POLICE COMMUNICATIONS CENTRE MENTAL HEALTH LIAISON SERVICE

EVALUATION REPORT

QUEENSLAND FORENSIC MENTAL HEALTH SERVICE

MAY 2016

CONTENTS

GLOSSARY

AMHS	Authorised Mental Health Services
BPCC	Brisbane Police Communications Centre
CATT	Crisis Assessment and Treatment Team
CIMHA	Consumer Integrated Mental Health Application
CIP	Crisis Intervention Plan
CIT	Crisis Intervention Team
EEO	Emergency Examination Order under the Mental Health Act
HHS	Hospital and Health Service
JEO	Justices Examination Order under the Mental Health Act
Mental Health Act	*Mental Health Act 2000 (Qld)*
MOU	Memorandum of Understanding
MHIP	Mental Health Intervention Coordinator
MHIP	Mental Health Intervention Program
NSW	New South Wales
PCC MHL	Police Communications Centre Mental Health Liaison
QAS	Queensland Ambulance Service
QCAD	Queensland Computer-Aided Dispatch
QFMHS	Queensland Forensic Mental Health Service
QFTAC	Queensland Fixated Threat Assessment Centre
QH	Queensland Health
QPS	Queensland Police Service
RBWH HREC	Royal Brisbane and Women's Hospital Human Research Ethics Committee
SDO	State Duty Officer

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In the 2015/16 financial year, the Queensland Mental Health Commission (QMHC) provided funding support to the Queensland Forensic Mental Health Service (QFMHS) for a project position to lead the evaluation and development of a number of mental health and police projects. This included an evaluation of the Police Communications Centre Mental Health Liaison (PCC MHL) service. The QFMHS would like to thank the QMHC for funding this work.

The evaluation team would like to thank and acknowledge the Queensland Police Service (QPS) for their collaboration in establishing the PCC MHL service, and for their support and assistance throughout the evaluation.

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INTRODUCTION

In 2014, a number of incidents involving police responses to mental health crises in the community identified a gap in Queensland's mental health-policing models. In particular, these gaps related to information sharing and support for police responding to mental health crises after hours and on a statewide basis. The introduction of a pilot program involving the placement of a clinician in the Brisbane Police Communications Centre (BPCC), the Police Communications Centre Mental Health Liaison (PCC MHL) service, was commenced in January 2015 as one mechanism to fill these identified gaps.

This report describes evaluation outcomes from the first 12 months of operation of the PCC MHL service and makes recommendations based on the findings.

RECOMMENDATIONS

MODEL OF SERVICE

- The model of service should identify clear referral pathways and strategies to ensure appropriate referrals to the PCC MHL service. These strategies should include incorporating a clinical triage process for the PCC MHL clinicians that works in conjunction with the process of referral by the State Duty Officer (SDO).
- Clear roles, responsibilities and oversight processes including clinical reviews, escalation pathways, and regular inter-agency meetings should be embedded within the model of service. Consideration should also be given to appointing a team leader to coordinate and manage the service.
- Within the model of service, clear priorities and responsibilities need to be established to enable the strategic elements of the role, such as education, training and service development, to be fulfilled.
- To ensure consistent and auditable practices, the model of service should detail the documentation requirements (e.g. CIMHA records and agreed protocols for corresponding with local mental health services) that must be undertaken by the PCC MHL clinicians for each referral.
- Clear and documented feedback process to mental health services should be developed. This includes processes for:
    a. Liaison with the treating team and local Mental Health Intervention Coordinators in relation to Crisis Intervention Plan development,
    b. The provision of advice to the treating team responsible for a client's ongoing care where a valid diagnosis is not recorded in CIMHA, and
    c. The ability to escalate systemic matters, such as issues related to the *Mental Health Act 2000*, to Clinical or Executive Directors.

SERVICE EXPANSION

- The number of clinicians working within the PCC MHL service, including on-call psychiatric support, should be expanded as soon as practicable as additional clinical services are required to ensure clinical support for the following:
    a. Alignment of the Tuesday and Wednesday shifts to cover 16:00 to midnight as occurs with the Thursday to Saturday shifts.
    b. Monday and Sunday evening shifts (16:00 to midnight), as nearly 30% of after-hours 'mental health related' calls are received on Monday and Sunday evenings.
    c. Saturday and Sunday 'business hours' (08:00 to 16:00) to provide a direct avenue for QPS to be able to obtain assistance in relation to mental health matters at times when regular service provision at the local level may be reduced.
- Other time periods that require further analysis with respect to potential for enhanced service delivery include:
    a. A comprehensive analysis of local responses available to the QPS during weekday business hours (08:00 to 16:00) as 27% of the total mental health related calls received by the Brisbane Police Communications Centre occur on weekdays during these times, and
    b. Consideration of expansion of the PCC MHL service to include midnight to 08:00 shifts Monday to Sunday to augment local responses which may not be readily accessible during these hours.

EDUCATION AND SUPPORT

- Operating at the interface between the QPS and mental health services, the PCC MHL clinicians are in a valuable position to assist with the development and implementation of further education and training. Future education material and resources for both QPS and mental health services should be developed in a manner that ensures training:
    - can be implemented and delivered on a statewide basis,
    - can be incorporated into existing education or training sessions to minimise time away from work for police officers or clinicians,
    - incorporates the views of clients, carers and service providers, and
    - promotes the collaboration and enhancement of relationships between mental health services and the QPS.

INFORMATION MANAGEMENT

- Continued collaboration across the QFMHS, local mental health services and the QPS is required to improve processes associated with data collection and information management. This collaboration should, at a minimum, include:
    a. regular auditing processes for the PCC MHL service, and
    b. examination of enhancements that can be made to CIMHA and QCAD to record and analyse information currently being recorded separately on the PCC MHL

service excel spreadsheet.

QUEENSLAND AMBULANCE SERVICE

- Development of information sharing protocols, referrals pathways and collaborative relationships that enable the Queensland Ambulance Service (QAS) to access the PCC MHL service.

MENTAL HEALTH AND QPS COLLABORATION

- Future mental health and QPS collaboration opportunities should consider the role of the PCC MHL service and mental health services in supporting the QPS police negotiator program.
- Accurate and clear communication between mental health service staff and the QPS, or where appropriate the QAS, is required to ensure that patients who are absent without permission can be safely returned. A coordinated approach to education, training and the provision of advice across mental health services, the QPS and QAS regarding these processes should be implemented. The PCC MHL service, together with local Mental Health Intervention Coordinators, may be uniquely placed to assist in developing this training.
- Due to the involuntary nature of transportation and detention that occurs under an Emergency Examination Order (EEO), it is recommended that further investigation of the QPS and QAS practice of jointly enacting an EEO occur. This investigation should consider data collection issues and operating processes to ensure compliance with the *Mental Health Act 2000.*
- It is recommended that consideration be given to statewide data collection for Emergency Examination Authorities under the new *Mental Health Act 2016* as well as the development of clear communication pathways and responsibilities across Emergency Departments and mental health services. The development of these processes should involve the PCC MHL service and local Mental Health Intervention Coordinators.

BACKGROUND

The increasing frequency of interactions between police and individuals with mental illness accounts for a growing percentage of overall police activity.[1] In Australia, these interactions account for as much as 50% of police time being directed towards responding to events involving individuals with mental illness.[2] In Queensland, calls to police coded as mental health incident types are the seventh most common requests for assistance and equate to approximately 72 calls per day that require police responses across the State.[3] The increasing frequency of interactions between police and individuals with mental illness has, in part, been attributed to a failure of mental health services being able to cope with demand.[4] The outcomes from these interactions for individuals with mental illness, police and the community can be varied and warrants the attention of health services, police and other government agencies such as community services, disability services, housing and the department of justice.

In Queensland, police officers initiated 6,931 Emergency Examination Orders (EEOs) under the *Mental Health Act 2000* (the Mental Health Act) in 2014/15, which is a 12% increase from the 2013/14 reporting period.[5] Additionally, in relation to Queensland Police Service (QPS) calls for service; in 2012/13, police recorded 21,118 as mental health incident types (excluding Mental Health Act calls) and this increased up to 24,416 in 2014/15 (an increase of 13%).[6] The Queensland experience is similar to other Australian jurisdictions. For example in New South Wales (NSW), 2,642 police events relating to mental health legislation were recorded in 2000 compared with 22,234 events in 2009.[7] In Victoria, a cross-sectional study found that three quarters of police detainees met criteria for a diagnosable mental disorder.[8]

Calls for police assistance can result in police officers being a pivotal point of contact to engage individuals that require mental health intervention.[9] However, police officers, particularly those not working in specialised areas such as police negotiation, may receive only limited training in relation to responding to individuals with mental illness.[10] Police uncertainty regarding how to best respond to a crisis situation involving a person with mental illness may result in the person's behaviour being interpreted by police as dangerous or aggressive.[11] As a result, the pivotal role that police may have in engaging persons with mental health needs may instead lead to an overuse of arrest or detention options. For example, a data-linkage study from Western Australia found that 66.4% of arrestees with schizophrenia, and 61.6% of arrestees with other psychiatric illnesses, had contact with

[1] Butler, 2014; Hails & Borum, 2003; Martin, Ogloff, & Thomas, undated; Reuland, Schwarzfeld & Draper, 2009
[2] National Mental Health Commission (NMHC), 2013
[3] Queensland Government, 2013
[4] NMHC, 2013
[5] Queensland Health (QH), 2015
[6] Queensland Police Service (QPS) unpublished, 2015
[7] Herrington, Clifford, Lawrence, Ryle, & Pope, 2009
[8] Baksheev, Thomas, & Ogloff, 2010
[9] Ogloff, David, Rivers, & Ross, 2007
[10] Browning et al., 2011
[11] Ibid.

police prior to any engagement with mental health services.[12]

The frequency of interactions between persons with mental illness and police can lead to a number of challenges for both police and individuals with mental illness. Police have described low levels of confidence, reported that they are inadequately equipped to deal with mental health crises, have had increased frustration associated with accessing health responses, and subsequently negative views regarding requirements of police in mental health related matters.[13] Significantly, a Victorian survey of police attitudes identified receiving support from mental health services as the most frequent challenge experienced by police.[14] Police frustration can translate to negative experiences for individuals with mental illness, their families and carers with various studies reporting individuals with mental illness have a pervasive fear of the police and a feeling of being victimised or unduly targeted.[15] They further reported that they felt police were fearful of them and that this fear could contribute to an escalation of the original situation.[16]

Challenges associated with accessing mental health services can be compounded if police and mental health service have different views about the level of mental health assistance required. For example, in Queensland, 74% of the total number of EEOs made in 2014/15 did not lead to the person requiring involuntary assessment under the Mental Health Act.[17] A proportion of these people will still have received treatment either through voluntarily engagement with mental health services, or a pre-existing involuntary status, while for the remainder the mental health service may assess the person as not requiring treatment or care from a mental health service. This assessment may contribute to police frustration if the person then has repeat contact with police for a matter that appears to be mental health related.

Notwithstanding that discrepancies between mental health and police assessments of treatment need may occur, generally police decisions to transport a person under mental health legislation appear to be appropriate. A study in Victoria for example, found that police made appropriate determinations about the need for hospital transfer under mental health legislation, with just over 75% of people admitted to a mental health service or determined to require psychiatric review following police transfer.[18] Further, it was found that almost all of the hospital transfers (~91%) occurred in the context of psychiatric crises and 94% related to persons with a diagnosed mental illness.[19]

Although police interactions with persons who may have a mental illness generally occur without incident, the prevalence of mentally ill persons involved in adverse outcomes related to police interactions is significantly higher than for persons without mental illness. For example, a Victorian data-linkage study found rates of schizophrenia and other psychosis were between 17.3 and 11.3 times higher for individuals fatally shot by police, than in the general community.[20] From 1989/90 to 2010/11, there were 105 persons fatally shot by

[12] Morgan et al., 2012
[13] Hails & Borum, 2003; Herrington et al., 2009
[14] Ogloff et al., 2013
[15] The Allen's Consulting Group (ACG), 2012; Herrington et al., 2009
[16] ACG, 2012
[17] QH, 2015
[18] Ogloff et al., 2013
[19] Ibid.
[20] Kesic, Thomas, & Ogloff, 2010

police nationally and of these, 44 (42%) were identified as having a mental illness.[21] This is likely to be a conservative estimate of the prevalence of mental health issues in police shootings as the rates are based on coronial inquest findings, and do not include circumstances where mental illness is not yet diagnosed or documented in available material.[22] While this may be an underestimate, it is important to also acknowledge that determinations by the coroner that a person had a mental illness is indicative of the presence of the illness only, and does not by itself, indicate that the person was unwell or displaying symptoms of mental illness at the time of police interaction.[23]

Police-related fatalities are a particularly concerning outcome of police involvement in mental health related crises in the community. Fatalities highlight, in the most tragic manner, the complex nature of mental health related calls responded to by police.[24] In 2014, a number of fatalities from police shootings occurred in Queensland, including fatalities involving persons known, or suspected, to have a mental illness.[25] Within the Queensland context, these adverse outcomes highlight the need to further enhance and develop collaborative processes across mental health and police to support effective responses in circumstances where persons with mental illness may be affected.

MENTAL HEALTH AND POLICE COLLABORATIVE MODELS

In response to the challenges experienced locally, nationally and internationally, police-mental health collaborative intervention models have begun to be implemented.[26] Various collaborative models exist across the United States, Canada, as well as in various jurisdictions in Australia (Victoria, NSW, Western Australia and the Australian Capital Territory). Models for collaboration discussed below include establishment of specialised co-responder teams, specialist police or mental health liaison officers, and integration of mental health clinicians within a police organisation. Each model has its advantages and challenges, but overall the introduction of any evidence-based specialised response lowers the use of arrest or police authority to manage mental health related matters.[27]

The first model is the Crisis Intervention Team (CIT) model that was first established in 1988 when the Memphis Police department partnered with the National Alliance on Mental Health, the University of Memphis and the University of Tennessee.[28] The CIT model utilises specially trained police officers who provide first line response to calls and act as liaisons to the mental health system. They receive approximately 40 hours of training and establish strong partnerships with local advocacy groups and health providers. In the United States, the use of CITs has led to reduced arrest rates, reduced use of force and it is considered to be a cost savings model.[29] In Australia, in 2008, NSW implemented a pilot project which was an adaption from the CIT model – titled the Mental Health Intervention Team.[30] Independent

[21] Australian Institute of Criminology (AIC), 2013
[22] Ibid.
[23] Ibid.
[24] Durbin, Lin, & Zaslavska, 2010; Schwarzfeld, Reuland, & Plotkin, 2008
[25] QH, 2015
[26] Butler, 2014
[27] Steadman, Deane, Borum, & Morrissey, 2000
[28] Hails & Borum, 2003
[29] Comptom, Bahora, Watson, & Oliva, 2008
[30] Butler, 2014

evaluations indicate that the MHIT is a promising evidence-based model that demonstrates effective responses.[31]

In contrast, the Birmingham model integrates mental health clinicians into a police organisation. Clinicians participate in a six week classroom and field training program and their role, in addition to responding to mental health calls, is to also respond to social service callouts like domestic violence, transportation, shelter, and other general assistance matters. The focus of the model is networking and maintaining professional relationships with community resources to provide the best possible response to crisis situations.[32] Evaluations of the program have identified challenges with this model relating to the availability of clinicians and the limited dedicated support from police services. However, positive aspects of the program have also been identified with up to two-thirds of mental health related calls received through the program in Birmingham being addressed in the community without the need for police transportation or coercive measures.[33]

The third model, the Crisis Assessment and Treatment Team (CATT) model, promotes the sole use of mental health professionals for responding to mental health crises. The major concern that has been identified with the CATT model is that it does not allow for collaboration between the police and mental health services. There are a number of risks associated with mental health clinicians operating alone in roles that have traditionally been undertaken by police. These risks include physical risks to clinicians, undermining of relationships between the police and mental health sector, and ethical issues for clinicians who may be required to use of force or coercion to achieve outcomes.[34] Research into police and mental health responses therefore generally advises against utilising mental health services in this way; instead research strongly supports collaboration between the criminal justice system, the mental health system and the community.[35]

The final model is the co-responder model which aligns with the research and promotes collaboration between services to ensure a multi-disciplinary response to mental health crises. A full-time police officer and a mental health clinician team are specifically employed, each with expertise and discipline specific knowledge to respond together to all mental health calls and provide strategies to reduce the risk to both police and individuals. In Australia, Victoria developed the PACER project in 2007 to mimic the United States co-responder models. Results from data collated between December 2009 and March 2011 indicated that 78% of contacts resulted in onsite advice or assessment, a reduction in police time, increase in ambulance transport and a decrease in the use of Emergency Departments from 83.5% to 33.9%.[36]

QUEENSLAND MODELS

Within Queensland, there are a number of existing collaborative models in operation:

- The Mental Health Intervention Program (MHIP) which was implemented statewide in 2005. The MHIP is a consultation liaison initiative between the QPS, QAS and

[31] Ibid; Herrington et al., 2009
[32] Butler, 2014
[33] Steadman et al., 2000
[34] Hatcher, Mohandie, Turner, & Gelles, 1998
[35] Steadman et al., 2000
[36] ACG, 2012; Butler, 2014

Queensland Health (QH) to manage various mental health issues in the community. The MHIP operates during business hours only to provide this consultation liaison service. As these positions are based within each Hospital and Health Service (HHS), program models differ with services and are determined at a local level.

- The Cairns HHS implemented a co-responder model in 2010. QPS data indicates that the Cairns co-responder team is responsible for one in three EEOs which is reducing demand on the QPS[37]. Further, this team also links directly with the QAS to improve responses to mental health crises in the community and minimise the need for hospital presentations.[38] In 2015, the Caboolture Hospital within the Metro North HHS introduced a similar co-responder model.
- The Queensland Fixated Threat Assessment Centre (QFTAC), based at QPS Headquarters in Brisbane, was implemented in 2013. QFTAC is a joint initiative between the QPS and the Queensland Forensic Mental Health Service (QFMHS) that identifies fixated individuals through their abnormal communications with public office holders. QFTAC mitigates the risk posed by these individuals, many of whom are seriously mentally ill but not receiving treatment, by linking them with mental health interventions and addressing other identified risk factors. Since fixated persons often pose a greater risk of harm to themselves and those around them, QFTAC also serves a public protection role.

The above Queensland models operate either within a single hospital or health service (e.g. co-responder, MHIP); for a dedicated and discrete purpose (e.g. QFTAC); or during business hours only (e.g. MHIP).

A number of police responses to mental health crises in the community in 2014 identified a gap in Queensland's mental health-policing models. In particular, these gaps related to information sharing and support for police responding to mental health crises after hours and on a statewide basis. The PCC MHL service was implemented in January 2015 as one mechanism to fill these identified gaps.

[37] Coolican, 2014
[38] QH, 2014

EVALUATION

SCOPE AND LIMITATIONS

The PCC MHL service has been operating for 14 months at the time of this evaluation (since January 2015). The evaluation was undertaken to determine the potential benefits or otherwise of the service and to make relevant recommendations in this regard.

The evaluation primarily considers the first 12 months of operation of the PCC MHL service from its commencement on 8 January 2015 to 31 December 2015. It should be noted however that due to recruitment matters, the service did not operate between 27 September 2015 and 28 October 2015 and as such there is no referral information included in the evaluation for this one month period.

This evaluation includes descriptive non-identifiable retrospective data, policy and procedural documents. Relevant data sources for the evaluation include the PCC MHL spreadsheet, the QH Consumer Integrated Mental Health Application (CIMHA) and the QPS Queensland Computer-Aided Dispatch (QCAD) system (described in detail below).

The evaluation used a descriptive evaluation methodology that was designed to describe and assess the effectiveness of the functions of the PCC MHL service in relation to:

- providing a mechanism for mental health and police information sharing in mental health crisis situations,
- providing a statewide service for mental health and police collaboration after hours; and
- enhancing responses by police and mental health services to persons with mental illness in the community.

OBJECTIVES

Objectives of the evaluation were to:

- describe, using aggregated data, the types and characteristics of calls referred by QPS to the PCC MHL service
- assess the volume of calls actioned by the clinicians and the extent to which the service provides statewide coverage
- assess the ability for information to be shared across mental health and police services through the PCC MHL service, and
- identify opportunities for training needs, model of service improvement, or expansion of the PCC MHL service.

The scope of the evaluation is limited to the PCC MHL service. The extent to which other QPS/QH collaborative models or interactions are operating effectively is outside of the scope of the evaluation. Notwithstanding the limited scope, where the evaluation identifies systemic issues, recommendations may be made in relation to these matters.

Due to the nature of the evaluation, a waiver for ethics consideration was sought from the Royal Brisbane and Women's Hospital Human Research Ethics Committee (RBWH HREC). An exemption from ethics approval was granted by the Chair, RBWH HREC on 7 December 2015.

METHOD

From commencement of the PCC MHL service in January 2015, data was collected by the clinicians to inform future evaluations and model of service development. Descriptive statistics about activity and outputs for the PCC MHL service were obtained to form an aggregated data extraction of the following data sources:

- *The PCC MHL spreadsheet* – an excel spreadsheet maintained by the PCC MHL clinicians that contains information about all referrals to the service.
- *The Consumer Integrated Mental Health Application (CIMHA)* – a clinical information system that records information about client[39] engagement with Queensland public mental health services. Relevant CIMHA data was provided by the Mental Health Alcohol and Other Drugs Branch within the Department of Health.
- *The Queensland Computer-Aided Dispatch (QCAD) system* – an information management system used by QPS to record and dispatch calls made for police assistance. Data from QCAD for the evaluation was provided by the Public Safety Business Agency within the QPS.

In addition to an analysis of the retrospective data, policy and procedural documents were also reviewed for the evaluation. Stakeholder consultation occurred with the clinicians working within the PCC MHL service and QPS officers working within the BPCC. From this consultation, a hypothetical case scenario has been developed to assist with demonstrating the roles and functions of the PCC MHL service (page 34).

Finally, senior officers from QH, the QPS and QAS were consulted about the service as the evaluation progressed to provide feedback, particularly in relation to identifying strategic matters relevant to the PCC MHL service and to provide oversight of evaluation activities.

[39] Throughout this report, the term client is used to describe individuals who have had, or are having, contact with mental health services.

PCC MHL SERVICE OVERVIEW

The PCC MHL service is a consultation liaison service that was established in January 2015 as an initiative across QH and the QPS. The PCC MHL service embeds mental health clinicians in the BPCC after business hours (after 16:00). The BPCC receives triple zero phone calls, organises first response officers and dispatches QPS crews. Regional QPS communication centres are able to access the PCC MHL service via the BPCC as required.

The PCC MHL service is part of the statewide QFMHS that aims to improve responses to people with a mental illness who are, or who may be, at risk of being engaged with the criminal justice system. The PCC MHL service consists of two dedicated full time clinical positions (HP4/ NRG6 and HP5/NRG7) supported by an on-call forensic psychiatrist based within the QFMHS (introduced in July 2015). Additional clinical support for complex referrals and for clinical case reviews is also provided as required by the Director, QFMHS or other forensic psychiatrists based within the QFMHS. Strategic work of the service, and administrative duties, are undertaken by the clinical positions.

The PCC MHL service aims to improve outcomes for individuals experiencing mental health crises in the community by increasing situational awareness for frontline QPS officers, enhancing mental health service responses and by facilitating improved mental health service and QPS collaboration. The PCC MHL service facilitates the provision of meaningful and timely mental health information, advice and assistance to the QPS on a statewide basis. Information and advice provide by PCC MHL clinicians to the QPS is respectful of an individual's confidentiality and is shared in accordance with an established Memorandum of Understanding. An important function of the PCC MHL service is to interpret relevant clinical information and provide this in a way in which it is useful for immediate use by QPS. Information provided to the QPS is meaningful for the immediate management of the individual including communication strategies and styles, triggers, and strategies for de-escalation and engagement with the individual.

The PCC MHL service operates through a consultation liaison framework and does not provide case management or primary service delivery. The PCC MHL service does not replace local responses but augments local service provisions and facilitates appropriate linkages across QPS and mental health services. A key role of the PCC MHL service is to provide linkages with local mental health services through early referrals and notifications of potential presentations and liaison regarding existing clients.

In addition to the information sharing aspect of the PCC MHL service, the service works in partnership with the QPS and mental health services in a strategic capacity to identify opportunities for effective mental health and police collaboration, education, training and procedures that contribute to improving client outcomes. A component of this strategic work is to evaluate the pilot PCC MHL service.

The PCC MHL service commenced operating as follows:

- Three nights per week on Thursday to Saturday from 4pm to midnight.
- On 14 April 2015, this was expanded to five after-hours shifts per week which is the current operating capacity of the service. These shifts cover Tuesdays and Wednesdays (17:00 to 22:00) and Thursday to Saturday (16:00 to midnight).

GOVERNANCE

As part of the statewide QFMHS, the PCC MHL services reports to the Operations Manager and Director of the QFMHS. The operation of the service is supported by a governance framework that includes clinical review processes, escalation pathways and a strategic oversight committee.

During shift periods when the PCC MHL clinicians are situated in the BPCC, an on-call psychiatrist is available to provide clinical support and provide advice in relation to referrals. In general, the on-call psychiatrist is only contacted when the matter is particularly complex or high profile (e.g. a siege) or where the matter falls outside the intended scope of the PCC MHL clinician's role, for example where the matter does not meet the information sharing requirements for the clinician and additional authority needs to be sought to release information.

In addition to being available during shift periods, the on-call psychiatrist (or a forensic psychiatrist based within the QFMHS) also attends the weekly PCC MHL Clinical Review Meeting. At this meeting, all cases referred to the PCC MHL service are reviewed by a multi-disciplinary team consisting of the PCC MHL clinicians, the Operations Manager, QFMHS and the on-call psychiatrist. The review process includes discussing the reason for referral, the actions taken by the PCC MHL clinician, outcomes and follow up actions required. Each review outcome is documented on CIMHA as appropriate.

The review meetings also provide an opportunity for challenges to be identified, both at an individual level for the relevant referral and for strategic matters relevant to the operation of the PCC MHL service. When operational challenges relevant to the regular operations of the PCC MHL service are identified, these may be referred to the Operations Manager, QFMHS for consultation and discussion with the Inspector-Manager, BPCC as required.

The final governance process for the PCC MHL service that has been established is a steering committee comprised of senior QH and QPS executive officers. The purpose of this committee is to provide expert clinical and strategic advice to inform the model of service; provide direction in relation to the evaluation of the PCC MHL service and to provide a forum for discussion and resolution of matters arising across QH and the QPS where resolution at officer level has not been reached.

RECOMMENDATION

- *The above governance structures, including roles, responsibilities and oversight processes should be documented and embedded within the model of service for the PCC MHL service.*

LEGISLATION, POLICY AND PRACTICE GUIDELINES

The primary legislative instruments relevant to the PCC MHL service are the Mental Health Act and the *Hospital and Health Boards Act 2011*. The *Information Privacy Act 2009*, insofar as it provides that health agencies must comply with the National Privacy Principles, is also a relevant legislative instrument for the PCC MHL service.

THE *MENTAL HEALTH ACT 2000*

The Mental Health Act establishes a legislative framework for the provision of involuntary treatment and care of persons with a mental illness. The Act provides mechanisms for persons in the community (including custodial settings) to be involuntarily assessed, treated and detained in an authorised mental health service (AMHS). The Act also provides processes for persons charged with an offence who have a mental illness or an intellectual disability to be diverted away from the criminal justice system through the making of forensic orders.

The Mental Health Act empowers police to act in relation to persons with a mental illness through a number of mechanisms, the most relevant of which are outlined below:

- Emergency Examination Order (EEO) – Police may make an EEO for a person if there is a reasonable belief the person has mental illness and there is an imminent risk of significant physical harm to the person or others. An EEO provides authority for the police to take the person to an AMHS for involuntary detention and examination.
- Justices Examination Order (JEO) – Police may detain a person subject to a JEO (an involuntary examination order) at the place where the person is being examined if requested by a doctor or authorised mental health practitioner.
- Transportation – Police are empowered under the Mental Health Act to transport involuntary patients[40] under a range of circumstances. Police may act alone to return patients from the community to an AMHS under an *Authority to Return*, or alternatively they may act in conjunction with a health practitioner if police assistance is requested.

THE *HOSPITAL AND HEALTH BOARDS ACT 2011*

The Hospital and Health Boards Act provides the primary legislative authority under which the PCC MHL clinicians can access and disclose, under relevant circumstances, clinical information. Part 7 of the Hospital and Health Boards Act outlines the circumstances when confidential information may be disclosed by designated persons, which includes health service employees and health professionals engaged in delivery a public sector health facility. These 'confidentiality' provisions apply to the PCC MHL clinicians working within the BPCC.

The Hospital and Health Boards Regulation 2012 prescribes the *Memorandum of Understanding between the State of Queensland through Queensland Health and the State of Queensland through the Queensland Police Service, Mental Health Collaboration 2011* which is pertinent to the operation of the PCC MHL service.

MOU – MENTAL HEALTH COLLABORATION (2011)

In conjunction with the provisions of the Hospital and Health Boards Act, this MOU enables the PCC MHL clinicians to provide health information to QPS as part of the PCC MHL service. In general terms, this MOU permits the disclosure of confidential information by

[40] An involuntary patient includes a person liable to be detained under a Request and Recommendation, a person subject to an involuntary treatment order, a forensic order or the classified patient provisions of the Mental Health Act.

delegated QH staff in circumstances where there is a mental health crisis situation; and to facilitate the development and implementation of Crisis Intervention Plans[41].

Relevantly, the Mental Health Alcohol and Other Drugs Branch is undertaking a review of this MOU. The PCC MHL clinicians and QFMHS have been consulted throughout this review process to ensure that the information sharing circumstances that occur for the PCC MHL service continue to be appropriately reflected in the MOU.

PCC MHL SERVICE PRACTICE GUIDELINES

Practice guidelines have been developed that articulate the purpose, functions, legislative obligations, and record keeping requirements of the PCC MHL service. The referral pathway and potential outcomes is outlined in Figure 1.

RECORD KEEPING AND INFORMATION SYSTEMS

The PCC MHL clinicians work across two primary QH information systems; the PCC MHL spreadsheet and CIMHA. The clinicians also source information from HHS Integrated Electronic Medical Records (ieMR) and the Viewer, a read-only application that displays consolidated clinical information sourced from a number of existing QH systems.

The PCC MHL spreadsheet in particular provides an essential overview of referrals to the PCC MHL. Both health information (patient details, CIMHA client number, diagnosis, etc.) and police information (QCAD number and outcome) is recorded on this spreadsheet. This cross-agency information enables efficient data-linking to occur as required across QH and QPS. Throughout the first 12 months of operation of the PCC MHL service, this spreadsheet was refined and amended to add new or refine existing data fields.

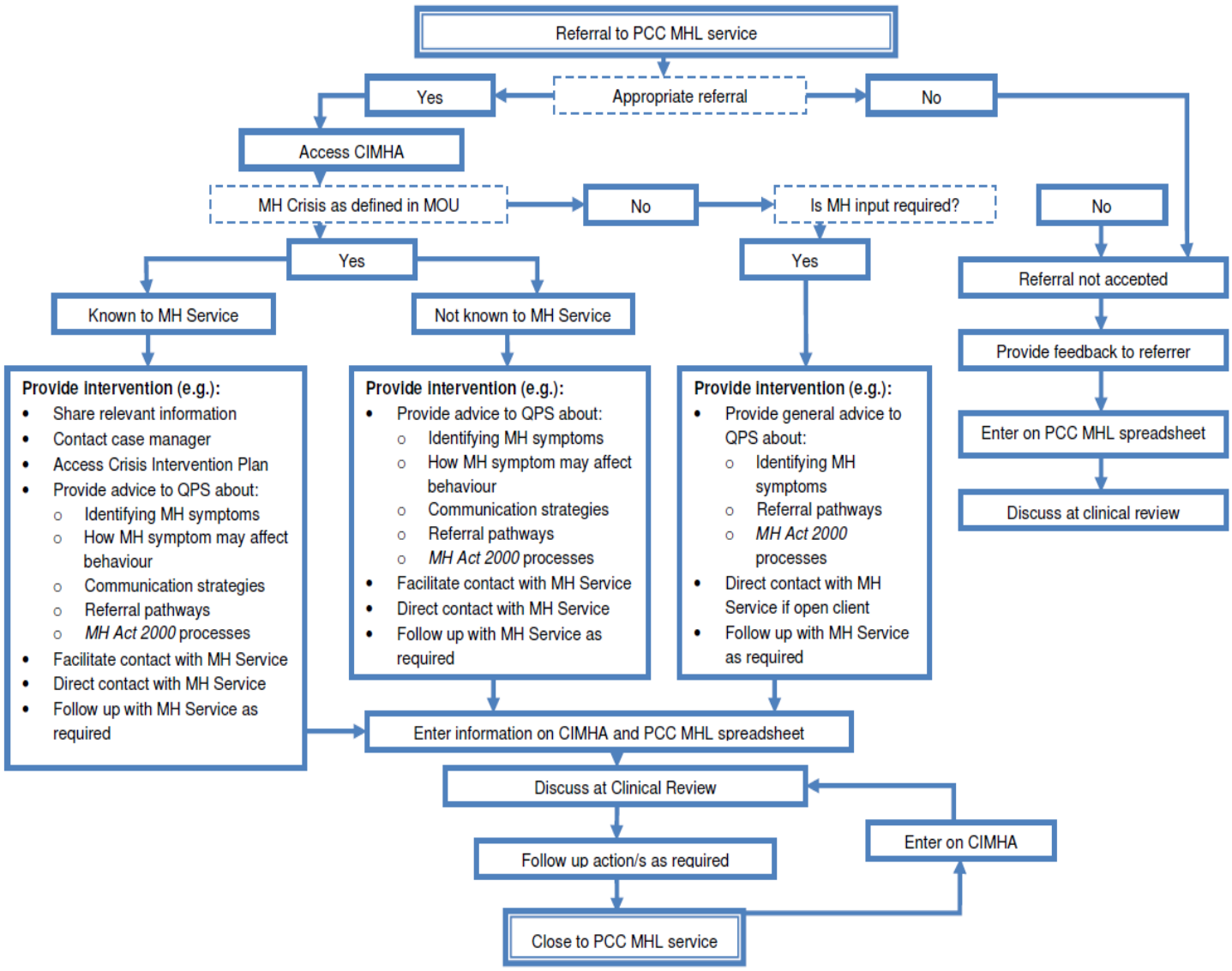
In addition to recording specified data in the PCC MHL spreadsheet, the clinicians may also record free-text notes on referrals. Free-text notes have been used to identify particular challenges or factors that have worked well, in order to inform the evaluation and model of service development.

The QPS also records information relevant to the PCC MHL service in the QCAD system. Generally, a referral to the PCC MHL is accompanied by a print out of the relevant QCAD record which includes pertinent information for the PCC MHL clinicians, including demographic information, location, presenting problem (as recorded by the call-taker) and mental health flags (as recorded within the QPS database). Enhancements have been made to the QCAD system to support the implementation of the PCC MHL service.

Access to multiple systems ensures that a large amount of information can be obtained in order to support responses to mental health crises occurring in the community. However, working across these multiple systems also requires a significant amount of consolidation to be undertaken by the PCC MHL clinicians prior to providing advice to the QPS. Where information is not able to be easily sourced due to variation in HHS practices and requirements, this can create complexities and delay responses.

[41] Refer Page 35.

FIGURE 1. PCC MHL SERVICE REFERRAL PATHWAYS

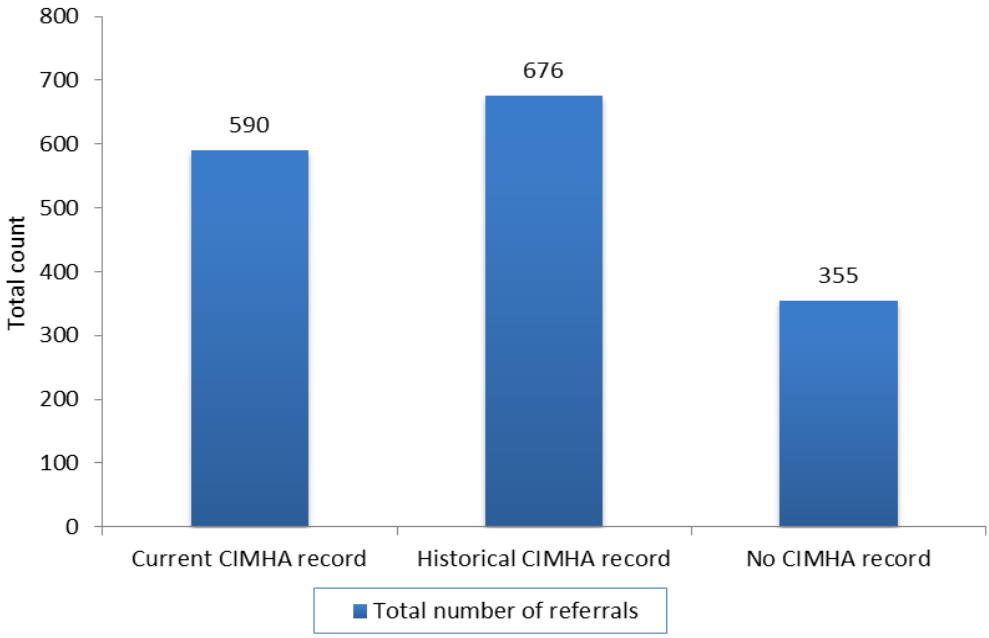


EVALUATION FINDINGS

OVERALL SERVICE USE

From 8 January 2015 to 31 December 2015, there were 1621 referrals to the PCC MHL service[42]. The majority or referrals (78%) related to matters involving individuals with either historical or current contact with mental health services. This data is outlined in Figure 2.

FIGURE 2. NUMBER OF REFERRALS (8 JANUARY 2015 TO 31 DECEMBER 2015)



The referrals related to 1,431 distinct individuals, of which 1,145 (80%) had prior or current mental health service contact. While most referrals to the PCC MHL service related to new individuals each time, there were a number of clients who were referred to the service on multiple occasions (range 1 to 13).

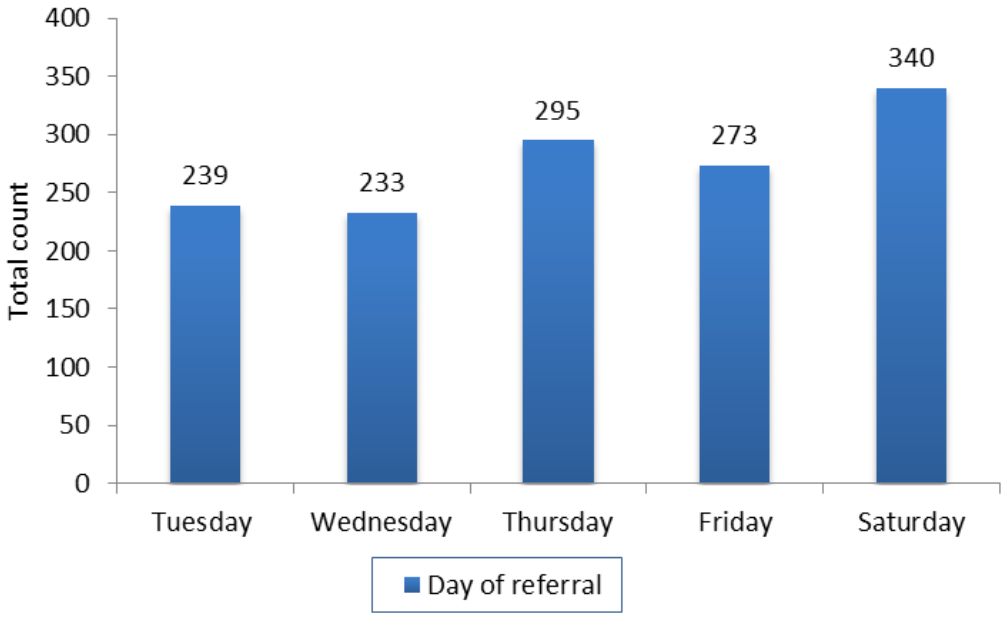
Of the 590 referrals relating to clients who had a current CIMHA record, 28% (n = 167) were subject to involuntary provisions of the Mental Health Act. Of the involuntary patients, approximately 80% were on an involuntary treatment order, 12% were subject to involuntary assessment documents and 8% were on a forensic order.

PEAK PERIODS

On 14 April 2015, the PCC MHL service expanded from three nights per week to five nights (Tuesday to Saturday evening shift). Data collected from 14 April 2015 to 31 December 2015 (n = 1391) indicates that in terms of numbers of referrals, Saturday and Thursday evenings appear to be the busiest shifts (Figure 3). However, overall the number of referrals received each night is reasonably consistent.

[42] As outlined earlier, the PCC MHL service did not operate between 27 September 2015 and 28 October 2015 and therefore data was not collected for this period.

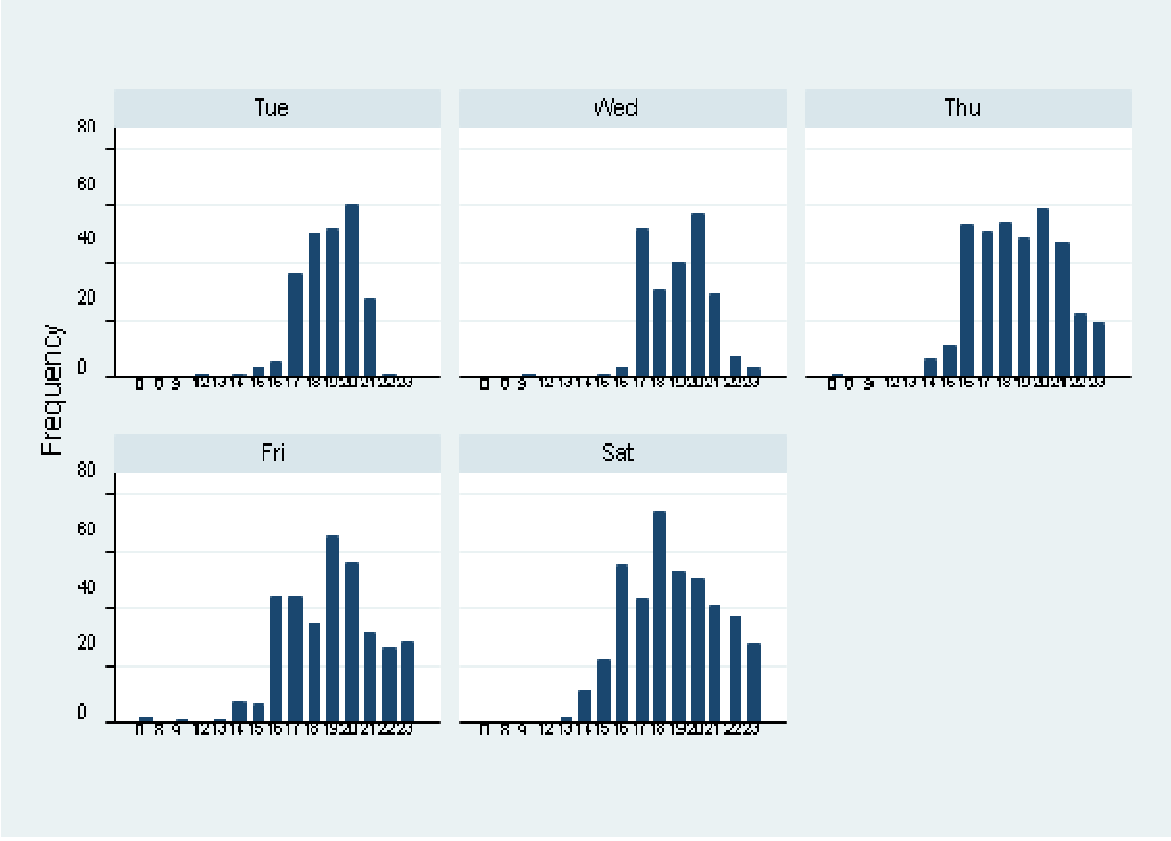
FIGURE 3. REFERRALS BY DAY (14 APRIL 2015 TO 31 DECEMBER 2015)*



11 referrals related to calls received on Sunday or Monday and have been excluded

In terms of peak times during PCC MHL service shifts, Figure 4 demonstrates that there is a reasonably consistent throughput of referrals, regardless of the day of the week.

FIGURE 4. REFERRALS – TIME OF CALL BY DAY OF WEEK (14 APRIL 2015 TO 31 DECEMBER 2015)*



* Tuesday and Wednesday shifts end at 22:00

REFERRAL CHARACTERISTICS

The primary reason for referral to the PCC MHL service was that the person was experiencing a mental health crisis (82%). In the remaining cases, the referral reason included requests for information or general advice regarding the mental health system or mental health matters (11%), clinical advice (3%), assistance regarding Mental Health Act processes (3%) or matters requiring liaison with mental health services (1%).

CALL TYPES

All calls to the BPCC are coded with an initial call type by the call taker. QPS data about initial call types was provided for 1514 referrals to the PCC MHL service (between 8 January 2015 and 31 December 2015) where the QCAD code was recorded in full by the clinician.

The majority of referrals to the PCC MHL service were initially coded as 'Personal Trauma' (68%). This QCAD grouping includes:

- attempting/threating suicide (59%)
- mentally ill person (8%)
- suicide (~1%), and
- sudden death (n = 6).

Figure 5 describes the initial call types for referrals to the PCC MHL service in the Personal Trauma type. Figure 6 describes the remaining category of initial call types (32%, n = 480) for calls referred to the PCC MHL Service.

FIGURE 5. REFERRALS – INITIAL CALL TYPE (PERSONAL TRAUMA CODES)

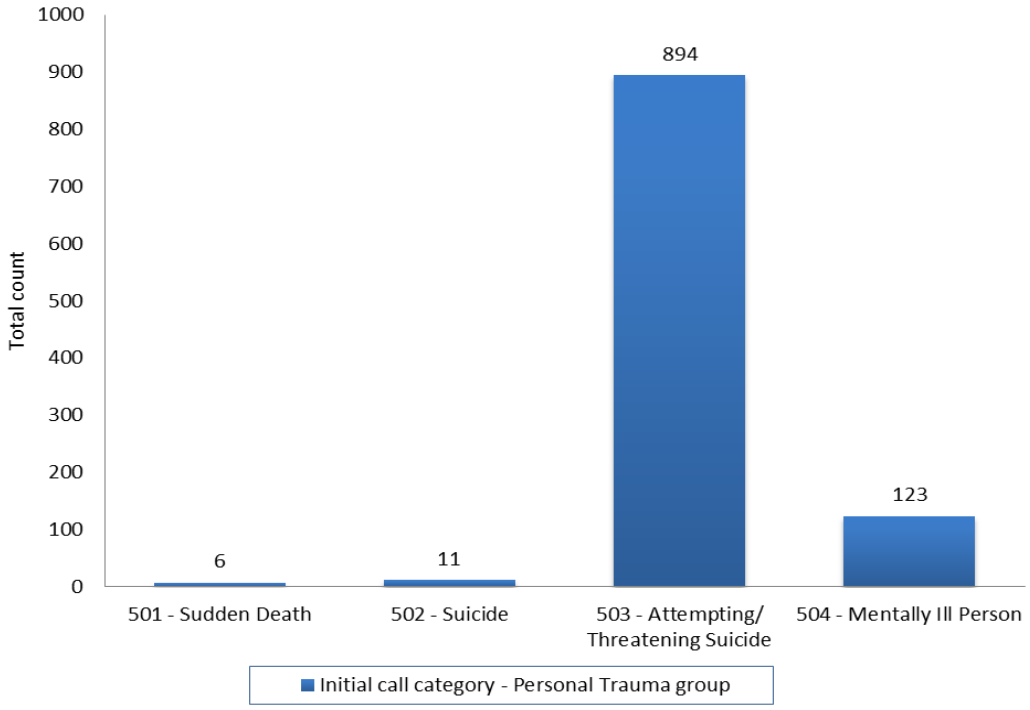
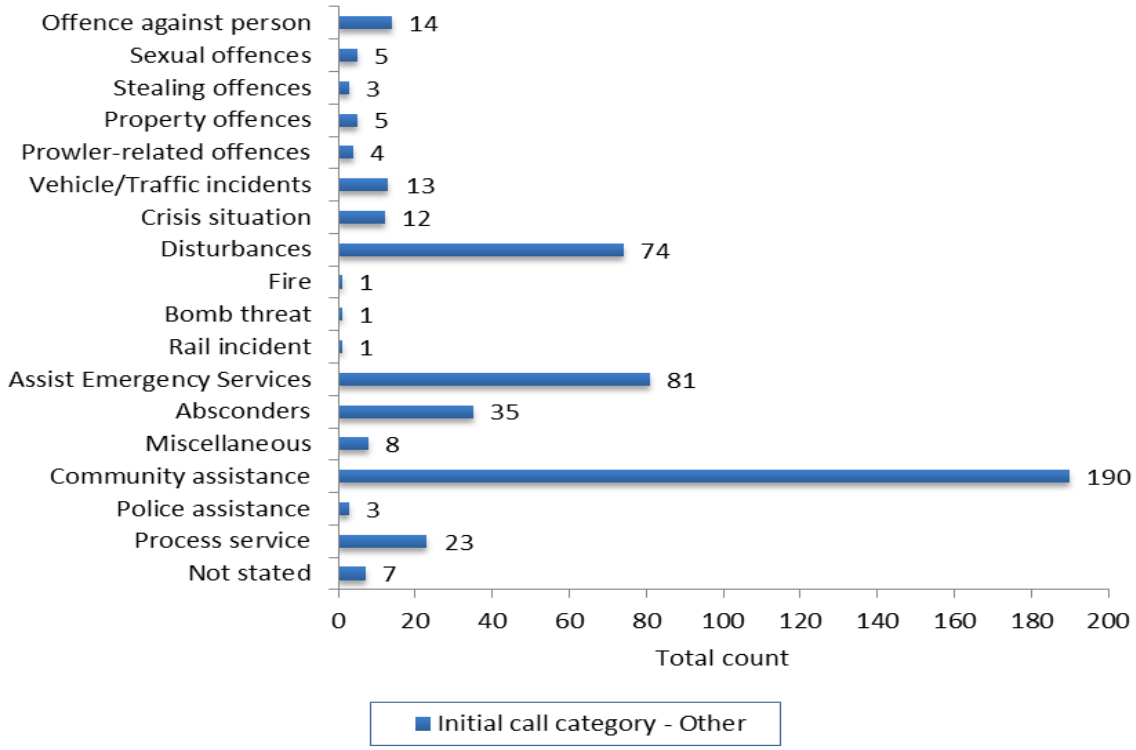


FIGURE 6. REFERRALS – INITIAL CALL TYPE (OTHER)



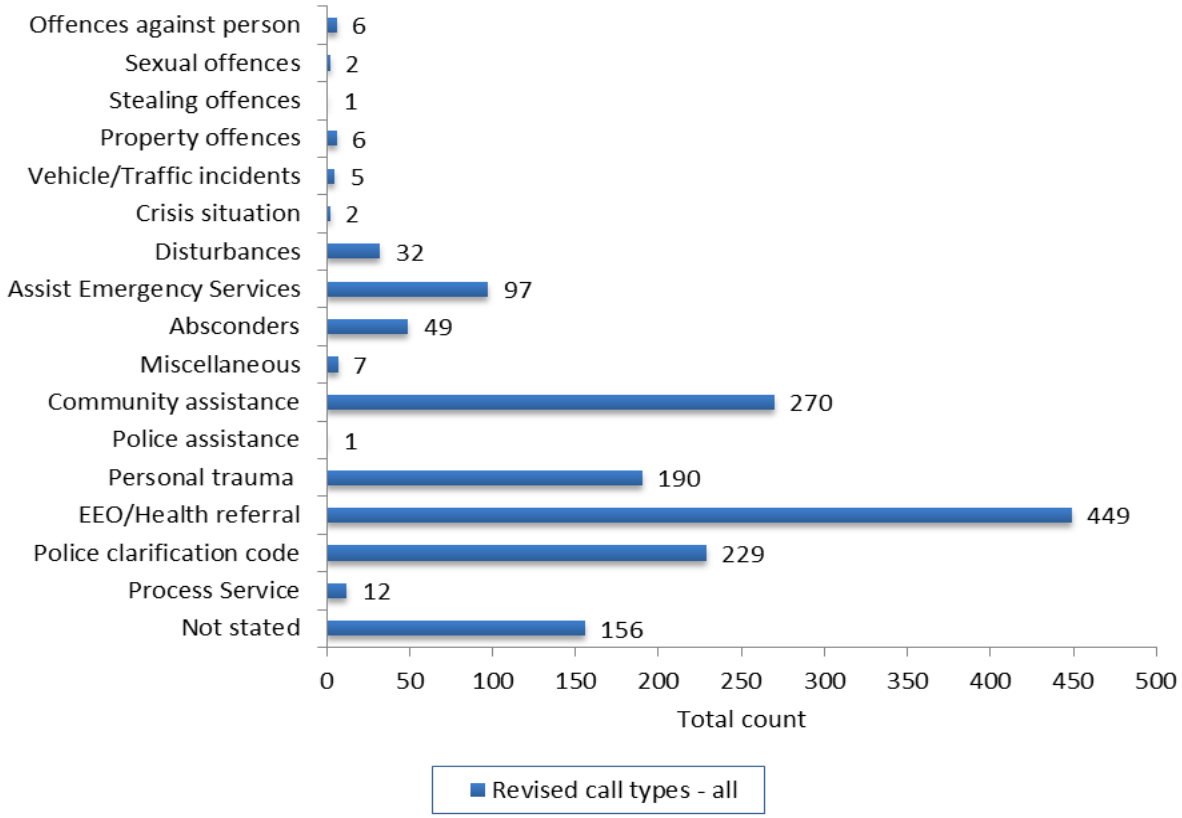
For each referral to the PCC MHL service, the clinicians reviewed the QCAD information and also recorded a primary presenting problem, and for some cases a secondary presenting problem (~8%, n = 126). The presenting problem was recorded based on a revision of the QCAD information and assessment by the clinician of the likely concern. Consistent with the QCAD call types, the majority of referrals were assessed by the PCC MHL clinician as having a primary presenting concern related to a suicide attempt or self-harming (~64%).

REVISED CALL TYPES

Caller codes in QCAD may be subsequently revised based on further information. The revised call type may be the same as the initial call type, or may be changed to a new category based on the events that have occurred during the incident. For example, while the majority of initial call types referred to the PCC MHL service have been coded as attempting/threating suicide, the majority of revised call types relate to EEOs or other referrals to health services (~30%, n = 449). The revised call type for all referrals made to the PCC MHL service with a recorded QCAD (n = 1514) are detailed in Figure 7.

As demonstrated from the referral call codes, during the first 12 months of operation, the PCC MHL service has received referrals relating to a wide range of initial call types that generally fall within the referral category of mental health crisis. The broad nature of referrals to the PCC MHL service however has meant that, at times mental health assistance was not required, or the referral did not meet the criteria for a mental health crisis which would enable relevant clinical information to be shared in accordance with the Mental Health Collaboration MOU.

FIGURE 7. REFERRALS – REVISED CALL TYPE (ALL)



REFERRAL PRIORITISATION

The PCC MHL clinician's action eight calls per shift on average; however there is a large degree of variability regarding the amount of referrals able to be completed, ranging from one or two complex referrals to more than 25 referrals in one shift.

In early 2016, in order to assist with prioritising calls that may be referred to the PCC MHL clinicians, the QPS implemented a filter process within QCAD for SDOs to monitor relevant QCAD incidents. This filter process includes the following QCAD codes:

301 – Armed Person
302 – Siege
305 – Hostage Taken
502 – Suicide
503 – Attempting/Threatening Suicide
504 – Mentally Ill Person
513 – QAS
522 – Absconder Hospital/Institution
524 – Missing Person
716 – Authority to Return
840 – Queensland Health Referred

Through the implementation of a filter process, the SDO has visibility over incidents that could reasonably be referred to the PCC MHL service which has improved prioritisation and referral processes. In addition to this filter process, the SDO is required to prioritise calls which may be referred to the PCC MHL service. Although this process has assisted with prioritising referrals, the PCC MHL input into the triaging process currently occurs on an ad-hoc basis.

Given the degree of variability in the number of calls able to be actioned each shift, a number of strategies could be implemented to assist with prioritising calls and ensuring the most effective and efficient use of the PCC MHL service. These strategies could include reviewing the process of referral and triage by the SDO and incorporating a clinical triage process in the PCC MHL model of service. The SDO and clinician triage process needs to occur in parallel and in a collaborative manner to ensure the referrals that can be actioned each shift are, as far as possible, reflective of priorities from both a QPS and mental health perspective.

Additionally, the PCC MHL model of service should also detail the CIMHA and documentation requirements that must be undertaken by the PCC MHL clinicians for each referral. Given that referrals decrease towards the end of each shift (refer Figure 4) as jobs are finalised, an opportunity exists for a period of each shift to be 'quarantined' to enable the PCC MHL clinician to ensure all documentation and follow-up processes are completed by the end of each shift. This should, as far as possible, include seeking feedback from the SDO about the outcome of the job from a QPS perspective, as well as cross-checking the jobs that the QPS and the PCC MHL service recorded as being actioned throughout the shift.

As with all triage and prioritisation processes, there must however be a recognition within the PCC MHL service and the QPS that urgent or extreme situations may arise (e.g. a particularly complex or resource intensive referral), and that any quarantine periods may not be able to be adhered to in all circumstances. It is important that the model of service for the PCC MHL clinician document the recommended processes and note that these may change, as determined by the clinician or in consultation with the SDO as necessary to ensure the best and most productive use of clinical support of police through the PCC MHL service.

RECOMMENDATIONS:

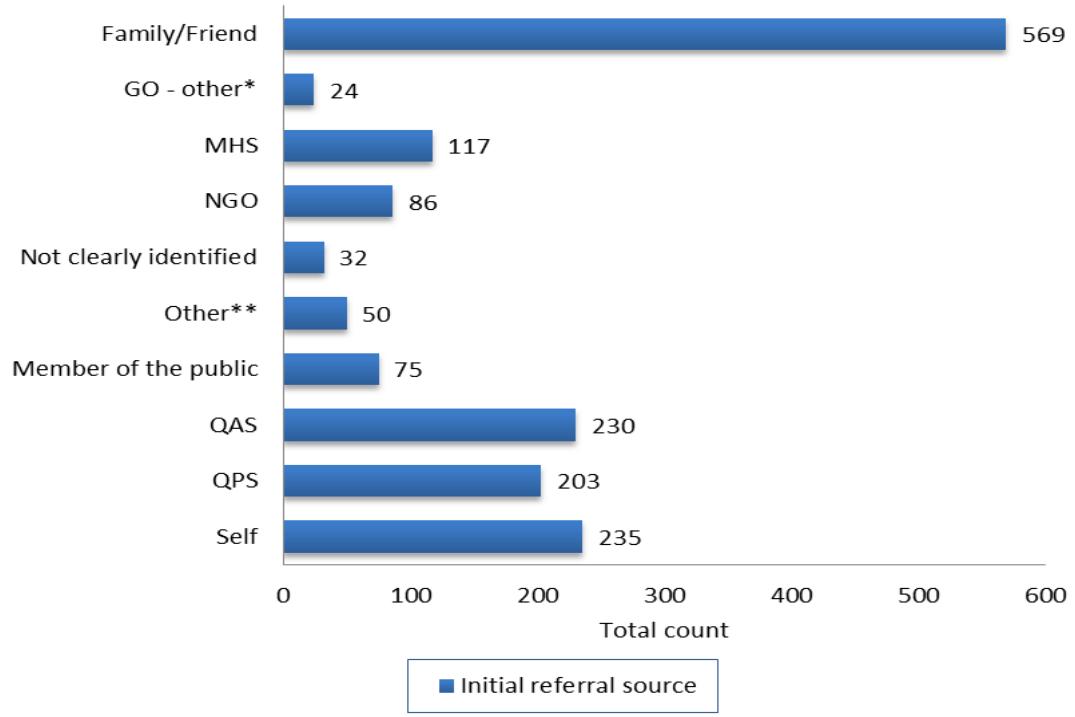
- *The model of service should identify clear referral pathways and strategies to ensure appropriate referrals to the PCC MHL service. These strategies should include incorporating a clinical triage process for the PCC MHL clinicians that works in conjunction with the process of referral by the State Duty Officer (SDO).*
- *To ensure consistent and auditable practices, the model of service should detail the documentation requirements (e.g. CIMHA records and agreed protocols for corresponding with local mental health services) that must be undertaken by the PCC MHL clinicians for each referral.*

REFERRAL SOURCES

The PCC MHL service receives referrals from the SDO who coordinates incoming calls to the BPCC. Initially, the clinicians were co-located with call-takers and referrals also came directly from call-takers without SDO oversight. However, following a refurbishment of the BPCC which included designated office space and hardwiring to the QH network for the PCC MHL clinicians, referrals have, generally, been coordinated by the SDO.

For all referrals to the PCC MHL service, the clinicians have documented the original source of the call for QPS assistance (Figure 8). The majority of calls for police assistance referred to the PCC MHL service were from family or friends (35%).

FIGURE 8. INITIAL SOURCES OF REFERRALS TO PCC MHL SERVICE



**GO - other includes Queensland Fire and Rescue, Queensland Rail, Probation and Parole, Child Safety*
***Other includes GP, private psychologist, private psychiatrist, employers, and insurance companies*

REFERRAL DEMOGRAPHICS

AGE AND GENDER

Referrals to the PCC MHL service related to individuals aged 8 to 92, with an average age of 35. Ten percent of referrals were for children or adolescents (n = 168). Further detail regarding key findings relevant to young people (below 18) is detailed at page 37.

As outlined in Table 1, the gender distribution of referrals was slightly skewed towards males.

TABLE 1. GENDER DISTRIBUTION OF REFERRALS

	Count	Percentage
Male	865	53.4
Female	749	46.2
Not stated	7	0.4
Total	**1621**	**100**

INDIGENOUS STATUS

Table 2 outlines the percentage of referrals to the PCC MHL service where the CIMHA record indicated that the person identified as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander[43]. Although Indigenous status on each person's CIMHA record was checked and recorded where the person had a current or prior CIMHA record, it should be noted that this data is not necessarily an accurate reflection of Indigenous status. Issues impacting on the data integrity include that the treating team may not be aware that the person identifies as Indigenous, data entry issues may have occurred, or the person may not have had sufficient contact with the service to enable the information to be obtained (e.g. the referral may have just been opened).

Notwithstanding these limitations, the majority of referrals related to individuals who did not identify as Indigenous (Table 2). Further specific findings are outlined at page 38.

TABLE 2. REFERRALS BY INDIGENOUS STATUS

	Count	Percentage
Aboriginal	88	5.43
Torres Strait Islander	16	0.99
Both Aboriginal and Torres Strait Islander	3	0.19
Neither	1217	75.08
Not stated*	297	18.32
Total	**1621**	**100**

** Includes new CIMHA records opened by the PCC MHL service (e.g. where there was no prior CIMHA record)*

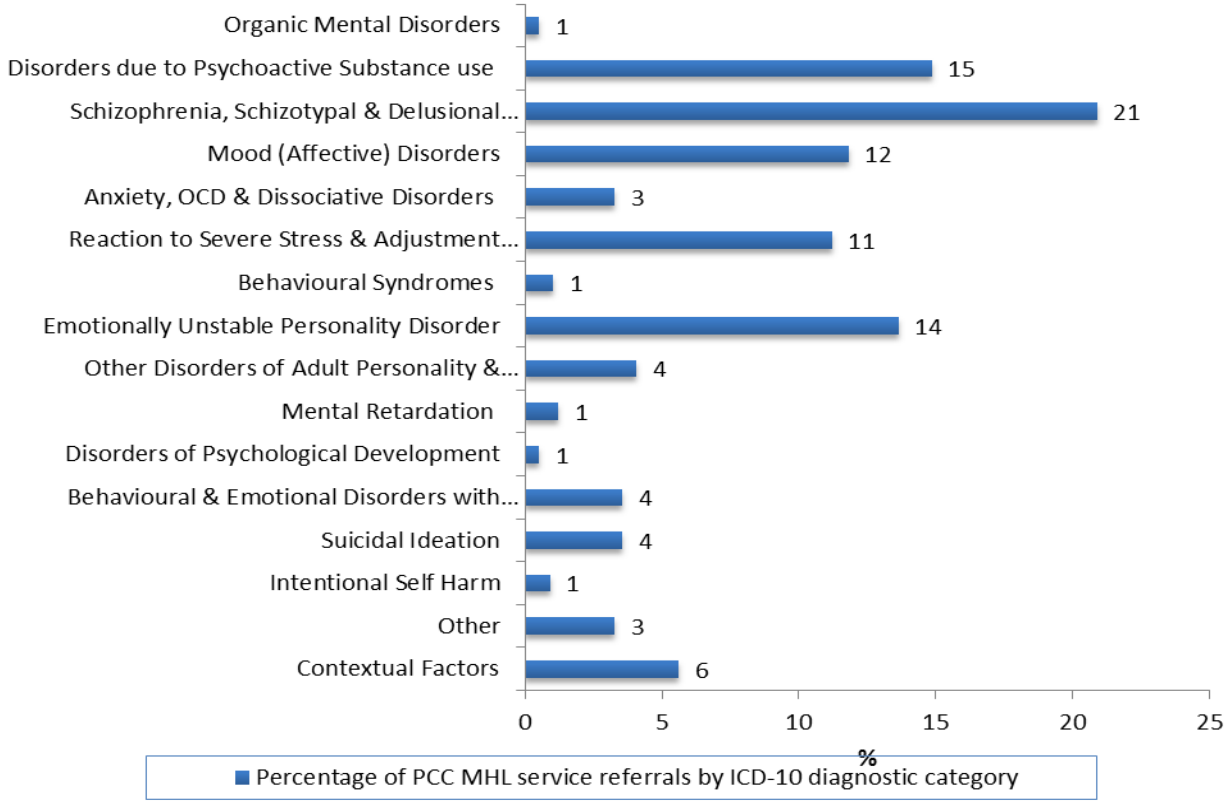
DIAGNOSIS

For referrals to the PCC MHL service that related to a person with a prior or current CIMHA record (n = 1266), the person's most recent primary and secondary diagnosis, as documented in CIMHA, was recorded on the PCC MHL spreadsheet. Figure 9 provides the CIMHA primary diagnosis for these referrals by percentage.

Referrals to the PCC MHL service consisted primarily of clients with schizophrenia, schizotypal and delusional disorders; mental and behavioural disorders due to psychoactive substances; and personality (emotionally unstable) disorders.

[43] Throughout the remainder of this report, the term 'Indigenous' is used to refer to individuals who identify as Aboriginal and/or Torres Strait Islander.

FIGURE 9. CIMHA DIAGNOSIS FOR CURRENT OR HISTORICAL CLIENTS REFERRED TO THE PCC MHL SERVICE (BY PERCENTAGE*)



**Percentages have been rounded to be presented as whole numbers.*

A significant proportion (~18%) of current or historical clients of mental health services referred to the PCC MHL service did not have a recorded primary diagnosis. Further, a secondary diagnosis was not recorded in CIMHA for 48% of current or former clients. This finding may be explained, in part, by the number of records on CIMHA where an 'open service episode' was not commenced, rather the contact with mental health services was limited only to a referral, and then no further engagement with the service was required. However, the PCC MHL clinicians also utilised clinical notes within CIMHA to source diagnostic information. When clinical notes were used, a primary diagnosis was available for almost 85% of clients, with nil diagnosis noted only in 15% of cases. Although a crude estimate, this indicates that in almost 40 open cases on CIMHA, a primary diagnosis has not been recorded.

For the PCC MHL clinicians, the additional time required to search through clinical notes for a valid diagnosis can create unnecessary delays in responding to QPS requests for information. In circumstances where this arises, feedback should be provided by the PCC MHL service to the treating team responsible for the client's ongoing care.

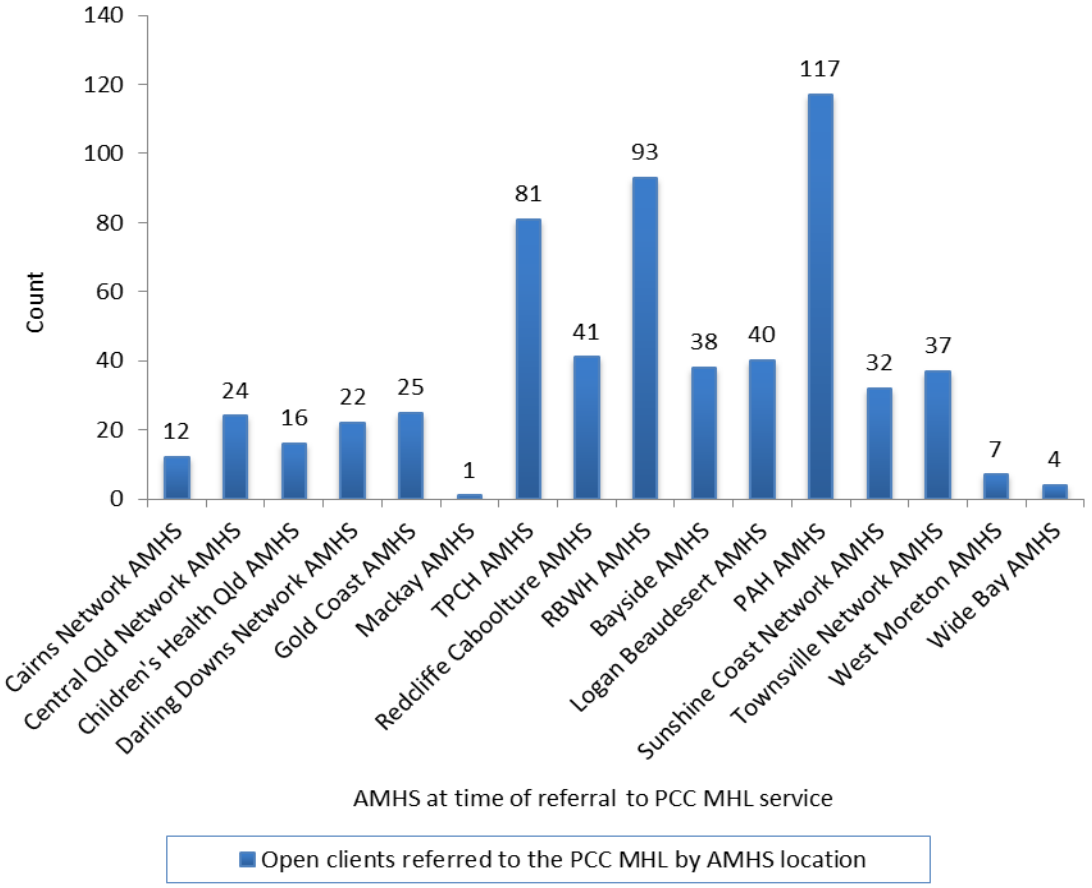
Recommendation

- *Clear feedback process to mental health services should be developed and incorporated into the PCC MHL model of service. This includes processes for providing advice to the treating team responsible for a client's ongoing care where a valid diagnosis is not recorded in CIMHA.*

LOCATIONS

Although located within the BPCC, the PCC MHL service provides statewide after hours coverage. The SDO in charge can refer matters from regional QPS communications centres to the PCC MHL service as required. For clients who are currently open to mental health services at the time of the referral to the PCC MHL service, details regarding which AMHS the client is linked to is important information that the PCC MHL clinicians can share with the QPS, and enables the clinicians to liaise with the client's current principal service provider where follow up care is required. The treating AMHS for each open client was recorded on the PCC MHL spreadsheet to track the statewide impact of the service (Figure 10).

FIGURE 10. TREATING AMHS FOR OPEN CLIENTS (N=590) REFERRED TO THE PCC MHL BETWEEN 8 JANUARY 2015 AND 31 DECEMBER 2015



Clients who were open to mental health services at the time of the referral were linked to the following services:

- Community Care Team (38%)
- Acute Care Team (34%)
- Child and youth mental health teams (11%)
- Inpatient units (9%)
- Homeless Health Outreach Teams (3%), or
- other teams such as older person's mental health, Mobile Intensive Rehabilitation Teams, consultation liaison, or dual diagnosis services (6%).

OUTCOMES

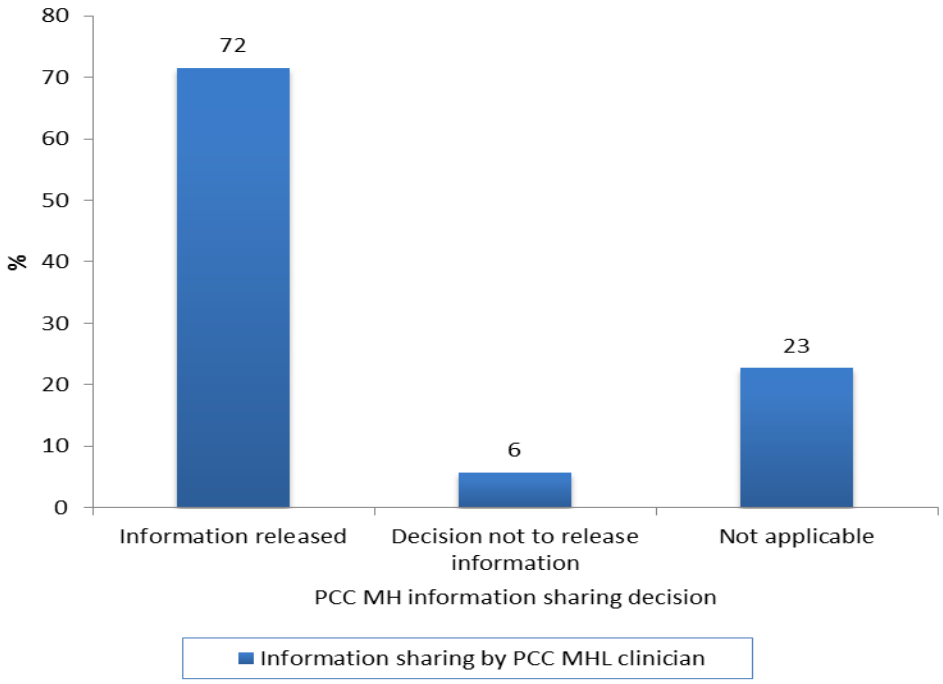
The PCC MHL service aims to improve outcomes for individuals experiencing mental health crises in the community by increasing situational awareness for frontline QPS officers, enhancing mental health service responses and by facilitating improved mental health service and QPS collaboration. By achieving this aim, the PCC MHL service also contributes to the delivery of efficient and effective services by the QPS and mental health services. The outcomes detailed below for clients referred to the PCC MHL service consider this aim and describe the extent to which the PCC MHL service achieved this aim during the evaluation period (8 January 2015 to 31 December 2015).

INFORMATION SHARING

In approximately 72% of all referrals made to the PCC MHL service, information was shared with the QPS by the clinician (Figure 11). For almost 6% of referrals, a decision was made by the PCC MHL clinician that no relevant information was available to share with the QPS about the particular individual who had been referred. This includes referrals where information sharing was not required because the job had been completed prior to the PCC MHL service becoming involved.

For the remaining referrals, there was no relevant or applicable information to be shared with the QPS. These cases primarily relate to referrals for clients who had no current or prior CIMHA history or referrals that did not include sufficient demographic information to conduct a search on CIMHA. This aligns with the number of referrals made to the PCC MHL service where the person did not have a current or prior history on CIMHA (22%). This finding is consistent with the PCC MHL clinicians ensuring that information shared with the QPS is provided in accordance with the provisions of the Mental Health Collaboration MOU.

FIGURE 11. PERCENTAGE OF REFERRALS TO THE PCC MHL SERVICE WHERE INFORMATION WAS SHARED*



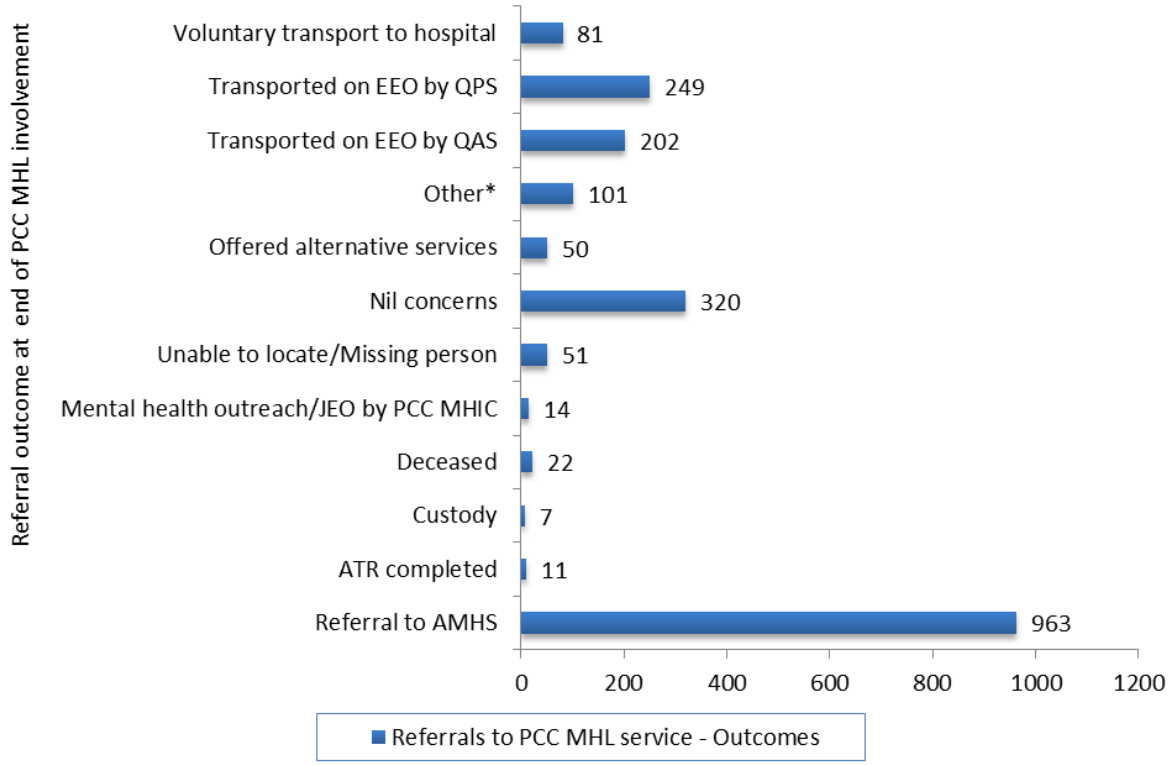
Percentages have been rounded up to be presented as whole numbers.

REFERRAL OUTCOMES

Outcomes data for the evaluation was collated using QPS feedback and follow up by the PCC MHL service of client pathways through the mental health system. Additionally, data was extracted from CIMHA for all clients with a CIMHA record who were referred to the PCC MHL service between 8 January 2015 and 31 December 2015.

At the end of each shift (or the next business day), the PCC MHL clinicians received feedback from the QPS about outcomes of matters referred to the clinicians (e.g. QPS transport to hospital, nil concerns, etc.). This feedback was recorded in the PCC MHL spreadsheet, together with outcomes known by the PCC MHL clinicians through follow up with the mental health service (e.g. JEO or mental health outreach) or as recorded in CIMHA. Figure 12 details these outcomes.

FIGURE 12. OUTCOMES FOR MATTERS REFERRED TO THE PCC MHL SERVICE**



**Other includes referrals where the patient was already within hospital grounds, hoax calls, the person was located interstate, and referrals that were unable to be accepted due to limited information.*
***More than one may apply*

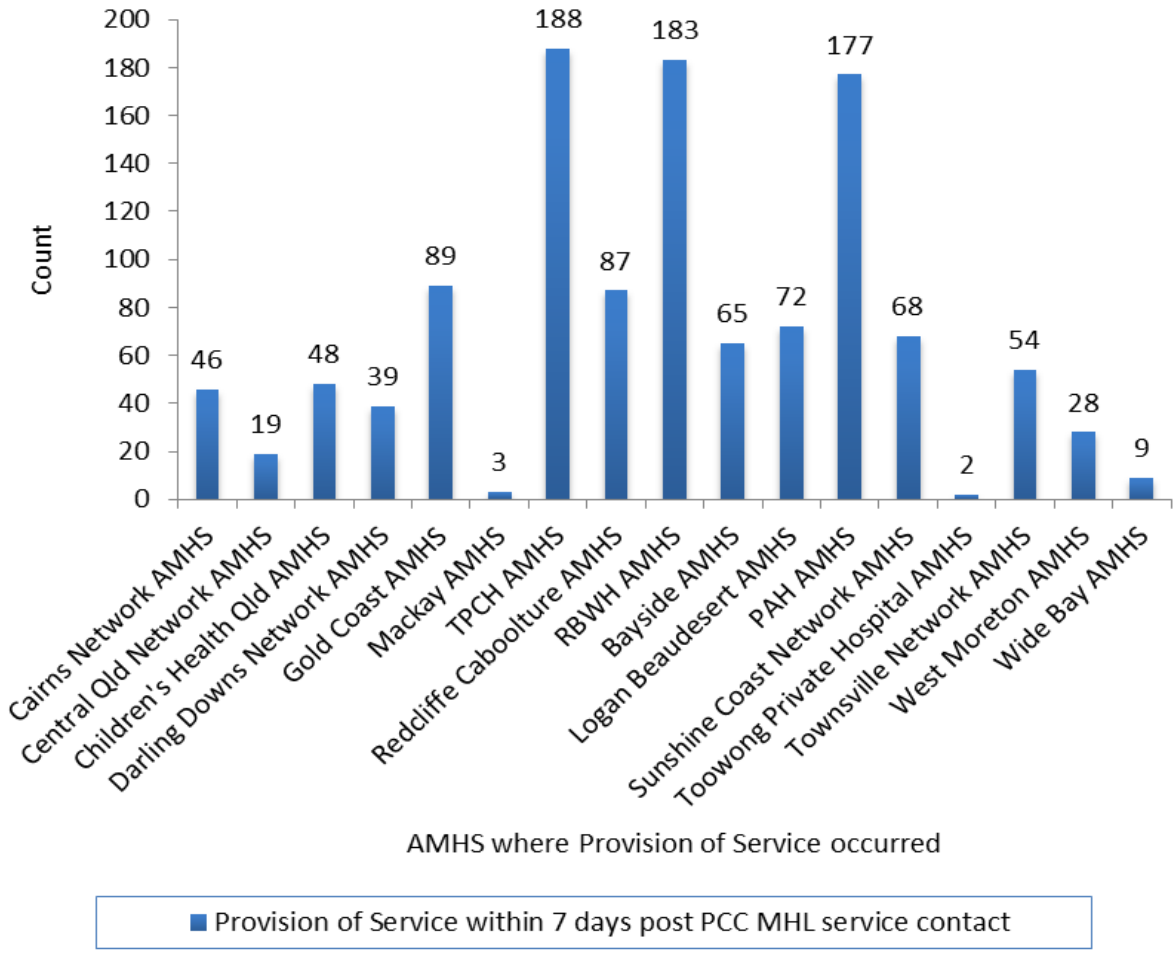
PROVISION OF SERVICE

An important role of the PCC MHL service is to provide a liaison service between the QPS and AMHS. To evaluate the mental health follow up of clients who have had contact with the PCC MHL service, provision of service counts, continuity of care and mental health service admissions for referrals to the PCC MHL service were considered.

A total of 1177 provision of service (POS) events were commenced by a clinician (other than a PCC MHL clinician) within the seven day period after a person had contact with the PCC MHL service. Primarily these entries related to referrals (60%), however 23% of POS entries

were linked to an acute inpatient episode and the remaining 17% were linked to community mental health service episodes. Figure 13 outlines the POS entries by each AMHS.

FIGURE 13. POS COUNT PER AMHS COMMENCED WITHIN 7 DAYS AFTER A PERSON HAD CONTACT WITH THE PCC MHL SERVICE



The majority of referrals who were followed up by mental health services relate to individuals who reside within the Metro North (39%) and Metro South (27%) Hospital and Health Services.[44] However, Figure 13 clearly demonstrates that the PCC MHL service operates on a statewide basis with the majority of public sector AMHS[45] having had involvement with a client who has been referred to the PCC MHL service within the preceding 7 days.

EMERGENCY EXAMINATION ORDERS AND ADMISSIONS

CIMHA data for all clients identified by the CIMHA ID number (as recorded by the clinicians) was extracted to evaluate mental health pathways. This data collection included identification of any admissions within the three month period post-contact with the PCC MHL service, and any EEO made within the evaluation period (8 January 2015 to 31 December 2015) during the work hours when the PCC MHL service was available.

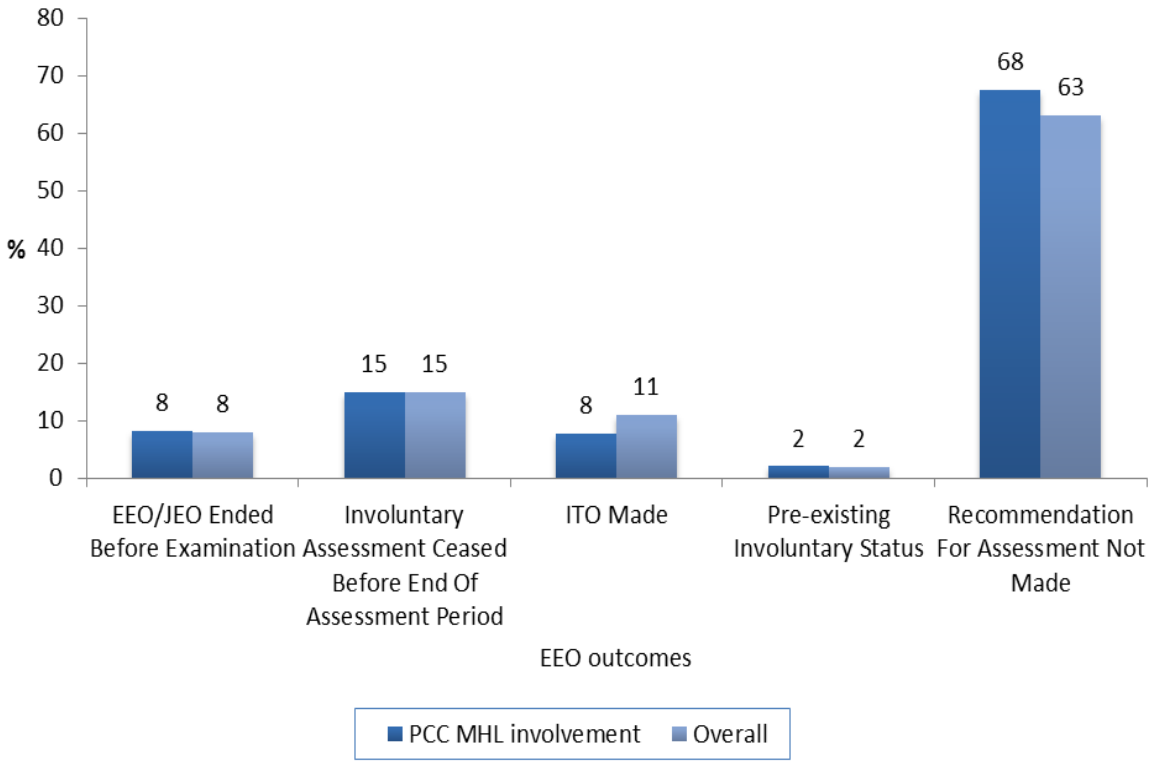
[44] Metro North HHS includes the TPCH AMHS, Redcliffe Caboolture AMHS and the RBWH AMHS. Metro South HHS includes Bayside AMHS, Logan Beaudesert AMHS and the PAH AMHS.
[45] Only The Park Centre for Mental Health AMHS and the two High Secure AMHS did not have contact with a client who had been seen by the PCC MHL service in the preceding 7 days of the provision of service.

This data collection identified:

- A significant proportion of clients referred to the PCC MHL service (37%, n = 535) were transported to hospital by either the QPS or QAS under an EEO.
- 289 individuals were the subject of one EEO.
- 246 individuals were the subject of more than one EEO (range 2 to 68).
- A total of 699 admissions to a mental health service occurred in the three months post-contact client's contact with the PCC MHL service.
- The admissions related to 278 individuals, with just over half having multiple admissions (range 2 to 20).
- For clients admitted to a mental health service in the three months following contact with the PCC MHL service, the average length of stay was 7.45 days.[46]

To consider EEO outcomes for clients where the PCC MHL service has been involved, a comparable dataset (the Director of Mental Health's Annual Report 2014/15) was utilised. Figure 14 outlines this data and identifies comparable outcomes for clients brought in under an EEO with or without PCC MHL involvement. The majority of EEOs (68%) where the PCC MHL service was involved did not result in a recommendation for assessment being made for the client.

FIGURE 14. EEO OUTCOMES – PCC MHL SERVICE INVOLVEMENT VS. TOTAL NUMBER OF EEOS MADE BY PERCENTAGE**



**Overall data sourced from Director of Mental Health Annual Report 2014/15 and therefore date range is not directly comparable (PCC MHL range 08/01/2015 to 31/12/2015; Overall range 01/07/2014 to 30/06/2015).*
**Percentages have been rounded to be presented as whole numbers*

[46] One client was still admitted at the time the data was analysed. The analysis date (31/03/2016) was substituted for this client.

CASE SCENARIO

A 30 year old patient subject to an involuntary treatment order was referred to the PCC MHL service following an emergency call to police made by the patient during which the patient made a number of statements that raised concern by the BPCC call taker about the patient's mental state. These statements indicated the patient believed there were people getting into her house and "moving around furniture and chipping off paint from the wall". The patient also stated that these acts were making her paranoid and she told the BPCC call taker that she wanted to "find the person in her house".

The referral to the PCC MHL service was made as the QPS reported the patient sounded unwell and that an Emergency Examination Order (EEO) may need to be enacted by police. To assist with their preparations for responding to the matter, QPS requested information about any prior or current mental health concerns that may relate to the contact. Once receiving the referral from QPS, the PCC MHL clinician reviewed CIMHA and obtained relevant mental health history. From this history, the clinician became aware that the patient had paranoid schizophrenia and had been admitted to an authorised mental health service within the preceding three months due to medication non-compliance.

Utilising the available information on CIMHA, the PCC MHL clinician advised the QPS that the patient was known to mental health services and that the current presentation appeared consistent with previous presentations by the patient when unwell. On presentation to the patient's address however, the criteria for the QPS officers to make an EEO was not met as there did not appear to be an immediate risk to the patient or others.

Concurrently to the QPS response, the PCC MHL clinician contacted the patient's case manager to inform about the contact with the QPS and the possible deterioration in the patient's mental health. As a result of this contact, members of the patient's treating team attended the patient's residence in the community the following day. Through this outreach contact, the deterioration in the patient's mental health was confirmed and a decision was made by the treating team to commence an inpatient admission. The treating team then contacted the PCC MHL clinician to advise of this decision and to seek further assistance from the QPS. Acting as a conduit between the treating team and the QPS, the PCC MHL clinician escalated the referral back to the SDO to enable QPS assistance for transportation to occur in a timely manner.

Without the PCC MHL clinician involvement and contact with the mental health service, the patient may have remained in the community and continued to experience deterioration in their mental health for an extended period of time. However, through liaison with the mental health service, an outreach examination occurred and the patient's treatment was able to be re-commenced in a timely manner.

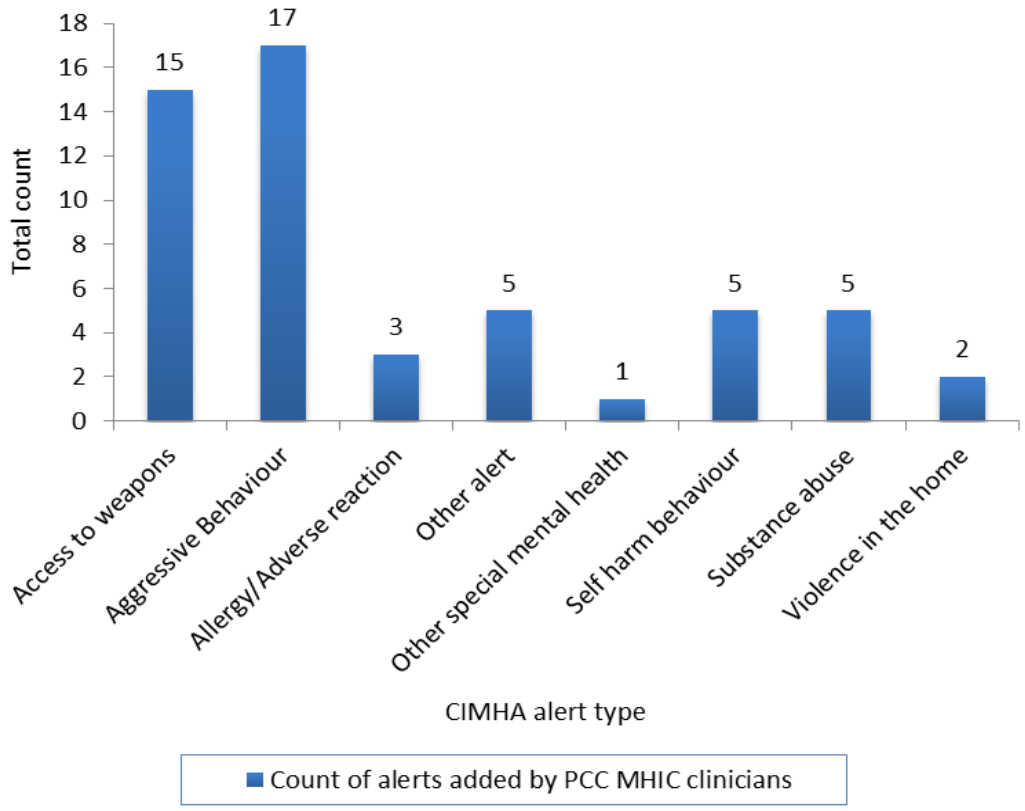
ALERTS

Within the CIMHA system, 'alerts' may be added to client records to support the delivery of safe, appropriate and timely mental health care. Alerts may be added to a client record where special consideration for the client or their circumstances is required prior to any treatment or care being provided to avert an unfavourable healthcare event, and to ensure

the care and safety of the client, staff or other people.[47]

Through the implementation of the PCC MHL service, QPS information about risk or other issues that may be relevant to delivering health care has been able to be accessed by the PCC MHL clinicians for clients who are referred to the service. Where the PCC MHL clinician has become aware of a relevant risk issue through the referral information provided by the QPS, these have been added to the CIMHA. In total, the PCC MHL clinicians added 53 alerts to CIMHA for clients referred to the PCC MHL service during the evaluation period. The primary types of alerts added were for aggressive behaviour and access to weapons. Figure 15 provides a breakdown of the total number of alerts added by the PCC MHL clinicians during the evaluation period.

FIGURE 15. ALERTS ADDED TO CIMHA BY THE PCC MHL CLINICIANS FOR REFERRALS BETWEEN 8 JANUARY 2015 AND 31 DECEMBER 2015



Although the addition of alerts to CIMHA by the PCC MHL clinicians accounts for only a small percentage of the overall role of the PCC MHL service, access to this type of QPS information is important for ensuring that, as far as possible, health service staff are sufficiently informed regarding the needs of the relevant client to support the delivery of treatment and care in the most effective and safe manner possible.

CRISIS INTERVENTION PLANS

Crisis Intervention Plans (CIPs) are individual client specific plans that identify, articulate and document risks and interventions in order to support the safe resolution of mental health crisis in the community. Crisis Intervention Plans are intended to be developed in a

[47] Queensland Government, undated

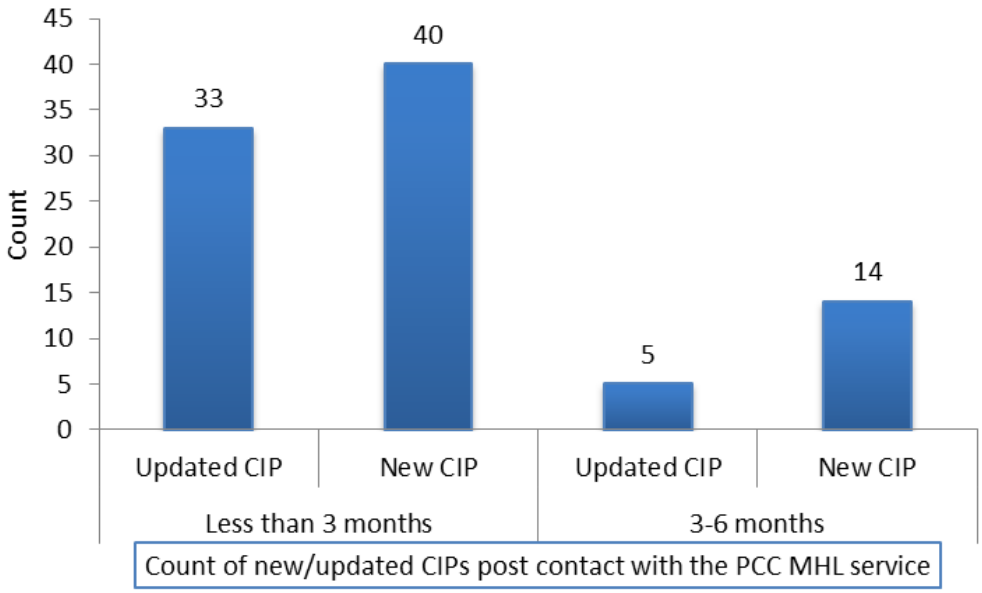
collaborative manner between the relevant individual, their treating team, support persons and first responders including the QPS and QAS. Clients who are currently receiving treatment from mental health services may have a CIP developed if they have frequent contact with the QPS or QAS, regardless of the nature of that contact (e.g. they may be low or high risk).

An analysis of the matters referred to the PCC MHL service revealed that 203 individual clients had a current or historical (e.g. relating to a past service episode) CIP. While this figure is very low there may be a number of factors impacting why a person does not have a current CIP in place. These factors include the person being a new referral, the service not being aware that the person is also having repeated or multiple contacts with the QPS, or the service not deeming that a plan is necessary.

An important outcome of the implementation of the PCC MHL service within the BPCC is the ability for feedback to be provided to mental health services about an interaction occurring with the QPS that enables the treating service to consider the need to develop a CIP. Where a CIP has been deemed to be warranted by the PCC MHL clinicians, they have contacted the relevant treating team or local Mental Health Intervention Coordinator to discuss the need for a CIP to be developed or updated. Additionally, the PCC MHL clinicians have supported mental health services to develop CIPs that provide more meaningful information for the QPS. It is recommended that this feedback process be formalised within the PCC MHL model of service.

In 73 matters that were referred to the PCC MHL service, a new CIP was implemented or an existing one updated by the treating service within the three month period following contact with the PCC MHL service. In a further 19 matters, a CIP was implemented or updated within the following six month period. Figure 16 outlines the impact the PCC MHL service has in this regard.

FIGURE 16. NEW AND UPDATED CIPS FOLLOWING CONTACT WITH THE PCC MHL SERVICE



RECOMMENDATION:

- *Clear feedback process to mental health services should be developed and incorporated into the PCC MHL model of service. This includes processes for liaison with the treating team and local Mental Health Intervention Coordinators in relation to Crisis Intervention Plan development.*

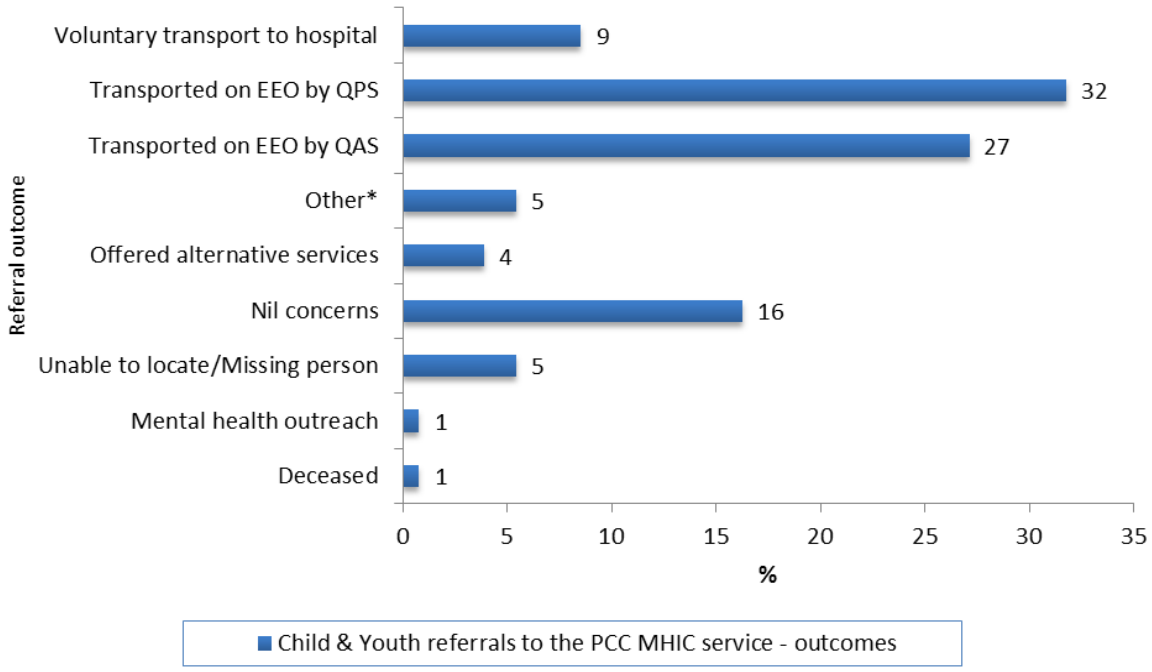
SPECIFIC POPULATIONS

CHILD AND YOUTH

Ten percent of referrals to the PCC MHL service were for children or adolescents (n = 168), with an age range of 8 to 17. Key referral and outcome findings for persons under 18 are outlined below:

- Just over half of the referrals (52.98%, n = 89) were previously or currently known to mental health services at the time of their referral to the PCC MHL service.
- Referrals related predominately to female clients (69%, n = 116)
- The primary diagnosis categories were Behavioural & Emotional Disorders with usual Youth Onset (19%) and Reaction to Severe Stress & Adjustment Disorders (15%).
- An EEO by QPS or QAS was made in 45% (n = 59) of referrals (Figure 17).
- 52 admissions occurred within 7 days of an EEO being made within the same event that resulted in the person's referral to the PCC MHL service
- The median admission period following an EEO was two days. The range of admission periods was from 1 to 106 days.

FIGURE 17. KNOWN OUTCOMES (N = 129) FOR CHILD AND YOUTH MATTERS REFERRED TO THE PCC MHL SERVICE BY PERCENTAGE



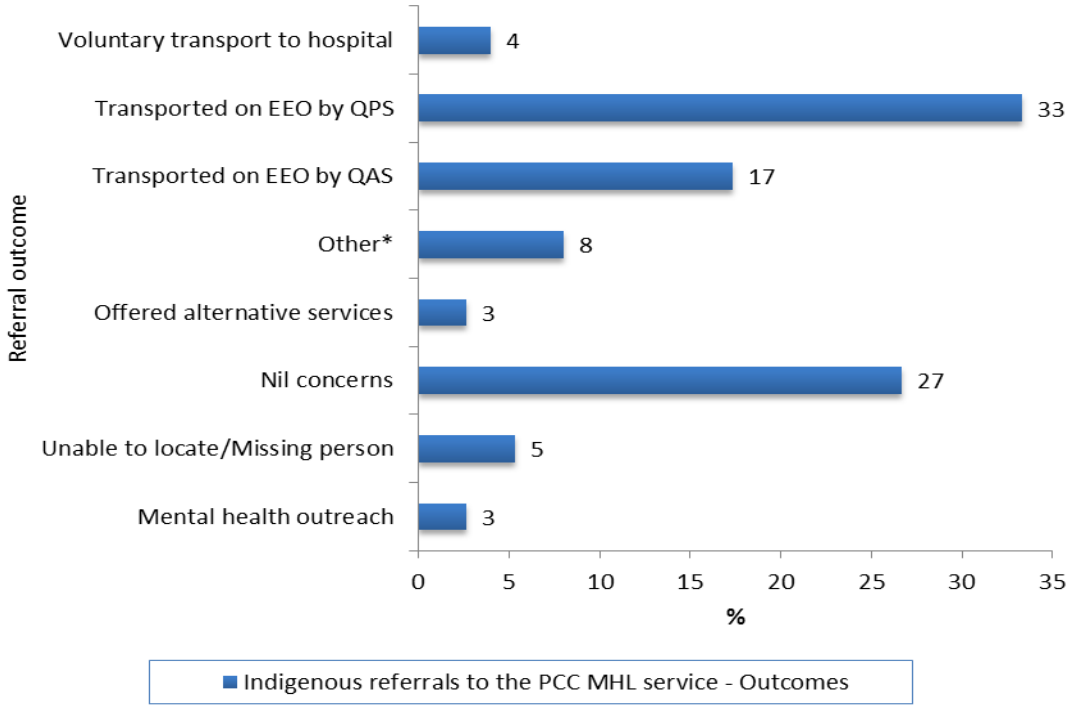
*Percentages have been rounded to be presented as whole numbers.

INDIGENOUS PEOPLE

107 referrals to the PCC MHL service were for individuals who identified as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. The average age of referrals relating to Indigenous people was 32 (range 13 to 58). Key referral and outcome findings for Indigenous persons are outlined below:

- The majority of referrals (60%) were not previously or currently known to mental health services at the time of their referral to the PCC MHL service.
- The gender distribution was slightly skewed towards males (57%).
- The primary diagnosis categories were Schizophrenia, Schizotypal & Delusional Disorders (22%) and Mental & Behavioural Disorders due to Psychoactive Substance use (16%)
- An EEO by QPS or QAS was made in 50% (n = 28) of referrals (Figure 18).

FIGURE 18. KNOWN OUTCOMES (N = 75) FOR INDIGENOUS MATTERS REFERRED TO THE PCC MHL SERVICE BY PERCENTAGE



**Percentages have been rounded to be presented as whole numbers.*

SERVICE POTENTIAL

To assess the relative need and potential utility of expanding the PCC MHL service beyond the current five after-hours shifts per week, QCAD data from a subset of call-types were examined over a 13 month period (1 January 2015 to 31 January 2016). QCAD data for call types that could reasonably be identified as 'mental health related' were included in this

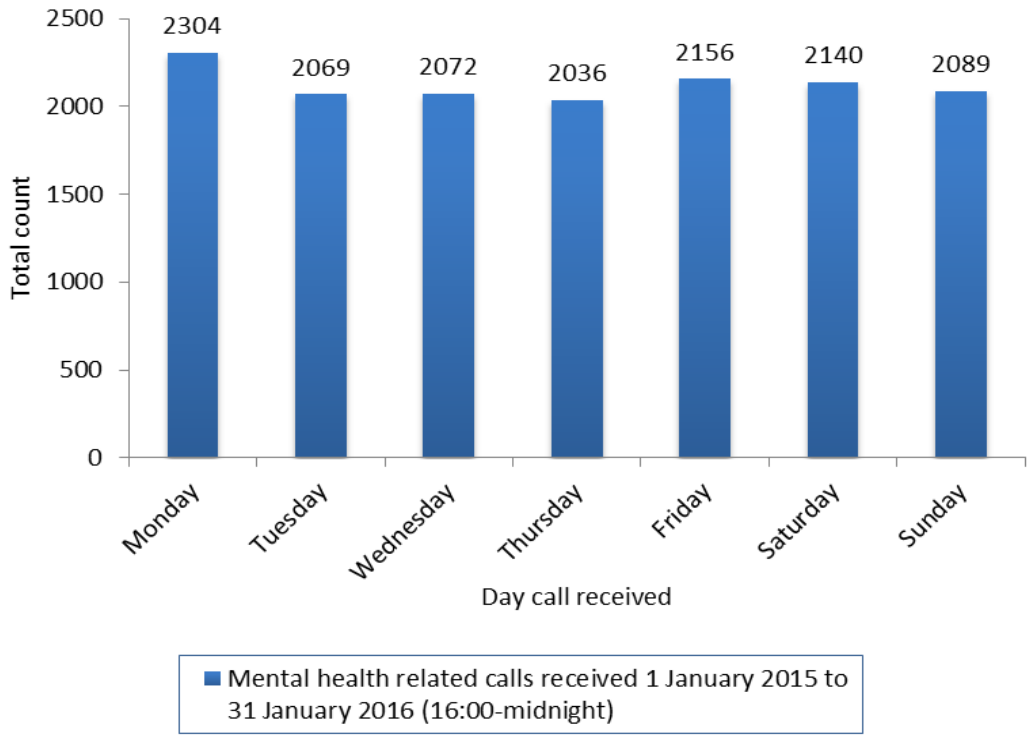
analysis. These call types (referred to below as 'mental health related calls'[48]) include the following QCAD codes:

300 – Crisis Situation
502 – Suicide
503 – Attempting/Threatening Suicide
504 – Mentally Ill Person
716 – Authority to Return
836 – EEO and transport by QPS due to risk
838 – EEO and transport by QAS
839 – Justices Examination Order
840 – Queensland Health Referred
842 – Voluntary Referral by Person to Health

Siege events (code 302) were also included despite these matters not necessarily relating to a mental health matter due to advice from the PCC MHL clinicians regarding their involvement in assisting the QPS in providing advice during siege events. Stakeholder advice from both the PCC MHL clinicians and the QPS indicates that in 2016, there appears to be increasing role for the PCC MHL clinicians to assist police during siege events.

During the 13 month period, there were a total of 30,744 mental health related calls received by the BPCC. Calls received after hours (between 16:00 and midnight) represent the largest proportion of calls (48%, n = 14,866) (Figure 19). This after hour period is currently completely covered by the PCC MHL service on Thursday to Saturday nights, and largely covered on Tuesday and Wednesday evenings when the PCC MHL clinicians work a short shift (17:00 to 22:00). However, there is a clear and identified need to expand the PCC MHL coverage to include Monday and Sunday evening shifts, as nearly 30% of after-hours mental health related calls are received on Monday and Sunday evenings.

FIGURE 19. MENTAL HEALTH RELATED CALLS RECEIVED AFTER HOURS (16:00 TO MIDNIGHT) (1 JANUARY 2015 TO 31 JANUARY 2016)

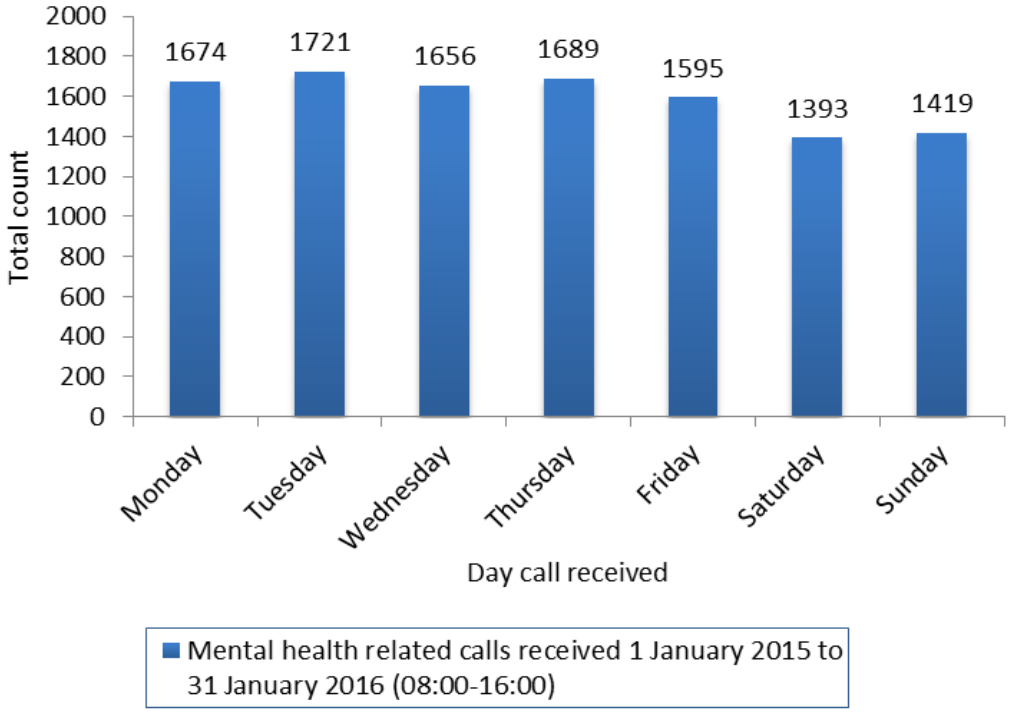


[48] As these all types represent only a subset of the types of calls referred to the PCC MHIC service, this analysis may be an underrepresentation of relative need.

Additionally, to improve management of the workload of the PCC MHL clinicians each shift there is a need to consider expansion of both shift times (for Tuesday and Wednesday evenings) and the number of available clinicians across each after hours shift. Effectively ensuring sufficient coverage for referrals and time for clinicians to complete all clinical and administrative tasks is of particular importance when determining new shift times and rostering for an expanded PCC MHL service.

Mental health related calls received by the BPCC during business hours (between 08:00 and 16:00) account for 36% (n = 11,147) of calls (Figure 20). This time period is currently not covered by the PCC MHL. During weekdays, it is reasonable to assume that a proportion of these calls will have received mental health assistance and advice from an available business hours program, such as the MHIC program, an Acute Care Team or a community mental health service. Further investigation of how the local responses are assisting the QPS during business hours is recommended, given that the basis for establishing the PCC MHL service is to augment existing local responses, rather than replace these services. It is therefore important to identify and establish working relationships between the PCC MHL and local responses to ensure comprehensive coverage and assistance can be provided to the QPS at all times.

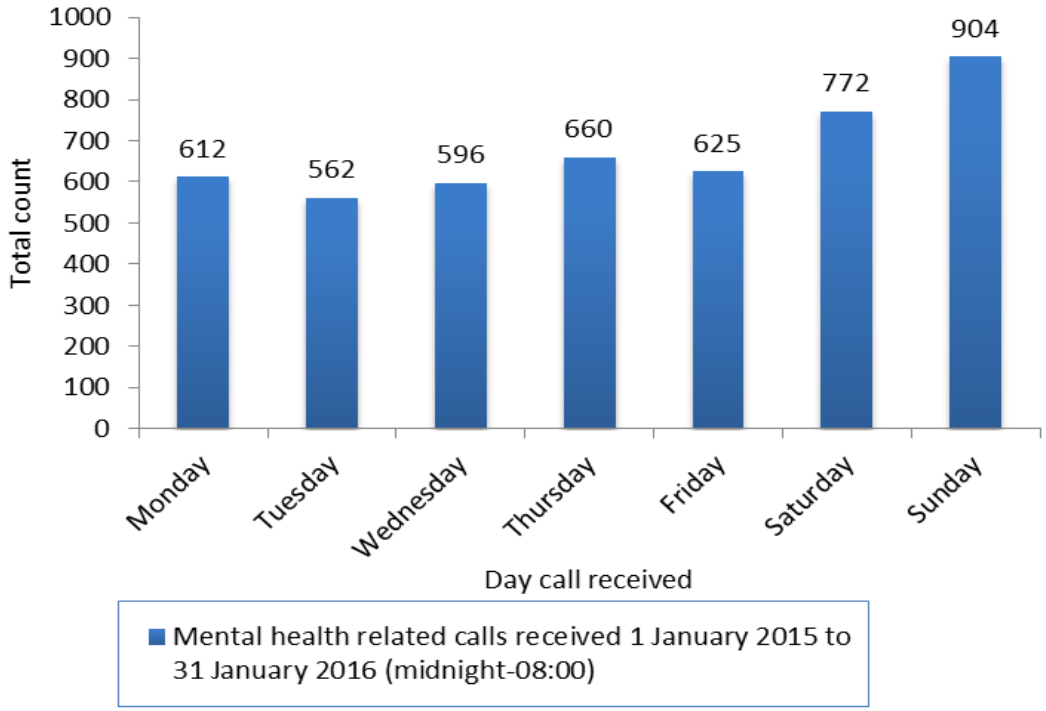
FIGURE 20.MENTAL HEALTH RELATED CALLS RECEIVED DURING BUSINESS HOURS (08:00 TO 16:00) (1 JANUARY 2015 TO 31 JANUARY 2016)



On weekends however, local responses for the QPS to access assistance may not be as readily available, particularly for example the MHIC program which does not operate on weekends. Twenty-five percent of 'mental health related' calls received during the 08:00 to 16:00 hour period occur on Saturday and Sunday and there may therefore be justification for expanding the PCC MHL service to include weekend 'business hours' shifts. This would provide a direct avenue for QPS to be able to obtain assistance in relation to mental health matters at times when regular service provision at the local level may be reduced.

As part of the analysis of service need and potential for expansion of the PCC MHL service, the time period between midnight and 08:00 was also considered. Overall, mental health related calls during this time period account for 15% (n = 4, 731) of calls (Figure 21). While this represents a smaller volume of calls received by the QPS, there is also a reduced capacity for local mental health services to respond during these hours. The direct availability of a clinician within the BPCC therefore may provide a cost-effective and timely mechanism for the QPS to receive mental health advice during times when there may be reduced mental health service responses locally. This time period therefore represents a further opportunity for expansion of the PCC MHL service.

FIGURE 21. MENTAL HEALTH RELATED CALLS RECEIVED BETWEEN MIDNIGHT TO 08:00 (1 JANUARY 2015 TO 31 JANUARY 2016)



RECOMMENDATIONS:

- *The number of clinicians working within the PCC MHL service, including on-call psychiatric support, should be expanded as soon as practicable as additional clinical services are required to ensure clinical support for the following:*
    a. *Alignment of the Tuesday and Wednesday shifts to cover 16:00 to midnight as occurs with the Thursday to Saturday shifts.*
    b. *Monday and Sunday evening shifts (16:00 to midnight), as nearly 30% of after-hours 'mental health related' calls are received on Monday and Sunday evenings.*
    c. *Saturday and Sunday 'business hours' (08:00 to 16:00) to provide a direct avenue for QPS to be able to obtain assistance in relation to mental health matters at times when regular service provision at the local level may be reduced.*
- *Other time periods that require further analysis with respect to potential for enhanced service delivery include:*

a. *A comprehensive analysis of local responses available to the QPS during weekday business hours (08:00 to 16:00) as 27% of the total mental health related calls received by the Brisbane Police Communications Centre occur on weekdays during these times, and*

b. *Consideration of expansion of the PCC MHL service to include midnight to 08:00 shifts Monday to Sunday to augment local responses which may not be readily accessible during these hours.*

- *Future mental health and QPS collaboration opportunities should consider the role of the PCC MHL service and mental health services in supporting the QPS police negotiator program.*

QAS

The implementation of the PCC MHL service has improved communication and information sharing between QPS and mental health services and in doing so, has highlighted an opportunity to improve communication and interface between the QAS and mental health services. Of the total calls referred to the PCC MHL service during the evaluation period, 14.2% related to calls that originated from a QAS request for QPS assistance. Additionally, in 18% of referrals, the outcome resulted in the QAS enacting an EEO to transport the person to hospital.

The evaluation of the PCC MHL service has highlighted that there are clear and responsive communication pathways between the PCC MHL clinicians and the QPS. However, there is currently no clear pathway for the PCC MHL clinicians to communicate directly with the QAS, either in jobs that are jointly being responded to by the QPS and QAS, or in cases where only the QAS is responding.

Currently, communication with the QAS via the PCC MHL service is limited to providing information to the QPS, which, if able to be released under the Mental Health Collaboration MOU, is then shared by the QPS with the QAS officers. This is clearly inefficient, and unnecessary given the PCC MHL clinicians could share information directly with QAS officers under the Hospital and Health Boards Act.

Stakeholder consultation with senior officers from the QAS has also identified that the QAS respond to a significant number of ‘mental health related calls’ that do not involve a joint response with the QPS. As the communication pathway between the the QAS and the PCC MHL clinician currently relies on involving the QPS, there is an identified need to ensure direct communication with the QAS.

Currently, the absence of direct communication between the PCC MHL service and the QAS results in the QAS officers having only limited access to potentially relevant mental health information that may assist in responding to mental health crises in the community. This limitation may result in risks to the person experiencing the crisis, the QAS officer or other members of the community.

RECOMMENDATION:

- *Development of information sharing protocols, referrals pathways and collaborative relationships that enable the Queensland Ambulance Service (QAS) to access the PCC MHL service.*

STRATEGIC ELEMENTS

In addition to clinical functions, as a statewide service the PCC MHL service is uniquely placed to identify opportunities to enhance relationships and collaboration across the QPS and mental health services. In undertaking this function, the PCC MHL clinicians work in partnership with local mental health services and the QPS in a strategic capacity to identify opportunities for effective collaboration, education, training and procedural enhancements that contribute to improving client outcomes. Strategic work undertaken by the PCC MHL service to date has been considered as part of the evaluation and is outlined below.

EDUCATION AND TRAINING

In addition to the liaison that occurs between the PCC MHL service and treating teams, throughout the first twelve months of the PCC MHL service, education and information sessions have been provided by the clinicians to a number of mental health services, primarily from South East Queensland (see Table 3). An important element of these sessions has been the opportunity for the PCC MHL clinicians to meet with the MHICs in Hospital and Health Services, as well as work collaboratively with the Cairns and Caboolture Co-responder programs to discuss and problem-solve the interface between the statewide, after hours PCC MHC service and local services.

The PCC MHC service has also identified opportunities to provide education and training for the QPS. Importantly, it has been noted that training and education for the QPS must take account of the needs of police officers working with the BPCC, civilian call takers, and frontline police officers.

To date, the education and training provided by the PCC MHC clinicians to staff in the BPCC has primarily occurred on a ‘case by case’ and ‘as-needed’ basis. This has included assisting officers within the BPCC in developing reference sheets for frequently used mental health terms and providing mental health information for inclusion on noticeboards and in regular BPCC communiqués.

While there has been progress in terms of education and training for both mental health services and the QPS during the evaluation period, there are further opportunities that exist. For example, interactive sessions for the QPS that include working through frequently encountered scenarios and the inclusion of consumer and carer experiences in this training may be beneficial. Additionally, across both mental health services and the QPS, the further development of resources and communication styles that focus on understanding, responding to, and describing observable behaviours of persons in mental health crises may assist when there is a transfer of care between the QPS and mental health services.

Operating at the interface between the QPS and mental health services, the PCC MHL clinicians are in a valuable position to assist with the development and implementation of further education and training. However, it is important to acknowledge that implementing successful and regular training is not without its challenges. The limitations most commonly identified include resource issues, including the time and cost of making staff available for training, and remaining respectful of existing education and training programs. These concerns can be ameliorated by keeping training short, leveraging off existing education programs, utilising alternate methods of communication, and targeting areas of need.

TABLE 3 – MENTAL HEALTH SERVICE ENGAGEMENT

Children's Health Queensland	
Lady Cilento Children's Hospital (LCCH) Meeting	6 May 2015
LCCH tri-agency meeting (QPS, QH, QAS)	27 August 2015
LCCH Strategic Operational Management Meeting	20 November 2015
Darling Downs HHS	
Toowoomba MHIC meeting	29 April 2015
ACT Multi-agency meeting (ACT, CCT, QPS, MHIC)	27 May 2015
Metro North HHS	
MHIC Meeting	15 April 2015
RBWH ACT	6 May 2015
RBWH PEC	21 May 2015
Redcliffe-Caboolture ACT	25 May 2015
RBWH Team Managers and Discipline Seniors Meeting	3 June 2015
Metro North tri-agency meeting (MHICs, QPS, QAS)	19 June 2015
TPCH ACT and Senior Staff	24 February 2016
TPCH Sub group meeting-ED Frequent Presenter Response Project	2 March 2016
Metro South HHS	
Metro South MHIC Meeting	28 April 2015
ACT/Triage Team Manager meeting	28 April 2015
MH Call in-service	23 June 2015
Metro South Innovation & Implementation Committee	16 December 2015
Statewide services and networks	
Forensic Liaison Officer Forum	21 April 2015
MHIC Forum	3 June 2015
Clinical and Executive Mental Health Directors Meeting	23 July 2015
HSIS forensic advanced training lecture	5 August 2015
CFOS in-service	17 August 2015
PMHS in-service	1 March 2016
Sunshine Coast HHS	
Multi-agency operational meeting (ED, QPS, QAS, QH)	10 June 2015
West Moreton HHS	
Ipswich MHIC meeting	29 May 2015
Ipswich ACT	26 April 2015

RECOMMENDATIONS:

- *Within the model of service, clear priorities and responsibilities need to be established to enable the strategic elements of the role, such as education, training and service development, to be fulfilled.*
- *Future education material and resources for both QPS and mental health services should therefore be developed in a manner that ensures training:*
    - *can be implemented and delivered on a statewide basis,*

- *can be incorporated into existing education or training sessions to minimise time away from work for police officers or clinicians,*
- *incorporates the views of clients, carers and service providers, and*
- *promotes the collaboration and enhancement of relationships between mental health services and the QPS.*

PCC MHL SERVICE MONITORING AND AUDITING

In September 2015, the QPS implemented a 'mental health clinician' flag in the QCAD system as a mechanism for recording referrals to the PCC MHL service. This flag is intended to capture any QCAD call that has been referred to and actioned by the PCC MHL service and provides an important mechanism for auditing processes.

Comparison data between the QPS and QFMHS record keeping indicates that initially this flag did not provide an accurate representation of referrals to the PCC MHL (Table 4). Risks associated with the different record-keeping across QPS and QFMHS were however identified, primarily relating to mental health related calls being put on-hold pending PCC MHL coming onto shift, or inaccurate reporting which indicated that the PCC MHL was involved when they had no knowledge of the event.

However, in January 2016, in response to these identified issues a revised 'cross-checking' system was implemented. This cross-checking involves the SDO and the PCC MHL clinician checking the QCAD numbers for all referrals recorded by the clinicians and tagged with a mental health clinician flag. This cross-checking process has significantly improved the extent to which the QFMHS and QPS record keeping align.

TABLE 4. NUMBER OF REFERRALS AS RECORDED BY THE PCC MHL CLINICIANS AND THE QPS*

Month	QFMHS recorded data	QPS recorded data
September 2015	448	253
October 2015	47	45
November 2015	155	174
December 2015	197	236
January 2016*	220	223
Total	**1067**	**932**

**Data from 2016 has been included due to 'mental health clinician' flag only being implemented part-way through the pilot period.*

The continuation of a regular auditing and monitoring process of the PCC MHL service would be an invaluable inclusion in the model of service. In addition to aligning information captured across the QCAD and QFMHS data, there is also an opportunity for regular auditing to highlight strategic matters impacting broader QH and QPS collaboration, for example issues relating to Mental Health Act processes, referral pathways or expansion issues. Currently these matters are largely being identified in an ad-hoc matter, rather than through a regular inter-agency auditing or monitoring process.

RECOMMENDATION:

- *Continued collaboration across the QFMHS, local mental health services and the QPS is required to improve processes associated with data collection and information management. This collaboration should, at a minimum, include:*
    a. *regular auditing processes for the PCC MHL service, and*
    b. *examination of enhancements that can be made to CIMHA and QCAD to record and analyse information currently being recorded separately on the PCC MHL service excel spreadsheet.*

MENTAL HEALTH ACT 2000

Interactions between the QPS and individuals with mental illness can often result in, or be initiated by, Mental Health Act processes. One of the roles of the PCC MHL clinicians is to assist the QPS with queries relating to Mental Health Act processes.

RETURNING ABSENT PATIENTS

When an involuntary patient is absent without permission from an AMHS, a number of processes can be initiated under the Mental Health Act that enable QPS to return the patient to the nearest hospital. A *Request for Police Assistance* provides authority for the QPS to assist a health practitioner to return a patient who is absent without permission. An *Authority to Return* provides authority for the QPS to act alone to return an involuntary patient who is absent without permission.

During a 13 month period from 1 January 2015 to 31 January 2016, 3090 *Authorities to Return* were issues to QPS by AMHSs. It is not a requirement for all *Authorities to Return* to be provided to the BPCC (they can be dealt with locally), however, data from the QPS for the same period indicates that 1862 mental health related[49] calls were coded in QCAD as an initial call type of *Authority to Return*.

From 8 January 2015, the PCC MHL clinicians have provided a role in the BPCC to assist within both *Requests for Police Assistance* and *Authorities to Return*. In particular, clinician assistance has been provided where:

- QPS are unclear about whether action is required (particularly relevant in circumstances where only a *Request for Police Assistance* is provided);
- incomplete or illegible paperwork has been provided by the AMHS;
- no contact or illegible contact details and no follow up phone call by the AMHS;
- incorrect paperwork has been provided by the AMHS
    - including *Request and Recommendation for Assessment* paper being sent to the BPCC rather than, or in addition to, the *Request for Assistance* or *Authority to Return*, and

[49] Mental health related calls include the following initial or revised QCAD codes: 300 - Crisis Situation, 302 - Siege, 502 - Suicide, 503 - Attempting/Threatening Suicide, 504 - Mentally Ill Person, 716 - Authority to Return, 836 - E.E.O. and transport by QPS due to Risk, 838 - E.E.O. and Transport by QAS, 839 - Justice Examination Order, 840 - Queensland Health Referred, 842 - Voluntary Referral by Person to Health.

    - sending a *Request for Assistance* in lieu of an *Authority to Return*; and
- sending both the *Request for Assistance* and the *Authority to Return;*
- issuing an *Authority to Return* without the capacity to admit the client when QPS bring them to the relevant service.

In these circumstances, liaison by the PCC MHL clinician with the relevant AMHS occurs to clarify the QPS actions required, obtain correct or amended paperwork, obtain information regarding possible whereabouts of clients or advise on Mental Health Act requirements. The clinician also provides education to the QPS regarding Mental Health Act processes and the actions that may be taken by the QPS.

In addition to assisting with these issues on a case by case basis, during the evaluation period the PCC MHL clinicians prompted a review by the Office of the Chief Psychiatrist of the *Request for Police Assistance* paperwork based on the experiences of the PCC MHL clinicians in liaising between the QPS and mental health services. As a result of the PCC MHL clinicians' advice and consultation with the QPS, a revised *Request for Police Assistance* form was issued by the Director of Mental Health on 14 March 2016. This revised form has been simplified to assist with completion and interpretation, and more clearly articulates the basis for requesting police assistance.

Notwithstanding the capacity for the PCC MHL service to assist both mental health services and the QPS with the processes associated with returning a patient who is absent without permission, the extent to which issues have been identified through this process is of significant concern. Accurate and clear communication between mental health service staff and the QPS, or where appropriate the QAS, is required to ensure that patients who are absent without permission can be safely returned.

RECOMMENDATIONS:

- *A coordinated approach to education, training and the provision of advice across mental health services, the QPS and QAS regarding these processes should be implemented. The PCC MHL service, together with local Mental Health Intervention Coordinators, may be uniquely placed to assist in developing this training.*
- *Clear and documented feedback process to mental health services should be developed. This includes processes for escalating systemic matters, such as issues related to the Mental Health Act 2000, to Clinical or Executive Directors.*

EMERGENCY EXAMINATION ORDERS

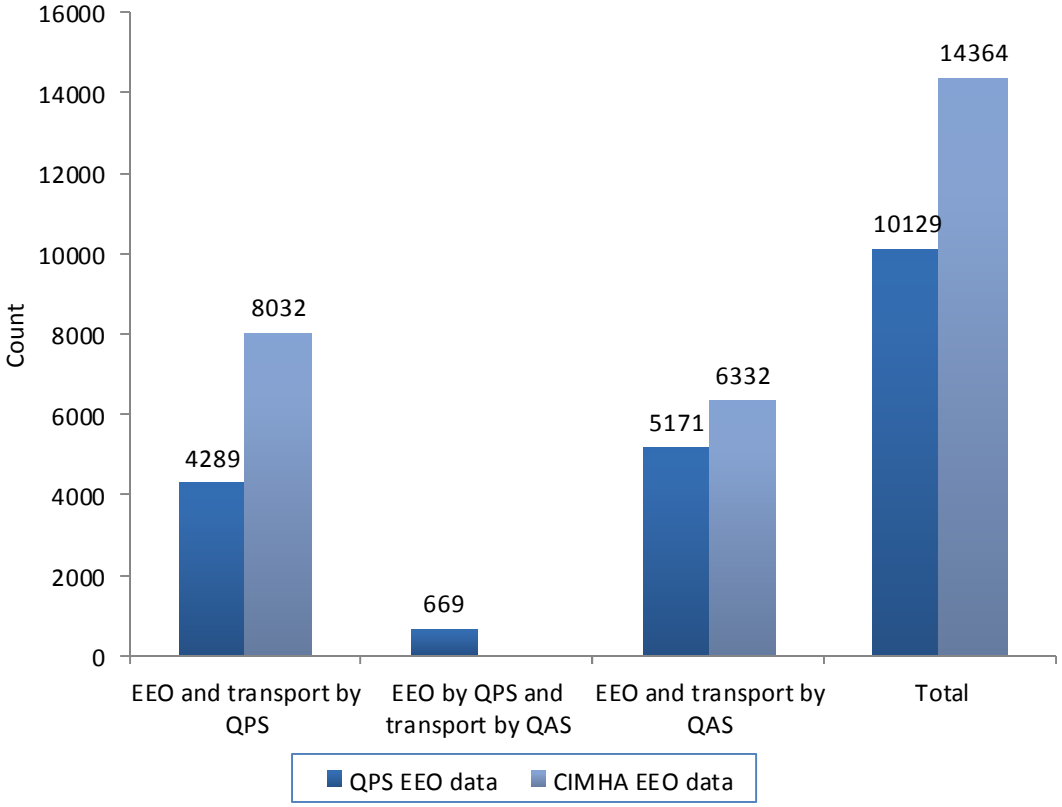
An EEO made by a police or ambulance officer provides authority for the officer to take a person to an AMHS for involuntary detention and examination.

The evaluation of the PCC MHL service has identified that there is a discrepancy in EEO data across the QPS and QH. Data from QPS indicates that during the 13 month period from 1 January 2015 to 31 January 2016, there were 10,129 calls coded in QCAD as resulting in transportation by QPS or QAS under an EEO. For the same period however, QH data indicates 14,391 EEOs were made by QPS or QAS. There are a number of factors impacting this data discrepancy, including that access to specific QAS data was not available at the time of the evaluation.

Notwithstanding this data limitation, there are marked differences in the recording of EEOs

across QH and QPS. Significantly, as detailed in Figure 23, QPS records of EEOs include three distinct categories of EEOs while QH only reflects two categories.

FIGURE 23. TRANSPORTATION BY QPS OR QAS UNDER AN EEO (1 JANUARY 2015 TO 31 JANUARY 2016)



Under the Mental Health Act, there is no capacity for an EEO to be made by QPS and for transport to then be done by QAS. Under section 35 of the Mental Health Act, immediately *after* transporting a person to an AMHS, the QPS officer *or* QAS officer must make the EEO. The Mental Health Act envisages that the officer making the EEO at the point of 'handover' to the AMHS is the same officer who has transported the patient. For this reason, the Mental Health Act does not provide for circumstances where an EEO has been made by police and the transport has occurred by QAS.

The data recorded in QCAD that envisages an EEO by police and transportation by QAS may be arising from the following factors:

- data collection and recording processes
- transfer of responsibility at the point of arrival to the AMHS from QPS to QAS due to prolonged wait periods, or
- completion of EEO documentation prior to arrival at the AMHS.

RECOMMENDATION:

- *Due to the involuntary nature of transportation and detention that occurs under an EEO, it is recommended that further investigation of this practice occur to ensure that data collection and/or operating processes associated with EEOs is compliant with the Mental Health Act.*

EMERGENCY EXAMINATION AUTHORITIES – NEW *MENTAL HEALTH ACT 2016*

Having regard to the extent to which matters relating to an EEO were referred to the PCC MHL service during the evaluation period (n = 449), it is considered that there will be a significant role for the PCC MHL clinicians assisting the QPS with understanding and interpreting the requirements for Emergency Examination Authorities under the new *Mental Health Act 2016*. Under the new Act, the EEO provisions of the current Mental Health Act will be replaced by emergency transport powers contained within the *Public Health Act 2005* (Public Health Act).

The new emergency transport provisions operate similarly to the current EEOs and will empower the QPS or QAS to transport a person to a treatment or care place (including a public sector health service facility, AMHS or another place) if the following grounds apply:

- a person's behaviour, including, for example, the way in which the person is communicating, indicates the person is at immediate risk of serious harm; and
- the risk appears to be the result of a major disturbance in the person's mental capacity, whether caused by illness, disability, injury, intoxication or another reason; and
- the person appears to require urgent examination, or treatment and care, for the disturbance.

The new Public Health Act provisions have expanded the emergency transport powers from mental illness only (as currently applies) to include other forms of major disturbance in mental capacity (as will apply under the new Act). Additionally, mental health services may not necessarily be involved in the examination of a person transported under a new Emergency Examination Authority, and as a result, data will not be recorded in the CIMHA in relation to emergency transports unless the person transported reaches the threshold for a mental health assessment or referral to mental health services.

Given the degree of involvement the PCC MHL clinicians have had in liaising between QPS, QAS and mental health services in relation to current EEO processes, it is reasonable to assume that there will be a continued role for the PCC MHL service in providing advice and assistance regarding the new Emergency Examination Authorities. This role may be complicated however as there will be less visibility over the outcomes (due to data collection not occurring within CIMHA).

RECOMMENDATION:

- *It is recommended that consideration be given to statewide data collection for Emergency Examination Authorities as well as the development of clear communication pathways and responsibilities across Emergency Departments and mental health services. The development of these processes should involve the PCC MHL service and local Mental Health Intervention Coordinators.*

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