Queensland Safety Priorities

in Mental Health Alcohol and Other Drugs Care

Queensland Government

This document includes elements from Making Tracks artwork,

produced for Queensland Health by Gilimbaa

Acknowledgment of Country

Queensland Health acknowledges the Traditional and Cultural Custodians of the lands, waters and seas across Queensland, pays our respects to Elders past and present, and recognises the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

'First Nations' and 'Aboriginal and Torres Strait Islander' peoples are used respectfully within this document to refer to the first peoples of the lands known today as Australia who are living in Queensland. This is done with the acknowledgement that Aboriginal and Torres Strait Islander peoples maintain the right to self-determine the description of their cultural identity.

The term 'First Nations people' is used to describe when the focus is at the individual, rather than population level.

Recognition of Lived Experience

Queensland Health recognises people with lived experience of mental illness, problematic alcohol and other drug use, and/or mental health crisis and suicidality, their families, carers and support persons. Their contribution to driving and informing reforms to the mental health alcohol and other drug service system is critical and valued.

A note about language

There are multiple terms used to describe people who access mental health and alcohol and other drugs care, including consumers, clients, or patients. To ensure this document is inclusive of the broad range of people who engage with mental health and alcohol and other drugs care, the term 'people receiving care' has been used throughout.

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Foreword

The Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care (the Safety Priorities) establish Queensland Health's position on safety and quality improvement activity within mental health alcohol and other drug (MHAOD) services.

Safety is a critical component of quality, and the Safety Priorities complement other significant quality improvement work progressing under *Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drugs services to 2027* (Better Care Together)[1] including the development of a statewide safety and quality improvement framework and enhancements to legislative and regulatory improvements associated with the *Mental Health Act* (2016).

We believe that it is possible to make MHAOD care safer and that it is possible to prevent adverse events by identifying, learning from, and avoiding potential harm. This set of safety priorities are linked with a range of strategies to support services in identifying, measuring and developing system changes that can reduce harm across the MHAOD service sector.

The Safety Priorities support committed action by encouraging and guiding all health care services to act to improve the safety of MHAOD care, with a focus on care delivered by Queensland publicly run, funded and licensed MHAOD services. We hope that these priorities will be supported in other sectors, such as other non-government services delivering MHAOD care to assist shared approaches to making care safer.

The delivery of MHAOD care in Queensland is complex. The treatment, care and support delivered through state funded MHAOD services takes place with and alongside primary health care and other specialist treatment, as well as other clinical and psychosocial support programs and services. The Safety Priorities acknowledge this complexity and support the message in Better Care Together [2] that a strong commitment, supportive culture, adequate resources, and effective and appropriate governance structures are essential for safety and quality improvement.

The Safety Priorities have been developed with recognition that many individuals play an essential role in implementing the identified strategies and that action is needed not only by those providing MHAOD care, but also by those who have governance responsibility for health care and those working in other health sectors where people require MHAOD care. Furthermore, the inclusion of people receiving care, their carers and families is an essential and valued aspect of the successful implementation of many of the strategies outlined below.

Our appreciation and thanks is extended to all of the people with lived experience, representatives from Aboriginal and Torres Strait Islander community controlled health organisations, MHAOD non-government organisations, advocacy groups and peak bodies, Hospital and Health Services and the Department of Health who participated in the consultation and refinement process for their hard work and support in developing this robust set of agreed Safety Priorities that provide the basis for continued improvements in the safety of MHAOD services across Queensland[i].

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Introduction

All people deserve health care that is safe and high quality. MHAOD care can, and often does, have profound and positive impacts on the lives of people receiving care, and their families. But, like all health care, it also has the potential to cause harm. Individuals should be confident that receiving MHAOD care will not pose a risk to their personal, physical, spiritual or psychological safety. Families, carers and health professionals also have the right to feel safe. It is critical that a balance is achieved between individual rights to dignity, respect and privacy and the need to protect the safety of individuals, carers, families, staff and others.

The goal of the Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care (the Safety Priorities) is to identify, avoid, or reduce actual or potential harm from MHAOD care delivered by Queensland publicly run, funded and licensed MHAOD services. The purpose of the Safety Priorities is to identify the specific areas of increased risk of harm for people receiving MHAOD care in these settings in Queensland and provide strategies for improvement and options to monitor progress.

It is intended that this document provides Queensland publicly run, funded and licensed MHAOD services with an agreed set of priorities for focus as part of their own continuous improvement processes, and will be supplemented in implementation through the *Digital Information Strategy 2022-2027: a plan for Queensland's state-funded mental health, alcohol and other drugs services to 2027,* the development of the Queensland MHAOD Safety and Quality Improvement Framework, and the ongoing work of the MHAOD Branch within Queensland Health.

The MHAOD Branch led the development of the Safety Priorities. The process to identify the Safety Priorities built on the Queensland-led update of the National Safety Priorities in Mental Health in 2020.[ii]

To create Queensland-specific priorities fit-for-purpose for both mental health and alcohol and other drugs care, the development process included:

- Review of contemporary documents and literature, including:
  - *Queensland Alcohol and Other Drug Treatment Service Delivery Framework*[3]
  - *Queensland Alcohol and Other Drug Treatment and Harm Reduction Outcomes Framework*[4]
  - *Don't Judge, and Listen: Experiences of stigma and discrimination related to problematic alcohol and other drug use*[5]
  - *National Quality Framework for Drug and Alcohol Treatment Services*[6]
  - *Changing attitudes, changing lives: Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use*[7]
  - *Plan for Transcultural Mental Health Services in Queensland Health*[8]
- Consultation through virtual focus groups with over 80 sector representatives from:
  - The Queensland Network of Alcohol and Other Drug Agencies (QNADA), Queensland Aboriginal and Islander Health Council (QAIHC) and the Queensland Alliance for Mental Health (QAMH)
  - Executive and clinical representatives of all Hospital and Health Service (HHS) MHAOD services
  - Non-government organisation (NGO) mental health service providers
  - NGO alcohol and other drug service providers
  - Aboriginal and Torres Strait Islander Community Controlled Health Services
  - Queensland Injectors Voice for Advocacy and Action
- Validating the consultation and research findings through a survey of people who have received or are currently receiving care from MHAOD services.

An HHS Advisory Group, QAIHC, QNADA and the QAMH were engaged at various points to test and refine the priorities.

[ii] Since the dissolution of the Council of Australian Government (COAG) Health Council in 2021, jurisdictions have been encouraged to locally adopt the safety priorities. The Queensland Safety Priorities in Mental Health Alcohol and Other Drug Care is Queensland's tailored adoption of these priorities.

Improving safety and reducing harms in MHAOD care

A focus on safety in health care delivery has emerged with the evolving complexity of the health care systems that increases the risk of harm for people receiving care.[9] It aims to reduce risks, errors and harms that occur during provision of health care. Safety is fundamental to delivering quality health services that are effective and people-centred.

An overview of the potential harms that may occur for people receiving MHAOD care is provided in Figure 1. Some of these harms may be mild and temporary, while others may be severe and even life-threatening. MHAOD systems and services have an obligation to continually improve the safety of their care to reduce the likelihood and severity of these harms occurring.

Figure 1 | Potential harms that may be experienced in MHAOD care

Deterioration of health state, which is a change for the worse in a person's mental state or in their substance use pattern, compared with the most recent information available for that person, and may indicate a need for additional care. People are at risk of harm if, despite this deterioration, they cannot or do not access health care until they are in a state of crisis.

Psychological harms can result from distressing, stigmatising or traumatic experiences that occur as people access or receive care. These psychological harms commonly arise from experiences of victimisation by other people receiving care or staff, witnessing distressing scenes, use of coercive practices, some psychotherapeutic interventions, and/or invalidating or insensitive communication.

Sexual harm and assault are risks for some people receiving care due to the vulnerability of their circumstances, including restrictive practices, power imbalances, and poor facility design.

Physical assault and injury may occur in various settings. During inpatient care, coercive and restrictive practices such as restraint and seclusion may result in physical harm, and physical assault may occur.

Impaired physical health can occur due to substance use itself, adverse medication side effects, and/or physical health conditions can be overlooked or not treated effectively during health care.

Suicide and self-harm is a risk across all health service settings. This includes mental health, alcohol and other drugs and acute health care services and the risk is heightened in the period immediately following discharge from inpatient care.

Individuals receiving care can experience **stigma and discrimination** from the community and care providers, in relation to many factors including race, gender, location, mental conditions and alcohol and other drug use. Stigma further marginalises people who may avoid seeking help, due to the real or perceived attitudes of others.

Some people receiving MHAOD care may be more vulnerable to harms than others. For example, women are more likely to be subject to sexual harms.[10] Aboriginal and Torres Strait Islander people or people who are from culturally and linguistically diverse backgrounds may experience care that is not culturally safe, which may exacerbate intergenerational trauma or pre-migration trauma. People from culturally and linguistically diverse backgrounds can also face language, health literacy and/or systemic barriers that make them more vulnerable to harm and less able to communicate safety concerns. Individuals who experience co-occurring mental health and substance use disorders can also experience poorer health outcomes, higher rates of relapse and subsequent hospital visits, imprisonment, unemployment, and family difficulties due to a lack of coordinated or comprehensive integrated care responses.[11] Variation in the likelihood and experience of harm is recognised in the Safety Priorities.

Fundamental elements of service quality underpin service safety

Safety and quality of care are inextricably linked. There are four fundamental elements of service quality that may have implications for the safety of people receiving, or attempting to access, care:

- **Appropriate governance** - Reduces system risks and improves the service's stability, efficiency and ability to deliver quality care.
- **Qualified, sufficient and supported workforce** - Ensures people receive required levels of care from appropriately qualified and supported staff and that care is delivered in a way that supports the physical and psychological wellbeing and safety of staff.
- **Evidence-based treatment** - Ensures that people receive appropriate care informed by best-practice.
- **Service supply that meets demand** - Reduces likelihood of turning people away when they seek help.

The Safety Priorities recognise these elements of quality may affect the capacity of MHAOD service providers to deliver safe care. The consultation process confirmed that adequate access to services and resources remains a significant barrier to ensuring quality. As there is significant work being undertaken to address each of these four issues across Queensland, the scope of this work defines safety priorities as those that remain problematic, even when the four areas of quality are operating as expected.

The role of the safety priorities within the safety and quality landscape

The Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care are designed to sit alongside existing frameworks and guidance for providing MHAOD care in Australia and Queensland, while setting a state-wide agenda for improving safety in the identified priority areas.

The Safety Priorities are aligned to:

- The *National Safety and Quality Health Service Standards*, which provide eight standards, which aim to ensure nationally consistent statements about the level of care people can expect from health services[12].
- The *National Quality Framework for Drug and Alcohol Treatment Services* (National Quality Framework) which aim to provide more consistent approaches to ensuring minimum quality standards through eight accreditation standards and nine guiding principles[13].
- The *National Mental Health and Suicide Prevention Information Priorities* which set out a vision to have national mental health information, including safety information, that is personalised, comprehensive and connected[14].

Eight priorities for improving safety in Queensland MHAOD care

The Safety Priorities identify eight priorities for improving safety and reducing potential and actual harms that may occur in MHAOD care. These priorities are intended to serve as a framework to guide safety improvements in the years ahead. They are a statement of collective intent aimed at focusing the work of government, system administrators and Queensland publicly run, funded and licenced MHAOD care providers. The priorities were identified on the basis that they have:

- significant potential to improve safety and reduce harms
- known and practical strategies for improvement, and
- the potential to be monitored over time.

The eight priorities are:

1. Partnering for improved safety
2. Improving the identification of deterioration or increased risk of harm
3. Providing trauma-informed care
4. Providing culturally safe care
5. Improving medication safety
6. Reducing suicide and self-harm
7. Increasing the safety of transitions
8. Recognising stigma to reduce discrimination.

An overview of the priorities is provided in Figure 2. For each safety priority, this document outlines:

- the key issues that make up each safety priority, based on the evidence and consultation
- suggested strategies for improvement, and
- options for monitoring progress over time.

It also outlines the shared responsibility for implementation between government and service providers.

Figure 2 | Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care

1 Partnering for improved safety
- Recognising and responding to individual needs and preferences
- Improving collaboration between all health care providers
- Improving access to and coordination with psychosocial support and other service providers

2 Improving the identification of deterioration or increased risk of harm
- Improving identification of worsening health state
- Making it easier to escalate care and harm reduction responses
- Improving crisis and sub-acute care options

3 Providing trauma-informed care
- Reducing use of potentially traumatising practices
- Applying trauma informed strategies
- Responding to inter-generational traumas

4 Providing culturally safe care
- Ensuring cultural capability across all services
- Strengthening pathways for First Nations and culturally diverse people seeking care
- Increasing the First Nations and cultural diversity of the workforce
- Enhancing First Nations and culturally diverse leadership

5 Improving medication safety
- Improving information sharing and collaborative decision making with multi-disciplinary teams, people seeking care, and their families and carers
- Reducing acute and chronic side-effects of medication

6 Reducing suicide and self-harm
- Enabling routine screening, assessment and safety planning
- Increasing use of suicide specific interventions and assertive follow-up
- Addressing alcohol and other drug use that can increase the risk of self-harm and suicidality

7 Increasing the safety of transitions
- Improving transitions between care providers and other services
- Enhancing safety of emergency transport
- Improving transitions across the age spectrum

8 Recognising stigma to reduce discrimination
- Identifying and collaboratively addressing stigma and discrimination
- Working to provide health equity

Harms to be identified, avoided and reduced through the priorities

Worsening health	Physical assault and injury	Impaired physical health
Suicide and self-harm	Sexual harassment and assault	Psychological harms

Partnering for improved safety

Key issues

For people receiving MHAOD care, there are three important elements to 'partnering' – between the MHAOD care provider and the person receiving care, their families and support networks; between all elements of a person's health care provision team; and between MHAOD care and broader support services.

Recognising and responding to individual needs and preferences

MHAOD care is more likely to be safe and effective when individuals are genuine partners in their care and when their goals are at the centre of decision making. However, too many people receiving care report feeling disempowered and that they do not have an active voice or role in their own care. This can lead to care that is inappropriate for the person's circumstances, goals, and/or health care history, which can have profound impacts on the efficacy and safety of the care.

Services need to meaningfully engage with people receiving care, and their families, carers and support networks, in ways that reduce the real or perceived power imbalance that can occur. This includes taking into account a person's health literacy when discussing care options and working to ensure people receiving care feel control and empowerment over decisions and actions affecting their health. This may involve discussing and negotiating all available and appropriate treatment options and associated information, including non-clinical options, and working together to design a treatment plan that will meet the person's needs and goals.

People receiving care, and their families, carers and supports also need to be aware of the ways in which they can provide anonymous feedback, make a complaint, and/or seek advocacy support. Independent Patient Rights Advisers (IPRAs) are available within each Hospital and Health Service (HHS) to advise people receiving care and their nominated support persons, family, carers and other support persons of their rights under the *Mental Health Act 2016* and the *Human Rights Act 2019.* IPRAs play an important role in liaising between clinical teams, people receiving care and their support persons.

There are also particular barriers for First Nations peoples and people from culturally and linguistically diverse backgrounds when partnering in their care. Limited cultural understanding among MHAOD staff and culturally appropriate models of care, alongside racism and biases, can make it difficult for people receiving care to engage in a genuine partnership and communicate their needs and experiences.[15] This is discussed further in Safety Priority 4.

Peer workers, Aboriginal and Torres Strait Islander health workers and Multicultural Mental Health Coordinators may have important roles in supporting these discussions.

Improving collaboration between all health care providers

For many people receiving MHAOD care, there is likely to be an element of diagnostic complexity across their physical, mental health and AOD use disorder treatment and care needs. MHAOD care is therefore more likely to be safe when it is delivered in partnership with other health providers. This includes appropriate collaboration between mental health and AOD services as well as between MHAOD care and other forms of health care for people with co-occurring conditions.

There needs to be particular focus on how government and non-government providers work together, and how collaboration with the Aboriginal and Torres Strait Islander Community Controlled Health Organisations occur, for the benefit of people receiving care.

Improved collaboration, at all levels, will support people to access the multi-disciplinary, collaborative and comprehensive care they need to stay safe and sustain their recovery.

Improving connection to and coordination with psychosocial support and other service providers

Insufficient partnership and coordination between health and human services has been associated with poor health and social outcomes for people with mental health, substance use and co-occurring conditions. It has also been associated with some of the most serious harms, including deaths from suspected suicide, overdose, homicides, and other causes.[16] It is critically important to improve access to and coordination with psychosocial support and other service providers. This includes greater collaboration between MHAOD care providers and other relevant services, including, but not limited to, health, housing, employment, welfare, child and family services and justice and law enforcement, in providing care.

Challenges to partnering between health and human services include a lack of service models that promote partnerships, funding models that discourage collaboration, and barriers to information sharing.

Strategies for improvement

To support partnering with people receiving care, their families, carers and support networks:

- Create care plans that allocate resources in ways that enable people to be owners and drivers of their own care.
- Support people's ownership of care plans that are recovery oriented.
- Consider the health literacy of the person receiving care and work to promote their health literacy by providing clear information, effective communication and structured education.
- Improve engagement with families, carers and support networks, with consent from the person receiving care, in the development of care plans.
- Improve Aboriginal and Torres Strait Islander peoples' access to community controlled services or other culturally appropriate services.
- Improve access to specialised support that enables people from culturally and linguistically diverse communities to be partners in their care.
- Include an explicit focus on social, economic, educational and occupational, and physical health goals in care planning.
- Work in partnership with people receiving care and their families, carers or other support persons, and provide support in a way that builds on strengths and promotes empowerment.
- Increase access to peer workers, Aboriginal and Torres Strait Islander health workers and Bicultural workers/consultants through Multicultural Mental Health Coordinators.
- Support people receiving care to access health care information and support resources, including those that facilitate self-care and collaboration with service providers, through the consumer website portal to be established under the MHAOD Healthcare Digital Information Strategy.

To support collaboration between all health care providers:

- Encourage active engagement and a collaborative approach between MHAOD care providers and other health service providers including paramedics, emergency department staff, GPs, other health specialists, private providers and non-government agencies during assessment, planning and the delivery of care.
- Enhance the sharing of relevant information between service providers, where it is appropriate, necessary and in accordance with legislation.
- Ensure people with co-occurring conditions are able to access collaborative mental health, physical health and AOD treatment, care and support.
- Enable more multi-disciplinary and diverse MHAOD care teams.
- Embed Aboriginal and Torres Strait Islander community-controlled organisations as a core element of service delivery models.

To support partnerships between health and human services:

- Make care plans more integrated and easily accessible across health and human service providers, people receiving care, their family, carers or support people.
- Adopt collaborative models for care planning and delivery across key health and human services agencies to ensure agreed and clearly defined roles for service providers.
- Enable co-location and outreach models of service to promote improved partnerships between health and human services.

Options to monitor progress

Options for monitoring the quality of partnerships in MHAOD care remain limited but are improving, with options including:

- The Your Experience of Service (YES), Family of Youth (FoY) and Carer Experience of Service (CES) surveys which provide measures for monitoring people's involvement in their care.
- Surveys of National Disability Insurance Scheme participants which provide information to assess participants' choice and control in their care and if they are achieving their goals.
- Working towards the consistent and routine use of YES, FoY and CES across public MHAOD services to improve the ability to monitor partnership with people receiving care and their carers.
- Implementing a fit-for-purpose experience of service survey in NGO services.
- Data linkage may provide a better understanding of the extent to which health and non-health services are partnering to support care.
- An AOD service user experience survey is yet to be developed. Some NGOs have surveys and performance measures however this is largely ad hoc.
- Clinical audit tools have been designed to monitor clinical documentation for evidence of partnering with people receiving care, their carers and other service providers.
- Consumer advisory and feedback mechanisms can monitor the extent and quality of partnerships between health care providers, people receiving care and their carers.

Improving the identification of deterioration or increased risk of harm

Key issues

The course of mental health and substance use conditions can change over time. Even with appropriate and well-coordinated care, a person's physical and mental health can deteriorate, and/or their pattern of substance use may change, increasing the risk of harm. This may occur rapidly or over an extended period. When this occurs, a person's care needs to adapt to prevent worsening health.

Improving identification of worsening health state

Recognising and responding early to a worsening health state can improve prognosis, alleviate distress, and hasten recovery.[17, 18] Responding early improves safety by reducing the likelihood of deterioration to the point of risk of significant harm to the individual and to others. It also potentially reduces the need for involuntary treatment and restrictive practices, or involvement in the justice system.

Families, carers and support networks play a critical role in the identification of a person's worsening health, but there are barriers to escalating care.

Making it easier to escalate care and harm reduction responses

Responding early and effectively to worsening health state requires three elements: the ability to recognise the change; respond to the change; and escalate care to match the person's changing needs.[19]

The National Safety and Quality Health Service Standards require health services to have processes in place for clinicians to recognise acute deterioration in mental state and escalate care accordingly. The Queensland Adult Deterioration Detection System (Q-ADDS), used in most Queensland Health adult inpatient settings, has recently been revised to include visual observation monitoring for confusion and changing behaviour. These new components are suitable for use by nursing staff across all sectors of the hospital including mental health facilities and provide a user-friendly approach to identifying deterioration in most people.

However, there is a lack of consistent and accepted practices for monitoring and responding to deterioration across all elements of the MHAOD care system. Similarly, approaches to escalating care when a change in a person's substance use pattern is identified are not in place or consistent across all services.

Barriers exist for people with co-occurring mental illness and substance use disorder, as a change in a person's mental state may be attributed to substance use alone, and not considered a reason to escalate care.

Improving crisis and sub-acute care options

Lack of care options for people not yet in crisis has also been widely noted. The capacity of health services to identify and respond to deterioration of a person's health due to mental health and substance use related problems may be impacted by a wide range of factors. The most often cited are lack of access to treatment, competing priorities and large caseloads, a lack of processes or tools for detecting deterioration, a lack of community outreach and 'step-up' options, and poor communication between care providers, people receiving care and their carers.

There is a need for alternative options to the emergency department (ED) for people seeking to escalate their care, to avoid long wait times and potentially not being eligible to receive care from the tertiary service. However, for those who do present to ED, there is a need to ensure they are treated with compassion and respect, and connected to the most appropriate care, in a timely manner.

Strategies for improvement

To improve identification of worsening health:

- Implement standardised processes to monitor and identify changes in mental state and substance use patterns, with clear criteria for escalating care.
- Ensure tools and processes for monitoring deterioration are designed to identify cultural needs and how deterioration may or may not be expressed from a cultural perspective.
- Empower people and their families, carers and support persons to monitor their own health and be able to escalate care where required (e.g. through safety plans).
- Enable improved information sharing and trust of judgement between providers, people receiving care, their family, carer or support people to aid detection and a coordinated response to deterioration.
- Increase post admission clinical follow up and care in the community to recognise a change in mental state, or increased risk associated with substance use.

To improve ability to escalate care before a crisis:

- Establish clear pathways for escalating care as quickly as possible, including through genuine partnering with the person and their family, carers and support persons.
- Ensure co-occurring conditions are not a barrier to receiving care during a crisis.
- Improve access to preventative strategies and relapse prevention supports to improve care outcomes.
- Improve access to lower intensity MHAOD and health supports including self-help and digital health care options.
- Increase availability of moderate intensity community-based MHAOD care options to prevent deterioration.
- Develop alternatives to emergency departments for crisis MHAOD care, including crisis support spaces and mobile mental health care teams (including co-responder services).
- Increase access to solution-oriented interventions aimed at responding to psychosocial issues (e.g. homelessness, domestic and family violence) impacting health.

Options to monitor progress

- National measures already exist to monitor contacts of people who access care with public community mental health in the week prior to an inpatient admission, an indicator that care is being appropriately escalated. Similar measures are not currently available for alcohol and other drug services and should be investigated.

- Readmissions to an acute mental health unit within 28 days of discharge may indicate that follow-up care was inadequate to maintain the person's treatment out of hospital, including early identification of a worsening mental state, escalation of care to match the person's changing needs and the availability of crisis and sub-acute care options. Data linkage may allow improved monitoring of contacts with other services including general practice, private providers and non-government services, and should be investigated.

- The use of emergency services and departments to access MHAOD care can provide a measure that MHAOD related deterioration is not being appropriately detected or addressed.

- Monitoring the use of ED by people already under the care of a MHAOD team may indicate that deterioration is not being managed as needed and should be a priority.

- Data in hospital service settings capturing substance use and substance use disorders could be used to better understand the changes in AOD use, the number of presentations and length of stay over time as an indication of whether early intervention and out of hospital services are reducing deterioration and the need for hospitalisation.

Providing trauma-informed care

Key issues

Many people with substance use and/or mental health conditions have histories of trauma that affect their health and engagement with health and other services. These may include experiences of physical abuse, life-threatening events, domestic and family violence, interactions with the forensic and/or justice system, sexual assault, neglect, racism and intergenerational trauma.

Applying trauma informed strategies

Trauma-informed care can reduce the risk of further psychological harm and increase future engagement and trust with services to improve mental health outcomes. Trauma-informed care is both an organisational and practice approach to delivering health care.[20] The principles for trauma-informed care are a strengths-based approach that seeks to promote physical and psychological safety, foster trust and collaboration, enable choice and control, and empower people receiving care through the understanding of how symptoms and presentations may be adaptations to trauma histories rather than pathologies.[21] It respects diversity and recognises the role of culture in recovery.[22,23]

The provision of trauma informed care extends beyond the work of MHAOD services and professionals. All services engaged in the delivery of care have a role, including emergency services, law enforcement, security personnel, agency staff, emergency department staff, private specialists and general practice.

Responding to intergenerational traumas

Understanding and responding to intergenerational trauma stemming from colonisation specifically, is an important component of cultural capability when working with First Nations people. Intergenerational trauma involves the transmission of trauma from one generation to the next. For First Nations peoples, a history of forced removals, policies such as racial assimilation, socially sanctioned racism and violence and grief over the loss of land and culture have all contributed to intergenerational trauma.[24] Although this contributes to the social and health disadvantages experienced by Aboriginal and Torres Strait Islander peoples, the influence of unresolved trauma is often overlooked in policy and practice. Part of responding to intergenerational trauma requires culturally safe care, which is described in Safety Priority 4.

People from culturally and linguistically diverse (CALD) (including refugee) backgrounds, and those involved in the child protection system may also carry intergenerational trauma or pre-migration trauma. This can be triggered in the context of facing systemic barriers while accessing health care. Culture plays a significant role in the way trauma is expressed and/or manifested. MHAOD services should therefore be committed to understanding trauma and enhancing cultural competence when working with people through a trauma-informed lens.

Reducing use of potentially traumatising practices

Elements of MHAOD care provision may in and of themselves cause trauma. MHAOD services have an important role in reducing the use of potentially traumatising practices, creating a climate of safety (including the physical, social and cultural environment), and creating opportunities for people receiving care to rebuild a sense of control, belonging and empowerment.[25] They also have an obligation to protect people receiving care from further trauma that may occur in the course of MHAOD care through, for example:

- use of coercive or restrictive practices
- experiences of victimisation or stigmatisation
- experiences of prejudice and racial discrimination
- physical or sexual assault or harassment
- culturally unsafe practices
- insensitive communication
- limited engagement and appropriate choice in care
- poorly implemented therapies.

These practices and experiences have potential to cause trauma and psychological harm to people receiving services, families and staff.[26,27,28,29] They can erode trust and damage relationships between people receiving care, families, and care providers, and discourage the seeking of care.[30] These experiences can occur across all MHAOD care settings. People may be particularly vulnerable in acute care settings where restrictive practices are more likely to be used.

Consultations have highlighted that such traumatic experiences are often intertwined with the perceived safety of staff, particularly in acute care settings. This may occur, for example, if staff perceive a risk to their physical safety and respond by increasing use of restraint and other restrictive practices, in turn affecting the psychological safety (and potentially physical safety) of the person receiving care.

Strategies for improvement

To provide a more trauma-informed approach to care:

- Review existing policies, procedures, training and practices to incorporate trauma-informed principles.
- Develop trauma-informed service plans.
- Adopt evidence-based interventions to reduce potentially traumatic experiences including use of seclusion and restraint in higher risk settings (e.g. Safewards, Six Core Strategies).
- Enable identification of the impact of trauma as part of standard MHAOD service screening, assessment, formulation and care planning.
- Increase access to appropriately experienced and supported peer workers, Aboriginal and Torres Strait Islander health workers and Bicultural workers as a means of improving experiences of care.
- Provide enhanced choice in care, including access to Aboriginal and Torres Strait Islander community controlled services for First Nations peoples.
- Partner with emergency services, law enforcement, security services, agency nurses and residential aged care workers to improve responses to people who have experienced trauma.

Options to monitor progress

- The level of trauma-informed care processes and practices could potentially be measured, such as the number of policies, procedures and workforce development strategies implemented that have a trauma-informed care focus.

- National measures exist on some practices and experiences that may lead to or exacerbate trauma for people receiving care, including use of seclusion and restraint in mental health care in authorised mental health services.

- The Australian Bureau of Statistics Patient Experience Survey provides data to monitor the extent to which people with mental health conditions avoid care due to 'dislike or fear of a service'.

- The Your Experience of Service (YES) survey gathers feedback from people receiving mental health care regarding their perceived safety during their care and the effect of services on their overall wellbeing.

- Working toward consistent use of YES and inclusion of items measuring traumatic experiences in care may improve the ability to monitor improvements over time.

- Other options to improve monitoring including monitoring of restraint and other potentially traumatic experiences in settings outside authorised mental health services (e.g., emergency departments).

Providing culturally safe care

Key issues

The role of culture and cultural differences are important considerations in effective health care. Cultural and language diversity within the Queensland population is significant and will continue to grow into the foreseeable future.

People from culturally diverse backgrounds often have differing MHAOD needs and lower access to care, as they are more likely to experience language difficulties, different cultural understandings of mental health, cultural stigma, confidentiality concerns, unfamiliarity with the Australian health systems, and the overall lack of culturally competent health services.[31]

MHAOD services are under utilised by people from culturally diverse backgrounds. When culturally diverse individuals do access MHAOD services, there are significant disparities in the quality of care received, for example higher rates of involuntary treatment and treatment on Forensic Orders, longer periods of seclusion, lower rates of community follow up post discharge from acute inpatient settings, higher rates of diagnoses of schizophrenia and mood disorders.[32,]

First Nations peoples view health through a social and emotional wellbeing lens, which differs from the non-First Nations conceptualisation of mental health and wellbeing in important ways. Social and emotional wellbeing connects the wellbeing of communities and families to individuals, and takes a holistic understanding of life and health, which includes physical health, mental health and other factors such as cultural, spiritual and social wellbeing.[33]

First Nations Queenslanders are resilient, with culture and customs continuing to be a source of strength and pride, and the foundation for good social and emotional wellbeing. This is a protective factor against adverse life events, suicide, problematic alcohol and other drugs use, and some mental illnesses.[34]

However, First Nations peoples are less likely to experience health care that recognises their historical and social context, and the importance of social and emotional wellbeing. Research has found that First Nations peoples experience health professionals explaining things in ways that are not easily understood, do not respect their cultural views and are potentially racist.[35] This results in adverse experiences for people receiving care which reduces the efficacy of care and future help seeking. Social and emotional wellbeing, drug and alcohol use for First Nations people needs to be understood within the social and historical context of colonisation, dispossession of land and culture, economic exclusion and intergenerational trauma.[36]

Ensuring cultural capability across all services

The vast majority of MHAOD care accessed by First Nations people and those from culturally and linguistically diverse backgrounds is delivered through 'mainstream' MHAOD services. Mainstream services therefore have an essential responsibility for improving cultural safety for people receiving MHAOD care. People from culturally diverse backgrounds should be able to access any MHAOD service and receive culturally safe care where they feel respected and receive appropriate social and emotional wellbeing care.

Cultural capability must be embedded within service delivery models.[37] Cultural capability should be an employment requirement for all MHAOD services. Employees need to be provided with leadership, information, support and mentorship to increase their cultural knowledge and its application in treatment and promote a culturally safe workplace.

The Queensland Health Cultural Information Gathering Tool (CIGT) is designed for use by Aboriginal and Torres Strait Islander health workers to help create a culturally safe environment for people receiving care from MHAOD services. The CIGT embraces significant cultural concepts of Social and Emotional Wellbeing with connection to culture, community, land, family and kinship, spirituality, physical and mental wellbeing and assists MHAOD services to develop culturally appropriate care plans by encouraging consideration of matters of cultural significance which may have an impact on clinical care[38].

Strengthening pathways for culturally diverse people receiving care

While people from culturally diverse backgrounds will often receive care from mainstream services, many First Nations people will also receive care from Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs). ATSICCHOs are a vital part of the health care system for First Nations' peoples which operate through the principles of self-determination and aim to achieve health equity between First Nations and non-First Nations people.

Transitioning from care in a local community, whether it is from ATSICCHOs or mainstream services, to other services, often hospital care in another location, represents a significant risk to safety for culturally diverse people. During this transition, discontinuity of care and reduced social and emotional wellbeing support is more likely. Partnerships between HHSs and ATSICCHOs are therefore essential to ensure there are culturally effective models and continuity of care for First Nations people entering, moving through and leaving hospital.[39]

Partnership between the health system and broader community support services is another important interface to support recovery in the community of First Nations people and those from culturally and linguistically diverse backgrounds. Fundamental to care coordination for First Nations and people from culturally diverse backgrounds is consideration of their social and emotional wellbeing needs and care planning that links their physical and mental health clinical care needs with any other community based social and disability support services.

Increasing the First Nations and cultural diversity of the workforce

Strengthening the cultural capability of MHAOD services across Queensland requires a strong First Nations and culturally diverse workforce. Aboriginal and Torres Strait Islander health workers and Bicultural workers working within MHAOD services play a pivotal role as part of, and supporting, multi-disciplinary teams to engage with and provide the highest quality of equitable care.

Increasing the First Nations and culturally diverse MHAOD clinical and peer workforce, and ensuring all staff are enabled to work to the full scope of their practice should continue to be a key focus.

Enhancing First Nations and culturally diverse leadership

Embedding culturally safe care across 'mainstream' services and ATSICCHOs is enhanced through ensuring First Nations and people from culturally diverse backgrounds fulfill leadership positions across the MHAOD service system. Greater representation in leadership and governance enables considerations of cultural diversity at a system level, and provides strong direction, advocacy and support for co-design of policies and programs, culturally safe evaluation, as well as career progression pathways for First Nations and culturally diverse staff.

Strategies for improvement

To improve cultural capability in all services:

- Require cultural capability for employment in MHAOD services.
- Embed cultural capability training and competency for all MHAOD staff.
- Ensure there is leadership accountability for service cultural competence.
- Recognise the role of Traditional Healers and acknowledge traditional methods of treatment e.g. access to land and sea country, being on country, spirituality, culturally diverse explanatory models of illness, treatment and recovery.
- Utilise information from the Cultural Information Gathering Tool to inform comprehensive care planning.
- Improve the data collection, use and availability of information for people from culturally and linguistically diverse communities.

To improve care pathways:

- Strengthen partnerships between HHSs and ATSICCHOs in relation to service planning, implementation of culturally safe models of care and evaluation.
- Strengthen partnerships between HHSs and the Queensland Transcultural Mental Health Centre (QTMHC).
- Build strong and trusting relationships between MHAOD care providers and Aboriginal and Torres Strait Islander people and communities through improved cultural competency and communication.
- Improve processes for coordinated care planning and delivery across ATSICCHOs and HHSs.

To increase the First Nations and culturally diverse workforce:

- Implement focused Aboriginal and Torres Strait Islander and culturally diverse recruitment strategies.
- Ensure Aboriginal and Torres Strait Islander health workers, peer workers and Bicultural workers, are working to the full scope of their practice.

To enhance First Nations and culturally diverse leadership:

- Increase Aboriginal and Torres Strait Islander and culturally diverse workforce involvement in service leadership and governance.

Options to monitor progress

It is important to note that the presence or absence of cultural safety is determined by the experience of the recipient of care and is not defined by the caregiver.[40] Work to determine the extent to which cultural safety in health care is improving is underway at the national level, which could be adopted locally:

- The Australian Institute for Health and Welfare has developed a monitoring framework for cultural safety in health care.[41]
- The CSIRO has developed and validated a Cultural Safety Survey that measures cultural safety for Aboriginal and Torres Strait Islander peoples in hospital settings.[42]

While the YES survey does not have specific questions regarding cultural safety, the data can be disaggregated by Aboriginal and Torres Strait Islander people, and responses to questions that cover the extent to which people felt safe, their individuality and values were respected and they were listened to, could act as proxies for the extent to which the service was culturally safe.

In addition to the routine identification of First Nations and South Sea Islander status, Queensland public MHAOD services are now able to accurately and consistently record information relating to ethnic and cultural identity to support the delivery of safe and respectful health care.

Monitor collection of cultural information from Aboriginal and Torres Strait Islander people receiving care via the Cultural Information Gathering Tool.

Improving medication safety

Key issues

Medications can be an important and effective part of health care and are widely used across general practice and specialist services. Medication is widely used in mental health care, with 4.3 million Australians prescribed medications for a mental health condition in 2018-19.[43]

In AOD care, medication can be used in withdrawal practices, to help with symptom management, and to treat problems with alcohol, tobacco and other drugs.[44] In Queensland, on a snapshot day in 2020, 7,014 people received pharmacotherapy treatment for opioid dependence.[45]

Improving information sharing and collaborative decision making with people seeking care, and their families and carers, and between care providers

A range of adverse events and outcomes can arise in the use of medications, with varying potential for harm to people receiving care. Key safety concerns include inadequate monitoring of side-effects, a lack of shared decision making with people receiving care, their families, carers and support people, and a lack of information sharing across multi-disciplinary teams.[46] Safety risks also include the use of multiple sedating substances, including prescribed medications.

Reducing acute and chronic side-effects of medication

Most people using psychotropic medications as part of their health care will experience some form of side-effects. While many side-effects are mild, a substantial proportion report that side-effects have a moderate to severe impact on their daily lives.[47] These impacts include metabolic and cardiovascular changes, hormonal and sexual changes, movement symptoms, and cognitive changes.[48] Reducing acute and chronic side-effects of medication is an important focus for delivering safe MHAOD care.

Some medications can have serious and long-term impacts on health and require particularly careful monitoring.[49,50] Polypharmacy is widespread in mental health care and can be associated with a higher likelihood of adverse outcomes in addition to contributing to risks of substance use. [51] Medication errors such as incorrect dosages and use of contra-indicated medicines can in some circumstance result in serious adverse outcomes.[52] Medication treatment should be underpinned by evidence-based prescribing, aligned to best practice and regulatory guidance and supported by an established system and process for tracking and reviewing outcomes for people receiving care.

A range of strategies have been identified as effective for improving the safe use of medication in health care, but these have had inconsistent uptake, including in MHAOD service settings.[53] These include standardised processes for prescribing, administering and monitoring medicines, engaging pharmacists in medication reviews and decisions, and the use of electronic medication management systems. Initiatives such as QScript and opioid stewardship are examples of particular relevance to MHAOD services. There is an opportunity to improve the use of QScript and MyHealth Record to reduce the prescribing of inappropriate combinations of medications.

Adverse medication outcomes are less likely to occur when there are established systems and processes for tracking and reviewing medications, when decisions are made in collaboration with people receiving care, and when language barriers and cultural needs are appropriately taken into account. They can also be reduced through adherence to evidence-based guidelines.

Strategies for improvement

To improve involvement of people receiving care in medication decisions:

- Implement tools that enable self-monitoring and reporting on medication experiences, side-effects and preferences.
- Enable shared decision making, informed by the person's previous medication experiences, preferences and goals, including as described in an Advance Health Directive where relevant.
- Engage people in ongoing education on safe medication use.
- Ensure access to plain language information and advice, such as information leaflets available on Queensland Health Choice and Medication website, to support choice, autonomy and informed decision making by people receiving care.

To improve the prescribing, administration and monitoring of the effects of medication:

- Adopt standardised protocols to improve the monitoring of higher risk medications and reporting of adverse events.
- Implement consistent and regular reviews of medication effectiveness and side effects as part of care planning.
- Involve multi-disciplinary teams in medication reviews and decisions, including pharmacists.
- Adopt standardised prescribing, administering, and recording practices.
- Increase the monitoring of medication use in public prescribers.
- Increase use of electronic medication management systems to reduce error.
- Enhance education and decision support tools for specialist services as prescribers of psychotropic medications.

Options to monitor progress

- The Therapeutic Goods Administration provides a mechanism to report adverse events for medicines in Australia, but notes this system is not suitable for monitoring the safety of medicines.
- The Pharmaceutical Benefits Scheme provides a potential mechanism to examine medication use by people prescribed psychotropic medications but does not record safety concerns.
- The Fourth Atlas of Health Care Variation[54] has provided data on variation in use of psychotropic medications.
- The YES survey provides a single item assessing satisfaction of people receiving care with the information provided to them about their medication and treatments.
- YES measures could be extended to include whether people receiving care understand the information provided and feel their preferences and experiences have informed medication decisions.
- Consistent use of local incident reporting and management systems that allow for recording of adverse medication events.
- Any enhancements in the monitoring of medication safety should enable surveillance of medication safety across all settings.
- Provision of easy-to-understand information for people receiving care and their carers on psychotropic medications.

Reducing suicide and self-harm

Key issues

Premature loss of life is the most serious of harms in any health care system. Loss of life to suicide is of particular concern in MHAOD care. About half of all people who take their lives in Australia have contact with a general practitioner or mental health professional in the weeks prior to their death.[55] The reduction of suicide and self-harm has been a significant policy focus at the national and state levels for some time to improve the quality of care. Suicide and non-fatal self-harm continue to be safety risks and a focus area for the Safety Priorities.

Enabling routine screening, assessment and safety planning

Suicide is typically the result of a complex interaction of factors across a person's life. A history of mental illness, substance use disorder, and prior suicide attempts each significantly increase the risk of suicide. MHAOD care providers have an important role in preventing suicide. While evidence suggests that the ability to predict who will die by suicide is poor, there are strategies that health systems can adopt to reduce the likelihood of suicide. It is important for MHAOD services to ensure appropriate measures are taken to understand a person's clinical and other needs, and to consider how co-occurring conditions might affect their presentation and formulation of risk.

Increasing use of suicide specific interventions and assertive follow-up

The period after discharge from hospital care is known to be particularly high risk for suicide and self-harm.[56] Key health strategies for reducing suicide include routine screening, comprehensive assessment and safety planning, lethal means restriction and counselling on access to lethal means, suicide-specific treatments, and assertive follow-up care. These strategies need to be continually aligned with best practice and supported by a culture that recognises suicide care as a core function of health services and seeks to continuously learn and improve.

Considering substance use in the context of self-harm and suicidality

Reviews have indicated that the quality of suicide related care provided across health services is variable but often falls short of contemporary best practice.[57] People receiving care also continue to report seeking care for suicidality and non-fatal self-harm, including where substance use or substance dependence may be involved, to be a stigmatising and negative experience, particularly when seeking help through ED.[58]

Consultations suggest that barriers to providing effective suicide care include stigma, fear and blame associated with suicidality and substance use, suicidality not being seen as core business for health services, lack of suicide-specific assessment and treatment options, and limited follow-up care options and support for families. Consultations also highlight the need to consider the complexity of a person's need at the time of crisis, especially where an individual experiences co-occurring conditions.

Alcohol use disorders are strongly associated with suicidal behaviour, especially among people with mental illnesses.[59] Individuals attempting suicide after consuming alcohol face barriers accessing care following emergency assessment due to underreporting of suicidal ideation when intoxicated, and views that alcohol-related suicide attempts are less amenable to treatment offered on inpatient wards. Interventions must account for the dynamic nature of suicide risk that acute alcohol use causes.[60]

Strategies for improvement

To improve identification and management of suicide risk:

- Reduce stigma associated with suicidality and promote suicide care as core business across the health care system.
- Embed routine screening, assessment and formulation of suicide risk as a standard component of health care.
- Improve collaborative management of suicide risk across general practice, specialist mental health alcohol and other drug services, emergency and general medical services.
- Enable processes for sharing information about potential suicide risk and safety plans across care providers, with the consent of the person whose information is being shared.
- Ensure risk identification and management tools are culturally informed and appropriate.

To improve safety planning, treatment and aftercare:

- Support the development of risk management and safety plans for all people receiving care identified as experiencing suicidality as standard practice.
- Develop and implement resources that enable people receiving care, families and carers to be active partners in recovery from suicide attempt.
- Develop and implement suicide-specific treatment options, including brief therapeutic interventions, lethal means counselling, treatment and support for people who repeatedly self-harm.
- Implement assertive clinical, psychosocial and peer support after a suicide attempt and discharge from emergency or inpatient care, including culturally appropriate follow-up care options.

Options to monitor progress

- The Australian Institute for Health and Welfare has developed the National Suicide and Self Harm Monitoring System to improve the accessibility of statistics on suicide, intentional self-harm and suicidal behaviour across jurisdictions.
- There are significant gaps in data available on suicide and self-harm specifically within the health system, including indicators of quality of care and outcomes for those who present to health services with suicidality.
- A potential indicator of assertive follow up could be the number of people who have presented to a Queensland HHS for suicidality/self-harm who receive follow-up within seven days of discharge.
- The Guide to Fidelity Monitoring for the Zero Suicide in Healthcare Multisite Collaborative: Suicide Prevention Pathway makes recommendations for monitoring suicide prevention pathway elements including assessment and risk formulation, safety planning and brief interventions, care planning, structured follow up, and transition of care.
- Data enhancements are needed to improve the ability to monitor suicides occurring following contact with health services, track emergency department presentations for self-harm, monitor the timeliness of follow-up care, and measure experience of care.

Increasing the safety of transitions

Key issues

Transitions within health care settings (such as between inpatient and community care settings), across service types (such as between ATSICCHOs and HHSs or between age or specialty specific services) and between health care and other services (such as from hospital to supported accommodation), are points of particular vulnerability for people receiving care. Poorly managed transitions can compromise care, resulting in a range of harms.

Poorly managed transitions may result in lengthy gaps in care, make it difficult to recognise and respond to deteriorating health, and contribute to serious medication errors.[61] They are also associated with disengagement from care, preventable hospital admissions and an increased risk of suicide.

Improving transitions between care providers and other services

People receiving care, their carers and families consistently report difficulties transitioning and navigating between care and other service providers. This may be compounded by a highly complex health system, insufficient communication with people receiving care and families, limited sharing of information between service providers, and an over-reliance on 'cold' referrals. It is important that individuals and their families receive appropriate information and support when transitioning between care providers and other health services, and that care providers and services have improved collaboration and handover.

The quality of information shared between MHAOD care providers at key transition points is often reported as limited and incomplete, posing a potential safety risk.[62] Basic information about referral circumstances, care plans, follow-up appointments, medications, mental health and substance use histories and family involvement in care is often missing.

Consultations indicate that navigating health care can be particularly challenging for First Nations people and people from culturally diverse backgrounds, and their carers and families. Language barriers and a history of discrimination within health systems increase risk during transitioning care.

Poor coordination within the service system not only results in increasing the complexity of navigation for individuals, families and carers, but also results in inconsistent access to care. Stakeholders noted a lack of comprehensive cross-agency policy and planning for individuals with mental health and substance use conditions, particularly across other Queensland Government departments focused on housing, homelessness, cultural diversity, domestic and family violence, education, and law and justice. Specifically, services supporting individuals transitioning from prison back into the community were noted as a significant gap.

For individuals receiving AOD withdrawal services, the transition to rehabilitation services is often problematic. Consultations described the frequent disconnect between the two services, which may result in a delay between completing withdrawal and receiving rehabilitation. There are also challenges with the service model of residential rehabilitation often being inappropriate for people with children in their care, requiring particular consideration of supportive care transitions.

Enhancing safety of emergency transport

Emergency transport has been identified as a particularly high-risk transition point. Emergency transport often occurs in the context of involuntary treatment and may involve use of restrictive practices that may lead to psychological and physical harms. Improving risk identification for emergency transport, especially in the context of involuntary treatment and use of restrictive practices, is important for avoiding psychological and physical harms.

These risks are heightened in rural areas where the transport processes can be complicated and lengthy, specialist staff may be unavailable, and air transport may be required. For First Nations people, transportation from home to a major centre for treatment can result in a disconnection from land and cultural supports necessary for healing.

Improving transitions across the age spectrum

Transitions from child and youth to adult services can also be particularly problematic; due to the frequent distinct differences in models of care for children and adults. For younger people receiving mental health services, abrupt change can lead to deterioration in their mental and physical health and disengagement from care. The Queensland Health Guideline Transition of care for young people receiving child and youth mental health services, emphasises that transition of mental health care for young people needs to be a planned, systematic and formal process that provides for a gradual and generous timeframe reflective of the young person's needs and strengths.[63]

Older people with mental health and substance use conditions also require consideration. Because of the physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance use, even at relatively modest levels of intake. Ensuring continuity of MHAOD service access and support can be a challenge for people entering residential aged care. [64]

Strategies for improvement

To improve transition planning:

- An assessment of readiness to transition should consider the person's capacity and support needed and available.
- Develop transition plans that enable people receiving care, families and carers to take ownership of their care.
- Ensure transition plans include clear processes for managing deterioration or increased risk, particularly when discharging from inpatient care or during other higher-risk transitions.
- Establish protocols between service providers with clear roles and responsibilities in the transfer of care.
- Improve planning and coordination between withdrawal and rehabilitation services.
- Increase day-program models of rehabilitation.
- Improved risk identification for emergency transport, especially in the context of involuntary treatment and use of restrictive practices that can lead to psychological and physical harms.

To improve the transition experience:

- Adopt 'warm referral' processes as standard practice between care providers to prevent significant gaps in care.
- Engage service navigator, cultural and peer support options to assist people receiving care, families and carers through critical transition points.
- Establish specific transitional programs to enable transitions from child and adolescent to adult mental health care.

To improve information sharing:

- Develop standardised transfer of care documentation to communicate critical care and safety issues between key care providers.
- Promote shared access to health records (e.g. My Health Record) with consent from the person receiving care, to support improved transitions in care.

Options to monitor progress

- National measures exist to track community follow-up by public mental health services within seven days of discharge from hospital, as well as unplanned readmissions to hospital.
- These measures do not allow tracking of follow-up by other community health services. They also provide limited insight into the quality of transitions in care.
- Existing indicators could be improved through linkage that allows tracking of follow-up by general practitioners, non-government providers, private specialists and private hospitals.
- Leverage the National Integrated Health Services Information Analysis Asset (NIHSI-AA) to analyse the links between state and federal health and aged care data and gather insights on the nature of transitions.
- They may also be improved through tracking the time taken for follow-up to be initiated and by developing measures of transition quality.
- Consideration should be given to developing a data collection on emergency mental health transportation events, in collaboration with emergency services.
- Measures of the experience of transition, particularly experience of emergency transportation are needed.
- Through the Mental Health Alcohol and Other Drugs Healthcare Digital Information Strategy and supporting Roadmap (2022–2027), Queensland Health will explore enhancements to information exchange capabilities across government agencies and wider service delivery partners, and with people with lived experience, to support coordinated care for people experiencing mental health and/or alcohol and other drugs issues.

Recognising stigma to reduce discrimination

Key issues

Stigma and discrimination continue to be significant barriers for people receiving MHAOD care and other essential health care. People receiving care can experience multiple forms of stigma and discrimination related to race, cultural identity, gender, location, mental illness and alcohol and other drugs use. Experiencing stigma and discrimination can place a significant burden on individuals and is likely to reduce engagement with care and deter individuals from accessing the care they need.

Identifying and collaboratively addressing stigma and discrimination

Stigma and discrimination towards substance use is informed by societal values, often driven by the illegality of some substances. This contributes to stigmatisation and discrimination, particularly against people who use illicit drugs.[65]

Structural discrimination towards people with mental illness and substance use disorders results in problems with service access and quality. Access issues are reflected in inequitable distribution of resources, undertreatment of health problems, withholding of services, and fragmented care. Structural discrimination manifests in the reduced life expectancy of people with low prevalence mental illness and substance use disorders. This is partly attributed to diagnostic 'overshadowing' in which a person's physical health problems are ignored due to a focus on their mental health or substance use disorder. Discrimination experiences also vary by type of mental illness, with people with diagnoses of borderline personality disorder citing treatment in emergency departments as particularly problematic. Structural discrimination also arises when people with mental illness and substance use disorders systematically receive lower quality care due to negative attitudes and poor practices among health-care practitioners, adverse health-care interactions and experiences, and the overuse of coercive or paternalistic approaches.[66]

A multi-layered and multi-level response is required to eliminate stigma and discrimination, and to support people on their journey to recovery and reconnection to the community. Queensland MHAOD care providers have a role in breaking down barriers to care due to a lack of understanding of mental health and substance use recovery, which may influence community perceptions of people accessing MHAOD care. There is a clear role for MHAOD care providers to work to eliminate discrimination within their services to foster a welcoming and inclusive environment.

The experience of stigma and discrimination is keenly felt by Aboriginal and Torres Strait Islander people receiving care, which can be associated with racial stereotypes of First Nations peoples, including in relation to alcohol and other drugs use. Further work is needed to ensure mainstream services are working effectively for First Nations peoples and are properly coordinated with First Nations-specific programs.

Working to provide health equity

Many people receiving MHAOD services identify with more than one group and experience more than one form of stigma and discrimination (e.g. Aboriginal and Torres Strait Islander peoples, LGBTIQ+ communities, culturally and linguistically diverse peoples, and asylum seekers and refugees). The intersection and effect of a range of factors involved in a person's experience of discrimination and privilege (e.g. gender, sexuality, race and religion) can create additional barriers to receiving the care they need. Health services must consider the broad range of needs of people receiving care, including their mental and physical health, psychosocial and cultural needs.

MHAOD services also have a role to play in ensuring people are connected to appropriate care, particularly those with co-occurring conditions. Many people experiencing problematic substance use also have other complex social needs. They may also experience issues such as, but not limited to, homelessness, mental health problems, health conditions such as hepatitis C and HIV/AIDS, or involvement with the criminal justice and/or child protection systems.[67] Stigma is separately associated with each of these areas and can compound to further marginalise people from their families and communities and entrench social disadvantage.

Strategies for improvement

To reduce stigma and discrimination:

- Include people with lived experience of mental health and substance use conditions in service delivery, development and leadership.
- Involve the peer workforce to assist those seeking care to navigate the service system, provide a 'lived experience' perspective and help to reduce 'self-stigma' by providing positive role modelling and non-judgemental supportive, professional relationships.
- Develop and deliver culturally sensitive materials to support people receiving care in understanding trauma and available support.
- Improve education and awareness among mental health, AOD, health and other service providers of the needs of people with mental illness, substance use disorders and co-occurring conditions.
- Apply appropriate population specific frameworks, partnership, strategies and guidelines, ongoing training, and workforce and sector capacity building to effectively support the full range of people receiving care.
- Provide trauma informed care and practice strategies.

To respond to people's needs holistically:

- Improve education and awareness among service providers of the social, cultural, structural, and historical determinants of health.
- Ensure people are supported to find appropriate care, particularly those with co-occurring conditions.
- Undertake legislative and policy reforms that seek to strengthen the integration and coordination of care.

To contribute to cultural safety and health equity:

- Apply a social and emotional wellbeing approach to health care working with First Nations peoples, families and communities, and with culturally diverse people and communities.
- Inform service delivery improvements through participation and engagement of First Nations workforce, Elders and community members.
- Ensure workforce and sector development is delivered through Aboriginal and Torres Strait Islander agencies and relevant specialist transcultural services.
- Apply strategies from Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework, the Don't Judge, and Listen report, and the Queensland Transcultural Mental Health Practice Framework.

Options to monitor progress

- Consumer experience surveys could provide some insight into the experience of people receiving care and the extent to which they consider the care to be culturally safe and appropriate, and free of discrimination.
- Data on patterns of service use by people receiving MHAOD care would also provide insight into their preferences and experiences. Specifically, individuals receiving services outside their primary diagnosis more frequently and accessing GP and other physical health services.

Putting the priorities into practice

The Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care outline a set of priorities that have the potential to markedly improve safety and prevent harms in MHAOD care. They have been informed by available data and by the experiences of people receiving care, their carers and families, carers, mental health alcohol and other drugs and health workforces.

The priorities are relevant to a wide range of settings across public, non-government, Aboriginal and Torres Strait Islander community controlled and private MHAOD services and providers.

It is acknowledged that these priorities may or may not be the most pressing priorities for a given sector, service or setting. Decisions about local priorities and safety improvement initiatives should always be based on the views of those with lived experience and best available local data.

A shared responsibility

Improving safety in MHAOD care is a shared responsibility. Policy makers, system administrators, funding bodies, service managers, practitioners, people receiving care and families all play an important role in improving the safety of MHAOD care. Not everyone's role is the same.

We all have a role to play to ensure people receive safe care. While this document does not mandate actions, it suggests the following roles across the health service system to support implementation of the safety priorities:

- **Statewide forums responsible for safety in MHAOD care** have a role to ensure safety priorities are clearly communicated, well-promoted and being monitored. This includes supporting implementation of the priorities within various health service settings and organisations.

- **Forums on MHAOD information** have a role to support collaboration across health service organisations, people receiving care and carer peak bodies, sector peak bodies and key data custodians to improve monitoring of the MHAOD system, including safety. This includes supporting the development of mechanisms to monitor the impact of the safety priorities.

- **Government policy makers** have a role to drive policies and resources to support the safety priorities in the services they fund, regulate and deliver.

- **People receiving care, carers and families** have key roles in identifying safety priorities and implementing solutions to improve the safety of care at a local, state or territory and national level.

- **Health service organisations** have a role to develop and implement continuous improvement strategies, taking into account identified priorities, local data and evidence.

- **Practitioners** have a role to reflect on and improve their own practice as well as inform their organisation's safety priorities, and work with people receiving care, families, and carers to implement safety improvements.

The evidence is clear that safety improvement initiatives that rely solely on 'top down' approaches are not likely to be effective.[68] The most significant shifts in safety occur when stakeholders with different roles in the MHAOD system work together toward a common goal, each bringing their own expertise and contribution.

Evidence-based safety improvement

The MHAOD system, like all health systems, is highly complex. The needs of people seeking and receiving care and the treatments, models of care, technology, funding arrangements, and resourcing of services are constantly changing and evolving.[69]

To be safe and effective, the MHAOD system must be able to adapt to changing circumstances and advances in care. Contemporary approaches to improving safety in health care emphasise the need to be guided by and promote 'what goes right', as well as reducing 'what goes wrong'.[70,71]

All MHAOD services and systems should be actively and effectively partnering with people receiving care, carers and workforces to drive continuous improvements in safety as part of core business. The Model for Improvement and Plan-Do-Study Act (PDSA) cycles provide an evidence-based guide for improving safety and quality across the health sector[72]. Together, they outline a systematic approach to forming improvement teams, setting goals and measures, and agreeing changes. They describe how initiatives can be tested, refined and scaled up across a health service or system.
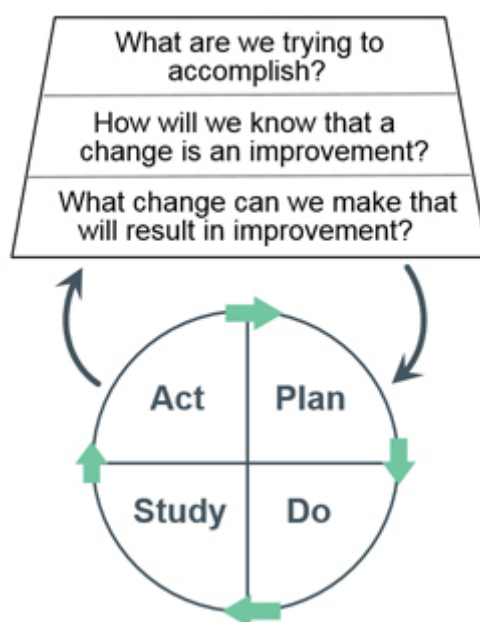
The success of safety and quality improvement initiatives are influenced by many different factors. The nature of the initiative, the leadership within the organisation, the policy and operational environment, the individuals involved, and the process used to drive change all have a major influence.[73] Safety improvement initiatives are more likely to be successful when they explicitly address these influences in their design.

Evidence suggests that initiatives are more likely to be effective when they employ multiple mutually reinforcing strategies, targeting various aspects of the MHAOD care environment. Safety initiatives that have shown success in health care have typically combined:

- people receiving care, family/carer, workforce feedback processes
- systematic review and identification of safety issues
- organisational culture and leadership strategies
- changes in policies and guidelines
- adoption of new evidence-based tools and ways of working
- workforce development strategies
- service re-design and changes to the care environment
- ongoing monitoring and evaluation of progress[74].

Service level initiatives can be further reinforced by system wide changes. For example, resourcing, accreditation processes, care standards and evidence-based guidelines, price signals and other financial incentives, as well as advancements in research, and shifts in paradigms of care.

Collaboration and partnership are central to sustainable change. Collaborative methodologies have been recognised as effective in driving long-term change, bringing together key partners to identify improvement opportunities, explore strategies for improvement, and spread change across health care systems, however their implementation requires understanding of local context and appropriate context.[75]

Monitoring progress over time

Safety improvements should be based on sound evidence that helps identify key safety issues, inform solutions and track progress over time. This may include service performance data to inform service level improvements, research and evaluation to understand effective strategies, and whole-of-system data to track changes in the overall safety of care.

Tracking the extent to which safety is improving in MHAOD care is critical to continuous improvement. The National Mental Health and Suicide Prevention Information Priorities have acknowledged that there are significant gaps in our understanding of safety in mental health care, across all settings.

The Queensland Safety Priorities in Mental Health Alcohol and Other Drugs Care identify opportunities to address critical information gaps in MHAOD safety in the years ahead. Through implementation of the Mental Health Alcohol and Other Drugs Healthcare Digital Information Strategy under Better Care Together, the Queensland Government will improve how we use and share information to deliver a more safe and efficient care system. This includes, for example:

- working toward nationally consistent measures to track safe practice and harms
- extending safety data to encompass a wider range of sectors and settings
- using data linkage to improve understanding of safety of MHAOD care
- improving capacity to learn from people receiving care and families' experience of care
- enhancing the utility of harms data captured in incident management systems
- increasing visibility and transparency in public reporting of safety issues.

Health service organisations should also act to improve the availability and use of data to drive safety and monitor safety improvements This includes establishing meaningful metrics to aid health care professionals and system administrators to monitor safe practice and identify harms, establish feedback mechanisms for people receiving care and families to report on their experiences of care, and establishing feedback mechanisms for staff experiences of safety.

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