Actions relating to investigation into the treatment and care of Anthony O'Donohue

Background/Context

On 31 October 2016, the Queensland Minister for Health and Ambulance Services announced an independent investigation into the management, administration and delivery of public sector mental health services provided to Mr Anthony O'Donohue. On 20 January 2017, the investigators submitted their report to the Director-General of Queensland Health.

Professor Paul Mullen, a preeminent forensic psychiatrist led the investigation. The health service investigators identified systemic issues that were attributable to prevailing culture, practices and protocols of the Metro South Hospital and Health Service. They did not attribute any deficiencies to the service given by individuals involved in the treatment and management of Mr O'Donohue.

On 27 January 2017, the Director-General of Queensland Health requested that Metro South Hospital and Health Service undertake an investigation in relation to risk management activities, prevailing culture, and service leadership in the Metro South Hospital and Health Service. That investigation, led by Associate Professor Richard Newton, provided its report on 21 August 2017.

On 10 August 2018, the Mental Health Court found that Mr O'Donohue was unsound at the time of the offence and he was made subject to a forensic order, with a non-revoke period of 10 years being imposed. The reports have not been released until this time pending finalisation of the criminal proceedings.

Key Statewide Initiatives

The response to the investigation findings is best understood within the broader context of the significant work that has been undertaken to improve the treatment and care provided for people with severe, persistent and complex mental health needs across the State.

Key statewide initiative are as follows:

Mental Health Sentinel Events Review Committee recommendations implementation

The Mental Health Sentinel Events Review Committee reviewed fatal events involving people with mental health issues in Queensland. A copy of the resulting report, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*, along with the Queensland Health response to the report and implementation progress reports can be found at https://publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016.

A key initiative being progressed is a violence risk assessment and management framework for mental health services. The framework provides mental health services with a systematic three-tiered approach for the identification, assessment, and management of consumers who pose a risk of violence towards others, and is supported by principles of good practice, clinical tools and training.

In addition, in line with the investigation findings regarding fragmentation in forensic mental health services, the Director-General has approved a staged approach to the development of a statewide integrated forensic mental health service model. This follows an independent consultancy of forensic mental health experts engaged to develop options for the service model. Over the coming 12 to 18 months, the Department of Health will lead activities to enhance clinical governance of forensic mental health services, including establishment of a governance structure to monitor the forensic mental health service system against standards of quality, safety and consistency and consider resourcing implications.

A number of other initiatives resulting from the Sentinel Event Review also address the findings of the investigation into the treatment and care of Mr O'Donohue.

Review and implementation of standard clinical documentation

Clinical documentation is fundamental to comprehensive risk assessment and management. In early 2016, an expert panel of senior mental health clinicians reviewed the core suite of clinical documents. Based on feedback from clinicians, targeted literature reviews, and information about clinical documentation used in other jurisdictions in Australia, the expert panel made 25 broad recommendations for changes to the documentation. The standard suite of clinical documentation that the recommendations referred to includes: Triage and rapid assessment; Risk screening tool; Child and youth assessment; Child and youth substance use assessment; General assessment; Substance use assessment; Case review; Care plan and Transfer of care.

As companions to the clinical documentation, a guideline on the use of the documentation and a user guide were released with the revised clinical documentation.

An acute management plan has also been revised and is in use throughout mental health services. The plan is a tool designed for consumers with complex needs, involving multiple service providers, with a history of regular contact with police and ambulance services and/or frequently presenting to emergency departments. This plan allows clinicians to record succinct and relevant clinical information for other clinicians working within emergency departments or acute care team settings, to have that information readily available if they have contact with the consumer and are better able to provide assistance to the consumer.

The review and implementation of the standard clinical documentation was completed on 5 March 2017.

Mental Health Act 2016 implementation

On 5 March 2017, the *Mental Health Act 2016* commenced. On commencement, the Chief Psychiatrist published policy and practice guidelines including the *Chief Psychiatrist Policy for the treatment and care of forensic order, treatment support order and high risk patients.* This policy provides governance arrangements and escalation pathways for treating teams, along with the clinical directors of the service, to review the treatment and care being provided to high risk consumers.

The policy prescribes that an Assessment and Risk Management Committee (ARMC) must be established at each service to review the care given to particular consumers on a regular basis. The ARMC's role is of a clinical nature and functions as a peer review of the treatment and care of consumer's subject to orders or whose risk profile is assessed as high by their treating teams. ARMC membership must include the clinical director of the service, the treating psychiatrist, other members of the treating team, and forensic mental health specialists. The policy can be found at: https://www.health.qld.gov.au/__data/assets/pdf_file/0028/635932/cpp-forensic-policy.pdf.

Mental Health Alcohol and Other Drugs Quality Assurance Committee

Emphasising its commitment to ongoing improvement in this area, Queensland Health established in September 2017 a Quality Assurance Committee with the specific purpose of improving the safety and quality of public mental health alcohol and other drugs services. The Committee will review and analyse relevant investigation and audit findings to monitor deaths, suspected suicides, significant incidents, suspected homicides, acts of violence and the management of risk to identify trends and system level improvements. This will inform continuous improvement, implementation of reform strategies and the provision of quality and safe care. This occurs within a wider safety and quality context for all Queensland Hospital and Health Services of the implementation of the Second Edition of the National Safety and Quality Health Service Standards. The Standards specifically identify strategies to minimise consumer harm including predicting preventing and managing self-harm and suicide, aggression and violence and the minimising of restrictive practices, across all health services. The Committee will report upon and provide recommendations to improve the safety and quality of services.

The Quality Assurance Committee will provide a triennial report on its activities to the Director-General of Queensland Health, with the first report due in 2020. Reports will be publicly available.

Service development

Queensland Health is committed to improving mental health care to Queenslanders. The 2018-19 State Government Budget allocated new funding of $106.4 million over four years to support individuals with severe and complex mental illness through recurrent enhancements to community mental health treatment services provided by Hospital and Health Services. These services are also commonly described as public-sector ambulatory care provided by specialist clinical professionals and are for example, acute care teams and community care teams. The $106.4 million funding equates to $26.6 million per annum for four years from 2018-19 to 2021-2022.

This additional funding complements existing investment under *Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health alcohol and other drug services*, which aims to optimise the level and mix of services across the care continuum, with a focus on expanding care and treatment, rehabilitation and support delivered in the community.

It is important to acknowledge the profound impact that this tragedy has had on many individuals, as well as the broader community. While recognising that it could not have been predicted, Queensland Health is committed to strongly supporting mental health services to prevent such events, learning from all clinical incidents with an ongoing commitment to safety and quality for all consumers and carers.