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I refer to your email of 14 December 2005 and thank the Committee for permitting me to make a submission at this late stage.

There have been a series of reports handed down in Queensland in the latter part of the year, which I do not believe the Committee have had the opportunity to consider.

The reports are:

1. The Annual Report of The Director of Mental Health 30 June 2005
http://www.health.qld.gov.au/mha2000/annual_reports.asp

2. The Mental Health Review Tribunal Annual Report 2005
http://www.mhrt.qld.gov.au/

3. The Report of the Commission for Children and Young People and Child Guardian – Annual Report - Deaths of Children and Young People in Queensland 2004 -2005

Particularly item 7 - the link to suicide -
http://www.ccypcg.qld.gov.au/about/publications/dcyp05.html

4. Achieving Balance – Summary Report - Queensland Review of Fatal Mental Health Sentinel Events (Period 2002 -2003) Completed March 2005
http://www.health.qld.gov.au/mental_hlth/default.asp

The Queensland Government has made 2 submissions to the Inquiry Numbers 377 and 377A.

The initial submission was a general summary of the position and policies regarding Mental Health issues in Queensland. The subsequent one, dealt in greater detail with many matters and considered National Issues, funding problems and contained a more extensive description of the Government's approach. It is not the purpose of this submission to deal in depth with any of the reports referred to above or to provide a detailed analysis of Submissions 377 and 377A. Rather, I hope to provide a series of snapshots of what is reported by those closer to the coal face, and where appropriate relate these to aspects of the Government's submissions.

Interesting comparisons can be made regarding the Criminal Justice System and the procedures for dealing with Forensic Patients, references of patients to the Director of Mental

Health, the Mental Health Court, as discussed the Submissions, and the discussions and statistics set out in the various reports

The Report of the Commission for Children and Young People and Child Guardian – Annual Report - Deaths of Children and Young People in Queensland 2004 -2005, Chapter 7

To quote from the Report, *"From 1 January 2004 to 30 June 2005, 19 children and young people were suspected of committing suicide[140]. This cause of death was responsible for23.8% of external deaths among children aged 10 to17 years. Suicide accounted for the highest number of external deaths of children aged 10 to 14 years and the second highest for children aged 15 to 17 years, exceeded only by transport fatalities."* (Chapter 7 page 98)

I realize it can be unfair to quote statistics in isolation in this way, but one does wonder whether the approach, referred to in Submission 377 (submission page 14)regarding Child Acute admissions has worked, given these tragic statistics. The Commission referred to a recent University of Queensland study which found that*", many young people who are admitted to hospital for non-fatal deliberate self-harm do not receive mental health assessments or follow-up care."* (report page 108) It was a key recommendation of the study that *"all young people who present to emergency departments for nonfatal deliberate self-harm undergo mental health assessments."* (report page 108) The study further recommended that there be follow-up appointments within 48 hours of discharge. The Commission stated that it supported this recommendation given the potential such action could have in reducing suicides. (report page 108).

Submission 377A elaborates on the State's policies in relation to children, education and suicide prevention (submission pages 26, 27, 28 29, 35 and 36) but does not address the concerns raised here.

The Annual Report of The Director of Mental Health 30 June 2005

The interaction between the Police and people with a mental illness has always been problematic; this issue is not just confined to Queensland, as other submissions to the Committee have indicated. The Partnership Agreement referred to in Submission 377 is to be applauded (submission page 19). As are the various measures cited in Submission 377A (submission pages 11and 58,)

The Director of Mental Health however, referred to the situation that arises when Emergency Examination Orders are made under the provisions of the Mental Health Act. This arises in circumstances *where "the person represents an imminent risk of significant physical harm (either to him or herself or someone else) as a result of a mental illness."* (report page 15) The Order authorizes a Police Officer an Ambulance officer or a Psychiatrist to immediately take the person to an Authorised Mental Health Service for examination.

There were 3787 EEO's made in Queensland in 2004 -2005 (report Table 5, page 17) of these only 14% were made by Ambulance Officers, with the Police making 85%. The Director said, *"I hope in future years that the Ambulance Service will become the primary agency in dealing with mental health emergencies and transferring persons to Authorised Mental Health Services from the Community"* (report page 17).

Submission 377A indicates that training of Police is being undertaken to help them better deal with this difficult area (submission page 58). It also shows the discrepancy between the role of the Ambulance Service and the police and the confusion regarding practices generally. (submission page 59)

Despite the Government's policy, clearly more needs to be done to ensure that severely ill people are dealt with as health emergencies, and the trauma and distress and dehumanization caused by being transported by the Police rather than in an Ambulance can be avoided.

Another matter of interest in the Annual Report of the Director of Mental Health relates to Justices Examination Orders. These orders are made by a Magistrate or Justice of the Peace JP. Any concerned member of the community may seek a JEO in relation to a person they believe requires examination. The application is sworn and sets out the grounds for seeking the order. The Magistrate or JP may make an order if he/she believes the person has a mental illness, and the order is required to ensure that the person is properly examined by a doctor or Authorised Mental Health Practitioner. The order remains valid for 7 days.
The Order is sent to the appropriate Authorised Mental health Service, which arranges the examination often in the person's home or some other place nominated in the order. (This description of the process is a para-phrased summary of the process taken from page 12 of the report).

My concern is that of the 914 JEO's made during 2004 -2005, 877 were made by JP's. Only 37 by magistrates (report Table 3 page 14). I realize that at times these requests may be made after court hours, but given that any person may make an application, and the likelihood that a magistrate will have more experience in reviewing evidence and making judgements about it weight, it is of concern that so many such orders are referred to JP's,who while well meaning, community minded citizens, are not well trained, and I believe are more likely to be influenced by the person seeking the request. Particularly if that person is a Police Officer.

The Mental Health Review Tribunal Annual Report 2005

"The Tribunal is an independent statutory authority established under the Mental Health Act 2000 to safeguard the rights of people receiving involuntary treatment (treatment without consent) under the Act." (report page 8)

The Tribunal panel is made up of Lawyers, Psychiatrists and Community Members.

In the President's Report, he expressed particular concern regarding people with the dual diagnosis of intellectual disability and mental illness*. "Like my predecessor I have been particularly aware of the distress and frustration of health professionals who have no alternative to detaining such patients in inappropriate places because resources are inadequate for their proper care in less restrictive environments."* (report page 6)

It is of concern that the President expresses this view given the objective of the Government as set out in Submission 377 (submission page20). It seems that the policy objectives are not flowing through to patients as yet.

It is worth considering two paragraphs from the President's report, the first relates to delays in hearings,

"Hearings are generally listed four to six weeks in advance to provide sufficient time for treating teams to prepare reports. Some services remain of concern in failing to supply clinical reports or in having doctors attend Tribunal hearings. This results in lost productivity because hearings must then be adjourned at short notice to be relisted for one or more further hearings. But the more significant concern is that patients, whose individual rights have been affected as a result of mental illness, are not receiving the legal protection to which they are entitled within the proper timeframe accorded by the law. Another consequence is that other patients may not be heard because there is insufficient time to fill the gap created by the adjourned hearing. Thus two patients may be disadvantaged because one report was not done." (report page 6)

A more detailed discussion of this problem is contained in the body of the report (pages 28 and 29) The statistical data regarding this problem is contained in Appendix13. (report page 64.)

The Mental Health Act sets out specific rights for patients and these delays can mean that a patient may stay longer as an inpatient or the subject of the restrictions of an Involuntary Treatment Order than is necessary.

Also of concern to the President was the issue of forensic patients absent without permission.

"An important concern exists with patients on Forensic Orders who are absent without permission. There has been a marked reluctance by the Attorney-General's Office, which attends hearings as the representative of the community, to contribute resources to locating these patients. At the same time the authorised mental health services argue they aren't resourced to track people down. In this situation there is potential for patients, who have been placed on Forensic Orders for the purposes of treatment and care, to avoid the very treatment or care that is designed to help them stay well and thus not become an unacceptable risk to the community." (report page 6)

This is a serious matter and should be rectified as soon as possible.

Submission 377 refers to various Quality Improvement Programs, of particular interest are 5.16.1, 5.16.2 ,5.16.3, 5.16.6, 5.16.7, and 5.16.8, (report pages 23 – 27) These deal in part with the systemic and other issues relating to forensic patients. But as yet do not appear to have address the issue.

Queensland Review of Fatal Mental Health Sentinel Events (period 2002-2003) March 2005 (Summary Report)

A general reference to this report was made to this report in Submission 377 (Submission pages 28 and 29). This summary of the Government's response did not indicate to the Committee the extent of the problem being dealt with. I believe the Committee should consider the Review and its recommendations in detail.

The terms of reference were *"to investigate deaths that had occurred in a 2 year period 2002 – 2003, involving people with serious mental illness and to determine if there systemic issues in mental health services that needed to be addressed* "(report page 1)

The deaths included suicides, and unexpected deaths of people receiving mental health assessment or treatment in acute inpatient units or emergency departments, homicides where the offender had a mental illness, and people with a mental illness who were shot by the police. (report page 1)

There were 45 cases identified by the Review Committee. Inpatient Suicides 23, Unexpected Deaths 7, Homicides 12, Police Shootings 3. (report page 3)

I do not propose to discuss these in detail, the report speaks for itself. The number of deaths in which systemic issues were involved is most disturbing however.

The issues raised were in the areas of *Assessment* (report page 5 and 6). *Treatment Issues* (report page 6), *Leave and Discharge Planning* (report page 7), *Inpatient Observations* (report page 7), *Environment and means of Suicide* (report pages 7 and 8*), Control and Restraint* (report page 8), *Administration of the Mental Health Act 2000* (report page 8*), Drugs and Alcohol* (report page 9), *Communication and Information Management* (report page 9) *Immediate Responses to Sentinel Events* (report page 10*) Investigations of Sentinel Events* (report page 10) *Emergency Departments* (report page 10) *Resources* (report page 11).

A list of Key Recommendations is also made. (report page 12)

In conclusion, I hope that my submission has assisted the Committee in gaining a more up to date picture of the official situation, and some of the problems in Queensland, as set out in various Public Documents.

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