

**Developing a Quality Assurance Framework
for
Mental Health in Western Australia**

Final Report

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Contents

	Page
Introduction	2
Summary list of Recommendations	4
A Quality Assurance Framework for Mental Health in WA	5
Component 1 – Rights and Protections	10
Component 2 – Quality Management	17
New Mental Health Legislation	28
Developing a QA Framework – Next Steps	33
Appendices	35
Appendix 1 – Expert Team, Role and Remit	
Appendix 2 – Stakeholder Meetings in July	
Appendix 3 – Information sheet on interim report feedback	

Developing a Quality Assurance Framework for Mental Health in Western Australia

Introduction

In April 2011, the Mental Health Commission on behalf of the Government of Western Australia commissioned a team of external experts to provide advice to help inform the development of a Quality Assurance Framework for Mental Health in Western Australia (Appendix 1 provides details of the team and the remit of the work). This report presents a framework for the future that builds on the already substantial work that has taken place on quality assurance in mental health in Western Australia and on the views of the many stakeholders and agencies that made comments on the work as it developed over the last few months.

The work was commissioned as part of the Western Australian Government's commitment to modernize, streamline and improve quality assurance across the mental health system and health system more generally and improve outcomes for the public through improved and modernized public sector management (Western Australian Government, Economic Audit Committee 2009)

Following a visit to WA in May 2011, an interim report was produced and disseminated in June. This final report builds on the interim report and on people's responses to the interim report, and to a further visit to WA from 4 – 12 July (Appendix 2 provides details of who we met in July and Appendix 3 provides information on the written feedback received). During our most recent visit in July we embarked on an interactive series of meetings and discussions, where we were able to test our findings, thoughts and suggestions with the people, groups and agencies we met. This process and interactions over the last few weeks have enabled us to modify and update the framework and suggested recommendations presented in this report.

The final report marks the end of the two initial stages of work we have been commissioned to undertake. We have made a series of recommendations, with justifications for each recommendation and a suggested outline of options for implementation of the framework and the possible stages of implementation to be followed. This final report is linked to and informed by the interim report, and we would strongly recommend that these two reports be considered together.

We would like to give our thanks to everyone we met and to all those who engaged with and responded to the work as it developed. Everyone we met during this work responded with great openness about how to improve the current situation and the possibilities and ambitions for real change, not just in improving quality assurance for mental health care in Western Australia but in significantly adding to the ambitions already underway to transform the mental health system across Western Australia.

We were once again humbled by the commitment and hard work of the people we met during both visits and the aspirations they share to improve the lives of people living with and recovering from mental illness and those of their carers, supporters and families and the wider community. There is a real desire to create something better for the people of Western Australia.

The desire for change and for much greater collaboration across sectors and agencies was palpable and the enthusiasm for grasping the moment to create an improved quality assurance system and make real progress on wider system and human transformation was impressive.

This final report draws on the enthusiasm, experiences and expertise of the people we met and those who provided us with written feedback and comments. The aim is to help provide a starting point for further debate and discussion on the future direction of quality assurance for mental health in Western Australia as part of a wider process of system transformation. The framework presented here is not intended to be a blueprint. Our aim, put simply, is to set out a framework that builds on and complements what has been developed to date and help strengthen quality assurance for the future. The ambition being to help you develop a QA system that continues to improve and modernize. The framework we present is not foolproof or perfect, but we believe it will be an improvement and help take you to the next necessary stages of development in quality assurance for mental health in Western Australia.

What we have recommended here needs to be seen in the context of the services that are currently provided, the resources available to improve them, your plans and aspirations for the future, along with the wider communities views of both mental health and mental illness. Any Quality Assurance framework or system cannot be uncoupled from these wider contextual, social and resource issues.

The interpretations and recommendations we make are ours, and are our responsibility alone. We stand by what we have presented here and hope they help you achieve your aspirations to improve quality assurance in mental health as part of overall health and help underpin and accelerate change in the Western Australian mental health system for the benefit of all Western Australians.

Ultimately, the voices of the people who use the services and those who care for them and those who stand alongside them will be the judges as to whether or not the new framework for QA that we have suggested and the one that you develop will bring with it the benefits you told us you wish to see.

Summary List of Recommendations

i) Rights and Protection

Recommendation 1: Create a Mental Health Tribunal to protect the rights of users of services under involuntary status.

Recommendation 2: Create an Advocacy Service to provide users of services with access to information about their rights and to provide support in exercising those rights and pursuing complaints and to provide a systemic overview of services from an advocacy stance.

Recommendation 3: Strengthen the role of the Office of Health and Disability Services Complaints Office (HADSCO) as an independent body to address complaints relating to mental health services.

Recommendation 4: Publish and Implement a Consumer Charter for mental health that covers all users of services and their carers.

ii) Quality Management

Recommendation 1: Develop an integrated quality management framework building on existing Commonwealth and WA processes using a joint Collaborative and Partnership approach between the Mental Health Commission and the Department of Health

Recommendation 2: Develop an outcomes-based set of standards to help drive quality assurance

Recommendation 3: Establish a 'pre-qualification' system for non-profit providers

Recommendation 4: Build on existing standards for accreditation and improve the implementation of both accreditation and licensing processes

Recommendation 5: Commission an Independent evaluation and monitoring service

Recommendation 6: Ensure an integrated and comprehensive mental health sentinel events reporting process

A Quality Assurance Framework for Mental Health in Western Australia

What follows is a description of what we mean by quality assurance, a summary of the views people expressed about QA, the two pillars we propose for the QA framework going forward, the importance of building on what has been established and achieved to date in QA in WA, the principles underpinning our recommendations, and finally a detailed set of recommendations with justifications for each and an outline of possible options for implementation for consideration.

What is quality assurance?

Quality assurance is generally defined as the process where the performance of a system or service is assessed and evaluated to ensure that a high quality, safe service is offered and delivered to those using it, and that it complies with agreed standards, accreditation and any relevant legislation and safety requirements. Quality assurance generally takes the form of a range of activities, from the identification and monitoring of appropriate standards (international, national, regional and local) including clinical safety and clinical standards, to the formal and informal monitoring and inspection of services, to the lodging of, investigation into and reporting of complaints and serious incidents to advocacy for those using the service. The main objective of these activities is to ensure a good quality and safe service system for those using them, their families and carers and a level of assurance for the wider community.

Your views

A QA system that you told us you wanted for the future will be one that is:

- Transparent and understandable.
- Fair and impartial.
- Centred on the needs of the person and the outcomes being achieved in their lives, for them, their family, friends, neighbours and colleagues.
- Supporting safe and reliable services.
- Helping in the development of better services and improved practice.
- Supporting continuous improvement, evaluation and learning.
- Enabling partnerships and collaboration to happen across agencies and across sectors.
- Culturally competent, both in the way it responds to indigenous people's needs and culture and also to the wide variety of a range of cultures and ethnic groups resident in WA.

- Providing incentives for improving quality through continuous improvement and shared learning across the whole health and human welfare system.

The two proposed pillars of Quality Assurance

In our interim report we proposed two main and linked components for a QA framework– there was a high level of support for these two key components as the foundation of a future QA framework.

1 - Rights and protections

2 - Quality management

These are set out below in Table 1 – Defining Quality Assurance and Figure 1 – Quality Assurance Framework Diagram.

Figure 1 shows that underpinning the implementation of these components requires a combination of legislation and appropriate funding, and that the work going forward needs to be supported by a level of ‘authority’ or ‘authorisation’ that supports and enables the future direction of travel to be achieved based on a set of agreed and values and principles. In this way any future framework can be underpinned and supported by a range of actions that link to each other.

Table 1: Defining Quality Assurance

Our suggested framework for quality assurance consists of two key ‘pillars’, each with a core set of interrelated functions:

1 Rights and protections

- Protecting the rights of involuntary users of services
- Protecting the rights of voluntary users of services and their carers / supporters
- Independent advocacy for users of services and their carers / supporters
- A complaints procedure for users of services and their carers / supporters

2 Quality management

- Setting standards and outcomes
- Independent inspection, monitoring and evaluation
- Pre-qualification and licensing of providers
- Reporting and monitoring of sentinel events

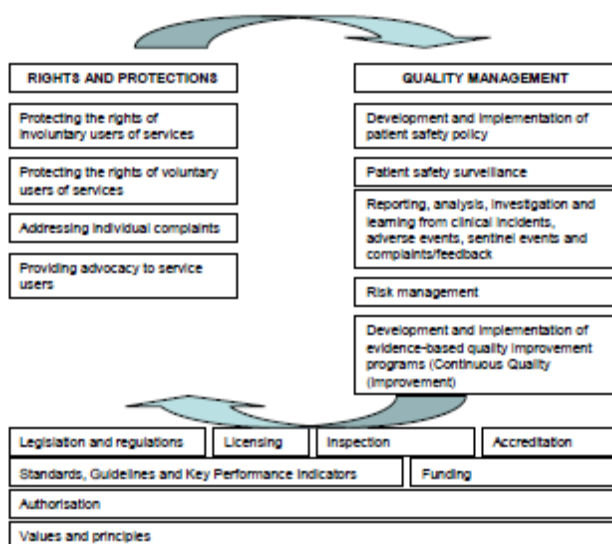
Figure 1. Quality Assurance Framework Diagram
QUALITY ASSURANCE FRAMEWORK



A helpful submission was received from the Performance and Quality Division of the Department of Health, in that submission they proposed a revised framework, which we present below as Figure 2. This has particular merits and helps illustrate how a future framework can be built on the governance framework presented below.

Figure 2. Governance Framework for QA in Mental Health Services in WA

Governance Framework for Quality Assurance in Mental Health Services in WA



Building on what has been established and achieved

It was clear to us that significant strides have been made in QA for mental health in WA over the last 10 to 20 years or so. People told us of the importance of what has been built up and progressed. Both in progressing rights, advocating for people and families, and in quality assurance, clinical governance, risk management and patient safety. These improvements and changes have been made by service providers, Government Departments, key agencies, individuals, families and supporters. Almost universally people said that whilst progress has been made and should rightly be recognised, more is needed to help build a modern and effective QA system for mental health.

One of the areas where we are keen to see mental health benefit further from is the work that the Department of Health is taking forward on general clinical governance, quality assurance and improvement using internationally and nationally recognized practice.

Our intention in proposing a high level framework for taking QA forward in mental health is to encourage building on and complementing work that has already been established that is working well to national and international standards and practice in both health and mental health, and also in human services and other parts of public welfare and support for individuals, families and communities. It will be important to find ways of ensuring that current good practice is not diluted and similarly that any necessary changes are not made in ways that duplicate work and or create additional burdens on the system and on people, families and supporters. These will be key issues for discussion around implementation and moving forwards in operationalising an improved QA system for mental health as part of wider health and human welfare systems.

Principles underpinning our QA Framework recommendations

We started with the principle of mainstreaming mental health, and avoiding any sense of exceptionalism or separatism for mental health, and during our visit in July this was subjected to considerable debate. Views varied. First that when part of the mainstream health agenda, mental health in WA was perceived as not getting an adequate level of support or profile, and second that the word 'mainstream' was felt by some to mean a way that did not recognize culturally diverse and indigenous cultural beliefs. We altered our views during our July visit and have gone for a set of principles that attempt to recognize both where the mental health system currently is in relation to mainstream health, and also the need to do more to ensure both indigenous and cultural competency and an appreciation of cultural and indigenous diversity.

We believe therefore that the quality assurance framework going forward should aim to adhere to the following principles:

- Parity between mental and physical health

- Have a long term goal of Integration between mental and physical healthcare systems and between the public, private and not for profit sectors
- A system focused on the outcomes that matter to people's lives
- A system that puts people at the centre
- A system that helps achieve a greater public understanding of mental health, and improved community inclusion and integration
- A system that is culturally competent both to indigenous cultures and the diversity of new cultures and languages in WA.

While these are the principles that underpin the new QA framework we recommend, they need to be built on and monitored in the implementation of the new QA system. *We therefore recommend that the new system be independently evaluated after a period of five years.*

We are recommending pursuing the new QA framework in a phased approach. There are actions that can be taken now and others at a later stage. Inevitably the success of a new QA framework will depend on its implementation. This will require investment not just in additional resources but also in training and support and by planning the transition to the new system in a phased and supported way.

What will also be crucial to the success of the new QA framework is recognizing the current status of mental health within the healthcare system (and wider system of public funded services) and the maturity of the mental health system as a whole. Some of the recommendations presented here continue to separate mental health from the rest of health to a certain degree. While there is a long term risk of mental health exceptionalism or separatism, we believe from what we have been told and what we have seen of the Western Australian mental health system that it should continue to remain administratively closely linked and aligned to the overall Health system (and other systems) and that effective links, effective collaboration and co-ordination, and joint arrangements are established with the Mental Health Commission for a period of time while the mental health system matures under the Commission and whilst a more robust quality assurance system is put in place with progress reviewed after an initial period of five years.

COMPONENT 1 - Rights and Protections

The main functions involved in rights and protections are:

- Protecting the rights of involuntary users of services
- Protecting the rights of voluntary users of services and their carers / supporters
- Independent advocacy for users of services and their carers / supporters
- A complaints procedure for users of services and their carers / supporters.

What we saw and what you told us centred on a number of main observations on the current system of protections and ensuring rights, namely that there is a lack of capacity to deliver what is required to assure that rights and protections for people are upheld, promoted and supported, and a lack of transparency in the system with insufficient powers to hold agencies and practitioners to account, despite the best efforts of the current organisations responsible (the MHRB, C of OVs and OCP). And that the efforts of the agencies currently involved could be more co-ordinated and integrated around a set of key functions.

The Mental Health Review Board requires additional capacity to ensure that people's rights in the future as part of any new legislation are adequately protected and requires a wider remit to help ensure that the right outcomes are being pursued for people in a system that places greater emphasis on community inclusion and human rights.

The role and remit of the Council of Official Visitors again requires greater capacity and a more focused direction and remit around advocacy – both improved individual advocacy and wider systemic advocacy.

The Office of the Chief Psychiatrist could benefit from having a wider more strategic role and function both in mental health and in overall health.

The system of an independent overview of taking and dealing with complaints about mental health care and services needs to be simplified and streamlined and provided by one coherent service outside of mainstream mental health and health provision in tandem with the complaints systems being taken forward by mental health providers.

There is also support for and a benefit to having an overriding set of principles on rights and responsibilities set out in what we are calling a 'consumer charter' for mental health that will help guide future actions. This can be effectively linked to other similar work already in train. For example the WA Public Patient's Hospital Charter and the Carers Recognition Act 2004.

In our Interim Report we set out a number of suggestions for rights and protections. We are building further on these and are proposing that these functions can be best delivered by pursuing the following recommendations.

Recommendation 1: Create a Mental Health Tribunal to protect the rights of users of services under involuntary status.

Build on the work of the MHRB to establish a new Mental Health Tribunal (MHT) in the new legislation. The overriding purpose is to ensure that the right capacity and a broader remit centred on community inclusion and community living with a stronger human rights focus is achieved. Some key points include:

- MHT reports to the Minister for Mental Health with a statutory requirement to produce an Annual Report to Parliament.
- MHT has a 'Head of Tribunal' appointed by Cabinet, with Tribunal members also appointed by Cabinet on recommendation of the Minister for Mental Health for a term of 3 – 5 years. Consisting of equal numbers of medical members, legal members and lay / community members. Each to receive full induction and training in mental health and also in cultural competency. Significant attempts should be made to ensure representation from indigenous and culturally diverse communities in WA as Tribunal members.
- Any appeals on the work and findings of the MHT to be referred to the State Administrative Tribunal.
- The MHT to conduct its role and functions with a focus on patient's rights with regard to involuntary status, and based on the principles of reciprocity – where any restrictions on people's freedoms are met with a statutory duty to provide for an individualized care, support and treatment plan for all users of services under involuntary status. This plan to be reviewed by the MHT, noting that the care and treatment plan must address all aspects of recovery not only clinical issues, so therefore needs to include housing, employment, education, wellbeing and social development (social, emotional wellbeing). This will require close links and liaison across human services agencies, especially welfare officers, social workers, housing officers and those providing employment support services.
- MHT to also include a statutory right of review for all patients who have been in hospital for 12 months or more under inpatient care.

Justifications

- Builds on what has gone before by updating and modernizing the role and functions of the Mental Health Review Board. The development of a MH Tribunal signals an increase in priority for upholding rights and responsibilities and recognizes that the aim of any use of legislation is for a clinical, treatment, therapeutic and improved outcomes need.
- A broader based MHT to ensure that increased considerations are given to individualised care and support plans that have real community links, improving relationships with family, friends and community and for emphasizing the social aspects of people's lives (housing, employment, education, leisure and recreation, cultural and arts activities) and lived experiences and for ensuring a holistic care plan that includes housing, employment / vocational status, education and learning, and wellbeing and social development in a wider community context.
- Based on International best practice in developing new Mental Health Care and Treatment legislation, especially around reciprocity (as in Scotland). And fits well with a more person-centred, outcomes focused approach.

- Aligns well with work being undertaken by Professor Bernadette McSherry and colleagues at Monash University on examining international mental health legislation and rethinking rights based mental health laws.
- MHT reporting to Minister at this time of change, with new and greater emphasis given to mental health to help ensure consistent reporting. Also helps to allay any fears that MHT may not be given due consideration under SAT. Further, helps to emphasize that improving care and treatment is the reason for removing people's rights for a short period of time.

Options for implementation

The following is a suggested outline for implementation of establishing a MHT.

- Stage 1 – Set out role and functions of the MHT in new legislation, building on the experience of MHRB, CoOV and OCP, but going further in line with international best and emerging practice. Have the new drafted legislation independently assessed in line with new and emerging international best practice.
- Undertake a rigorous costs assessment exercise based on current costs of MHRB and expanded functions and capacity of proposed MHT.
- Stage 2 – Following legislation move to establish new MH Tribunal by building on experience of MHRB (and CoOV and OCP), prepare for transition stage during the passage of legislation.
- Appoint key Staff to oversee and implement transition plan.
- Stage 3 – MHT operational

[A note on an increase in capacity and funding - The creation of the MHT will require an accurate assessment of costs. This will include looking at the costs of the current MHRB and getting comparable costs of MHT functions from other jurisdictions, notably Scotland.]

Recommendation 2: Create an Advocacy Service to provide users of services with access to information about their rights and to provide support in exercising those rights and pursuing complaints and to provide a systemic overview of services from an advocacy stance.

This was an area that received widespread support from all stakeholders and is one that corresponds well with the direction of public services in WA and in helping to ensure and promote rights and responsibilities.

- The Head of the Advocacy Service to be appointed by Cabinet on the recommendation of the Minister for Mental Health
- The Advocacy Service to build on the effective advocacy role played to date by the Council of Official Visitors and the service will retain the right of entry into facilities and to look at medical records. The new Advocacy Service will transition out of the Council of Official Visitors (CoOV) with a clear remit laid down in legislation.
- Advocacy Service to report to the Minister for Mental Health
- Advocacy Service to provide an annual report to Parliament with information provided to Mental Health Commission to act upon through contracting and also information provided to

the Department of Health and other Government Departments and Publicly funded agencies to ensure the Service can play an effective 'systemic' advocacy role.

- Advocacy to include housing, education, employment and transport services (wider systemic advocacy as it affects achieving real outcomes in people's lives.)
- Cultural competency and the need to ensure effective cultural brokerage and cultural liaison.

Although the administrative support for the Advocacy Service would most likely be provided through the Mental Health Commission, it must be given the mandate to operate independently of all other parts of the mental health system. This will be in time a professionalized service, therefore adequate training and capacity building will be required.

Justifications

- International examples – New Zealand District Inspector model and Scotland's system of access to local independent advocacy.
- Well supported in system.
- Helps to ensure an enhanced protection of rights and a supportive advocacy culture to help achieve improved outcomes for individuals, families, supporters and carers.
- Aligns and helps with the move to more individualized care planning that covers range of needs including clinical as well as psychological and social needs.
- Builds on leadership, expertise and processes developed by the Council of Official Visitors.

Options for implementation

- Year 1: Advocacy to be a requirement for all users of services under involuntary status or who have been an inpatient for 12 months or more
- Year 2: All inpatients, whether voluntary or involuntary, have a right to advocacy
- A third step would be to grow the capacity over time to eventually provide advocacy to all users of services who request it.
- A detailed identification of the costs of the Advocacy service will need to be prepared, based on the three levels of operation outlined above.

Stages to implementation:

- Stage 1 – Outline new roles and responsibilities of Advocacy Service in new Legislation. Scope other international advocacy services – roles, functions and costs.
- Stage 2 – Build on current role and functions of CoOV and develop a Transition plan to develop into the future Advocacy Service. As part of Transition plans and preparation prepare a costed outline proposal for new Advocacy Service building on the current resources aligned to the CoOV.
- Stage 3 – New Advocacy service operational at same time as MHT.

Recommendation 3: Strengthen the role of the Office of Health and Disability Services Complaints Office (HADSCO) as an independent body to address complaints relating to mental health services.

There was an overwhelming desire for a simplified and more independent complaints system. One of the main issues was the desire for a complaints mechanism that was independent from those providing or funding mental health or health services.

This part of the future QA framework going forward should recognize and build on current work around improving complaints systems across area health services and the ongoing work undertaken by all providers in taking forward complaints processes as a key part of their own quality, governance and continuous improvement functions. Stakeholders all want complaints to be dealt with in a timely and appropriate manner and it was recognized that all providers need to continue to review their complaints systems and effectively use the data and learning from complaints, and be seen to address both individual and systemic issues that are raised in complaints.

The core elements of this new 'independent' complaints system are suggested as:

- A comprehensive complaints process: involving complaint to provider, complaint to MH Commission as the funder of services, and complaint to HADSCO as the independent body for complaints.
- HADSCO to deliver an Annual report to Parliament and information to MH Commission to inform commissioning of services and to the relevant range of service providers as part of their continuous improvement.
- HADSCO will need MH specific expertise and additional capacity to fulfill this function.
- HADSCO process for dealing with complaints involves an initial stage with a negotiated settlement, building to a conciliation and mediation (with not compelling, but agreed forward actions and a follow up both short and longer term), to an investigation, both individual and systemic, with recommendations for actions, if no follow through then HADSCO can report to the Minister.
- Bi-annual meeting of Head of HADSCO, Advocacy Service and Mental Health Tribunal, facilitated by the Mental Health Commission. Key issues reflected to relevant agencies across the system.
- Consider improved and more powerful sanctions / powers for HADSCO.

Justifications

- Integration with complaints process for other areas of health and disability but with an investment in helping people negotiate the system and building the capacity of HADSCO
- Increases recourse in the system for consumers and carers and helps create a powerful lever for quality improvement
- Widespread support for a more independent complaints body.

Options for implementation

- Need to consider any consequential amendments required to existing legislation with new role for HADSCO
- Identification of required additional capacity and expertise in mental health for HADSCO.
- Scoping of future additional costs to handle increase in activity.

There was also a concern from carers and consumers for some form of remedy or redress, for example the right to transfer to another hospital. We are of the view that there is sufficient scope within the proposed system to meet these demands, if all the levers are properly used. For example, we note that a recent complaint about alleged ill-treatment of a patient has led to a police investigation¹ It will be the role of the MHC to make sure that people are aware of the options and, if necessary, facilitate access to advocates for people with complex problems.

Elsewhere in the existing legislation it is noted that the Chief Psychiatrist and the Mental Health Review Board already have powers to overturn decisions. The challenge is to make sure these powers are used when required, and their use is reported in a transparent manner.

It may also be necessary to have a recognized power in the new system to respond when a situation is untenable and to therefore seek an immediate remedy or to get care from another provider.

We were made aware that a lot of work is going into improving the way that complaints are managed and improvements made. This work is key and it is heartening to learn that actions are in train to help ensure that complaint management processes across WA in the public health system are working to ensure that relevant recent national agreements are being met and implemented.

What we were struck by most in the views around complaints were the points people made about both the complexities that people experienced in making a complaint and that some felt that there was either no or insufficient powers to enforce improvements following complaints. This is a serious issue and one that people recognized and said they were committed to addressing as these views and experiences can undermine confidence in the system. A suggestion was made that an advisory or helpline number be established that can help guide people in how to make a complaint, who to complain to and what help is available. This may be a helpful service and could be sited in a number of places – the Advocacy service or indeed as one of the administrative functions of the MHC. This is worthy of further discussion.

Stages to Implementation

- Stage 1 – scope additional capacity and costs required to run a full complaints service in mental health.
- Build HADSCO functions for dealing with mental health complaints into any necessary new or existing legislation.
- Stage 2 – Develop costed operational plan for implementation.

¹ <http://au.news.yahoo.com/thewest/a/-/wa/9869083/patient-claims-attack-by-nurse/>

Recommendation 4: Publish and Implement a Consumer Charter for mental health that covers all users of services and their carers.

This work can build on work that is going on nationally, and also take cognizance of other charters that exist in WA. For example we have been told of the WA Public Patient's Hospital Charter. This can be built on in developing a more wider reaching consumers charter.

The charter can include:

- Statement on rights and responsibilities under the new mental health legislation
- Basis for complaints to the Health and Disability Services Complaints Office (HADSCO)
- Aligned with Carers Recognition Act 2004
- Alignment with other relevant charters, nationally and state wide.

Justifications

- International good practice – New Zealand and will help with bringing legislation and actions more in line with the UN Convention on the Rights of Persons with Disabilities.
- To align with the Australian National Mental Health Statement on Rights and Responsibilities (currently being updated and due shortly for review)
- Route to strengthening rights of all users of services and their carers not just those under involuntary status
- Route to providing greater sanction in the system for poor quality providers
- Ministerial oversight as part of implementation of new Act. Can act as a powerful lever for equality and fairness.

Options for Implementation

- To draft the Consumer Charter or Statement of Rights and Responsibilities as one of the main core aspects of the new mental health legislation. Might be helpful to draft for consultation and engage stakeholders in developing and shaping the charter.

COMPONENT 2 - Quality management

Quality management is the second main component of the proposed QA framework.

The main functions involved in quality management are:

- Setting standards and outcomes
- Independent inspection, monitoring and evaluation
- Pre-qualification and licensing of providers
- Reporting and monitoring of sentinel events

It was here that a lot of our attention was focused during our second visit. What we experienced was a health and mental health system that already has much in place with respect to quality management and quality assurance that can be built on, complemented and extended. We were also mindful that any future quality management system will need to work with the inherent complexity of integrating and aligning Commonwealth standards with State processes.

We were told about the fragmentation between the public health system and other providers in the context of quality management and the lack of basic accreditation for non-profit providers. However, we were not convinced of the merits of the proposal of developing a separate quality management system for clinical services provided by the public health system, and one for community-based services provided by the NGO sector, as some people had suggested to us. The principle of having one quality management system was favoured by the majority of people with whom we consulted and it was generally recognised that a unified quality management system could play an important role in bringing the different sectors in the system together.

Another issue raised to us was the lack of information about quality and performance flowing from Area Mental Health Services to the Mental Health Commission as the commissioner of services. Dialogue and close collaborative working between the MHC and Area Mental Health Services did not appear to be the norm. People we spoke with expressed a desire to have a much closer relationship in order to progress both strategic and operational issues, including quality management which was an issue of great importance to Area Mental Health Services. Beyond this, there appeared to be a general lack of transparency with regard to quality and system performance for users of services, their carers and the wider public.

Generally there seem to be two key issues.

First, all providers should already be involved in work that assures the quality, safety and appropriateness of their services. National accreditation and quality management systems should be in place and in evidence as a matter of course and as part of a providers' 'license' to operate.

For example, the national Australian Council of Healthcare Standards (ACHS) is a must for all publically funded mental health care services operating clinical services in hospitals or in the community. We were

able to ascertain that all WA public providers currently have up to date ACHS accreditations. Within these accreditations, there has been the opportunity for mental health services to have an in-depth review against the National Standards for Mental Health. In the last four years, only one provider in WA has undertaken the in-depth mental health review. However, from July 2011 this in-depth mental health accreditation is now integrated into the ACHS EQuIP5 organisation wide survey and reviews. All WA organisations will therefore be undergoing the mental health review (against the new national mental health standards) within their next ACHS organization wide surveys.

At national level there are also new clinical safety and quality standards developed by the Australian Commission on Safety and Quality. These set out 21 areas for action that all providers in the health system can take to improve quality and safety over the next 10 years.

National Standards for Mental Health Services have recently been revised and now include a recovery standard. This is a helpful addition to the national picture and can be built upon in Western Australia alongside the Fourth National Mental Health Plan 2009-2014 which identifies 24 performance indicators. These national activities and processes will help, and all providers will need to be aware of the national plans, standards and accreditation systems, key performance indicators they should be adhering to and working towards as one part of their ongoing quality management. They also need to ensure the suitability and applicability of more generic quality, safety and accreditation programmes to the specific needs of mental health care and services.

The work within the Department of Health's Performance, Activity and Quality Division aligned with that of the Office of the Chief Psychiatrist is key here. We saw and were told of the internationally and nationally recognized governance frameworks for quality assurance and improvement that have been established and of the improvements that have been made in supporting performance and improving patient safety. There is significant potential for these to be built on and extended in an integrated way for mental health, where mental health can benefit further from the expertise established across health.

Second, in WA there needs to be a system of quality management that is understood by and applicable to all providers (public, private and NGO), irrespective of whether they are State or Commonwealth funded. This system should have as its basis a set of standards and outcomes that make sense to the WA system and the needs of its populations and stakeholders, and it should be applied to providers in a way that is commensurate with the complexity and level of risk inherent in the services they provide.

As part of our work, we looked at the system of quality management in WA's Disability Services Commission (DSC) and were impressed with what we saw: nine explicit standards, a clear vision for the sector, an independent inspection (evaluation) and monitoring service visiting all 'pre qualified' providers every three years, a pre-qualification process for all providers of disability services, a quality management system and process supporting a culture of continuous quality improvement, an emphasis and investment in service and sector development and an annual investment / allocation in the core budget of the DSC to fund the quality management process. There is a lot here to learn from and build on that has relevance to a developing mental health QA framework. Albeit, one that will have to take into account both health care provision, clinical risk as well as social care and human services provision.

We recommend that a more coherent and streamlined system of quality management be established in WA. This does not mean adding a new system of quality management or a new separate agency to the extensive range of processes and agencies that are already in place in the public health system. It means building on what is already in place, and using this experience and expertise to help it move to the new system, rationalizing current functions in a few places, with more focus and universal coverage to help achieve a more coordinated and integrated system of quality management. One that applies to all providers, makes the best use of national standards, national accreditations, policies, strategies, frameworks and processes, one that enforces compliance and brings credibility to the task of improving services to meet the required standards and most importantly helps assure that services are focused on and achieving the right outcomes with and for people and the communities they live in, their friends, neighbours, families and supporters. This is a task that will require good management and a clear and well managed implementation plan.

We suggest that the development of such a coherent new system of quality management be overseen and managed through a new *joint partnership* between the Mental Health Commission and the Department of Health. Perhaps through a jointly agreed Memorandum of Understanding or the appointment of a joint team or QM partnership unit, or other option. There are options and discussion will be required to help identify the best option going forward, but the principle of a joint partnership approach makes sense for us. The combined expertise for overseeing this QA component and for commissioning and coordinating the quality management tasks sits well as a collaborative and partnership enterprise. There is considerable expertise to be built on and expanded, and a knowledge of the current health system that is crucial to the future success of a modern and updated quality assurance framework.

As well as the expertise and knowledge in the Department of Health's Performance Activity and Quality Division, there is also expertise in quality management in the Area Mental Health Services and further capacity to support this collaborative and joint work can be added through the expertise developed through the relevant current functions of the Office of the Chief Psychiatrist.

If these agencies formed the basis of this new suggested *Quality Management partnership or collaborative*, and were further strengthened by extending membership to representatives of NGO's through WAAMH, to Aboriginal Mental Health Services and Consumer and Carer / Supporters, this would indeed be a significantly representative and powerful quality management collaborative or partnership.

These suggestions above can be built into the ongoing and wider partnership working that we saw developing between the MHC and the Department of Health and wider stakeholders.

Recommendations for quality management

The recommendations set out below are underpinned by the following objectives for quality management:

- To create a level playing field across sectors
- To integrate with existing Commonwealth and State systems, especially those within the Department of Health and including Area Mental Health Services and Aboriginal Mental Health services
- To pursue an outcomes-focus and work towards a set of agreed standards
- To develop a system that is proportionate to the level of complexity and risk inherent in the services provided
- To incentivize and support continuous improvement and service development.
- Not to create unnecessary bureaucracy
- To complement, build on and make use of existing expertise, experiences and skills.

We propose that these functions can best be delivered by pursuing the following recommendations. These should be pursued by a combined and joint 'team' of people from the MHC and the Department of Health, building on the expertise developed through the Performance Activity and Quality Division and the Office of the Chief Psychiatrist and involving other key stakeholders.

Given the interconnected nature of the six quality management recommendations set out below, separate implementation steps are not appropriate. Instead, implementation is discussed following the presentation of the six following recommendations.

Recommendation 1: Develop an integrated quality management framework building on existing Commonwealth and WA processes using a joint Collaborative and Partnership approach between the Mental Health Commission and the Department of Health

Given the intention to limit bureaucracy and create a level playing field across the sector, our recommendation is to develop an integrated quality management system that encompasses all providers across all sectors and builds on existing processes. Specifically, this would entail:

- A matrix-approach to quality management being adopted, which also helps bring existing accreditation and licensing processes under a single combined framework that is applied across all sectors.
- The quality management framework extending across the continuum of care from community-based support services to complex clinical care.
- The standards and assurances that would have to be met would be proportionate to the type of service provided. All providers would be held to account for the improvements they make in people's lives but support service providers would not for example be subject to the same process of accreditation, licensing and quality management as an acute hospital.
- Gaps in existing accreditation and licensing processes would be identified by mapping these against the National Standards for Mental Health. Additional standards or processes would only

be put in place where existing processes were found to be inadequate. This would help limit bureaucracy and duplication.

- Undertake a review of the licensing arrangements for private and hostel providers to identify ways in which the licensing function can be modernized and harmonized as part of an integrated quality management system. This may require changing legislation, where for example there may be a need to remove any barriers preventing the sharing of information across the system and between all relevant parties.
- Continuing to ensure that all public services and hospitals are accredited by an appropriate external agency. And that in being subject to accreditation, all relevant data on performance and activity is made available to be used as part of an integrated quality management system.
- As part of the suggested Quality Management collaborative or partnership between the MHC and the Department of Health, information emanating from existing licensing and accreditation processes should be available to both partners in order to inform future commissioning and service development work across all sectors.
- Given the specific geographical challenges in Western Australia, there will be a need to identify how this integrated quality management framework applies to and can be adapted for the needs of country, rural and remote services.
- There will also be a need to identify the specific cultural competencies required to ensure quality management in the future is culturally appropriate.
- Quality across other sectors will also be important in improving outcomes in people's lives. This integrated quality management approach should also work with other areas to ensure that they are playing their part in improving the outcomes in people's lives. This will include housing services, employment services, education services, arts, culture and recreation, criminal justice and corrections / prisons services and others.

With proposed changes in joint responsibility between the Department of Health and the Mental Health Commission, it is essential that the collaborative work in quality management between mental health and physical health is maintained. This will help ensure an integrated approach to quality assurance, where mental health needs require to be met by all providers of health and social care services, thus underlining the importance of moving to parity of esteem between mental and physical health.

Justification

- An integrated approach is in line with international good practice and facilitates the achievement of parity between physical health and mental health and the long-term integration between the mental and physical healthcare systems, both of which are principles underpinning the approach to quality assurance set out in this report.
- An integrated framework provides the flexibility to deal with the complexity of Commonwealth and State standards and processes as well as being able to adapt to the specific needs of country services.

- The framework limits additional bureaucracy which aligns with objectives for wider public sector reform in WA but addresses important gaps in the context of mental health.
- Builds on existing systems and experiences and allows the mental health system to benefit from and build on existing expertise in quality management in the Department of Health, Office of the Chief Psychiatrist and Area Mental Health Services and others. For example, building on the experience and processes of the Disability Services Commission in quality management, as one example of learning from others within the WA wider public policy system.
- A flexible framework approach can take account of the needs of indigenous and culturally diverse communities.
- Moving towards an inclusion of wider services such as housing, education, employment and others is in line with national and international policies and strategies to ensure that people living with and recovering from mental illness are included in all aspects of public and community life and accorded equal rights and protections to do so.

Recommendation 2: Develop an outcomes-based set of standards to help drive quality assurance

This was an area that received widespread support from stakeholders. The development of a set of specific WA ‘outcomes based standards’ that set out the aims and goals for services working in an integrated way to help make improvements in people’s lives.

- An outcomes-based approach to quality management ensures that providers are judged against the difference they make to people’s lives.
- An outcomes-based approach to quality management needs to be informed by and aligned with the Consumer Charter discussed under the previous rights and protections section.
- Outcomes need to be developed in consultation with stakeholders to ensure that they reflect what stakeholders consider meaningful in terms of outcomes and are implementable.
- There are National Standards for Mental Health but these have not been set into specific standards for mental health in WA derived from the national standards and have not been specifically linked to outcomes. National standards for mental health exist and can be built into WA standards, specifically linked to outcomes.
- Outcomes need to cover areas of people’s lives that include good housing, employment and vocational opportunities, education and learning, arts, culture and recreation activities.

Justification

- An outcomes-based approach moves away from a disease-based ‘illness’ approach to mental illness that is deficit-oriented and based on symptom reduction to a recovery-oriented approach that is in keeping with the wider direction of travel for mental health in WA and internationally.
- Over a three year period, the Disability Services Commission developed nine disability standards that are outcomes-based and are derived from national disability standards. We are recommending a similar approach for the development of outcomes-based standards for mental health in WA.
- Outcomes that cover the full scope of people’s lives are an essential element in working towards gaining and sustaining recovery. The focus on ensuring that attention is paid to the

social determinants in people's lives and mental health is gaining significant international attention and requires a more holistic overview of what services and supports should be helping people to achieve in their lives.

Recommendation 3: establish a 'pre-qualification' system for non-profit providers

There was overwhelming support for a level playing field in a new and updated quality assurance framework. To help achieve this, it was felt important to undertake early work to bring the NGO sector into the quality management system. Drawing on the DSC model we are recommending developing and implementing a 'pre-qualification' system for all NGOs operating in mental health in WA.

- Given the fragmentation in the system, there is currently no accreditation process to which non-profit providers are subject. Given the WA Government's commitment to expanding the capacity of non-profit providers across public services, it is important to be able to demonstrate that non-profit providers in mental health meet certain basic quality standards as a first step.
- A pre-qualification set of standards will ensure that providers who do not meet basic standards cannot receive public funding. Providers who do not meet pre-qualification standards will not be permitted to compete for contracts.
- Pre-qualification will assess the financial sustainability of providers, the robustness of their governance processes and their capacity for service delivery and development.
- The pre qualification system can be used to initially bring all NGO providers up to an acceptable standard and for those that don't meet the pre-qualification, they will know what they need to do to achieve the desired standards.

Justification

- This approach to pre-qualification has been well-used by the Disability Services Commission for all providers. They have 110 pre-qualified providers who can provide services purchased through individual service funds.
- Pre-qualification is also consistent with the "service pre-qualification process" outlined in the Government's *Delivering Community Services in Partnership Policy, May 2011*²
- Pre-qualification helps achieve a level playing field in quality assurance.
- NGO Providers will be clear as to what is expected of them to qualify for receiving state funding for providing services.

Recommendation 4: Build on existing standards for accreditation and improve the implementation of both accreditation and licensing processes.

The approach suggested here is to build on existing accreditation processes that have been developed, overseen and led by the Department of Health in recent years (including national and international accreditation standards). Hospital services are subject to a four year accreditation cycle conducted by

2

<http://www.dpc.wa.gov.au/Publications/EconomicAuditReport/Documents/Delivering%20Community%20Services%20in%20Partnership%20Policy.pdf>

ACHS. All public hospitals in WA are required to be accredited, including hospital based specialised mental health services as are all WA Health provided public community based mental health services.

The Department of Health has a leadership role in ensuring that proven existing accreditation processes are undertaken by all relevant providers (public, private and NGO), including a strong encouragement for providers to undertake any in-depth mental health accreditation as part of wider accreditation reviews.

- Information on which services have achieved which accreditations should be shared across the system and be made available to the MHC and the public.
- The Licensing and Standards Review Unit (LSRU) that licenses private providers plays an important part in the WA quality management system by helping to regulate to ensure good quality, modern and safe services and for supporting continuous quality improvement. The LSRU needs to remain an integral part of any future combined quality management system developed in partnership between the MHC and the Department of Health.
- Included in this is a need to develop a more modern licensing and accreditation regime for private hostels. Private hostels will in the future also be subject to meeting the outcomes and standards to be developed as part of the future quality management system and in line with the recommended charter of consumer rights. It may therefore also be desirable for each private hostel to also go through the 'pre-qualification' recommended above for NGOs.

Justification

- The approach to quality management suggested here specifically aims not to create additional, unnecessary bureaucracy. However, this is only possible if existing standards and processes are built upon and implemented.
- Building on and improving existing processes and the role of the Department of Health builds confidence in the quality management system because these processes are well established, are nationally accepted and there is already considerable expertise in the system related to their implementation and achievement.
- Any Licensing system should ensure that it is awarding licenses in line with acceptable modern practices, meeting standards and achieving outcomes in people's lives. When these are transgressed or not met, remedial action is necessary and needs to be taken.
- As the system is transformed, stakeholders need to be assured that all providers - public, private and community – meet comparable and acceptable standards for accreditation and licensing.

Recommendation 5: Commission an independent evaluation and monitoring service

While self-assessment and a commitment to continuous quality improvement by each provider will continue to be an important part of the quality management system, there is a need in some parts of the system for independent evaluation and monitoring at certain (regular) points to provide an objective assessment of provider quality and performance and the meeting of standards and outcomes within the developed consumer charter (suggested in rights and protections section). This process is already well established in DSC and we believe it to have considerable merit. We therefore recommend that:

- The Mental Health Commission contract with an independent evaluation and monitoring agency to conduct evaluations of mental health services based on the outcomes-based standards developed under recommendation 2 every three years. (Unless it is confident that this evaluation is already being undertaken and it has access to the reports of that agency, for instance through more in-depth reviews by ACHS where appropriate.)
- Any independent evaluation agency should use teams to conduct evaluations that include people with lived experience and carers/supporters.
- In between external evaluations, providers should continue to conduct self-assessments and demonstrate commitments to continuous quality improvement.
- Where providers are found through the evaluation and monitoring process (on-going and every three years) to not be meeting the required outcomes-based standards, they should be given an assessment of what they need to do and by when to comply. If this step fails to bring the required improvements, then a 'turn around' team will be assigned to attempt to make the required improvements. If this fails then the provider will have their license to operate removed and services will be transferred to others based on a clear implementation plan. It will be important in the future to ensure that contracts with providers make the right provision for this independent monitoring function and the implications of any failures to meet the required standards and outcomes.
- Over time, independent evaluation should focus less on individual providers and more on the mental health service system within a local area a whole. This will involve assessing the contribution of the public health system and clinical service provision alongside other sectors to the outcomes achieved for individuals in that area.

Justification

- International good practice indicates that inspection (evaluation, monitoring) should be independent of provision. If clinicians who are part of the service system are responsible for assessing their own services, they are less likely to be critical of their peers, particularly in relatively small service systems such as WA where personal relationships are well developed.
- The Disability Services Commission uses independent evaluation as described above. Teams involving service users and their carers evaluate services every three to four years. The ultimate sanction for poor performance in an independent evaluation is for the DSC to remove the contract. But this does not happen frequently. The DSC takes a developmental approach and works closely with providers who are underperforming to bring their performance up to standard over time.

Recommendation 6: Ensure an integrated and comprehensive mental health sentinel events reporting process

Recording, monitoring and acting on sentinel events (serious and untoward incidents) is an essential component of any modern quality management system. This needs to continue to be accorded a high status in any QA framework with reliable systems of reporting and monitoring. It is encouraging to note that we were told of the WA Clinical Governance Framework instituted by the Department of Health,

which is in place to report and investigate serious adverse events and sentinel events and ensure corrective actions are taken by health services.

- The joint quality management partnership of the Department of Health and Mental Health Commission (recommended above) needs to ensure that a 'sentinel events' system is maintained and built upon for mental health, designed to receive reports of all untoward and serious incidents and events and the action that is to be taken in response.
- As part of developing wider system-level intelligence, a process needs to be developed to ensure the future recording, monitoring and follow up of these events.

Justification

- Sentinel events are an important indicator of problems in the system and need to be reported accurately across the system and responded to thoroughly.

Options for Implementation

We have presented the above 6 recommendations as being linked to each other as part of an integrated quality management function. In terms of moving to implementation, establishing a joint quality management 'team' or partnership across the MHC and the DH is our preferred option.

This joint partnership approach has several strengths. It provides the greatest synergy between the existing work of the DH and the remit of the MHC around commissioning and contracting. A partnership would put quality management firmly at the centre of commissioning and contracting where it can have the most impact. It provides the best opportunity to use the existing skills and expertise in quality and safety that have been developed by the DH and it also enables the LSRU to be integrated within the broader quality management system. It also helps build on the skills and experience developed by the Office of the Chief Psychiatrist in quality assurance. Any collaborative or partnership should also include the Area Mental Health Services and representatives of mental health NGO's, Aboriginal Mental Health Services, consumers and their supporters.

There will need to be an assessment of the capacity required to ensure the function of integrated quality management can be undertaken by such a joint team and that this is adequately funded and staffed to undertake the range of tasks identified.

Implementation stages

Stage 1 (over a period of 12 - 18 months)

- Create a quality management partnership between the Mental Health Commission and the Department of Health (and involving other key stakeholders). This partnership will build on existing expertise on quality and safety in the Department of Health, including the Office of the Chief Psychiatrist, in Area Mental Health Services and in the Aboriginal Mental Health Services. This partnership will work closely with providers from the private and NGO sectors and with people who use services and their carers and supporters.

- Develop and agree the partnership functions and operational model and identify the related costs for quality management activities.
- Agree joint management arrangements and lines of accountability.
- Agree the information flows between the partners and shared access to data.
- Review existing accreditation and licensing standards across all sectors against the National Standards for Mental Health (and other relevant national standards or key performance indicators) and identify the gaps that exist where additional standards need to be developed.
- Build in the comprehensive and integrated sentinel events process for mental health.
- Develop a pre-qualification process for non-profit providers as a first step to filling the gap in quality standards for the sector.

Stage 2

- Develop a set of outcomes-based mental health standards for Western Australia that are linked to the National Standards for Mental Health (This process can be started in stage 1, but is unlikely to be completed for at least 18 months if done in a way that involves and engages stakeholders)
- Develop a specification for independent evaluation and monitoring and begin the process of commissioning the independent evaluation and monitoring service.

With these recommendations taken together and implemented in planned stages towards achieving a modern quality management system we believe the future system can build on the experience and expertise of the current system in a way that takes the work required to the next stage of development. A modernized, focused and integrated system involving each of the major stakeholders is suggested. We are confident that these recommendations acted upon together in a collaborative and partnership way with a focus on achieving better outcomes for people and their families will meet the desires and aspirations that those we spoke with and heard from want to see.

In the next section, we consider some of the changes that may be required in legislation to help bring about the changes in quality assurance that we have recommended.

New Mental Health Legislation

In underpinning the recommendations we have made for both rights and protections and quality management, we outline below the role of using legislation to help achieve the changes required in moving to a new quality assurance system.

We recommend that the new mental health legislation be underpinned by the United Nation's Convention on the Rights of Persons with a Disability (UNCRPD). This is in keeping with international good practice and will provide strong support for the recommendations set out in the rights and protections section of this report and will align well with the proposed 'consumers charter'.

In addition, we recommend that a 'legislation light' approach should be taken to the new mental health legislation and that only key issues that need to be included in legislation should be. This will make the legislation more flexible to adapt to wider system changes and future developments that cannot currently be anticipated. The detailed implementation of the legislation can be set out in codes of practice following the passing of the legislation. Along with a detailed implementation and action plan. We also feel that *after a period of five years implementation of any new Act there should be an independent evaluation of the Act.*

In developing the new legislation, it will be important to make appropriate links to other relevant legislation that impinges on the mental health legislation and is affected by it, including the Carers Recognition Act, criminal justice and guardianship legislation. It is also likely that other legislation may also need to be referred to and cross-referenced or checked to ensure that it meets the aspirations of the UNCRPD and the consumer's charter you will also be developing as part of the work underpinning your new quality assurance framework and a move to a more rights based approach. For example housing legislation and ensuring people are given the right individualised support to remain in their homes and employment legislation, where people with a mental health problem are not discriminated against.

It may also be desirable to develop a language and title for the Act that refers to what it is, namely legislation that seeks to remove someone's rights to freedom for a period of time in order to respond to a care and treatment need. We also heard from people how important it is that any new legislation acknowledges and acts upon the wider aspects of people's lives. For example in ensuring access to and support to remain in good housing, be supported to access education and lifelong learning opportunities and also to access employment and vocational support.

Within the new legislation, we believe that there is a need for specific legislation around the following:

The role and functions of the Mental Health Commission

We consider it appropriate that consideration is given to legislating for the MHC. This will help ensure the credibility and functionality of the MHC. This should be reviewed after a period of five years.

Unless there is some other way of guaranteeing that the Mental Health Commission, as the strategic manager of the system and commissioner of services, has access to information and support from all providers, then the Commission will need to be given legislative powers. In our consultations, we noted that there was perceived to be a lack of openness between the public health system and the Commission and accordingly we see no other option than to provide the Commission with the legislative mandate to require information and co-operation from all funded services.

Possible oversight and governance of the MHC - We noted in discussion that in the Disability portfolio there is a Ministerial Advisory Council and a Board of Management both created in legislation. In our view, an Advisory Council for the MHC is more appropriate as it does not interfere with the direct line of accountability of the Commissioner to the Minister. Since the existing Advisory Council is appointed by Cabinet on the recommendation of the Minister, a line of reporting to the Minister rather than to the Commissioner is perhaps more transparent.

Transforming and updating the role of the Council of Official Visitors to a new professionalized Advocacy Service

The Council of Official Visitors has performed an important role but its role needs to be modernized as part of developing a quality assurance framework. The COV currently has two functions: advocacy and inspection.

The Advocacy Service which will need to be written into legislation will build on the advocacy role of the COV. It will have an individual advocacy role and a systemic advocacy role, much as the COV currently does. It will retain the important rights currently exercised by the COV to enter into mental health facilities for the purpose of visiting individuals and the right to inspect medical records. Building on the existing annual report on the COV, the Advocacy Service will continue to submit an annual report to Parliament that will form an important part of its systemic advocacy role.

The Head of the Advocacy Service will meet regularly with the Heads of the Mental Health Tribunal, the Head of HADSCO and the Head of the proposed quality management partnership.

Responsibility for ensuring that the inspection (independent evaluation and monitoring) function is delivered will pass to the MHC through the quality management partnership, the MHC will ensure that gaps in current inspection processes are addressed by commissioning an independent evaluation and

monitoring service / function. This will be informed by the advice from the Clinical Advisor Lead within the MHC.

Alongside a legislative role for the Advocacy Service, the new legislation will create a requirement on providers that individuals who have been detained involuntarily or who have been inpatients for 12 or more months are provided with independent advocacy through the Advocacy Service.

Transforming and updating the role of the Office of Chief Psychiatrist and ensuring a wider strategic role

The Office of the Chief Psychiatrist has played a critical role in providing quality assurance with limited resources. While many of the functions of the Chief Psychiatrist will pass to the Mental Health Commission with the appointment of a Clinical Advisor Lead (or other appropriate name), there continues to be a need for clinical expertise in a reformed quality assurance system.

The new mental health legislation can introduce a Chief Clinical Advisor or Clinical Advisor Lead role within the Mental Health Commission to provide strategic clinical advice across all MHC functions and all aspects of quality assurance as a role that will be key to the joint quality management partnership. This role would continue to work closely with the Department of Health and would work in partnership with all providers. This role could be supported by a 'clinical advisory committee' consisting of a range of clinical advice covering a variety of life stages (children's, adults, older age) and medical, psychological, nursing, occupational therapy and social work expertise and including clinical expertise from Aboriginal Mental Health Services. An annual report submitted by the Clinical Advisor could be one way of reporting on clinical issues and would need to address the full range of clinical expertise in the system.

These are suggestions and obviously further discussion and negotiation is required as the legislation develops.

The role of the Health and Disability Services Complaints Office

The new legislation would specifically include the role of HADSCO as the agency responsible for dealing with complaints related to mental health services, including those services that support individual recovery such as education, employment and housing services.

Amendments necessary to align existing legislation with this new role for HADSCO would need to be made.

Transforming and updating the role of the Mental Health Review Board

The new legislation would update the role of the Mental Health Review Board to legislate for a new Mental Health Tribunal (MHT) responsible to the Minister for Mental Health.

The MHT would be rooted in the principle of reciprocity whereby having restricted the freedom of individuals, the mental health system has a duty to promote the well being and social development of individuals who have been detained and to ensure that they have appropriate care and support in the community when they are discharged. Reciprocity could be delivered through an individual plan of care with a strong focus on therapeutic interventions, advance directives / crisis plans and on building towards improving their life once they leave hospital.

Other important principles could underpin the MHT including:

- An onus on the provider to demonstrate clear treatment aims and plans
- Involuntary detention should be for the shortest possible time and in the least restrictive setting possible
- Reviews should take place promptly and with all required parties present.

Legislation to also consider:

In addition to the above, we also suggest that the new legislation also encourages and supports:

- An all ages approach where the suitability of the legislation to all age groups is achieved.
- A move to more 'supported decision making', where for example the criteria for detention is based on assessment of risk and an assessment of 'capacity'.
- A detailed consideration of the responsibilities of the police. And to align this with modern updated practice from international practice. This can be a sensitive area, but one that is essential to get right. An area where this is key is in the issues of responding to people who may be acting in a way that is a danger to themselves or others, or acting in a violent or aggressive manner and also in escorting or transportation. In other jurisdictions this can involve taking a person to a place of safety for an assessment. And also in escorting someone who is to be transferred to a hospital after assessment. This can work especially well where there is a good relationship and regular liaison and communication between local mental health services and the police. This form of joint and partnership working is to be encouraged.
- The need for tri-state or interstate agreements so that transfers across and between different state jurisdictions can be effectively managed in the interests of patients
- An effective system for transportation between hospitals - where there is a need for transportation this is done in a manner that puts care and welfare first and where all possible attempts are made to manage risk and safety in a local and consensual way.
- A continual focus on care and treatment needs, and where there are blocks to releasing someone from involuntary care, that these are not due to a lack of services or supported accommodation or due to any failings in an individualized care plan. These will need to be developed through effective care planning across the system.

- A significant emphasis in the legislation to help ensure cultural competency and the need to meet the diverse needs of the communities of WA, including ways of addressing the overrepresentation of people from Aboriginal backgrounds in the current mental health system.

Not all of these necessarily require legislative changes to enable them to happen.

Some thoughts and suggestions on 'Risk'

Serious harm, to self or others, is very rare but when it occurs it causes severe and widespread personal and systemic distress. Historically, mental health systems have addressed risk and the avoidance of risk in such a way as to more often unreasonably restrict the lives and opportunities of the many who have severe mental illness. There is a growing move to reframe risk through the lens of safety. At a time of increasing choice and control for those receiving services, clinicians, the public and politicians have to feel confident that risks are mitigated. Through a new, more inclusive and more holistic approach, the responsibility for achieving safe outcomes is beginning to move to a process that is shared by the person who is ill, their family /close friends, and the psychiatrist and other professionals involved. These more inclusive processes move away from the false assumption or perception that all risks can be prevented and seeks to develop a more mature approach to managing risk, collectively. This is not always possible to appropriately legislate for and with therefore require a collective effort by all parts of the system to develop a more updated and appropriate attitude and response to risk and risk management. It may therefore be worth developing a WA position statement on managing risk to go alongside the implementation of the new Act.

To also help ensure that the new Mental Health legislation is developing in a way that is in keeping with best international practice and experience, it may be worth having the proposed legislation independently assessed in relation to current best international practice.

Finally, however good the new legislation is or will be, there will still need to be action taken on community views and public perceptions. Addressing community inclusion and overcoming stigma and discrimination and asserting equal rights and opportunities for people living with and recovering from mental illness is a crucial part of any future transformed system.

Developing a Quality Assurance Framework - Next Steps

This report has attempted to provide a series of recommendations and suggestions that will help facilitate the development of a new quality assurance framework for mental health services in Western Australia, and, at the same time help inform the development of new mental health legislation. Both of these are complex and interrelated tasks and will require further discussion and development between key stakeholders.

The likely next steps are:

- Detailed consideration of this report and its suggestions and recommendations by key stakeholders.
- Cabinet Submission on recommendations for a QA framework for mental health.
- Development of a Green Bill for mental health legislation.

What may help in moving to a new QA framework:

- A series of 'Roadshows' across WA on the evolving framework and the key proposed components of the new legislation.
- The development of a detailed QA Framework Implementation Plan, including plans for transition, future functions and operations and an outline of detailed costings.
- The establishment of a 'Transition Group' to help lead the preparation for and implementation of the QA framework and the new proposed legislation
- Creating opportunities for key stakeholders to come together on a regular basis to share their views and experiences and at the same time help develop a more shared understanding of quality assurance.

End Note and thanks

We have been extremely fortunate to have been invited to undertake this important work and we hope that we have been able to set out a helpful way forward for all stakeholders.

We would like to thank all those people we met and all those who engaged with the work over the last four months.

Gregor Henderson, Vidhya Alakeson, Kevin Lewis

Gregor Henderson Limited

10 October 2011

APPENDICES

Appendix 1 – Expert Team, Role and Remit

Appendix 2 – Stakeholder Meetings in July

Appendix 3 – Information sheet on interim report feedback

Appendix 1 – Expert Team, Role and Remit

Gregor Henderson

Gregor is a well known and respected expert in mental health and for the last three years has provided advice and support to a number of mental health systems and Governments as a consultant and adviser. These include mental health systems in Scotland, England, Northern Ireland, Wales, Canada and Australia. Gregor has built up a wide international network of contacts and colleagues and is also a member of the International Initiative for Mental Health Leadership (IIMHL). Over the last three years Gregor has also been working for the National Mental Health Development Unit in England leading a programme of work in support of policy and its implementation. Prior to that Gregor was the first Director of Scotland's National Programme for Improving Mental Health and Wellbeing, an internationally renowned national programme in mental health, which established Scotland's national anti-stigma campaign, suicide prevention strategy and national recovery network. Gregor also has experience of managing local mental health services and believes in combining policy, practice, research and people's lived experiences to help transform how communities think and act about mental health.

Kevin Lewis

Kevin is the Programme Lead for Values and Culture at Berkshire NHS Healthcare Trust in England and for two days each week provides advice to the Department of Health on personalisation in mental health. Working across government and NGO sectors, with commissioners, providers, consumers and carers, Kevin has helped generate a new debate on the re-framing of governance to ensure probity and high quality services are achieved. He is currently leading a project of work with the Royal College of Psychiatrists to help devise a more enabling approach to risk in mental health care. In the late 1990s, he set up an NGO to work on an individual basis with people, some of whom had spent up to 40 years on locked wards, to support them in community living. A decade on, people continue to live in their own homes, their lives recovered and the cost to the taxpayer reduced by 25%. Kevin is particularly interested in building governance systems that protect citizens, support choice and control and empower front-line staff to provide recovery oriented and personalised services.

Vidhya Alakeson

Vidhya currently leads a national learning set for personal health budgets in mental health on behalf of the Department of Health in England. Vidhya is also the Director of Research and Strategy with the Resolution Foundation, a UK based economic and social policy foundation. In 2006 Vidhya was awarded a Harkness Fellowship to carry out comparative health policy research between healthcare systems in the US and UK. Her research focused on self-directed care initiatives in mental health and in both countries, Vidhya's recommendations have been taken up by state and national governments. At the US Department of Health and Human Services, Vidhya was part of the team that coordinated the stakeholder engagement process developing the mental health parity regulations affecting the health insurance industry. This involved informing the development of the regulations, reviewing close to 500 public comments, working across government Departments to coordinate responses and conducting stakeholder events to gather feedback on the proposed regulations. Vidhya is an experienced researcher and analyst in the public and social policy world and has a special interest in mental health.

Tony Jameson Allen

Tony has a passion for improving mental health care and systems through collaborative working and the effective management of information and communications. With clinical and managerial experience in mental health and social care, Tony believes that effective and sustainable developments can only be achieved if these are carried out in collaboration with appropriate stakeholders, ensuring service users and carers are actively engaged in planning, implementation and evaluation. Tony has implemented and managed complex communication, consultation and knowledge management systems and Tony's main role in the project team is to support web based and online methods of stakeholder consultation and engagement.

Role and Remit

The Mental Health Commission of Western Australia commissioned a group of external mental health experts (brought together by Gregor Henderson Ltd) to provide advice to help inform the development of a Quality Assurance Framework for Mental Health in Western Australia.

The experts involved were Gregor Henderson, Kevin Lewis, Vidhya Alakeson and Tony Jameson Allen from the UK. (see above profiles). The work took place in two stages.

Stage one involved desk-based research about Quality Assurance and how other mental health systems across the world approach and provide for modern and appropriate quality assurance in mental health. Along with discussions and meetings with key stakeholders which took place in Western Australia during the week of 9 – 13 May. An interim report based on the research and stakeholder discussions was produced by the end of May and then disseminated and made available in early June to stakeholders for comments.

Stage two used the interim report as a consultation paper to form the basis for further discussions with stakeholders to canvas a broad range of opinions, views and experience. Consultation meetings and discussions took place in Western Australia from 4 – 12 July. Following this, a draft final report with suggested recommendations for a new quality assurance framework was produced by the beginning of August. Following consideration by the project's WA Reference Group members a final report was submitted in October 2011.

Appendix 2 – Stakeholder Meetings in July

Gregor Henderson and Vidhya Alakeson met with the following groups and individuals from 4-12 July 2011

Allies in Change group
Ann Hodge, Area Executive Director Mental Health, North Metropolitan Area Health Services
Consumer group
Consumers and Carers Meeting
Council of Official Visitors - Debora Colvin
Disability Services Commission, (Geoff Holman and colleagues)
Dorothy Jones, Executive Director, Performance Activity and Quality, Department of Health
Eddie Bartnik, Commissioner, and Lesley Van Schoubroeck, Mental Health Commission
Health and Disability Services Complaints Office (Anne Donaldson)
Legislation working group – Damien Parke, Tim Rolfe, Michelle Wolstenholme
Mental Health Advisory Council
Mental Health Commission Corporate Executive
Mental Health Law Centre - Sandra Boulter
Mental Health Operational Review Committee (WA Health)
Michael Mitchell and colleagues from the Office of Aboriginal Health
Minister for Mental Health - Hon Helen Morton MLC
Nigel Armstrong – Consultant Psychiatrist, Royal Perth, and colleagues
Open Forum - Evening Stakeholder Meeting
Performance and Reporting staff, Mental Health Commission (Danuta Pawelek and staff)
Quality Assurance Reference Group
Rowan Davidson - Chief Psychiatrist, Department of Health
Roebourne Aboriginal Medical Service
Romily House (Judith Balfe and residents)
Steve Patchett – Forensic Psychiatrist, WA Health
Western Australian Association for Mental Health - Board members
Western Australian Centre for Mental Health Policy Research (Geoff Smith and Theresa Williams)
Western Australian Country Health Services at Port Hedland (Frances Keegan and colleagues)
Western Australian Country Health Services – Richard Menasse and colleagues

Appendix 3 – Information Sheet on Interim Report Feedback

Following the publication of the interim report by Gregor Henderson Ltd on the Government of Western Australia Mental Health Commission website June 2011, the project team embarked on gathering feedback from stakeholders and interested parties.

To maximise opportunities for receiving feedback, the team made an online feedback form available, linked from the commission's website, which was constructed using 6 guiding questions around the content of the report.

There were no limitations placed on how much feedback people chose to submit and there was a facility to upload feedback as a word document, which some did, or to upload a supporting document for the team to view.

The six questions the team asked were:

1. Tell us what we may have got wrong, any gaps you have identified or areas you would like to see more explanation/detail
 2. Tell us what you like about the proposals
 3. Can the existing systems as described in Appendix 2 embody greater confidence in the quality of services with minor changes to roles, functions, structures and processes?
 4. Are there approaches we can adopt from other health, wider disability arena(s) that will enhance greater confidence in the quality assurance of mental health services?
 5. Please give us your thoughts on the overall direction of travel set out in this interim report
 6. Any other points you wish to raise?
- Use the facility below to upload a supporting document

13 submissions were received directly through the web facility of which 9 responses answered questions directly via the online form and 4 uploaded their feedback as an attachment and 4 supporting reports were highlighted.

4 responses were received directly by the Mental Health Commission and passed on to the project team for consideration

A number of the responses supplied to the project team were marked 'confidential'