹ P Mullen 2006

⁵⁰ Allnutt, S., Ogloff, J. R. P., Adams, J., et al. (2013).

⁵¹ Mullen, P. E., & Ogloff, J. R. P. (2008)

⁵² Mullen, P. E., & Ogloff, J. R. P. (2008)

⁵³ MHCA, Not for Service

All of this activity has achieved service improvements in Queensland with

- accessibility key performance indicators
- mental health plans
- reduction in restraint and seclusion practices
- post discharge follow up.

However, some results indicate not all service components have improved:

- funding limitations
- recruitment and retention challenges
- average bed days (reduction may indicate resource shortfall and too early discharge)
- lack of step up / step down services in Queensland (residential care).

A core suite of themes from previous reports are repeated in the evidence and findings of this Review. These are the organisational structure and resourcing of the service sector, use of previous history or collateral information in treatment planning and community knowledge of the range of services available.

The need for a coordinated and sufficiently resourced mental health sector as identified in Achieving Balance and the Butler Review have been repeated here. A system under stress does not have the full capacity to treat and care for the consumers. Stress does not only come from availability of staff, but also resource availability such as beds or allied care, experience and knowledge of staff in dealing with consumers, accessibility and currency of information, capacity to provide supervision and clear overall guidance and accountability.

The second theme repeated is cases reviewed containing a history of past mental illness, including a risk of violence (including family violence) evident in the consumers' records or being readily available from families and friends, that was not integrated into their care and treatment. Many cases also identified preceding the sentinel event that the person was exhibiting disturbed or altered behaviours. The current practices around information sharing, risk assessments and treatment planning are missing vital links.

Thirdly there are still challenges with the public understanding of mental illness and the range services available. A lack of clarity exists between the roles of providing social services, general health services, mental health services and criminal justice services. The result is consumers with severe mental illnesses becoming engaged with the criminal justice system through committing violent offences.

4.2 Homicide, mental illness and violence data

Australian Institute of Criminology (AIC) provided data on homicide rates for each of the years 2003–04 through to 2011–12, disaggregated by state or territory. The data provided included both offender and victim demographics and separately identified those homicides perpetrated by a person with a mental illness. Data later than 2011–12 were not available from AIC at the time of finalising this report and has not been used in the Review considerations and analyses. While it is unfortunate that data were not available pertaining to the exact period of the Review, the trends in homicide are such that there are relatively few variations from year to year.

4.2.1 Homicide offenders

The overall rate of homicide in Queensland has actually been reducing in recent years, including the rate of homicide by people with a known mental illness. Offender data were segmented by year for each state and territory (expressed as a rate per 100,000 population). Figures 2 and 3 identify a reducing trend in the offending rate for homicide, both overall and those which involve offenders with a known or suspected mental illness. Figure 4 indicates Queensland has the lowest rate of this category of homicide in the nation for the time period reported. It is acknowledged that the data are affected by the fact that the presence of mental illness among homicide perpetrators is not always known since there is no systematic mental health assessment for people charged or convicted of homicide and the presence of mental illness is based upon known data⁵⁴.

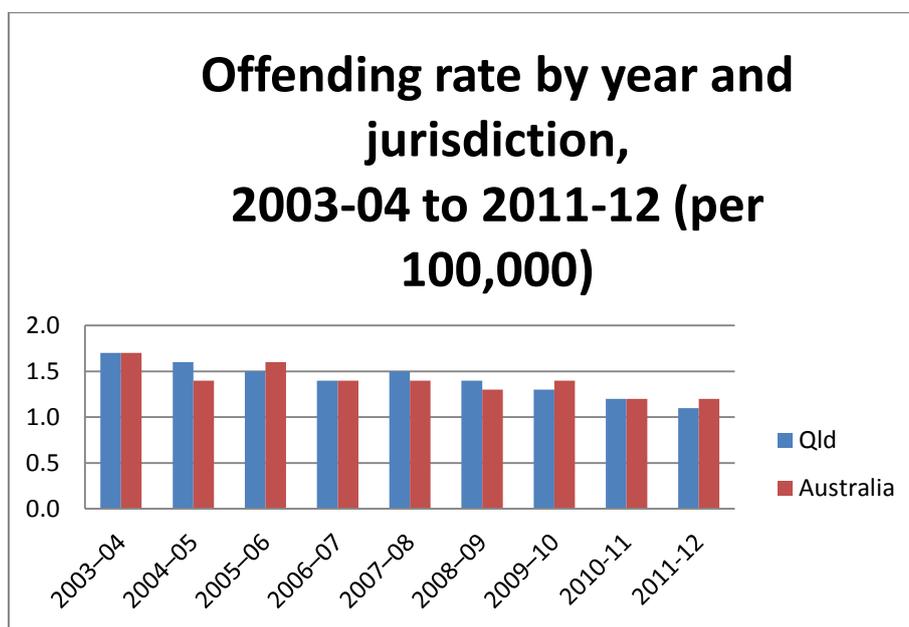


Figure 2 Offending rate comparing Queensland and Australia

⁵⁴ Bennett, D. J., Ogloff, J.R.P., Mullen, P.E., Thomas, S.D.M., Wallace, C., Short, T., (2011)

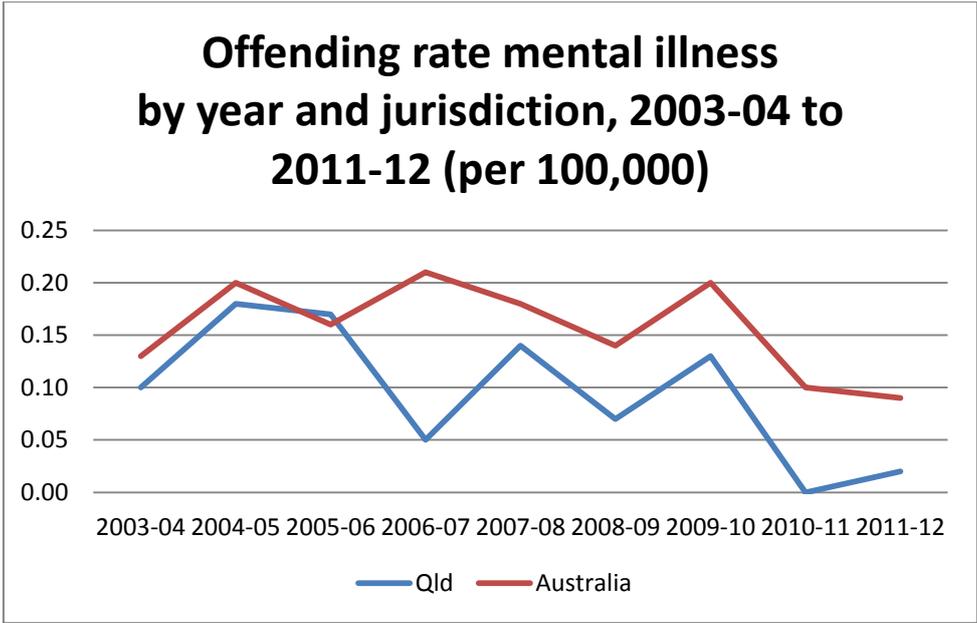


Figure 3 Offending rate where a mental illness was known

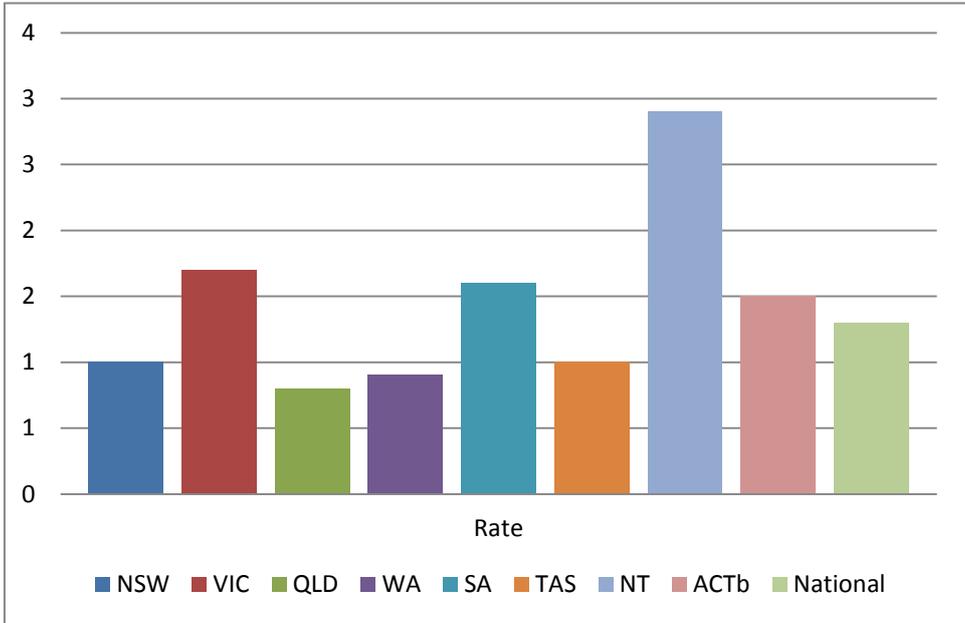


Figure 4 Offending rate where a mental illness was known or suspected by jurisdiction

4.2.2 Homicide victims

Victim data segmented by year and separated into each state and territory (expressed as a rate per 100,000 population) were reviewed.

Consistent with the offender rates identified above, overall there has been a sustained reduction in victims for the period 2003–04 to 2011–12, with Queensland decreasing at a similar if not slightly faster rate than the national average. This is presented in Figure 5.

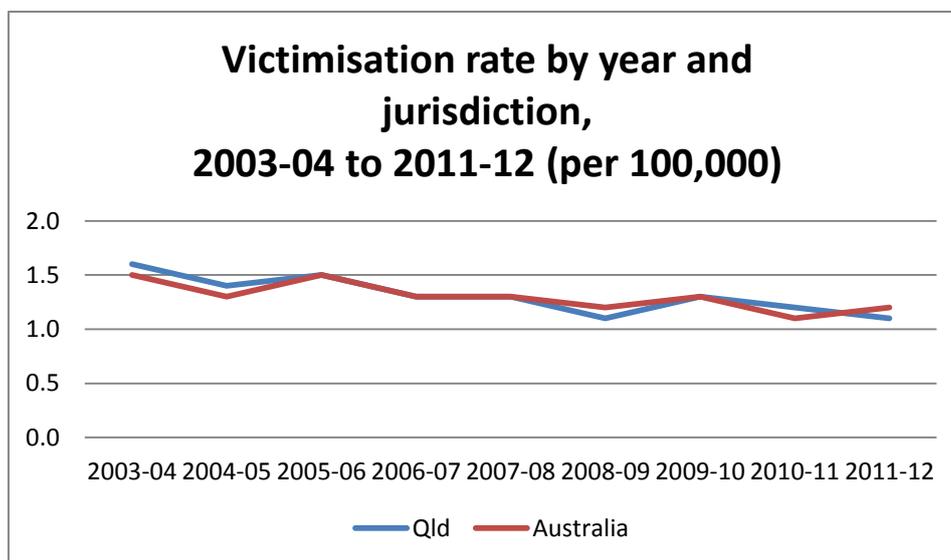


Figure 5 Victimisation rate by year: Queensland and Australia

Aligning with other reports and literature on this category of offences, Figure 6 shows victims who are family members account for just less than half of the group (45%), acquaintances for another 39 per cent and strangers for approximately 16 per cent. This highlights the low incidence of random stranger events.

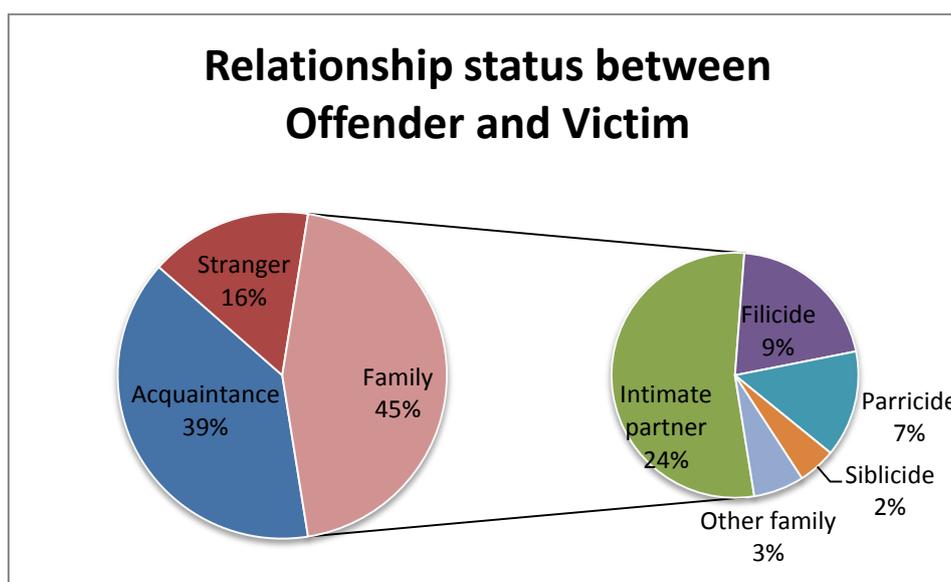


Figure 6 Victim offender relationship

5. Review results

5.1 Overall themes

Key themes identified in this Review are the low rates of homicide perpetrated by people with a mental illness, histories of violence and aggression amongst most perpetrators; the crimes committed were predominantly against family members or persons known to the perpetrator; issues with risk assessments; breakdown in information sharing between services and a lack of information sharing between the service and family members/carers.

These themes are consistent with previous reports commissioned in Queensland and Australia and are fundamental to the provision of quality mental health care and support to persons with severe mental illness. No new or emerging issue in mental health services was identified during the Review.

Queensland has made significant progress in implementing the Achieving Balance recommendations including consumer data consolidation and availability and improved governance and guidance. Rates of homicide have reduced and some key performance indicators have improved. Queensland Health and the HHSs have a solid core to their mental health services, both forensic and non-forensic. However, there are opportunities for service improvement. The findings and recommendations in the following sections are presented as strategies to improve these services within Queensland.

In conducting the Review, the Review Committee identified a high level of commitment to the service and professionalism by HHS staff members and by all persons with whom the Review Committee consulted. Nonetheless, given the focus of the Review on service development, a number of areas were identified where improvements can be made.

Rates of homicide by persons with mental illness

Events of this nature are rare. Since the Achieving Balance report, Queensland has maintained a low incident rate of homicide, including homicides committed by people with mental illnesses. For the period 2003–04 to 2011–12, these rates were decreasing in both total number of events and the number in which a person with a mental illness was involved. Data after 2011–12 were not available for the Review analysis at the time of preparing this report.

One key change between Achieving Balance and this report is the representation of women as the perpetrators of violent crimes. The events reviewed in Achieving Balance had a higher representation of women committing offences compared to men (8 females to 4 males or ratio of 2:1), opposite to the experience of all other states (a ratio of 1:7 or 1 female to 7 males). In the current review there were only [redacted] female perpetrators out of [redacted], bringing Queensland back into alignment with the demographics for these crimes as witnessed in the rest of the country. These inconsistencies emphasise the apparent variability of events, particularly low base-rate events, over time.

Overall the rates of homicide in Queensland are consistent with the rest of the nation and while it is difficult to attempt trend analysis on low numbers, do not raise any particular concerns or worrying trends based on the available data.

Rates of Indigenous occurrence / population

Previous reports on sentinel events, including Achieving Balance have highlighted the high prevalence of Indigenous Australian peoples (Indigenous) offenders in homicide cases.

Nationally the rate of Indigenous persons committing these offences has reduced between 2003–04 and 2011–12. The rate of representation of Indigenous members within the perpetrator population has remained constant around 18 per cent, that is, the rates of reduction in Indigenous and non-Indigenous offenders are the same.

Compared to the national rates, the number of Indigenous offenders in the cases under review was moderate and did not warrant further investigation. No conclusions could reasonably be drawn given the very low occurrence of homicides perpetrated by Aboriginal or Torres Strait Islander peoples in the current review.

Consultation with stakeholders did bring a wealth of knowledge on providing services and responding to needs in Indigenous communities. Particularly, some families had clear pathways for assistance and others not. The community responded by pulling together to help and support each other through the crisis and accessing assistance. Opportunities for service enhancements based on these observations and engagement has been included in the Review findings and recommendations.

Histories of violence and complexity

Similar to the findings of Achieving Balance, a theme repeated in these cases was that histories of past mental illness with a risk of violence were evident in the consumer's records or readily available from families and friends. Some consumers had histories of family or domestic violence. This information about risk of violence was, most unfortunately, not routinely integrated into the consumer's care and treatment.

“When a consumer has been identified as high risk... the treating team should consider completing a longitudinal history of the consumer, including any incidents related to the consumer.”

– Current HHS Guideline

Often the person in Categories 1, 2 and 4 was exhibiting disturbed or altered behaviours in the period leading up to the event. Other complexity, beyond mental illnesses, was evident, including such comorbidities as current substance misuse and intellectual impairment, as well as poor or intermittent medication compliance and limited social supports.

The current practices around information sharing, risk assessments, treatment planning and referrals appear to be missing vital links.

Community mental health literacy

The public understanding of mental illness and the range of services available is still challenged. A lack of clarity exists between the roles of those providing social services, general health services, mental health services and criminal justice services. The result is severely mentally ill consumers becoming the responsibility of the criminal justice system through committing violent offences. Also, mental health literacy may be particularly low in Indigenous communities such that when an individual is presenting in a way that is suggestive of irrationality or other mental abnormality, mental health services are not sought.

5.2 Common issues across cases

Case review summary data for Category 1, 2 and 4 are summarised in the table below. Due to the low number of consumers in Category 3 (), only general observations will be used in this category to ensure information remains de-identified.

Table 1 Case review summaries

| Classification | Category 1 | Category 2 | Category 4 |
|---|----------------------------|---------------------------------|------------|
| Number | () | () | () |
| Gender | () | () | () |
| Age | () | () | () |
| Relationship status | variable | variable | Variable |
| Ethnic status | () | () | () |
| Diagnosis of paranoid schizophrenia ⁵⁵ | () | () | () |
| Comorbidities present | () | () | () |
| Current substance use | () | () | () |
| Medication adherence (poor or intermittent) | () | () | () |
| Prior criminal history or history of aggression | () | () | () |
| Prior history of domestic violence (DVO) | () | () | () |
| Aggression management within treatment plans | () | () | () |
| Level of engagement poor or superficial | () | () poor remainder not relevant | N/A |
| Family / social supports | () | () | () |
| Victim relationship | () family, known, unknown | () family, known, unknown | N/A |
| Presence of identifiable triggers | () | () | () |

⁵⁵ Includes Paranoid Schizophrenia, Schizophrenic Disorder and other psychotic episodes

Additionally, 62 per cent of the Category 2 events and 40 per cent of Category 4 events involved persons who had previous contact with a mental health service. Events in Category 3 mirrored the profile of the Category 1 events above in Table 1.

Upon review of the documentation contained within CIMHA for the Category 1 events, the quality of the information was variable, from thorough assessments through to incomplete or absent assessments. Those consumers who commenced with well documented intake assessments tended to have more comprehensive assessments throughout their period of care. Likewise, superficial screening and assessment appeared to be reflected throughout all the consumer's episode of care. Of note only two consumers had their co-morbidities accounted for and only three consumers had standard 91 day reviews. There was no notification within the files that any consumer had received a copy of their Treatment Plan. It was noted that not all the documentation on file was contained within CIMHA and conversely not all CIMHA information was contained on file.

5.3 Mental health service key performance indicators

Australia has implemented a deinstitutionalised model for the care and treatment of mental health consumers. The levels of services provided in the health and community settings since removing the institutional model have received ongoing significant criticism⁵⁶ including lack of beds, resources, training and practices, with reports including cases of failure where these restricted services and lack of follow up have resulted in cases of suicide, management of mental illness through incarceration for criminal offences and, the event category of this report, homicide.

Nationally the federal government has responded to the needs of mental health services through the development of national health plans. The most recent version, *Fourth National Mental Health Plan 2009–2014*, has lapsed, with the development of fifth plan in place. The Fifth National Mental Health Plan is to address the federal government's reform agenda for mental health for the three year period 2016–19 and to be delivered within the existing funding envelope. This model of service is governed by the *National Standards for Mental Health Services 2010*.

Queensland Health undertook the Achieving Balance report and implemented the resulting recommendations. The primary focus of these responses and action plans has been for the improved care, wellbeing and hopefully recovery of individuals with a serious mental illness. However, as noted elsewhere in this report, the Review found that many of the policy changes recommended in Achieving Balance had not become embedded in standard care, in particular engagement with families and carers.

All of this activity has achieved some very clear service improvements in Queensland with key performance indicators identifying for the period 2008–09 to 2013–14

- reduction in restraint and seclusion practices from 18.2 to 11.1 events per 1,000 bed days
- improvement in post discharge follow up from 45.3 per cent to 72.8 per cent, second highest behind Australian Capital Territory at 73.9 per cent
- nearly complete compliance with the National Standards at 99.7 per cent

⁵⁶ MHCA – Not for Service.

- readmission rates within 28 days dropping from 15.4 per cent to 14.3 per cent, although this may not be a statistically significant result and overall rate is still a little higher than the national average.

Some activity has maintained service coverage for the same period. These key performance indicators are

- proportion of population receiving a clinical mental health service (1.9) which is the same as the national average
- beds in specialised psychiatric units or wards in public hospitals (Figure 7). Note however a reduction in public psychiatric beds generally.

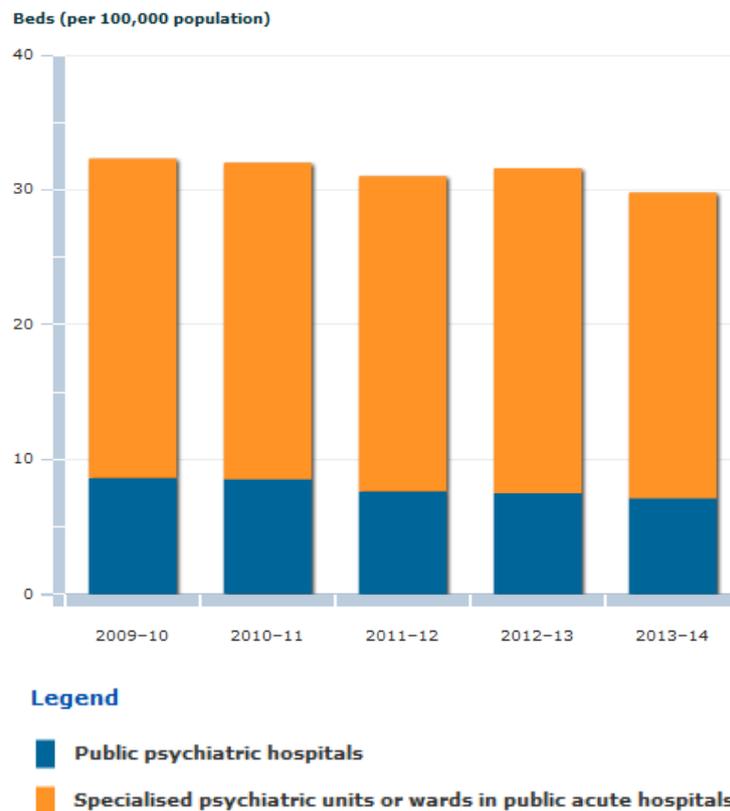


Figure 7 Beds per 100,000 in Queensland 2009-10 to 2013-14⁵⁷

Other national benchmarks that highlight potential areas for attention are:

- Rate of public acute and public psychiatric hospital mental health related hospitalisations with specialised psychiatric care are highest in the country (figure 8)
- Second lowest per person recurrent expenditure on specialised mental health services, with Victoria as the lowest (figure 9).

⁵⁷ AIHW data 2015

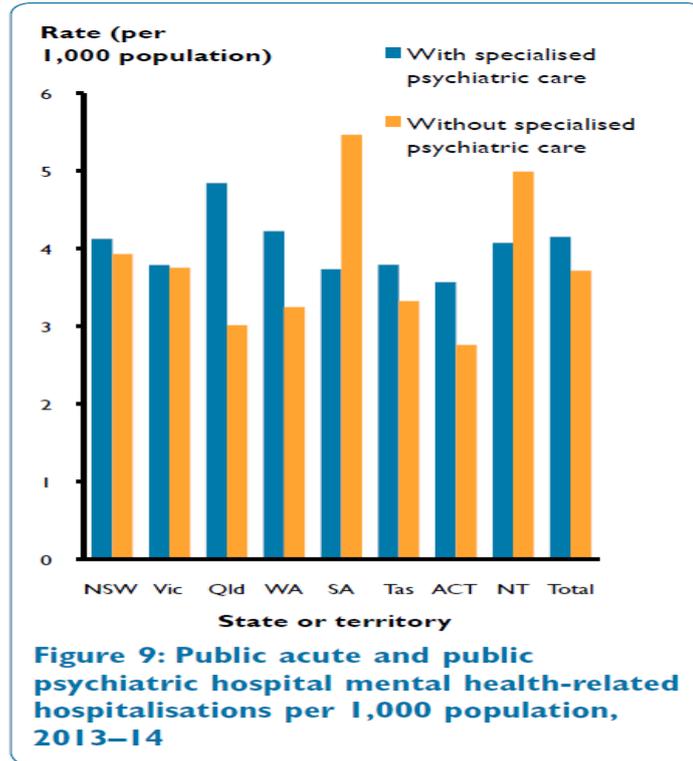


Figure 8 Rate of specialised psychiatric care admissions⁵⁸

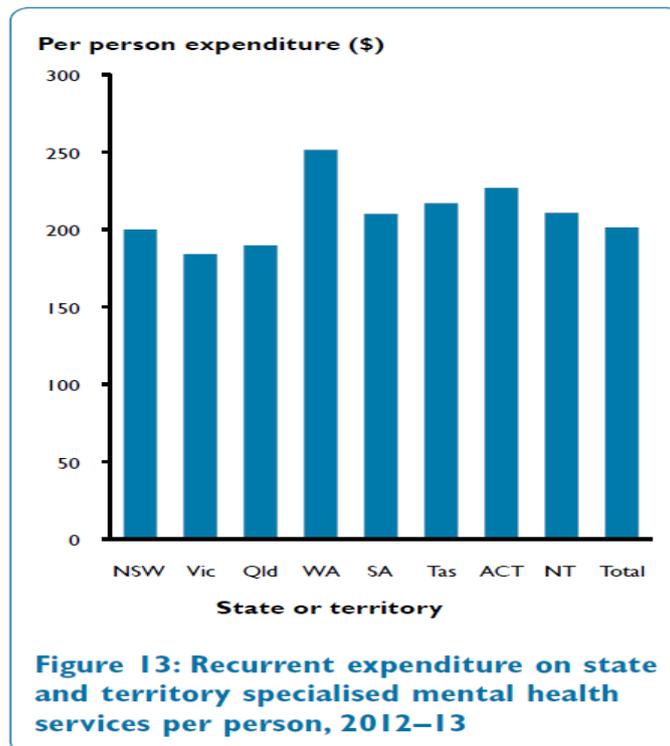


Figure 9 Recurrent expenditure on mental health services⁵⁹

⁵⁸ AIHW data 2015

⁵⁹ AIHW data 2015

6. Findings, discussion and recommendations

6.1 State-wide forensic mental health service model

Findings

The structure of the existing state-wide forensic mental health service system is decentralised and fragmented. While the components of a forensic mental health service are present in Queensland (e.g. inpatient units, community-based services, prison mental health services, court liaison services, and policing and mental health services), these service components are located administratively in six separate Hospital and Health Services (HHS). There is effectively no unified forensic mental health service with a clear governance structure and service delivery model. This impedes effective governance, responsive service delivery, management of forensic consumers, and the delivery of a consistent and integrated service.

The Review found a wide variation in the Hospital and Health Services' perceptions of the various elements of forensic mental health services including the usefulness of the assessments undertaken and recommendations made by Community Forensic Outreach Services (CFOS). Concerns were raised about the availability of resources within a HHS to fulfil some clinical recommendations made by CFOS. It was the perception of some HHS staff that some CFOS staff often appeared to have inadequate knowledge of the structure and resources of the HHS, resulting in impractical recommendations. Some reports provided by CFOS services were not reviewed and signed by senior forensic staff which limited their usefulness to the HHS, and also reduced the authority of their recommendations. Conversely, concerns were expressed by some forensic mental health staff that HHS clinicians have inadequate knowledge and understanding of risk assessment and management and that the resources committed to the Forensic Liaison Officers (FLO) are sometimes diverted to activities beyond their remit.

The reporting and monitoring requirements for the large number of consumers on forensic orders in Queensland currently does not differentiate between consumers based on the severity of the acts they have committed or the level of risk for violence that they pose. Many consumers on forensic orders do not pose an elevated risk and do not require the intensive monitoring requirements currently mandated.

Discussion

Queensland's decentralised model of health care established HHS Boards which are responsible for the provision of service delivery, standards, policies and practices. The Queensland Department of Health is responsible for creating public health policy and providing overarching guidelines and protocols. This service model is intended to promote responsive health care at the local level; however it may not be a suitable way of organising state-wide services that require common standards and centralised expertise.

The Queensland Forensic Mental Health Service (QFMHS) consists of a wide range of roles including Court Liaison Officers (CLO), Forensic Liaison Officers (FLO), Prison Mental Health Service (PMHS) and CFOS. Although described as a 'service', these service components and elements are embedded in key regional HHSs across the State as well as

Metro North HHS and West Moreton HHS. Metro North Hospital and Health Service (MNHHS) is the base of the Director of Forensic Mental Health Services (FMHS) and in conjunction with the Queensland Police Service (QPS), the point of contact for the QFTAC (Queensland Fixated Threat Assessment Centre) and the Police Communications Centre (PCC). West Moreton Hospital and Health Service (WMHHS) is the location of the high secure unit, The Park Centre for Mental Health and the lead in PMHS. The Mental Health Alcohol and Other Drugs Branch (MHAODB) within Queensland Health is responsible for setting state policy and guidelines on forensic mental health service and care.

QFMHS has a wide range of service coverage but lines of responsibility and accountability are not transparent. Two key roles have limited scope. Firstly, though state policy and guidelines are prepared centrally in the MHAODB, each HHS, statutory bodies governed by independent health boards, implement their own practices and procedures informed by these guidelines. Secondly, there are no formal reporting lines between the Director of FMHS and the FMHS located within other HHSs. The HHS model has resulted in perceived differences in levels of service standards and delivery between HHS. Gaps in the system can be a result of such devolution of responsibilities and these gaps became evident during the Review. The resultant overall findings in this Review were of a disaggregated and fractured care system.

Particularly, these weaknesses within the QFMHS were clearly evident in the risk assessment and management of high risk of violence consumers whose cases are within the scope of this Review. Without a central authority to enforce standards and protocols across the state, escalation processes for reporting and managing risks were either inconsistent or unclear. Overall the documentation standard varied widely from thorough and informative to poor, unhelpful and incomplete. Reviewing case material also identified the content of risk and other assessments varied depending on the author. The level of senior staff review and input was also not evident in many circumstances.

Supporting consumers who pose a high risk of violence requires advanced skills and capabilities in forensic mental health. Generalist mental health staff require input from specialist staff to adequately assess and address these high risk consumers. The state currently has these skills within the QFMHS, but these are in uncoordinated and disparate arrangements. For instance the FLOs are established within existing HHS budgets, making these positions open to redeployment within the HHS. They do not always attend state-wide training opportunities given the competing demands on their time and the costs involved for the HHS. The result is the necessary knowledge and skills for managing and reviewing high risk consumers are not readily available when required. It has proven difficult to recruit in areas without critical mass, such as the northern regional areas, leaving services short of key expertise and resources. There were missed opportunities in sharing between regions the knowledge and management skills of high risk of violence as teams are firmly embedded within each HHS.

Another outcome of a widely dispersed model can be variability in the level of usefulness and practicability of recommendations from 'expert' staff. Through the HHS consultations concerns were raised about the quality of the recommendations from the CFOS. Some

recommendations were viewed as overly general and obvious therefore not providing the necessary specialist input required. Other recommendations from CFOS were considered too onerous and impractical based on the available resources and staff of the HHS.

Alternative models more suitable to a decentralised population include creating key specialist teams to support a larger region composed of multiple HHSs. These teams would contain core staff highly trained in forensic mental health care that would bring their specialist skills and capability to manage high risk consumers. In turn this encourages stability in key contacts, strong relationships between QFMHS and HHS mental health services staff and more consistency in practices. Increased specialist skills would also provide guidance and advice on incorporating risk into treatment plans and reviews.

Different models of service provision exist in other Australian jurisdictions such as Victoria and New South Wales (NSW).

The Victorian Institute of Forensic Mental Health (Forensicare) is a statutory authority that is governed by a separate board, accountable to the minister of mental health. Forensicare is responsible for the standards, practices and services around forensic mental health care across the state. The forensic board's role is comparable to a HHS Board in Queensland.

The NSW Justice Health and Forensic Mental Health Network (JHFMHN) also is governed by a board that reports to the minister for health and is equivalent to a health district. Unlike the Victorian mode, the JHFMHN is responsible for all health and mental health services across the justice system, including prisons, police cells, forensic mental health services, and youth justice. Throughout NSW the JHFMHN is also responsible for governance and standards across the three medium secure forensic mental health facilities.

Regardless of the model adopted, an integrated forensic mental health service is required with clearer lines of responsibility and senior input into treatment and care plans. The minimum would include quarterly reviews between the Director, QFMHS, and each of the QFMHS teams, assessing the consumers' case reviews and providing specialist input to manage risk and enhance the treatment planning. Specialist skills in managing risk and incorporating appropriate intervention strategies into treatment plans must be available for all QFMHS.

Although it is beyond the scope of this review, consideration should be given to the organisation and governance of mental health and health services in the prisons in Queensland.

Recommendations

- 1 Develop an integrated state-wide forensic mental health service with a governance structure independent of Hospital and Health Services that enables the effective operation and maintenance of an integrated service across Queensland.
- 2 The position of Director of a state-wide forensic mental health service (SFMHS) is to have state-wide oversight of the integrated SFMHS, which provides and supports independence, governance, integrated standards and consistent practices.
- 3 Establish quarterly meetings between the Director of the state-wide forensic mental health services and Hospital and Health Services mental health service senior executives to improve quality, efficacy and integration of services.

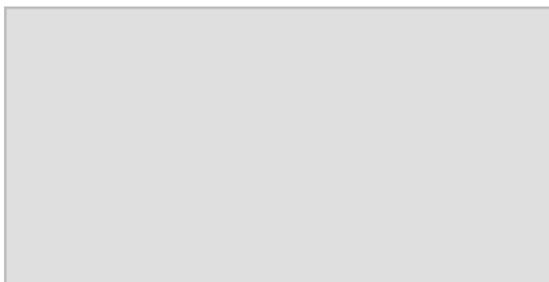
- 4 State-wide forensic mental health services are provided to consumers assessed as being at a high risk of violence in addition to consumers on forensic orders under the *Mental Health Act 2000*.
- 5 The role and function of the Forensic Liaison Officer positions located within mental health services be quarantined for undertaking assessments and management of forensic mental health consumers and other consumers who pose a high risk of violence.
- 6 Develop collaborative and effective relationships between forensic mental health services and Hospital and Health Services (HHS) mental health services staff and obtain knowledge of the models of mental health service delivery and available services/resources within the HHS region, by ensuring that identified Community Forensic Outreach Services teams are attached to specific HHSs, thus ensuring teams and clinicians assigned gain an increased understanding of the HHS necessary to provide tailored support to that specific HHS mental health service.
- 7 Upon completion of an assessment and prior to the finalisation of the recommendations state-wide forensic mental health services staff are to discuss their findings with the Hospital and Health Services (HHS) mental health service clinicians responsible for the consumer's care to enhance the validity of the recommendations and to help ensure that they reflect the availability of resources and services in the HHS.
- 8 Develop a categorisation system to differentiate lower risk from higher risk consumers on forensic orders and adjust the treatment and monitoring requirements accordingly.
- 9 Consider the engagement model of Mental Health Intervention Coordinators with the Queensland Police Service in responding to potential mental health crisis situations as a component of the service delivery model for state-wide forensic mental health services.

6.2 Family engagement

Findings

Insufficient engagement with families was identified, including poor communication during all phases of care (assessment, treatment and discharge planning), and specifically, no documented evidence of information provided to families/carers about the consumers' risk to others in the eight cases in which the consumer was receiving active current treatment.

In a few cases, inadequate risk management contingency plans were developed in circumstances where an increased risk or known threats were foreseeable.



For some of the cases too much responsibility was placed on the consumer's family/carer to help manage the consumer's relapse symptoms, with little evidence of mental health services staff working with families to inform them of the relationship between mental illness and violence or to provide strategies to assist in managing violent behaviour and addressing the family members'/carers' need for safety and protection.

Despite evidence of previous history of domestic violence or threats to intimate partners, family members, children and parents, these risks were either not identified from collateral information provided by the family, or if known, strategies to manage them were not shared with the family, and often not specifically noted in clinical file material.

People at risk of violence by consumers tend to minimise, deny or be naïve about the risks that they may face even when they may have been threatened. Clinicians need to be aware of this and specifically address these matters.

Discussion

Overall, advice from the HHS consultations, and a review of relevant policies and procedures, revealed that appropriate policies are in place to obtain collateral from families and to engage with them over the care of the consumer, and the Review noted a number of excellent policies at the HHS level. However site visits confirmed that the sharing of information with the family did not regularly occur. This was confirmed by information obtained from the Victim Support Services. The main explanation for the variation in collateral information obtained centred on capacity limitation within the system due to the mental health services being busy and, at times, taxed. Contents of the case reviews identified varying levels of collateral information obtained from others.

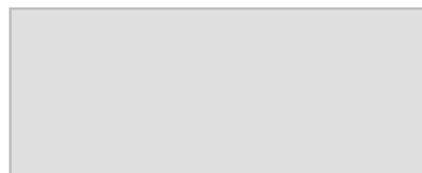
The lack of information sharing between the mental health service and other knowledgeable parties was also a consistent theme during the consultations with stakeholders. Previous coronial recommendations echoed the lack of information sharing and engagement with families and it was a main recommendation of the Achieving Balance report. With the high incidence of family and acquaintance relationships between the perpetrator and victim, sharing of increased risk or behaviour changes is very important to mitigate violent behaviours and harm to others.

Family and friends can also be a good source of information about the status of a consumer's behaviour. In the category 1 and 2 cases, changes in behaviour had become apparent and could have been interpreted as warning signs of increased risk if these conversations had been open.

From HHS staff perspective a major constraint to actively sharing information with families is privacy legislation and the rights of the consumer. Concerns with phone calls focussed on the inability to confirm the identity of the caller and the risk they may be media personnel or others not entitled to information as well as the fear of litigation if privacy has been breached.

The MHAODB have published an excellent, informative yet brief and highly readable, information sharing booklet which describes the roles, responsibilities and the appropriate release of information. This booklet describes a number of situations where it is suitable and potentially necessary to provide information to others.

This booklet is an excellent resource for clinicians and should be referred to when dealing with some of the difficult questions about information sharing. This booklet will need to be updated with the changes in the MHA 2000. It should be widely known and used by mental health services staff.



Recommendations

- 10 The comprehensive assessments conducted by clinicians must be informed by collateral information obtained from families/carers. Prompts on obtaining this information are to be added to the State-wide Standardised Suite of Clinical Documentation and, where no collateral is provided, the efforts made to contact and obtain the information are to be documented and audited.
- 11 Engagement with families is to occur at initial contact with the consumer and throughout the consumer's episode of care, consistent with the *National Standards for Mental Health Services 2010* and reflective of a tripartite model involving the consumer, clinician and the family/carer.
- 12 Families/carers are to be informed of potential risks to their safety, provided with support and strategies on how to mitigate risks, and given clear advice on how to maintain their own safety in crisis and ongoing situations, including information about available support including support external to mental health services.
- 13 Prompts are to be included in comprehensive assessment, risk assessment and treatment planning as well as reminder included within staff training to ask about safety of family members, including ensuring that clinicians ask difficult questions about safety and risk.
- 14 Educate mental health services staff on information sharing legislation, particularly the approval to release information to family and other parties.
- 15 Revise the Mental Health Alcohol and Other Drugs Branch information sharing booklet to include information about providing advice and supporting families who may be at risk.
- 16 Identify opportunities to build mental health services staff knowledge on information sharing into the *Mental Health Act 2016* implementation process.

6.3 The consumer journey

Ideally the consumer journey should reflect the following steps:

- initial comprehensive assessment
- risk assessment
- collaborative treatment planning, including recommendations from the risk assessment
- regular review
- recovery

Overall, as previously stated documentation reviewed was either poor due to being incomplete or lacked necessary detail in mandatory fields. Two practices were common especially in regard to risk screening/assessment. The first was only ticking boxes with no explanatory details provided, and the second was extensive material written, but no clear assignment of category or issue as no tick boxes were checked. Neither practice is the correct application of the assessment methodology. Possible causes for these practices include:

- level of staff experience as junior staff may not have sufficient capability or confidence to undertake a comprehensive assessment
- workload or cultural pressures impacting on capacity to complete assessments fully

- lack of awareness of requirements of protocols and procedures due to change in local policies, directions and staffing
- usability and accessibility of systems and forms in the mental health service
- lack of training on how to undertake an assessment or identify risk.

A review of sample HHS policies, protocols and procedures identified Queensland Health guideline requirements have been adopted locally. Some of the documents are well written and clear in their direction. Many include escalation practices and recognition of risk factors, though these were more expressly stated in some than others. The use of CIMHA as the information collection tool was also clearly stated, including at which stages of the assessment process.

The evidence points to a disconnect between policies and clinician practice. With a relatively mature training program, to be discussed under capabilities in 6.6, this raises concerns about local appetite for risk and assessment, issues with adequacy of supervision and senior support, or workload stress. Another plausible explanation relates to the presentation of the documents. Though the audience of the governance documentation is clinicians, the policy and procedure documents are written to meet governance requirements and may not be in a form digestible for daily practice. Solutions to create more practice friendly procedures may include adding one page flowcharts for each procedure that can be pinned to noticeboards and folders. Many health procedures have flowcharts.

The Review Committee noted the Department of Emergency Medicine (DEM) use their own documentation for the purposes of risk and comprehensive assessments. While the processes and practices of DEM services are out of scope of the Review, the use of different documentation - with questionable validity - adds complexity to the ongoing care and treatment of forensic mental health consumers. This is of particular importance to the Category 2 and 4 cases.

6.3.1 Comprehensive assessments

Findings

Mental health assessments and management plans for many new consumers or consumers re-presenting after a break of service were not sufficiently comprehensive to provide for appropriate mental health care or, where necessary, enable accurate risk assessment and formulation.

The review revealed that in many instances mental health assessments did not adequately consider longitudinal information as part of the assessment and development of care plans. Rather services were often limited to the presentation of the current episode of mental illness.

“The Consumer Assessment Form is a comprehensive tool... when not completed in full it is an expectation that, at minimum, a Mental State Examination, risk assessment and formulation be completed.”

– Current HHS Procedure

Of the materials reviewed it appeared that many consumers did not receive comprehensive formal assessment and the instruments of assessment from the State-wide Standardised Suite of Clinical Documentation were incomplete or not utilised.

Discussion

Assessments reviewed appeared to be cross sectional or episodic, and did not adequately consider or note historical information available. For more than 50 per cent of cases across Categories 1, 3 and 4, there was little evidence of a longitudinal assessment. There was a lack of recording of process undertaken in formulation and little evidence of projecting future risk. Clear examples of this were identified in 5.2, where Category 1 cases contained histories of either risk or violent behaviours which did not appear to be acknowledged in the comprehensive assessments.

Comprehensive assessments at a minimum should include:

1. Identification of health problem
2. Assessment of severity of condition and risks
3. Triage with the appropriate treatment and interventions

Recommendations

- 17 Mental health services need to undertake a comprehensive mental health assessment for all new consumers accepted into treatment.
- 18 Mental health services need to undertake a comprehensive mental health assessment for any persons who frequently present to emergency departments or are frequently referred by other services, regardless of whether the consumer is admitted to the service. Frequency is defined as presenting on three or more separate occasions within a three month period.
- 19 In emergency situations the minimum standard for an assessment includes:
 - identification of presenting problem
 - consideration of previous mental health history and contacts
 - mental state examination
 - risk screen
 - identification of any relevant co-occurring conditions
 - collateral information.
- 20 Comprehensive mental health assessments should, insofar as possible, be a longitudinal assessment informed by a consideration of historical, contextual and current factors.
- 21 Mental health services should ensure appropriate training, supervision and auditing of comprehensive mental health assessments.

6.3.2 Violence risk assessment

Findings

While there was widespread use of risk screening, there was little evidence of more comprehensive risk assessments being conducted even when the consumer had a history of violence that was known to the mental health service. It was unclear from the evidence which practices triggered the engagement of specialist input and in some high risk cases there was no evidence of specialist input. Very few cases employed any validated risk assessment measure apart from the standard risk assessment screening form.

Consistent with the findings regarding comprehensive mental health assessments, risk screening, risk assessments and management plans did not contain evidence of a consideration of the consumer's previous history of violence.

There was a lack of evidence of matching appropriately skilled and experienced clinicians and providing suitable services for the treatment and care and ongoing monitoring of plans that are commensurate with the identified risk and complexity of the consumer.

The lack of evidence of senior staff involvement in the provision of treatment, management and supervision of high risk consumers has resulted in unclear escalation processes for assessing and managing risk.

There has been limited access to, and uptake of, specialist forensic mental health advice and support, including coordination, supervision and leadership, for generalist clinicians managing forensic consumers or other consumers who pose a high risk of violence.

Discussion

Structured risk assessments were not apparent in most of the cases reviewed, suggesting that correct processes, tools and triggers for escalation are either unknown by clinicians or not sufficiently embedded in practice. The result is a gap between the consumer's initial assessment and the engagement of the FLO / CFOS. There was no evidence of a graduated approach to risk assessment and risk management. Many assessments appeared based on a current presentation of the consumer with no language indicating reference to, or awareness of, further material or past history. Although these findings pertain to all cases, this is especially a consideration for the cases in Category 2 and Category 4.

Given the large number of consumers treated in mental health services, and the relatively low number of them who present as a high risk for violence, it is not necessary or efficient for all of them to have a risk assessment. Conversely, there is a small number of consumers who present with a level of risk for violence that requires a greater level of scrutiny and care.

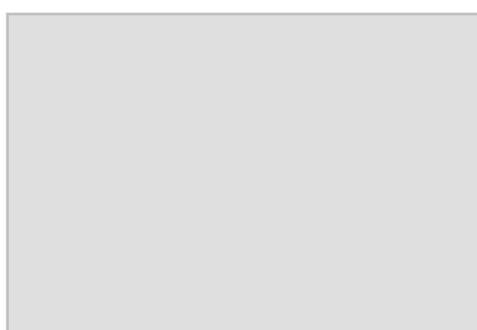
For these reasons, it would be useful to implement a three phase approach to risk assessment and management within Queensland mental health services.

Level 1 would include all consumers of the mental health service. This would consist of a brief risk screening that is equivalent to the current practice for consumers being admitted for services. Such screenings should be conducted by frontline clinical staff members who conduct the intake assessments.

Level 2 would be reserved for consumers who are identified in the risk screening as having indicators consistent with an elevated level of risk. A risk assessment is required for these consumers. Such an assessment should be conducted by a senior clinician with training and experience in violence risk assessment or a consultant psychiatrist. A risk assessment would also be required for consumers who have recently engaged in aggression or violence regardless of the results of the risk screen. Consideration should be given to implementing the HCR-20 (see the

discussion of risk assessment and risk assessment measures on page 40 of the summary of literature) or another validated violence risk assessment measure.

The highest level of risk assessment, **Level 3**, would be the province of specialist clinicians/services with training and expertise in forensic mental health risk assessments. These specialist assessments would be required for those consumers identified through the Level 2 risk assessment process as being at high risk, or for those consumers who have engaged in repeated acts of aggression and violence or in one or more acts of serious violence. As the services are currently configured, these assessments should be conducted by CFOS or the FLO. These assessments must include an evaluation based on a validated violence risk assessment measure, such as the HCR-20. Risk management would be linked the level of risk presented and the presence of risk factors.



The application of a three stage model would support junior or less experienced staff in identifying when to engage the senior consultant within the mental health service and identifying the triggers for engaging with the FLO / CFOS.

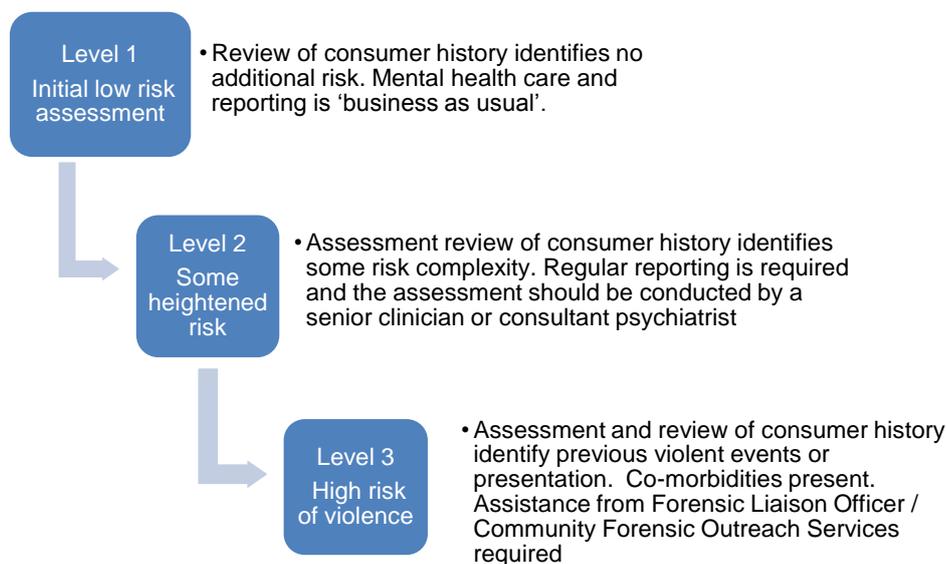
Recommendations

22 Implement the following three level violence risk assessment:

Risk Assessment Framework



23 The level of services required to address the consumer's level of risk should be commensurate with the level of risk identified for the consumer.



24 Consultant psychiatrists, and other senior clinical staff, are required to actively review and be involved in the development of management plans that expressly address violence risk factors for all consumers rated as Risk Level 3.

25 Forensic Liaison Officer positions should be quarantined from non-forensic mental health, or management of consumers at high risk for violence, service demands in order to maintain role, presence and expertise. Refer to Recommendation 5.

6.3.3 Formulation and treatment planning

Findings

Treatment planning did not appear to be consistently informed and formulated by:

- comprehensive mental health assessments
- violence risk assessments including Community Forensic Outreach Services recommendations, historical and contextual information
- longitudinal assessment, treatment and competencies
- recovery oriented care, in particular plans made in collaboration with consumers.

Discussion

Consistent with the issues identified in comprehensive assessments and risk assessments, there did not appear to be appropriate provision in the treatment planning to address the heightened risk of violence in any of the material reviewed. Also, little evidence existed to reveal the extent to which consideration was given in the mental health assessments of the extent to which the mental illness was contributing to aggression and violence for those consumers with such behaviour. There were very few formulations that considered risk for violence. The professional qualifications or affiliations of the author also were not easily identifiable within the clinical notes.

Consultation with the HHSs identified issues with the access to and experience of specialist staff. In some situations, this has resulted in a lack of assistance in developing a treatment plan due to insufficient access. Other times the limited access to appropriately skilled staff manifests as junior forensic staff stating obvious (generic) recommendations that provide limited guidance to clinicians or unrealistic options considering the operational practicalities of the HHS such as the recommendation to keep the consumer admitted to an acute inpatient unit for an extended period [REDACTED]

Though procedural documentation defined some processes and triggers for further review, limited evidence was observed within the files that these were applied or even known by staff. Reviews should occur where there is evidence of a significant change to a consumer or new information become available. Some key review points are:

“A case review must be conducted when there has been an increase in acuity, or consumer outcomes indicate a significant or sustained decline.”

– Current HHS Guidelines

- 91 day review
- special, more thorough reviews for complex consumers
- when a consumer’s circumstances change.

These review points also provide triggers for junior staff as to when to engage with more senior clinicians or consultants in the care and treatment of a consumer.

Reviews conducted with a risk triaging framework provide a mechanism to promote movement of consumers between the levels of risk in both directions rather than only in an escalating manner. Ongoing evaluation of the effectiveness of risk management strategies allows for changes in management strategies, and provides the opportunity to reduce a consumer’s risk in tandem with their recovery. The current processes are consistent with a risk averse system where mechanisms are in place to elevate risk, but not to systematically assess risk reduction.

Recommendations

- 26 Formulations require a longitudinal perspective and should include information about mental illness, the relationship between mental illness and risk factors for violence, and the impact of risk of violence.
- 27 Management plans are to be informed by issues identified in the risk assessment and include proposals to address these issues including referrals to relevant agencies that can provide services that are outside of the scope of mental health services.
- 28 All consumers must have a completed care review and summary plan within six weeks of being accepted into the mental health service. A Recovery Plan should also be developed at this time, or explanation for its delay.
- 29 Undertake the 91 day Clinical Reviews in accordance with the *National Standards for Mental Health Services 2010* with a separate system of more comprehensive review to be developed by Hospital and Health Services for complex and high risk consumers.
- 30 Include within the State-wide Standardised Suite of Clinical Documentation a mechanism to trigger a comprehensive ad hoc review where indicated.
- 31 Clinical reviews to include an assessment of the effectiveness of the previous care plans and include strategies to mitigate and reduce the level of risk and stabilise behaviour.

32 Community Forensic Outreach Services' reports to be noted by a consultant psychiatrist and resulting changes to the management plan documented in the clinical file.

6.3.4 Therapeutic relationships

Findings

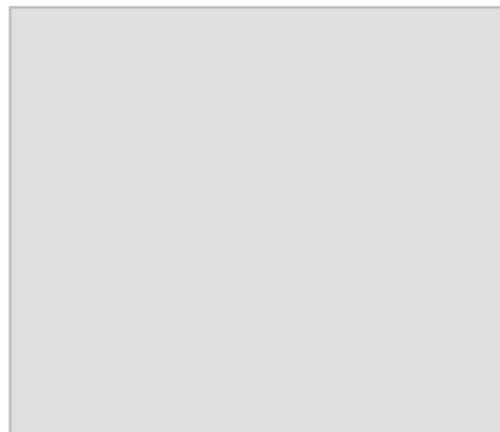
There was variable evidence of active engagement with consumers in their treatment and care to support recovery. Many occasions were observed of mental health services performing more passive monitoring roles such as medication compliance.

Discussion

The treatment plans viewed by the Review Committee predominantly contained reported medication or clinical changes and immediate treatment requirements. Very little detail was observed of planning for recovery clearly indicating the focus has been on clinical matters.

Most forms and documentation contained a range of tick boxes for clinician use. On the recovery plans, tick boxes are included for recording the involvement of the consumer in the plan's development and whether the consumer had been provided with a copy. These boxes were rarely ticked.

Actively engaging with the consumer in their recovery has multiple benefits and performs a risk mitigation function. Regular risk assessments and reviews that include the consumer provide opportunities for identifying high risk triggers, high risk situations for the consumer and an understanding of their relationships with others. It builds trust between the clinician and consumer assisting with consistency in treatment and medication compliance. With the consumer's recovery as the focus of the plans, containment management and transition processes become effective in preventing decompensation.



Recommendations

- 33 Mental health services should accelerate training of clinicians to work in collaborative, recovery-oriented practice with consumers, including those with a history of violence and/or forensic issues. For such consumers, clinicians may require more sophisticated training in application of the recovery model and techniques for addressing difficult issues, and specifically for managing risk of violence.
- 34 Training in more specialised applications of the recovery model and techniques to manage risk of violence should include input from consumers and forensic specialists.
- 35 Regular audits of case files should be undertaken ensuring evidence of consumer engagement is being documented, and shortfalls addressed in supervision and line management.

6.4 Consumers with co-morbid conditions

Findings

Review of case profiles repeatedly identified co-occurring or dual diagnosis conditions (substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury) which serve to increase the complexity of the case and may increase the risk of engaging in violent behaviours. Unfortunately, there was little systematic review of such conditions and the treatment plans rarely addressed these matters.

Discussion

In many cases reviewed, there was significant evidence of alcohol and other drugs issues. Alcohol and other drugs use has a significant influence on mental health and adds layers of complexity and increases the risk of violent behaviour, both impulsive and planned.

Following on, the need to integrate treatment for a consumer with co-morbidities is a recurring topic of recommendations from reports into mental illness and violence. It is important in the consumer journey, starting at the comprehensive assessment, that these high risk factors are identified in the screening and appropriately addressed in the risk assessment and ongoing management to ensure the correct referrals to other services, liaison paths and management strategies are identified and interlinked. Clinically this continually proves to be a challenge to manage. MHAODB have a Dual Diagnosis Toolkit and Resource for Clinicians available. This is currently under review, but is still relevant and should be actively used as a resource in these complex cases.

A care coordinator role in Queensland Health to assist management for disability and forensic cross agency consultation would be beneficial. This role could also be a member of a panel across multiple agencies to provide support and management plans. Previously Project 300 was implemented to manage the most disadvantaged, complex and challenging consumers. This project has ceased and some of its functions may now be subsumed by the National Disability Insurance Scheme (NDIS). Opportunities exist to engage with the program management of the scheme for improved coordination and management of consumers with high level needs.

Recommendations

- 36 Greater consideration by clinicians is required during the comprehensive mental health assessment for the identification of dual diagnosis and co-occurring conditions (substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury) to ensure referral pathways are initiated.
- 37 Greater attention should be paid to the presence, and need for treatment, of co-morbid alcohol and other drug use and the implications of the substance misuse on consumer's mental health and risk of violence.
- 38 Greater attention should be paid to the presence of, and need for interventions for, co-morbid personality vulnerability and personality disorders and the implications of these conditions on consumer's mental health and risk of violence.

- 39 As part of the development of a formulation that includes mental health and risk of violence considerations, the role of any co-morbid or co-occurring conditions should be considered and incorporated.
- 40 Treatment plans should address and provide for the integrated management of complex consumers. Where required services fall outside the remit of mental health services, appropriate referrals should be made and, insofar as possible, the provision of external services should be monitored.
- 41 Multi-service case conferences would be beneficial to coordinating service efforts for consumers with co-morbid conditions, or those who repeatedly present to the mental health services.
- 42 Investigate ways to renew the functions of service integrated care coordinators for complex consumers, including those with mental health and dual disability, in consultation with the National Disability Insurance Scheme.
- 43 Investigate further mechanisms for managing particularly complex mental health consumers (i.e. those with any two of: substance misuse, personality disorder, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury, history of violence or offending) employing a whole of government approach.

6.5 Clinical systems and information

Findings

Clinical information is currently stored in a fragmented way and is inconsistent across the Hospital and Health Service. There is inconsistent access to reports, particularly *Mental Health Act 2000* related, and other longitudinal information. There is a lack of the systematic method for recording, storing, access and retrieval of clinical information within the Consumer Integrated Mental Health Application (CIMHA) relating to a consumer's risk which is used to inform assessment, management and review. CIMHA alerts indicating risk status are not easily visible and review dates had expired.

Discussion

The CIMHA was one response by Queensland Health to the Achieving Balance recommendations for access to clinical information (See Appendix 6). CIMHA is used by mental health services, to varying extents, for recording all assessments, including risk assessments and for recording a consumer's outcome measures. It is extensively used by the mental health services, though is used in a limited capacity in other health arenas, including inpatient units and DEM. These services do access some mental health related information through either the Viewer or leMR. Not all relevant information on a consumer's history or risk is available in either of the Viewer or leMR. This represents a major and unacceptable gap in the availability of information.

Concerns were raised by users of the system about the limited access to Mental Health Court Reports and the non-alerting nature of the "alerts" functionality. These have been promptly addressed throughout the course of the Review, with some additional reports now being available and alerts now flashing conspicuously when a consumer's file is opened. Further enhancements should be considered to make review of other reports compulsory, such as mandatory fields or forcing functions.

Of note was also the completeness of information contained within CIMHA. When reviewing the case material, it was noted some information was only contained on the hard copy file, some information was only available on CIMHA and the balance was in both. This meant there was not one full version of a consumer's history and information in any one location, either hard copy file or electronic record. This has implications for missing critical information when a consumer transfers between services, or when there has been a significant break from services.

Recommendations

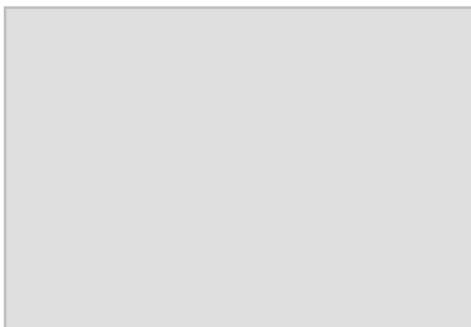
- 44 Use one consistent integrated state-wide clinical information system for mental health information. As Hospital and Health Services use the Consumer Integrated Mental Health Application (CIMHA), its continued use should be considered, however it is acknowledged that comment on Queensland Health information technology systems is out of scope of the Review.
- 45 Provide one area within the Consumer Integrated Mental Health Application for the storage of all information relating to a consumer's risk assessment, management and ongoing reporting. In addition to Mental Health Review Tribunal Reports, establish a clinical note category with a heading such as 'forensic reports' or similar to include all information relating to a consumer's history of aggression, criminal history, Community Forensic Outreach Service report, and Mental Health Court reports and risk assessment and management plans.

6.6 Building competencies and capabilities

Findings

Most of the cases reviewed demonstrated a lack of integration between assessments and treatment plans and an absence of effective escalation processes in the face of deteriorating mental health. Insufficient attention was paid to considerations of risk for violence and such matters were typically not considered in formulations, treatment plans, and interventions. This suggests issues with generalist clinicians' awareness, competency and capability and could reflect gaps in their supervision, education and training in mental health assessment, risk assessment, specialist forensic assessment, treatment planning and delivery.

Discussion



Overall, training by itself is considered one of the least effective and most expensive methods of knowledge and skill transfer. However, when developed as part of ongoing professional development, training is the necessary foundation on which skills and knowledge are built. Poor training can result in gaps in knowledge of processes and a lack of confidence in undertaking roles.

Complementary to training are

- education, or formal acquisition of knowledge and skills through the acquisition of a tertiary qualification
- supervision, or reinforcement of the knowledge through on the job practice and experience under the leadership and direction of a supervisor
- implementation, or audit of level of skill acquisition through review of documentation and other evidence.

Each of these four components (training, education, supervision and implementation) is necessary to build a competent and confident workforce. When training is complete an important method of reviewing its effectiveness is to undertake quality audits of the documentation produced by the attendee. Such quality audits within a mental health service would review the quality of the written work including formulation, the completeness of the documentation, relevance of its contents, consideration of related material and suitability of its treatment recommendations. This would cover both a review of processes (completeness) and capability (formulation).

Significant attention in this review has been brought to the identification and management of risk. It is therefore important that supervisors are highly skilled in the recognition of risk, review of risk assessments and strategies and providing opportunities for triggers to be easily identified. Poor supervision can lead to passive plans that monitor symptoms and medication rather than being active and focussed on recovery strategies.

Upskilling of mental health services staff would be required in the identification, assessment and management of the 3 levels of risk nominated under the finding related to violence and risk assessment.

Skill mix is a concern as 'risk' generalists, or clinicians with generalised risk training, will often avoid topics that are likely to make the consumer angry / agitated. The focus of a generalist role is to de-escalate. Having risk conversations is a specialist skill and training should be provided on asking difficult questions of both the consumer and the family so that risk issues can be identified and treatment / management plans put in place.

Queensland Health is not a one stop shop for all a consumer's issues as its service provision is centred on a consumer's recovery and successful integration into the community. This raises broader questions around Queensland Health's role in community programs beyond health care. Relevant topics for recovery such as social skills and anger management are more suited to delivery by the NGO sector where non mental health consumers may also be attendees. Examples of these programs include intervention advice and courses for issues with domestic violence.

Recommendations

- 46 Consistent with the recommended phased model of risk assessment and management, all clinicians require training in principles of risk assessment of people with mental illnesses. This knowledge is necessary to complete the risk assessment screening required for all consumers. Senior clinicians require training in risk assessment and management necessary to enable them to undertake the level two risk assessments using and interpreting validated risk assessment measures.

- 47 Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumers' needs rather than being passively identified in documents.
- 48 Provide training and supervision specific to identification of risk factors of violence to ensure appropriate escalation processes are included where indicated.
- 49 Provide training and supervision specific to recovery principles, and the dignity of risk (i.e. the realisation that all people including consumers carry with them some degree of risk and the important factor is how they manage that risk), to ensure treatment plans assist with firstly stabilising the consumer's presentation and working towards recovery which includes addressing violence risk factors.
- 50 Provide training on consumer confidentiality and release of information so that information sharing between the forensic mental health services, other service providers and family/carers allows for open discourse on risk and discovery of important factors to be considered in care planning.
- 51 Provide training and implementation support for the *Queensland Health dual diagnosis clinical guidelines and dual diagnosis clinical toolkit* to ensure all the consumer's needs for treatment and management are integrated and the necessary referral pathways engaged.
- 52 Implement a program of auditing skill acquisition for all relevant staff through review of documentation and other evidence to ensure necessary competencies have been transferred and evident in practice.
- 53 Explore opportunities to develop training and relationships with Primary Health Networks in relation to the assessment and management of risk of violence to others. Mental health services should develop better collaboration with domestic violence services in the management of family violence.

6.7 Support services and linkages with other agencies

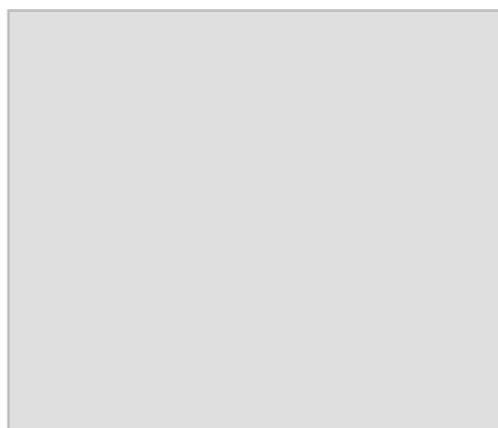
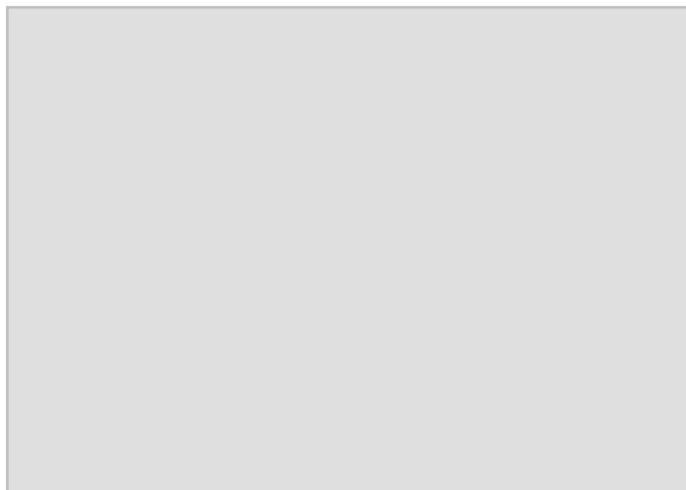
Findings

A lack of awareness and utilisation of available services to support people at risk either as perpetrators or victims of violence was evident. Consultation, collaboration and information sharing between mental health services and community supports requires improvement to support consumers, private mental health service providers, non-government organisations, health workers, Victim Support Services (VSS), domestic violence services and the Queensland Police Service.

Discussion

Stakeholders advised there is a lack of information given to families about the range of services and pathways available for support. For instance, avenues to the VSS are not limited to families and people impacted by violence where a person has been charged.

Referral pathways between the stakeholder organisations did not appear to be clear or necessarily contained within policy and consultation documentation, including between mental health services and these organisations.



Trust your Instinct and *DV Connect* are the Queensland Government programs to address the issue of domestic violence. Many consumers had prior histories of violence including domestic violence. The majority of victims in these cases were either family members or persons known to the perpetrator. With a known connection between some mental illness and domestic violence, engagement and collaboration between QFMHS and the Domestic and Family Violence Death Review Unit, Office of the State Coroner may result in improved awareness and understanding of the impact mental illness may have on domestic violence.

Recommendations

- 54 Given the disproportionate number of victims of homicide who were family members, there is an urgent need to enhance the awareness and capacity of the role of Victim Support Services to work with families who have experienced violence. This could be achieved by making the service more visible to Queensland clinicians, consumers, and the broader community, via an awareness campaign.
- 55 Consider the role that Victim Support Services could play in supporting consumers, family members, and others who have been victimised or are vulnerable to victimisation. Information about the service should be readily available at all points of contact with Queensland Health (e.g. emergency departments and outpatient units). This may result in an increase in the workload for the service, and this needs to be managed accordingly.
- 56 Undertake exploration to identify other government/non-government organisations/community-based services to support people at risk either as perpetrator or victim of violence, and to establish inter-disciplinary links so as to maximise service delivery to the families/carers of consumers.

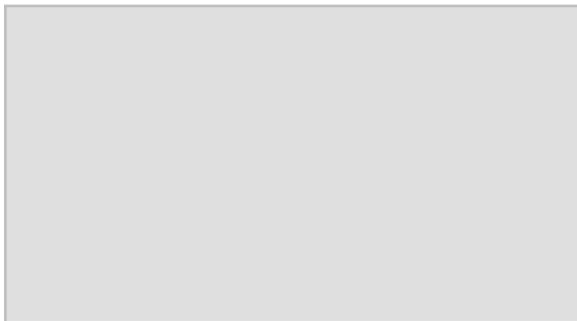
6.8 Mental health literacy and access

Findings

Over the past twenty years, there have been improvements in mental health literacy within Queensland as in the rest of Australia; these have enhanced the community's general knowledge on prevention and early intervention for those with or at risk of a mental illness. However, the Review identified a number of incidents where access to and engagement with mental health services, or non-specialised services such as Primary Health Networks, general practitioners, nurse practitioners, Victim Support Services, domestic violence support, was lacking.

Discussion

Review of case material identified that many of the consumers had been clearly displaying behaviour changes in the lead up to the event, and / or suffering from a crisis event. For



Category 2 perpetrators, there appears to be a lack of mental health literacy amongst the community and a lack of knowledge of how to access services. It has been suggested that the general improvement in mental health literacy is more apparent in high prevalence disorders such as anxiety and depression than it is in the schizophrenia spectrum disorders experienced by most

consumers in this review. Another important finding in regard to access was that there were considerable difficulties with appropriate communication between the public and private sectors where a consumer was engaged with both sectors during an episode of care.

Recommendations

57 A whole of government strategy aimed at enhancing mental health literacy and access to support services with a focus on referral pathways and access to public mental health services would have beneficial effects for the management of all cases within scope of the Review.

6.9 The Queensland Police Service

Findings

No findings have been made regarding the provision of mental health services to those who died as a result of police use of force intervention (Category 4 cases). Examination of the information provided identified that in each case the victim either had no involvement with Queensland mental health services or where they did, there were no immediate concern regarding the appropriateness and competency of the mental health treatment provided.



Our review of those matters did not raise particular concerns about any way in which mental health services could have been provided in a manner to reduce the likelihood of the death of the

individuals [REDACTED]

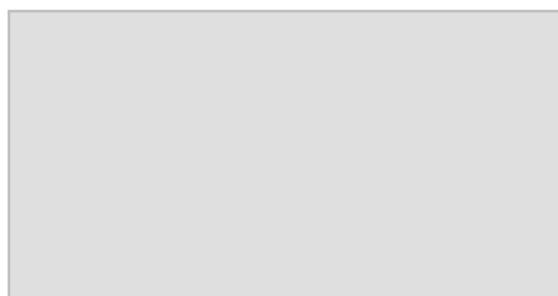
Consistent with other findings of the Review, opportunities for improvement were identified in information sharing and collaboration as well as in level of specialist forensic mental health support.

Discussion

Consistent with other findings of the Review, opportunities for improvement were identified in information sharing and collaboration as well as in level of specialist forensic mental health support.

Transfer of information between the QPS and mental health services is vital, especially on the occasions when a person is brought to emergency departments for assessment and treatment in a crisis situation. At the time of the transfer the QPS will be in possession of important and necessary information including presentation of the person and information provided by the person and family members or witnesses. The QPS may have further rich information on the person from within their records system, QPRIME, which includes previous criminal history, behavioural history and call out notes. A process should be established that includes prompts for the QPS to provide this collateral information, particularly regarding violence or other risk, at the time of presentation to a Queensland Health service.

Crisis Intervention Plans (CIP) are prepared with the consumer to assist the QAS and the QPS to achieve improved outcomes in the management of people with a mental illness who present in crisis. These plans are currently being reviewed and Queensland Health advised feedback from the stakeholder parties to the plan review is that their utility will be greatly enhanced.

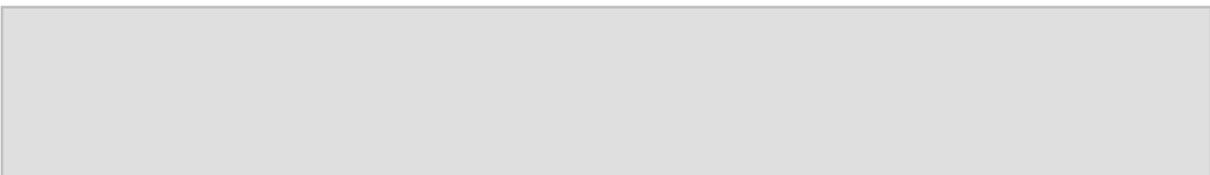


Feedback [REDACTED] included frustrations over the perceived revolving door situation with persons being taken to emergency departments for detention and treatment due to a suspected mental illness episode and the person being released back into the community within a short period of time. Improved understanding and knowledge of mental illness and the ability to detain a person under the MHA 2000 will help address [REDACTED] perceptions of the revolving door syndrome. This would include communication protocols for mental health services to advise the QPS when a person brought in for treatment is permitted to leave.

Following on from the earlier commentary regarding sharing information between mental health services and relevant persons, improved understanding between clinicians and the QPS on information sharing will improve access to and availability of information from each, in turn improving outcomes for the consumer and the community. The co-responder model currently used by the Police Communications Centre (PCC) supports this by having two mental health clinicians co-located on site to review CIMHA for any records and to be able to provide advice on incidents potentially involving a person in a mental health crisis.

Advice to the Review Committee was that Queensland Health is currently undertaking an evaluation of the PCC co-responder model. It is hoped the model is supported in the evaluation and an outcome that Queensland Health give serious consideration to expanding the model to have mental health cover 24 hours, seven days a week.

The Review Committee would like to acknowledge the quality of existing collaboration, initiatives and practices such as the MHIC program, individual CIPs, the MOU on information sharing, the co-location of mental health clinicians within the PCC and the co-responder models (for more details see section 3.4).



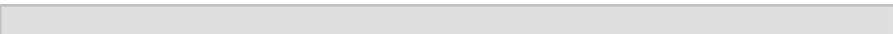
Recommendations

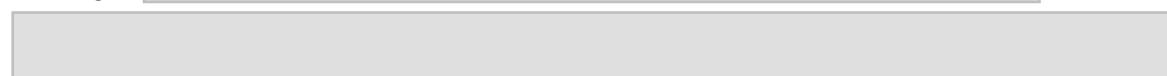
- 58 Establish communication protocols between mental health services and the Queensland Police Service to advise of changes in care status (including discharge from care) for those consumers who were brought to emergency departments by the Queensland Police Service.
- 59 Update training in mental health for Queensland Police Services to include de-escalation techniques for persons presenting in mental health crisis, understanding the difference between mental illness and being affected by substance use and knowledge of criteria for detaining a person involuntarily under mental health legislation.
- 60 Retain the co-responder model where mental health clinicians are available within the Police Communications Centre to provide support and access to necessary information to assist in managing police matters where the individual appears to be affected by mental illness. The services should be expanded to offer 24-hour coverage, as required.

6.10 Aboriginal and Torres Strait Islander peoples mental health and social and emotional wellbeing

Findings

Aboriginal and Torres Strait Islander peoples were not over-represented within the events reviewed. The Review Committee did not identify any specific findings in relation to the provision of mental health care for these individuals and is therefore not able to provide any systemic recommendations. This of course does not mean that there are not important considerations for mental health services for Aboriginal and Torres Strait Islander people, rather that they are not over-represented in the cases reviewed and, therefore, do not warrant specific comment within the scope of the present review.

During the course of consultation, information was provided to the Review Committee relating to 



 As this information did not relate to the assessment, treatment and care of an individual with the mental illness it fell outside the scope of the Review.

Reflecting on the differences in smaller communities including access to services, the Review Committee concluded that the important information obtained should be recorded for further consideration by Queensland Health.

Discussion

The Indigenous population rate in Queensland is 3.6 per cent⁶⁰.

Review of the national AIC data (Figures 10 and 11 below) portray a decreasing trend nationally in rates of homicide, in both Indigenous and non-Indigenous populations. The rate of representation of Indigenous persons within the perpetrator population has remained constant around 18 per cent. Compared to these rates, the number of Indigenous persons in the cases under review was moderate and did not warrant further investigation or comment.

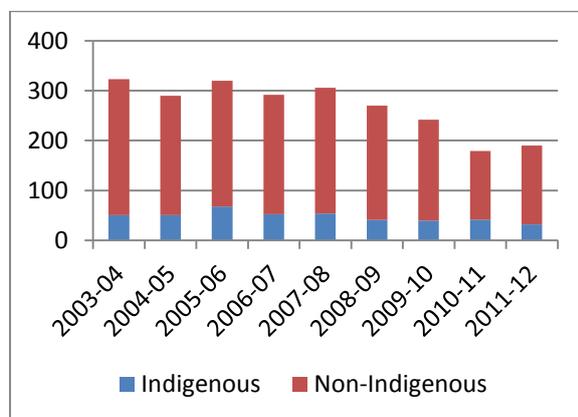


Figure 10 Indigenous status of offender in numbers (Australia)

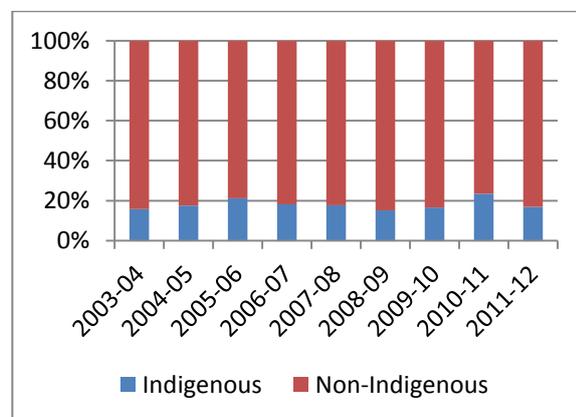


Figure 11 Indigenous status of offender as % of total offenders (Australia)

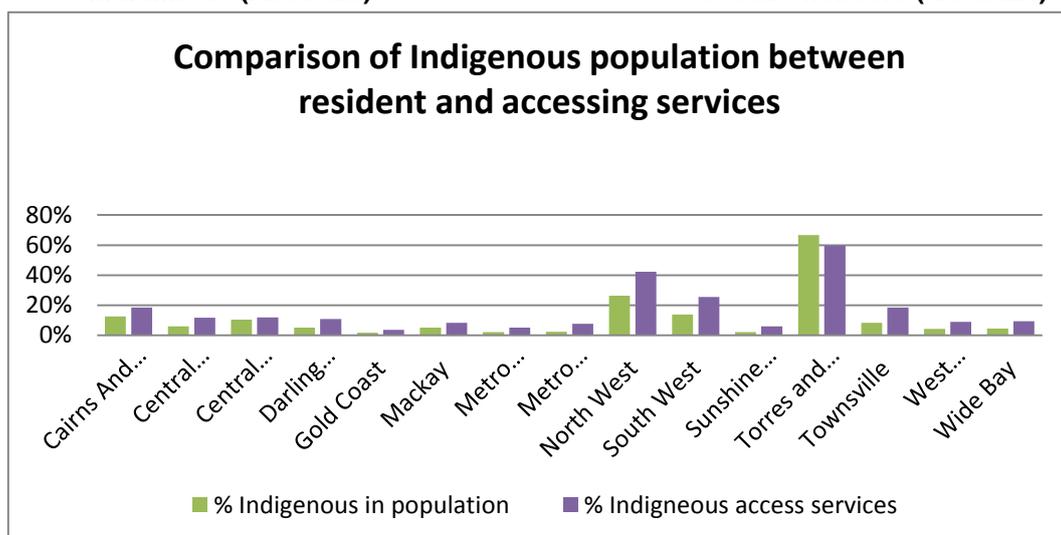


Figure 12 Comparing Indigenous population rates to Indigenous population accessing mental health services in Queensland

⁶⁰ Queensland Health Annual Report

Considerations

As discussed above in the Findings section,

There should be further consideration of this or a similar model of locating within a community health services hub, a service which provides support and advice across all forms of social and emotional wellbeing including housing, employment, health, mental health, and community support within targeted areas where there are high levels of social economic disadvantage and separation from family and support. Models considered would need to be attuned to the cultural requirements and different needs and available resources within regional, remote and urban areas. Consideration also needs to be given to increasing mental health literacy among Aboriginal and Torres Strait Islander communities to help enhance access when services may be required. A component of the plan would address mental health training requirements for the Indigenous Health Workers workforce to provide support to families in crisis after such events.

The need for a holistic perspective to health and wellbeing, local literacy on mental health issues, and engagement with the community to improve access to services was highlighted. Part of these discussions focussed on the need for community engagement and the factors needed to sustain engagement such as continuity of staff, both mental health clinicians and Indigenous Health Workers; the need to involve families more; the importance of following up with individuals when they are doing well to reinforce the progress of recovery and develop meaningful relationships over time which would increase the likelihood of the individual re-engage with the service if needed.

It is essential to learn from positive models introduced by Indigenous Health Organisations and to engage in real collaboration on the planning for and implementation of services to better meet the social and emotional wellbeing and mental health needs of Indigenous peoples.

6.11 Mental health quality assurance

Findings

Overall, the clinical documentation reviewed by the Review Committee was often considered poor due to being incomplete or lacked the necessary detail within mandatory fields. At times it was difficult to determine the qualifications of the staff member completing the forms (in hard copy), or whether the contents and formulation had been reviewed and endorsed by a more senior clinician.

The Hospital and Health Services (HHS) policies, protocols and procedures reviewed demonstrate that the Achieving Balance recommendations and Queensland Health guidelines had been adopted locally. However, examination of the materials within

consumers' files indicated local processes and policies had not been consistently translated into standard practice.

Likewise, there were inconsistencies and gaps in processes across HHS and some disconnect when consumers were transferring between services.

Discussion

Consistently in this review the Review Committee has been concerned with the level of detail and quality of the documentation contained within the consumer's records. This has ranged from missing information, inappropriate use of forms and missing forms. Also of concern has been the difficulty in identifying the level of senior input or supervisory review of the recommendations and formulations contained within comprehensive assessments, risk assessments and treatment planning.

Of greater concern is the apparent lack of implementation of the Achieving Balance recommendations into standard practice observed in these particular cases. The recommendations made within this report have been to assist more robust and continuous application of local policies and processes.

One gap identified was the levels of quality assurance that have occurred to ensure policies and practices are being applied consistently and uniformly. This gap applies equally to practices, training, supervision and overall reporting of forensic mental health service matters.

The creation of a state-wide mental health Quality Assurance Committee (QAC) would improve the safety and quality of mental health services, through the assessment and evaluation of the quality of health services delivered; the regular review of sentinel events, the reporting and making of recommendations concerning those services; and monitoring the implementation of its recommendations. This would result in improved quality of mental health care provided to the community, and an increased emphasis on quality assurance processes.

Recommendations

- 61 Create a state-wide mental health Quality Assurance Committee to oversee the safety and quality of mental health services through formal assessment and evaluation processes.
- 62 Include within the remit of a Quality Assurance Committee the review of homicides and other serious acts of violence committed by or on consumers of public mental health services.
- 63 Include within the remit of a Quality Assurance Committee an oversight role in monitoring the regularity and suitability of care reviews and summaries of consumers identified as at a Category 3 risk of violence.

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Appendices

Appendix 1 – Membership of sentinel event review committee

Clinical Reviewers appointed under s. 125 of the *Hospital and Health Boards Act 2011*

- **Professor James Ogloff AM** trained as a lawyer and psychologist and has worked in clinical and forensic psychology for 30 years. Professor Ogloff has specific expertise in forensic psychology, forensic mental health, mental health law, and the assessment and management of offenders. He is the Foundation Professor of Forensic Behavioural Science at Swinburne University of Technology and Director of Psychological Services and Research at the Victorian Institute of Forensic Mental Health.
- **Associate Professor Peter Burnett** is a psychiatrist of 30 years' experience, a Fellow of the Royal Australian and New Zealand College of Psychiatrists, and the Director of Clinical Governance, North Western Mental Health, Victoria. He has experience in serious incident reviews and system issues in patient safety.
- **Dr Fiona Hawthorne** is a PhD, and Churchill Fellow, with more than 30 years' experience in the Queensland health sector. She has taught clinical communication; healthcare ethics; and adverse incident analysis in tertiary settings. Fiona has also worked as a Clinical Ethicist at a large tertiary hospital. Fiona has expertise in patient safety, adverse incident management and analysis; quality and systems analyses; and was previously employed within the Patient Safety Unit, Department of Health. Fiona is the General Manager, of Hummingbird House, Wesley Mission Brisbane.
- **Ms Melissa Homan** is a credentialed mental health nurse with 30 years' experience in forensic, public sector and private sector psychiatric nursing and is currently employed within the mental health Acute Care Team, Sunshine Coast Hospital and Health Service.

- **Ms Jackie Bartlett** was appointed as Manager of the Sentinel Events Review Team in August 2015. Ms Bartlett trained as a nurse and psychologist, and has experience in mental health strategic policy and clinical governance. She has worked within the Mental Health Alcohol and Other Drugs Branch, Department of Health since 2008. Ms Bartlett's role on the Review Committee is to allow management direction to the Review Team.
- **Ms Janet Martin** was appointed as a Clinical Reviewer from 1 April 2016 to support the Review Team in the final stages of the preparation of the report due to unforeseen circumstances resulting in Ms Bartlett being unavailable to finalise the report. Ms Martin trained as an Occupational Therapist and has qualifications in business administration. She has experience as a mental health clinician, service manager, and with leading the development of mental health strategic policy and clinical governance. Ms Martin has worked within the Mental Health Alcohol and Other Drugs Branch, Department of Health since 2000. Ms Martin's role was to provide management direction to the Review Team.

Advisor to the clinical reviewers

- **Ms Catherine Roper** is a Consumer Academic, Centre for Psychiatric Nursing, University of Melbourne, Victoria. As a person with a lived experience of mental illness Ms Roper's expertise is well recognised, and she continues to develop her reputation not only within Victoria but also throughout Australia. Ms Roper has co-authored many articles, journals and books and presented at the 10th National Seclusion and Restraint Reduction Forum in May 2015.

Appendix 2 – Sentinel events review terms of reference

1. Purpose

- 1.1. The purpose of the Clinical Review is to conduct a state-wide review of sentinel events involving individuals with a mental illness to assess the standard and quality of clinical assessment, treatment and care provided to those individuals by a public sector health service, and compliance with relevant clinical and administrative policies and procedures.
- 1.2. For the purposes of the Clinical Review:
 - (a) 'sentinel event' is exhaustively defined in '3. Scope of the Clinical Review' of these Terms of Reference; and
 - (b) 'public sector health service' has the same meaning as in Schedule 2 of the *Hospital and Health Boards Act 2011* (HHB Act 2011), which defines it as meaning, among other things, a health service provided by a Hospital and Health Service or Queensland Health (the department).

2. Appointment

- 2.1. Pursuant to sections 124(a) and 125(1) of the HHB Act 2011, following my assessment that the appointee has the necessary expertise and experience, I have appointed _____ as a Clinical Reviewer to conduct the Clinical Review.
- 2.2. _____ is to consider the matters outlined under '3. Scope of the Clinical Review' and work collaboratively with any other appointed clinical reviewer (as appropriate) in preparing a joint report containing expert clinical advice in accordance with section 135 of the HHB Act 2011.
- 2.3. The Terms and Conditions of the indemnity provided to _____ are detailed in Attachment 1 Instrument of Indemnity.

3. Scope of the Clinical Review

- 3.1. _____ is to undertake the Clinical Review in respect of the following types of sentinel events that occurred in the period 1 January 2013 to 30 April 2015:
 - (a) incidents where a person receiving a Queensland public sector mental health service is involved in an event that results in the death or significant injury of a person, and could reasonably result in the charge of murder or attempted murder
 - (b) incidents where a person is admitted to a Queensland public sector mental health service for assessment and/or treatment of mental illness subsequent to an event that results in the death or significant injury of another person, where the event could reasonably result in the charge of murder or attempted murder and where the admission occurs within within two months of the event
 - (c) the homicide of a person receiving Queensland public sector mental health services
 - (d) incidents involving police use of force intervention that result in the death of a person with a known or suspected mental illness.
- 3.2. With respect to the sentinel events specified in paragraphs 3.1(a)-(d) of these Terms of Reference, the Clinical Review will consider the standard and quality of clinical assessment, treatment and care provided to the person receiving a Queensland public sector mental health service. If uncertainty arises as to whether a particular event is within these Terms of Reference, the Clinical Reviewer may consult with the Chief

Psychiatrist, Queensland Health, in making a decision in collaboration with any other appointed Clinical Reviewer bound by these Terms of Reference.

3.3. Further to '5. Conduct of the Clinical Review' in these Terms of Reference, the Clinical Review process will include:

- (a) examination of documentation relating to an individual matter including clinical files and electronic records, independent expert clinical reports, and internal and external incident review or investigation reports;
- (b) examination of relevant local and state-wide policy, guidelines and protocols relating to the treatment and care of people with mental illness, and safety and quality in mental health service delivery;
- (c) conducting visits and/or inspections of selected mental health services;
- (d) consultation with key stakeholders including consumer and carer representatives, health service providers, relevant statutory entities (e.g. Director of Mental Health, Mental Health Review Tribunal), departmental officers, other government agencies, and community organisations;
- (e) the co-opting of a person with lived experience of mental health services either as a consumer, carer or peer worker. The participation of this person (or these persons) will form an integral part of the clinical review. The critical contribution of wisdom and expertise gained through lived experience to the development of mental health policy and services is well recognised and articulated within:
 - i. appointments to National, state and territories Mental Health Commissions
 - ii. a key principle of the *National Standards for Mental Health Services 2010*, 'participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services;
 - iii. the *national framework for recovery-oriented mental health services* (Australian Health Ministers' Advisory Council 2013);
- (f) as and when determined appropriate by the Clinical Reviewer; and after obtaining my prior approval before incurring any expenses in this regard the co-opting of
 - i. specialist clinical, clinical governance or human resource management expertise or opinion, or administrative, information technology or other assistance where necessary in accordance with section 132(3)(a) of the HHB Act;
 - ii. The expertise or opinion of a person or persons with experience in matters of cultural significance in the delivery of mental health services, including Aboriginal and Torres Strait Islander culture and practices.

3.4. The Clinical Reviewer will:

- (a) consider the recommendations of the report, *Achieving Balance – A review of systemic issues within Queensland Mental Health Services 2002-2003*, and the extent to which the recommendations have been implemented, and the related outcomes achieved for public sector mental health services;
- (b) make findings and recommendations on systemic matters relating to the sentinel events specified in paragraphs 3.1(a)-(d) of these Terms of Reference to inform strategic directions, policy and clinical practice, with a view to improving the care of people with mental illness, and to minimise or prevent the recurrence of such events;

- (c) submit a draft, joint Clinical Review report to me no later than 14 days prior to the due date for the joint report; and
- (d) provide a joint Clinical Review report on key issues, findings and recommendations to me by 31 January 2016, and an interim report on progress and significant findings to date, regarding the matters listed above in '3. Scope of the Clinical Review' by 31 October 2015.

4. Powers of the Clinical Reviewer

- 4.1. The Clinical Reviewer has the authority under section 129 of the HHB Act 2011 to enter a public sector health service and to access, copy and take extracts from any document (including documents that contain confidential information) that is relevant to the Clinical Reviewer's functions and is in the possession or control of an employee of Queensland Health or a public sector health service.
- 4.2. The Clinical Reviewer should make every reasonable effort to obtain any other material or documentation that is relevant to these terms of reference.

5. Conduct of the Clinical Review

- 5.1. The Clinical Reviewer is to make clear to any person who provides information to the Clinical Reviewer that they have been appointed as an independent Clinical Reviewer, having no conflict or perceived conflict in respect of the matters under review.
- 5.2. The Clinical Reviewer is to be aware of and comply at all times with the provisions of Part 6 Division 3 of the HHB Act 2011 which govern the undertaking of the Clinical Review, including the duty of confidentiality, requirements regarding stopping of a Clinical Review and the protection for Clinical Review reports.
- 5.3. With the prior notification to, and facilitation by the Director-General, the Clinical Reviewer has the authority to:
 - (a) interview any person who may be able to provide information which directly assists in the Clinical Review. The Clinical Reviewer may seek to interview persons who are not employees of Queensland Health or Hospital and Health Services who may be able to directly assist in the Clinical Review. The Clinical Reviewer needs only interview persons who can provide information that they believe is credible, relevant and significant to the matters under review; and
 - (b) give any appropriate lawful directions which may be required during the review. For example, to provide a lawful direction to an employee to maintain confidentiality, to attend an interview, or to provide copies of documents maintained by Queensland Health or the Hospital and Health Service. The Clinical Reviewer will inform me of any failure to comply with a direction and I will advise regarding the approach that will be taken.
- 5.4. The Clinical Reviewer must provide persons with the opportunity to respond verbally and/or in writing to the specific matters under review where the person may be able to provide information which directly assists in the matters set out in '3. Scope of the Clinical Review', and likely to be credible, relevant and significant to the matters under review.
- 5.5. The report prepared in accordance with section 135 of the HHB Act 2011 should specifically address the matters outlined above. The Clinical Reviewer is to provide in the body of the joint report, their assessment and reasons for conclusions. Any inferences, derived from hearsay, will be clearly identified.
- 5.6. A summary of evidence relied upon by the Clinical Reviewer to make a recommendation is to be referred to in the joint report.

- 5.7. The names of persons providing information to the Clinical Reviewer and any patient or staff names must be kept confidential and referred to in a de-identified form in the body of the report (with a legend confirming the identity of those persons to be provided by way of attachment), unless the identification of the person is essential to ensure that natural justice is afforded to any particular person.
- 5.8. Legal advice may be obtained by the Clinical Reviewer at the arrangement and cost of Queensland Health in accordance with section 132(3)(a) of the HHB Act 2011.
- 5.9. The Clinical Reviewer is to provide within seven days (or as otherwise agreed) of receiving the appointment and these Terms of Reference confirmation in writing of an ability to meet the timeframes for the conduct of the Clinical Review, including the due date for the joint report.
- 5.10. The Clinical Reviewer is to notify me about the progress of the review at regular intervals, as will be agreed following the submission of the Clinical Review plan.
- 5.11. Any request for an extension of the due date for the Clinical Review report being provided under section 135 of the HHB Act 2011 is to be in writing at least seven days before the due date, with supporting reasons.
- 5.12. The Clinical Reviewer's professional rate for the Clinical Review will be _____ per hour (maximum \$_____per day).
- 5.13. Out-of-pocket expenses incurred in the undertaking of the Clinical Review will be reimbursed by Queensland Health in accordance with *Public Service Directive 9/11 Domestic Travelling and Relieving Expenses* (or any replacement Directive as in force from time to time). The Clinical Reviewer will be required to forward a copy of all tax invoices in this regard to the attention of the Sentinel Event Review Team, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch at_____. Please retain original invoices in the event that they are required to be submitted.
- 5.14. All other travel arrangements will be made through the Sentinel Event Review Team. The contact for the Clinical Reviewer in this respect will be the Project Officer, Sentinel Event Review Team, at the above email or on (07) _____.
- 5.15. If necessary, the Clinical Reviewer should report back to me (or other person nominated by me) for further instructions during the course of the Clinical Review.

Appendix 3 – Sentinel events review committee operational guidelines

1. Purpose

The purpose of Sentinel Events Review Committee (SERC) is to undertake a Clinical Review, conducted pursuant to the clinical review provisions in Part 6 Division 3 of the *Health and Hospital Boards Act 2011* (HHB Act), of state-wide sentinel events involving individuals with a mental illness to assess the standard and quality of clinical assessment, treatment and care provided to those individuals by a public sector health service, and compliance with relevant clinical and administrative policies and procedures.

- 1.1. The Clinical Review will examine the following types of sentinel events that occurred in the period 1 January 2013 to 30 April 2015:
 - (a) a person receiving a public mental health service at the time of an event that could reasonably result in their being charged with murder or attempted murder (including where charges are not pursued as the person is deceased)
 - (b) a person is referred or admitted to a public mental health service for assessment and/or treatment within two months following an event which could reasonably result in their being charged with murder or attempted murder
 - (c) the murder of a person who was receiving a public mental health service at the time of their death
 - (d) fatalities involving police use of force intervention of a person with a known or suspected mental illness; and
 - (e) consider the recommendations of the report, *Achieving Balance – A review of systemic issues within Queensland Mental Health Services 2002-2003*, which are relevant to the scope of the current Clinical Review, and consider the extent to which the recommendations have been implemented, and the related outcomes achieved for Queensland public sector mental health services.
- 1.2. The SERC will make findings and recommendations on systemic matters relating to the sentinel events specified to inform strategic directions, policy and clinical practice, with a view to improving the care of people with mental illness, and to minimise or prevent the recurrence of such events.

2. Responsibilities

- 2.1 Members of the SERC are to be aware of and comply at all times with the provisions of Part 6 Division 3 of the HHB Act 2011 which govern the undertaking of the Clinical Review, including the duty of confidentiality, requirements regarding the cessation of a Clinical Review and the protection for Clinical Review reports.
- 2.2 Submit an interim report on progress and significant findings to date to the Director-General by the 31 October 2015.
- 2.3 Provide a joint Clinical Review report on key issues, findings and recommendations to the Director-General by the 29 April 2016. NB: a draft of the report must be submitted to the Director-General no later than 14 days prior to the due date.

3. Membership

- 3.1 Membership is comprised of the following:
 - Associate Professor Peter Burnett, psychiatric expertise

- Professor Jim Ogloff AM, law and mental health expertise
- Dr Fiona Hawthorne, patient safety expertise
- Ms Melissa Homan, nursing expertise
- Ms Jackie Bartlett, Manager, Sentinel Events Review Team
- Ms Cath Roper, person with a lived experience of mental illness, via the University of Melbourne.

3.2 **Guests** may be co-opted to the SERC to provide where necessary specialist expertise or opinion on clinical, clinical governance, cultural including Aboriginal and Torres Strait Islander culture and practices, human resource management, administrative, or information technology matters.

3.3 **The term of membership** will be for the duration of the review with the final report due to the Director-General Queensland Health 29 April 2016.

3.4 **Non-member participants:**

- Ms Jenene Tull, Project Officer, Secretariat, Sentinel Event Review Team, Office of the Chief Psychiatrist
- Ms Joanna Cull, Principal Policy Officer, Sentinel Event Review Team, Office of the Chief Psychiatrist.

3.5 **Role of membership**

To achieve its objectives the SERC will:

- examine documentation relating to an individual matter including clinical files and electronic records, independent expert clinical reports, and internal and external incident review or investigation reports
- examine relevant local and state-wide policy, guidelines and protocols relating to the treatment and care of people with mental illness, and safety and quality in mental health service delivery
- conduct visits and/or inspections of selected mental health services
- consult with key stakeholders including consumer and carer representatives, health service providers, relevant statutory entities (e.g. Director of Mental Health), departmental officers, other government agencies, and community organisations.

3.6 **Principles of consultation**

- consultations undertaken will be consistent with the overarching purpose of the Clinical Review
- key stakeholders and other informants identified will be able to provide information representative of broader view points such as state-wide, regional and/or local systemic matters
- consideration will be given to the acceptance of written submissions by individuals if deemed appropriate to further the work of the Clinical Review.

4. Governance and meeting particulars

The SERC is accountable to the Director-General of Queensland Health. Co-Chaired by Professor Ogloff and Associate Professor Burnett, the SERC is supported by a secretariat, the Sentinel Event Review Team (SERT), established within the Office of the Chief Psychiatrist, Department of Health.

4.1 **Decision making process**

A quorum for SERC meetings requires 50% plus one of the membership.

Recommendations and advice will be made by consensus by members. Where consensus is not reached, the Committee will consider action that can be taken to facilitate reaching a consensus (e.g. further consultation with a stakeholder group, or Queensland Health Chief Psychiatrist). In determining whether further action will proceed, the SERC will take account the significance of the issue and the need to progress business in a timely manner.

Where final consensus is not achieved, the recommendation/advice of the SERC will reflect the majority view. Where the determination results in a recommendation to a decision maker (e.g. the Director-General) the dissenting view/s will, as far as practicable, be identified. In such circumstances it is at the discretion of the holder/s of the dissenting view whether they wish to be personally identified. All members will have appropriate regard for the majority view. Where members are equally divided on recommendations/advice, the Co-Chairs will have the casting vote.

4.2 Proxies

Not allowed, each member has been appointed by the Director-General for their specific expertise.

4.3 Meeting frequency

Meetings will be held in Brisbane as outlined in the Clinical Review Plan, but may be scheduled more frequently by agreement of the membership to enable timely completion of the SERCs business. It is expected that work will be progressed out-of-session by the Co-Chairs. Papers will be circulated to members for feedback by a specified date. In these circumstances, the Co-Chairs will determine the final position based upon members feedback.

4.4 Clinical Review Plan

A Clinical Review Plan will be developed and submitted to the Director-General including confirmation of an ability to meet the time frames for the conduct of the Clinical Review. Updates on the progress of the review are to be provided to the Director-General, determined after the submission of the Clinical Review Plan.

4.5 Roles and responsibilities of the Secretariat

The Secretariat will:

- prepare and distribute agendas, agenda papers, minutes and arrange meetings
- support the Co-Chairs in managing the business of the SERC including preparation notes and follow up actions arising
- coordinate/prepare background information and briefings for agenda items as required
- compile correspondence, reports, data and submissions as required
- facilitate effective and productive working relationships and communication between the SERC and key stakeholders
- maintain administrative aspects of the SERC including the Clinical Review Plan and Terms of Reference.

4.6 Documentation from the Secretariat

Members of the SERT and secretariat will document minutes of meetings, compile correspondence, reports, data and submissions, and updates in draft form and distribute to members for feedback and endorsement. Members will provide feedback in a timely manner to allow time for corrections and re-distribution to the SERC for confirmation (either via track changes or a notation/comment is made to allow members to easily see what amendments have occurred) and the document is then finalised. It would be expected that requests for amendments raised by members, particularly in relation to their own work product, would be

accepted. Should there be a difference of opinion regarding the report content or recommendations the decision making process outlined above will apply.

4.7 Confidentiality

Proceedings and records of the SERC will not be publically available they are accessible via Right to Information requests under Queensland Legislation. However, information may from time to time be given by members or participants in confidence. Where the Co-Chairs identify that information is of a confidential nature, that information will not be minuted and members will respect the confidential nature of the information.

4.8 Review of the SERC Operational Guidelines

Amendments to the Operational Guidelines may be requested by the Co-Chairs at any time throughout the course of the Clinical Review. A quality review process needs to be dynamic and responsive to emergent information to ensure the purpose of the Clinical Review is achieved.

Appendix 4 – Consultation and engagement

| Date of consultation | Location | Stakeholder organisation | Stakeholder representatives |
|----------------------|----------|--|-----------------------------|
| 17 December 2015 | Herston | Victim Support Services | |
| 17 December 2015 | Herston | Queensland Voice for Mental Health | |
| 17 December 2015 | Brisbane | Office for Women and Domestic Violence Reform, Department of Communities, Child Safety and Disability Services | |
| 17 December 2015 | Herston | Mental Health Carers Arafmi Queensland | |
| 17 December 2015 | | | |
| 17 December 2015 | | | |
| 17 December 2015 | | | |

| Date of consultation | Location | Stakeholder organisation | Stakeholder representatives |
|----------------------|----------|-------------------------------------|-----------------------------|
| 17 December 2015 | | | |
| 18 December 2015 | Brisbane | Queensland Police Service | |
| 18 December 2015 | Brisbane | Queensland Mental Health Commission | |
| 18 December 2015 | Herston | Queensland Forensic Mental Health | |
| 18 December 2015 | Brisbane | Queensland State Coroner | |
| 20 January 2016 | | | |
| 20 January 2016 | | | |
| 20 January 2016 | | | |
| 1 February | | | |

Appendix 5 – Submissions and responses to call for submissions

This appendix provides a list of verbal and written submission received in response to targeted call for submissions from affected families and interested parties

- Name Withheld – [REDACTED]
- State-wide Forensic Mental Health Service
- Office of the Health Ombudsman
- Mental Health Carers Arafmi Queensland
- Mental Health Court
- Queensland Mental Health Commission
- Office of the State Coroner
- Queensland Police Service
- Office for Women and Domestic Violence Reform, Department of Communities, Child Safety and Disability Services
- Victims Support Service
- The Voice for Mental Health

Appendix 6 – Extract from Interim Report⁶¹

Part B: Implementation of the Achieving Balance report recommendations

8. Progress against the Achieving Balance Report

A requirement of the Terms of Reference (ToR) is that consideration be given to the recommendations of the report released in 2005 *Achieving Balance (A review of systemic issues within Queensland Mental Health Services 2002–03) March 2005* (the Achieving Balance Report) and the extent to which these recommendations have been implemented, and the related outcomes achieved for public mental health services.

Table 2 Key recommendations from Achieving Balance

Key recommendations:

- 1: A standardised process for mental health assessment, risk assessment and treatment
- 2: An integrated information system
- 3: Integrated responsibility for mental health and drug and alcohol treatment
- 4: Alternative models for delivery of emergency mental health assessment and treatment by emergency departments
- 5: Models to support General Practitioners
- 6: Removal of potential means of suicide within inpatient units
- 7: Ongoing monitoring of sentinel events
- 8: Increased staffing and bed resources
- 9: *Mental Health Act 2000* training and Mental Health Review Tribunal (MHRT) liaison.

On 26 October 2015 the Mental Health Alcohol and Other Drugs Branch (the MHAODB) provided the Review Committee with a report detailing implementation by the MHAODB of recommendations made in the Achieving Balance report.

The Achieving Balance review examined forty-five incidents that occurred from January 2002 to December 2003 involving:

- 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
- incidents involving police use of force intervention that resulted in the death of a person with a known or possible mental illness.

The Achieving Balance Report concluded that the extent and direction of mental health service reform in Queensland was appropriate however there were a number of systemic issues to be addressed.

⁶¹ Footnotes in this Appendix refer to Interim Report

Sixty recommendations and nine key recommendations for reform were made. These recommendations on systemic matters were made to inform Queensland Health strategic decisions, policy decisions and clinical practice, with a view to improving the care of people with a mental illness and decreasing mortality and morbidity.⁶²

The scope of the current Review is narrower than the Achieving Balance review as suicides and unexpected deaths of mental health consumers are not included. Therefore, some of the recommendations from the Achieving Balance Report and the Department of Health's subsequent response go to issues that are not directly relevant to the current Review (for example, recommendations regarding visual observation practices within inpatient units and structural works to reduce means of suicide). Broad consideration of all recommendations is warranted however as the essence of the recommendations was to improve the provision of mental health care to consumers, thereby preventing or minimising situations where a consumer experiences a crisis with potentially significant negative outcomes.

Before reporting on the implementation of these recommendations, it is important to note the changes to the landscape of the provision of health care from both federal and state led reforms since 2005. The passage of the *Hospital and Health Boards Act 2011* (HHB Act) resulted in the establishment of the Department of Health and what are now 16 Hospital and Health Services (HHSs). The decentralisation of authority to the HHSs was to enable the local delivery of health services to be tailored to meet the unique needs of each population and environment. The role of the Department of Health as system leader has led to a withdrawal of a large amount of policies and directives and a re-issuing of guidelines to support the delivery of best practice which HHSs are then able to amend to meet their own needs and implement through the issuing of policies, protocols and procedures. Throughout this report unless stated otherwise all documents referenced are guidelines.

The MHAODB, Clinical Excellence Division, Department of Health, is responsible for supporting the state-wide development, delivery and enhancement of safe, quality, evidence-based clinical and non-clinical services in the specialist areas of mental health and alcohol and other drugs treatment.

The Director-General Queensland Health was advised in September 2011 that implementation of all 60 recommendations and the nine key recommendations had occurred. Significant achievements during this period are set out below. Work has been ongoing since 2011, as is also set out below

8.1. Key Recommendation 1: A standardised process for mental health assessment, risk assessment and treatment

- Develop a core state-wide standardised process 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.

This recommendation was founded on the basis of an absence of a consistent approach to assessment and treatment resulting in varied and sometimes inadequate standards of clinical practice and the consequential implications for consumers and the community.

⁶² The Achieving Balance Report p. 37

8.1.1. Key achievements

- A state-wide standardised suite of clinical documentation (SSCD) was implemented in 2008 which includes forms to assist clinicians in the mental health assessment, risk assessment and treatment planning for consumers, including processes in relation to the management of non-compliance with treatment. A review of the SSCD was undertaken in 2012. Please refer to key achievements set out below under Key Recommendation 9 for strategies to address non-compliance with treatment for consumers under the *Mental Health Act 2000*.
- The then Patient Safety Centre undertook the implementation and provision of training regarding the SSCD and the Queensland Centre for Mental Health Learning (QCMHL) developed education and training modules of the forms and processes⁶³.
- The QCMHL provides free training to all Queensland Health staff on a variety of mental health subjects in both workshop and e-learning format via the Mental Health Professional Online Development. Examples of courses available include; mental state examination, suicide risk assessment and management, critical components of risk assessment, capacity assessment and case management. Where applicable the courses include education on the appropriate use of the corresponding document from the SSCD.
- The Queensland Health Clinical Supervision Policy Framework for Mental Health Services 2009 provided a standardised state-wide approach to clinical supervision for mental health professionals. Clinical supervision is essential to the personal and professional development of mental health clinicians and complements more structured training and e-Learning opportunities. Clinical supervision is one aspect of a wider framework of clinical governance activities that are designed to support staff and manage and monitor the delivery of high quality services and effective outcomes for mental health consumers.

8.1.2. Outcomes

- The SSCD, the availability of comprehensive training from the QCMHL and implementation of clinical supervision guidelines, combined with the introduction of the Consumer Integrated Mental Health Application (CIMHA)⁶⁴ has increased the capacity for mental health staff to undertake consistent high quality mental health assessments, risk assessments, treatment and management plans of mental health consumers.

8.1.3. Current activities

- A review of the core seven forms⁶⁵ within the SSCD is scheduled for 2015-2016.
- A review of the Clinical supervision guidelines for mental health services 2009 is underway for 2015-2016.

⁶³ Summary Report – Implementation of the Nine Key Recommendations – verified against 2008 and 2022 reports and briefings in the *Achieving Balance Corporate File*.

⁶⁴ Discussed below in relation to key recommendation 2.

⁶⁵ The core seven forms are: Consumer Demographic Information, Consumer Intake, Child and Youth Consumer Assessment, Adult Consumer Assessment, Older Persons Consumer Assessment, Consumer Care Review Summary and Consumer End of Episode/Discharge Summary.

8.2. Key Recommendation 2: An integrated information system

- Give high priority to the development of an information system to ensure the access of emergency department and mental health staff across service districts, to timely, accurate information.

This recommendation arose out of concerns that clinicians were making significant assessment and management decisions without an ability to obtain comprehensive mental health and drug and alcohol use histories of consumers.

8.2.1. Key achievements

- The Consumer Integrated Mental Health Application (CIMHA), integrating three different applications (19 separate mental health data bases), was implemented in November 2008.
- CIMHA is a state-wide mental health electronic clinical record, supporting clinical service delivery across inpatient, community and residential settings and with mandatory reporting obligations and is accessible to public mental health clinicians at any Queensland Health facility in the state that the consumer may present to.
- CIMHA contains information regarding consumer demographics, alerts, diagnosis, relevant third parties, referrals and service episode information, interventions, clinical outcome measures, electronic clinical documentation, and is an electronic register for the *Mental Health Act 2000* (MH Act).
- From 2009 read only access to CIMHA was made available to emergency department staff and other areas of Queensland Health. This access was taken up, at varying levels, by a number of areas including emergency departments, alcohol and drug services, and child protection units.
- As of April 2015 mental health data from CIMHA is available in The Viewer, a state-wide application that provides a web-based view of patient information from speciality and clinical systems across Queensland Health.
- Access to The Viewer provides healthcare professionals, including those in administrative roles, with timely access to key alert notifications, demographics and encounter history. Clinicians also have access to additional information such as clinical notes, mental health assessment, care plans and discharge summaries.
- Whilst CIMHA does not directly interface to the Emergency Department Information System, the interface to The Viewer completes the implementation of Key Recommendation 2.

8.2.2. Outcomes

- The ability of CIMHA to provide a central point of access to consumer information and mental health history provides clinicians with access to relevant information that will enhance decision making regarding the assessment, treatment and management planning for mental health consumers.

8.2.3. Current activities

- CIMHA and the Viewer are regularly upgraded to improve functionality and compliance with the requirements of the MH Act.

8.3. Key Recommendation 3: Integrated responsibility for mental health and drug and alcohol treatment

- This recommendation referred to the transfer of responsibility for alcohol and drug treatment services to mental health services. This recommendation was amended to *'increase integration of mental health services and alcohol, tobacco and other drugs services'* in 2006 to align with Report of the Review of Queensland Mental Health Systems (the Forster Review).

This recommendation was made in the context of increased levels of aggression and violence and the complicated clinical pictures of individuals with a dual diagnosis; and also two prior inquiries⁶⁶ reinforcing the importance of provision of integrated treatment for people with a dual diagnosis. The term dual diagnosis refers to a co-occurring mental illness and substance use problem.

8.3.1. Key achievements

- In 2010 the Mental Health Directorate and the Alcohol and Other Drugs Treatment Strategy Unit amalgamated to become the now Mental Health Alcohol and Other Drugs Branch (MHAODB).
- Integration at an organisational level of mental health and alcohol and other drugs services.
- The Queensland Health Policy for Service Delivery for People with a Dual Diagnosis September 2008.
- The Queensland Plan for Mental Health 2007-2017 established 10 Dual Diagnosis Coordinators, and one state-wide Coordinator, to provide consultation, advice, support and leadership for staff within mental health and also alcohol and other drugs services working with individuals with a dual diagnosis.
- The Dual Diagnosis e-Learning package, Clinical Guidelines and Toolkit guide clinicians in the provision of safe, effective and holistic care for people with a dual diagnosis.
- Establishment of the Alcohol and Other Drugs Service Improvement Group in 2014 to provide expert clinical advice to guide the delivery of safe and quality alcohol and other drugs services through effective leadership, planning, communication and support.

8.3.2. Outcomes

The above achievements have led towards a more integrated service system response and support clinicians in the delivery of quality mental health and drug and alcohol services to consumers with dual diagnosis and associated complex clinical presentations.

8.3.3. Current activities

- Review of the Dual Diagnosis Clinical Guidelines and Tool Kit
- Development of an alcohol and other drugs (AOD) model of service⁶⁷

⁶⁶ (*Tracking Tragedy, NSW and Safety First UK*)

⁶⁷ Models of Service (MOS) are guidelines have been developed to inform and guide Queensland Mental Health Alcohol and Other Drugs services on recommended best practice and the care and functions required to encourage state-wide consistency in service delivery for each type of public mental health alcohol and other drugs services.

The MOS are intended as a resource to support development of local models of care identifying key elements that are essential for the effective operation of a particular type of mental health service.

- Identification of best practice principles for the integration of mental health and alcohol and other drugs services at all levels
- Development of standardised AOD performance indicators and outcome measures.

8.4. Key Recommendation 4: Explore alternative models for delivery of emergency mental health assessment and treatment by emergency departments

Observations that informed the recommendations in relation to provision of mental health care by emergency departments were:⁶⁸

- that emergency departments were often the gateway to mental health services, particularly during out of hours, with an increasing number of presentations involving individuals affected by drug and alcohol or with a dual diagnosis
- that the structure and design of some emergency departments were not adequate to meet the needs of mental health patients
- access by emergency staff to specialist advice from mental health patients was important.

A number of related recommendations were made⁶⁹ in addition to the Key Recommendation 4 including:

- formal ongoing liaison between senior staff of mental health services and emergency departments
- that mental health be regarded as core business by emergency department staff
- access to timely expert advice and consultation and expert training for emergency department staff.

8.4.1. Key achievements

- Publication of the Clinical Services Capability Framework version 3.0 (CSCF 3.0) in January 2011 standardised practices regarding mental health presentations in emergency departments.
- The Acute Care Team Model of Service (ACT MOS) developed by the MHAODB identifies the need to develop strong partnerships between mental health services and local emergency departments as a key element of best practice service provision.
- Access to CIMHA information by emergency department clinical staff since 2009 and CIMHA joining to The Viewer IT system in 2015 enabling emergency department clinicians to view mental health documentation in relation to people presenting to emergency departments.

8.4.2. Outcomes

The ACT MOS and the availability of consumer mental health information to emergency department staff have improved the capacity of emergency departments to provide a first line response to mental health consumers as core business.

There has been an increased emphasis on strong partnerships between mental health service staff and emergency department clinicians, for example through the ACT MOS. In

⁶⁸ The Achieving Balance Report pp 150-155

⁶⁹ Achieving Balance Report pp 155 - 156

reach by Acute Care Team staff to undertake assessments, and where necessary treatment, has resulted in enhanced informal and formal relations and shared learning opportunities. Some HHSs have established formal case review meetings to discuss individuals who present frequently.

The 2015 commitment by the Minister for Health and Minister for Ambulance Services to provide specialised training and resource packages, tailored for emergency department staff will further enhance responses to people presenting with mental health concerns.

8.4.3. Current activities

- The Mental Health Alcohol and Other Drugs Clinical Network is currently collecting and analysing data (including survey data) relating to the provision of acute mental health services in emergency departments. The ultimate aim is to identify best practice principles for the delivery of emergency mental health assessment and treatment to people with mental health problems presenting to emergency departments in the current context of health service delivery.
- A 2015 commitment has been made by the Minister for Health and Minister for Ambulance Services to provide specialised training and resource packages, tailored for emergency department staff regarding how to recognise and respond to suicidal patients. This commitment is articulated with the Queensland Suicide Prevention Act Plan 2015-17 under Priority Area 2 Improving service system responses and capacity (Queensland Mental Health Commission 2015).
- The Emergency Department Suicide Prevention Project is in progress and due to be completed by July 2016 and includes the:
 - development of Working with and Assisting the Suicidal Person (WASP) Guidelines
 - Suicide Prevention Project Resources for Queensland Health Emergency Departments
 - review of the Queensland Mental Illness Nursing Documents (MIND) Essentials resource to include a greater focus on suicide risk assessment and management.

8.5. Key Recommendation 5: Models to support General Practitioners (GPs) upon patients being discharged from mental health services⁷⁰

- Develop models for continuing support of general practitioners when patients with major mental illness are discharged from mental health services to their care.

This recommendation was made in the context of evidence that mental health consumers are particularly vulnerable following discharge from mental health services. The need for adequate community resources to care for individuals on leave from mental health services or following discharge was emphasised.

8.5.1. Key achievements:

A key element of each mental health Model of Service (MOS) is working with other service providers, including general practitioners. HHSs are responsible for the implementation of clinical services to meet the needs of people within their region. The intent of all models of service is that strong partnerships are initiated with other local health, mental health service

⁷⁰ In addition to being a key recommendation, this recommendation is also set out separately in *Achieving Balance* as recommendation 14 under the heading 'leave and discharge planning'.

providers, including primary care and non-clinical sector services. Furthermore, the MOS provide best practice guidelines for the process of access and referral and other essential elements to assist in the development of local models of care.

8.5.2. Outcomes

Whilst the manner in which this key recommendation is implemented by HHSs varies across the state, the MOS provide a framework that assists in the development of local models of care and facilitates strong partnerships with primary health care providers. This provides a framework for improved support for general practitioners upon patients being discharged into their care and enhanced continuity of care for individuals with mental illness.

8.6. Key Recommendation 6: Removal of potential means of suicide within inpatient units

- Wherever possible by implementing searching procedures in accordance with the *Mental Health Act 2000* (MH Act) and correcting potential structural factors in all inpatient mental health units and their immediate environment.

This recommendation was made in the context of suicides within hospital environments where materials used had been brought into the hospital by the consumer. Noting somewhat inconsistent approaches to searching it was recommended that:⁷¹

- mental health services develop and implement (or review) policies regarding searching of patients within the framework of the MH Act
- district mental health services review the environment, fittings and fixtures on their wards to identify and remove ligature points
- all acute mental health units have access to intensive mental health care beds in high dependency units
- the Guidelines for Operation of Mental Health High Dependency Units 2003 be revised.

8.6.1. Key achievements

- Funding was provided to the then 14 district mental health services for environmental amendments and all projects were completed by 31 December 2006.
- Clinical practice and other guidelines were developed by the MHAODB to assist inpatient units in managing suicide risk in their services. These are set out in the Clinical Resources list at the conclusion of this document.

8.6.2. Current activities

- Review of the Guidelines for Managing Ligature Risks in Mental Health Services (for completion 2016).
- Development of Safe Environment in Mental Health Inpatient Services (for completion 2016).

8.6.3. Outcomes

Hospital environments that were identified as problematic were restructured. Guidelines such as the management of ligature risks and inpatient design provide ongoing support to

⁷¹ The Achieving Balance pp128-131

Hospital and Health Services to develop inpatient environments that minimize the risk of suicide. Guidelines for undertaking searches provide for consistent and effective searches practices to reduce risk, respectful to the rights of patients and compliant with MH Act requirements.

8.7. Key Recommendation 7: Ongoing monitoring and analysis of sentinel mental health events at the corporate level

- 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 services.

The Achieving Balance Report noted that all deaths examined had been reviewed or investigated by the health service districts concerned, the type of investigation varied from a discussion between members of the relevant treating team and debriefing of members, to a full external investigation with formal recommendations.

The Achieving Balance Report also noted the introduction of a state-wide Incident Management Policy by Queensland Health in 2004, which recommended routine investigation of sentinel events using a root cause analysis procedure. It went on to recommend (recommendations 51 and 52) that:

- All future mental health sentinel events be investigated in accordance with Queensland Health's Incident Management Policy (with one participant on the team being external to the service), and
- Queensland Health establish an ongoing process for monitoring results of analysis of sentinel events in mental health at the corporate level to determine trends and communicate these to services.

8.7.1. Key achievements

- The following initiatives have been implemented by the Patient Safety and Quality Improvement Service (PSQIS) in collaboration with the Mental Health Alcohol and Other Drugs Branch (MHAODB):
 - Establishment of Patient Safety Officer positions to investigate and review adverse events and review sentinel events.
 - Publication of the Queensland Health Clinical Incident Management Standard.
 - Creation of a standardised state-wide approach to the management of suspected suicides of consumers from community mental health services.
 - Establishment of Mental Health Mortality Review Committees.
 - Publication of the Open Disclosure Standard.
- In July 2010 responsibility for the Mental Health Patient Safety portfolio was transferred to the MHAODB, since this time some capacity has been lost in both the PSQIS and the MHAODB due to several departmental restructures. Despite this, there is ongoing monitoring of a range of clinical incidents and the current 2015 Sentinel Events Review provides a further opportunity for review of incidents and mental health service systems on a state-wide basis.

- In addition, the *Mental Health Act 2000* Resource Guide requires that all clinical incidents (including a near miss, adverse event or sentinel event) involving forensic patients should be reported to the Director of Mental Health or Delegate without delay.
- On 18 June 2013 the Director-General issued Health Service Directive Patient Safety #QH-HSD-032:2013 under the *Hospital and Health Boards Act 2011* (HHB Act) for reporting Severity Assessment Code (SAC) 1 clinical incidents⁷²:
 - HHSs are to report all SAC 1 incidents to the PSQIS by recording the incident in PRIME-CI within one business day of becoming aware of the SAC 1 event.
 - HHSs are to submit an analysis of all SAC1 incidents to the PSQIS within 90 calendar days of the incident being reported as a SAC 1 event. Each SAC 1 analysis report must contain:
 - a factual description of the event
 - the factors identified as having contributed to the event
 - recommendations to prevent or reduce the likelihood of a similar event happening again
 - HHSs may decide what form of analysis is to be undertaken for a SAC1 incident. However if a root cause analysis is chosen the commissioning authority must give a copy of the report to the Director of Mental Health.

8.7.2. Current activities

- Current policies require that HHS provide copies of root cause analyses to Director of Mental Health, but not other forms of critical reviews. Meetings between the MHAODB and the PSQIS have commenced with a view to being involved in reviewing the analyses of all SAC 1 incidents.
- A further aim of this collaboration is to identify processes to:
 - support HHSs to enhance the frequency and quality of reporting of suspected suicides of a person receiving mental health care
 - support HHSs to undertake high quality analysis of SAC1 incidents
 - review the results of analyses of SAC1 incidents to inform state-wide quality and safety initiatives
 - examine the potential capacity for the proposed Queensland Integrated Safety Information System (which is expected to replace PRIME in 2015) to capture the factors associated with aggressive incidents.
- The MHAODB will liaise with the Australian Institute for Suicide Prevention and Research (AISRAP) regarding their capacity to provide a timely analysis of mental health clinical issues relating to suspected suicides in Queensland to inform state-wide quality and safety initiatives.
- The Queensland Government, through the Queensland Mental Health Commission, funds AISRAP to manage the Queensland Suicide Register (QSR). The QSR is a comprehensive database of suicide mortality. However neither the Department of Health nor the HHSs provide data to the QSR. Currently the confidentiality provisions of the HHB

⁷² A SAC1 incident is defined as 'death or likely permanent harm which is not reasonably expected as an outcome of healthcare'. A suspected suicide of a person receiving mental health care from a Hospital and Health Service (whether as an inpatient or in the community) is typically entered as a SAC1 incident in PRIME-CI.

Act restricts the provision of suicide mortality information to AISRAP, but preliminary advice from the Queensland Health Legal Branch indicates that the provision of confidential information to AISRAP for the purposes of the QSR may be possible under s. 160 of the HHB Act - Disclosure of confidential information in the public interest.

8.7.3. Outcomes

Various departmental restructures has had an effect on capacity in this area, however there is departmental oversight and monitoring of sentinel events. All SAC1 analyses are submitted to the Department of Health's Patient Safety Unit. A Director of Mental Health policy requires the reporting of adverse and sentinels events in relation to forensic patients to enable the identification of any clinical practice or systemic issues that require attention. HHSs are required to review sentinel events to identify and address clinical practice and systemic issues reducing likelihood of similar events in the future.

8.8. Key Recommendation 8: Accelerated implementation of the 1996 10 Year Mental Health Strategy for Queenslanders 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.

This recommendation was made in the context of concerns regarding the variation in type and availability of inpatient beds and also inadequate numbers of specialist medical staff and/or inpatient nursing staff.

8.8.1. Key achievements

- The 10 Year Mental Health Strategy 1996 was fully implemented. Following this the Queensland Plan for Mental Health 2007–2017 (QPMH 2007–17) was developed.
- The Queensland Government implemented the QPMH 2007–17 between July 2007 and June 2011, with record investments in mental health of more than \$632 million. Seventeen capital projects delivered 277 new or redeveloped beds and produced a net gain of 146 new beds. An additional 569 staff were employed in the specialist ambulatory mental health sector. This investment included \$110 million to increase access to support services and accommodation in the community for people with a mental illness with additional transitional recovery services, housing and support program places, personal support packages for people transitioning from correctional facilities, and places for peer operated and respite services.

8.8.2. Outcomes

Whilst limited resources remain an issues for mental health service provision in Queensland, the implementation of the 1996 10 Year Mental Health Strategy and more recently the QPMH 2007–17 have seen record investments in mental health (both capital investment and increased staff) thus increasing the ability of Hospital and Health Services to provide appropriate support for individuals with a mental illness, thereby reducing risks of adverse events arising out of an inability to provide appropriate assessment, treatment and care.

8.8.3. Current activities

- In September 2014 the Queensland Mental Health Commission released the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019 which commits the Department of Health to develop a new mental health, drug and alcohol services plan.
- The MHAODB is currently developing the Queensland Health, Mental Health Drug and Alcohol Services Plan 2016–2021 (the Services Plan) which will guide service planning and delivery of state funded mental health, drug and alcohol services. The Services Plan will reflect the Queensland Government's ongoing commitment to deliver high quality, effective and efficient mental health and drug and alcohol services.

8.9. Key Recommendation 9: Competency based training regarding staff with *Mental Health Act 2000* functions, especially with respect to forensic patients and liaison with the Mental Health Review Tribunal regarding the conditions of limited treatment for patients under the *Mental Health Act 2000*

- Provide standardised competency based training for staff performing functions under the *Mental Health Act 2000* (MH Act) with particular emphasis on management of forensic order patients (including persons of special notification) and liaise with the Mental Health Review Tribunal (MHRT) regarding the conditions of limited community treatment (LCT) for patients under the MH Act.

This recommendation was made to ensure legislative responsibilities of mental health staff in relation to patients managed under the MH Act would be applied consistently across the state and across health care facilities.

8.9.1. Key achievements

MH Act training

- An online training system for the MH Act has been developed by the MHAODB. This training system provides mental health clinicians with information about key components of the MH Act and is a requirement for appointment as an authorised doctor or authorised mental health practitioner under the MH Act. The training package is designed to be undertaken in conjunction with the MH Act Resource Guide and provides clinicians with functions under the MH Act with up to date, accurate and comprehensive information regarding their responsibilities.
- A collaborative review of the above learning package has recently been undertaken by the MHAODB and the Queensland Centre for Mental Health and Learning.
- A new e-learning package released in November 2013 provides an interactive scenario-based program which includes a formal assessment for each scenario. The training is intended to be undertaken with reference to the MH Act Resource Guide and the legislation and is eligible for continuing professional development (CPD) points.

MHRT liaison regarding conditions of LCT for patients under the MH Act

- This recommendation was implemented as a consequence of changes to policy and practice as a result of the 2002 Mullen Chettleburg Review. Further changes were made following the 2006 review of the MH Act Promoting Balance in the Forensic Mental Health

System (the Butler Review).⁷³ For forensic patients, the MH Act Resource Guide and the Director of Mental Health Forensic Patient Management Policy and Procedures and Policy Guidelines for the Care of Disability Forensic Patients provides clear guidelines for dealing with non-compliance with conditions of limited community treatment. For patients on an involuntary treatment order the MH Act Resource Guide sets out the legislative and policy requirements where a patient is non-compliant with their treatment plan.

8.9.2. Outcomes

The implementation of this recommendation, in particular the comprehensive training developed in relation to MH Act functions (including in relation to provision of care to forensic patients) has provided a high level of support and guidance for clinicians with MH Act functions. This, combined with actions taken in response to other key recommendations above (in particular key recommendation 1), has enhanced the capacity of services to provide a standard of care that is also legislatively compliant.

8.9.3. Current activities

The online MH Act training system and the MH Act Resource Guide is regularly updated and available to clinicians (including at private authorised mental health services) on an ongoing basis. The MH Act Resource Guide also provides guidance to practitioners with respect to non-compliance by patients with their limited community treatment requirements (for forensic patients) or treatment plan (for patients on involuntary treatment orders).

8.10. Summary of the implementation of Achieving Balance recommendations:

Since the release of the Achieving Balance Report significant work has been undertaken by the MHAODB and mental health alcohol and other drugs services towards meeting the recommendations, with the ultimate goal being the provision of quality services to reduce the incidence of sentinel events.

There has been major investment in mental health services and significant work undertaken at a corporate level to provide a framework and support to local HHSs to deliver consistent, high quality, legislatively compliant and evidence based assessment, treatment and care to Queensland mental health consumers.

Whilst not all sentinel events can be predicted or prevented, every effort should be made to ensure that mental health service systems provide the highest possible assessment, treatment and care for mental health consumers and that when adverse events do occur the response to these is appropriate. It is anticipated that the 2015 Sentinel Events Review will provide a comprehensive assessment of recent sentinel events and make recommendations to further improve mental health service delivery in Queensland and the MHAODB welcomes the Review.

⁷³ Summary Report – Implementation of the Nine Key Recommendations – verified against 2008 and 2011 reports and briefings in the *Achieving Balance Corporate File*.

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Queensland Health documents

Queensland Public Mental Health Models of Services (Acute Care Team, Adult Acute Mental Health Inpatient Unit, Community Care Team)

State-wide Standardised Suite of Clinical Documentation (forms and user guide)

Interagency documents

Police Communications Centre Mental Health Intervention Coordination documentation (overview, steering committee terms of reference, work unit guideline for management of referrals)

Data summaries

Australian Institute of Criminology data summary, 25/02/2016

Australian Institute of Health and Welfare data summary, 14/03/2016

Abbreviations

| Acronym | Title |
|-----------------------------|---|
| AIC | Australian Institute of Criminology |
| AIHW | Australian Institute of Health and Welfare |
| AISRAP | Australian Institute for Suicide Research and Prevention |
| AMHS | Authorised Mental Health Services |
| CFOS | Community Forensic Outreach Service |
| CIMHA | Consumer Integrated Mental Health Application |
| CIP | Crisis Intervention Plan |
| CLO | Court Liaison Officers |
| DEM | Department of Emergency Medicine |
| FLO | Forensic Liaison Officer |
| FMHS | Forensic Mental Health Service |
| FTE | Full-time equivalent |
| HCR-20 | Historical Clinical Risk Management-20 |
| HHB Act 2011 | Hospital and Health Boards Act 2011 |
| HHS | Hospital and Health Service |
| leMR | Integrated electronic Medical Record Program |
| ITO | Involuntary Treatment Order |
| MHA 2000 | Mental Health Act 2000 |
| MHA 2016 | Mental Health Act 2016 |
| MHAODB | Mental Health Alcohol and Other Drugs Branch |
| MHIC | Mental Health Intervention Coordinator |
| MHRT | Mental Health Review Tribunal |
| MOS | Models of Service |
| MOU | Memorandum of Understanding |
| NDIS | National Disability Insurance Scheme |
| NGO | Non-government organisation |
| NMHS | National Mental Health Service |
| Coroner's Office | Office of the State Coroner |
| PACER | Police, Ambulance and Clinical Early Response |
| PCC | Police Communications Centre |
| PMHS | Prison Mental Health Service |
| PSQIS | Patient Safety Quality Improvement Service |
| QAC | Quality Assurance Committee |
| QAS | Queensland Ambulance Service |
| QFMHS | Queensland Forensic Mental Health Service |
| QFTAC | Queensland Fixated Threat Assessment Centre |
| QMHC | Queensland Mental Health Commission |
| QPMH 2007–17 | Queensland Plan for Mental Health 2007-17 |
| QPS | Queensland Police Service |
| SAC 1 event | Severity Assessment Code 1 event |
| Services Plan | Queensland Health Mental Health, Drug and Alcohol Services Plan 2016-2021 |
| SFMHS | State-wide forensic mental health service |
| SSCD | State-wide standardised suite of clinical documentation |
| START | Short-Term Assessment of Risk and Treatability |
| Strategic Plan | Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019 |
| The Review | The Mental Health Sentinel Events Review 2016 |
| The Review Committee | The Mental Health Sentinel Events Review Committee |
| The Review Team | Sentinel Event Review Team |
| TOR | Terms of reference |
| VSS | Victim Support Service |

Glossary

| TERM | DESCRIPTION |
|--|--|
| Assessment | Process by which the characteristics and needs of consumers, groups or situations are evaluated or determined so they can be addressed. The assessment forms the basis of a plan for services or action. |
| Carer | A person whose life is affected by virtue of close relationship with a consumer, or who has a chosen caring role with a consumer. Carer, in this document, may also refer to the consumer's identified family, including children and parents, as well as other legal guardians and people significant to the consumer. |
| Clinical formulation | A clinical summary of the assessment including information regarding the predisposing, precipitating, perpetuating and protective factors that are relevant to the person's clinical presentation, the diagnosis, the prognosis and current risks. |
| Co-morbid or co-occurring condition | Existing simultaneously with and usually independently of another condition. |
| Consumer | A person who is currently using, or has previously used, a mental health service. |
| Dual diagnosis | Co-occurring mental health and substance misuse problems. |
| Forensic | Related to, or associated with, legal issues. |
| Forensic mental health services | The forensic mental health system refers to the components, both in the health system and the justice system, which respond to people with a mental illness who have been charged with an indictable offence. |
| Indigenous | Indigenous Australian peoples |
| Involuntary | Where persons are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care. |
| Lived experience | The experience people have of their own or others' mental health issues, emotional distress or mental illness, and of living with, and recovering from, the impacts and consequences of their own or others' mental health issues, emotional distress or mental illness. |
| Mental health | The capacity of individuals within the groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice. |
| Mental health professional | A person who offers services for the purpose of improving an individual's mental health or to treat mental illness. These professionals include psychiatrists, clinical psychologists, clinical social workers, occupational therapists, psychiatric nurses as well as other professionals. |
| Mental health service | Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. |
| Mental illness | A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth |

| TERM | DESCRIPTION |
|---|---|
| | Edition (DSM-5) or the International Classification of Diseases, Tenth Edition (ICD-10). These classification systems apply to a wide range of mental disorders (for the DSM-5) and mental and physical disorders (for the ICD-10). |
| Model of service | <p>Models of service are guidelines have been developed to inform and guide Queensland Mental Health Alcohol and Other Drugs services on recommended best practice and the care and functions required to encourage state-wide consistency in service delivery for each type of public mental health alcohol and other drugs services.</p> <p>The MOS are intended as a resource to support development of local models of care identifying key elements that are essential for the effective operation of a particular type of mental health service</p> |
| Recovery | Clinical recovery pertains to a reduction or cessation of symptoms and restoring social functioning. Personal recovery is defined as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues |
| Relapse | A subsequent episode of mental illness. It is a recurrence of symptoms of mental illness similar to those that have previously been experienced. The threshold of symptoms required to identify a relapse varies according to the differing perspectives of the person experiencing the symptoms, their family and carers, and service providers. |
| Restraint | A restrictive intervention that relies on external controls to limit the movement or response of a person. |
| Risk | The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood. |
| Risk assessment | The process of identification, analysis and evaluation of a risk. |
| Risk management | In health care, designing and implementing a program of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution; to minimise financial losses (including legal liability) that might arise consequentially; and to transfer risk to others through payment of premiums (insurance). |
| Severity Assessment Code (SAC) 1 | A SAC 1 incident is defined as 'death or likely permanent harm which is not reasonably expected as an outcome of healthcare'. A suspected suicide of a person receiving mental health care from a Hospital and Health Service (whether as an inpatient or in the community) is typically entered as a SAC1 incident in the PRIME-Critical Incident (PRIME-CI) database |
| Seclusion | The act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of time out, where a patient is requested to seek voluntary social isolation for a minimum period of time. |
| Sentinel event | Events in which death or serious harm to a patient has occurred. They signal catastrophic system failure and have the potential to seriously undermine public confidence in the health-care system. |
| Wellbeing | The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition. |

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Queensland Health documents

Map of Queensland Health Hospital and Health Services

Overview of local Health and Hospital Services protocols and procedures, collated by the Review Team.

Queensland Public Mental Health Models of Services (Acute Care Team, Adult Acute Mental Health Inpatient Unit, Community Care Team)

State-wide Standardised Suite of Clinical Documentation (forms and user guide)

Community Forensic Outreach Services documentation (overview, model of service, referral criteria and concern levels, referral form, brochure, Forensic Intervention Service procedure manual back up, assessment and documentation guideline, QFTAC brochure)

Court Liaison Services documentation (overview, model of service, south east Queensland procedures manual, statewide CIMHA business rules, statewide court liaison service delivery guidelines 2012)

Prison Mental Health Services documentation (overview, model of service, workplace instructions for intake assessment, management of open consumers and response to risk of self-harm and suicide ideation)

Queensland Forensic Mental Health Services, Police Communications Centre and Mental Health Intervention Coordinator documentation (Management of referrals Work Unit Guideline, Terms of Reference)

High Secure Inpatient Service (HSIS) Extended Forensic Rehabilitation Unit (EFTRU) documentation (overview, models of service)

Forensic Liaison Officer network documentation (Handbook 2015, forensic orders and FLO 2015, summary of models 2011, self-assessment report 2011)

Victim Support Services, Resource guide for victims, 2014

documentation (clinical concern escalation procedure, alcohol and drug brief interventions, child and youth mental health service assessment procedure, clinical case review procedure, clinical review acute and community mental health, treatment planning procedure, non-attendance at appointments acute and community mental health service, responding to referrals procedure, clinical case management procedure, management of patients/clients with suicidal behaviour or risk procedure, intervention / treatment in child and youth mental health service community mental health, carers inclusion in the admission, treatment and recovery process,

management of consumers with dual diagnosis, clinical risk assessment procedure, 1300 MH CALL fact sheet)

Queensland Centre for Mental Health Learning program facilitator guides (QC9 Critical Components of Risk Assessment and Management, QC14 Mental Health Assessment, QC19 Risk Assessment and Management Refresher)

Queensland Centre for Mental Health Learning elearning summaries (Dual Diagnosis, Mental State Examination)

Interagency documents

Police Communications Centre Mental Health Intervention Coordination documentation (overview, steering committee terms of reference, work unit guideline for management of referrals)

Submissions to the Review Committee

Queensland Forensic Mental Health Service submission

Queensland Mental Health Commission submission

Victim Support Service submission

Data summaries

Queensland Centre for Mental Health Learning training data (program and elearning attendance)

Australian Institute of Criminology data summary, 25/02/2016

Analysis and Accountability Team data powerpoint presentation, 11/03/2016

Australian Institute of Health and Welfare data summary, 14/03/2016

Queensland mental health establishment report 30 June 2015