Queensland Government

# MEMORANDUM OF UNDERSTANDING

BETWEEN

**THE CHIEF EXECUTIVE OF QUEENSLAND HEALTH**

AND

**THE STATE OF QUEENSLAND ACTING THROUGH THE DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL REPRESENTED BY QUEENSLAND CORRECTIVE SERVICES**

**CONFIDENTIAL INFORMATION DISCLOSURE**

RTI RELEASE

This **MEMORANDUM OF UNDERSTANDING** ('MOU') is made on the day of 2017.

BETWEEN

**The Chief Executive of Queensland Health ('Queensland Health')**, 147-163 Charlotte Street, Brisbane, in the State of Queensland

AND

**The State of Queensland acting through the Department of Justice and Attorney-General, represented by Queensland Corrective Services ('Queensland Corrective Services')**, 50 Ann Street, Brisbane, in the State of Queensland.

## PURPOSE

The purpose of this MOU is to enable the sharing of Confidential Information between Queensland Health and Queensland Corrective Services ('the Parties') in circumstances where other legislative avenues for obtaining Confidential Information, in particular through obtaining consent of the Prisoner, have been exhausted.

The sharing of Confidential Information under this MOU will enable both Parties to undertake their respective roles and responsibilities, and to facilitate coordinated Health Services for Prisoners.

This MOU is supported by Operating Guidelines that provide additional detail for Queensland Health and Queensland Corrective Services Authorised Staff.

## RECITALS

A. Queensland Health and Queensland Corrective Services acknowledge that each party has their respective roles and responsibilities with regard to Prisoners within the Queensland Corrective Services System.

B. Queensland Health and Queensland Corrective Services wish to work in full cooperation to ensure the effective and efficient delivery of Health Services to Prisoners by Queensland Health and the management of Prisoners by Queensland Corrective Services, through the exchange of Confidential Information between Queensland Health and Queensland Corrective Services.

C. Queensland Corrective Services is responsible for the humane containment, supervision and rehabilitation of Prisoners in Corrective Services Facilities.

D. Since 2012, service agreements under the *Hospital and Health Boards Act 2011* between the





RTI RELEASE

Chief Executive of Queensland Health and relevant Hospital and Health Services have provided for the delivery of Health Services to Prisoners in most Corrective Services Facilities in Queensland. The Prison Mental Health Service provides Mental Health Services to Prisoners with a Mental Illness and the Prison Health Service and Offender Health Service provides Primary Health Care services such as medical, nursing, dental, optometry, radiology, pathology, dietary and sexual health care.

**E.** Authorised Staff have an obligation to maintain confidentiality with regard to Confidential Information. Designated Persons are prohibited from disclosing Confidential Information unless one of the exceptions to s.142 of the *Hospital and Health Boards Act 2011* apply. This MOU is prescribed under the exception provided at s.151(1)(b)(i) of the *Hospital and Health Boards Act 2011* to allow for disclosure of Confidential Information as described within this MOU. Informed Persons may only disclose Confidential Information under s.341 of the *Corrective Services Act 2006.*

**F.** The MOU is not intended to exclude other processes upon which either Party can rely for seeking information from the other party, including where disclosure is provided with the consent of the Prisoner.

**G.** The existence of this MOU cannot and does not preclude disclosure of Confidential Information by a Designated Person under any other exceptions in Part 7 of the *Hospital and Health Boards Act 2011*, where appropriate and/or allowable.

**H.** This MOU does not authorise the disclosure of Personal Information. Strict privacy obligations apply to the use and disclosure of Personal Information under the *Information Privacy Act 2009*, and Personal Information may only be disclosed under authority, and subject to, the relevant provisions of the Act, including compliance with the National Privacy Principles of the Act.

**I.** It is not intended that this MOU create any contractual relationship or that it be legally binding on the Parties.

**J.** This MOU revokes and replaces the MOU titled 'Memorandum of Understanding between the Chief Executive of Queensland Health and the State of Queensland acting through the Department of Justice and Attorney-General Queensland Corrective Services Confidential Information Disclosure' previously executed by the Parties on 24 November 2016.



RTI RELEASE

THE PARTIES TO THIS MOU AGREE AS FOLLOWS:

1. DEFINITIONS

In this MOU the following definitions apply:

**At Risk Assessment** means the process of gathering, analysing and interpreting information to support decision making about a Prisoner who is considered to be at-risk of self-harm or suicide.

**Authorised Mental Health Service** has the same meaning as the definition of the term 'Authorised Mental Health Service' in Schedule 3 of the *Mental Health Act 2016*.

**Authorised Staff** means:

i. for Queensland Health, a Designated Person; and

ii. for Queensland Corrective Services, an Informed Person who has delegation to disclose Confidential Information under s.341 of the *Corrective Services Act 2006.*

**Business Day** means between 9.00am and 5.00pm on a day other than a Saturday, Sunday or public holiday at Brisbane in the State of Queensland.

**Chief Executive** means the Chief Executive of Queensland Health and has the same meaning as the definition of the term 'Chief Executive' in Schedule 2 of the *Hospital and Health Boards Act 2011*.

**Classified Patient** has the same meaning as the definition of the term 'Classified Patient' in Schedule 3 and s.64 of the *Mental Health Act 2016*.

**Commissioner** means the Commissioner of Queensland Corrective Services.

**Confidential Information** means:

i. for information held by Queensland Health, the same meaning as the definition of the term 'Confidential Information' in s.139 of the *Hospital and Health Boards Act 2011* ; and

ii. for information held by Queensland Corrective Services, the same meaning as the definition of the term 'Confidential Information' in s.341(4) of the *Corrective Services Act 2006*, but does not include:

a) information already disclosed to the general public, unless further disclosure of the information is prohibited by law; or

b) statistical or other information that could not reasonably be expected to result in the identification of the person to whom the information relates.

**Corrective Services Facility** has the same meaning as the definition of the term 'Corrective Services Facility' in Schedule 4 of the *Corrective Services Act 2006.*

**CS Act** means the *Corrective Services Act 2006* (Qld).



RTI RELEASE

**Custody** means held in the custody of the chief executive of Queensland Corrective Services in a Corrective Services Facility, whether on remand or incarcerated under State or Federal law.

**Death in Custody** has the same meaning as the term 'Death in Custody' in s.10 of the *Coroners Act 2003* and includes one month after Release Date.

**Designated Person** for Queensland Health has the same meaning as the term 'Designated Person' in s.139A of the *Hospital and Health Boards Act 2011*.

**Director-General, DJAG** for the purposes of this MOU means the Director-General of the Department of Justice and the Attorney-General; or another chief executive who may have responsibility for the administration of the CS Act from time to time.

**Disclosure** includes providing Confidential Information orally, in writing, and in any other format.

**DJAG** means the Department of Justice and Attorney-General.

**Engaged Service Provider** has the same meaning as the definition of the term 'Engaged Service Provider' in s.272 of the CS Act.

**Forensic Patient** has the same meaning as the definition of the term 'Forensic Patient' in Schedule 3 of the *Mental Health Act 2016*.

**Health Facility** has the same meaning as the definition of the term Public Sector Health Service Facility in Schedule 2 of the *Hospital and Health Boards Act 2011*.

**Health Service** has the same meaning as:

i. the definition of the term 'Health Service' in Schedule 3 of the *Mental Health Act 2016* ; and

ii. the definition of the term 'Health Service' in s.15 of the *Hospital and Health Boards Act 2011*;

and includes the prevention, treatment, and management of physical and mental illness and the preservation of physical and mental well-being.

**HHB Act** means the *Hospital and Health Boards Act 2011* (Qld).

**HHS** means a Hospital and Health Service.

**Hospital and Health Service** has the same meaning as the definition of the term 'Hospital and Health Service' in Schedule 2 of the *Hospital and Health Boards Act 2011*.

**Immediate Risk Needs Assessment** identifies any immediate risks or needs that require immediate attention upon a Prisoner's admission to the Queensland custodial system or arrival after transfer from community supervision to a custodial facility.

**Information** includes verbal information; a document (as defined in s.36 of the *Acts Interpretation Act 1954* (Qld)); a statement; or any other form of media whatsoever, including electronic communication, on which Information is recorded.



RTI RELEASE

**Informed Person** for Queensland Corrective Services has the same meaning as the definition of the term in s.341 of the CS Act.

**IP Act** means the *Information Privacy Act 2009* (Qld).

**Legal Proceeding** includes, but is not limited to, an application under the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) and an initial notice under s.9A of the *Personal Injuries Proceedings Act 2002* (Qld).

**Mental Health Services** has the same meaning as the definition of the term 'Treatment' in Schedule 3 of the *Mental Health Act 2016* and means, for a person who has a mental illness, anything done, or to be done, with the intention of having a therapeutic effect on the person's illness.

**Mental Illness** means has the same meaning as the definition of the term 'Mental Illness' in s.10 of the *Mental Health Act 2016*.

**MH Act** means the *Mental Health Act 2016* (Qld).

**MOU** means this Memorandum of Understanding.

**Notice** means a notice in writing under or in connection with the MOU from one Party to the other Party.

**Offender Health Services** means the HHS that provides Prisoners with access to health practitioners for the purpose of Primary Health Care, dental, optometry, radiology, pathology, dietary and sexual health care provision.

**Operating Guidelines** means the guidelines that are used by Authorised Staff to operate the MOU.

**Parole Board** has the same meaning as the definition of the term 'Parole Board' in s.204 of the CS Act.

**Parties** mean the signatories to this MOU.

**Patient** means any individual who is receiving either Primary Health Care Services or other Health Services from the Offender Health Service or Prison Health Service or Mental Health Services from Prison Mental Health Services.

**Personal Information** has the same meaning as the term 'Personal Information' in s.12 of the IP Act.

**Primary Health Care** means a basic level of health care that includes the promotion of health, early diagnosis of disease and disability and prevention of disease. It is generally the first line of health care, covering a broad range of health issues.

**Prison Health Services** includes Offender Health Services and means the HHS that provides Prisoners with access to health practitioners for the purpose of Primary Health Care, dental, optometry, radiology, pathology, dietary and sexual health care provision.

RTI RELEASE

**Prison Mental Health Service** means the in-reach Mental Health Services that provide specialist mental health care to consumers incarcerated in Corrective Services Facilities in Queensland.

**Prisoner** has the same meaning as the definition of the term 'Prisoner' in Schedule 4 of the CS Act and applies only to those Prisoners who have received, are currently receiving, or may receive Primary Health Care or Mental Health Services.

**QCS** means Queensland Corrective Services.

**Queensland Health** means the department and Hospital and Health Services, as described in s.8 of the HHB Act. Queensland Health is administered by the Queensland Minister for Health and Minister for Ambulance Services under Administrative Arrangements Orders issued under the *Constitution of Queensland 2001* (Qld).

**Queensland Corrective Services System** means the system responsible for community safety and crime prevention through the humane containment, supervision and rehabilitation of offenders.

**Regulation** means the *Hospital and Health Boards Regulation 2012* (Qld).

**Release Date** means the date of release from a Corrective Service Facility.

**Security and Classification Placement** means the process of assigning a prisoner's security classification in accordance with legislative requirements and informs the prisoner's level of supervision, placement and management requirements, taking into account their individual circumstances.

**Steering Committee** is the committee with the function to oversee the state-wide partnership between Queensland Health Prison Mental Health Services, Prison Health Services and Offender Health Services; and Queensland Corrective Services to ensure the effective provision of mental health services in Queensland Correctional Centres. For the purposes of this MOU, this Committee's function includes addressing implementation issues that arise in relation to the MOU.

## 2. COMMENCEMENT AND DURATION

2.1 This MOU will commence on the date it is prescribed in the Regulation and continue until the following occurs:

i. the Regulation is repealed; or

ii. all obligations under the MOU are satisfied and completed; or

iii. clauses 8 or 9 of this MOU are invoked.



RTI RELEASE

## 3. OPERATION OF MOU

3.1. The operation of this MOU is contingent on:

i. the MOU having been prescribed in the Regulation pursuant to s.151(1)(b)(i)(B) of the HHB Act; and

ii. the Chief Executive having made a determination that disclosure of Confidential Information by a Designated Person in the circumstances described in this MOU is in the public interest pursuant to s.151(1)(b)(ii) of the HHB Act; and

iii. the Chief Executive stating in writing that disclosure of Confidential Information by a Designated Person in the circumstances described in this MOU is in the public interest pursuant to s.151(1)(b)(ii) of the HHB Act, as evidenced by the signature of the Chief Executive, Queensland Health on this MOU; and

iv. the Director-General, DJAG having made a determination that disclosure of Confidential Information by an Informed Person in the circumstances described in this MOU complies with the provisions detailed under s.341(3) of the CS Act.

## 4. GUIDING PRINCIPLES

4.1. The Parties agree that this MOU is based on mutual respect, cooperation and shared principles to ensure that Confidential Information can be shared to facilitate the management of Prisoners and enable the provision of a coordinated system of health care.

4.2. The Parties agree that in situations where there is a risk to the safety of Prisoners, staff members of Queensland Health, QCS or Engaged Service Providers, or members of the community, the primary consideration is ensuring the safety of all persons. In such a situation both Parties agree that maintaining the health needs of the Prisoner and the preservation of the Prisoner's rights and dignity will be significant considerations within the overall objective of ensuring the safety of all persons.

## 5. INFORMATION NOT COVERED BY THIS MOU

5.1. This MOU only applies to the disclosure of Confidential Information regarding Prisoners.

5.2. This MOU does not permit Designated Persons to disclose the following to QCS:

i. Confidential Information regarding persons who are not Patients or Prisoners (for the purpose of the MOU) and who are receiving Health Services.

ii. Information in the possession of Queensland Health for the purpose of Queensland Health meeting its obligations under the *Public Health Act 2005* (Qld), for example, Information contained within the Notifiable Conditions Register as defined within that Act.



RTI RELEASE

iii. Information within the Queensland Health Monitoring of Dangerous Drugs (MODDS) database.

iv. Information for the Parole Board. Prisoner consent is required before Confidential Information is provided to the Parole Board.

## 6. INFORMATION SHARING

6.1. The following describes the protocols to be followed by the Parties for the sharing of Confidential Information with regard to Prisoners.

### 6.2. Information provided by Queensland Health to QCS

6.2.1 It is the preferred position of Queensland Health that disclosing Confidential Information to QCS should, in the first instance, be with the written consent of the Prisoner, pursuant to s.144 of the HHB Act.

6.2.2 If a prisoner has impaired capacity, the preferred position in relation to disclosing Confidential Information is in accordance with the supported decision making regimes established under the *Guardianship and Administration Act 2000*, the *Public Guardian Act 2014* and the *Powers of Attorney Act 1998*.

6.2.3 However, the Parties recognise that there will be situations where consent to disclose Confidential Information from a Prisoner cannot be obtained, and the disclosure is required to facilitate the safe and effective management of the Prisoner by the Parties.

6.2.4 The following table provide examples of the situations where Confidential Information may be disclosed by a Designated Person to QCS under this MOU.

6.2.5 The scenarios are not an exhaustive list, and there may be other circumstances where Confidential Information may be disclosed under this MOU. If a situation arises that is not described in the table below, a Designated Person should refer to the relevant contact person listed in the Operating Guidelines to this MOU and referred to under clause 10 'Dispute Resolution' for guidance on whether or not to disclose Confidential Information.

6.2.6 In all the situations, a Designated Person has the discretion not to disclose Confidential Information to QCS. However, this MOU has been entered into under the spirit of cooperation between the Parties.

RTI RELEASE

| QUEENSLAND HEALTH | |
|---|---|
| **CIRCUMSTANCES** | **EXAMPLE SCENARIO** |
| Suicide attempt / self-harm history | A Designated Person may identify that a Prisoner has current risk factors which increase their risk of suicidal or self-harm behaviour, including a history of suicidal and self-harm behaviour. This Confidential Information may be provided to QCS to establish that the Prisoner has an elevated risk of suicide or self-harm and would inform a more intensive management regime to monitor the risk than would otherwise be provided without this Information. |
| Any of the following:<br>• Notable behavioural changes e.g., increased affective instability and associated challenging behaviours<br>• Notable mental state changes e.g., emergence of symptoms of major mental illness, such as hallucinations and paranoia<br>• Observable risk factors e.g., reported violent ideation/intent/plan. | To inform the management of the Prisoner, Confidential Information may be provided to QCS when a Prisoner presents a possible risk that:<br>- they may cause harm to themselves or other persons, or<br>- suffer serious mental or physical deterioration. |
| QCS management assessment, planning and intervention regarding a Prisoner – for example, conducting Immediate Risk Needs Assessments, and assessments informing Security Classification and Placement decisions regarding a Prisoner | To inform the management of the Prisoner, Queensland Health may disclose to QCS, Confidential Information in its possession that may impact upon travel arrangements and /or may impact upon the management and placement of a Prisoner by QCS in a Corrective Services Facility. This may include, for example, where a Prisoner has a history of self-harm attempts; or has an existing medical condition. |
| QCS psychologists or counsellors | When a QCS psychologist or counsellor is conducting an At Risk Assessment, a Designated Person may provide Confidential Information regarding that Prisoner to facilitate an appropriate Security Classification and Placement for that Prisoner that is commensurate with the Prisoner's medical condition. |
| Illness, medical condition or medication that may impact upon the behaviour of a Prisoner | To assist with the management of a Prisoner who may present with behaviours that relate to cognitive impairment or psychiatric disorder that may impact upon a Prisoner's vulnerability in a Corrective Services Facility, a Designated Person may disclose relevant Confidential Information to QCS. |
| Transportation and escort of | To inform transportation planning, a Designated |





RTI RELEASE

| | |
|---|---|
| Prisoners | Person may disclose Confidential Information about a Prisoner to QCS where a Prisoner's health or well-being; or the health and well-being of other Prisoners or QCS officers, may be adversely impacted by the transportation or escort of that Prisoner. |
| Death in Custody | Confirmation of the deceased status of a Prisoner may be provided to QCS to enable QCS to commence their obligations regarding a Prisoner's Death in Custody. |
| Significant Health Risks | To inform management decisions about the Prisoner, Confidential Information may be provided to QCS when a Prisoner's health condition requires specialised management or self-monitoring equipment. This includes, but is not limited to, when a Prisoner is at risk of serious health consequences including death (e.g. Prisoners with a Terminal Illness). |

6.3. **Information provided by QCS to Queensland Health**

6.3.1 QCS Informed Persons may disclose Confidential Information about a Prisoner to Queensland Health pursuant to s.341 of the CS Act, and in accordance with relevant procedures and delegations.

6.3.2 Section 341(3) of the CS Act lists the circumstances in which Informed Persons can disclose Confidential Information about a Prisoner. QCS may disclose Confidential Information to Queensland Health for the purpose of this MOU in the following circumstances:

- deterioration or significant changes in Prisoner behaviour or mental state;
- self-harm or suicide concerns, or Prisoner being placed on suicide observations;
- assault (prisoner either alleged victim or alleged perpetrator);
- major psychosocial stressor experienced by the Prisoner (for example, death in family or relationship breakdown), or exposure to other potentially destabilising events (for example, participation in intensive intervention);
- any mental health concerns;
- any new charges or convictions;
- sentence calculations (including offence and sentence details);
- court outcomes (including pending court dates);
- daily movement lists (including court escorts, medical escorts, reception and discharge lists);
- planned or actual movements (for example, transportation or placement to another Corrective Services Facility / Health Facility or significant



RTI RELEASE

accommodation change);

- Release Dates;
- concerns about a Prisoner's risk of harm to themselves or towards others;
- child safety concerns, including, but not limited to, potential harm to children;
- Death in Custody;
- injuries that occur to Prisoners in Corrective Services Facilities and require treatment at a Health Facility;
- when a Prisoner is required to be taken to an Authorised Mental Health Service as a Classified Patient or on release:
    - Security Classifications and Placement assessments;
    - escape from custody risk assessments;
    - custodial breach / incident history (including violence risk).

## 7. NOTIFICATION OF BREACH

7.1. If a Party becomes aware of any breach of this MOU that involves an unauthorised use and/or disclosure of Confidential Information that Party must:

i. immediately notify the other Party of that breach; and

ii. fully cooperate with the other Party when dealing with any unauthorised use and/or disclosure of Confidential Information; and

iii. use its best endeavours to immediately rectify the breach and prevent the recurrence of any such breaches.

## 8. VARIATION AND REVIEW

8.1. This MOU may be varied by agreement between the Parties in writing. Any proposed alterations shall be raised and addressed through the Chief Executive of Queensland Health and the Commissioner, QCS.

8.2. The Parties agree that this MOU will be reviewed within 24 months of the date of its taking effect, and thereafter bi-annually on the anniversary of the initial review, or at such other time as may be agreed between the Parties.

## 9. TERMINATION

9.1. Either Party may terminate this MOU by giving the other party 28 days prior Notice in writing of its intention to terminate.

9.2. Where this MOU is terminated under Clause 9.1, the Parties agree to provide all reasonable assistance and cooperation necessary to ensure a smooth transition to a new working arrangement.



RTI RELEASE

## 10. DISPUTE RESOLUTION

10.1. For any matter in relation to this MOU that may be in dispute, the Parties:

i. will use their best endeavours to resolve the matters in dispute at the workplace level in the first instance, between the Authorised Staff of Queensland Health and QCS;

ii. will, if the matter in dispute is not resolved in accordance with clause 10.1(i), refer the matter to the relevant contact person identified in the Operating Guidelines to this MOU for resolution;

iii. will, if the matter impacts on systemic or operational planning, refer the matter in dispute to the Steering Committee for consideration

iv. agree that during the time when the Parties are endeavouring to resolve the matter in dispute, the Parties will continue to comply with this MOU.

## 11. NOTICES

11.1. Any Notice or communication given under clauses 8 or 9 of this MOU may be delivered to the other Party by way of:

i. registered post;

ii. ordinary prepaid post;

iii. by email; or

iv. by facsimile to the Parties facsimile number (as the case may be) notified by the Party from time to time.

11.2. A Notice or other communication given under or about this MOU is taken to be received:

i. if delivered personally, on the Business Day it is delivered;

ii. if sent by registered post, the date the Notice is signed for;

iii. if sent by ordinary post, six Business Days after posting;

iv. if sent by email, on the date recorded on the device from which the Party sent the email, unless the sending Party receives an automated message that the email has not been delivered;

v. if sent by facsimile, when the sender receives confirmation that the facsimile has been transmitted in its entirety to the addressee's facsimile number.

11.3. Unless otherwise advised in writing, the addressees for each Party are set out in the Operating Guidelines to this MOU and are available at:

https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/guidelines/info_share_opp_guide.pdf





RTI RELEASE

THIS MOU IS EXECUTED

For and on behalf of **the State of Queensland**

acting through **Queensland Health**

on this 1 June 2017 by

(signature)

Michael Walsh
Chief Executive, Queensland Health

I, Michael Walsh, Chief Executive, Queensland Health, state that in signing this MOU, pursuant to s.151(1)(b)(ii) of the *Hospital and Health Boards Act 2011* (Qld), I consider the disclosure of Confidential Information for the purpose of this MOU is in the public interest.

1 June 2017

(signature of witness and date)

Axèle-Brigitte Mary
Senior Administration Officer
(name and designation of witness)

For and on behalf of **the State of Queensland**

acting through the Department of Justice and Attorney-General,

**Queensland Corrective Services**

on this 4 July 2017 by

(signature)

I, Mark Rallings, Commissioner, Queensland Corrective Services, state that in signing this MOU, I consider the disclosure of Confidential Information for the purpose of this MOU complies with the provisions of s.341(3) of the *Corrective Services Act 2006* (Qld).

Emily B 04/07/2017
(signature of witness and date)

Emily Bradshaw, Executive Services Officer, Office of the Commissioner
(name and designation of witness)

RTI RELEASE

**Attachment 3 – Background and changes made to the MOU for MHC and the MOU for CID**

## The Memorandum of Understanding between Queensland Health and the Queensland Police Service - Mental Health Collaboration

- In 2005, QH became party to the Memorandum of Understanding between Queensland Health and the Queensland Police Service for Mental Health Collaboration (the MOU for MHC) to permit the disclosure of confidential information between the two agencies in mental health crisis situations (now referred to as mental health incidents or situations involving vulnerable persons) to support the safe resolution of crisis situations.
- The MOU for MHC was revised in 2011 to provide increased clarity and consistency for the disclosure of confidential information when attending to a mental health incident.
- The MOU for MHC was revised again in 2016; the following changes were made:
    - The MOU for MHC was strengthened to better support the fluid and timely sharing of information required to effectively respond to a mental health incident and to enable information sharing for the development of mental health intervention strategies.
    - Definitions were revised and new terminology included reflecting the current roles and activities undertaken in QH and the QPS.
    - All references to legislation were updated.
    - Schedule 1 was replaced with the protocol for proactive information sharing and the development of mental health intervention strategies. The previous schedule is no longer required as section 151(1) of the Hospital and Health Boards Act 2011 authorises a 'designated person' to disclose 'confidential information' in the circumstances detailed under section 151 (1)(b).
    - Schedules 2 and 3 were expanded to allow for more information to be shared if deemed relevant.
    - A new provision was added to allow for the sharing of information via a number of methods of communication.
- Minor changes made to the MOU for MHC in 2017 include:
    - References to mental health legislation updated to reflect the *Mental Health Act 2016*
    - The definition of QPS Officer included.
    - Reference to the *Mental Health Act 2016 Statement of Rights for patients of mental health services* included in 3.3(b).
    - Formatting updated to align with QH editorial style guide.
- A guideline for mental health collaboration for QH and the QPS is currently under development.



RTI RELEASE

## The Memorandum of Understanding between Queensland Health and Queensland Corrective Services – Confidential Information Disclosure

- The Memorandum of Understanding between QH and Queensland Corrective Services (QCS) for Confidential Information Disclosure (the MOU for CID) was established in 2011 to help facilitate the coordination of health services for prisoners by allowing confidential information to be shared between QH and QCS in circumstances where other legislative avenues of obtaining confidential information, particularly obtaining consent from the prisoner, have been exhausted.
- Operating guidelines for the MOU for CID have been implemented to assist staff through the process of sharing confidential information as required in accordance with the MOU.
- The MOU for CID was revised in 2016 to reflect current legislation and current management practices across QH and QCS.
- Minor changes made to the MOU for CID in 2017 include:
    - References to mental health legislation updated to reflect the *Mental Health Act 2016*
    - Formatting updated to align with QH editorial style guide.

RTI RELEASE

DOH RTI 4812

# Ministerial Brief for Noting

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-17/6955** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

**SUBJECT: Update – Adolescent Extended Treatment Facility (AETF) and Youth Mental Health Program**

**Recommendation**

**It is recommended the Minister:**

1. **Note** progress by the Department with implementing the next phase of work and priorities following delivery of the Government response to the Barrett Adolescent Centre Commission of Inquiry.

**NOTED** **PLEASE DISCUSS**

**Cameron Dick MP** **Date: / /**
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

| |
|---|
| |
| |
| |
| |

**Issues**

1. The next phase of work and priorities the Department of Health is progressing includes two streams of work:
   1.1. the program of reform for the child and youth mental health service system based on recommendations as part of the Government response; and
   1.2. the capital program to deliver the Adolescent Extended Treatment Facility (AETF), two Step Up Step Down Units and two Day Programs.
2. A Committee will be established to oversee implementation of priorities with the first meeting scheduled for 13 October 2017, to be chaired by the Deputy Director-General, Clinical Excellence Division. In addition to senior internal membership, health consumers and other relevant Departments are included (Attachment 1).
3. On 14 September 2017 Governor in Council project commencement approval was provided for the infrastructure projects as part of the 2017-18 State Budget.
4. To progress capital works the Mental Health Alcohol and Other Drugs Branch (MHAODB) and Capital and Asset Services Branch (CASB) are collaboratively managing this program.
5. An external consultant has been engaged to provide project management and principal consultant (architect) services.
6. A Project Management Group has been established to provide governance and direction in delivery of the capital program, with an initial focus on early works. This group comprises nominated representatives with infrastructure expertise including MHAODB, CASB, the Department of Education and Training, the external consultant and Metro North and Children's Health Queensland Hospital and Health Services.

**Michael Walsh**
**Director-General**
**/ /2017**

RTI RELEASE

| Department RecFind No: | C-ECTF-17/6955 |
|---|---|
| Division/HHS: | CED |
| File Ref No: | |

7. The early works program to progress car parks at The Prince Charles Hospital is on-track to be on-site to meet the Government commitment for building to start in 2017. A Request for Tender to build the car parks is scheduled to be released on 6 October 2017 and will remain open for four weeks.
8. The Department has committed to continuing the successful stakeholder engagement and participation approach. A meeting to orientate mental health consumer and carer representatives is scheduled for 6 October 2017 prior to the Oversight Committee meeting.
9. During the period 3 to 9 October 2017 the Executive Director, MHAODB is meeting individually with mental health service Executive Directors from Children's Health Queensland, Gold Coast, Metro North and Metro South Hospital and Health Services to update about the program of work ahead of the Oversight Committee meeting on 13 October 2017.

**Vision**

10. The development of the AETF and Youth Mental Health Program aligns with the vision of 'My health, Queensland's future: Advancing health 2026', in particular for Delivering and Connecting healthcare. Delivering the AETF improves access to healthcare for young people with a lived experience of mental illness and carers by expanding the range of mental health services across the care continuum.

**Background**

11. Government approved the detailed business case for the capital program to deliver:
    - 11.1. a new adolescent mental health facility at The Prince Charles Hospital;
    - 11.2. two Step Up Step Down facilities (North and South Brisbane); and
    - 11.3. refurbishment of two day programs spaces at Gold Coast and Logan.

**Sensitivities**

12. Consumers, carers and families involved with the former Barrett Adolescent Centre continue to be involved in this ongoing program of work.

**Results of Consultation**

13. This brief has been prepared following MHAODB consultation involving staff with specific expertise to contribute including the capital program Project Director from CASB.

**Resource Implications (including Financial)**

14. The 2017-18 State Budget announcement on 13 June 2017 was $68.237 million over four years with $8.713 million allocated in 2017-18 (source: budget paper 3).

**Attachments**

15. Attachment 1: Proposed governance structure

**Department Contact Officer**

Assoc Prof John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, Department of Health on telephone 3328 9536 or [redacted]

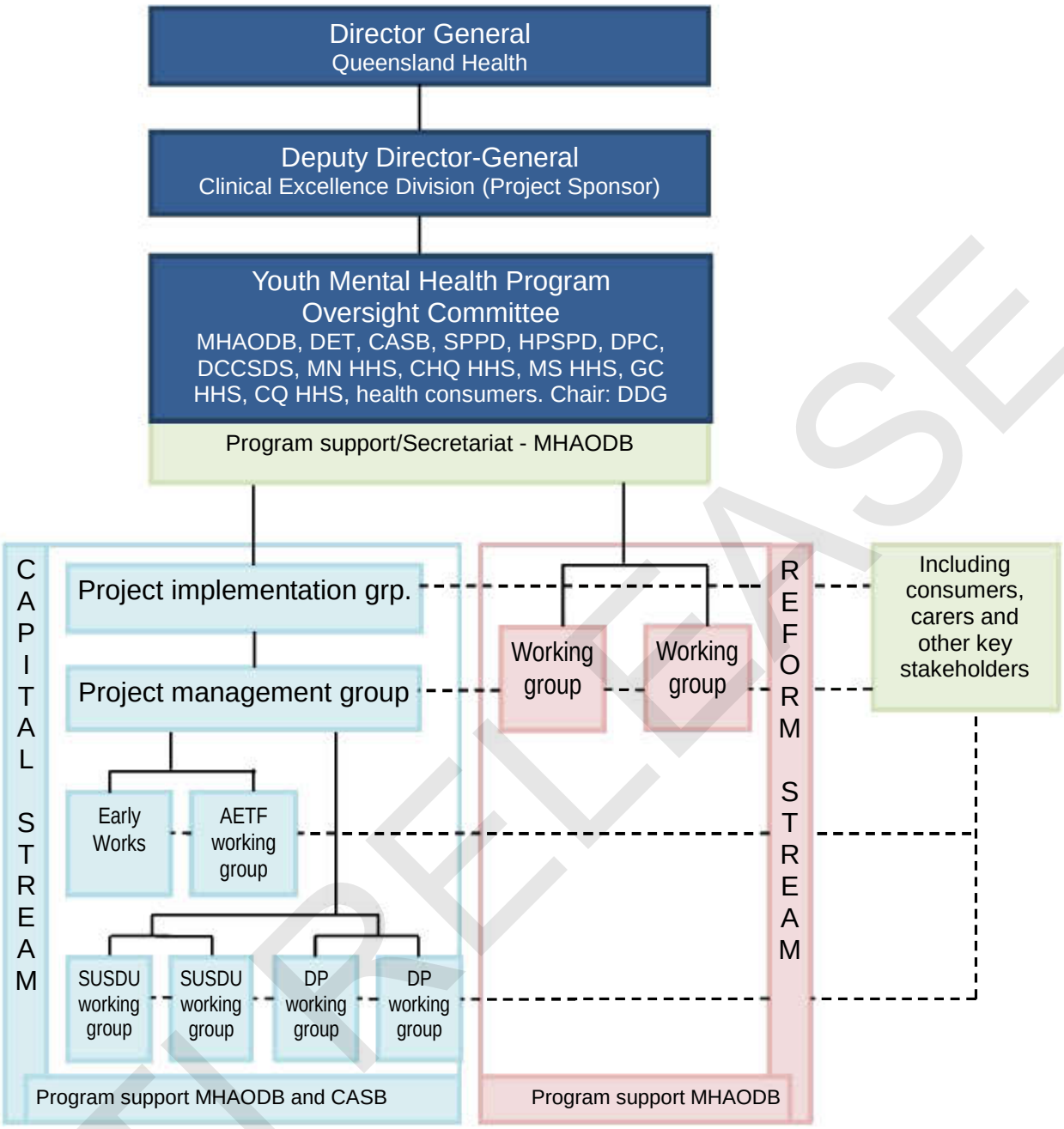
RTI RELEASE

| | |
|---|---|
| **Department RecFind No:** | **C-ECTF-17/6955** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

| Author | Cleared by: (SD/Dir) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Bruce Ferriday | Assoc Prof John Allan | Dr John Wakefield |
| A/Principal Project Officer | Executive Director | Deputy Director-General |
| Mental Health Alcohol and Other Drugs Branch | Mental Health Alcohol and Other Drugs Branch | Clinical Excellence Division |
| 3328 9550 | 3328 9536 | 3708 5337 |
| | | |
| 3 October 2017 | 4 October 2017 | 4 October 2017 |

RTI RELEASE

Governance structure for the Youth Mental Health Program




| Legend | | | |
|---|---|---|---|
| YMHP | Youth mental health program | MHAODB | Mental Health Alcohol and Other Drugs Branch |
| DoH | Department of Health | GC HHS | Gold Coast Hospital and Health Service |
| DET | Department of Education and Training | CHQ HHS | Children's Health Queensland HHS |
| DPC | Department of Premier and Cabinet | MN HHS | Metro North HHS |
| DCCSDS | Department of Communities, Child Safety and Disability Services | MS HHS | Metro South HHS |
| DDG | Deputy Director-General | CQ HHS | Central Queensland HHS |
| CED | Clinical Excellence Division | HCQ | Health Consumers Queensland |
| HPSPD | Healthcare Purchasing and System Performance Div. | AETF | Adolescent Extended Treatment Facility |
| SPPD | Strategy Policy and Planning Division | SUSDU | Step Up Step Down Unit |
| CASB | Capital and Asset Services Branch | DP | Day Program |
| * Committee, Oversight, Management and Working Groups will be established to progress this program. The purpose of these groups will be outlined in a terms of reference or equivalent documentation. | | | |

RTI RELEASE

DOH RTI 4812

# Ministerial Brief for Approval

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-18/667** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | **QCOS/030444** |

**SUBJECT:** **Approval to proceed to engage with the market for the support, maintenance and ongoing enhancement of the Integrated Mental Health Data Reporting Repository (IMHDRR)**

**Recommendation/s**
It is recommended the Minister:

1. **Approve** project commencement by exercising non-recurrent financial delegation to proceed to publishing an Invitation to Offer (ITO) in the market place to procure services to support, maintain and enhance IMHDRR to the value of $9,985,362 (GST inclusive) for a five year period (inclusive of one optional extension – 1 x 2 year) from approximately September 2018 to August 2023.
   **APPROVED / NOT APPROVED** **PLEASE DISCUSS**

**Steven Miles MP** **Date: / /**
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

| |
|---|
| |
| |
| |
| |

**Issue/s**

1. Urgent - financial approval is required prior to procurement approval that will enable the release of an ITO to the market to procure services to support, maintain and enhance IMHDRR. This process will ensure that a new contract is in place in September 2018 prior to the lapse of the existing contract.
2. The Queensland Department of Health signed a contract, HIT1397, with the vendor SMS Consulting to build, implement and support IMHDRR on 14 March 2013. This customer contract remains in force until 14 September 2018.
3. The Deputy Director-General, Clinical Excellence Division, endorsed the IMHDRR Development Program Business Case in August 2017 (Attachment 1).
4. Queensland Health is required to go out to market to procure services to ensure continued support, maintenance and enhancement services for IMHDRR. This will ensure the Department engages the best value and lowest risk vendor to support IMHDRR.
5. Approval is being sought on the projected value of the proposed contract over the next five years. Following financial approval, Type 1 procurement approval to proceed to publish an ITO in the market place will be sought from an appropriate delegate.
6. If approval is not granted the Department will need to vary the existing contract ICT2530 with the current vendor in order to support, maintain and enhance IMHDRR.
7. Failure to vary the existing contract or enter into a new contract would leave the Department with an unsupported application that cannot be enhanced as the business or source system changes. This will impact the Department's ability to meet mandatory national reporting requirements and support the business of Hospital and Health Services (HHS) mental health services.

**Michael Walsh**
**Director-General**
**/ /2018**

DOH RTI 4812

RTI RELEASE

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-18/667** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | **QCOS/030444** |

**Vision**

8. The IMHDRR development program aligns to the Delivering healthcare, Connecting healthcare and Pursing innovation directions set out in the 10 year vision My health, Queensland's future: Advancing health 2026 by creating a business intelligence solution to support service monitoring, planning and evaluation for Queensland's mental health services.

**Results of Consultation**

9. Consultation has occurred with the Mental Health Alcohol and Other Drugs Branch (MHAODB) and eHealth Queensland, through specific consultations and the current governance processes for the IMHDRR Development Program. All stakeholders agreed on the need to test the market through an ITO. Staff from these areas has also been involved in the development of ITO documentation.

10. An independent probity advisor was engaged to review the proposed process and advised it was appropriate and aligned to procurement guidelines and policies.

**Resource Implications (including Financial)**

11. Future funding requirements are based on the annual allocation of funding since IMHDRR was implemented in 2013. The estimated expenditure for 2017-18 has been used to project future annual funding levels.

| Component | Initial contract period | | | Extension options | | 5 year total (GST Incl) |
|---|---|---|---|---|---|---|
| | 2018/19 | 2019/20 | 2020/2021 | 2021/2022 | 2022/23 | |
| Support | $270,537 | $281,359 | $292,613 | $304,317 | $316,490 | $1,465,316 |
| Development | $1,573,031 | $1,635,953 | $1,701,391 | $1,769,446 | $1,840,224 | $8,520,046 |
| **Total** | **$1,843,569** | **$1,917,311** | **$1,994,004** | **$2,073,764** | **$2,156,714** | **$9,985,362** |

12. A minor capital budget for the development component has been identified through Queensland Health budget processes for the period to June 2022. Additional funding will be sought for the final year of the proposed contract.

13. Recurrent non-discretionary budget to fund the support component for the proposed duration, including extensions, is part of the annual MHAODB budget build.

**Background**

14. The IMHDRR is a business intelligence solution that provides the foundation for reporting and analysis on mental health related data. IMHDRR collates data from multiple source systems and provides mechanisms to report and analyse comprehensive information about Queensland's mental health consumers and services. IMHDRR provides a secure platform for access to a broad range of performance information and provide mechanisms for 'self-service' reporting functionality utilised by HHS.

15. Implementation, enhancement and maintenance services for IMHDRR are provided under the GITC Customer Contract ICT2530 by SMS Consulting who were engaged via a Type 1 procurement pathway.

16. The proposed tender will be a competitive open tender process on the eTender website for provision of services under GITC contracting standards.

**Sensitivities**

17. Nil.

**Attachments**

18. Attachment 1: IMHDRR Development Program Business Case

RTI RELEASE

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-18/667** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | **QCOS/030444** |

**Department Contact Officer**
Ms Ruth Fjeldsoe, Director, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division on telephone 33289840

| Author | Cleared by: (SD/Dir) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Kristen Breed | Associate Professor John Allan | Dr John Wakefield |
| Manager, Analysis and Accountability Team | Executive Director | Deputy Director General |
| Clinical Systems, Collections and Performance Unit | Mental Health Alcohol and Other Drugs Branch | Clinical Excellence Division |
| 3328 9588 | 3328 9536 | 3708 5342 |
| 20/12/2017 | 24/01/2018 | XX/01/2018 |
| | | |

**Joe Riverstone, Business Manager, MHAODB/CPB comments**

**Date:** 18/01/2018
**Delegation check:** Yes, Band1, non-recurrent financial (project Commencement) is sufficient
**Purchasing arrangements check:** N/A (to follow)
**Funding / Budget availability:** Yes, Support Budget Non-Discretionary $1.465M will be sourced as part of the annual MHAODB budget build.

| Component | Initial contract period | | | Extension options | | 5 year total (GST Incl) | Budget Available |
|---|---|---|---|---|---|---|---|
| | 2018/19 | 2019/20 | 2020/2021 | 2021/2022 | 2022/23 | | |
| Support | $270,537 | $281,359 | $292,613 | $304,317 | $316,490 | $1,465,316 | To be sought from CED Non Discre budget build |

Development Minor capital budget : $8.520M. $6.679M (GST Incl) to 2021/2022 is approved and in the QH CAP portal. The outer year 2022/23 amount of $1.840M (GST Incl) will be submitted in the MHAODB Minor Cap budget build for 22/23.

| Component | Initial contract period | | | Extension options | | 5 year total (GST Incl) | Budget Available to 2021/20/22 |
|---|---|---|---|---|---|---|---|
| | 2018/19 | 2019/20 | 2020/2021 | 2021/2022 | 2022/23 | | |
| Development | $1,573,031 | $1,635,953 | $1,701,391 | $1,769,446 | $1,840,224 | $8,520,046 | $ 6,845,154 |

Total budget required is $9.985M

**Project commencement non-recurrent approved value:** N/A
**Items / $ previously committed against project commencement approval:** Nil
**Is funding going past this current FY if yes $value:** $7.74M
**Sufficient Support Documentation :** Yes
**Type 5 Contract for Q Contracts Y/N:** N/A
**General Comments**
OK to proceed

RTI RELEASE

DOH RTI 4812

Clinical Excellence Division

# Integrated Mental Health Data Reporting Repository (IMHDRR) Program Business Case

Version 1.1
August 2017

RTI RELEASE

Queensland Government

# Document details

| Version | Date | Author | Summary |
|---|---|---|---|
| 0.1 | 12 January 2017 | Kristen Breed | • Initial draft |
| 0.5 | 31 March 2017 | Kristen Breed | • Second draft |
| 0.8 | 30 May 2017 | Kristen Breed | • Incorporation of internal feedback |
| 1.0 | 6 June 2017 | Kristen Breed | • Incorporation of final internal review. This version circulated to IMHDRR Delivery Board for endorsement |
| 1.1 | 10 August 2017 | Kristen Breed | • **Final.** Incorporation of minor changes following endorsement from IMHDRR Delivery Board. Includes updates to budget advised by DAS. |

RTI RELEASE

**Integrated Mental Health Data Reporting Repository (IMHDRR) Program Business Case – Version 1.1**

Published by the State of Queensland (Queensland Health), August 2017

This document is licensed under a Creative Commons Attribution 3.0 Australia licence. To view a copy of this licence, visit creativecommons.org/licenses/by/3.0/au

© State of Queensland (Queensland Health) **2017**

You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland (Queensland Health).

For more information contact:
Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, Department of Health, GPO Box 48, Brisbane QLD 4001, email IMHDRR@health.qld.gov.au, phone 07 3328 9588.

**Disclaimer:**

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability including without limitation for liability in negligence for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

# Contents



RTI RELEASE

# Approval and endorsement

## Approval

The following officer has **approved** this document

*Name:* **Dr John Wakefield**

*Position:* Deputy Director-General, Clinical Excellence Division

*Signed*  *Date:* 28/8/17

## Endorsement

The following officers have **endorsed** this document

*Name:* **Associate Professor John Allan**

*Position:* Executive Director, Mental Health Alcohol and Other Drugs Branch

*Date:* 21 August 2017

*Name:* **Ruth Fjeldsoe**

*Position:* Director, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch

*Date:* 17 August 2017

## Review

The following officers have **reviewed** this document

*Name:* **Kristen Breed**

*Position:* Manager, Analysis and Accountability Team, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch

*Date:* 10 July 2017

*Name:* **Garry Thorne**

*Position:* Manager, Systems and Collections Team, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch

*Date:* 10 July 2017 (via email)

*Name:* **Brad Foy**

*Position:* Manager, Systems and Collections Team, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch

*Date:* 28 June 2017 (via email)

*Name:* **Helen Murray**

*Position:* Manager, Systems and Collections Team, Clinical Systems, Collections and Performance Unit, Mental Health Alcohol and Other Drugs Branch

*Date:* 5 July 2017 (via email)

RTI RELEASE

# 1. Background

Mental health is an information rich environment. Over the past two decades significant investment has been made in establishing the building blocks to collect the data required to answer the key questions of 'who receives, what services, from whom, at what cost and with what effect?' The Clinical Systems, Collections and Performance Unit (CSCPU), Mental Health Alcohol and Other Drugs Branch (MHAODB) and Hospital and Health Services (HHS) have a requirement to use this information to make informed decisions regarding the quality, safety and effectiveness of service delivery; planning, resourcing and policy development. However, due to a lack of consolidation of different data sources (clinical and administrative), cumbersome and limited access to data and laborious effort required to create and manage regular reports; it is difficult to efficiently use and access this information.

A number of national and state initiatives, including the implementation of the Australian Mental Health Care Classification (AMHCC) and the growing information literacy of the mental health workforce are key drivers in increasing the importance and urgency of the need to provide accessible, integrated mental health information. Additionally, there is increased community expectation that Government improve the basis for its decision making, and a business intelligence capability is required to support a range of core activities including service planning, evaluation, funding and the enhancement of an evidence base to support clinical practice. To address these issues, CSCPU embarked upon the development of the Integrated Mental Health Data Reporting Repository (IMHDRR), a business intelligence solution that provides the foundation for improved reporting and analysis of mental health related data.

Further information regarding the design and development of IMHDRR are available here: https://qh-mhaodb.atlassian.net/wiki/spaces/NIMD/pages/1097159/IMHDRR.

## 1.1 Development to date

The development of IMHDRR has been managed by CSCPU as a series of projects with specific objectives.

- Project 1: IMHDRR Pilot Project:
  - *Project initiation*: July 2009
  - *Invitation to Offer published*: December 2011
  - *Vendor contract signed*: March 2013
  - *Project end*: June 2014
- Project 2: IMHDRR Enhancement Project.
  - *Project initiation*: April 2014
  - *Project end*: June 2016
- Project 3: IMHDRR Ongoing Development Project.
  - *Project initiation*: April 2016
  - *Project end*: March 2017

The key deliverables and releases to date are outlined in Table 1.

**Table 1: IMHDRR release timelines**

| Release | Release Date | Project | Key Deliverable(s) |
|---|---|---|---|
| **1.0** | October 2013 | Pilot | Pilot (MHIPA replacement) |
| **1.2** | October 2014 | Support and Maintenance | Alignment to CIMHA POS Upgrade (support and maintenance) |
| **3.0** | November 2015 | IMHDRR Enhancement Project | SQL upgrade, data vault |

RTI RELEASE

| Release | Release Date | Project | Key Deliverable(s) |
|---|---|---|---|
| **3.1** | December 2015 | IMHDRR Enhancement Project | Defect fixes (from release 3.0)<br>NMDS versioning |
| **4.0** | February 2016 | IMHDRR Enhancement Project | Inclusion of QHAPDC Data, RMHC NMDS Extract, Cube for Security and Reporting |
| **4.1** | September 2016 | IMHDRR ongoing development project | Dependency on CIMHA ASH Changes, reporting views, Consumer Details FACT, improved data linkage |
| **5.0** | 1 November 2016 | IMHDRR ongoing development project | Inclusion of YES data |
| **5.0.1** | 7 December 2016 | IMHDRR ongoing development project | NMDS Versioning, FOY scope change |
| **5.0.2** | 12 January 2017 | Support and Maintenance | Support release required to address single admitted patient record from QHAPDC which was causing load failure |
| **5.1** | 15 February 2017 | IMHDRR ongoing development project | New Service Episode Data, Referral Fact, Diagnosis Fact, New reference files (including targets) |
| **5.1.1** | 15 March 2017 | Support and Maintenance | Dependency on CIMHA 2.3 Upgrade |
| **5.2** | 12 July 2017 | IMHDRR Development Program | New consumer details (income source and education level), external contacts, smoking cessation (QHAPDC), report audit functionality, changes to national definition of service contact, reporting tables |

## 1.2 Transition to agile development

The initial projects to develop IMHDRR were undertaken utilising a traditional waterfall approach. In 2016, the development of IMHDRR commenced a process to transition to agile development framework. This has moved the focus from fixed scope with a fixed timeframe to deliver a substantial package of work with long development lead time to a focus on a development program that is able to respond to the needs of the business and variation in priorities. This transition has seen a significant reduction in the time between requirement identification and release, a reduction in underlying assumptions and associated risks to development, improvements in communication and engagement between all stakeholders, and enhanced effectiveness and efficiency of the overall delivery process. Overall, the products delivered more closely align to requirements and benefits are realised more rapidly.

# 2. Program definition

## 2.1 Vision

The overall goal of IMHDRR is to create a central mental health reporting repository that collates data from multiple source systems and provides the mechanisms to report comprehensive information about mental health consumers and services. IMHDRR will enhance the accessibility of mental health related data, provide a secure platform for access to a broad range of performance information and provide mechanisms for 'self-service' reporting functionality that can be utilised by Hospital and Health Services (HHS).

IMHDRR will also assist the Department of Health to make informed decisions and create capacity for deeper analytics and proactive reporting. This will enable the Department of Health to drive the quality, safety, effectiveness of clinical practice, service delivery and planning, resourcing and policy development for Queensland public sector mental health services.

RTI RELEASE

## 2.2 Objectives

The primary objective of transitioning the ongoing development of IMHDRR to a business program (or 'business as usual') is to ensure the sustainability and consistency of system development to enable the vision, and requirements outlined in the *Connecting Care to Recovery 2016-2021* to be met.

## 2.3 Strategic alignment

**Table 2: IMHDRR strategic alignment**

| Government Program | Goals and objectives |
|---|---|
| Department of Health Strategic Plan 2016-2020 (2016 Update) | The Department of Health's role includes supporting and monitoring the quality of health service delivery and delivering health information and communication technology. The key strategic objectives that the IMHDRR program aligns to are:<br>• *Enabling safe, quality services*: delivering and enabling safe, clinically effective, high quality health services<br>• *High performance*: responsive, dynamic and accountable management of the department, and of funding and service performance |
| Clinical Excellence Division Strategy Map 2016-2019 | • Provide trusted and timely information on clinical quality across the system<br>• Provide increased transparency and utility of clinical quality data<br>• Lead system wide improvement initiatives and capacity building through the delivery of market leading products and services |
| Connecting care to recovery 2016–2021: A plan for Queensland's. State-funded mental health, alcohol and other drug services | • Priority three: Better use of ICT to enhance clinical practice, information sharing, data collection and performance reporting, specifically improving analytics and reporting of mental health data to respond to changing needs by:<br>– developing the self-service reporting capability within IMHDRR to assist services to access mental health, alcohol and other drug data and analytics for planning and clinical improvement<br>– enhancing data linkage of disparate data sets to improve access to better intelligence on the outcomes and costs of health intervention and facilitate the identification of areas of clinical practice where change needs to occur<br>– expanding the capacity to monitor and manage the performance of existing and new service delivery models for mental health, alcohol and other drug services through improved access to available data and further development of data analytics capability |
| National Health Reform Agreement | • Development of the Australian Mental Health Care Classification |
| eHealth Investment Strategy | • Having access to the right information, at the right time, in the right place is crucial to ensuring quality health service provision |
| My health, Queensland's future: Advancing health 2026 | • *Connecting health care* by simplifying and connecting access to relevant information that supports performance monitoring and development of funding models<br>• *Delivering healthcare* through supporting continuous improvement culture and clinical practice<br>• *Pursuing innovation* through smart technology and infrastructure that supports a strong innovation and research culture |

## 2.4 Scope

The following areas are **in scope** for this business case:

- New development (minor and major)

RTI RELEASE

- Support and maintenance
- Licensing – current and future upgrades
- Hardware

The following areas are **out of scope**:

- Contract renewal, variation and negotiation

### 2.4.1 IMHDRR road map – July 2017 to June 2019

Table 3 provides a high level road map of the current development priorities and timeframes for IMHDRR, whilst Table 4 identifies the range of support, maintenance and minor enhancements (currently identified) that are required to ensure the continued availability and currency of IMHDRR.

**Table 3: IMHDRR high level development deliverables**

| Description | Dependencies | Timeframe |
|---|---|---|
| Mental Health Establishments Data is available for reporting within IMHDRR | | October 2017 |
| User data from CIMHA is available for reporting within IMHDRR | | December 2017 |
| Alerts Data from CIMHA is available for reporting within IMHDRR | | December 2017 |
| Delivery of initial mental health dashboard | Collaborative initiative being established with System Performance Branch | December 2017 |
| National Outcomes and Casemix Data from CIMHA is available for reporting within IMHDRR | | March 2018 |
| Additional consumer detail information from CIMHA is available for reporting within IMHDRR (accommodation type) | CIMHA views being made available to vendor, anticipated to late 2017 | March 2018 |
| Emergency Department Collection Data is available for reporting within IMHDRR | | July 2018 |
| Self-service functionality is designed and implemented within IMHDRR to support CSCPU and HHS | | July 2018 |
| *Mental Health Act* Data from CIMHA is available for reporting within IMHDRR, with initial focus on Seclusion, Mechanical Restraint, Absent Without Permission, Charges and Offences, Stream/Status | CIMHA views being made available to vendor, anticipated to be early 2018 | November 2018 |
| Clinical note data from is available for reporting within IMHDRR | CIMHA views being made available to vendor, anticipated to be mid 2018 | March 2019 |
| Smoking status data from CIMHA is available for reporting in IMHDRR | | March 2019 |
| Community Alcohol and Other Drug data is available for reporting within IMHDRR (with an initial focus on elements that align to current CIMHA structures) | ATODS-IS replacement being implemented within CIMHA.<br>There will be a release dependency associated with the CIMHA upgrade that should be leveraged where possible to bring in AOD data for early reporting | July 2019 |

PRE-RELEASE

**Table 4: IMHDRR core support and maintenance deliverables**

| Description | Timeframe |
|---|---|
| Community Mental Health Care (CMHC) National Minimum Data Set (NMDS) Versioning | Annual |
| Residential Mental Health Care (RMHC) NMDS Versioning | Annual |
| CMHC NMDS validations | Annual |
| RMHC NMDS validations | Annual |
| Continued alignment to source systems (CIMHA, CPOC-A, QHAPDC, MHEC) | As required |
| Incorporation of new items and fix to survey (Your Experience of Service and Family of Youth) functionality | December 2017 |
| Upgrade to SQL 2016 | May 2018 |
| Changes to QHAPDC to accommodate new residential mental health care reporting requirements | July 2018 |
| Introduction of Statistical Area 2 (SA2) 2016 code set | July 2018 |

# 3. Business options

## 3.1 Identification of options

The Business Case considers three options to deliver the IMHDRR development objectives:

1. Maintain existing functionality (do nothing)
2. Project-based development
3. Business program development

Note the funding requirements and categorisation are based on the 2017-18 budget bid.

### 3.1.1 Option 1: Maintain existing functionality (do nothing)

This option limits the development of IMHDRR, with a focus on maintaining existing functionality that enables continuation of reporting of the Community Mental Health Care National Minimum Data Set and creation of ad hoc and regular reports against currently available data (admitted patient, service episode, referral and provision of service). Support for production (including break fixes) form part of the core support and maintenance functionality. Oversight for maintenance of functionality will be through the MHAODB and Clinical Excellence Division processes.

Table 5 provides a summary of the benefits, dis-benefits, risks, issues and funding requirements for this option. As shown, the dis-benefits outweigh the benefits and despite being the lowest cost, has the highest risk value of all options.

This option is **not recommended** as Queensland Health will not meet its obligations outlined in *Connecting Care to Recovery* in regards to improving HHS self-sufficiency of reporting. IMHDRR will quickly become obsolete as business processes and source systems are updated and changed.

RTI RELEASE

**Table 5: Option 1 summary of benefits, dis-benefits, risks, issues and funding requirements**

| Option 1: Maintain existing functionality (do nothing) | |
|---|---|
| **Benefits** | **Dis-Benefits** |
| • reduced requirement for additional funding above maintenance<br>• limited change management impacts<br>• limited impact on business for testing | • Queensland Health will not meet its obligations outlined in *Connecting Care to Recovery* in regards to improving HHS self-sufficiency of reporting<br>• Lack of access to core data, such as clinical outcomes, Mental Health Act, and consumer demographic information<br>• No further improvement in the efficiency and quality of reporting<br>• CSCPU and HHS resources continue to operate through inefficient and burdensome manual processes<br>• Continued dependence on CSCPU for access to data, which leads to delays in access to information and higher risk of error through manual intervention<br>• No business intelligence functionality to support planning (basic reporting functionality remains)<br>• No self-service functionality for Hospital and Health Services (HHS) to be able to extract and analyse own data<br>• No dashboard functionality can be built into IMHDRR and reliance on external services will be dependent upon manual processes<br>• Stranding of more than $5 million in past investment made in preceding IMHDRR projects in anticipation of additional IMHDRR development |
| **Risks** | **Issues** |
| • Lack of integration with current and evolving data sets<br>• Lack of access to required information impacting upon the quality of decision making at HHS and departmental levels<br>• Staff movement leading to significant reduction in reporting capacity and risk to regular reporting (through manual processes) as recruitment and training is undertaken<br>• Alternate reporting mechanisms may prove more costly in terms of time and funding required<br>• Current support and maintenance arrangements via vendor may be untenable | • Does not meet current and future business requirements<br>• Increased reporting requirements cannot be met in a timely or efficient manner<br>• Capacity to delivery accurate and timely analysis is compromised as staffing resources focus on delivery of regular reporting<br>• HHS will continue to have limited access to data unless an alternate platform to enable reporting to HHS is identified and funded<br>• Opportunity cost of existing resources<br>• Dependency on source systems, and need to develop and release to keep alignment |
| **OVERALL RISK LEVEL: HIGH** | |
| **Funding requirements** | |
| • Recurrent funding is required to maintain existing capabilities (such as reporting against NMDS) including operational support, software licences and minor (non-capital) development.<br>*Recurrent support cost (GST exclusive): $748,223* | |
| ***TOTAL ANNUAL COST (GST exclusive):* $748,223** | |

RTI RELEASE

### 3.1.2 Option 2: Project-based development

This option will deliver benefits managed through a series of projects targeting specific enhancements. Through this option required enhancements will be identified at the initiation of each project life cycle and the full project lifecycle undertaken for the period of the project. Each project will utilise a mixture of agile development concepts and waterfall based management and be supported through the business Product Owner and a dedicated ICT Project Manager. Support and maintenance (as outlined in option one) will also form part of this option. Governance will be through the IMHDRR Delivery Board that was established under the previous projects.

Funding for development will need to be identified and allocated as part of each project initiation. However, base funding for ongoing development and support and maintenance would form part of CSCPU's non-discretionary budget.

Table 6 provides a summary of the benefits, dis-benefits, risks, issues and funding requirements for this option. As shown, the dis-benefits outweigh the benefits, is the highest cost and has a higher risk value than option three. This option is **not recommended** because option three is less expensive and lower risk, and enhances IMHDRR with the features that will deliver the greatest business value in the most efficient manner.

**Table 6: Option 2 summary of benefits, dis-benefits, risks, issues and funding requirements**

| Option 2: Project-based development | |
|---|---|
| **Benefits** | **Dis-Benefits** |
| • The agile project methodology allows for shortened timeframe between requirement gathering, development and production than traditional waterfall methodology<br>• Improved ability to modify erroneous or misunderstood requirements within a timely manner<br>• Realisation of benefits on a progressive, and hence more timely, basis | • Documentation overhead of project requirements that do not align to the agile methodology, requiring a hybrid use of agile and waterfall methodologies<br>• Additional costs (financial and time) in terms of procuring project resources on a more regular basis<br>• Additional project management costs to manage regular ICT development projects<br>• Need for regular bidding for project and capital funding creates additional risks to achieving the overall vision and objectives of IMHDRR through loss of expertise and higher potential of individual projects not being funded<br>• Purchased test resources will continue with a coordination role, requiring significant testing to be prepared and delivered by the business<br>• Reduced flexibility to redirect development priorities and achieve business benefits that align to evolving strategic requirements.<br>• Increased complexity in managing the backlog due to uncertainty of future developments |
| **Risk** | **Issues** |
| • Funding will not be identified for key projects<br>• Loss of technical expertise due to uncertainty of funding<br>• Delays in development associated with delays in procurement of funding for next project<br>• Current support and maintenance arrangements may become untenable due to impact on pre-determined project timeframes<br>• Increased staff turnover associated with test and project management resourcing, leading to reduced productivity | • Increased pressure on business to re-orientate resources for test purposes<br>• Capacity to deliver accurate and timely reporting is compromised as staffing resources focus on testing and delivery of regular reporting<br>• Delay in delivery of benefits due to need to utilise waterfall methodology for some aspects<br>• Dependency on source systems, and need to develop and release to in alignment with source system changes, impacting on project schedules |
| **OVERALL RISK LEVEL: HIGH** | |

RTI RELEASE

| Option 2: Project-based development |
| --- |
| **Funding requirements** |
| • Recurrent funding is required to maintain existing capabilities including operational support, software licences and minor (non-capital) development.<br>*Recurrent support cost (GST exclusive): $748,223*<br>• Development resources, Project Management, Delivery and Test Management Services.<br>*Estimated Annual Program Expense:$758,706*<br>*Estimated Annual Program Capital:$1,148,648*<br>• Internal staffing resources (Product Owner)<br>*Estimated Annual Labour Expense: $124,298* |
| ***TOTAL ANNUAL COST (GST exclusive): $2,779,875*** |

### 3.1.3 Option 3: Business program agile development

This option will deliver benefits managed through a series of releases targeting specific enhancements, guided by:

- overarching business case
- strategic road map
- development backlog
- release strategy (including annual release plans), and
- test strategy (including release specific plans).

The business program will use the agile management style to develop IMHDRR on an ongoing basis through operating a delivery team (encompassing business, vendor and other stakeholders functioning as a virtual team). The key priorities are focused on benefits being realised through agreed, regular releases that align to overall strategic goals, rather than through project based objectives. The business Product Owner will manage the development backlog, informed through governance processes and regular stakeholder engagement. A high level overview of roles and responsibilities are further outlined in Appendix A. Support and maintenance (as outlined in option one) will also form part of this option. Governance will be through the IMHDRR Delivery Board and Advisory Group established under the previous projects. Funding for both support and maintenance and program development would form part of CSCPU's non-discretionary budget.

Table 7 provides a summary of the benefits, dis-benefits, risks, issues and funding requirements for this option. As shown, the benefits outweigh the dis-benefits of this option, as well as far exceeding the benefits of the other identified options. The flexibility and capacity to meet evolving and growing business reporting requirements is best met with this option. Overall, this option has the lowest risk of all options. The proposed costs are lower than option two due primarily to reduction in overhead costs.

This option is **recommended** because it enhances IMHDRR with the features that will deliver the greatest business value at the best price through quicker delivery of releases. This option is the most cost effective return on the time and resources to be invested, given that the costs are low-medium and the benefits are high. It is a medium risk undertaking, due primarily to the complexity of information assets, competing priorities and reporting requirements for mental health.

RTI RELEASE

**Table 7: Option 3 summary of benefits, dis-benefits, risks, issues and funding requirements**

| Option 3: Business program agile development | |
|---|---|
| **Benefits** | **Dis-Benefits** |
| • The agile project methodology allows for shortened timeframe between requirement gathering, development and production<br>• Improved ability to modify erroneous or misunderstood requirements within a timely manner<br>• Realisation of benefits on a progressive, and hence more timely, basis<br>• Maximum flexibility to redirect developmental priorities to meet new and emerging requirements.<br>• Test capacity can be developed within purchased resources<br>• Improved capacity for knowledge transfer and building expertise that can ease impact on business, particularly in terms of testing<br>• Greater capacity for succession planning of business and test resources<br>• Stakeholders will have access to more data on a more timely basis<br>• Reporting can grow with business requirements<br>• Increased capacity of existing resources to undertake additional reporting/analysis that aligns with evolving departmental goals | • CSCPU will need to implement additional governance and assurance processes |
| **Risks** | **Issues** |
| • Backlog management will not align to strategic organisational objectives<br>• Reduced governance over the development and delivery processes<br>• Reduced assurance over testing and development and delivery processes | • Dependency on source system, and need to develop and release to keep alignment |
| **OVERALL RISK LEVEL: MEDIUM** | |
| **Funding requirements** | |
| • Recurrent funding is required to maintain existing capabilities including operational support, software licences and minor (non-capital) development.<br>*Recurrent support cost (GST exclusive): $748,223*<br>• Development resources, Project Management, Test Management Services.<br>*Estimated Annual Program Expense:$518,004*<br>*Estimated Annual Program Capital:$1,148,648*<br>• Internal staffing resources (Product Owner and Delivery Manager)<br>*Estimated Annual Labour Expense: $248,596* | |
| ***TOTAL ANNUAL COST (GST exclusive): $2,663,471*** | |

## 3.2 Summary of options

*Option one* is **not recommended** as Queensland Health will not meet its obligations outlined in *Connecting Care to Recovery* in regards to improving HHS self-sufficiency of reporting. IMHDRR will quickly become obsolete as business processes and source systems are updated and changed.

*Option two* is **not recommended** because option three is less expensive and lower risk, and enhances IMHDRR with the features that will deliver the greatest business value in the most efficient manner.

*Option three* is **recommended** because it enhances IMHDRR with the features that will deliver the

RTI RELEASE

greatest business value at the best price through quicker delivery of releases. This option is the most cost effective return on the time and resources to be invested, given that the costs are low-medium and the benefits are high. It is a medium risk undertaking, due primarily to the complexity of information assets, competing priorities and reporting requirements for mental health.

# 4. Benefit analysis

The anticipated high level benefits of IMHDRR and progressing to a Business Program are outlined in Table 8. All benefits are owned by the Executive Director, Mental Health Alcohol and Other Drugs Branch and each release will incrementally achieve against one or more benefits.

**Table 8: Key benefits**

| Benefit No. | Description |
|---|---|
| 1 | **Mental health information is available for regular and consistent reporting**<br>A range of data is available through IMHDRR to support HHS and Department of Health reporting requirements through the most effective mechanisms (such as standard reports or dashboards). End users will see IMHDRR as a reliable source of information and reports will be accessed and utilised for multiple purposes |
| 2 | **Enhanced timeliness in access to mental health reporting**<br>HHS are able to access and utilise data as required without MHAODB having to provide data through alternate mechanisms. Data is reliably updated as per agreed schedule with no unplanned outages. |
| 3 | **Enhanced efficiency in the development and maintenance of regular reports**<br>There is a reduction in the time and effort required to develop regular reports, with appropriate security. This will enable analytic resources to be able to provide more reporting and/or be redirected to policy driven analysis rather than reporting.<br>The majority of performance reports being delivered within 20 working days and other regular reports within ten working days.<br>Maintenance of reports should be minimal, with a single report being able to be utilised across all HHS. |
| 4 | **Enhanced service (HHS) reporting self-sufficiency**<br>HHS are able to securely access data via IMHDRR through a combination of MHAODB developed reports, as well as capacity to extract data to own systems and create own reports utilising IMHDRR infrastructure. This functionality should also support capacity to develop state-wide mental health dashboards. |
| 5 | **Improved data linkage and patient matching**<br>Linkage between source systems maximises accurate identification of individuals across systems. This will leverage existing and evolving linkage solutions. |
| 6 | **Improved validation processes and data quality**<br>The collation of data within IMHDRR will enable enhanced validation to support both national and state reporting |
| 7 | **Queensland continues to be able to meet its national reporting requirements**<br>IMHDRR can be leveraged to facilitate submission of a range of national reporting, including National Minimum Data Sets, National Best Endeavours Data Sets and Performance reporting. |
| 8 | **IMHDRR development is cost effective**<br>An initial function of IMHDRR was to enable legacy systems to be retired whilst enabling access to data. This reduced the support costs associated with the systems. This initial benefit was met. IMHDRR should remain cost effective in terms of development as well as ongoing support costs. This will be monitored through procurement processes, as well as the extent that other benefits are realised. |

RTI RELEASE

| Benefit No. | Description |
|---|---|
| 9 | **Enhanced efficiency in system development and management**<br>The architecture of IMHDRR should continue to deliver efficiencies to system development, data storage and overall management. Changes to IMHDRR (including new and enhanced data sources) should be able to be accommodated without a need to reconfigure existing architecture. |

# 5. Risk analysis

**Table 9: IMHDRR Development Risks**

| Risk ID | Risks | Likelihood | Consequence | Management Strategy |
|---|---|---|---|---|
| 1 | Backlog management will not align to strategic organisational objectives | Possible | Moderate | Dedicated position (Product Owner) to manage the backlog.<br>Use of electronic backlog management tool (JIRA) to support documentation, communication and prioritisation.<br>Development and maintenance of Strategic Talkbook.<br>Implementation of HHS User Group to support communication and linkages with HHS requirements.<br>Continuation of CSCPU Advisory Group to support backlog management. |
| 2 | Reduced governance over the development and delivery processes | Unlikely | Moderate | Continuation of IMHDRR Delivery Board, including external representation. |
| 3 | Reduced assurance over the development and delivery processes | Possible | Moderate | Engaging testing resources through clinical program, eHealth Queensland to enable access to test expertise and linkages to current processes and requirements.<br>Utilising eHealth Queensland processes, such as Change Advisory Board, as required.<br>Undertaking an annual 'health check', that aligns of whole-of-government assurance requirements, regarding development and delivery processes.<br>Development of overarching Test Strategy to support test processes. The strategy will support development of Test Plans for each release.<br>Development of overarching Release Strategy to support release processes. The strategy will support development of release plans for each release. |

RTI RELEASE

**Table 10: IMHDRR Development Issues**

| Issue ID | Risks | Likelihood | Consequence | Management Strategy |
|---|---|---|---|---|
| A | Dependency on source systems | Possible | Moderate | Maintenance of Interface Dependency Agreements between CSCPU and each System Custodian.<br>Establishment and maintenance of communication channels between source systems and IMHDRR delivery team to identify source system changes. |

# 6. Achievability

## 6.1 Funding (Option Three)

**Table 11: Budget breakdown, 2017-18**

| Type | | Category | Annual |
|---|---|---|---|
| Support and Maintenance | Expense (Non-Labour) | Operational support (DAS)[1] | $397,239 |
| | | Support and Maintenance (Vendor) | $236,484 |
| | | Licence fees (SQL, Jira, Confluence, ALM) | $69,500 |
| | | External Services ( including Annual Health Check, Penetration Testing)* | $45,000 |
| | **Support and Maintenance Sub-Total** | | **$748,223** |
| Development | Expense (Non-Labour) | Test Services | $241,624 |
| | | Interface development and maintenance | $50,000 |
| | | Development Project Management[2] | $226,380 |
| | | Delivery Management[3] | $240,702 |
| | | *Sub-Total* | *$758,706* |
| | Expense (Labour) | IMHDRR Product Owner (1 FTE)[4] | $124,298 |
| | | *Sub-Total* | *$124,298* |
| | Capital | Software Development | $1,148,648 |
| | | *Sub-Total* | *$1,148,648* |
| | **Development Program Sub-Total** | | **$2,031,652** |
| **Program Total** | | | **$2,779,875** |

**Notes**

1. This figure is the revised annual support requirement advised by DAS in August 2017.
2. Based on previous advice the vendor's project management costs were bid for as expense as part of the 2017-18 budget. From 2018-19 it is anticipated that this cost will be a component of the capital funding. This assumption is shown in the five year forecast outlined in Table 12.
3. The 2017-18 budget assumes that the IMHDRR Delivery Manager role will be filled through eHealth Queensland Clinical Program. This business case proposes that an additional MOHRI position be allocated to CSCPU to support long term recruitment to the role. If the MOHRI is approved, this will reduce costs by approximately $116,404.
4. The Product Owner has temporary funding until 30 June 2019. Additional funding and MOHRI will need to be found to support continuation of the role post this date.
5. These costs do not include the costs borne by the business to incorporate IMHDRR within business as usual.

RTI RELEASE

**Table 12: Five-year funding requirements, Option Three**

| Budget Breakdown | | | | | | |
|---|---|---|---|---|---|---|
| Financial Year | Year 1 **2017-18 (Approved)** | Year 2 **2018-19** | Year 3 **2019-20** | Year 4 **2020-21** | Year 5 **2021-22** | Total investment cost |
| **Labour** | | | | | | |
| Number of Internal Staff (MOHRI Occupied FTE)[1, 2] | 1 | 2 | 2 | 2 | 2 | 2 |
| Internal Labour Budget | $124,298 | $254,811 | $261,181 | $267,711 | $274,403 | $1,182,404 |
| **Labour Total** | $124,298 | $254,811 | $261,181 | $267,711 | $274,403 | $1,182,404 |
| **Non-Labour** | | | | | | |
| Capital[3] | $1,148,648 | $1,443,779 | $1,515,968 | $1,591,766 | $1,671,355 | $7,371,515 |
| Non-Labour (Development) | $758,706 | $558,943 | $586,890 | $616,234 | $647,046 | $3,167,820 |
| Non-Labour (Support and Maintenance) | $748,223 | $785,634 | $824,916 | $866,162 | $909,470 | $4,134,404 |
| **Non-Labour Total** | $2,655,577 | $2,788,356 | $2,927,774 | $3,074,162 | $3,227,870 | $14,673,739 |
| **Total Budget** | $2,779,875 | $3,043,167 | $3,188,955 | $3,341,873 | $3,502,273 | $15,856,143 |

**Notes**

1. The Product Owner has temporary funding (and MOHRI) until 30 June 2019. Additional funding and MOHRI will need to be found to support continuation of the role post this date.
2. The funding requirement assumes that the full cost saving for the IMHDRR Delivery Manager role will be realised from 2018-19.
3. The vendor's project management costs were bid for as expense as part of the 2017-18 budget. From 2018-19 it is anticipated that this cost will be a component of the capital funding.
4. Capital and non-labour out-years have been forecast based on a 5% annual increase. For labour expense, this is forecast at a 2.5% annual increase.

## 6.2 Staff resources

The Program will be managed within CSCPU with oversight provided within existing staffing resources, primarily via the Analysis and Accountability Team who report directly to the Director, CSCPU. Essential governance roles are managed through Manager, Analysis and Accountability.

There is a requirement for dedicated resources to support this program, with a lead to support the three key areas: Development → Testing → Delivery (Figure 1).

MHAODB acquired funding and engaged a temporary Product Owner until 30 June 2019 to support delivery. Test resources are accessed through engaging Clinical Program, eHealth Queensland.

Delivery management is a new concept adopted as part of the Business Program. The role takes on some


**Figure 1: IMHDRR Staff Resources**



RTI RELEASE

elements previously managed through the Project Manager (engaged through Clinical Program), but focuses on supporting the delivery of releases (for both development and support and maintenance) rather than overarching project management. Initially, MHAODB attempted to source a delivery manager through the Clinical Program, however an available resource with the requisite skill set was not able to be identified and the Clinical Program subsequently identified that they are unable to provide program-based resources (that is, they only provide delivery management resources for discrete projects). CSCPU does not have the capacity to manage the Delivery Manager role within existing resources, so to manage the risk post end of previous project, MHAODB engaged a project officer (AO7) until 30 September 2017. This position reports directly to Manager, Analysis and Accountability, CSCPU.

Engaging a resource directly affords considerable financial savings. The key risk to this approach relates to the governance and support to the role provided when engaged through Clinical Program. However, continuation of the Delivery Board, which includes Clinical Program representation, and purchasing an independent annual health check of delivery and test processes, is seen as a mitigating factor. If the MOHRI can be expanded to accommodate an additional resource, engaging a Delivery Manager directly is a viable option. If the MOHRI cannot be expanded, then resources will need to be engaged through the Clinical Program at an additional annual cost of approximately $116,404. Use of the Clinical Program will also require a re-configuration of the role to focus more on project management aspects of the role (to align to the remit and focus of Clinical Program).

Service agreements will manage the technical development, including support and maintenance, with the vendor and system support with Digital Application Services, eHealth Queensland.

## 6.3 Governance and accountability

The IMHDRR Program will be governed through Clinical Excellence Division approval processes, supported by the IMHDRR Delivery Board. The development work will be managed through use of a development backlog, whereas release and test activity will be governed through overarching test and release strategies, with specific plans developed for each release. These strategic documents will be provided through the IMHDRR Delivery Board.

Figure 2 provides an overview of IMHDRR's governance structure and Table 13 identifies location of current endorsed governance documentation.

**Table 13: Governance documentation**

| Document | Location | Version |
|---|---|---|
| **Delivery Board Terms of Reference** | U:\MHD\CSCPU\PPR\IMHDRR\IMHDRR Delivery Board\ToR | **1.0, October 2016** |
| **Advisory Group Terms of Reference** | U:\MHD\CSCPU\PPR\IMHDRR\CSCPU Advisory Group\TOR | **1.0, November 2016** |
| **User Group Terms of Reference** | U:\MHD\CSCPU\PPR\IMHDRR\IMHDRR User Group\TOR | **1.0, November 2016** |

RTI RELEASE

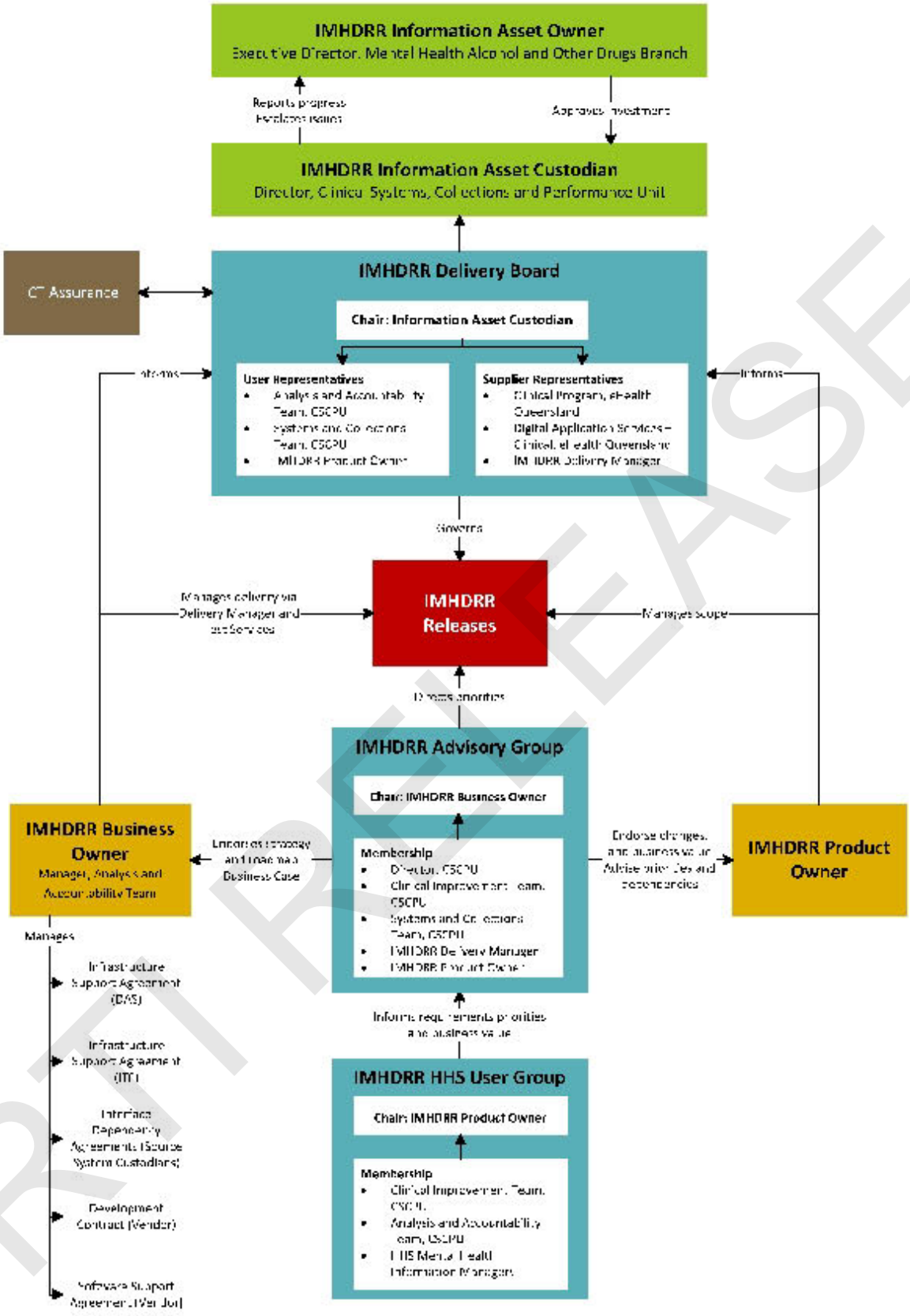



**Figure 2: IMHDRR Development Governance**

RTI RELEASE

## 6.4 Considerations

### 6.4.1 Related initiatives

- Implementation of the *Connecting care to recovery 2016–2021: A plan for Queensland's. State-funded mental health, alcohol and other drug services*
- Measurement Strategy for *Connecting care to recovery 2016–2021: A plan for Queensland's. State-funded mental health, alcohol and other drug services*
- Hospital and Health Service (HHS) Service Agreements Performance Framework
- Implementation of the Mental Health Act 2016
- Development of the Australian Mental Health Care Classification
- Implementation of the Residential Mental Health Care National Minimum Data Set
- National Best Endeavours Data Sets related to Your Experience of Service, Seclusion and Restraint

### 6.4.2 Assumptions

The following assumptions have been made as part of the business case:

- Governance continues to include representation at an appropriate executive level to enable effective decision making
- Stakeholder and subject matter experts are available to support identification of requirements and development of technical solution
- Subject matter experts providing input to the business requirements can agree on common ways of undertaking business processes
- A new IMHDRR Development and Support contract will be in place when the current contract reaches its expiry date in September 2018 with little or no loss of development cadence

### 6.4.3 Constraints and dependencies

The following constraints have been identified:

- IMHDRR is an operational system currently in production.
- There are limitations on MHAODB resources which may impact on timeliness of delivery.
- There are limited application support resources in eHealth Queensland Digital Application Services (DAS) Clinical team, which may impact implementation dates of the required releases.
- Access to some data sources (e.g. admitted patient) is dependent upon accessing resources and support from a range of data custodians and subject matter experts from across the Department of Health.
- The quality of data in the system and reporting from the system will be significantly determined by the quality of data contained in the source systems that can be delivered through the interfaces into the IMHDRR system.
- The IMHDRR roadmap is based on known departmental and HHS priorities and ongoing budgetary support. When program/project budgets are known it may be necessary to re-prioritise and reschedule the roadmap.

There is an ongoing dependency for the continued availability and alignment with source systems that may impact upon scheduling and resources:

- Consumer Integrated Mental Health Application (CIMHA).
- Consumer Perceptions of Care Application (CPOC-A)
- Queensland Hospital Admitted Patient Collection (QHAPDC)
- Mental Health Establishments Collection Application (MHECA)

RTI RELEASE

- Emergency Department Collection (EDC)

# 7. Contact Officer

If you have any questions regarding this document or if you have a suggestion for improvements, please contact:

Contact officer: Kristen Breed

Title: Manager, Analysis and Accountability Team, Clinical Systems, Collections and Performance Unit

Phone: 3328 9588 / [redacted]

Email: kristen.breed@health.qld.gov.au

RTI RELEASE

# Appendix A. The agile delivery team – roles and responsibilities

There are six key components to the agile delivery team: Business (CSCPU) → Product Owner → Development Team (vendor) → Test Services → Delivery Manger → Digital Application Services. This virtual team provides the foundation to the ongoing development of IMHDRR. The following table outlines the key (that is, mandatory) roles and responsibilities associated with each role

**M** – Manage/Coordinate, **P** – Participate, **R** – Monitor/Review, **A** – Approve

| Function / Task | Business | Product Owner | Development Team | Test Services | Delivery Manager | Digital Application Services |
|---|---|---|---|---|---|---|
| **Requirement Gathering** | | | | | | |
| Stakeholder identification and engagement | | M | | | | |
| Workshops | P | M | | P | P | |
| Documentation | A | M | | P | P | |
| **Backlog Management** | | | | | | |
| Manage addition and progression of items through the backlog (including support and maintenance) | P | M | | | | |
| Identification and comparison of business value | M | P | | | | |
| Backlog grooming (*ceremony*) | | M | P | P | P | |
| Requirement estimating (*ceremony*) | | M | P | P | P | |
| Sprint goals and prioritisation | | A | M | | | |
| Sprint Planning (*ceremony)* | | P | M | P | P | |
| Sprint task identification | | | M | | | |
| Sprint review (*ceremony*) | P | A | M | P | P | |
| Sprint retro (*ceremony*) | | P | M | P | P | |

RTI RELEASE

| Function / Task | Business | Product Owner | Development Team | Test Services | Delivery Manager | Digital Application Services |
|---|---|---|---|---|---|---|
| **Feature Development** | | | | | | |
| Analysis and Design | A | A | M | R | R | |
| Technical development | | | M | | | |
| Peer review | | | M | | | |
| Issue management | P | P | M | | | |
| **Release Management** | | | | | | |
| IMHDRR Release Strategy | A | P | P | P | M | P |
| Determination of release scope | A | M | P | P | P | |
| Release plan (*release specific*) | A | P | P | P | M | P |
| Release planning (*meeting*) | P | P | P | P | M | P |
| Dependency management | P | | P | | M | P |
| Risk and Issue Management | P | | P | | M | P |
| Change Advisory Board | P | P | | | P | M |
| Cyber Security Risk Assessment | | | | P | M | |
| Pen Testing | | | | P | M | |
| Annual Assurance Check | P | P | P | P | M | P |
| Request for Change (RFC) Summary | A | R | R | P | M | P |
| Test Risk Register | A | R | | P | M | P |
| System Capacity Plan (SCP) | A | | P | | R | M |
| Solution Implementation Design (SID) | P | | P | | | M/A |
| Interface Dependency Agreement(s) (IDAs) | A | | M | | R | |
| System Release Activity | P | P | P | P | P | M |
| Source system coordination | P | P | P | P | M | P |

RTI RELEASE

| Function / Task | Business | Product Owner | Development Team | Test Services | Delivery Manager | Digital Application Services |
|---|---|---|---|---|---|---|
| **Test Management** | | | | | | |
| IMHDRR Test Strategy | A | R | R | M | R | |
| Master Test Plan Lite (*release specific*) | P | P | P | M | P | P |
| Test Assurance (*release specific*) | | | | M | | |
| Test Environment Coordination (*release specific*) | | | P | P | M | P |
| *Feature Acceptance Testing* | | | | | | |
| System Test | | | M | R | | |
| Business Test Case Development | P | | | M | R | |
| Business Test Case Execution | P | | | M | | |
| Defect Management | P | P | P | M | P | |
| *User Acceptance Testing* | | | | | | |
| UAT Test Plan | A | P | A | M | P | A |
| System Test | | | M | R | | |
| Environment Shake-down | | | | M | | |
| Regression Testing | P | | | M | | |
| Business Test Case Execution | P | | | M | | |
| Defect Management | P | P | P | M | P | |
| Test Summary | A | R | R | M | R | R |
| *Production Acceptance Testing* | | | | | | |
| PAT Test Plan | A | P | A | M | P | A |
| System Test | | | M | | | |
| Environment Shake-down | | | | M | | |
| Regression Testing | P | | | M | | |
| Business Test Case Execution | P | | | M | | |

RTI RELEASE

| Function / Task | Business | Product Owner | Development Team | Test Services | Delivery Manager | Digital Application Services |
|---|---|---|---|---|---|---|
| Defect Management | P | P | P | M | P | |
| Test Summary | R | R | R | M | R | R |
| *Go-Live Testing* | | | | | | |
| Go Live Shake-down | | | | M | | |
| **System Support and Maintenance** | | | | | | |
| System support | | | | | | M |
| Production issue notification | M | | | | | |
| Production issue investigation | | | M | P | | M |
| Production issue solution | P | P | M | | P | M |
| Production issue solution implementation | P | P | P | P | M | P |
| **Governance** | | | | | | |
| Business Case | M | | | | | |
| Strategy TalkBook | M | R | | | | |
| Program Management (including reporting) | M | | | | P | |
| IMHDRR Delivery Board | P | P | | | M | P |
| IMHDRR Advisory Group | M | P | | | P | |
| IMHDRR User Group | P | M | | | | |
| Account Level Meeting | P | P | M | | P | |
| Service Level Agreement (Support) | M | | | | | M |
| Vendor Contract (Development and Support) | M | | | | | |
| Budget Management | M | | | | P | |
| Licencing (including SQL, Jira, Confluence) | A | | P | | M | P |

RTI RELEASE

| Function / Task | Business | Product Owner | Development Team | Test Services | Delivery Manager | Digital Application Services |
|---|---|---|---|---|---|---|
| **End-User Engagement and Support** | | | | | | |
| Access Management | M | | | | | |
| Help Desk | M | | | | | |
| User Guide (End Users) | M | | | | | |
| *Communication* | | | | | | |
| Development | P/A | M | | | | |
| Release | P/A | | | | M | |
| Production | M | | | | | |
| Communication and Engagement Plan | M | | | | | |
| Training Strategy | M | | | | | |

RTI RELEASE

# Appendix B. Abbreviations

| | |
|---|---|
| CIMHA | Consumer Integrated Mental Health Application |
| CSCPU | Clinical Systems, Collections and Performance Unit |
| HHS | Hospital and Health Services |
| IMHDRR | Integrated Mental Health Data Reporting Repository |
| MHAODB | Mental Health Alcohol and Other Drugs Branch |
| MHEC | Mental Health Establishments Collection |
| QHAPDC | Queensland Hospital Admitted Patient Data Collection |
| YES | Your Experience of Service |

RTI RELEASE

DOH RTI 4812

# Ministerial Brief for Noting

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-17/6908** |
| **Division/HHS:** | |
| **File Ref No:** | |

**SUBJECT:** Victim involvement in Mental Health Review Tribunal hearings

**Recommendation/s**

**It is recommended the Minister note the options provided in the attached paper (Attachment 1).**

**NOTED** **PLEASE DISCUSS**

**Cameron Dick MP** **Date: / /**
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

| |
|---|
| |
| |
| |
| |

**Issue/s**

1. This brief is urgent. On Thursday 21 September 2017, this Minister's office requested the information be provided 'within a few days'.
2. Consideration is being given to changes that can be made to the Mental Health Review Tribunal (MHRT) processes to increase the involvement of victims in relevant proceedings under the *Mental Health Act 2016* (MHA 2016).
3. Five options are outlined in the attached discussion paper (Attachment 1):
   - 3.1. Expanding the type of information that may be provided to victims by the MHRT
   - 3.2. Requiring the MHRT to make more prescriptive conditions which may provide surety to victims by limit the treating psychiatrist's authority to authorise community leave
   - 3.3. Establishing a separate tribunal for reviews of forensic patients charged with the most serious offences (prescribed offences under the MHA 2016)
   - 3.4. Enabling victims to attend MHRT hearings (currently these are closed hearings)
   - 3.5. Providing for an 'automatic stay' to a decision of the MHRT to provide the parties to the proceeding (e.g. the Attorney-General) an opportunity to appeal against the decision before it was enacted.
4. The above options have all been costed in the attached discussion paper.

**Vision**

5. Enhancing victim involvement in MHRT proceedings may lead to increased confidence in the mental health system. This in turn, aligns with the direction set out for Connecting healthcare in the 10 year vision *My health, Queensland's future: Advancing health 2026* which seeks to, amongst other things, ensure the health system works for the broader community

**Background**

6. Under the MHA 2016, the MHRT has jurisdiction to review forensic orders which provide for a person's involuntary treatment and care.

**Michael Walsh**
**Director-General**
**/ /2017**

RTI RELEASE

| | |
|---|---|
| **Department RecFind No:** | |
| **Division/HHS:** | |
| **File Ref No:** | |

7. The MHRT may approve a forensic patient be detained as an inpatient with/without access to community leave, or approve that the person be placed on a community category order.
8. Decisions of the MHRT can be appealed to the Mental Health Court, and decisions of the MHC are appealable to the Court of Appeal.
9. Prescribed offences under the MHA 2016 include murder, attempted murder, manslaughter, grievous bodily harm and acts intended to cause grievous bodily harm, rape, attempt to commit rape, assault with intent to commit rape.

**Sensitivities**

10. Not applicable.

**Results of Consultation**

11. The President of the MHRT has been consulted as part of the development of options in the attached paper and her feedback has been incorporated. However, consultation with the President has not occurred in relation to costing these options.

**Resource Implications (including Financial)**

12. Resourcing implications for each option are outlined in the attached paper.

**Attachments**

13. Attachment 1 - Victim involvement in Mental Health Review Tribunal Processes

**Department Contact Officer**

| Author | Cleared by: (SD/Dir) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Bobbie Clugston | Dr John Reilly | Dr John Wakefield |
| Director – Legislative Projects | A/Executive Director | Deputy Director-General |
| OCP/MHAODB | MHAODB/CED | CED |
| 3328 9590 | 3328 9536 | <Tel number> |
| [redacted] | <Mob number> | <Mob number> |
| 27/09/2017 | <Date> | <Date> |
| | | |

**Joe Riverstone, Business Manager, MHAODB/CPB comments**

**Date:** 28/09/2017
**Delegation check:** N/A, discussion paper for noting only.
**Purchasing arrangements check :** N/A
**Funding / Budget availability:** N/A. Discussion paper for noting, funding will depend on options if undertaken in the future.
**Project commencement non-recurrent approved value:** N/A
**Items / $ previously committed against project commencement approval:** N/A
**Is funding going past this current FY if yes $value:** N/A
**Sufficient Support Documentation :** Yes
**Type 5 Contract for Q Contracts Y/N:** No
**General Comments**
Ok to proceed.

NOT RELEASE

Clinical Excellence Division

# DDGCED

Excellence | Transparency | Patient Safety | Clinician Leadership | Innovation

PT RELEASE

## Title: Victim involvement in Mental Health Review Tribunal Processes

1. This paper provides advice regarding processes by which victim involvement may be increased in Mental Health Review Tribunal (MHRT) proceedings under the *Mental Health Act 2016* (MHA 2016).
2. The President of the MHRT has not been consulted in relation to the costing estimates in this paper. Further consultation with the MHRT would be required prior to determining final resourcing requirements.

## Report of Findings

3. Section 320 of the MHA 2016 provides that a 'registered victim' has a right to receive an information notice which includes the decision of the MHRT on a review of a forensic patient. The information notice is issued by the Chief Psychiatrist and contains limited information about the decision of the MHRT (e.g. whether the patient can access the community, non-contact orders and decisions relating to requirements to take medication and/or undertake drug screening
4. If a decision of the MHRT results in an increase of community leave, the victim is also entitled, under section 324, to receive a brief explanation of the reasons for the decisions (e.g. the person has responded well to treatment). The MHRT has developed a 'check-box' form for this explanation.
5. In New South Wales (NSW), the MHRT may, on a case by case basis, publicly issue an Official Report of its proceedings. An Official Report contains the significant information from the hearing however all identifying information about the particular patient is removed.
6. These Official Reports are not specifically developed for victims, rather are available publicly if the MHRT determines that it is appropriate to publish a decision, for example, if a particular case has broader significance. The NSW MHRT has issued 5 official reports in 2017 to date.
7. The NSW Official Reports are comprehensive and include the MHRT decision as well as background (original court decision), MHRT legislative requirements, attendees present (by position), evidence list or summary, present circumstances, risk issues, submissions from parties and determination.

*Options*

8. Option 1:
   - 8.1. Section 758 of the MHA 2016 provides that the MHRT may publish decisions and reasons for decisions provided the reasons do not identify any person, or contravene a confidentiality order or order prohibiting disclosure of a victim impact statement.
   - 8.2. The MHRT could publish reasons for decision using a similar approach to the NSW Official Reports.
   - 8.3. This option could commence within existing resources.



Queensland Government

9. Option 2:

9.1. To specifically enhance victim information access for matters where a prescribed offence has occurred (e.g. murder, attempted murder, rape, etc.), it may be appropriate to provide 'registered victims' with a report of findings that contains identifiable information.

9.2. Currently there are 57 'registered victims' who would be eligible for such a report.

9.3. Amendments to section 324 and Schedule 1 of the MHRT would be required to provide that victims of a prescribed offence may apply for an information notice which includes a written report of reasons for decisions made by the MHRT.

9.4. Sufficient resourcing would be required to support the additional administrative function of routinely (every six months) providing reasons for findings for 'registered victims'.

*Costing estimates*

9.5. Table 1 outlines the additional FTE required to fulfil this function. Estimates include:

9.5.1. FTE for the MHRT to manage additional administrative processes (application processing, drafting reports):

- 1x 0.3 Administration officer (AO5)
- 1x 0.2 MHRT member (presiding)

9.5.2. FTE for the Office of the Chief Psychiatrist (OCP) to manage additional information management processes (notifications to victims)

- 1x 0.5 Administration officer (AO6)

Table 1

| | Funding type | Additional for 2018/19 | Additional for 2019/20 |
|---|---|---|---|
| MHRT | Operational and recurrent | $83,593 | $85,411 |
| OCP | Operational and recurrent | $71,177 | $73,219 |
| Total | | $154,770 | $158,630 |

*Assumptions:*

9.6. Estimates are based on 72 written statements being required bi-annually (there are 57 eligible victims currently, plus an additional 15 per year in potential new applications). This equates to approximately 22 additional MHRT sittings days per annum.

9.7. Costing estimates for the MHRT member are based on the 2016/17 presiding member allocated fees. The Queensland Health Costing Template 2014-15 V1.3 has been utilised to estimate the additional administration support costs.

9.8. Additional costs associated with non-FTE resourcing (e.g. IT, printing, mail) have not been costed as these may be able to be met within existing non-FTE resources

RTI RELEASE

## Progression of leave

10. A key feature of the forensic mental health system is the progression of patients from inpatient detention to community leave in line with their recovery.
11. In some high profile cases, concerns have been raised regarding the apparent speed with which forensic patients may transition back to the community.
12. The extent of community leave a person may access is determined by the Mental Health Court (MHC) or MHRT. Within the limits set by the MHC or MHRT, an authorised doctor may, with the approval of these bodies, authorise that a person access leave on a day to day basis.
13. The management of community leave by the person's treating doctor allows for decisions about leave to be made on a day-to-day basis and take account of the patient's current circumstances.
14. The MHRT may determine that a patient should access leave in a graduated manner (e.g. starting with day leave with incremental increases up to full community leave). However, the MHRT does not generally prescribe the timeframe within which a person would progress through the various stages of community leave.
15. In some cases however, it may be appropriate for the MHRT to make more prescriptive conditions (including for example timeframes for leave, or a requirement for a further review to occur before leave is progressed) within which the treating psychiatrist may authorise leave.
16. Prescriptive conditions would essentially place narrower limits on the treating psychiatrist, who would still be able to authorise community leave within those limits to the extent it is appropriate for the patient at the relevant time.
17. Victims may experience greater certainty in a prescriptive MHRT decision if there are concerns about the patient access community leave. Victims who are entitled to receive an information notice about MHRT decisions would be entitled to receive a copy of the MHRT decision.

*Option*

18. Prescriptive decisions by the MHRT could commence immediately without legislative changes.
19. This option could commence within existing resources.

## Forensic Review Tribunal

20. Within their forensic mental health systems, NSW and Victoria have a dedicated tribunal that is responsible for reviewing forensic patients. These tribunals are administratively separate from the tribunal which reviews 'civil' involuntary treatment.
21. Forensic review panels operate similarly to civil tribunals however only consider matters relating to forensic patients. For this reason, different members (i.e. with forensic mental health or legal expertise) may be appointed.
22. In Queensland, both civil and forensic matters are considered by the MHRT and in general, panel members may be consistently appointed across both civil involuntary treatment and forensic reviews.
23. In 2015/16, the number of forensic MHRT hearings was approximately 1,965. This compares with 10,456 for civil MHRT hearings.

RTI RELEASE

23.1. Generally, MHRT panels in Queensland consist of a legal, psychiatric and community member. For prescribed offences (e.g. murder, attempted murder, rape, etc.,) the President of the MHRT has instigated a practice which requires an expanded panel of MHRT members; four members are appointed instead of three. In cases where the panel is unable to be expanded, the President (or delegate) presides over the panel.

24. The expanded panel consists of an additional community or legal member and all members are required to have specialist training in the forensic mental health system.

*Options*

25. Option 1

25.1. A forensic leave panel could be specifically established in Queensland. Depending on the model developed, this would require amendments to the MHA 2016 and would have significant potential implications for MHRT functioning with associated resourcing implications.

*Costing estimates*

25.2. Three different options for the forensic leave panel could be considered:

25.2.1. Establish a separate forensic leave panel to review all forensic patients (FLP A)

25.2.2. Establish a separate forensic leave panel to review forensic patients charged with a prescribed offence (FLP B)

25.2.3. Prescribe that the MHRT be constituted with specialist members with forensic expertise to review forensic patients charged with a prescribed offence (FLP C)

25.3. Estimates for FLP A include member sitting fees, training and administrative costs for running a wholly separated forensic leave panel (staff, office space, computers, phone, travel).

25.4. Estimates for FLP B include members sitting fees and training.

25.5. Estimates for FLP C include training only.

25.6. Table 2 outlines the resources required for each forensic leave panel type.

Table 2

| | Funding type | Additional for 2018/19 | Additional for 2019/20 |
|---|---|---|---|
| FLP A | Operational and recurrent | $1,172,617 | $1,181,261 |
| FLP B | Operational and recurrent | $152,300 | $171,900 |
| FLP C | Operational and recurrent | $20,000 | $20,000 |

*Assumptions:*

25.7. Estimates for FLP A are based on 1000 reviews of forensic patients being required bi-annually (there are currently 899 forensic patients and approximately 150 new patients each year). This equates to approximately 286 sitting days per annum.

RTI RELEASE

25.8. Estimates for FLP B is based on 170 reviews of forensic patients with prescribed offences being required bi-annually (there are currently 161 eligible patients and approximately 10 new eligible patients each year). This equates to approximately 49 MHRT sittings days per annum.

25.9. Costing estimates for the MHRT member are based on the 2017/18 allocated fees. The Queensland Health Costing Template 2014-15 V1.3 has been utilised to estimate additional administration support costs.

25.10. Administrative costs (FTE and non-FTE resourcing) for FLP A assume a completely separate administrative process. Costs have been based on the administrative support process for forensic patient reviews equating to approximately .1FTE equivalent for the existing MHRT staff numbers (e.g. 10% of each FTE's time). Calculations for the President and Deputy President for FLP A are based on .2 FTE equivalent due to the likelihood of these positions sitting more frequently on FLP A panels.

25.11. Administrative costs for FLP B and C have not been costed as it is assumed that the MHRT would continue to provide oversight /administrative functions to the FLP (i.e. the President of the MHRT would also be the President for the FLP and administrative staff would support FLP members).

25.12. Recruitment costs for a newly established FLP have not been estimated.

*Notes:*

25.13. Resourcing for member sittings fees could potentially be transferred from the MHRT to any FLP A or FLP B due to these hearings currently being undertaken by the MHRT.

26. Option 2

26.1. The current expanded panel for prescribed offences could be formalised through a practice direction from the MHRT President.

26.2. This process currently occurs, and therefore could continue without additional changes.

26.3. This option could commence within existing resources.

**Attendance at hearings**

27. Under the MHA 2016, victims in Queensland are able to make submissions (a victim impact statement) to the MHC and the MHRT.

28. A victim impact statement may include the views of the victim about the risk a person represents and a request by the victim that that a non-contact condition be made. The victim impact statement is not provided to the patient unless the victim requests that it be disclosed.

29. The MHC and MHRT are required to have regard to the statement in their decisions about for example, whether a forensic order is required and the amount of community leave a forensic patient can access.

30. If a victim impact statement is provided in the MHC hearing, it is automatically given to the MHRT to enable it to be considered by the MHRT in forensic order reviews.

31. Although MHRT hearings are not open to the public, the attendance of victims at an MHRT hearing as an 'observer' is able to be facilitated under section 741 of the MHA 2016 with the approval of the President of the MHRT and the consent of the patient.

RTI RELEASE

32. NSW MHRT hearings are open to the public, however in practice are not publicly accessible (e.g. there is no public hearings list and hearings are held at various hospital and correctional facilities [similar to Queensland]).
33. Registered victims in NSW are able to observe hearings of forensic patients, generally by videolink or teleconference. In 2016, 7% of forensic patient hearings were attended by victims (79 of 1079).
34. The NSW MHRT advised:
    - 34.1. The victim's right to participate in a hearing is limited to outlining any request for a non-association or place restriction condition.
    - 34.2. Registered victims do not have a right to legal representation before the Tribunal and cannot cross-examine any other person appearing before the Tribunal.
    - 34.3. If the Tribunal is not considering a leave or release application, then the registered victim is only an observer in the hearing and may not otherwise participate.
    - 34.4. Every effort is made to set up hearing rooms and video equipment so that the registered victim and forensic patient cannot see each other.
35. The following issues were identified by NSW based on their experience of victim attendance:
    - 35.1. Hearings are still required to be closed (in full or partially) at times to facilitate open discussion and to:
        - 35.1.1. Respond to clinicians not being as frank when victims are present (e.g. in order to reduce distress or maintain confidentiality), and
        - 35.1.2. Reduce the potential for the victim to obstruct the treatment of the patient (e.g. in NSW community accommodation has fallen through after victim's disclosed information obtained through the tribunal hearing to the accommodation).
    - 35.2. The management of victim attendance at MHRT hearings is reliant on very experienced MHRT members presiding over the panels.
36. NSW also advised that they considered the Queensland victim support service and MHA 2016 provisions to be best practice for victim assistance. NSW are in the process of developing a similar victim support service.

*Option*

37. Amendments to the MHA 2016 could be made to enable victims to attend at MHRT hearings.
38. Significant resourcing (facilities, videoconference, support staff, office works, and security staff) would be required to ensure safety of the proceedings.

*Costing estimates*

38.1. Table 3 outlines the additional resources required to fulfil this function. Estimates include:

38.1.1. FTE for the MHRT to manage additional administrative processes:

- 1 x 0.3 Administration officer (AO5)

38.1.2. Security staff

- 1 x .02 Security officer

38.1.3. Security upgrade of current MHRT premises (e.g. cameras and duress system)

38.1.4. Additional sitting days and training for members

RTI RELEASE

| Table 3 | | | |
|---|---|---|---|
| | Funding type | Additional for 2017/18 | Additional for 2018/19 |
| MHRT | Operational and recurrent | $97,253 | $98,343 |
| Security staff | Operational and recurrent | $28,471 | $29,288 |
| Security upgrade | Operational and recurrent | $50,000 | $50,000 |
| Training | Operational and recurrent | $20,000 | $20,000 |
| Total | | $195,724 | $197,631 |

38.2. Assumptions: Estimates are based on 72 potential hearings with victims in attendance bi-annually (there are 57 eligible victims currently, plus an additional 15 per year in potential new applicants). It is likely that these hearings will be extended due to victim involvement (up to 2 hours). This equates to approximately 22 additional MHRT sittings days per annum.

38.3. The Queensland Health Costing Template 2014-15 V1.3 has been utilised to estimate the administration support costs. Security costs have been provided by the Assets and Facilities Unit.

*Note*

38.4. The MHRT has limited space to hold face-to-face hearings (one room only). Additional capital works may be required in the event that hearings involving both the victim and the patient are to be regularly held at the MHRT leased offices.

**Automatic stay**

39. The MHA 2016 provides that decisions of the MHRT are able to be appealed to the MHC (s539).
40. An application for appeal may be made within 60 days of the appellant receiving the decision. The application may include a request for the MHC to grant a 'stay' against the MRHT decision.
41. Unless the MHC grants a stay, the MHRT decision can be enacted despite the appeal not yet being decided.
42. NSW previously made provision for an 'automatic stay' of 28 days. This stay provided the parties to the proceeding (other than the patient) an opportunity to appeal against the decision before it was enacted.
43. The automatic stay has been removed from the NSW process over the last four years. The primary reason for removing it was due to the resourcing implications associated with patients routinely being required to remain in hospital beds during the stay period. The low level of numbers of appeals in NSW did not balance out the resource implications.
44. Similarly low appeal rates exist in Queensland (refer table 5).
45. As an alternative to the automatic stay period, the NSW MHRT have implemented a system (via practice direction) whereby a 'stay' can be applied for directly to the MHRT, in addition to the Supreme Court when an appeal is made. This allows for more timely consideration of the stay application.

RTI RELEASE

*Options*

Option 1

46. Amend the MHA 2016 to provide for an 'automatic stay' of 28 days for MHRT decisions relating to forensic order decisions for people with prescribed offences.
47. This may have significant resources if patients are required to be admitted as an inpatient without access to LCT while the stay period applies.

*Costing estimates*

47.1. The 2016-17 'Per diem' rates for a Psychiatric Adult Acute Unit admission is $1,622.

47.2. The estimates for this amendment is provided in Table 4 as a range (from 1 to 28 days) given the timeframe may vary for a decision to be made regarding whether an appeal will be lodged during the automatic stay period.

Table 4

| | 1 day admission for 1 patient | 1 day admission for 72 patients | 28 day admission for 1 patient | 28 day admission for 72 patients |
|---|---|---|---|---|
| Amount | $1,622 | $116,784 | $45,416 | $3,269,952 |

*Assumptions:*

47.3. Estimates are based on 72 eligible patients (patients with prescribed offences). As at 27 September 2017 there were 62 forensic patients admitted as inpatients and there are approximately 10 new eligible patients each year.

*Notes*

47.4. The Per diem rates differ for child, adolescent, older persons and secure units from $796.57 (Adult Community Care Unit) to $2,604.20 (Adolescent Acute Unit). Resources could therefore be significantly increased if an adolescent had an automatic stay resulting in an inpatient admission for 28 days ($72,917.60).

47.5. It should also be noted that an automatic stay could apply to a person who is already residing in the community (e.g. a decision to revoke an order is stayed) in which case an inpatient admission may not be required and therefore the additional inpatient resource would not apply (existing community resources would still be required to manage the person during the automatic stay period).

Option 2

48. The MHRT could issue a practice direction similar to that of NSW whereby a 'stay' can be applied for directly to the MHRT, in addition to the Supreme Court when an appeal is made against the decision of the MHRT. This allows for more timely consideration of the stay application. This has the effect of immediately implementing the 'stay period' if the order is being appealed against, without the need to apply an arbitrary stay for those patients where there is no intention of appealing the decision.
49. The above resourcing requirements would be reduced and would likely be able to be met within existing resources, given a stay process already exists within the MHA 2016.

RTI RELEASE

## Data:

50. The below table outlines decisions of the MHC in relation to appeals against decisions of the MHRT for forensic patients charged with a prescribed offence.
51. During the period (1 July 2014 to 30 June 2016), there were 19 appeals to the MHC against MHRT decisions. In general, appeals to the MHC uphold the decision of the MHRT.

Appeals to the MHC for patients charged with prescribed offences (1 July 2014 to 30 June 2016)

Table 5

| Decision appealed against | Appeal made by Attorney-General | Appeal made by patient or someone on their behalf | MHRT set aside | MHRT decision confirmed | Appeal withdrawn |
|---|---|---|---|---|---|
| FO confirmed with LCT | 4 | 9 | 2 | 8 | 3 |
| FO revocation | 4 | 0 | 2 | 2 | 0 |
| Patient found fit for trial | 0 | 1 | 0 | 1 | 0 |
| Total | 8 | 10 | 4 | 11 | 3 |

## Background

52. Under the MHA 2016, the MHC has jurisdiction to determine criminal responsibility and fitness for trial for person's charged with serious offences. For person's found unsound mind or unfit for trial, the MHC may make a forensic order which provides for the person's involuntary treatment and care by an authorised mental health service.
53. The MHRT's jurisdiction includes reviewing forensic orders and treatment support orders.
54. The MHC and MHRT may approve a forensic patient be detained as an inpatient with/without access to community leave, or approve that the person be placed on a community category order.
55. Decisions of the MHRT can be appealed to the MHC, and decisions of the MHC are appealable to the Court of Appeal.
56. Prescribed offences under the MHA 2016 include murder, attempted murder, manslaughter, grievous bodily harm and acts intended to cause grievous bodily harm, rape, attempt to commit rape, assault with intent to commit rape.

RTI RELEASE

RECEIVED
DATE 16/12/16 BY JT

# Ministerial Brief for Noting

15 DEC 2016

DOH RTI 4812

| | |
|---|---|
| Department RecFind No: | BR065403 |
| Division/HHS: | CED |
| File Ref No: | |

**SUBJECT: Suicide Prevention Health Taskforce Action Plan**

**Recommendation**

**It is recommended the Minister:**

1. **Note** the Suicide Prevention Health Taskforce Phase 1 Action Plan.

NOTED PLEASE DISCUSS

**Cameron Dick MP** Date: 07/02/17
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

## Issues

1. **Urgent**. During the opening address at the Suicide Prevention Health Roundtable held 8 September 2016, the Minister for Health and Minister for Ambulance Services announced that the Suicide Prevention Health Taskforce (Taskforce) would develop a detailed plan of action by November 2016.
2. The Suicide Prevention Health Taskforce Phase 1 Action Plan (Action Plan) (Attachment 1) focuses on the development of suicide prevention policy, strategies, services, and programs to be used in a health service delivery context in order to contribute to a measureable reduction in suicide and its impact on Queenslanders.
3. The Action Plan encompasses three priority areas:
   - 2.1 education and development;
   - 2.2 evidence based treatment and care; and
   - 2.3 pathways to care within and external to specialist mental health services.
4. The planning and delivery of phase one Taskforce initiatives will commence from January 2017 (refer pages 8 to 10 - Attachment 1).
5. Phase two initiatives require further consideration and will be implemented throughout 2017-2018 and 2018-2019 (refer page 15 - Attachment 1).
6. The Action Plan identifies 18 key areas for Taskforce investment across the three priority areas. Some actions will be progressed by Taskforce members without requiring significant financial investment.

## Vision

7. The Action Plan aligns with *Direction 2: Delivering healthcare and Direction 3: Connecting healthcare* of the 10 year vision set out in the *My health, Queensland's future: Advancing health 2026*. Through implementation of the Action Plan, the Taskforce aims to identify and translate the evidence base for suicide prevention initiatives in a health service delivery context, support implementation of early intervention initiatives, and promote the strengthening of partnerships across Hospital and Health Services and Primary Health Networks at a statewide and local level.

**Michael Walsh**
**Director-General**
15/12/2016

DOH RTI 4812 157 of 207

RTI RELEASE

DOH RTI 4812

| Department RecFind No: | BR065403 |
|---|---|
| Division/HHS: | CED |
| File Ref No: | |

## Background

8. Data from the interim Queensland Suicide Register (iQSR) administered by the Australian Institute for Suicide Research and Prevention shows that there was a significant increase in deaths by suspected suicide in Queensland in the 2015 calendar year.
9. The 2015 suicide data analysis project indicates that almost 25 per cent of people who died by suspected suicide had contact with a Queensland Health service within seven days prior to their death.
10. The Queensland Suicide Prevention Action Plan 2015–2017 was developed by the Queensland Mental Health Commission as a whole-of-government, whole-of-community plan aimed at reducing suicide and its impact on Queenslanders
11. The work of the Taskforce complements that of the Queensland Mental Health Commission under the Queensland Suicide Prevention Action Plan 2015–2017. The Mental Health Commissioner is a member of the Taskforce.

## Sensitivities

12. Nil.

## Results of Consultation

13. A Suicide Prevention Health Roundtable was held on 8 September 2016 to bring together the collective expertise of a broad range of stakeholders across government, industry, and the community, and particularly those people with a lived experience, in order to inform the key priority areas for Taskforce investment. Key themes from the Roundtable have been addressed in the Action Plan (refer to page 7 – Attachment 1).
14. Taskforce members developed the Action Plan during Taskforce workshops held on 19 October 2016 and 14 November 2016.
15. The Action Plan was also informed by an Aboriginal and Torres Strait Islander suicide prevention workshop held on 31 October 2016.

## Resource Implications (including Financial)

16. On 28 April 2016, the Minister approved the reallocation of $9.6 million over three years (2016-2017 to 2018-2019) for a suicide prevention in health services initiative.
17. Funding for all phase one and phase two Taskforce initiatives is included within the $9.6 million for the suicide prevention in health services initiative.

## Attachments

18. Attachment 1: Suicide Prevention Health Taskforce Phase 1 Action Plan

## Department Contact Officer

Ms Janet Martin, Acting Director Clinical Governance, Mental Health Alcohol and Other Drugs Branch, on telephone 3328 9456.

RTI RELEASE

DOH RTI 4812

| | |
|---|---|
| **Department RecFind No:** | **BR065403** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

| Author | Cleared by: (ED) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Dr Rebecca Soole | Assoc Prof John Allan | Dr John Wakefield |
| Principal Project Officer | A/Executive Director | Deputy-Director General |
| Mental Health Alcohol and Other Drugs Branch | Mental Health Alcohol and Other Drugs Branch | Clinical Excellence Division |
| 3328 9251 | 3328 9536 | 3405 6181 |
| 24 November 2016 | 1 December 2016<br>14 December 2016 | 1 December 2016 |

RTI RELEASE

DOH RTI 4812


Clinical Excellence Division

# Suicide Prevention Health Taskforce

## Phase 1 Action Plan
November 2016

UNRELEASED



Queensland Government

# Suicide Prevention Health Taskforce — Phase 1 Action Plan

Published by the State of Queensland (Queensland Health), February 2017


This document is licensed under a Creative Commons Attribution 3.0 Australia licence.

**© State of Queensland (Queensland Health) 2016**

You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland (Queensland Health).

## For more information contact:

Mental Health Alcohol and Other Drugs Branch
Clinical Excellence Division
Department of Health
GPO Box 48, Brisbane QLD 4001
SuicidePreventionHealthTaskforce@health.qld.gov.au
(07) 3328 9374

RTI RELEASE

## Disclaimer:

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

DOH RTI 4812

# Contents



RTI RELEASE

DOH RTI 4812

# Context

## Suicide prevention is a high priority for the Queensland Government.

The Queensland Suicide Prevention Action Plan 2015–2017 was developed by the Queensland Mental Health Commission as a whole-of-government, whole-of-community plan aimed at reducing suicide and its impact on Queenslanders through actions under four priority areas:

1. Stronger community awareness and capacity
2. Improved service system responses and capacity
3. Focused support for vulnerable groups
4. A stronger more accessible evidence base.

The Queensland Suicide Prevention Action Plan 2015–2017 emphasises the importance of a comprehensive cross-sectoral approach to suicide prevention. Within this context, Hospital and Health Services and Primary Health Networks play an important leadership role in partnering with other local service providers and people with a lived experience to improve the health system's capacity to respond to people at risk of suicide. The delivery of quality, timely, and appropriate suicide risk assessment, management and ongoing care is a vital component to a comprehensive cross-sectoral approach to suicide prevention.[1]

Data from January to June 2015, indicates that almost 25% of people who died by suspected suicide had contact with a Queensland Health service within the seven days prior to their death. Whilst it is unknown what proportion of these people had recent contact with a General Practitioner (GP) or other primary health care provider, research has identified that up to 45% of individuals who died by suicide saw their GP within one month prior to death, and up to 20% within one week before death.[2,3]

To help drive improvements across the health system, $9.6 million over three years has been allocated through the Suicide Prevention in Health Services Initiative (the Initiative). The Initiative forms an integral part of the plan for Queensland's state-funded mental health, alcohol and other drug services – Connecting care to recovery 2016–2021, and comprises of three major components:

1. The establishment and operation over three years of a Queensland Suicide Prevention Health Taskforce as a partnership between the Department of Health, Hospital and Health Services and Primary Health Networks.
2. Analysis of events relating to deaths by suspected suicide of people that had a recent contact with a health service to inform future actions and improvements in service responses.
3. Continued implementation of training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk.

Effective suicide prevention requires a comprehensive multi-sectoral approach.

Hospital and Health Services and Primary Health Networks play an important leadership role in improving health service system responses and capacity.

PRELEASE



DOH-DL 17/18-033 163 of 207

DOH RTI 4812

# Suicide in Queensland: A snapshot

Many individuals at risk of suicide are, in principle, identifiable and their deaths preventable.

Health services are well placed to recognise and intervene with suicidal persons.

Preliminary data, released by the Australian Bureau of Statistics showed there were 746 Queenslanders who died by suicide in 2015. This compares to 648 in 2014.

By contrast, there were 279 deaths from transport accidents in Queensland in 2015.[4]

Between 2011 and 2015 the average suicide rate in Queensland was 14.1 per 100,000. In comparison the national average was 11.5 per 100,000.[4]

Between 2011 and 2013 males died by suicide three times more often than females.[5]

There is no single factor that contributes to suicide, suicidal ideation or suicide attempts. Rather, suicidal behaviour is best understood as a complex interaction of a range of protective and risk factors.

The highest suicide rates for males were observed in those aged 35-44 years (32.59 per 100,000 and the 75+ age-group (32.33 per 100,000).[5]

The highest suicide rates for females were observed in those aged 35-44 years (11.7 per 100,000) and the 45-54 age-group (9.15 per 100,000).[5]

On a per population basis, rural and remote areas often have greater suicide rates than urban areas.

For each person who dies by suicide, an estimated 20 people attempt suicide.[6]

Suicide rates within the Aboriginal and Torres Strait Islander population, across the lifespan, are higher than other Australians. Between 2011 and 2013 the age-standardised rate in Aboriginal and Torres Strait Islander persons was 1.7 times that of other Queenslanders.[5]

While the suicide rate is higher in males than females, females attempt suicide more often.[7]

Although suicide in children is considered rare it is disproportionate in relation to all deaths in this age group. Recently released ABS data showed that 31 children aged 5-14 years died by suicide in Queensland in the five years between 2011 and 2015. This corresponds to a Queensland child suicide rate of 1.0 per 100,000.[4]

The impacts of suicide are immediate, far-reaching and long-lasting. They are felt by families, friends, work colleagues and the broader community.

RTI RELEASE

DOH RTI 4812

# Suicide Prevention Health Taskforce

The Suicide Prevention Health Taskforce (the Taskforce) was established in August 2016 to focus on the development of suicide prevention policy, strategies, services, and programs to be used in a health service delivery context in order to contribute to a measureable reduction in suicide and its impact on Queenslanders.

The Taskforce will fund initiatives based on the best available evidence and where empirical evidence is absent, or lacking, will obtain and articulate 'good practice' advice based on clinical and lived experience. All initiatives will be evaluated in order to add to the suicide prevention evidence base.

Identifying and leading innovative partnerships between Hospital and Health Services, Primary Health Networks and people with a lived experience to promote the delivery of high quality, evidence-based treatments for people identified with suicide risk is a key Taskforce objective.

Activities falling outside the scope of the Taskforce may fall within the remit of other agencies represented on the Queensland Suicide Prevention Reference Group established to support the implementation of the Queensland Suicide Prevention Action Plan 2015–2017.

The Reference Group, supported by the Queensland Mental Health Commission exists to provide increased leadership, oversight and coordination of suicide prevention and risk reduction activities being undertaken across the State; identify opportunities to improve and inform the Queensland Government's response to suicide prevention activities; and identify future directions for suicide prevention and suicide risk reduction activities in Queensland from 2017. Membership consists of representatives from Queensland Government and non-government agencies (including four Taskforce members).

New initiatives, examples of promising practice and other activities that have demonstrated effectiveness but are outside a health service delivery context will be communicated to members of the Queensland Suicide Prevention Reference Group as required.

> A critical attribute to the successful implementation of suicide prevention strategies is organisational leadership which articulates and instils the fundamental tenet that suicide is preventable; thereby, creating a culture that considers a suicide attempt or death an unacceptable outcome of care.

Figure 1: Suicide Prevention Health Taskforce agreed principles for action


RTI RELEASE


DOH-DL 17/18-033 165 of 207

DOH RTI 4812

# Priorities for Taskforce action

On 8 September 2016 the Suicide Prevention Health Taskforce held a Roundtable to bring together the collective expertise of a broad range of stakeholders across government, industry, and the community, and particularly those people with a lived experience, in order to inform the key priority areas for Taskforce investment. Key themes that emerged from the Roundtable included:

- Enduring cultural and systemic issues which may impact and/or hinder suicide prevention efforts.
- The importance of identifying and translating the evidence base, supporting innovation, and ensuring a commitment to robust and embedded evaluation.
- The importance of coherent, connected and consistent treatment and care
- Identifying gaps and improving linkages between hospitals and community-based services and appropriately engaging families and other support persons in the treatment and care of individuals at risk of suicide.
- Ensuring that Taskforce considerations and actions are continually informed by lived experience including that which is culturally specific.

A discussion paper considered by Taskforce members to inform the development of this Action Plan synthesized the agreed principles for Taskforce action (see Figure 1), evidence from the literature outlined on pages 11 to 14, and the abovementioned themes identified by Roundtable attendees.

The Taskforce identified three priority areas for action which were supported by the Honourable Cameron Dick MP, Minister for Health and Minister for Ambulance Services during his opening address at the Suicide Prevention Health Roundtable.

1. Skills development and support
2. Evidence based treatment and care
3. Pathways to care within and outside specialist mental health services.

Specific initiatives for Taskforce investment were further informed by engaging cultural expertise through an Aboriginal and Torres Strait Islander workshop. A mechanism for ongoing meaningful and comprehensive guidance from Aboriginal and Torres Strait Islander community members is currently under consideration. This will be guided by the Aboriginal and Torres Strait Islander Taskforce members and will ensure that cultural integrity is maintained through cultural governance and continuous feedback on all initiatives that the Taskforce has committed to.

Taskforce initiatives will be delivered in two phases. The program logic underpinning Phase 1 is outlined on pages 8 to 10. The planning and delivery of Phase 1 initiatives will commence in 2016–17. Phase 2 initiatives require further consideration and will be implemented throughout 2017–18 and 2018–19. These initiatives are outlined on page 15.

The Taskforce acknowledges that there are a number of existing exemplar programs and activities occurring within the health system and the broader social service system. The discussion paper considered by Taskforce members to inform the development of this Action Plan included information regarding the existing initiatives identified to date as described in Appendix A.

> *“Knowing is not enough; we must apply.*
>
> *Willing is not enough; we must do.”*
>
> - Goethe 1833

PRELEASE

DOH RTI 4812

# Program logic for Phase 1

## Suicide remains a major public health problem and one of the leading

In 2015, approximately 25 per cent of people who died by suspected suicide had contact with a Queensland Health who died by suicide saw their GP within one week before their death.

The Taskforce intends to address specific, tangible issues, amenable to change in a health service delivery context contribute to a measureable reduction in suicide and its impact on Queenslanders.

| Inputs | | Anticipated outputs |
|---|---|---|
| **Resources** | **Action areas** | |
| **Enhance the attitude knowledge, skills and resources of primary mental health care providers to** | | |
| Taskforce members | General Practitioner (GP) attiudes, knowledge and skill development<br><br>(Action area 1) | Strategic communication with relevant peak bodies regarding Taskforce recommendation of greater inclusion and representation of lived experience within education programs targeted at GPs<br><br>Strategic communication with relevant peak bodies and practicing GPs regarding identification of GP development and support needs |
| $557K (2016/17 - 2018/19)<br><br>Partners in Prevention project | First responders attitudes, knowledge and skill development<br><br>(Action area 2) | Education and development needs analysis of first responders - ambulance and police - with repect to responding in suicide crisis situations<br><br>Education and training for QAS and QPS staff |
| $70 K (2016/17) | School based 'gatekeepers' attitudes, knowledge and skill development needs<br><br>(Action area 3) | Scope of practice review and needs analysis of support required for school based 'gatekeepers' |
| **Enhance the attitudes, knowledge, skills and resources of specialist mental health providers to** | | |
| $1.5M (2016/17 - 2018/19)<br><br>Public mental health service capacity building collaborative<br><br>(Action area 5) | Establishment of a locally identified collaborative group. Including service leaders, lived exerience representatives, primary care providers and emergency department representives | Development and implementation of a coherent, connected and consistent evidence-based suicide prevention pathway within specialist public mental health services |
| | Provision of training in a range of evidence-based interventions for suicide including safety planning, restriction of access to means and medication safety | |
| **Enhance consistent treatment of suicidal behaviour by specialist mental health services using high** | | |
| Public mental health service capacity building collaborative<br><br>(Action area 5) | Development of an implementation plan to increase the delivery of an access to evidence-based interventions that directly target suicidal behaviour (e.g. CBT) | Development and implementation of a coherent, connected and consistent evidence-based suicide prevention pathway within specialist public mental health services |
| | Development and implementation of an evaluation strategy to measure the effectiveness of implemented actions | |

RTI RELEASE


DOH-DL 17/18-033

# Taskforce initiatives

## causes of death in Queensland.

service within the seven days prior to their death. Further, research has identified that up to 20 per cent of people

in order to ensure safe, accessible, integrated care is availabe to all individuals at risk of suicide and in turn

| | Aspirational goals | | |
|---|---|---|---|
| | Short-term | Intermediate | Long-term |
| **appropriately recognise, respond to and refer people experiencing a suicidal crisis** | | | |
| | Increased involvement of individuals with a lived experience of suicide in GP education programs<br><br>Identification of GP's development and support needs | Increased empathy and reduction in stigma<br><br>Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk | Reduction in repeated attempts and suicides |
| | QAS and QPS officers receive education and training in suicide risk recogition, response and referral appropriate to their needs | Increased empathy and reduction in stigma<br><br>Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk | Reduction in repeated attempts and suicides |
| | Identification of school based 'gatekeepers' needs | Earlier recognition of risk<br><br>Enhanced capacity to appropriately respond and refer | Reduction in repeated attempts and suicides |
| **comprehensively assess and appropriately respond to a person experiencing a suicidal crisis** | | | |
| | Best practise management of presentations for suicidal behaviour | Reduction in admissions, longer community tenure, increased discharge rates<br><br>Improved treatment adherence | Reduction in repeated attempts and suicides |
| **quality, evidence based treatments** | | | |
| | Best practise management of presentations for suicidal behaviour | Reduction in admissions, longer community tenure, increased discharge rates<br><br>Improved treatment adherence | Reduction in repeated attempts and suicides |

RTI RELEASE

DOH RTI 4812

| Inputs | | Anticipated outputs |
|---|---|---|
| Resources | Action areas | |
| **Enhance appropriate continuing care options following an acute crisis** | | |
| Taskforce members | HealthPathways<br>(Action area 8) | Review and strengthen HealthPathways to incorporate professional and patient resources relating to suicide risk |
| Up to $100K (2017/18) | Lived experience peer support<br>(Action area 6) | Development and evaluation of lived experience peer support approaches (including Aboriginal and Torres Strait Islander peer support) |
| Partners in Prevention project | Enhancing first responses to suicidal crisis situations<br>(Action area 2) | QAS access to mental health clinical advice<br>Identification of appropriate care pathways for people experiencing suicidal crisis |
| **Strengthen the cultural capacity and capability of public mental health providers** | | |
| $50K (2016/17) | Cultural appropriateness of SRAM-ED<br>(Action area 4) | Video resources depiciting a culturally appropriate assessment of an Indigenous person for use in the simulation training component of SRAM-ED |
| **Enhance the provision of support for carers in order to reduce caregiver burden** | | |
| Up to $100K (2017/18) | Carer support<br>(Action area 7) | Development of a model of care for people who care for someone who has attempted suicide |

NOT RELEASE



DOH-DL 17/18-033 169 of 207

| Aspirational goals | | |
|---|---|---|
| Short-term | Intermediate | Long-term |
| GPs will have increased access to relevant professionals and patient resources relating to suicide risk recognition and pathways to care | Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk | Reduction in repeated attempts and suicides |
| A clearly articulated model for lived experience peer support | Availabillity of lived experience peer support as a therapeutic option | Reduction in repeated attempts and suicides |
| Increased mental health clinical support to QAS and QPS officers involved in a suicidal crisis<br><br>Increased use of appropriate referral pathways by QAS and QPS | Enhanced recognition, response and referral of people presenting with a suicial crisis or considered at risk by QAS and QPS | Reduction in repeated attempts and suicides |
| Strengthening of cultural appropriateness of SRAM-ED | Increased cultural capability and capacity of staff | Reduction in repeated attempts and suicides |
| A clearly articulated model of care for people who care for people with issues related to suicide | Improved responses to the specific needs of individuals who care for people with issues related to suicide in order to reduce caregiver burden | Reduction in repeated attempts and suicides |

RTI RELEASE

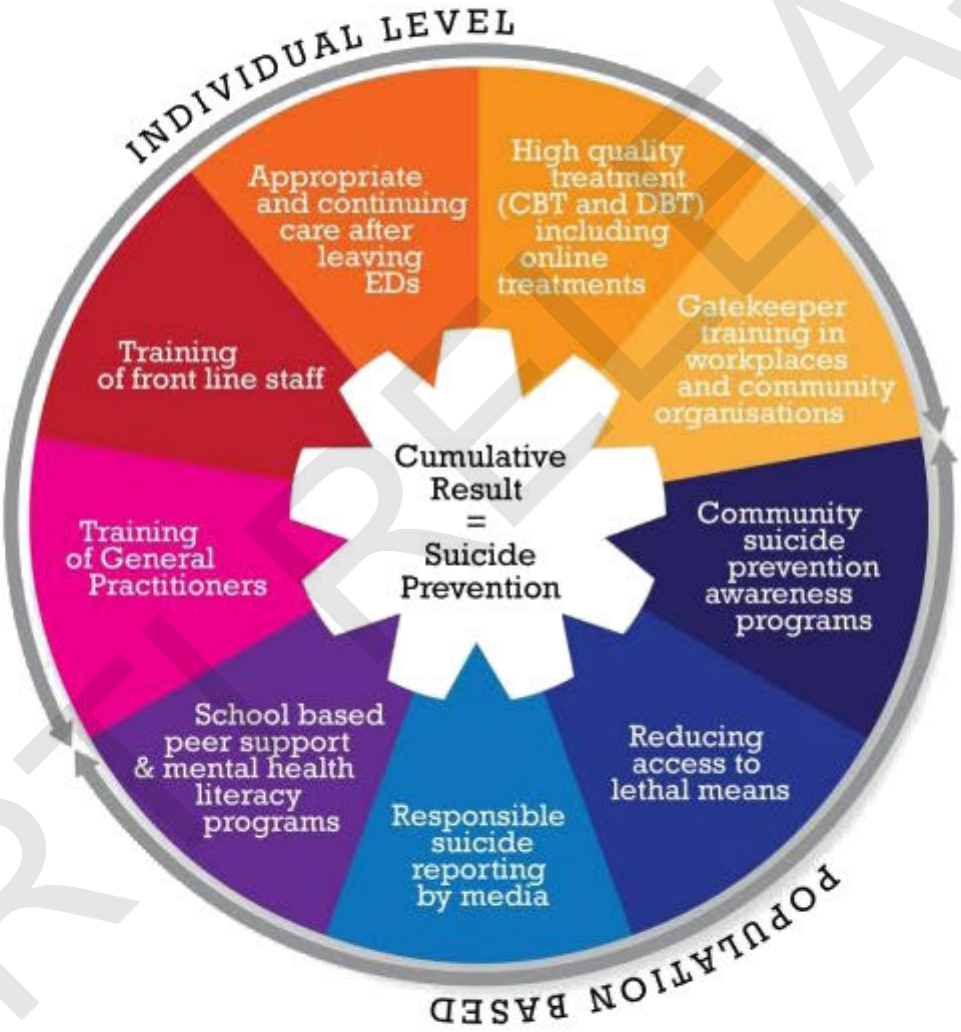
DOH RTI 4812

# Rationale behind Taskforce initiatives

To effectively reduce suicide and its impact a multi-level, multi-component, systems-based approach is required. The Black Dog Institute and the NHMRC Centre of Research Excellence in Suicide Prevention (CRESP) have developed an integrated systems approach to suicide prevention. Derived from contemporary empirical evidence, the systems approach consists of nine strategies.

Predictions of impact for each of the nine strategies shown in Figure 2 have been calculated by research at the NHMRC Centre for Research Excellence in Suicide Prevention (CRESP)[8] and are shown in Figure 3 and 4.

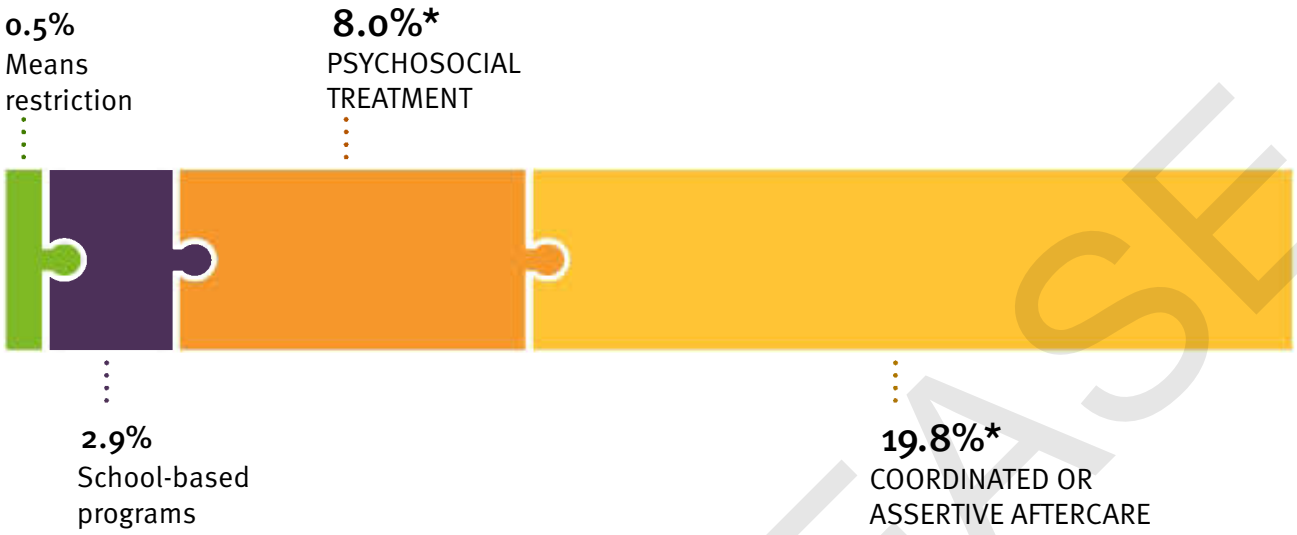
Figure 2: The nine strategies that make up the systems-approach to suicide prevention




RTI RELEASE

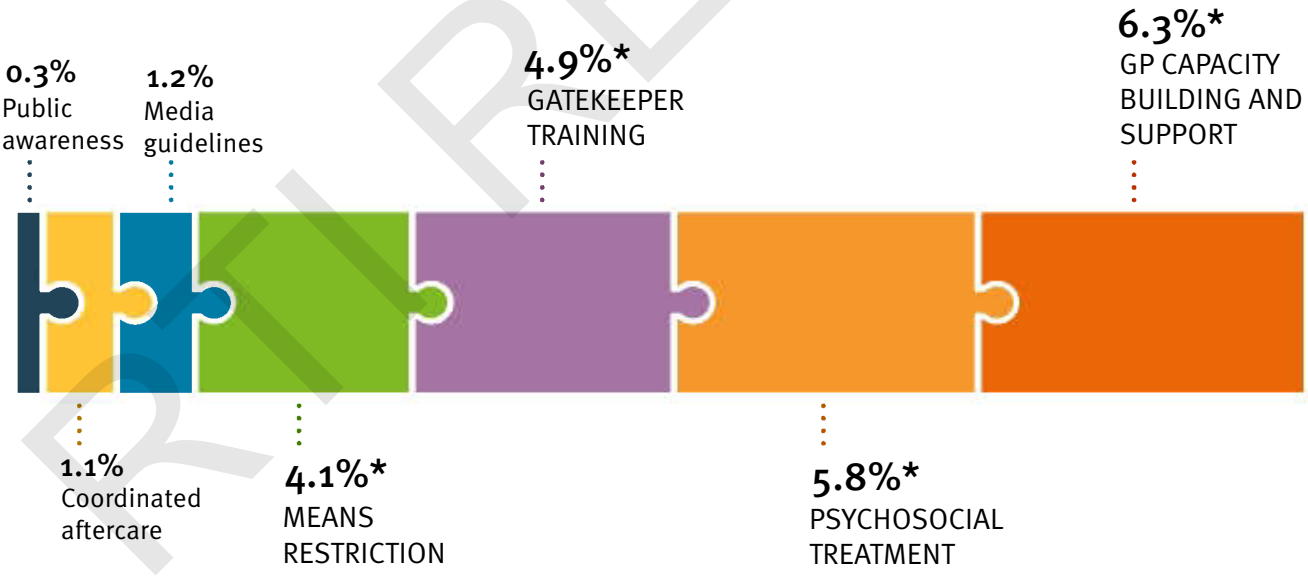

DOH-DL 17/18-033 171 of 207

Figure 3: Estimated reduction in suicide attempts for certain strategies




*priority strategies for reducing suicide attempts

Figure 4: Estimated reduction in suicide deaths for certain strategies




*priority strategies for reducing suicide deaths

Figures 1-3 images source: Ridani, R., Torok, M., Shand, F., Holland, C., Murray, S., Borrowdale, K., Sheedy, M., Crowe, J., Cockayne, N., Christensen, H. (2016). An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring. Sydney: Black Dog Institute

RTI RELEASE

DOH RTI 4812

# Priority area one: Skills development and support

## Why is this important?

- Regular suicide prevention training for front line staff (including ambulance) and GPs are core features of an integrated systems-approach to suicide prevention (Black Dog Institute and CRESP).
- Strong themes emerge from both literature sources and anecdotal evidence that there are varying levels of competence and confidence amongst medical, nursing and allied health clinicians.[9,10]
- Improving GP recognition of depression and suicide risk evaluation is one of the most promising interventions towards a reduction of suicide.[1]
- GP capacity building is one of the most promising suicide prevention strategies.[1]
- Preliminary consultation has revealed divergent views on the needs of GPs in Queensland and applicability of existing training to meet these needs.
- Ambulance officers are a pivotal point of contact to engage individuals that require mental health intervention.[11] An analysis of emergency calls to the Queensland Ambulance Service (QAS) in 2015 identified that over 38,000 calls were attributed to mental health related emergency situations. 73% of these calls were associated with self-harm or suicidal behaviours.
- However, emergency officers may receive only limited training in relation to responding to individuals with mental illness.[12]
- There is no uniform national approach to suicide prevention at a tertiary education level. Overall, knowledge and attitudes related to suicide prevention are taught more comprehensively than are skills[13] (the age of this study is acknowledged here however anecdotal evidence indicates few changes in current tertiary curriculum content).
- Improving the education and training of tertiary students is a complex task due to the independence of and variety of educational institutions. There is a need for suicide prevention training early in the education and training of health related professionals.[14]
- In addition to knowledge-ability, attitudes towards suicide influence an individual's ability to effectively recognise and appropriately intervene with suicidal behaviour. As such, training needs to also incorporate reducing stigmatising attitudes and beliefs toward suicide and suicidal individuals.
- Research on Australian ED nurses found that attitudes towards individuals presenting with self-inflicted injuries were influenced by their perceptions of their ability to effectively respond.[15] Studies have shown that staff attitudes toward suicidal behaviour are mixed.

### Good practice spotlight

**Suicide Risk Assessment and Management in Emergency Departments (SRAM-ED)**

The Queensland Centre for Mental Health Learning, in conjunction with the Clinical Skills Development Service, has developed and delivered a training package using a train-the-trainer model, tailored specifically for ED doctors, nurses and allied health staff, to recognise, assess and appropriately manage people at risk of suicide. Suicide Prevention in Health Services Initiative funding of $620K over three years will support the ongoing implementation of this training program.

RTI RELEASE


DOH-DL 17/18-033 173 of 207

# Priority area two: Evidence based treatment and care

## Why is this important?

- Research shows that treatment helps people recover from suicidal thoughts or feelings.[16,17]
- Treatment of people at risk of suicide must address all factors identified in the comprehensive assessment of the individual. Treatment planning should be directed at mitigating the risk factors and strengthening the protective factors that are modifiable.
- Interventions should be evidence based and consider the person's needs, wishes and resources.
- While not all people who die by suicide have a mental illness, a mental illness may heighten a person's risk for suicide. Treating psychiatric disorders is a central component of suicide prevention.
- Suicide risk needs to be addressed directly, rather than only as a symptom of an underlying mental health condition. Research suggests that targeting and treating suicidal ideation and behaviour independently of co-existing diagnoses hold the greatest promise for care of suicidal risk.

### Good practice spotlight

**Engaging with and responding to the needs of the suicidal person**

The Guidelines are designed to provide recommendations regarding best practice to support healthcare professionals working in Queensland Health emergency departments and mental health alcohol and other drug services to improve the assessment and management of people with suicidal behaviours.

- Hospital emergency departments (ED) play a significant role in assessing and treating mental illness. EDs can be used as an initial point of care for those seeking mental health-related services for the first time, as well as an alternative point of care for people seeking assistance in crisis or after-hours.
- In 2015, there were approximately 65,000 ED occasions of service with a mental health-related principal diagnosis (22% suicidal ideation/self-harm).
- Families and carers play vital roles in safeguarding and improving the health and wellbeing of the people they care for. However, people caring for individuals experiencing a suicidal crisis often have limited access to resources and support.[18]
- A suicidal crisis has a significant negative impact on the overall health and wellbeing of carers. Caregivers may experience persistent stress, shame, anxiety, and guilt[19], resulting in 'caregiver burden'; the emotional, social, and/or financial stress placed on caregivers.[20]
- The ability of support persons to appropriately respond to a suicidal crisis and provide support is influenced by previous experience, knowledge, and available social and personal resources.[18] The provision of appropriate information and resources to families and other support persons may help to reduce caregiver burden and improve the outcomes for the person experiencing the suicidal crisis. Treatment models with proactive carer involvement have demonstrated significant positive improvement for individuals experiencing acute suicidal crisis.[21] The provision of appropriate information and resources to health service providers to support carers is similarly important.

RTI RELEASE

DOH RTI 4812

# Priority area three: Pathways to care within and outside specialist mental health services

## Why is this important?

- Suicide risk is by nature dynamic. An individual's suicide risk status will fluctuate in duration and intensity.[22]
- There is evidence that a person remains at risk of suicide after a suicidal crisis is over. The risk appears greatest in the first year – especially the first six months – after an attempt (remaining high for several years).[23,24] Suicides occurring post-hospitalisation occur predominately during the first month after discharge with the peak of suicides occurring within one week.[25,26]
- The rate of suicide during the first month after discharge has been shown to be more than 100 times the rate in the general population.[27]
- Up to 25% of individuals who re-present to EDs make another attempt following discharge.[29,30]
- Risk may be alleviated by appropriate and systematic follow-up, including assertive outreach where indicated.[31,32]
- Follow up affords an opportunity for reassessment of suicide risk, review of treatment effectiveness, re-evaluation of previously detected 'at-risk' mental states, and collection of further collateral information from family, friends and service providers.

### Good practice spotlight

**HealthPathways**

HealthPathways (originating in Canterbury, New Zealand) is a web-based information portal supporting primary care clinicians to plan patient care through primary, community and secondary health care systems.

HealthPathways are designed to be used at the point of care, primarily by General Practitioners. And are tailored to reflect local resources.

- Several studies have investigated relatively simple, low-cost, low-intensity interventions including letters, crisis cards, telephone contact, and mixed interventions. While further research regarding effectiveness is warranted, a recent review of various contact modalities showed that post discharge follow up can be effective in reducing repeat attempts and suicides.[33] An increase in social connectedness and decrease in perceived burdensomeness that these interventions provide may be the mechanism that makes them effective.[34]
- Too frequently, suicide risk evokes apprehension and avoidance behaviour in health service providers. The promotion of shared responsibility and improvement in linkages between systems will increase health service provider's confidence to address suicide risk more openly and appropriately.
- Mental health system barriers – formalised linkages between different settings is imperative. They include linkages between primary care and specialist mental health care; emergency department care and mental health care; substance abuse and mental health care.
- Structured collaboration between hospitals and teams providing follow-up care has been demonstrated to improve treatment compliance and decrease new attempts.[35]

RTI RELEASE


DOH-DL 17/18-033 175 of 207

DOH RTI 4812

# Identified areas for Phase 2 Taskforce investment

## Skills development and support

| | |
|---|---|
| Health related students | Cross sectoral strategic conversation regarding the education and training needs of new staff in health related fields.<br><br>Development of core competencies in suicide prevention in clinical placements undertaken within Queensland Health. |
| Supporting Aboriginal and Torres Strait Islander led/facilitated training | Work with the Queensland Mental Health Commission and other key agencies to develop a model of statewide support and coordination for Aboriginal and Torres Strait Islander led/facilitated training. |
| Culturally diverse groups | Ensure skills development and support resources respond appropriately to the needs of culturally diverse groups including:<br>• Culturally and Linguistically Diverse communities (based on research currently being completed by the Queensland Mental Health Commission).<br>• Lesbian, gay, bisexual, transgender, intersex and/or queer (LGBTIQ) communities. |

## Evidence based treatment and care

| | |
|---|---|
| Sensory-based approaches | Conduct a feasibility study of sensory-based approaches in hospital emergency department settings. |
| Trauma informed model of care for Aboriginal and Torres Strait Islander persons | Develop protocols relating to the presentation of an Aboriginal and Torres Strait Islander person experiencing a suicidal crisis. |

## Pathways to care within and outside specialist mental health services

| | |
|---|---|
| Alternative models of care | Conduct a feasibility study regarding community based models of care such as place of sanctuary |
| Culturally appropriate resources for Aboriginal and Torres Strait Islander individuals, families and workers | Conduct a feasibility study for the development, maintenance and marketing of an online portal of resources for Aboriginal and Torres Strait Islander individuals, families and workers |
| Aboriginal and Torres Strait Islander community-based suicide surveillance system for the provision of wrap-around postvention support | Development of pilot project replicating the White Mountain Apache Tribe (WMAT) project occurring in the US adapted to be applicable to an Indigenous Australian population context – requires liaison with the Queensland Mental Health Commission and other key agencies |
| Brief interventions | Pilot project in a clinical context to evaluate the effectiveness of brief contact interventions for people with suicide and self-harm risk. |
| Pathways to care mapping | Map pathways to care for people identified at varying levels of suicide risk. |

RTI RELEASE

DOH RTI 4812

# Appendix A

Please email SuicidePreventionHealthTaskforce@health.qld.gov.au if you would like your organisation's initiative added to the list below. Please note to be included the initiative or activity needs to meet the following criteria:

- Examine suicide prevention issues across the whole of life continuum and pertaining to a health service delivery context.

## What is happening?

### Education and development

Gatekeepers are people who are likely to come into contact with individuals who are at risk of suicide. Gatekeepers can be divided into two groups:

- Designated gatekeepers – formally-trained persons such as GPs, psychiatrists, psychologists, nurses, and social workers
- Emergent gatekeepers – not formally trained but are potential gatekeepers as recognised by those with suicidal intent, such as family and friends, school and work peers, police, clergy, pharmacists, teachers, counsellors, and crisis line staff.

GP education and capacity building is recognised as one of the most promising suicide prevention strategies. There is a range of education and development programs available which specifically focus on suicide prevention. Appropriateness of programs requires consideration regarding the needs of the intended audience and identified gaps of the workforce.

**General practitioners (GP)**

- Advanced Training in Suicide Prevention: This accredited program is available for primary care clinicians. The course aims to help participants to undertake a suicide risk assessment effectively and develop a collaborative management plan. www.blackdoginstitute.org.au › For Health Professionals › GPs › Advanced Training in Suicide Prevention.
- The General Practice Mental Health Standards Collaboration (GPMHSC) has developed mental health first aid resources on suicide prevention and postvention to support general practitioners (GPs) in their day-to-day practice, to recognise and respond to patients whose mental health issues might be risk factors for suicide. This tool kit is not exhaustive and does not replace training. Resources are available from www.racgp.org.au/education/gpmhsc/gp-resources/suicide-prevention/
- Training for healthcare workers: This program provides trainees with a greater understanding of risk assessment, suicide prevention, intervention strategies, and patient support and management. www.wesleymission.org.au › Our services › Wesley Mental Health Services › Wesley Suicide Prevention Services › Suicide prevention – Wesley LifeForce training › Healthcare Workers training

**Designated gatekeepers**

- Suicide risk assessment and management in emergency department (SRAM-ED): The Queensland Centre for Mental Health Learning, in conjunction with the Clinical Skills Development Service, has developed and delivered a training package using a train-the-trainer model, tailored specifically for ED doctors, nurses and allied health staff, to recognise, assess and appropriately manage people at risk of suicide. Suicide Prevention in Health Services Initiative funding of $620K over three years will support the ongoing implementation of this training program.
- Suicide Prevention Skills Training Workshop for workforces: This course, delivered by The Australian Institute for Suicide Prevention and Research (AISRAP), is for workplaces and organisations. It helps individuals attain knowledge and skills in suicide prevention across prevention, intervention, and postvention. www.griffith.edu.au › Health › Research › Australian Institute for Suicide Research and Prevention › Programs and courses › Suicide prevention skills training.
- Suicide to hope (s2H): This recovery and growth workshop is primarily designed for clinicians and other professional helpers who work with persons previously at risk of and currently safe from suicide. It aims to provide clinicians and other professional helpers with skills to help persons previously at risk identify opportunities for recovery and growth arising out of their experiences with suicide. Find out more at www.livingworks.com.au/programs/suicide-to-hope/

PI RELEASE


DOH-DL 17/18-033 177 of 207

**Emergent gatekeepers**

- Applied Suicide Intervention Skills Training (ASIST): A two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognise when someone may be at-risk of suicide and work with them to create a plan that will support their immediate safety. For more information go to www.livingworks.com.au › programs › ASIST
- Mental Health First Aid (MHFA): The original 12-hour MHFA course teaches adults how to provide initial support to individuals who are developing a mental illness or experiencing a mental health crisis. Mental health crisis situations covered include suicidal thoughts and behaviours, and deliberate self-harm. Also, Aboriginal and Torres Strait Islander MHFA, MHFA for Nursing Students, Medical Students and Financial Counsellors, Youth MHFA, and Teen MHFA. MHFA for the Suicidal Person (4 hours) will soon be available based on the revised Mental Health First Aid Guidelines for Suicidal Thoughts and Behaviours. Find out more at www.mhfa.com.au
  - MHFA is working with Melbourne University under a NHRMC grant to develop two new short courses both for Aboriginal and Torres Strait Islander Suicide and Non Suicidal self-injury that further explores the cultural considerations in this support. Expected to be rolled out in 2017 and currently on hold.
- Question, Persuade, Refer (QPR) training for individuals and organisations: Offers online and face-to-face courses for gatekeepers. A range of ongoing courses, such as risk assessment and management are also offered. For more information visit www.qprinstitute.com
- headspace School Support: is a suicide postvention program, which assists Australian school communities to prepare for, respond to and recover from the death of a student by suicide. It is part of a suite of headspace programs developed to promote mental health and support young people aged 12-25 dealing with difficult issues in their lives.
- UHELP: is a community-owned social and emotional wellbeing initiative that involves cultural governance and a group program developed specifically for use with Aboriginal and Torres Strait Islander young people.

  UHELP groups take a holistic approach – combining physical health, nutrition, social and cultural connection, and activities that promote good mental health and emphasises the importance of connection to Culture.

## Evidence based treatment and care

**Queensland Health Guides for Suicide Risk Assessment and Management**

The Guidelines, renamed 'Engaging with and responding to the needs of the suicidal person' have been reviewed and updated; due for release December 2016. The Guidelines are designed to provide recommendations regarding best practice to support healthcare professionals working in Queensland Health emergency departments (ED) and mental health alcohol and other drug services to improve the assessment and management of people with suicidal behaviours.

The Guidelines aim to support and complement clinical training in suicide risk assessment and facilitate the delivery of quality, timely, and appropriate suicide risk assessment, management, and ongoing care for individuals, regardless of their point of access. More specifically, the Guidelines have been developed to ensure alignment with SRAM-ED training.

**Queensland Health emergency mental health models of care**

The Mental Health Alcohol and Other Drugs Clinical Network and the Queensland Emergency Department Strategic Advisory Panel (QEDSAP) funded the Service Evaluation and Research Unit, School of Mental Health at The Park – Centre for Mental Health, West Moreton Hospital and Health Service to conduct a study which examined the extent to which the introduction of the National Emergency Access Target (NEAT) has impacted on the assessment and management of patients presenting with mental health concerns to hospital EDs in Queensland. The study aimed to:

RTI RELEASE

1. Conduct an audit of data contained in the Emergency Department Information System (EDIS) to identify whether the introduction of NEAT had resulted in changes to the assessment and treatment of patients with mental health conditions in EDs
2. Identify factors impacting on the capacity of EDs to treat patients presenting with mental health concerns within the four hour timeframe specified by NEAT
3. Identify implications for policy and practice.

The final report on the study was submitted to the Chair of the Mental Health Alcohol and Other Drugs Clinical Network in September 2016. Following consideration of the final report by the clinical network and QEDSAP, relevant advice will be provided to the Suicide Prevention Health Taskforce.

**Psychosocial treatment**
Several psychotherapies have been shown to reduce suicidal behaviour including:

- Cognitive behaviour therapy for suicide prevention and mentalisation-based treatment – for adults
- Multi-systemic therapy and group therapies – for adolescents
- Dialectical behaviour therapy – for individuals with borderline personality disorder
- Problem solving therapy to reduce repeat hospitalisation – for individuals with a history of self-harm
- Psychodynamic interpersonal psychotherapy to reduce repeat attempts – for individuals hospitalised for repeat poisoning.

**New Zealand Suicide Prevention Toolkit for District Health Boards**
The New Zealand Ministry of Health has developed a Suicide Prevention Toolkit for District Health Boards to support their district health boards to implement suicide prevention and postvention activities within their regions. District Health Boards have a similar role to PHNs in regional planning for suicide prevention. The toolkit includes:

- suicide prevention and postvention plan template
- stakeholder analysis map and analysis tool
- suicide prevention logic model
- plan-do-study-act cycle
- core suicide prevention messages
- suicide prevention workshop and resources

**Gold Coast Mental Health and Specialist Services – Zero suicide framework**
The Gold Coast Mental Health and Specialist Services (GCMHSS) are currently implementing the Zero Suicide framework within the service. This is a systems approach to suicide prevention that focuses on a number of broad strategies, including leadership to instil the belief that suicides can be prevented in people under the care of a health service, support training and skills development of staff, a continuous quality improvement cycle and embedding research in the work and a "Suicide Prevention Pathway" that includes engagement, evidence based assessment processes, risk formulation, safety planning interventions, counselling on access to lethal means, and effective transitions of care.

**Peer support**
Peer support can be defined as 'social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change'.[36] The central tenet of the peer support 'approach' assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation.[37]

Peer workers are either people (consumers) who have lived experience of mental distress (mental illness) or people (carers) who are loved ones in the life of a person who experiences mental distress. There are three broad types of peer support: informal (naturally occurring) peer support, peers participating in consumer or peer-run programs and the employment of consumers/service users as providers of services and supports within traditional services.[38] Where peers are employed to provide support in services, the individual employed in the support role is generally considered to be further along their road to recovery.[39]

A recent review on peer support in mental health services found that Peer Support Worker roles can lead to a reduction in admissions, longer community tenure, increased discharge rates, increased empowerment, improved social functioning, sense of hope and greater feelings of being accepted and understood.[40]

RTI RELEASE

Programs piloting Peer Support Worker Roles within mental health in Scotland have been found to be, on the whole, positive.[41] Peer support offers a unique and complementary role to health service provision and can act as a conduit between clinicians and the individuals experiencing a crisis and their support persons.

A recent review on peer support in mental health services found that Peer Support Worker roles can lead to a reduction in admissions, longer community tenure, increased discharge rates, increased empowerment, improved social functioning, sense of hope and greater feelings of being accepted and understood.[40]

### Sensory-based approaches

Sensory modulation involves providing a range of activities that engage the senses in a safe environment. Smell, touch, sight and even taste may be engaged as well as sensory motor functions such as rocking or squeezing to reduce distress, induce calmness and create a feeling of being in control … evidence is beginning to emerge that this approach can be helpful in 'avoiding the use of restrictive interventions and in promoting recovery-oriented treatment environments'.[42,43]

Sensory-based alternatives and sensory modulation have been recognised as a way of reducing trauma and improving wellbeing among people in a state of psychological distress.[44] Wait times and physical environments of emergency departments can further exacerbate the distress of individuals during crisis. A recent review suggests that utilizing sensory interventions can facilitate a calm state, enhance interpersonal connection, support self-management, promote adaptive emotional regulation, de-escalate arousal, and reduce distress and the rates of restraint.[45]

Sensory modulation approaches have been implemented across various jurisdictions including in Australia. It usually involves setting up sensory rooms accompanied by workforce development to achieve appropriate and effective use of sensory modulation options.

Te Pou o Te Whakaaro Nui (Te Pou) is a national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand. Te Pou has supported District Health Boards (DHB) to embed sensory modulation. Many DHBs now have sensory rooms and use sensory modulation effectively. In some settings, the use of sensory modulation is used as a de-escalation tool and is actively linked to the purpose of reducing seclusion and restraint.[46]

## Pathways to care within and outside specialist mental health

### HealthPathways

HealthPathways (originating in Canterbury, New Zealand) is a web-based information portal supporting primary care clinicians to plan patient care through primary, community and secondary health care systems. It is like a 'care map', so that all members of a health care team – whether they work in a hospital or the community – can be on the same page when it comes to looking after a particular person.

HealthPathways are designed to be used at the point of care, primarily for General Practitioners but is also available to Hospital Specialists, Nurses, Allied Health and other Health Professionals.

Each health jurisdiction tailors the content of HealthPathways to reflect local arrangements and opinion.

The Queensland Department of Health has purchased the licence for HealthPathways which is now being implemented by PHNs across the state. The suicide prevention HealthPathway provides an opportunity to link GPs to online education and other resources, as well as provide information about services available statewide or nationally.

### Brief contact interventions

- Treatment and aftercare of individuals experiencing a suicidal crisis often constitutes a considerable cost burden on healthcare facilities. Many treatments that do exist are relatively resource intensive and require significant prior specialist training.[47]
- Brief contact interventions differ from other forms of outreach care and case management in key ways:
  - Brief contact interventions are not required to be conducted by a mental health professional
  - Occur on a structured schedule and,
  - Delivered over a sustained period of time.[47]
- Can be time limited contact for people discharged after presentation to an emergency department or admission to hospital for intentional self-harm. Contact can take the form of a postcard, letter, or phone call.

RELEASE

- Brief contact interventions typically do not include any formal therapy or provides minimal psycho-education or supportive intent.
- Another form of brief intervention is the provision of an emergency access or crisis card (sometimes referred to as 'green cards').[48] The card encourages help-seeking and offers an on-demand crisis admission.[49]
- A recent systematic review and random-effects meta-analysis on randomised control trails using brief contact interventions found a non-significant positive effect on the number of episodes of repeated self-harm or suicide attempts per person.[47]
- Milner and colleagues[47] concluding recommendations were not in support of widespread clinical implementation however "given the possible benefits, low cost and unlikely adverse effects, large-scale trials in clinical populations would be worthwhile' (p.189).

## Non-clinical integrated community based support

**The Way Back Service**
The Way Back Support Service is a low-cost, low-stigma suicide prevention model that delivers person-centred, non-clinical care and practical support in the critical three months after a suicide attempt through assertive outreach. The service aims to prevent repeat suicide attempts and suicide deaths. The service adopts a culturally sensitive, strengths-based and collaborative approach to care. Support Coordinators are recruited from a range of backgrounds and receive training and ongoing support to provide evidence-informed care to people. Following a referral to the Support Service, Support Coordinators contact the client within 24-48 hours.

**Community Action for the Prevention of Suicide (CAPS) / TALK Suicide Support Service**
Community Action for the Prevention of Suicide (CAPS) has been providing ongoing care and support to young people and adults at risk of suicide and their families and friends since 2008 through its TALK SUICIDE Support Service (TSSS).

TSSS is a strengths-based, person-centred, non-clinical integrated community based response to suicide that strives to fill the gap between crisis response and clinical interventions.

TSSS Client Support Caseworkers coordinate a continuum of care response and work collaboratively with agencies, services and informal supports, whilst maintaining an ongoing and comprehensive support role with the person at risk and their support network. In addition, TSSS work with youth focuses on positive role modelling while assisting them to identify coping strategies to deal with challenges commonly faced by youth today.

CAPS are currently finalising a partnership agreement with Metro South Addiction and Mental Health Services that will enable CAPS to provide comprehensive and ongoing follow up support to individuals at risk of suicide who present to the hospital's emergency departments, contact MHCall and do not meet the requirements for admission or those upon discharge following a suicide attempt with the aim of improving continuity of care and creating positive outcomes.

**Maytree (UK)**
Maytree provides (up to 4) people in the midst of a suicidal crisis with the opportunity for rest and reflection, and gives them the opportunity to stay in a calm, safe and relaxed environment. The service runs 24 hours a day, 365 days a year. Paid and volunteer staff spend up to 77 hours with each guest over their stay, giving them the opportunity to talk through their fears, thoughts and troubles. Maytree offers a free 4-night/5-day stay. It is the only place of its kind in the UK and fills a gap in services, between the medical support of the NHS and the helplines and drop-in centres of the voluntary sector.

PREPRELEASE


DOH-DL 17/18-033 181 of 207

# References


1. Mann, JJ., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A...Hendin H 2005, 'Suicide prevention strategies: a systematic review', JAMA, vol. 294, no. 16, pp. 2064.
2. Luoma, JB, Martin, CE & Pearson, JL 2002, 'Contact with mental health and primary care providers before suicide: a review of the evidence', American Journal of Psychiatry, vol. 159, pp. 909-916.
3. Pirkis, J., & Burgess, P 1998, 'Suicide and recency of health care contacts: a systematic review', British Journal of Psychiatry, vol. 173, pp. 462-474.
4. Australian Bureau of Statistics 2016a, '3303.0 – Causes of death, Australia, 2014', retrieved 20 April 2016, ‹http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0›
5. Boyd, B, Kõlves, K, O'Gorman, J & De Leo, D 2016, Suicide in Queensland: mortality rates and related data 2011-2013, Australian Institute for Suicide Research and Prevention, Mt Gravatt.
6. De Leo, D, Cerin, E, Spathonis, K & Burgis, S 2005, 'Lifetime risk of suicide ideation and attempts in an Australian community: prevalence, suicidal process, and help-seeking behaviour', Journal of Affective Disorders, vol. 86, no. 2-3, pp. 215-224.
7. Cantor, C & Neulinger, K 2000, 'The epidemiology of suicide and attempted suicide among young Australians', Australian and New Zealand Journal of Psychiatry, vol. 34, no. 3, pp. 370–387.
8. Karysinska, K, Batterham, PJ, Tye, M, Shand, F, Calear, AL, Cockayne, N & Christensen, H 2016, 'Best strategies for reducing the suicide rate in Australia', Australian & New Zealand Journal of Psychiatry, vol. 50, no. 2, pp. 115-118.
9. Sivakumar, S, Weiland, TJ, Gerdtz, MF, Knott, J & Jelinek, GA 2011, 'Mental health-related learning needs of clinicians working in Australian emergency departments: a national survey of self-reported confidence and knowledge', Emergency Medicine Australasia, vol. 23, pp. 697-711.
10. Jelinek, GA, Weiland, TJ, Mackinlay, C, Gerdtz, M & Hill, N 2013, 'Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: findings from a national qualitative study', Journal of Emergency Medicine, vol. 6, no. 2, pp. 1-7.
11. Ogloff, JRP, Davis, MR, Rivers, G & Ross, S 2007, 'The identification of mental disorders in the criminal justice system: Trends and Issues in Crime and Criminal Justice no. 334', Canberra: Australian Institute of Criminology.
12. Browning, SL, Van Hasselt, VB, Tucker, AS & Vecchi, GM 2011, 'Dealing with individuals who have mental illness: the Crisis Intervention Team (CIT) in law enforcement', The British Journal of Forensic Practice, vol. 13, no. 4, pp. 235-243.
13. Hazell, P, Hazell, T, Waring, T & Sly, K 1999, 'A survey of suicide prevention curricula taught in Australian universities', Australian and New Zealand Journal of Psychiatry, vol. 33, pp. 253-259.
14. Hawgood, J, Krysinska, KE., Ide, N & De Leo, D 2008. 'Is suicide prevention properly taught in medical schools?' Medical Teacher, vol. 30, no. 3, pp. 287-295
15. McAllister, M, Creedy, D, Moyle, W & Farrugia, C 2002, 'Nurses' attitudes towards clients who self-harm', Journal of Advanced Nursing, vol. 40, no. 5, pp. 578-586.
16. Brown, GK., Ten Have, T, Henriques, GR., Xie, SX, Hollander, JE & Beck, AT 2005, 'Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial', JAMA: Journal of the American Medical Association, vol. 294, no. 5, pp. 563-570.
17. Linehan, MM, Comtois, KA, Murray, AM, Brown, MZ., Gallop, RJ, Heard, HL, Korslund, KE, Tutek, DA, Reynolds, SK & Lindenboim, N 2006, 'Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder', Archives of General Psychiatry, vol. 63, no. 7, pp. 757-766.
18. Grant C, Ballard, ED, & Olson-Madden, JH 2015. 'An empowerment approach to family caregiver involvement in suicide prevention: Implications for practice', The Family Journal: Counselling and Therapy for Couples and Families, vol. 23, no. 3, pp. 295-304.


PI RELEASE

DOH RTI 4812

19. Tzeng, W & Lipson, J 2004. 'The cultural context of suicide stigma in Taiwan', Qualitative Health Research, vol. 14, pp. 345–358.

20. Chessick C., Perlick DA, Miklowitz, DJ, Kaczynski, R...& Family Experience Collaborative Study Group 2007. 'Current suicide ideation and prior suicide attempts of bipolar patients as influences on caregiver burden', Suicide and Life-Threatening Behavior, vol. 37. no. 4, pp. 482-491.

21. Anastasia T, Humphries-Wadsworth, T, Pepper, CM & Pearson, TM 2014, 'Family centered brief intensive treatment: a pilot study of an outpatient treatment for acute suicidal ideation', Suicide and Life-Threatening Behavior, vol. 45, no. 1, pp.78-83.

22. O'Connor, N, Warby, M, Raphael, B & Vassallo, T 2004, 'Changeability, confidence, common sense and corroboration: comprehensive suicide risk assessment', Australasian Psychiatry, vol.12, no. 4, pp. 352–360.

23. Cooper, J, Kapur, N, Webb, R, Lawlor, M, Guthrie, E, Mackway-Jones, K & Appleby, L 2005, 'Suicide after deliberate selfharm: a 4-year cohort study', American Journal of Psychiatry, vol. 162, no. 2, pp. 297–303.

24. De Leo D, Bertolote J & Lester, D 2002, Self-directed violence, ed EG Krug, LL Dahlberg, JA Mercy, A Zwi & R Lozano, World report on violence and health. World Health Organization, Geneva.

25. Hunt, I, Kapur, N, Webb, R, Robinson, J, Burns, J, Shaw, J & Appleby, L 2008, 'Suicide in recently discharged psychiatric patients: a case-control study', Psychological Medicine, vol. 39, no. 3, pp. 443–449.

26. Meehan, J, Kapur, N, Hunt, IM, Turnball, P, Robinson, J, Bickley, H, Parsons, R, Flynn, S, Burns, J, Amos, J, Shaw, J & Appleby, L 2006, 'Suicide in mental health in-patients and within 3 months of discharge: national clinical survey', British Journal of Psychiatry, vol. 188, no. 2, pp. 129–134.

27. Goldacre, M, Seagroatt, V & Hawton, K 1993, 'Suicide after discharge from psychiatric inpatient care', Lancet, vol. 342, no. 8866, pp. 283–286.

28. Ho, T 2003, 'The suicide risk of discharged psychiatric patients', Journal of Clinical Psychiatry, vol. 64, no. 6, pp. 702–707.

29. Larkin, GL & Beautrais, AL 2010, 'Emergency departments are underutilized sites for suicide prevention', Crisis: The Journal of Crisis Intervention and Suicide Prevention, vol. 31, no. 1, pp. 1–6.

30. Owens, D, Horrocks, J & House, A 2002, 'Fatal and nonfatal repetition of self-harm: systematic review', British Journal of Psychiatry, vol. 181, no. 3, pp. 193–199.

31. Cooper, J, Hunter, C, Owen-Smith, A, Gunnell, D, Donovan, J, Hawton, K & Kapur, N 2011, '"Well it's like someone at the other end cares about you." A qualitative study exploring the views of users and providers of care of contact-based interventions following self-harm', General Hospital Psychiatry, vol. 33, pp. 166-176.

32. Links, PS & Hoffman, B 2005, 'Preventing suicidal behaviour in a general hospital psychiatric service: priorities for programming', Canadian Journal of Psychiatry, vol. 50, no. 8, pp. 490-496.

33. Luxton, DD, June, JD, & Comtois, KA 2013, 'Can postdischarge follow-up contacts prevent suicide and suicidal behavior?' Crisis: The Journal of Crisis Intervention and Suicide Prevention, vol. 34, no. 1, pp. 32-41.

34. Van Order KA, Witte, TK, Cukrowicz, KC, Braithwaite, SR, Selby, EA & Joiner, TE 2010, 'The interpersonal theory of suicide', Psychological Review, vol. 117, no. 2, pp. 575-600.

35. Dieserud G, Loeb M & Ekeberg O 2000, 'Suicidal behavior in the municipality of Baerum, Norway: a 12-year prospective study of parasuicide and suicide'. Suicide Life Threat Behav. 2000;30:61-73.

RTI RELEASE



DOH-DL 17/18-033 183 of 207

36. Solomon, P 2004, 'Peer support/peer provided services underlying processes, benefits and critical ingredients', Psychiatric Rehabilitation Journal, vol. 27, no. 4, pp. 392–401.

37. Mead S & MacNeil C 2006, 'Peer Support: What Makes It Unique?', International Journal of Psychosocial Rehabilitation, vol. 10, no. 2, pp. 29-37.

38. Davidson, L, Chinman, M, Kloos, B, Weingarten, R, Stayner, D & Tebes, JK 1999, 'Peer support among individuals with severe mental illness: a review of the evidence', Clinical Psychology Science and Practice, vol. 6, pp. 165–187.

39. Davidson, L, Chinman, M, Sells, D & Rowe, M 2006, 'Peer support among adults with serious mental illness: a report from the field', Schizophrenia Bulletin, vol. 32, no. 3, pp. 443–45.

40. Repper J & Carter T 2011, 'A review of the literature n peer support in mental health services', Journal of Mental Health, vol. 20, no. 4, pp.392-411.

41. McLean, J, Biggs, H & Whitehead, I, Pratt, R & Maxwell, M 2009, 'Evaluation of the delivering for mental health peer support worker pilot scheme', Social Research, no. 87. Retrieved from http://www.scotland.gov.uk/socialresearch.

42. Wilson, M 2009, 'Creating alternatives: reducing the use of seclusion and restraint by creating sensory modulation areas in patient units', Stories of Change, no. 15. Retrieved from http://www.tepou.co.nz/assets/images/content/your_stories/files/story043.pdf

43. Champagne T & Stromberg N 2004, 'Sensory approaches in inpatient psychiatric settings: innovative alternatives to seclusion and restraint', Journal of Psychosocial Nursing in Mental Health Services, vol. 42, no. 9, pp. 34–44.

44. Chalmers, A, Harrison, S, Mollison, K, Molloy, N & Gray, K 2012, 'Establishing sensory-based approaches in mental health inpatient care: a multidisciplinary approach', Australasian Psychiatry, vol. 20, no. 1, pp. 35-39.

45. Bowman, S & Jones, R 2015, 'Sensory interventions for psychiatric crisis in emergency departments: a new paradigm', Journal of Psychiatry and Mental Health, vol. 1, no. 1.

46. Te Pou o te Whakaaro Nui 2010, 'Impact of sensory modulation in mental health acute wards on reducing the use of seclusion'. Auckland: Te Pou o te Whakaaro Nui.

47. Milner, AJ, Carter, G, Pirkis, J, Robertson, J & Spittal, MJ 2015, 'Letters, green cards, telephone calls and postcards: systematic and meta-analytic review of brief contact interventions for reducing self-harm, suicide attempts and suicide', The British Journal of Psychiatry, vol. 206, pp. 184-190.

48. Morgan, HG, Jones, EM & Owen, JH 1993, 'Secondary prevention of non-fatal deliberate self-harm. The green card study', British Journal of Psychiatry, vol. 163, pp. 111-2.

49. Kapur, N, Cooper, J, Bennewith, O, Gunnell, D & Hawton, K 2010, 'Postcards, green cards and telephone calls: therapeutic contact with individuals following self-harm', The British Journal of Psychiatry, vol. 197, pp. 5-7.

PI RELEASE

DOH RTI 4812

# Notes

RTI RELEASE



DOH-DL 17/18-033 185 of 207

DOH RTI 4812

RTI RELEASE

# Suicide Prevention Health Taskforce Phase 1 Action Plan

© State of Queensland (Queensland Health) 2017

## For more information contact:

Mental Health Alcohol and Other Drugs Branch
Clinical Excellence Division
Department of Health
GPO Box 48, Brisbane QLD 4001
SuicidePreventionHealthTaskforce@health.qld.gov.au
(07) 3328 9374

DOH-DL 17/18-033

# Help is available

## National 24/7 crisis services

| | |
|---|---|
| **Lifeline** | 13 11 14 |
| **Suicide Call Back Service** | 1300 659 467 |
| **MensLine Australia** | 1300 78 99 78 |
| **Kids Helpline** | 1800 55 1800 or www.kidshelp.com.au |

## Support services

**Beyondblue support service**
1300 22 4636 or email/chat at www.beyondblue.org.au

**Harmony Place** (mental health services for culturally and linguistically diverse people)
(07) 3848 1600 or http://www.harmonyplace.org.au/default.asp?contentID=616

**Queensland Transcultural Mental Health Centre**
1800 188 189

**headspace**
1800 650 890 or www.headspace.org.au

**Lifeline**
www.lifeline.org.au/Get-Help/

**Suicide Call Back Service**
www.suicidecallbackservice.org.au

**SANE Australia Helpline**
1800 18 SANE (7263) or www.sane.org

**QLife (LGBTI People)**
1800 184 527 or https://qlife.org.au

**1300 MH CALL 1300 64 2255**
(24/7 centralised phone number for mental health referrals, crisis and support)

RTI RELEASE

RECEIVED
DATE 28/3 BY

23 MAR 2017
DOMRTI 4812

# Ministerial Brief for Approval

| | |
|---|---|
| Department RecFind No: | BR065810 |
| Division/HHS: | CED |
| File Ref No: | |

**SUBJECT: Proposed agreement between the Mental Health Review Tribunal and Legal Aid Queensland for the provision of free legal representation to persons appearing before the Tribunal**

**Recommendations**

It is recommended the Minister:

1. **Exercise** non-recurrent financial delegation by approving funding of $5.3 million for the Mental Health Review Tribunal to enter into an agreement with Legal Aid Queensland to provide legal representation for persons appearing before the Tribunal from 5 March 2017 to 30 June 2020.

APPROVED / ~~NOT APPROVED~~ ~~PLEASE DISCUSS~~

**Cameron Dick MP** **Date:** 07/04/17
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

**Issues**

1. The Mental Health Review Tribunal (MHRT) is seeking to enter a three-year, sole supply arrangement with Legal Aid Queensland (LAQ) to provide legal representation at Tribunal hearings at a total estimated cost of $5.3 million from 5 March 2017 to 30 June 2020. The Expenditure Delegations Framework specifies that Ministerial approval must be sought for non-recurrent expenditure exceeding $5.0 million.
2. Negotiations for an agreement for the supply of the legal services commenced in the latter part of 2016. The Queensland Law Society, LAQ and the Queensland Bar Association have been consulted regarding this initiative. Only the Queensland Bar Association and LAQ responded. The Queensland Bar Association's fees were almost twice the cost per matter as the fee proposed by LAQ, and would have required considerable additional work by MHRT to provide the required legal representation. In addition, the Queensland Bar Association's proposal lacked the overall efficiency, flexibility and statewide nature of the LAQ scheme.
3. In addition to value for money, LAQ is also well placed to provide this service as it can leverage from its current statewide service delivery model and can use both its in-house resources and panel of preferred suppliers. In addition, the service delivery model is similar to that used by LAQ in providing the domestic violence service and will provide opportunities for efficiency.
4. The Procurement Advice to the Director-General indicates that 'sole supply' has been demonstrated 'on the basis that the alternative suppliers lack overall efficiency, flexibility and State-wide nature of the scheme to achieve value for money'; see Attachment 1.
5. The Procurement Advice also stated that a valid business need had been demonstrated, noting that a fee-for-service agreement will be negotiated to meet the business demand.

**Michael Walsh**
**Director-General**
27/3/2017

Page 183


PUBLIC RELEASE

| | |
|---|---|
| Department RecFind No: | BR065810 |
| Division/HHS: | CED |
| File Ref No: | |

6. Departmental officers, including the Executive Director, MHAODB, reviewed the initial draft arrangements and have since met, and had other communications, with LAQ officers on several occasions to progress this initiative.
7. The Department believes that LAQ is in a sound position to deliver the services and supports LAQ being considered the sole supplier for the provision of legal services to meet the business need.
8. MHRT and Queensland Health are negotiating a fee-for-service arrangement with LAQ at a cost per matter of $756, based on 1,500 matters per annum. A management overhead fee of 25 per cent would also be charged by LAQ, and travel expenses, bringing the total estimated cost of $1.5 million for each financial year. The actual amount of funds will vary with the number of matters in each year. This is expected to increase in 2017-18 due to the new legislation but reduce after that time as some persons on forensic orders transition to treatment support orders (where the related hearings do not require legal representation).
9. The cost for the four months to 30 June 2017 is $0.8 million and includes block funding for LAQ salaries (for set-up and service delivery), set up costs of $150,000, outsourced fee-for-service costs and travel expenses.

**Vision**

10. Provision of legal representation to people who would otherwise be unrepresented when appearing before the MHRT aligns with the directions of Promoting Wellbeing and Delivering Healthcare as set out in *My health, Queensland's future: Advancing health 2026* by ensuring people can access the mental health services and supports they require.

**Results of Consultation**

11. The Department, MHRT and LAQ support an agreement for the provision of legal services to persons appearing before the Tribunal. Advice has been provided by Strategic Procurement and Supply (attached) on the proposed arrangements and confirms that this request meets the minimum requirements for approval.

**Resource Implications (including Financial)**

12. Funding for free legal representation has been allocated at $1.186 million in 2016-17, and $1.575 million in each of the following three financial years. A small proportion of these funds (including set-up costs) will be retained by the Tribunal. Total funding under the agreement is estimated at $5.3 million, although this may be higher due to the fee-for-service model under the agreement.
13. The GST Team has advised that, as this agreement is with a Queensland Government entity, GST is not applicable.

**Background**

14. Under section 740(3) of the *Mental Health Act 2016*, free legal representation must be provided to persons for the following types of Tribunal hearings:
    - 14.1 where the Attorney-General is represented;
    - 14.2 for hearings of applications to perform electroconvulsive therapy;
    - 14.3 where the hearing relates to a minor, and
    - 14.4 for 'fitness for trial' hearings.
15. The Mental Health, Alcohol and Other Drugs Branch was approached in January 2017 to assist in developing an agreement.



RTI RELEASE

| Department RecFind No: | BR065810 |
|---|---|
| Division/HHS: | CED |
| File Ref No: | |

**Sensitivities**

16. There will be a community expectation that legal presentation is available to persons appearing before the MHRT as set out in the *Mental Health Act 2016*.

**Attachments**

17. Attachment 1: Advice from Strategic Procurement and Supply.

**Department Contact Officer**

Associate Prof. John Allan, Executive Director, MHAODB, on telephone 3328 9536, or mobile [redacted]

RTI RELEASE

| | |
|---|---|
| **Department RecFind No:** | **BR065810** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

| Author | Cleared by: (SD/Dir) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Paula Corrigan | John Allan | John Wakefield |
| Manager | Executive Director | DDG |
| Mental Health Act Implementation Team | Mental Health, Alcohol and Other Drugs Branch | Clinical Excellence Division |
| 33289670 | 33289536 | 34056181 |
| | | |
| 16 February 2017 | 17 February 2017<br>Amended 8 March 2017 | 20 February 2017<br>Reviewed 28 February 2017 |

RTI RELEASE

RECEIVED
DATE 6/10 BY M

DOH RTI 4812

# Ministerial Brief for Noting

| | |
|---|---|
| RM folder reference No: | C-ECTF-17/6954 |
| Division/HHS: | CYMHS/CHQ |
| File Ref No: | |

**SUBJECT: Expansion of the Assertive Mobile Youth Outreach Service (AMYOS)**

**Recommendation**

It is recommended the Minister:

1. **Note** the expansion of the Assertive Mobile Youth Outreach Service.

**NOTED** **PLEASE DISCUSS**

**Cameron Dick MP** **Date: / /**
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

Noted BK 6/10

**Issues**

1. The Assertive Mobile Youth Outreach Service (AMYOS) is a component of the Adolescent Extended Treatment Programs that are currently being implemented across Queensland as part of the Connecting Care to Recovery (2016 to 2021).
2. There are currently AMYOS teams in 11 Hospital and Health Services (HHSs) throughout Queensland.
3. Identified areas of high need have received additional funding to meet the growing demand particularly in the growth corridor of South East Queensland.
4. 7 new teams are being established and include:
   - 4.1. West Moreton Hospital and Health Service, 3.3 FTE team fully recruited;
   - 4.2. Sunshine Coast Hospital and Health Service, 3 FTE recruited, 0.3 FTE recruitment for Psychiatrist in progress;
   - 4.3. Mackay Hospital and Health Service, 2 FTE recruited, 0.2 FTE recruitment for Psychiatrist in progress;
   - 4.4. Wide Bay Hospital and Health Service, 2 FTE recruitment process yet to commence, 0.2 Psychiatrist cover under negotiation to be provided by Children's Health Queensland;
   - 4.5. Metro South Hospital and Health Service (Browns Plains), 2.2 FTE recruitment in progress; and
   - 4.6. Children's Health Queensland (CHQ):
     - 4.6.1. Brisbane North, 2 FTE recruited, 0.3 FTE recruitment for Psychiatrist in progress;
     - 4.6.2. Brisbane South, 2 FTE recruitment process yet to commence, 0.3FTE recruitment for Psychiatrist in progress.

MWalsh

**Michael Walsh**
**Director-General**
**6/10/2017**

RTI RELEASE

| Department RecFind No: | C-ECTF-17/6954 |
|---|---|
| Division/HHS: | CYMHS/ CHQ |
| File Ref No: | |

5. Expansion of two existing AMYOS teams include;

   5.1. Metro North, Redcliffe Caboolture 1.1 FTE fully recruited; and

   5.2. Gold Coast, 1 FTE recruitment in progress, 0.1 FTE Psychiatrist recruited.

**Vision**

6. The recruitment of the AMYOS teams aligns with Promoting wellbeing and Delivering healthcare directions as outlined in the 10 year vision *My health, Queensland's future: Advancing health 2026*: Promoting wellbeing, Delivering healthcare, Connecting healthcare, and Pursuing innovation.

**Background**

7. AMYOS commenced operation in 2014 as a component of the Adolescent Mental Health Extended Treatment Initiative.
8. AMYOS provide specialised, targeted mental health care and treatment for young people and their families who have previously found it difficult to engage with or access mental health services.
9. AMYOS is administered by CHQ Child and Youth Mental Health Service via Service Level Agreements with the relevant HHS's. Statewide education and clinical supervision is facilitated by CHQ CYMHS.
10. To date AMYOS have provided approximately 300 young people and their families with support in their homes, community or locations suitable to their need.

**Sensitivities**

11. Nil.

**Results of Consultation**

12. Consultation has occurred with the CHQ Communication and Engagement team, Mental Health Alcohol and Other Drugs Branch and AMYOS State-wide Co-ordinator to advise them of request for Ministerial Brief for Noting and reduce duplication of information.

**Resource Implications (including Financial)**

13. There is a total Government investment of $4,439,151 phased over five years (2016 to 2021) for the AMYOS initiative.

**Attachments**

14. Nil.

**HHS Contact Officer**

Ms Judi Krause, Divisional Director, CYMHS, CHQ HHS, telephone: 3310 9408

RTI RELEASE

| | |
|---|---|
| **Department RecFind No:** | **C-ECTF-17/6954** |
| **Division/HHS:** | **CYMHS/ CHQ** |
| **File Ref No:** | |

| Author | Content verified by: (CEO/DDG/Div Head) |
|---|---|
| Judi Krause | Frank Tracey |
| Divisional Director | A/Health Service Chief Executive |
| CHQ CYMHS | Children's Health Queensland |
| 3310 9408 | 3068 5579 |
| | |
| 4 October 2017 | 4 October 2017 |
| | |

RTI RELEASE

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-17363** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

Final speech to DDG / SD for approval? **Required** ☐ **Not required** ☐ (Please choose at least one)

**SUBJECT: Visit by Minister to Gold Coast University Hospital – Parent and Infant Unit**

## Event

- Visit by the Minister on Tuesday 14 March 2017to Lavender Parent and Infant Unit at Gold Coast University Hospital, Mental Health and Specialist Services, Gold Coast Hospital and Health Service.

## Background

- The Lavender Parent and Infant Unit is due to be commissioned by 27 March 2017.
- The unit is a partially purpose built. When commissioned, it will offer a specialist four bed mental health mother and infant pod which will provide contemporary safe assessment, care and treatment for mothers with acute perinatal psychiatric conditions.
- The primary function of the service offered through the Lavender Parent and Infant Unit is the management of the maternal mental illness, while giving consideration to the needs of the mother infant relationship.
- There are currently no public mental health inpatient beds in Queensland for women with moderate to severe perinatal mental illness where they can be co-located with their infant.
- Dedicated units where mothers and babies can be admitted together are currently established in Victoria, Western Australia, South Australia, Tasmania and the ACT.
- The Queensland *Maternal and Perinatal Quality Council Report 2011* highlighted that the most concerning outcome of perinatal mental illness is the mortality rate for Queensland women in the perinatal period, with suicide being the highest indirect cause of maternal death following the birth of an infant, in the period between 42 and 365 days postpartum.
- The unit provides four inpatient beds which are for use state-wide. Access will need to be closely managed, with referrals to be accepted initially from South East Queensland.

## Resource Implications (including Financial)

- Operational funding of $3.5m in 2016-17, with recurrent funding of $4.6 million allocated from 2017-18 for the Lavender Parent and Infant Unit is available under *Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services.*
- The lack of dedicated perinatal mental health public beds and the recognised service gap within Queensland was highlighted by the Mental Health Alcohol and Other Drugs Branch (MHAODB) through its planning processes, including use of the draft National Mental Health Services Planning Framework (NMHSPF).

RTI RELEASE

| | |
|---|---|
| **RM folder reference No:** | **CTF 17363** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

# Brief for Speech

## Talking points

- In Queensland, a mother requiring inpatient treatment for perinatal mental illness is usually admitted to an acute mental health unit without her baby.
- International best practice guidelines recommend that, where possible, mothers and their babies are admitted together to dedicated Parent Infant Units.
- The Lavender Parent and Infant Unit is the first of its kind in Queensland, and will provide contemporary perinatal mental health care to this vulnerable consumer group.
- The Queensland Centre for Perinatal and Infant Mental Health and specialist mental health clinicians provided valuable input to the model of care that will be implemented in the Unit.

RTI RELEASE

| Author | Cleared by: (SD/Dir) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Anna Davis | Assoc. Prof. John Allan | Dr John Wakefield |
| A/Director, SPP | Executive Director | Deputy Director-General |
| Strategic, Planning and Partnerships | Mental Health Alcohol and Other Drugs Branch | Clinical Excellence Division |
| 332 89561 | 3328 9538 | 3405 6181 |
| 10 March 2017 | 10 March 2017 | 12 March 2017 |

DSDSATSIA-DL 17/18-033

DOH RTI 4812

# Ministerial Brief for Noting

| | |
|---|---|
| **RM folder reference No:** | **C-ECTF-17/2630** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

**SUBJECT: Proposed approach to reducing restrictive practices in Queensland Health acute mental health inpatient units**

**Recommendations**

It is recommended the Minister:

1. **Note** the proposed approach to reducing restrictive practices in Queensland Health acute adult mental health inpatient units.

**NOTED** **PLEASE DISCUSS**

**Cameron Dick MP** **Date: / /**
**Minister for Health and Minister for Ambulance Services**

**Ministerial Office comments**

| |
|---|
| |
| |
| |
| |

**Issues**

1. The Mental Health Alcohol and Other Drugs (MHAOD) Branch and the MHAOD Statewide Clinical Network are working in partnership with Hospital and Health Services to drive ongoing service reform in reducing absence without permission and promoting a least restrictive, therapeutic environment in Queensland's public adult acute mental health inpatient units (acute inpatient units).
2. In May 2017, the Queensland Mental Health Commission published a progress report on implementation of their 2014 report Options for Reform: moving towards a more recovery oriented, least restrictive approach in acute mental health wards including locked wards (Attachment 1).
3. The Commission's report acknowledges the steps taken by Queensland Health to implement recovery oriented, least restrictive practices and enhance assessment and management of risk in acute inpatient units.
4. The Commission's report also states that 'the Commission is of the view that a decision to lock doors should be discretionary and based on local decision making' supported by a 'Statewide policy framework that takes a whole-of-ward approach to recovery oriented, least restrictive practices'.
5. The Department of Health's proposed approach to service reform in this area is staged and involves the following steps:

   5.1. scope requirements for a coordinated support model for implementation and evaluation of the Safewards program in Queensland, including resourcing and change management implications. Consideration will be given to pilot implementation in a limited number of identified sites prior to supporting Statewide investment;

**Michael Walsh**
**Director-General**
**7/6/2017**

DOH RTI 4812-033

5.2. Further strengthen management of the risk of patient absence without permission, including through the development of a structured approach to assessing individual consumers' risk of absence without permission;

5.3. develop tools to support local decision-making regarding the locking of acute mental health inpatient units (discretionary locking), dependent upon each unit meeting clear and evidence-based standards. These may include:

5.3.1. identification of a draft set of standards against which services can be assessed for readiness to trial discretionary locking (standards would include implementation of Safewards); and

5.3.2. development of key criteria to support decisions about locking units.

5.4. to support comprehensive implementation of the Safewards model, a controlled trial of discretionary locking can be considered in a small number of acute inpatient units, following the development of appropriate standards. The trial would examine:

5.4.1. the effect of a return to discretionary locking on rates of absence without permission and the use of restrictive practices, such as seclusion;

5.4.2. the use of criteria to support decisions regarding locking of units; and

5.4.3. the impact on staff and consumers (both benefits and challenges).

5.5. Based on the results of the trial, consideration will be given to the feasibility, sustainability and investment for Statewide implementation of discretionary locking, as part of the broader move to enhance recovery oriented, least restrictive care in acute inpatient units.

6. Safewards is being implemented in other jurisdictions within Australia and overseas. In 2015, Victoria conducted the largest coordinated multi-site implementation of Safewards outside of the United Kingdom.

7. Representatives from Queensland Health recently attended the Towards Eliminating Restrictive Practices: 11th National Forum held in Perth on 4 to 5 May 2017. Of note:

7.1. the forum highlighted the recent strengthening of the national focus on restrictive practices in mental health services, with the aim of elimination of those practices, rather than reduction; and

7.2. the Safewards model featured prominently at the forum as a vehicle for reduction in restrictive practices and broader whole-of-ward positive change in acute inpatient units.

8. The locking of acute inpatient units is noted to be a restrictive practice.

**Vision**

9. This aligns with *My health, Queensland's future: Advancing health 2026: Delivering healthcare* and *Pursuing innovation.*

**Background**

10. Acute mental health inpatient units were locked in December 2013 to reduce rates of patient absence without permission. Since that time there has been an increased focus on reducing restrictive practices in acute mental health units.

11. The MHAOD Branch and Hospital and Health Services have utilised a range of measures to promote a recovery oriented, least restrictive environment in acute mental health units while maintaining the safety of patients and staff.

RTI RELEASE

12. The MHAOD Statewide Clinical Network has held two Statewide forums for senior clinicians and managers in acute mental health units to promote and share learnings about evidence based and innovative practice in achieving a less restrictive environment in inpatient settings. The forums have highlighted Statewide interest in Safewards implementation as a crucial component in achieving both improved safety for consumers and staff, and a less restrictive and more recovery-oriented environment in acute mental health inpatient units.
13. The Safewards model is a structured, whole-of-ward approach designed to improve staff-patient interaction; reduce the incidence of aggression and self-harm; and reduce the use of restrictive practices within mental health inpatient units.
14. Trials of Safewards to date have not explored a possible effect on rates of patient absence without permission. However, Safewards has a positive impact on some factors thought to contribute to absence without permission, such as rates of aggressive incidents and poor staff-patient communication.
15. Implementation of Safewards will assist in progressing the increased emphasis on reducing restrictive practices introduced with the commencement of the *Mental Health Act 2016*, which places greater restrictions on the use of seclusion and restraint, including physical restraint.

**Sensitivities**

16. In May 2017, considerable media attention focused on the death of Ms Miriam Merten after she spent several hours in seclusion in the mental health unit of the Lismore Base Hospital. A coronial inquest found Ms Merten died from "traumatic brain injury caused by numerous falls and the self-beating of her head on various surfaces, the latter not done with the intention of taking her life". The New South Wales Government has announced an independent review and parliamentary enquiry into the incident.

**Results of Consultation**

17. Consultation has occurred with the MHAOD Statewide Clinical Network, senior clinical staff and management from acute mental health inpatient units across Queensland, selected staff involved in a recent tri-site Safewards trial in South East Queensland, and the team responsible for evaluating the large-scale Safewards implementation in Victoria in 2015.
18. Hospital and Health Services are experiencing a range of challenges in implementing and maintaining the Safewards model. The experiences of services in other jurisdictions both nationally and internationally suggest that Queensland will struggle to achieve widespread and sustainable uptake of the model without dedicated funding to support comprehensive training, implementation and evaluation.
19. Key requirements identified for successful Safewards implementation include partnering with consumers; sustained executive leadership; training for relevant staff; identification of dedicated change champions; multidisciplinary involvement across psychiatry, nursing, allied health and other staff; and commitment to evaluating and sustaining the model over time.

**Resource Implications (including Financial)**

20. The MHAOD Branch plans to scope potential resource requirements to support sustainable uptake and evaluation of the Safewards model in Queensland acute mental health units.

RTI RELEASE

| | |
|---|---|
| **Department RecFind No:** | **C-ECTF-17/2630** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

**Attachments**

21. Attachment 1: Queensland Mental Health Commission progress report on implementation of the 2014 report Options for Reform: moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards.

**Department Contact Officer**

Ms Janet Martin, Director, Clinical Governance, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch, Clinical Excellence Division, on telephone [redacted]

RTI RELEASE

| | |
|---|---|
| **Department RecFind No:** | **C-ECTF-17/2630** |
| **Division/HHS:** | **CED** |
| **File Ref No:** | |

| Author | Cleared by: (SD/Dir) | Content verified by: (CEO/DDG/Div Head) |
|---|---|---|
| Ailie Perich | Assoc. Prof. John Allan | Dr John Wakefield |
| Principal Policy Officer | Executive Director | Deputy Director-General |
| Mental Health Alcohol and Other Drugs Branch | Mental Health Alcohol and Other Drugs Branch | Clinical Excellence Division |
| 3328 9673 | 3328 9536 | 3405 6181 |
| | | |
| 16 May 2017 | 24 May 2017 | 30 May 2017 |

RTI RELEASE

May 2017

# Implementing recovery-oriented, least restrictive practices

Queensland Mental Health Commission

**Implementation progress of the 2014 report *Options for Reform: Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards*.**

## Purpose

In December 2014, the Queensland Mental Health Commission released *Options for Reform: Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards* (Options for Reform). This report provides an update on implementation of the Options for Reform by Queensland Health and Queensland's Hospital and Health Services (HHSs).

## About the Commission

The Commission was established by the *Queensland Mental Health Commission Act 2013* to drive reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

One of its functions is to undertake and commission research in relation to mental health and substance misuse issues (section 11(1)(f)); and to review, evaluate, report and advise on the mental health and substance misuse system (section 11(1)(d)).

## Background

In December 2013, the Director of Mental Health issued a directive to lock all publicly operated acute mental health inpatient units in Queensland following concern regarding the number of people who were absent without permission[1].

[1] A patient is considered to be absent without permission in certain circumstances, for example if they are on: an in-patient involuntary order and they leave an acute mental health ward without approval; or is on leave in the community but does not return to the ward when required.

Following this decision the Commission received several submissions and heard the views of a range of people including people with a lived experience of mental illness, their families, carers and supporters, professionals and others. Views shared with the Commission were diverse. Some indicated locking wards was inconsistent with a recovery-oriented, least restrictive treatment and others indicated that locking wards would better ensure the safety of people receiving mental health treatment.

The Commission engaged the University of Melbourne to conduct research into least restrictive practices in acute mental health facilities and convened a series of five forums with mental health staff (Rockhampton and Gold Coast), people with a lived experience of mental illness (Rockhampton and Logan) and carers (Gold Coast), in consultation with the Queensland Mental Health and Drug Advisory Council.

## Recovery-oriented, least restrictive practices and environment

While there is no single definition of recovery, all descriptions focus on consumer empowerment, self-determination, hope and inclusion. The *National Framework for recovery-oriented mental health services: Guide for practitioners and providers* defines personal recovery 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'.

Each person's recovery journey will be different based on their personal circumstances and aspirations. A person's recovery needs will evolve over time and may include treatment in an acute mental health ward.

Recovery-oriented mental health service delivery is defined by the National Framework as the 'application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.'

RELEASE

Least restrictive practices form an essential foundation to a recovery-oriented approach and have been accepted internationally and nationally as best practice. For example, the World Health Organisation's *Mental Health Care Law: Ten Basic Principles* include the provision of least restrictive practices and indicate that institution-based treatments should be provided in the least restrictive environment.

## The options for reform

The research and consultation informed the Commission's Options for Reform report. The Options for Reform report examined and outlined options for reform to support the implementation of recovery-oriented and least restrictive practices in acute mental health wards in Queensland, with a particular focus on locked wards.

While many policies and practices regarding recovery-oriented and least restrictive practices focus on an individual's treatment and support, the Options for Reform report focused on the need to adopt a whole-of-ward approach with issues such as the environment and culture of wards playing a significant role. The report was intended to enhance understanding of a complex situation in a way that balances the rights of individuals with concern for their safety, and in some circumstances, the safety of others.

Consistent with feedback provided by those consulted and the research, the Options for Reform report acknowledges that from time to time, and in certain circumstances, wards may need to be locked. However, when these decisions are made there is a need to continue to adopt a recovery-oriented, least restrictive approach within the ward. The report also outlined options for ensuring safety in acute mental health wards and approaches to reducing absences without permission.

The report outlined 15 options for Queensland Health and HHSs to consider implementing to promote recovery-oriented, least restrictive practices adopting a whole-of-ward approach across three key areas:

1. ***Supportive relationships*** – supporting the development and maintenance of positive connections and relationships through increasing contact with family, carers and friends; and the involvement of appropriately trained and supported peer support workers.
2. ***Organisational culture which encompasses policies and procedures, ward routine and environment and staffing*** – shifting the culture and practices of the ward towards those that support recovery by increasing choice, self-determination and inclusion; appropriate and ongoing risk assessment and mitigation; and well trained and supported staff who practise from a recovery-oriented perspective.
3. ***Monitoring and reviewing elements of a recovery-oriented approach*** – identifying and reporting against clearly identified indicators to assess the implementation of recovery-oriented approaches and ensure continual improvement.

The 15 options for reform proposed by the Commission are in Appendix 1.

## Progress

Since the Options for Reform report was released Queensland Health and HHSs have taken steps to implement recovery-oriented, least restrictive practices and enhanced assessment and management of risk in acute mental health facilities in a wide range of ways. Queensland Health continues to closely monitor these issues.

The Options for Reform report focused on supportive relationships as essential to recovery and was considered by all consulted as important to maintaining continuity of care after discharge and to reducing absences without leave. Options identified included increasing the ability of people receiving inpatient treatment to maintain their personal relationships including by enabling the use of electronic devices.

The new *Mental Health Act 2016* increases the way people receiving treatment can communicate with families, carers and friends by enabling communication using a mobile phone or other electronic device; however this may be restricted or prohibited if communicating in this way is likely to be detrimental to the health or wellbeing of the person or others.

New models of care, adopting a whole-of-ward approach, are also being implemented in Queensland. These include the trial of the Safewards model of care in Central Queensland, Metro North, Metro South, and West Moreton HHSs.

Safewards is an evidence-based approach that is designed to reduce conflict (aggression, rule breaking) and containment (coerced medications, restraint and seclusion) in acute adult mental health inpatient units. The Safewards model proposes that conflict within a ward can arise when a person is faced with situations that increase their emotional distress or 'flash points'. The Safewards approach focuses on what staff can do before the person reaches a flash point by being aware

PRELIAS

of potential triggers and determining the best method to reduce the impact or best containment method for the situation. The model helps staff to work together with consumers on the wards to reduce conflict and containment as much as possible and make the inpatient unit a more therapeutic and peaceful place. Queensland Health is working with HHSs across the state to strengthen and sustain the implementation of the Safewards model.

Many inpatient units also use sensory approaches to reduce distress and agitation and restore a sense of safety and stability. Sensory approaches use activities and equipment, behavioural strategies and modifications of the physical and social environment to help regulate emotions and responses. They aim to increase awareness of sensory preferences and sensitivities and support management of arousal and are considered to be non-invasive, self-directed and empowering interventions that may support recovery-oriented practice. Sensory approaches are used in most acute mental health units across the State.

Mackay HHS has introduced a therapeutic leave agreement process to clarify limited community treatment provisions. This process is discussed with consumers when they are admitted to the inpatient unit and regularly throughout their admission. It has been found to reduce confusion and agitation and enhance feelings of self-determination and control.

The introduction of the *Mental Health Act 2016* in March 2017 will also include enhanced mechanisms to balance the rights of people receiving involuntary treatment for mental illness with appropriate risk assessment and management and a more person-centred approach to managing instances of absence without permission. Unlike the previous *Mental Health Act 2000*, the new Act will require hospital staff to attempt to contact people who are absent, if reasonable, before notifying police.

As part of the *Mental Health Act 2016*'s implementation, the Chief Psychiatrist has issued policies and guidelines which must be implemented by authorised mental health services. These policies include the Treatment and Care of Patients Policy which focuses on recovery-oriented practice which respects human rights and adopts a least restrictive approach to treatment and care. This is consistent with current policy and practice.

Since the release of the Options for Reform report the Mental Health, Alcohol and other Drugs Clinical Network has convened two roundtables bringing together senior clinicians to discuss approaches to promoting consumer and staff wellbeing in adult acute mental health inpatient settings through maximising the therapeutic environment. The Commission has been invited to attend these roundtables.

## Conclusion

The issue of locking wards remains of concern to people with a lived experience of mental illness, their families, carers and supporters with many expressing divergent views.

The Commission upholds its position that all mental health services should be provided within a recovery-oriented and least restrictive framework which considers not only the individual consumer's journey but also the environment in which treatment and support is provided. Services should allow people choice and control over their recovery pathway as much as possible, having regard to issues of risk and safety for the person and others where necessary; be tailored to the unique needs of each individual; and delivered in a way that demonstrates respect and promotes dignity.

It is encouraging to see that Queensland Health has increased its focus on these issues and that evidence-based approaches are being implemented in many HHSs across the state.

However, efforts must continue to ensure that models of care that promote recovery-oriented and least restrictive practices are implemented in all services across the State and that there are clear processes in place to assess the implementation of these practices.

The Commission is of the view that a decision to lock doors should be discretionary and based on local decision making. Local decision making should be supported by a statewide policy framework that takes a whole-of-ward approach to recovery-oriented, least restrictive practices.

A statewide framework should set clear and objective criteria for making a decision to lock doors, including a timeframe and process for reviewing that decision.

As noted in the Options for Reform report, there is a need to clearly communicate to consumers receiving treatment in a ward about the basis for locking the ward, the timeframes for reviewing the decision and the basis upon which the ward will become unlocked. There should be a requirement for these decisions to be clearly and sensitively communicated to people receiving treatment, their families, carers and supporters.

PRIVILEGE

The statewide policy framework should clearly articulate the requirements for practising within a recovery-oriented and least restrictive approach, at both the individual and whole-of-ward level, and how this will be measured and monitored.

It should also include consideration of various factors that impact on the ability to provide recovery-oriented service delivery such as infrastructure and be developed in partnership with people with a lived experience, their family, carers and supporters. Implementation of the statewide policy framework should be mandatory for all HHSs.

The Queensland Mental Health and Drug Advisory Council support the Commission's position.

## Next steps

The Commission will continue to monitor this issue closely through ongoing discussions with Queensland Health and other stakeholders, including the Queensland Mental Health and Drug Advisory Council.

The Commission encourages the continued involvement of people with a lived experience in discussions about this issue and how acute mental health services can truly move towards a recovery-oriented and least restrictive approach.

## References

1. Australian Health Ministers' Advisory Council. A national framework for recovery-oriented mental health services: guide for practitioners and providers. Canberra: Australian Government; 2013.
2. World Health Organisation. Mental health care law: ten basic principles. Geneva: World Health Organisation; 1996.
3. Bowers, L., Alexander, J., Bilgin, H., et al. Safewards: the empirical basis of the model and a critical appraisal. Journal of Psychiatric and Mental Health Nursing, 2014, 21: p. 354-364.
4. Scanlan, J.N. & Novak, T. Sensory approaches in mental health: A scoping review. Australian Occupational Therapy Journal, 2015, 62 (5): p. 277-285.

RTI RELEASE

# Appendix 1
# Options for reform

## Supportive relationships

*Increasing contact with family, carers and friends*

1. Investigate options to enable consumers to communicate with families and friends through greater access to phones and the internet, subject to treatment plans, and by encouraging the presence of families, carers, friends and other supporters on the ward.

*Peer support workers*

2. Enhance peer support worker programs in Hospital and Health Services by:
    - involving peer support workers in each stage of a consumer's treatment from admission to discharge
    - providing appropriate training to assist peer support workers to undertaken their roles
    - involving peer support workers as part of the treatment team.

## Changing culture

### *Organisational policy and procedures*

*Enabling consumers to set and achieve their goals*

3. Policy and procedures to adopt a risk management approach which enable consumers to take measured risks as part of their recovery.

*Discretionary approach to locking wards*

4. Hospital and Health Services and the Director of Mental Health to provide clear and timely advice to staff and consumers, families and carers regarding decisions to lock doors. Decisions are to be made on the basis of clear and stated factors and processes including a set time for review of a decision to lock ward doors.

*An approach to absences without permission*

5. To reduce absence without leave, an approach be implemented by Hospital and Health Services which includes developing a plan for individuals based on recovery-oriented practice and addressing the issues leading to their absence. This plan should be regularly reviewed and monitored and its development should involve peer support workers.

### *Routine and environment*

*Reducing the custodial features on of the ward*

6. Decrease impersonal and custodial features (or non-caring environment) of the ward through creating more appealing and liveable spaces in the ward via decor, family friendly spaces, tea and/or coffee making facilities including a welcome or reception area.

7. Where access to outdoor or recreational spaces has been limited including as a result of locking the ward, appropriate action be taken in a timely manner to make the entire ward freely accessible to consumers.

*Orientation*

8. Provide face-to-face orientation for consumers, and involving families and carers where appropriate. The orientation process should include information about the ward rules and daily routines and emphasising consumer comfort, personal safety and how to access support and involve peer support workers.

*Purposeful activities*

9. Hospital and Health Services, in consultation with consumers, families and carers, provide opportunities for consumers in mental health wards to undertake activities to reduce boredom, including those that promote physical health.

*Consumer safety*

10. Wherever possible, women and children and young people should be accommodated separately in wards. Any future refurbishments or construction should take into account the need to have capacity to separate consumers on the basis of age and gender.

### *Staffing*

11. Staff, including nursing staff and allied health workers as well as casual/agency staff working in the acute inpatient wards to be trained in mental health.

12. Provide on-going training and professional development opportunities focused on recovery-oriented practice to nursing staff.

PT RELEASE

## Monitoring and review

13. An audit be undertaken in each ward to identify the extent to which options outlined in this report are being implemented and additional steps that should be taken to enhance recovery-oriented services adopting a least restrictive approach.

14. To understand the full extent of unintended consequences that have been highlighted in the literature, but as yet remain undocumented, conduct a comparative analysis of data from before and after the introduction, where possible, of the new policy regarding:

    - the rate of voluntary admissions
    - the rate of self-harm in inpatient settings
    - the rate of aggressive incidents in inpatient settings
    - the rate of illegal drug use
    - smoking related incidents (including fire setting)
    - the use of seclusion and restraint in inpatient settings
    - use of recreational areas
    - visits by family, friends, carers.

15. Audit and monitor data relating to Absences Without Permission including:

    - conducting a quality audit of AWOP data to ensure that the data are being captured accurately and within the expected parameters
    - conducting an analysis of AWOP data taking into account any issues identified with data integrity
    - monitoring the levels of AWOP including by comparing levels from locked and unlocked wards.

RTI RELEASE