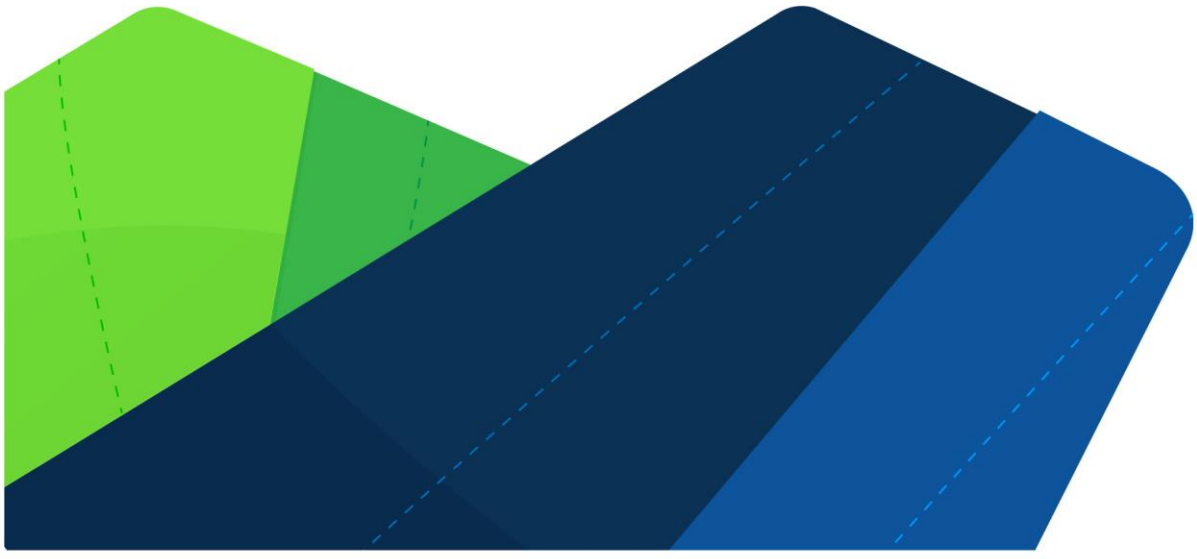
Final report – June 2019:

Queensland Health response to the Final Report – When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services



Clinical Excellence Queensland

Queensland Government

Final Report – June 2019:

Queensland Health response to the Final Report - When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services 2016

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1. Message from the Director-General

The continued progress towards improving the care of people with mental illness through excellence in mental health service delivery strategic directions, policy and clinical practice, reflects one of the five principles underpinning the vision and strategic direction of *My health, Queensland's future: Advancing health 2026*. The principle of excellence means that we will deliver appropriate, timely, high quality and evidence-based care, supported by innovation, research and the application of best practice to improve health outcomes.

As part of the ongoing clinical practice and service improvement process it is my pleasure to present the third and final report on the implementation of the *Queensland Health response to the Final Report – When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health service*s (2016).

It is important to emphasise that the vast majority of people with serious mental illness do not engage in violence. Violence can be regarded as a behavioural complication of serious mental illness in some sufferers, and the primary goal of violence risk assessment is the prevention of violence by effectively managing risk factors that moderate the interaction between mental illness and violent behaviour.

While violence involving people with a mental illness is rare it has a devastating impact on the victim, the victim's family, the perpetrator's family, carers, staff and the perpetrator. It adds to the stigma that people with mental illness are to be feared and erodes public confidence in mental health services.

Implementation of the Queensland Health response to the 63 recommendations arising from the sentinel events review was led by the Department of Health in collaboration with and informed by expert representation from Hospital and Health Services, consumer and carers, Queensland Police Service and other key stakeholders. The three-year implementation program represents a significant body of work and the resulting achievements reflect the commitment of all stakeholders to deliver the best possible care to people with a mental illness and to reduce or wherever possible prevent acts of violence, support and protect families and carers, and to benefit the broader community.

I would like to thank the many people who contributed their expertise and experience to this important work. I also want to acknowledge that this work is built on a foundation of the efforts of many, and thank the contributions by health services and clinicians, by non-government organisations and peak bodies, by researchers, by people with lived experience, and by communities.

This report is dedicated to the people whose lives have been lost to homicide, or as a result of an incident involving police use of force intervention, and to the families, friends and communities for the pain they have experienced and continue to endure.

Michael Walsh
Director-General

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2. Overview of the sentinel events review and implementation of the When mental health care meets risk report recommendations

In May 2015 the establishment of a mental health sentinel events review was announced by the Minister for Health and the Minister for Ambulance Services.

The review focused on homicides or attempted homicides involving people with a mental illness (either as the victim or perpetrator), as well as fatalities resulting from incidents involving police use of force intervention where the person may have had a mental illness.

The aim of the review was to examine sentinel events that occurred between January 2013 and April 2015, and assess the standard and quality of clinical assessment, treatment and care provided, and the compliance with relevant clinical and administrative policies and procedures.

An independent Sentinel Events Review Committee was tasked with making findings and providing recommendations to improve systems and clinical practice with respect to reducing and where possible preventing such events.

The Committee was also asked to consider the recommendations of the 2005 report *Achieving Balance: A review of systemic issues within Queensland Mental Health Services 2002–03* (Achieving Balance report 2005), and the extent to which the recommendations had been implemented and outcomes achieved.

In April 2016 the Committee submitted their report *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services* (When mental health care meets risk 2016*).*

The Committee reported that the Queensland mental health service system had made genuine efforts and significant progress since the Achieving Balance report 2005, resulting in a range of system reforms including standardised clinical processes, statewide education and training, policy and information system development (see appendix 6 When mental health meets risk 2016 for details).

The Committee identified no concerning trends or emerging system issues and concluded that overall the events reviewed were isolated occurrences. They noted their findings should be interpreted in context of the challenge of consumers with complex needs who pose a high risk of violence, rather than as a general representation of the quality and standard of mental health service provision in Queensland, and recognised the high level of commitment and professionalism by public health service staff and all persons consulted throughout the course of the review.

However, the review identified a number of areas for improvement, several of which were consistent with themes reflected in the Achieving Balance report 2005 and other Australian reviews, such as the assessment of risk, sharing information between services, and sharing information with family members and carers. The When mental health care meets risk 2016 report contained findings across 10 key areas and provided 63 recommendations.

Released in September 2016 the *Queensland Health response to the Final report - When mental health care meets risk: A Queensland sentinel events review into homicide and*

public sector mental health services (Queensland Health response), accepted in-principle all 63 recommendations and proposed actions to address them.

Implementation of the Queensland Health response will achieve a consistent approach to service delivery and quality of care through enhancements to: the identification, assessment and management of violence risk; engagement with and support of families; information sharing practices; competencies and capabilities of clinical staff, clinical governance structures, referral pathways and access to forensic mental health expertise, and the promotion of working relationships and coordination between services.

In brief: key achievements

At June 2019, 51 recommendations are fully implemented, rising to 62 of 63 by December 2019. The final recommendation is being addressed through the planning process, commencing in the latter half of 2019, for release of the next state-funded mental health alcohol and other drug services plan.

- *Guideline on the use of the standard suite of clinical documentation* provides guidance on best practice for engaging with families, carers and support services, the frequency and timing of comprehensive mental health assessments, risk screening, care and recovery plans, and the importance of training, supervision and auditing.
- *User guide for mental health clinical documentation* provides information and instructions on the use of the clinical forms to facilitate high quality, comprehensive clinical records, and which align to the recommendations in the When mental health care meets risk 2016 report.
- Inclusion within the *Information sharing between mental health workers, consumers, carers, family and significant others* booklet of the provision of information and support to families and carers who may be at risk.
- A report for Hospital and Health Services on Strategies to enhance information sharing for mental health alcohol and other drug services to support clinicians and build knowledge on the legislative framework within which consumer information can and should be shared.
- At risk of violence: a safety planning information and resource guide to assist clinicians inform and support families and carers who may be at risk.
- Clinical audit tools to support Hospital and Health Services in the assessment and review of the quality of documentation across four phases of care: Assessment, Care Plans, Case Review and Transfer of Care. The tools also examine whether consideration has been given to consumer/family/carer engagement; comorbid conditions; cultural requirements; and partnering with other service providers.
- The *Violence risk assessment and management framework – mental health services* provides a three-tiered systematic approach for the identification, assessment and management of consumers who may pose a risk of violence. Each tier is supported by clinical documentation and training to build clinical competence and capability.
- Violence Risk Report function in the Consumer Integrated Mental Health Application, collates clinical note templates relevant to all domains of risk, and provides clinicians with readily accessible collateral to inform violence risk assessments and decision making.

- The Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* established a clinical governance framework for the management of patients subject to a forensic order, treatment support order, and patients whose risk profile is assessed as high by their treating team. Under this framework, Assessment and Risk Management Committees, which include forensic mental health representation, were established at each Authorised Mental Health Service to provide a clinical peer review that operates to strengthen the assessment, risk management and monitoring of this patient group.
- Training modules updated, and new training packages developed to enhance clinician's skills in the identification, assessment and management of risk:
    - Updates to the QC9 *Critical Components of Risk Assessment and Management* training package to strengthen the importance of gathering collateral including longitudinal information from families and carers, and the impact of co-occurring illnesses on the risk for violence.
    - Newly developed QC30 *Violence Risk Assessment and Management* training package delivered statewide to 745 senior clinicians and consultant psychiatrists
    - Specialist forensic mental health services training on the application of validated violence risk assessment measures.
- Community forensic mental health services (adult) guidelines to support a statewide standardised response for consumers, including referral criteria, Tier 3 and the application of validated risk assessment measures.
- Strengthened the role of Service Integration Coordinators to support the treatment and care of consumers with a severe mental illness through education and guidance on engagement with the National Disability Insurance Scheme.
- Ongoing collaboration with the Queensland Police Service and the delivery of joint programs, training and information sharing to improve the outcomes for and management of people in the community who may be suffering a mental health crisis.
- Establishment of a Mental Health Alcohol and Other Drugs Quality Assurance Committee which will review critical events, including those involving homicides and serious acts of violence suspected to have been committed by people with mental illness, to drive ongoing improvements to the safety and quality of services delivered.
- Independent review of Queensland's forensic mental health service and proposal of options for an integrated statewide service model.

At the end of three-year implementation program (2018-19) only two groups of actions from the 63 recommendations are yet to be completed.

- The clinical audit tools to support Hospital and Health Services in the assessment and review of the quality of documentation across the care continuum will be released by December 2019 (recommendations 10, 21, 35 and 52: four in total).
- The determination of, and planning for, an integrated statewide forensic mental health service model (recommendations 1-6, 9 and 25: eight in total).
    - In order to address recommendation 1 the assumption was made that recommendations 2-6, 9 and 25 were to be considered as part of the

proposed service models. Finalisation of a service model for Queensland will be addressed through the next state-funded mental health alcohol and drug services plan, with the planning process commencing in 2019.

- Recommendations 4, 6, and 9 have been addressed through clinical governance enhancements able to be implemented within existing resources and independent of the final service model. Responses to address recommendations 2, 3, 5, 25 and an element of 1, have begun and will be completed by December 2019.

Implementation of the Queensland Health response was led by the Department of Health oversighted by a governance structure comprising a Steering Committee, Advisory and Working Groups representing multiple stakeholders such as Hospital and Health Services, consumers and carers, Queensland Police Service and others.

A communication strategy to inform and engage Hospital and Health Services throughout the implementation process included; consultation with clinicians and key stakeholders through meetings, presentations, newsletters, regular updates to the statewide Mental Health Alcohol and Other Drugs Senior Leaders Group, and quarterly updates to the three Mental Health Alcohol and Other Drugs Clinical Clusters and the Mental Health Alcohol and Other Drugs Clinical Network.

3. Final implementation progress report

Detailed progress reports on the implementation of the Queensland Health response to the When mental health care meets risk report 2016 were published after the first (2016-17) and second year (2017-18) of implementation. This final report includes information on activities undertaken during the third year (2018-19) and provides an overall summary of all actions undertaken for each recommendation during the three-year implementation program.

Information is presented in the same order of the 11 key areas identified within the When mental health care meets risk report 2016, with a brief overview of the findings in relation to each, list of associated recommendations (in italics), report of the number of recommendations completed/to be completed, and summary of all activities undertaken (blue text boxes). In most instances, implementation activities meet the requirements of a number of recommendations. Therefore, the recommendation/s corresponding to the initiatives described are noted in parentheses.

Appendix 1 provides an abbreviated summary of each recommendation, implementation status and key deliverables for each year through to 30 June 2019 and identifies the agency or service with the ongoing responsibility for implementation and monitoring of the outcomes.

The When mental health care meets risk report 2016, Queensland Health response and two implementation progress reports are available at the following website https://publications.qld.gov.au/dataset/mental-health-sentinel-events-review-2016

3.1 Key area: Statewide forensic mental health service model

The When mental health care meets risk report 2016 acknowledged that all components of a forensic mental health service were present in Queensland i.e. inpatient units, community-based services, prison mental health services, court liaison services, and policing and mental health services. However, it argued that the administration of the various components across several separate Hospital and Health Services resulted in a lack of a unified service model with a clear governance structure.

It was proposed that the development of an independent integrated statewide forensic mental health service would result in improved governance, service responsiveness, management of forensic consumers, and the delivery of a consistent and integrated service.

Recommendations from the 2016 review

1 *Develop an integrated statewide forensic mental health service with a governance structure independent of Hospital and Health Services that enables the effective operation and maintenance of an integrated service across Queensland.*

2 *The position of Director of a statewide forensic mental health service (SFMHS) is to have statewide oversight of the integrated SFMHS, which provides and supports independence, governance, integrated standards and consistent practices.*

3 *Establish quarterly meetings between the Director of the statewide forensic mental health services and Hospital and Health Services mental health service senior executives to improve quality, efficacy and integration of services.*

4 *Statewide forensic mental health services are provided to consumers assessed as being at a high risk of violence in addition to consumers on forensic orders under the Mental Health Act 2000.*

5 *The role and function of the Forensic Liaison Officer positions located within mental health services be quarantined for undertaking assessments and management of forensic mental health consumers and other consumers who pose a high risk of violence.*

6 *Develop collaborative and effective relationships between forensic mental health services and Hospital and Health Service mental health staff; and obtain knowledge of the models of mental health service delivery and available services/resources within the Hospital and Health Service region, by ensuring that identified Community Forensic Outreach Service teams are attached to specific Hospital and Health Services, thus ensuring teams and clinicians assigned gain an increased understanding of the Hospital and Health Service necessary to provide tailored support to that specific mental health service.*

7 *Upon completion of an assessment and prior to the finalisation of the recommendations statewide forensic mental health services staff are to discuss their findings with the Hospital and Health Services mental health service clinicians responsible for the consumer's care to enhance the validity of the recommendations and to help ensure that they reflect the availability of resources and services in the Hospital and Health Service.*

8 *Develop a categorisation system to differentiate lower risk from higher risk consumers on forensic orders and adjust the treatment and monitoring requirements accordingly.*

9 *Consider the engagement model of Mental Health Intervention Coordinators with the Queensland Police Service in responding to potential mental health crisis situations as a component of the service delivery model for statewide forensic mental health services.*

Implementation of recommendations: completed 7 and 8, commenced 1 to 6, and 9 for completion by 2022

The development of an integrated statewide forensic mental health service will result in improved clinical governance, services responsiveness, management of forensic consumers, and the delivery of a consistent and integrated service. An integrated service refers to integration within the forensic mental health service, and also between the forensic mental health service components and the authorised mental health services.

Deliverables for recommendations 1 to 9 and 25

An independent expert forensic mental health consultancy team was engaged to develop an *Options paper for a statewide integrated forensic mental health services model in Queensland 2018* (Options Paper). The consultancy was undertaken to assist the department to address recommendation 1 with the assumption that recommendations 2 to 6, 9 and 25 would be addressed as a consequence of addressing recommendation 1.

The Options Paper represents an extensive body of work comprising:

- a literature review of international and national service models
- data capture, mapping exercise and analysis to develop an overview of mental health services in Queensland, and an in-depth understanding of forensic mental health service delivery

- consultation with over 160 representatives from mental health, justice and related key stakeholder agencies.

The Options Paper acknowledged the good reputation that Queensland has for its innovative and strong forensic mental health service components and noted system improvements resulting from the *Mental Health Act 2016,* and the substantial progress made through the completion or commencement of actions in response to the recommendations of the When mental health care meets risk report 2016.

The Consultancy found that many of the adaptations made to service delivery since the establishment of 16 Hospital and Health Services under the *Hospital and Health Boards Act 2011* were positive, such as being more responsive to the health needs of the local population. However, there were challenges for the forensic mental health service as separate components across several Hospital and Health Services resulted in a lack of a unified service model with a clear governance structure. For example, the statewide team comprising a Director, Queensland Forensic Mental Health Services, operations manager, and six statewide coordinators of the forensic mental health services elements was established within one Hospital and Health Service.

The Consultancy identified three key issues to be addressed by the services models: the need for forensic services to work collaboratively rather than independently; to have clearly defined lines of accountability and authority; and to be integrated – both within the forensic mental health service system and with other mental health services.

Three services models were proposed, each requiring substantial changes to corporate and clinical governance and service system delivery. Each had a centralised hub of expertise.

The Options Paper did not identify resource implications however all three services models have financial, human resourcing and industrial relations implications to varying degrees. In addition, current service delivery gaps were identified for future consideration e.g. community forensic outreach services, forensic mental health beds, inpatient programs and problem behaviour services.

The Mental Health Alcohol and Other Drugs Branch undertook a preliminary analysis of the three services models through the development of an Evaluation Paper whereby each model was measured against six criteria; community confidence, governance and accountability, fair and equitable access, integration, sustainability, and provision of services to Aboriginal and Torres Strait Islander people.

In April 2018 the When mental health care meets risk Implementation Steering Committee endorsed the Evaluation Paper and agreed that each services model contained varying merits, costs and benefits with no one model being a clear standout best fit for Queensland.

Further consultation and consideration of service model options will be required to identify an integrated statewide forensic mental health service model consistent with the intent of the recommendations of the When mental health care meets risk report 2016.

At the conclusion of the second year of implementation (2017-18) a staged approach across two areas, service reform and clinical governance, was agreed to.

1. Service reform

Connecting care to recovery 2016-2021: A plan for Queensland's State funded mental health, alcohol and other drug services provides a guidepost for future action and investment in the mental health alcohol and drug service system. Resourcing requirements for a comprehensive statewide forensic mental health services model appropriate to the

Queensland context will be considered through the planning process to inform the next state funded mental health alcohol and other drug services plan. The Options Paper and Evaluation Paper were released to Hospital and Health Services in November 2018 and will be used to guide the next services plan's development phase, due to commence mid-2019.

2. Clinical governance

That over the 12 to 18 months commencing July 2018 the Mental Health Alcohol and Other Drugs Branch would consider clinical governance enhancements that could be undertaken within existing resources and independent of the final service model.

In 2019, recommendations 1-9 and 25 were re-examined in the context of mental health service changes driven either as a response to the recommendations of the When mental health care meets risk report 2016, or as part of the core business of the Mental Health Alcohol and Other Drugs Branch.

The review concluded that the following clinical governance enhancements have addressed recommendations 4, 6, 7, 8 and 9. Any further actions in relation to these recommendations will need to be considered in the context of any changes to the service model and/or available resources.

Recommendation 4

- The Violence risk assessment and management framework – mental health services (the Framework) provides a systematic approach for the management of consumers who may pose a risk of violence towards others. The approach includes referral to and engagement with specialist forensic mental health services.
- In February 2019, guidelines were developed by adult community forensic mental health services for the provision of a statewide standardised response to consumers referred through the Framework.
- The 2017 Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* established a clinical governance framework for the management of patients who pose a risk of violence. The Policy established Assessment and Risk Management Committees to provide a clinical peer review to strengthen the assessment, risk management and monitoring of this cohort of patients. A function of the Committees, which include forensic mental health representation, is to recommend, where necessary, that a referral be made to a forensic mental health service.

Recommendation 6

- Community Forensic Outreach Service (CFOS) Teams have been allocated to specific Hospital and Health Services. Some flexibility is required within this allocation to account for location, timing of request, and the expertise required to respond to the referral. Any further CFOS enhancements will work to strengthen this response and will be dependent on the outcomes of the next mental health alcohol and other drug services plan and the resultant statewide forensic mental health services model.
- Evaluation of the six-month pilot of the *Violence risk assessment and management framework – mental health services* indicated improved liaison with and engagement between specialist forensic and mental health services.

Recommendations 7 and 8

- The Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* requires CFOS clinicians to discuss any recommendations with the treating psychiatrist prior to their release in writing.
- The Policy provides a governance structure to support engagement with, and liaison between, forensic and other mental health services; and the determination of treatment and monitoring requirements for forensic patients based on their individual requirements.
- The *Violence risk assessment and management framework – mental health services* requires services to consider feedback processes for the results of the CFOS response including presentation at case review.
- Release of the *Mental Health Act 2016*.

Recommendation 9

The Mental Health Intervention Coordinator positions will be retained as part of the authorised mental health service setting to provide points of collaboration between the Queensland Police Service, Queensland Ambulance Service and all mental health alcohol and other drug services.

- The Mental Health Alcohol and Other Drugs Branch is responsible for the development of statewide models of collaboration and intersection between mental health alcohol and other drug services and first responders to strengthen the mental health crisis response system in Queensland.
- In 2018-19 the Mental Health Alcohol and Other Drugs Branch funded a project to map and analyse key police and mental health service interaction models across Queensland with the aim of promoting integration between service types and a consistent and holistic response for individuals who come into contact with emergency services.
- The 2019 State Budget allocated funding for a broader three-year Mental Health Crisis Care System Reform Project involving the design of a statewide framework to guide the implementation and evaluation of comprehensive and integrated models of crisis care at both a local and statewide level.
- Findings from the 2018-19 project and the role and function of Mental Health Intervention Coordinators will be considered as part of the Mental Health Crisis Care System Reform Project.
- The Queensland Health and Queensland Police Service Steering Committee, chaired by the Chief Psychiatrist and attended by senior forensic mental health service representatives, monitors and addresses any matters relating to police communications and collaboration.

Clinical governance responses commenced and for finalisation by December 2019

Recommendation 1

- Development of admission guidelines for statewide forensic mental health services.
- Utilisation of statewide meetings and forums to raise and address any existing or emerging clinical governance issues.

Recommendation 2

- The Chief Psychiatrist will continue to work with the Director, Queensland Forensic Mental Health Services on the provision of statewide oversight of the quality of clinical services provided by forensic mental health services.

- Any further response will be influenced by the outcomes of the next mental health alcohol and other drug services plan and the resultant statewide forensic mental health services model.

Recommendation 3

- A mapping was undertaken of existing governance structures, meetings and forums that include a focus on the improvement of quality, efficacy and integration of services. Processes to address practice improvement activities not being addressed through these meetings is under consideration.

Recommendations 5 and 25

- Forensic Liaison Officer positions were created to liaise with and promote service integration between forensic mental health services and Authorised Mental Health Services. Over time there have been variations regarding the scope of their role, including the adoption of clinical case management responsibilities. The Mental Health Alcohol and Other Drugs Branch will develop a policy position on the role and function of Forensic Liaison Officer positions for distribution to Hospital and Health Services.

3.2 Key area: Family engagement

The When mental health care meets risk report 2016 found that far greater involvement with, and support of, family members, carers and support services and networks is required. The recovery of and outcomes for people with a mental illness are optimised when the consumer, their family, support network and mental health service staff work together collaboratively and in partnership.

Recommendations from the 2016 review

10 *The comprehensive assessments conducted by clinicians must be informed by collateral information obtained from families/carers. Prompts on obtaining this information are to be added to the statewide Standardised Suite of Clinical Documentation and, where no collateral is provided, the efforts made to contact and obtain the information are to be documented and audited.*

11 *Engagement with families is to occur at initial contact with the consumer and throughout the consumer's episode of care, consistent with the National Standards for Mental Health Services 2010 and reflective of a tripartite model involving the consumer, clinician and the family/carer.*

12 *Families/carers are to be informed of potential risks to their safety, provided with support and strategies on how to mitigate risks, and given clear advice on how to maintain their own safety in crisis and ongoing situations, including information about available support including support external to mental health services.*

13 *Prompts are to be included in comprehensive assessment, risk assessment and treatment planning as well as reminder included within staff training to ask about safety of family members, including ensuring that clinicians ask difficult questions about safety and risk.*

14 *Educate mental health services staff on information sharing legislation, particularly the approval to release information to family and other parties.*

15 *Revise the Mental Health Alcohol and Other Drugs Branch information sharing booklet to include information about providing advice and supporting families who may be at risk.*

16 *Identify opportunities to build mental health services staff knowledge on information sharing into the Mental Health Act 2016 implementation process.*

Implementation of recommendations: completed 11 to 16, commenced 10 for completion December 2019

The treatment and care of persons with a mental illness who may pose a risk of harm to others is most effective when it engages the consumer's family, friends and support networks.

Service capacity to engage and collaborate with carers, families and support services has been strengthened through a focus on this issue through:

- *Guideline on the use of the standard suite of clinical documentation*
- a *User guide for mental health clinical documentation*
- revised clinical documentation
- updated training for improved competence and capability
- promotion of the *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others* booklet
- *Mental Health Act 2016* workshops and online education package
- tools to support ongoing quality assurance and review.

Deliverables for recommendations 10 to 16

The *Guideline on the use of the standard suite of clinical documentation* includes guidance on best practice for engaging with families, carers and support services and the importance of quality assurance processes (recommendations 10-13).

The *User guide for mental health clinical documentation* provides detailed information about the intended use of clinical forms and required clinical information and includes instructions that emphasise:

- consultation with families/carers for collateral information (recommendation 10)
- engagement with family/carers throughout the care period (recommendation 11)
- provision of information and support to families and carers identified as being at risk of harm, including actions to improve their safety (recommendations 12 and 13).

The information in the *User guide* is further reinforced by:

- prompts within the clinical forms that support clinicians to record engagement with the family/carer and safety strategies discussed (recommendation 10)
- content updates to the training packages *QC9 Critical Components of Risk Assessment and Management* and *QC14 Mental Health Assessment* relating to the importance of engaging with the consumer, their family and or carer to gather longitudinal and historical information as well as contemporary information (recommendations 10 to 13).

Mental health services staff are supported to share information with families, carers and support networks where appropriate through the *Mental Health Act 2016* workshops and online education package, and the Queensland Health *Information Sharing between Mental*

Health Workers, Consumers, Carers, Family and Others booklet, which are promoted and distributed with training provided by the Queensland Centre for Mental Health Learning (recommendations 14 and 16).

In 2018-19 the Mental Health Alcohol and Other Drugs Branch partnered with Hospital and Health Services to assess the implementation of several activities undertaken in the first year of implementation (2016-17) of the Queensland Health response to the When mental health care meets risk report. The evaluation comprised feedback from Hospital and Health Services on current practices including a description of planned activities, and where possible quantitative data from the Consumer Integrated Mental Health Application (CIMHA).

The results obtained from the evaluation were that:

- Services had reinforced the requirement that mental health assessments are to be informed by collateral from families, carers and support persons, through the development of clinical pathways, guiding documents outlining assessment requirements, and communication via Grand Rounds, staff forums and orientation processes (recommendation 10).
- The measurement strategy for *Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services* acknowledges that engaging with consumers and their families supports improvements in service delivery. The measure of performance on this indicator is the proportion of community mental health service episodes where a consumers' carer or family member is involved in care. For the first quarter of 2019, the statewide data reported an average of 49.5% although there was a large variation from 34.7% to 84%, with the highest rates being reported within child and youth mental health services. The performance data is readily available to Hospital and Health Services (HHS), and a report providing examples of good practice obtained through the qualitative feedback process was distributed to each HHS for consideration. Examples included consumer engagement strategies, and dashboards to monitor the key performance indicators (recommendation 11).

In January 2019 a full day focus group was held with mental health clinicians, carer consultants and training providers to consult on current practices of engaging and sharing information with families, carers and support networks (recommendation 11); and map effective methods to support clinicians, disseminate information and build knowledge on the legislative framework within which consumer information can and should be shared (recommendation 14). The outcome was a brief report documenting the content of the consultation and summarising communication strategies identified. The report Strategies to enhance information sharing for mental health alcohol and other drug services was disseminated to Hospital and Health Services through the Mental Health Alcohol and Other Drugs Senior Leaders Group for their consideration.

In January 2019 consultation with mental health services and training providers occurred in the form of a full day focus group to explore resource requirements and support needs for clinicians to be able to provide advice and support to families and carers whose safety is at risk. The outcome was the development of the At risk of violence: a safety planning information and resource guide to assist clinicians to ask difficult questions about safety and risk, and identify resources to help inform and support families and carers about potential risks to their safety and strategies to mitigate these risks (recommendations 12 and 13).

To support Hospital and Health Services to evaluate the provision of clinical care a suite of

audit tools is in development (recommendations 10, 21, 35 and 52).

- The four clinical audit tools are aligned to the statewide standard suite of mental health clinical documentation and assess the clinical care documented across the complete care pathway; Assessment, Case Review, Care Plan, and Transfer of Care.
- The audit tools also assess for evidence within the documented care of consideration of: family/carer engagement; partnering with the consumer; consumers with comorbid conditions; cultural requirements; and partnering with other service providers (recommendations 10 and 11).
- A six-month pilot of the Suite of Clinical Audit Tools within five Hospital and Health Services will conclude in July 2019. The Audit Tools under pilot were informed by an Expert Reference Group, a feasibility workshop, and findings from a mini-pilot within two Hospital and Health Services.
- The pilot will examine the reliability, validity, clarity, usability, usefulness, and time requirements of the Audit Tools and associated reporting functionality to inform the final version of the Suite of Clinical Audit Tools.
- The Expert Reference Group will consider implementation strategies, including education and training, necessary to promote the audit tools and embed into clinical practice.
- Statewide implementation will commence in December 2019 and it is anticipated that Hospital and Health Services will incorporate and routinely utilise the clinical audit tools within their clinical governance processes.

3.3 Key area: The consumer journey

3.3.1 Comprehensive mental health assessment

The When mental health care meets risk report 2016 identified several areas for improvement in relation to the undertaking and timing of more detailed comprehensive mental health assessments for persons presenting or re-presenting to a mental health service.

Recommendations from the 2016 review

17 *Mental health services need to undertake a comprehensive mental health assessment for all new consumers accepted into treatment.*

18 *Mental health services need to undertake a comprehensive mental health assessment for any persons who frequently present to emergency departments or are frequently referred by other services, regardless of whether the consumer is admitted to the service. Frequency is defined as presenting on three or more separate occasions within a three month period.*

19 *In emergency situations the minimum standard for an assessment includes:*

- *identification of presenting problem*
- *consideration of previous mental health history and contacts*
- *mental state examination*
- *risk screen*

- *identification of any relevant co-occurring conditions*
- *collateral information.*

20 *Comprehensive mental health assessments should, insofar as possible, be a longitudinal assessment informed by a consideration of historical, contextual and current factors.*

21 *Mental health services should ensure appropriate training, supervision and auditing of comprehensive mental health assessments.*

Implementation of recommendations: completed 17 to 20, commenced 21 for completion December 2019

Mental health assessments support improved outcomes for persons with a mental illness who pose a risk of harm to others when they are contemporaneous and provide quality information from a range of sources that is sufficiently comprehensive to inform decision making, care and treatment planning.

Service capacity to conduct high quality mental health assessments has been enhanced through:

- a *Guideline on the use of the standard suite of clinical documentation*
- a *User guide for mental health clinical documentation*
- newly developed clinical documentation
- training for improved competence and capability
- tools to support ongoing quality assurance and review.

Deliverables for recommendations 17 to 22

The *Guideline on the use of the standard suite of clinical documentation* provides guidance on best practice for frequency of assessment including undertaking a comprehensive mental health assessment for all consumers new to the service; and for people who present or are referred more than three times in a three-month period (recommendations 17 and 18), and underscores the importance of training, supervision and auditing (recommendation 21).

A *User guide for mental health clinical documentation* includes information on the Triage and Rapid Assessment clinical document in emergency situations (recommendation 19) and emphasises a longitudinal perspective as an important component of comprehensive mental health assessments (recommendation 20).

The training packages QC9 *Critical Components of Risk Assessment and Management* and QC14 *Mental Health Assessment* have been updated with content to enhance the collection of collateral information that is longitudinal, historical, contextual, and current (recommendation 20). The QC14 *Mental Health Assessment* training package encourages staff to access supervision when undertaking comprehensive mental health assessments (recommendation 21).

Hospital and Health Services will be supported to undertake clinical audits of mental health assessments through the provision of clinical audit tools scheduled for implementation in December 2019 (recommendations 17 to 21).

As part of the evaluation of the implementation of activities undertaken in year one (2016-17) Consumer Integrated Mental Health Application (CIMHA) data was examined in conjunction

with the feedback received from Hospital and Health Services to measure the extent to which new consumers accepted into the mental health service receive a comprehensive assessment (recommendation 17). The data examined a 21-month period before and after the release of the *Guideline on the use of the standard suite of clinical documentation* in March 2017. The statewide data in the period prior to March 2017 demonstrated 37.4% (with a range of 15.6% to 64.3%) had received an assessment and in the period after 33.7% (with a range of 7.7% to 65.8%), so rates remained relatively stable over time.

While these rates are low, they only relate to the presence of the mental health assessment document contained within the Standard Suite of Clinical Documentation within CIMHA. Within Hospital and Health Services there are variations in how assessments are recorded, such as the Triage and Rapid Assessment document or Clinical Note function, in addition to increasing use of the IeMR system in inpatient settings. The Mental Health Alcohol and Other Drugs Branch continues to work with Hospital and Health Services to improve on the quality of assessment, care planning, review and transfer of consumers, and will deliver a fully integrated suite of clinical documents for mental health alcohol and other drug services in mid-2020.

This revised suite has reconsidered assessment processes to simplify and streamline them within the CIMHA electronic medical record. Staff from mental health alcohol and other drug services across Hospital and Health Services will receive training in these processes during the first half of 2020 prior to the planned release of CIMHA 5.0 and associated implementation of the revised clinical documentation in July 2020.

Also evaluated was the extent to which people who are referred or present frequently to mental health services receive a comprehensive assessment (recommendation 18). The CIMHA data examined was a 21-month period both before and after the release of the *Guideline on the use of the standard suite of clinical documentation* in March 2017. For the period prior to March 2017 7.6% (with a range of 4.9% and 10.2%) of people who met the criteria for frequent presentations received a comprehensive assessment; and 5.8% (with a range of 4.5% to 7%) for the period after March 2017. While acknowledging that the data analysed captured only the presence of the mental health assessment document contained within the Standard Suite of Clinical Documentation within CIMHA, the low numbers support the findings and recommendation of the Sentinel Event Review and the need for considerable improvement. The revised clinical documentation processes are expected to support this improvement.

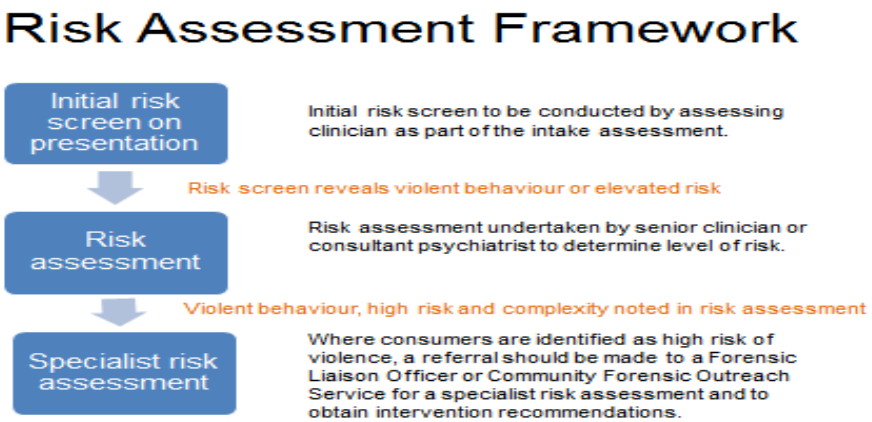
To provide some context for the above data, in 2015 CIMHA recorded more than 125,000 referrals to mental health community treatment services for more than 80,000 individuals. In 2018 CIMHA recorded that 2,066 people presented three or more times in a three month period.

3.3.2 Violence risk assessment and management

The When mental health care meets risk report 2016 noted the widespread use of risk screening but a lack of evidence to demonstrate the use of more comprehensive assessments or validated risk assessment measures or the engagement of specialist input. It was also unable to identify a clear process by which the complexity and needs of the consumer were matched with appropriately experienced clinicians, service responses, and treatment and care planning.

Recommendations from the 2016 review

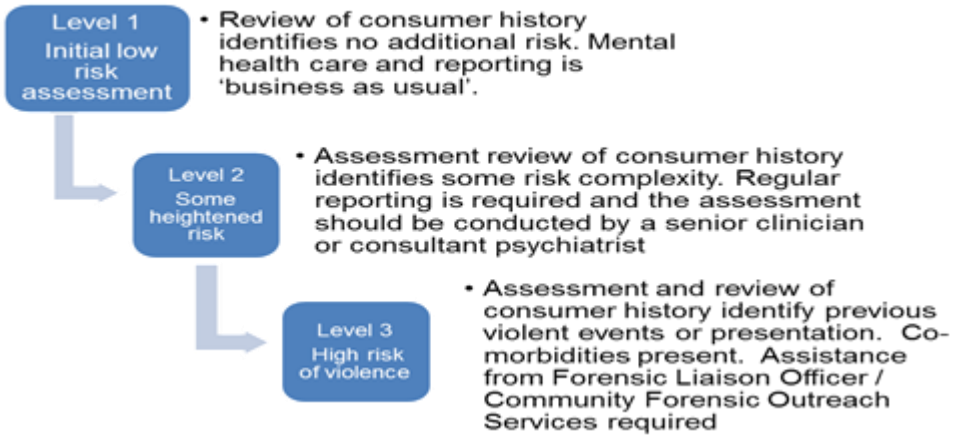
22 *Implement the following three level violence risk assessment:*



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

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

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



Implementation of recommendations: completed 22 to 24, commenced 25 for completion 2022

Violence risk assessment and management processes are most effective when they support services to identify persons with an elevated risk profile and provide a response consistent with the level of risk posed.

Service capacity to identify and respond appropriately to violence risk has been strengthened through:

- the *Violence risk assessment and management framework – mental health services*
- clinical documentation developed for use with the Framework
- education and training to build capability in violence risk screening, assessment, and management
- the Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High-Risk Patients*
- tools to support ongoing quality assurance and review.

Deliverables for recommendations 22 to 25

The *Violence risk assessment and management framework – mental health services* (the Framework) enhances risk assessment and management practices through:

- A three-tiered approach that supports mental health services to identify consumers at risk of violence, determine the extent of the risk posed, establish the service response that will be most effective in managing the risk, and execute that response (recommendations 22 to 24).
- Governance processes that support individual clinicians and teams to discuss concerns about violence, seek further input where appropriate, and liaise with forensic mental health services as needed (recommendation 24).

Each tier is supported by clinical documentation that enhances service capacity to respond effectively to the degree of risk identified (recommendation 23), and training to develop competence and capability in the administration and interpretation of the documentation. Both the training and the documentation were created or updated in consultation with content experts from adult and child and youth forensic mental health services, with funding provided by the Mental Health Alcohol and Other Drugs Branch.

- Tier 1 involves a brief risk screen undertaken by all mental health service clinicians using the Risk Screening Tool, which has been amended to emphasise violence risk indicators. Clinicians are supported to use the Risk Screening Tool through the QC9 *Critical Components of Risk Assessment and Management* training, which was updated for use with the Framework, and which builds capability in screening and prevention-oriented management for multiple domains of risk. Thirty-three deliveries of the QC9 training were provided in 2017 and 2018 (recommendations 24 to 26, and 46 to 48).
- Tier 2 involves a comprehensive violence risk assessment undertaken by senior clinicians and consultant psychiatrists using the newly developed Violence-risk assessment and management document which supports clinicians to examine violence risk factors more thoroughly and develop management strategies. The new QC30 *Violence Risk Assessment and Management* training package provides clinicians with skills to undertake the Tier 2 response. At 30 June 2019, 745 senior clinicians and consultant psychiatrists had completed the training (recommendations 24 to 26, and 46 to 48).
- Tier 3 involves a targeted response by specialist forensic services for consumers with highly complex forensic behaviours. To enable the use of validated violence risk assessment measures wherever possible, the Mental Health Alcohol and Other Drugs Branch provided funding for specialist forensic services to receive training in the Risk for Sexual Violence Protocol, the Spousal Assault Risk Assessment Guide, the Terrorist

Radicalization Assessment Protocol-18, the Assessment of Violence Risk in Youth, and the Short Term Assessment of Risk and Treatability-Adolescent version (recommendations 24 to 26, and 46 to 48).

- The Tier 3 Forensic Service Assessment and Response document provides specialist forensic services with a mechanism to document their planned response and involvement in a consumer's care and aids communication with the referring mental health service.

Evaluation of a six-month pilot in January 2019 found that the Framework:

- builds capacity to identify, assess violence risk and develop risk management plans
- provides a structured process that enhances awareness and discussion of violence risk
- improves senior clinician input
- facilitates discussion of risk at case review.

Statewide implementation of the Framework began in March 2019 and was completed by 30 June 2019.

The Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High-Risk Patients* supports high level oversight of patients assessed as high risk through:

- Governance processes that require consultant psychiatrist involvement in the review, development of mitigation strategies, and management planning for patients assessed as high risk (recommendations 23 and 24).
- Assessment and Risk Management Committees that include forensic mental health representation and provide a clinical peer review that operates to strengthen assessment, risk management, and monitoring (recommendations 23 and 24).

The quarantining of Forensic Liaison Officer positions from other general mental health service functions (recommendation 25) aligns with recommendation 5 and will be addressed within the response to the Options paper for a statewide integrated forensic mental health services model 2018 noted in section 3.1.

3.3.3 Formulation and treatment planning

The When mental health care meets risk report 2016 suggested that treatment planning did not appear to be consistently informed and formulated by:

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

Recommendations from the 2016 review

26 *Formulations require a longitudinal perspective and should include information about mental illness, the relationship between mental illness and risk factors for violence, and the impact of risk of violence.*

27 *Management plans are to be informed by issues identified in the risk assessment and include proposals to address these issues including referrals to relevant agencies that can provide services that are outside of the scope of mental health services.*

28 *All consumers must have a completed care review and summary plan within six weeks of being accepted into the mental health service. A Recovery Plan should also be developed at this time, or explanation for its delay.*

29 *Undertake the 91 day Clinical Reviews in accordance with the National Standards for Mental Health Services 2010 with a separate system of more comprehensive review to be developed by Hospital and Health Services for complex and high risk consumers.*

30 *Include within the statewide Standardised Suite of Clinical Documentation a mechanism to trigger a comprehensive ad hoc review where indicated.*

31 *Clinical Reviews to include an assessment of the effectiveness of the previous care plans and include strategies to mitigate and reduce the level of risk and stabilise behaviour.*

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

Implementation of recommendations: completed 26 to 32

Formulation and treatment planning support improved outcomes for all persons with a mental illness, including those who pose a risk of violence, when they incorporate outcomes of previous assessments, consider risk and other clinically relevant issues from a longitudinal perspective, are recovery oriented, and are developed in collaboration with the consumer.

Service capacity to engage in high quality formulation and treatment planning has been enhanced through:

- *Guideline on the use of the standard suite of clinical documentation*
- a *User guide for mental health clinical documentation*
- updates to clinical documentation, including the creation of a Longitudinal Summary form as a repository for formulation and clinical history, supporting the emphasis on these as key clinical tasks.
- processes and content embedded within the Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients*, and the *Violence risk assessment and management framework – mental health services*
- tools to support ongoing quality assurance and review.

Deliverables for recommendations 26 to 32

The *Guideline on the use of the standard suite of clinical documentation* and the *User guide for mental health clinical documentation* support practices that contribute to high quality formulation and treatment planning with guidance on the need for:

- A longitudinal history within a clinical formulation, and consideration of the interaction between mental illness and risk factors for violence (recommendation 26).

- Risk assessments and mitigation strategies that inform care plans, including referrals to other services (recommendation 27).
- A care plan within six weeks of service commencement; and a recovery plan or an explanation for the delay (recommendation 28).
- 91-day clinical reviews as per the National Standards for Mental Health Services 2010 and for Hospital and Health Services to develop a separate system to comprehensively review complex and high risk consumers (recommendation 29).

Enhancements to the *Guideline* and *User Guide* are strengthened by:

- Prompts within the revised suite of clinical documentation that support clinicians to consider an ad hoc review (recommendation 30).
- Prompts within the *Violence risk assessment and management framework – mental health services* that emphasise the importance of incorporating risk management strategies into the care plan (recommendation 26).
- The Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* requirement that consultant psychiatrists incorporate community forensic mental health service recommendations into the consumer's care plan within 14 days (recommendation 32).

The Project undertaken in year one (2016-17) to scope treatment planning and multidisciplinary team review found that in most cases (88%) 91-day reviews were undertaken in accordance with the National Standards for Mental Health Services 2010. Hospital and Health Services are able to utilise the Assessment and Risk Management Committees established under the Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* to provide a clinical peer review to strengthen the assessment, risk management and monitoring of complex and high risk consumers. The *Violence risk assessment and management framework – mental health services* also provides a structured governance and ongoing review process (recommendations 29 and 31).

Hospital and Health Services will be supported to undertake clinical audits of practices underpinning formulation, treatment and care planning through the provision of a suite of clinical audit tools to be implemented by December 2019 (recommendations 26 to 28 and 31).

As part of the evaluation of the implementation of activities undertaken in year one (2016-17), Consumer Integrated Mental Health Application data was examined to determine whether the addition of the prompt for consideration of an ad hoc review to the statewide Standard Suite of Clinical Documentation had been utilised (recommendation 30). Data available for the period 28 April 2018 to 31 May 2019 identified that the ad hoc case review prompt had been ticked in 1,644 Mental Health Services Case Review documents from a total of 120,169 equating to 1.4%.

3.3.4 Therapeutic relationship

The When mental health care meets risk report 2016 identified variations in the level of consumer engagement by mental health services in the treatment and care provided to support recovery.

Recommendations from the 2016 review

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

34 *Training in more specialised applications of the recovery model and techniques to manage risk of violence should include input from consumers and forensic specialists.*

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

Implementation of recommendations: completed 33 to 34, commenced 35 for completion December 2019

Recovery-oriented practices that engage consumers in all phases of care promote positive outcomes and assist consumers to better manage the multiple factors that contribute to an increased risk of violence and aggression.

Deliverables for recommendations 33 to 35

Service capacity to engage consumers in treatment and care that supports meaningful outcomes has been enhanced through:

- The QC24 *Working with Strengths in Recovery* training package, which educates clinicians on the recovery model to support the development of holistic care plans that set achievable recovery goals (recommendations 33 and 34).
- The *Guideline on the use of the standard suite of clinical documentation* and *User guide for revised mental health clinical documentation*, which outlines local governance responsibilities including the need for regular clinical chart/record audits (recommendation 35).
- A suite of clinical audit tools to be released in December 2019 that will support services to examine case files for evidence of consumer engagement and which can be deployed in whole-of-service capacity or to support supervision of individual staff (recommendation 35).
- Content incorporated into the new QC30 *Violence Risk Assessment and Management* training package to emphasise the importance of balancing risk and recovery considerations for persons with a mental illness who pose a risk of violence and to facilitate liaison with forensic mental health services (recommendations 33 and 34).

3.4 Key area: Consumers with co-morbid conditions

The When mental health care meets risk report 2016 emphasised the need to do more to improve the identification and management of mental health consumers with co-occurring or dual diagnosis conditions such as substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, and acquired brain injury.

Recommendations from the 2016 review

36 *Greater consideration by clinicians is required during the comprehensive mental health assessment for the identification of dual diagnosis and co-occurring conditions (substance misuse, personality disorders, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury) to ensure referral pathways are initiated.*

37 *Greater attention should be paid to the presence, and need for treatment, of co-morbid alcohol and other drug use and the implications of the substance misuse on consumer's mental health and risk of violence.*

38 *Greater attention should be paid to the presence of, and need for interventions for, co-morbid personality vulnerability and personality disorders and the implications of these conditions on consumer's mental health and risk of violence.*

39 *As part of the development of a formulation that includes mental health and risk of violence considerations, the role of any co-morbid or co-occurring conditions should be considered and incorporated.*

40 *Treatment plans should address and provide for the integrated management of complex consumers. Where required services fall outside the remit of mental health services, appropriate referrals should be made and, insofar as possible, the provision of external services should be monitored.*

41 *Multi-service case conferences would be beneficial to coordinating service efforts for consumers with co-morbid conditions, or those who repeatedly present to the mental health services.*

42 *Investigate ways to renew the functions of service integrated care coordinators for complex consumers, including those with mental health and dual disability, in consultation with the National Disability Insurance Scheme.*

43 *Investigate further mechanisms for managing particularly complex mental health consumers (i.e. those with any two of: substance misuse, personality disorder, intellectual disability, developmental disorder, cognitive impairment, acquired brain injury, history of violence or offending) employing a whole of government approach.*

Implementation of recommendations: completed 36 to 43

Managing co-morbid conditions, and other complex needs effectively is central to promoting positive outcomes for persons with a mental illness and assists in the management of risk for violence.

Service capacity to identify and respond appropriately to consumer's complex needs has been enhanced through:

- a *User guide for revised mental health clinical documentation*
- updates to the QC9 *Critical Components of Risk Assessment and Management*, and QC14 *Mental Health Assessment* training packages
- National Disability Insurance Scheme workshop activity modules
- enhancements to the Service Integration Coordinator role
- ongoing partnerships between statewide agencies
- tools to support ongoing quality assurance and review.

Deliverables for recommendations 36 to 43

The *User guide for revised mental health clinical documentation* supports clinicians to:

- note the presence of comorbidities, particularly personality vulnerabilities and substance use, and consider how those factors interact to influence risk
- identify co-occurring substance use disorders by prompting the use of structured screening and assessment tools within the March 2017 statewide clinical documentation update
- include co-occurring conditions such as substance use, addictive behaviours, acquired brain injury, intellectual disability, cognitive impairment, dementia and physical health diagnoses within the clinical formulation
- consider the relationship between co-occurring conditions and mental illness, including the impact of co-occurring conditions on mental illness and risk (recommendations 36 to 39)
- include within care plans strategies and interventions, involvement of other service providers, person/service responsible, and target dates (recommendation 40)
- liaise and consult with other services including medical subspecialties, alcohol and drug services, and psychosocial support services and consider the utility of comprehensive and/or complex case reviews involving multiple service providers (recommendation 41).

The QC9 *Critical Components of Risk Assessment and Management* and QC14 *Mental Health Assessment* training packages enhance clinician capacity to identify and respond appropriately to consumers with complex needs through education to:

- emphasise the importance of identifying dual diagnosis and co-occurring conditions and considering their implications on a consumer's risk of violence and mental health (recommendations 36 to 39)
- prompt clinicians to consider referrals to external services where appropriate (recommendation 40).

Hospital and Health Services are supported to monitor and reinforce practices that identify and support consumers with co-morbid conditions through provision of a suite of clinical audit tools implemented in the latter part of 2019 (recommendations 36 to 39).

The treatment and care of consumers with severe mental illness is also strengthened through enhancements to the Service Integration Coordinator role (recommendation 42) which:

- support consumers with severe mental illness and complex needs to access clinical and community support services tailored to individual needs
- facilitate access to the National Disability Insurance Scheme (NDIS) for eligible consumers with severe psychosocial disability and dual or multiple diagnoses
- monitor the adequacy of consumers' plans and the effectiveness of the support provided.

Service Integration Coordinators and Complex Care Coordinators continue to support mental health consumers to make access requests to the NDIS and prepare for planning meetings. They also work closely with consumers, families and carers and local and regional National Disability Insurance Agency staff to resolve issues, in particular to ensure that consumers receive adequate levels of psychosocial disability supports to remain living in the

community. The Mental Health Alcohol and Other Drugs Branch assists with the escalation of issues, particularly for consumers awaiting discharge to suitable accommodation and supports, to the State National Disability Insurance Agency that are unable to be resolved at a local or regional level.

Partnerships between the Mental Health Alcohol and Other Drugs Branch, Hospital and Health Services, Department of Communities, Disability Services and Seniors, the Magistrates Courts and the National Disability Insurance Agency provide ongoing opportunities to reinforce a whole-of-government approach to manage consumers with severe and complex mental illness and support needs (recommendation 43).

For example, the Mental Health Alcohol and Other Drugs Branch represents Queensland on a Senior Officers NDIS Mental Health Sub-Working Group which provides advice in relation to systemic scheme issues that impact on the mental health interface to the Disability Reform Council Senior Officers Working Group.

3.5 Key area: Clinical systems and information

The When mental health care meets risk report 2016 noted the importance of the need for clinical information to be stored and available in a consistent and accessible manner across Hospital and Health Services.

Recommendations from the 2016 review

44 *Use one consistent integrated statewide clinical information system for mental health information. As Hospital and Health Services use the Consumer Integrated Mental Health Application (CIMHA), its continued use should be considered, however it is acknowledged that comment on Queensland Health information technology systems is out of scope of the Review.*

45 *Provide one area within the Consumer Integrated Mental Health Application for the storage of all information relating to a consumer's risk assessment, management and ongoing reporting. In addition to Mental Health Review Tribunal Reports, establish a clinical note category with a heading such as 'forensic reports' or similar to include all information relating to a consumer's history of aggression, criminal history, Community Forensic Outreach Service report, and Mental Health Court reports and risk assessment and management plans.*

Implementation of recommendations: completed 44 to 45

Information storage systems best support the care of persons with a mental illness who pose a risk of violence when they are integrated, streamlined, and accessible.

Deliverables for recommendations 44 and 45

Service capacity to provide an integrated clinical information system has been enhanced through:

- The continuation of the Consumer Integrated Mental Health Application (CIMHA) use across Hospital and Health Services to record information related to mental health care. With the rollout of the integrated electronic medical record (ieMR) occurring across a range of hospital inpatient services, planning is being undertaken to exchange

information between CIMHA and the ieMR to provide a more complete record of care across the health sector (recommendation 44).

- A new Violence Risk Report was provided to CIMHA users that brings together identified clinical documentation and *Mental Health Act 2016* forms related to a consumer's risk assessment, management and ongoing reporting (recommendation 45).
- Further work to consolidate all clinical documentation and *Mental Health Act 2016* forms in one location will occur in a major CIMHA release scheduled for late 2019.

3.6 Key area: Building competencies and capabilities

The When mental health care meets risk report 2016 noted that quality clinical assessments, formulations and comprehensive treatment planning and delivery requires a competent, capable, supported and supervised workforce.

Recommendations from the 2016 review

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

47 *Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumers' needs rather than being passively identified in documents.*

48 *Provide training and supervision specific to identification of risk factors of violence to ensure appropriate escalation processes are included where indicated.*

49 *Provide training and supervision specific to recovery principles, and the dignity of risk (i.e. the realisation that all people including consumers carry with them some degree of risk and the important factor is how they manage that risk), to ensure treatment plans assist with firstly stabilising the consumer's presentation and working towards recovery which includes addressing violence risk factors.*

50 *Provide training on consumer confidentiality and release of information so that information sharing between the forensic mental health services, other service providers and carers/family allows for open discourse on risk and discovery of important factors to be considered in care planning.*

51 *Provide training and implementation support for the Queensland Health dual diagnosis clinical guidelines and dual diagnosis clinical toolkit to ensure all the consumer's needs for treatment and management are integrated and the necessary referral pathways engaged.*

52 *Implement a program of auditing skill acquisition for all relevant staff through review of documentation and other evidence to ensure necessary competencies have been transferred and evident in practice.*

53 *Explore opportunities to develop training and relationships with Primary Health Networks in relation to the assessment and management of risk of violence to others. Mental health services should develop better collaboration with domestic violence services in the management of family violence.*

Implementation of recommendations: completed 46 to 51, and 53. Recommendation 52 commenced and for completion December 2019

Effective and appropriate care of persons with a mental illness who pose a risk of violence relies on a competent, capable, supported, and supervised mental health workforce that is educated in risk assessment and management practices and principles, and how to apply them across all phases of care delivery.

Service capacity to build a workforce that can respond effectively and appropriately to violence risk has been enhanced through:

- the *Violence risk assessment and management framework – mental health services*
- the training packages QC9 *Critical Components of Risk Assessment and Management*, QC30 *Violence Risk Assessment and Management*, QC14 *Mental Health Assessment,* and QC24 *Working with Strengths in Recovery*
- the *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others* booklet and *Mental Health Act 2016* online education package
- the *Clinical Response to Domestic and Family Violence* training
- tools to support ongoing monitoring and review processes
- Chief Psychiatrist policies created under the *Mental Health Act 2016.*

Deliverables for recommendations 46 to 53

The *Violence risk assessment and management framework – mental health services* provides:

- Minimum training requirements for mental health service clinicians to effectively respond to persons with a mental illness where a risk of violence has been identified (recommendations 46 to 48).
- Governance processes that support clinicians at all levels to discuss concerns about violence risk with other stakeholders including senior clinical staff and specialist forensic services, as noted in section 3.3.2 Violence risk assessment and management (recommendation 48).
- Guidance on best practices for assessing, summarising, managing and reviewing risk as part of a recovery-oriented model (recommendations 46 to 48).

The training packages QC9 *Critical Components of Risk Assessment and Management,* QC24 *Working with Strengths in Recovery,* and QC30 *Violence Risk Assessment and Management* collectively address recommendations 46 to 50 through content to support clinicians to seek supervision and further education and training in:

- risk screening for persons with a mental illness, including the identification of violence risk factors

- administration and interpretation of tools to undertake comprehensive assessment for consumers with an elevated risk profile
- release of information to other services, family, carers, and support networks
- using evidence-based approaches to summarise risk and inform treatment planning
- recovery-oriented principles in violence risk assessment and management.

Education to support clinicians to make informed decisions about the release of information to carers, families, and support networks is available through the Queensland Health *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others* booklet and the *Mental Health Act 2016* online education package. These resources are available through the Queensland Health intranet and promoted by the Queensland Centre for Mental Health Learning during the delivery of related training (recommendation 50).

The January 2019 focus group which consulted on current practices of engaging and sharing information with families, carers and support networks (recommendation 11) found that the existing *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others* booklet provides sufficient information to support clinicians' understanding of consumer confidentiality and release of information (recommendation 50). The report Strategies to enhance information sharing for mental health alcohol and other drug services was distributed to Hospital and Health Services to raise awareness of the booklet and to provide examples of good practice for the provision of ongoing education to clinicians to maintain their contemporaneous understanding of the legislative framework for what information can and should be shared.

Additional training funded by the Mental Health Alcohol and Other Drugs Branch and delivered to Community Forensic Outreach Services (adult services) (recommendation 47) included:

- Risk for Sexual Violence Protocol
- Spousal Assault Risk Assessment Guide
- Terrorist Radicalization Assessment Protocol-18.

Additional training funded for Child and Youth Forensic Outreach Services (recommendation 47) included:

- Assessment of Violence Risk in Youth
- Short Term Assessment of Risk and Treatability-Adolescent version.

Training to support clinicians to respond to consumers with co-occurring substance use disorders and other mental health disorders is provided through:

- The QC9 *Critical Components of Risk Assessment and Management*, and QC14 *Mental Health Assessment* training packages, which educate clinicians on factors to consider in dual diagnosis with an emphasis on the impact of personality disorders and substance use on risk assessment and management (recommendation 51).
- Alcohol and drug assessment and treatment interventions available through *Insight,* a service offering free online induction modules, weekly seminars and a progressive

learning program, from credentialed core skills to specialised alcohol and other drugs training (recommendation 51).

- A Dual Diagnosis eLearning program available through the Queensland Centre for Mental Health Learning (recommendation 51).

Services are supported to monitor skills transfer through:

- Chief Psychiatrist policies created under the *Mental Health Act 2016* that outline provisions within the Act regarding notifiable incidents, non-compliance, and necessary competencies to be appointed as an authorised doctor and an authorised mental health practitioner (recommendation 52).
- a suite of clinical audit tools that capture evidence of clinical skills acquired through participation in training programs delivered by the Queensland Centre for Mental Health Learning (recommendation 52).

Service capacity to respond to domestic and family violence is now supported by:

- Collaborative relationships between the Department of Health and Primary Health Networks that promote sharing of resources and expertise (recommendation 53).
- The *Clinical Response to Domestic and Family Violence* training educates health professionals on responding to domestic and family violence in a range of settings and is supported by a train-the-trainer program (recommendation 53).
- The *Health workforce domestic and family violence training guideline*, which educates clinicians on available resources and training programs, promotes consistency and best practice, and supports all health employees to meet their roles and responsibilities in recognising and responding to domestic and family violence (recommendation 53).

3.7 Key area: Support services and linkages with other agencies

The When mental health care meets risk report 2016 stated that greater uptake, utilisation and collaboration with available services is required to support people at risk, either as perpetrators or victims, of violence.

Recommendations from the 2016 review

54 *Given the disproportionate number of victims of homicide who were family members, there is an urgent need to enhance the awareness and capacity of the role of Victim Support Services to work with families who have experienced violence. This could be achieved by making the service more visible to Queensland clinicians, consumers, and the broader community, via an awareness campaign.*

55 *Consider the role that Victim Support Services could play in supporting consumers, family members, and others who have been victimised or are vulnerable to victimisation. Information about the service should be readily available at all points of contact with Queensland Health (e.g. emergency departments and outpatient units). This may result in an increase in the workload for the service, and this needs to be managed accordingly.*

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

Implementation of recommendations: completed 54 to 56

The provision of support to potential or actual victims of violence is essential to prevent further harm and mitigate the harmful effects for the victim and their family/carers. Awareness raising and accessible information on available services that provide support to victims will promote their uptake.

Deliverables for recommendations 54 to 56

The Queensland Health Victim Support Service is responsible for enhancing the visibility of the service to Queensland clinicians, consumers, and the broader community. A video on the role of the Victim Support Service has been made available on their website, and the service collaborates with Victim Assist Queensland on the distribution of information brochures to key areas such as Queensland Health Emergency Departments (recommendation 54).

A 12-month project was undertaken to consider the role of the Queensland Health Victim Support Service and whether the service could be enabled to support families prior to, or in the absence of, any criminal charges (recommendation 55); examine the most effective way to provide information and support to family members/carers who are victims of violence (recommendation 54); and explore the establishment of effective partnerships and linkages, particularly with domestic and family violence victim and perpetrator services (recommendation 56).

The project outcomes were:

- That planning for the next mental health alcohol and other drug services plan will include consideration of a limited expansion to the Queensland Health Victim Support Service to provide specialised support to those who are victimised, or are vulnerable to victimisation, by a mental health consumer where charges are not brought (recommendation 55).
- The development of the At risk of violence: a safety planning information and resource guide for clinicians. The guide contains information on the roles and responsibilities of mental health clinicians in the provision of advice and support to families and carers whose safety is at risk. The guide also contains information on clinician's responsibilities when responding to domestic and family violence which is not related to the presence of a mental illness and lists specialist services to refer victims and perpetrators to (recommendations 54 and 56).
- The Mental Health Alcohol and Other Drugs Branch met with the Strategy Policy and Planning Division within the Department of Health to share information obtained during the project to help inform their current review of the Domestic and Family Violence Training Guideline and Toolkit.

3.8 Key area: Mental health literacy and access

While the When mental health care meets risk report 2016 acknowledges the achievements in improving mental health literacy within Queensland, there is more work to be done to engage people with mental health concerns with the appropriate support services.

Recommendation from the 2016 review

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

Implementation of recommendation: completed

The Queensland Mental Health Commission is the lead agency for mental health promotion, prevention and early intervention activities.

The Commission's *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023* sets a five-year direction for a whole-of-person, whole-of-community and whole-of-government approach to improving the mental health and wellbeing of Queenslanders.

Focus area 2 strategic priority 1 is to increase mental health, alcohol and other drug and suicide prevention literacy (recommendation 57) by strengthening awareness of mental health, mental illness, problematic alcohol and other drug use and suicide risk. Priority actions for consideration include expansion of universal and targeted programs for Queenslanders to promote and protect their own and others' mental health and wellbeing, as well as identifying early signs that require support and intervention.

Communication and collaboration between the Commission and the Mental Health Alcohol and Other Drugs Branch occurs on an ongoing basis and activities in relation to this focus area will continue to be monitored through regular senior executive meetings, action plans and reports.

3.9 Key area: The Queensland Police Service

No issues were raised within the When mental health care meets risk report 2016 regarding the appropriateness and competency of the mental health treatment provided to those who died as a result of police use of force intervention. However, opportunities were identified for improvements in information sharing, collaboration and the level of specialist forensic mental health support.

Recommendations from the 2016 review

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

59 *Update training in mental health for Queensland Police Services to include de-escalation techniques for persons presenting in mental health crisis, understanding the difference between mental illness and being affected by substance use and knowledge of criteria for detaining a person involuntarily under mental health legislation.*

60 *Retain the co-responder model[1] where mental health clinicians are available within the Police Communications Centre to provide support and access to necessary information to assist in managing police matters where the individual appears to be affected by mental illness. The services should be expanded to offer 24-hour coverage, as required.*

Implementation of recommendations: completed 58 to 60

Improved understanding and knowledge of mental illness will assist Queensland Police Service officers to respond to people with a known or suspected illness, and mechanisms to support information sharing will enhance communication between police and mental health services aimed at reaching the best possible outcome for all.

In addition to recommendations provided Queensland Health and the Queensland Police Service have a long history of collaboration and supporting the development of innovative programs. For example:

- The Queensland Fixated Threat Assessment Centre established in 2013 was the first to be established in Australia with similar services now implemented in Victoria and New South Wales. The jointly funded Centre focusses on concerning communications and approaches by lone fixated persons towards public office holders and provides risk assessment and management plans.
- Mental health support of Police Negotiator Program. The program operates 24 hours a day on a statewide basis to respond to negotiated incidents defined as suicide interventions, barricade sieges and hostage sieges. The Queensland Police Service leads the response and liaison and support is provided by Queensland Forensic Mental Health Service. Assessment and follow up treatment and care are arranged through local mental health services.
- Mental Health Intervention Program. Mental Health Intervention Coordinators operate within Hospital and Health Services as part of a tri agency partnership with the Queensland Police and Ambulance Services. The program operates under a consultation and liaison model to provide identification and system management for people who have/ may have a mental illness who frequently come into contact with emergency services (see recommendation 9).

Deliverables for recommendations 58 to 60

The Queensland Police Service capacity to collaborate with mental health services in provision of services to persons with a mental illness is supported through:

- The Memorandum of Understanding between the Chief Executive Queensland Health and the Chief Executive Queensland Police Service Confidential Information Disclosure, provides the legal framework to enable a Queensland Police Service officer to request information relating to the change of care status of a patient brought to an emergency department (recommendation 58).
- Updates to Queensland Police Service training packages to educate officers in de-escalation techniques, understanding the difference between mental illness and the effects of substance use, and knowledge of criteria for detaining a person under the appropriate legislation (recommendation 59).

[1] Note While the Sentinel Events Review Committee used the term co-responder model-they were referring to the Police Communications Centre Mental Health Liaison Service.

- A standing agenda item for the Queensland Police Service and Mental Health Steering Committee on training to raise any issues and consider the need for updates or enhancements on an ongoing basis (recommendation 59).
- The Police Communications Centre Mental Health Liaison Service was retained and expanded, forms part of core business for collaboration between the Mental Health Alcohol and Other Drugs Branch and Queensland Police Service, and will be reviewed as part of the planning process for mental health alcohol and other drug service plans (recommendation 60). The Police Communications Centre Mental Health Liaison Service program involves the provision of afterhours consultation liaison by mental health clinicians to support front line police officers responding to people experiencing a mental health crisis in the community.

3.10 Key area: Mental health quality assurance

The When mental health care meets risk report 2016 acknowledged improvements to the mental health service system standards of care since the Achieving Balance Review Report 2005 and noted the quality of Hospital and Health Services policies, protocols and procedures. However, the examination of the materials within consumer's files indicated local processes and policies had not been consistently translated into standard practice.

Recommendations from the 2016 review

61 *Create a statewide mental health Quality Assurance Committee to oversee the safety and quality of mental health services through formal assessment and evaluation processes.*

62 *Include within the remit of a Quality Assurance Committee the review of homicides and other serious acts of violence committed by or on consumers of public mental health services.*

63 *Include within the remit of a Quality Assurance Committee an oversight role in monitoring the regularity and suitability of care reviews and summaries of consumers identified as at a Category 3 risk of violence.*

Implementation of recommendations: completed 61 to 63

The system's capacity to deliver quality services to consumers and clients of mental health alcohol and other drug services has been enhanced through the establishment of the Mental Health Alcohol and Other Drugs Quality Assurance Committee which will provide independent governance and oversight.

Deliverables for recommendations 61 to 63

The Mental Health Alcohol and Other Drugs Quality Assurance Committee was established by the Director-General in September 2017 under the auspices of the Office of the Chief Psychiatrist. The Committee meets an identified need for quality assurance oversight and improvement of mental health alcohol and other drugs (MHAOD) service delivery. Membership comprises 18 senior clinical staff and consumer representatives with experience and knowledge reflecting the diversity of MHAOD services and stakeholder groups. The purpose of the Committee is to improve the safety and quality of public MHAOD services by:

- reviewing and analysing information and investigation findings to monitor deaths and other significant incidents involving consumers of Queensland public MHAOD services to inform continuous improvement and reform (recommendation 62)
- assessing and evaluating the quality of relevant health services (recommendation 61)
- reporting and making recommendations to improve MHAOD services.

In relation to recommendation 63 the role and function of the Mental Health Alcohol and Other Drugs Quality Assurance Committee is to provide oversight of clinical governance mechanism relating to safety and quality to inform mental health care of consumers. The governance of the care of consumers assessed at higher risk of violence, including Tier 3, will be embedded in sustainable local service governance structures, supported by the *Violence risk assessment and management framework – mental health services* (the Framework), and the Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High-Risk Patients*, recognising the following:

- Tier 3 of the Framework targets consumers identified as having a significantly elevated risk profile that is unable to be appropriately managed without specialist forensic mental health service input. The referring mental health service remains responsible for the oversight, communication and review processes. Embedded into the governance structure of the Framework is the requirement for ongoing monitoring and review by the primary multidisciplinary team with responsibility for the consumer's mental health care, including, consultant psychiatrist and other senior clinicians be actively involved in the review and development of management plans for consumers at higher risk. The frequency of case reviews and suitability of care plans is determined by relevant standards through the team case review process informed by the response from the specialist forensic mental health service in conjunction with other treatment and care requirements and recorded within the Case Review document.
- The 2017 Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* established a clinical governance framework for the management of patients subject to a forensic order, treatment support order, and those whose risk profile is assessed as higher by their treating team. Under this framework, Assessment and Risk Management Committees were established at each Authorised Mental Health Service. The Committees, which include forensic mental health representation, provide a clinical peer review that operates to strengthen the assessment, risk management and monitoring of this cohort of patients. Tier 3 of the Framework notes regard should be given to the Policy and whether the consumer and treating team would benefit from review by a Committee.

Clinical Directors of Authorised Mental Health Services are to include within their quality assurance cycle an oversight mechanism to review the regularity of case reviews and the suitability of care plans using locally established processes such as peer review, complex case review panels, and Assessment and Risk Management Committees.

The Chief Psychiatrist and the Mental Health Alcohol and Other Drugs Quality Assurance Committee are considering the most appropriate way to monitor ongoing processes for review of the care of this cohort, including relevant performance indicators. It is anticipated that the Mental Health Alcohol and Other Drugs Quality Assurance Committee will review relevant data on a regular cycle to identify themes and assist in the identification of preventative indicators to promote improved quality of care in the longer term.

The Committee is in the process of developing its workplan for the remainder of its inaugural reporting period and the 2020-2023 reporting period. The Committee will consider and agree an approach to the review of care of this cohort as a key activity for the Committee's work in the 2020-2023 reporting period.

3.11 Consideration: Aboriginal and Torres Strait Islander peoples mental health and social and emotional wellbeing

The When mental health care meets risk report 2016 did not identify any specific findings in relation to the provision of mental health care to Aboriginal and Torres Strait Islander peoples but provided information for consideration.

Considerations from the 2016 review

Queensland Health to learn from positive models introduced by Indigenous Health Organisations and engage in real collaboration on the planning for and implementation of services to meet the social and emotional wellbeing and also mental health needs for Aboriginal and Torres Strait Islander peoples [2].

The *Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021* includes several initiatives to promote a seamless service system between Hospital and Health Services and community-controlled health services. The strategy articulates an expectation that routine collaborative planning is undertaken in partnership between Hospital and Health Services and primary care providers to meet the social and emotional wellbeing and mental health needs of the local Aboriginal and Torres Strait Islander community. The Strategy contains result areas of:

- developing culturally capable mental health services
- connecting healthcare
- partnering for prevention and recovery
- enhancing the evidence base.

4. Next steps

The Department of Health (the department) under the *Hospital and Health Boards Act 2011* is responsible for the overall leadership and management of Queensland's public health system and Hospital and Health Services are responsible for the provision of public sector health services.

The department partners with and supports Hospital and Health Services in the delivery of safe, clinically effective, high quality health services by:

- providing strategic leadership and direction through the development and administration of policies and legislation
- developing statewide plans to provide comprehensive, high quality and safe recovery-oriented mental health, alcohol and other drug services and infrastructure
- supporting and monitoring the quality of health service delivery
- providing health information and communication technology

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

- working with the Australian Government to facilitate enhanced coordination of health services.

Hospital and Health Services as the principal provider of health services are individually accountable for their performance. This requires them to monitor and improve the quality of health services delivered, including by developing local clinical governance arrangements.

The responses to the recommendations have been deliberately designed to become embedded into core business practices within the mental health service system and will be the ongoing responsibility of the Hospital and Health Services, our partners such as the Queensland Police Service, and within the department the Mental Health Alcohol and Other Drugs Branch. Indicators of the roles and responsibilities for this core business have been included within the status section of Appendix 1.

The Mental Health Alcohol and Other Drugs Branch is currently finalising a quality assurance strategy that identifies options for the ongoing ownership, management and monitoring of the actions implemented to address the recommendations contained within the When mental health care meets risk report. Examples of monitoring and reporting mechanisms for those activities the Mental Health Alcohol and Other Drugs Branch has responsibility for include the planning cycle and release of mental health alcohol and other drug service plans, the release of Key Performance Indicators, and the Mental Health Alcohol and Other Drugs Quality Assurance Committee triennial report to the Director-General.

At the completion of three-year implementation program only a few items remain incomplete, however the Hospital and Health Services and the Mental Health Alcohol and Other Drugs Branch will continue to incorporate into their core business upon completion. These are:

- Release of the suite of clinical audit tools by December 2019 to support Hospital and Health Services in the evaluation of the quality of clinical care provided and guide decision making for targeted quality improvement activities where needed.
- Completion of the final clinical governance enhancements for an integrated statewide forensic mental health service model, by December 2019.
- Planning for the next state-funded mental health alcohol and drug services plan will commence in 2019.The finalisation of an integrated statewide forensic mental health service model will be addressed through this planning process and release of the services plan due to commence 2022. Given the substantial undertaking and significance of the reform an end date outside of the three-year program is to be expected.

5. Appendix 1: Summary of recommendations, implementation status and deliverables by year

When the mental health meets risk report recommendations (summarised)		Status Responsibility	Deliverables by year to June 2019
Key Area 1: Statewide forensic mental health service model			
1	Develop an integrated statewide forensic mental health service model with governance structure	Commenced MHAOD Branch	**Year 1** Engagement of an external consultancy to develop options for an integrated statewide forensic mental health service model **Year 2** Options paper proposing models completed February 2018 **Year 3** consideration of, and planning for, best fit model including resourcing, for completion by 2022
2	Director statewide forensic mental health service to have statewide oversight	Commenced MHAOD Branch	To be addressed in part as an element of consultancy to respond to recommendation 1 and within clinical governance arrangements for completion December 2019
3	Director and HHS mental health service executive to meet quarterly	Commenced MHAOD Branch	To be addressed in part as an element of consultancy to respond to recommendation 1 and within clinical governance arrangements for completion December 2019
4	Services to be provided to patients on forensic orders **and** consumers assessed at high risk	Commenced MHAOD Branch HHS core business	To be addressed in part as an element of consultancy to respond to recommendation 1 Clinical governance arrangements completed
5	Forensic Liaison Officer positions quarantined for forensic and high risk consumers	Commenced MHAOD Branch	To be addressed in part as an element of consultancy to respond to recommendation 1 and within clinical governance arrangements for completion December 2019
6	Community Forensic Outreach Services linked to specific HHS mental health services	Commenced MHAOD Branch HHS core business	To be addressed in part as an element of consultancy to respond to recommendation 1 Clinical governance arrangements completed
7	Forensic mental health service staff to discuss with mental health service staff recommendations arising from assessment prior to finalisation	Completed HHS core business	**Year 1** Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* https://www.health.qld.gov.au/__data/assets/pdf_file/0028/635932/cpp-forensic-policy.pdf
8	Categorisation system to differentiate between low and high risk patients on	Completed HHS core business	**Year 1** *Mental Health Act 2016* and Chief Psychiatrist Policy *Treatment*

	forensic orders and align treatment/monitoring		*and Care of Forensic Order, Treatment Support Order and High Risk Patients*
9	Consider inclusion of the Mental Health Intervention Co-ordinators within statewide forensic mental health service model	Commenced MHAOD Branch HHS core business	To be addressed in part as an element of consultancy to respond to recommendation 1 Clinical governance arrangements completed
Key Area 2: Family engagement			
10	Assessments to be informed by family/carer collateral. Prompts added to the clinical documentation, efforts to obtain recorded and audited	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* https://www.health.qld.gov.au/__data/assets/pdf_file/0030/368454/gh-gdl-365-1.pdf. *User guide for revised mental health clinical documentation* and revised core suite of clinical documents https://qheps.health.qld.gov.au/mentalhealth/resources/clinicaldocs. Content added to Queensland Centre for Mental Health Learning training packages Develop suite of clinical audit tools **Year 2** Preliminary testing of draft clinical tools **Year 3** Pilot of clinical audit tools completed, with statewide release scheduled December 2019
11	Engagement with families/carers from initial contact and throughout the consumers care	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* *User guide for mental health clinical documentation* and revised core suite of clinical documents Content added to Queensland Centre for Mental Health Learning training packages **Year 3** Report Strategies to enhance information sharing for mental health alcohol and other drugs services Ongoing quality assurance reinforced by the clinical audit tools
12	Families/carers informed of risks to safety and provided with support	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* *User guide for revised mental health clinical documentation* and revised core suite of clinical documents Content added to Queensland Centre for Mental Health Learning training packages

			Year 3 At risk of violence: a safety planning information and resource guide Ongoing quality assurance reinforced by the clinical audit tools
13	Prompts to ask about safety, consumer and family/carer included in assessment and care planning	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* *User guide for revised mental health clinical documentation* and revised core suite of clinical documents Content added to Queensland Centre for Mental Health Learning training packages Ongoing quality assurance reinforced by the clinical audit tools
14	Educate mental health service staff on information sharing with family and other parties	Completed HHS core business	**Year 1** *Mental Health Act 2016* online education package Module 10 disclosure of confidential information: https://ilearn.health.qld.gov.au/d2l/login. Queensland Centre for Mental Health Learning updated training materials to include links to Module 10 and the *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others* booklet **Year 3** Report Strategies to enhance information sharing for mental health alcohol and other drugs services
15	Include within information sharing booklet the provision of advice and support to at risk families	Completed HHS core business	**Year 1** Revised Queensland Health booklet *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others:*https://www.health.qld.gov.au/__data/assets/pdf_file/0026/444635/info_sharing.pdf
16	Opportunities during *Mental Health Act 2016* implementation to build knowledge on information sharing	Completed HHS core business	**Year 1** *Mental Health Act 2016* online education package Module 10 disclosure of confidential information *Mental Health Act 2016* implementation statewide education training sessions included information sharing provisions
Key Area 3: Consumer journey			
3.3.1 Comprehensive mental health assessment			
17	Comprehensive mental health assessment for all new consumers accepted into treatment	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* Ongoing quality assurance reinforced by the clinical audit tools

18	Comprehensive mental health assessment for consumers who are frequently referred or present to emergency departments (3 or more occasions within 3 months)	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* Ongoing quality assurance reinforced by the clinical audit tools
19	Emergency situations minimum standard for assessment	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* *User guide for revised mental health clinical documentation* Triage and Rapid Assessment form Ongoing quality assurance reinforced by the clinical audit tools
20	Comprehensive mental health assessments to include longitudinal history	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Content added to Queensland Centre for Mental Health Learning training packages Ongoing quality assurance reinforced by the clinical audit tools
21	Services to ensure appropriate training, supervision and auditing of comprehensive mental health assessments	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* Content added to Queensland Centre for Mental Health Learning training package Develop suite of clinical audit tools **Year 2** Preliminary testing of draft clinical tools **Year 3** Pilot of clinical audit tools completed, with statewide release scheduled December 2019
3.3.2 Violence risk assessment and management			
22	Implement a three-level violence risk assessment framework 1. initial risk screen 2. risk assessment 3. specialist risk assessment	Completed HHS core business	**Year 1** Commence development of guideline and clinical documentation for a three-level risk assessment framework QC9 *Critical Components of Risk Assessment and Management* training updated to support application of Tier 1 of the Framework **Year 2** Pilot draft *Violence risk assessment and management framework – mental health services* QC30 *Violence Risk Assessment and Management* training developed to support application of Tier 2 of the Framework **Year 3** CFOS/CYFOS provided with specialist violence risk assessment training

			Framework finalised. QC30 training delivered to HHSs. Statewide implementation of Framework https://qheps.health.qld.gov.au/__data/assets/pdf_file/0019/2300563/violence-risk-assessment-management-framework.pdf.
23	Level of services commensurate with identified level of risk	Completed HHS core business	**Year 1** Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* Included within *Violence risk assessment and management framework – mental health services* (see recommendation 22)
24	Consultant psychiatrists/other senior clinicians involved in review and development of management plans that address violence risk factors for Level 3	Completed HHS core business	**Year 1** Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* Included within *Violence risk assessment and management framework – mental health services* (see recommendation 22) Ongoing quality assurance reinforced by the clinical audit tools
25	Forensic Liaison Officer positions quarantined from non-forensic mental health	Commenced MHAOD Branch	To be addressed in part as an element of consultancy to respond to recommendation 1 and within clinical governance arrangements for completion December 2019 (see recommendation 5)
3.3.3 Formulation and treatment planning			
26	Formulations include longitudinal information on mental illness, relationship with risk factors for violence, and the impact on risk	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Ongoing quality assurance reinforced by the clinical audit tools
27	Management plans informed by risk assessment and mitigation strategies, including referrals to external services	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* and revised suite of core clinical documents Ongoing quality assurance reinforced by the clinical audit tools
28	Care review and summary plan completed within six weeks of acceptance into service. Recovery Plan developed or explanation for delay	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* *User guide for revised mental health clinical documentation* Ongoing quality assurance reinforced by the clinical audit tools
29	91 day clinical reviews as per *National Standards for Mental Health Services 2010*. HHS to develop separate	Completed	**Year 1** *Guideline on the use of the standard suite of clinical documentation*

	system to comprehensively review complex and high risk consumers	HHS core business	*User guide for revised mental health clinical documentation* Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients* Project to scope treatment planning and the multidisciplinary team review process, and capacity for comprehensive reviews
30	Statewide standardised suite of clinical documentation to include trigger for ad hoc review	Completed HHS core business	**Year 1** Revised core suite of clinical documents
31	Clinical reviews to assess effectiveness of previous care plans and include strategies to mitigate level of risk and stabilise behaviour	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Ongoing quality assurance reinforced by the clinical audit tools
32	Community Forensic Outreach Services' reports to be noted by a consultant psychiatrist and changes to management plan documented in the clinical file	Completed HHS core business	**Year 1** Chief Psychiatrist Policy *Treatment and Care of Forensic Order, Treatment Support Order and High Risk Patients*
3.3.4 Therapeutic relationship			
33	Mental health services to accelerate clinician training in recovery-oriented practice, including consumers with a history of violence/forensic issues	Completed HHS core business	**Year 1** Queensland Centre for Mental Health Learning training package *QC24 Working with Strengths in Recovery*
34	Training in specialist applications of the recovery model and management of risk of violence to include consumer/ forensic specialist input	Completed HHS core business	**Year 2** Principles of recovery-oriented practice incorporated into the QC30 Violence and Risk Assessment and Management training
35	Regular case file audits for documentation of consumer engagement; shortfalls addressed in supervision and line management.	Completed HHS core business	**Year 1** *Guideline on the use of the standard suite of clinical documentation* *User guide for revised mental health clinical documentation* Develop suite of clinical audit tools **Year 2** Preliminary testing of draft clinical tools **Year 3** Pilot of clinical audit tools completed, with statewide release scheduled December 2019
3.4 Consumers with co-morbid conditions			
36	Comprehensive mental health assessment to consider dual diagnosis /co-occurring conditions and initiate referral pathways	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Queensland Centre for Mental Health Learning training packages *QC9 Critical Components of Risk Assessment and Management,* and *QC14 Mental Health Assessment* augmented Ongoing quality assurance reinforced by the clinical audit tools

37	Address presence and need for treatment for co-morbid alcohol and other drug use and implications for mental health and risk of violence	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Queensland Centre for Mental Health Learning training packages *QC9 Critical Components of Risk Assessment and Management,* and *QC14 Mental Health Assessment* augmented Ongoing quality assurance reinforced by the clinical audit tools
38	Address presence and need for treatment for co-morbid personality vulnerability and personality disorders and implications for mental health and risk of violence.	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Queensland Centre for Mental Health Learning training packages *QC9 Critical Components of Risk Assessment and Management,* and *QC14 Mental Health Assessment* augmented Ongoing quality assurance reinforced by the clinical audit tools
39	Formulations that include risk of violence to consider role of co-morbid or co-occurring conditions	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Queensland Centre for Mental Health Learning training packages *QC9 Critical Components of Risk Assessment and Management,* and *QC14 Mental Health Assessment* augmented Ongoing quality assurance reinforced by the clinical audit tools
40	Treatment plans to address integrated management of complex consumers. Referrals to external services made and monitored	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation* Queensland Centre for Mental Health Learning training packages *QC9 Critical Components of Risk Assessment and Management,* and *QC14 Mental Health Assessment* augmented Ongoing quality assurance reinforced by the clinical audit tools
41	Multi-service case conferences for consumers with co-morbid conditions, or repeated presentations to mental health services	Completed HHS core business	**Year 1** *User guide for revised mental health clinical documentation*
42	Renew Service Integrated Care Co-ordinator functions for complex consumers (incl. mental illness and dual disability), in consultation with the National Disability Insurance Scheme	Completed HHS core business	**Year 1 and ongoing** Role to focus on complex consumers, and support access to and monitor progress of those linked with the National Disability Insurance Scheme
43	Mechanisms for a whole of government approach for consumers with particularly complex mental health needs (substance misuse, personality	Completed MHAOD Branch core business	**Year 1 and ongoing** Established partnerships between the MHAOD Branch, HHS, Department of Communities, Disability Services and

	disorder, intellectual disability, development disorder)		Seniors, Magistrates Courts and National Disability Insurance Agency
3.5 Clinical systems and information			
44	One integrated statewide clinical information system for mental health information, such as the Consumer Integrated Mental Health Application (CIMHA)	Ongoing MHAOD Branch core business	**Year 1 and ongoing** Improvements to integration/interface with broader health system
45	Provide one area in CIMHA for all information relating to risk of violence and management	Completed HHS core business	**Year 2** Violence risk report within CIMHA collates documents containing information on risk **Year 3** inclusion of *Mental Health Act 2016* forms within Violence risk report
3.6 Building competencies and capabilities			
46	All clinicians to be trained in risk assessment and management (screening Tier 1) Senior clinicians to be trained for Tier 2 assessments Use and interpretation of validated risk assessments measures (Tier 3)	Completed HHS core business	**Year 1** Queensland Centre for Mental Health Learning training package *QC9 Critical Components of Risk Assessment and Management* augmented **Year 2** Amendments to *QC9 Critical Components of Risk Assessment and Management* completed QC30 *Violence Risk Assessment and Management* training developed for senior clinicians for Tier 2 response to *Violence risk assessment and management framework – mental health services* **Year 3** QC30 training delivered to HHSs in preparation for statewide implementation of *Violence risk assessment and management framework – mental health services* CFOS/CYFOS specialist training to administer and interpret validated violence risk assessment measures
47	Training in violence risk assessment to strengthen skills in formulation, recommendations and active care planning	Completed HHS core business	**Year 1** Queensland Centre for Mental Health Learning training package *QC9 Critical Components of Risk Assessment and Management* augmented **Year 2** QC9 amendments to align with *Violence risk assessment and management framework – mental health services* QC30 *Violence Risk Assessment and Management* training to support Tier 2 of the Framework developed **Year 3** QC30 *Violence Risk Assessment and Management* training for Tier 2 of the Framework delivered to HHSs

48	Training and supervision on identification of risk factors to ensure escalation when indicated	Completed HHS core business	**Year 1** Training package QC9 *Critical Components of Risk Assessment and Management* augmented **Year 2** QC9 amendments to align with Tier 1 *Violence risk assessment and management framework – mental health services* QC30 *Violence Risk Assessment and Management* training to support application for Tier 2 of the Framework developed **Year 3** QC30 training delivered to all HHSs
49	Training and supervision on recovery principles, and the dignity of risk, so that treatment plans firstly assist with stabilising presentation and work towards recovery (incl. addressing violence risk factors)	Completed HHS core business	**Year 1** Queensland Centre for Mental Health Learning training package *QC24 Working with Strengths in Recovery* **Year 2** Recovery principles incorporated into QC30 *Violence Risk Assessment and Management* training developed for Tier 2 of the Framework **Year 3** QC30 training delivered to all HHSs
50	Training on information sharing between services and carers/family for open discourse on risk and care planning considerations	Completed HHS core business	**Year 1** *Information Sharing between Mental Health Workers, Consumers, Carers, Family and Others* *Mental Health Act 2016* online education package Module 10 disclosure of confidential information **Year 2** Incorporated into QC9 *Critical Components of Risk Assessment and Management* and QC30 *Violence Risk Assessment and Management* training **Year 3** Strategies to enhance information sharing for mental health alcohol and other drugs services report to HHSs
51	Training and implementation support for the *Queensland Health dual diagnosis clinical guidelines and dual diagnosis clinical toolkit* to enable integrated care and referral pathways	Completed HHS core business	**Year 1** Training packages QC9 *Critical Components of Risk Assessment and Management,* and QC14 *Mental Health Assessment* augmented Training in alcohol and drug assessment and treatment interventions available through *Insight*
52	Practice skills acquisition audit through review of documentation/other	Commenced HHS core business	**Year 1** The Chief Psychiatrist Policy, *Notifications to Chief Psychiatrist of Critical Incidents and Non-Compliance* with the Act https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465212/cpp-notific-critical-incidence.pdf. The Chief Psychiatrist Policy on *Appointment of Authorised Doctors*

			and Authorised Mental Health Practitioners https://www.health.qld.gov.au/__data/assets/pdf_file/0032/636854/cpp_appointment_ad_amhp.pdf. Develop suite of clinical audit tools **Year 2** Preliminary testing of draft clinical tools **Year 3** Pilot of clinical audit tools completed, with statewide release scheduled December 2019
53	Opportunities to develop training and relationships with Primary Health Networks in the assessment and management of risk of violence to others. Services to collaborate with domestic violence services in the management of family violence	Completed Department of Health, Strategic Policy and Planning Division (SPPD) HHS core business	**Year 1** *Health workforce domestic and family violence training guideline* https://www.health.qld.gov.au/__data/assets/pdf_file/0028/637453/qh-gdl-441.pdf. *Clinical response to Domestic and Family Violence* training developed in consultation with Primary Health Networks, train the trainer program available to private and public sector https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/duty-of-care/domestic-family-violence/healthcare-workers **Year 2** Additional resources developed on information sharing, non-lethal strangulation and antenatal screening
3.7 Support services and linkages with other agencies			
54	Enhance awareness of and capacity for QH Victim Support Services to work with families who have experienced violence	Completed QHVSS core business	**Year 1** release of a promotional video made available on QHVSS website
55	Consider role in supporting consumers, families and others who have been victimised or are vulnerable to victimisation. Information about QH Victim Support Services readily available at all points of contact within Queensland Health	Completed QHVSS core business HHS core business MHAOD Branch	**Year 1** Twelve month project to examine most effective way to support victims where charges are not / will not be made. Project report submitted for consideration **Year 3** Outcomes of project report: Release of *At risk of violence: a safety planning information and resource guide* Planning for the next mental health alcohol and other drug services plan to include consideration of expansion of service
56	Identify and establish links with other government / non-government / community-based organisations to support people at risk of violence - either as victim or perpetrator	Completed SPPD core business HHS core business	**Year 1** *Health workforce domestic and family violence training guideline* **Year 3** *At risk of violence: a safety planning information and resource guide*
3.8 Mental health literacy and access			
57	Whole of government strategy on mental health literacy and access to	Completed	Commission's *Shifting minds: Queensland Mental Health Alcohol and*

	support services. Focus on referral and access to public mental health services	Queensland Mental Health Commission	*Other Drugs Strategic Plan 2018-2023* Focus area 2 strategic priority 1 is to increase mental health, alcohol and other drug and suicide prevention literacy
3.9 The Queensland Police Service			
58	Establish communication protocols with mental health services and QPS to advise of changes in care status for people brought in to emergency departments	Completed Queensland Police Service and HHS core business	**Year 1** Authority to release information to be established within draft Memorandum of Understanding Confidential Information Disclosure under section 151 of the *Hospital and Health Boards Act 2011* **Year 2** MOU prescribed 29 March 2018
59	Update QPS training in mental health to include de-escalation techniques for persons presenting in a mental health crisis	Completed Queensland Police Service core business	**Year 1** Training modules reviewed **Year 2 and ongoing** monitoring of training needs by Queensland Police Service
60	Retain Police Communications Centre Mental Health Liaison Service	Completed Queensland Police Service and MHAOD Branch core business	**Year 1** Retained and increase to recurrent funding **Year 2 and ongoing** to be considered as part of planning for state funded mental health alcohol and other drug service plans
3.10 Mental health quality assurance			
61	Establish a statewide mental health Quality Assurance Committee	Completed MHAOD Branch core business	**Year 2** Quality Assurance Committee appointed
62	Quality Assurance Committee to include review of homicides and other serious acts of violence	Completed MHAOD Branch core business	**Year 2** Included within terms of reference
63	Quality Assurance Committee to monitor frequency and suitability of care reviews and plans for Level 3 risk of violence	Completed MHAOD Branch core business	**Year 2** Role of Committee in monitoring this level of activity under consideration **Year 3** Frequency and suitability of care reviews and plans to be undertaken within HHSs
3.11 Consideration: Aboriginal and Torres Strait Islander peoples mental health and social and emotional wellbeing			
	Learn from Indigenous Health Organisations' models and collaborate on planning and implementation of services	Completed Department of Health, Queensland Mental Health Commission, and HHS core business	**Year 1** *Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy* https://www.health.qld.gov.au/__data/assets/pdf_file/0030/460893/qhatsi-mental-health-strategy.pdf.

6. Glossary

Term	Description
Assessment	Process by which the characteristics and needs of consumers, groups or situations are evaluated or determined so they can be addressed. The assessment forms the basis of a plan for services or action.
Carer	A person whose life is affected by virtue of close relationship with a consumer, or who has a chosen caring role with a consumer. Carer, in this document, may also refer to the consumer's identified family, including children and parents, as well as other legal guardians and people significant to the consumer.
Clinical formulation	A clinical summary of the assessment including information regarding the predisposing, precipitating, perpetuating and protective factors that are relevant to the person's clinical presentation, the diagnosis, the prognosis and current risks.
Co-morbid or co-occurring condition	Existing simultaneously with and usually independently of another condition.
Consumer	A person who is currently using, or has previously used, a mental health service.
Dual diagnosis	Co-occurring mental health and substance misuse problems.
Forensic	Related to, or associated with, legal issues.
Forensic mental health services	The forensic mental health system refers to the components, both in the health system and the justice system, which respond to people with a mental illness who have been charged with an indictable offence.
Indigenous	Indigenous Australian peoples
Mental health	The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.
Mental health service	Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.
Mental illness	A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or the International Classification of Diseases, Tenth Edition (ICD-10). These classification systems apply to a wide range of mental disorders (for the DSM-5) and mental and physical disorders (for the ICD-10).
Recovery	Clinical recovery pertains to a reduction or cessation of symptoms and restoring social functioning. Personal recovery is defined as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.
Risk	The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood.
Risk assessment	The process of identification, analysis and evaluation of a risk.
Risk management	In health care, designing and implementing a program of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution.

Sentinel event	When a patient unexpectedly dies or is seriously physically or psychologically injured in a way that is not related to the natural course of the patient's illness or treatment.
Wellbeing	The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition.