Office of the Chief Psychiatrist

Chief Psychiatrist's Thematic Review Program

Thematic Review of Mental Health Services

Admission, Risk Assessment, Management Plans, Outcome Measures, Use of the Mental Health Act and Discharge Planning Processes in WA Public Mental Health Services

REPORT OF FINDINGS

This report is as a result of the Chief Psychiatrist's responsibility under the *Mental Health Act 1996* to monitor standards of care.

It is provided in to the Minister for Mental Health to assist in the continuing quality improvement of clinical service delivery.

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Government of **Western Australia**
Department of **Health**

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Thank you also goes to the mental health services who willingly accepted our presence and facilitated access to the information required to make the review effective.

Important Disclaimer

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Acronyms

BRA	Brief Risk Assessment
CTO	Community Treatment Order
DOH	Department of Health
EPT	Emergency Psychiatric Treatment
IMP	Individual Management Plan
HoNOS	Health of the Nation Outcome Scales
HoNOS 65	Health of the Nation Outcome Scales - 65+
HoNOSCA	Health of the Nation Outcome Scales - Child and Adolescent
LSP	Life Skills Profile
MBR	Mechanical Bodily Restraint
MDT	Multidisciplinary Team
MHA	Mental Health Act (1996)
MHS	Mental Health Service
NOCC	National Outcome Casemix Collection
NSMHS	National Standards for Mental Health Services
OCP	Office of the Chief Psychiatrist
PSOLIS	Psychiatric Services On Line Information System

Glossary

Carer
A person whose life is affected by virtue of close relationship with a consumer, or who has a chosen carer role with a consumer. Carer, in this document, may also refer to the consumer's identified family, including children and parents, as well as other legal guardians and people significant to the consumer. (*NSMHS, 2010*)

Community
In the context of treatment setting - where mental health services are provided to people in a location other than the mental health service, usually in the home.

Community Treatment Order (CTO)
Means a person subject to a community treatment order provided by division 3 of part 3 (*MHA, 1996*)
In line with the principle of the least restrictive alternative, CTOs allow involuntary patients to be treated in the community for up to three months, with the option of extension for a further three months, after which a new order is required. (*Clinician's Guide to the Mental Health Act (1996), 2009*)

Consumer
A person who is currently using, or has previously used, a mental health service. (*NSMHS, 2010*)

Continuity of Care
Linkage of components of individualised treatment and care across health service agencies according to individual needs. (*NSMHS, 2010*)

Emergency Psychiatric Treatment
Psychiatric treatment that is necessary to give to a person:
a) to save a person's life; or
b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.
(Mental Health Act (1996))

Individual Management Plan
A written statement developed for entitled persons which states the interventions to be undertaken, the health outcomes to be achieved and the review of care which will occur at regular intervals. (*NSMHS, 2010*)

Informed Consent
Consent obtained freely, without coercion, threats or improper inducements, after questions asked by the consumer have been answered, after appropriate disclosure to the patient, adequate and understandable information in a form and language demonstrably understood by the patient. Such answers and disclosures must be sufficient to enable the consumer to make a fully informed decision based on all relevant factors including the nature of treatment involved, the range of other options and the possible outcomes and implications, risks and benefits for the consumer and carer. (*NSMHS, 2010*)

Inpatient Psychiatric Service
A ward / unit / facility in a general hospital, private psychiatric hospital, stand alone psychiatric hospital or some other location used primarily for the treatment of mental health problems and / or mental illness. (*NSMHS, 2010*)

Involuntary
Means a person who is, for the time being, the subject of involuntary orders for the detention in an authorised hospital an involuntary patient, or a Community Treatment Order. (*MHA, 1996*)

Mechanical Bodily Restraint
Means restraint preventing the free movement of the person's body or limit by mechanical means other than by the use of a medical or surgical appliance for the proper treatment of physical disease or injury. (*MHA, 1996*)

Mental Health Service
Specialised mental health services are those with the primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental illness or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. (*NSMHS, 2010*)

Multidisciplinary
Care or a service given with input from more than one discipline or profession. (*NSMHS, 2010*)

Open
In the context of a type of admission, or inpatient ward setting. See 'Voluntary'

Outpatient
In the context of treatment setting - where mental health services are provided to people who are not currently in an inpatient psychiatric service.

Rights
Something that can be claimed as justly, fairly, legally or morally one's own. A formal description of the services that consumers can expect and demand from an organisation. (*NSMHS, 2010*)

Risk Assessment
The process of identification, analysis and evaluation of a risk. (*NSMHS, 2010*)

Risk Management
In health care, designing and implementing a program of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution. (*NSMHS, 2010*)

Seclusion
Means the sole confinement in a room that is not within the control of the person confined to leave. (*MHA ,1996*)
It should not be confused with the practice of time out, where a patient is requested to seek voluntary social isolation for a minimum period of time. (*NSMHS, 2010*)

Secure
In the context of a type of admission, or inpatient ward setting. See 'Involuntary'.

Voluntary
Admission to a mental health unit for treatment that results from the client making a decision for admission and signing the necessary agreement for inpatient treatment. (*NSMHS, 2010*)

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Executive Summary

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across Western Australia. In exercising this responsibility the Chief Psychiatrist has been conducting Clinical Governance Reviews of all public mental health services since 2003. During the period 2003 – 2009 a total of 19 Clinical Governance Reviews were completed with 500 recommendations made.

A number of salient themes have emerged, with the majority of services reviewed receiving recommendations in relation to each of these areas. In October 2010 the Chief Psychiatrist implemented Thematic Reviews of Mental Health Services (MHS).

The methodology utilized for the Thematic Reviews includes collecting baseline data, data analysis and trends, developing and disseminating guidelines and audit and reporting. The principles underpinning the National Standards for Mental Health Services (NSMHS) have been embedded into the methodology along with a standardized set of criteria for each section which has allowed for direct comparison of the data collected from the various streams and settings.

The first Thematic Review involved an examination of the Physical Health Care practices within all MHS in Western Australia (WA). The second area and subject of this report focused on six areas of clinical care. This review is concerned with examining the following six aspects of clinical care:

1. Initial Psychiatric Assessment
2. Initial and Ongoing Risk Assessment and Management
3. Individual Management Plans
4. Outcome Measures
5. Use of the Mental Health Act 1996
6. Discharge Planning

In total 1,248 clinical records were examined over a seven week period. In addition 306 consumers provided feedback to the OCP about the care they received whilst involved with mental health services (MHS) via either face to face interview with a consumer reviewer (32% of respondents) or via questionnaire (68% of respondents).

A total of 18 recommendations have been made with the expectation that all MHS will implement all of the recommendations. The Chief Psychiatrist will develop guidelines in relation to each of the clinical areas in order to facilitate adoption of the recommendations by MHS.

The predominant underlying themes in the recommendations relates to MHS ensuring that processes already in place within MHS are consistently applied and compliance is monitored. In addition the use of standardized forms was examined across the sector (by stream and setting where necessary) with the aim of reducing duplication and minimizing the number of times patients have to provide information. In all of the clinical areas reviewed the processes were found to be inconsistently applied.

Recommendations

1. All patients regardless of how well they are known to the MHS should receive a comprehensive psychiatric assessment on entry to the MHS for each specific episode of care including patients transferred from other facilities.

2. The MHS should utilise a standardised psychiatric assessment form to ensure consistency of data collection within and between MHSs.

3. The MHS should ensure that a BRA is completed for all patients on entry to the MHS.

4. The MHS adopt the CRAM policy as mandatory practice

5. The MHS utilises the CRAM audit document to ensure compliance with the policy.

6. The MHS ensures that where indicated patients have a current risk management plan (separate from the IMP)

7. The MHS ensures that all patients have a current multidisciplinary IMP on their clinical record and on PSOLIS.

8. The MHS ensures that all patients IMPs are reviewed within a time frame that is practicable for the MHS and appropriate for interval reviews.

9. The MHS ensures that all patients that are "Medical only" have a current IMP on the clinical record and on PSOLIS.

10. The MHS ensures that the goals and strategies in the IMP are reflective of the scores on the outcome measures.

11. MHS must ensure that outcome measures are collected on entry to the MHS, at three monthly intervals and on discharge.

12. MHS must ensure that the outcome measures summary score sheets are printed off and filed on the consumers' clinical record.

13. The MHS must ensure there is a process in place for consistent reporting to the MHRB

14. The MHS must ensure that there is a documented record of Seclusion and Mechanical Bodily Restraint if it is utilised, consistent with the requirements of Mental Health Regulations.

15. The MHS must ensure that patients and their families/carers are provided with documentation regarding their rights and copies of MHA forms where appropriate.

16. The MHS ensures that all patients receive a Multidisciplinary Team (MDT) comprehensive review prior to discharge.

17. The MHS ensures there is documented evidence in the file that the treating team is in agreement with the decision to discharge the patient. Alternatively, evidence is documented in the file as to why the decision was made that may have been different from the treatment team plan for discharge.

18. The MHS ensures that carers, where consent is provided and where appropriate, are involved in the patient's discharge planning.

Introduction

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across Western Australia. In October 2010 the Chief Psychiatrist implemented Thematic Reviews of Mental Health Services (MHS). The first Thematic Review involved an examination of the Physical Health Care practices within all MHS in Western Australia (WA). The second area and subject of this report focused on six areas of clinical care which are further detailed in the Background section of the report.

The Thematic Review approach also provides an opportunity for the Chief Psychiatrist to develop specific guidelines in relation to each of these areas. These Guidelines will be developed in conjunction with the Area MHS to ensure that they complement currently existing processes and practices.

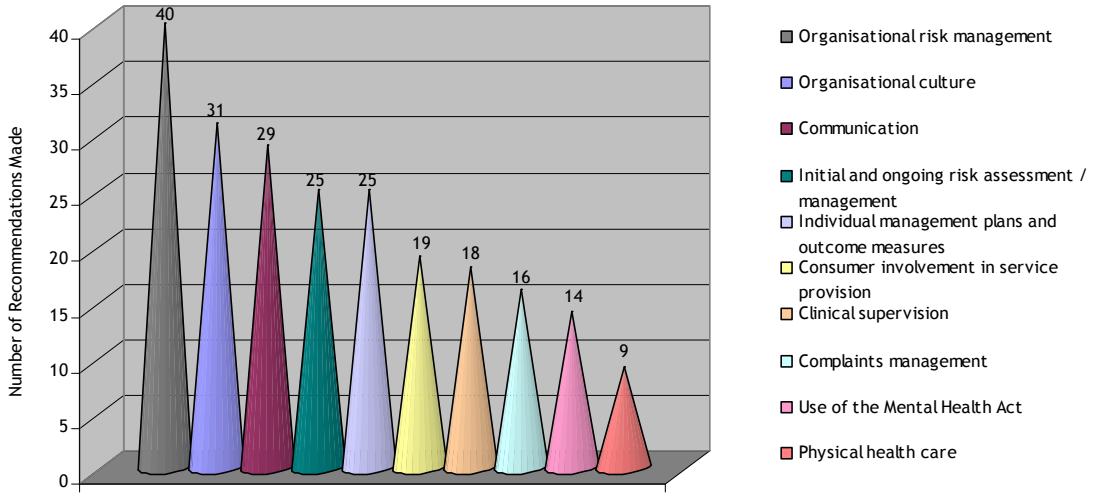
Dr Rowan Davidson
Chief Psychiatrist

Background: Establishing the Thematic Review

The Chief Psychiatrist has been conducting Clinical Governance Reviews of all public mental health services since 2003. During the period 2003 – 2009 a total of 19 Clinical Governance Reviews were completed with 500 recommendations made.

A number of salient themes have emerged, with the majority of services reviewed receiving recommendations in relation to each of these areas. Emergent themes are represented in the figure below.

Figure: 1 Recommendation by Theme



Having identified these themes, the Clinical Governance Review methodology has been modified to utilize a thematic approach.

The Chief Psychiatrist has recently completed a thematic review of all mental health services in relation to the following 6 aspects of clinical care:

1. Initial Psychiatric Assessment
2. Initial and Ongoing Risk Assessment and Management
3. Individual Management Plans
4. Outcome Measures
5. Use of the Mental Health Act 1996
6. Discharge Planning

An outline of the methodology utilized in this Thematic Review is summarized below.

Review Methodology

The initial phases of the review methodology will take one of two forms including either a baseline review of processes or collection of evidence in relation to a specific thematic area. The remaining three phases will be the same for either type of review.

Review of Processes

Where processes operating within MHS are unknown (e.g. Physical Health Care) the review will begin with a series of meetings with key personnel, within the MHS, to establish what processes are in place in relation to a specific thematic area.

This initial collection of data is only to understand the processes in place at mental health services, not compliance with the processes. The latter will be assessed during the audit phase. Where processes differ within a service, between programs (eg. inpatient, community, day programs), meetings with key program personnel will occur.

Collection of Thematic Evidence

In order to ascertain how mental health services are currently functioning in relation to the identified themes (e.g current review), baseline evidence has been collected from all public mental health services within Western Australia. The data has been collected via reviews of patients' clinical records and direct feedback from patients. The data was collected by mental health clinicians (Reviewers) who were seconded to the Office of the Chief Psychiatrist for part or all of the seven week review period. Reviewers were trained in the use of a standardised measure that was developed on the basis of the requirements of the Mental Health Act (1996) and the Chief Psychiatrist's requirements for the collection of relevant clinical data.

Data Analysis and Trend Report

Data collected from all mental health services has been analysed by the OCP. A copy of this report will be provided to the Director General of Health, Area Mental Health Directors and mental health services.

Development and Dissemination of Guidelines

Following a review of the data collected, the OCP will develop Chief Psychiatrist Guidelines relating to the specific thematic area (eg. similar to the Chief Psychiatrist's Guidelines for Clinical Audit). These Guidelines will be developed in conjunction with the Area Mental Health Services to ensure that they complement currently existing processes.

Upon the development and approval of the Guidelines, a copy will be sent to all mental health services. It is not intended that these guidelines are prescriptive, but rather provide general direction in relation to the thematic area in order to assist mental health services that do not have processes in place.

Audit and Reporting

The audit process varies from the baseline data collection process in that the intention of the audit phase is to assess whether processes identified in the collection of baseline data are actually operational. For those services that did not have processes in place, there is an expectation that these processes have been implemented following dissemination of the Chief Psychiatrist's Guidelines relating to the particular area under review.

National Standards for Mental Health Services

The National Standards for Mental Health Services (the Standards) were first introduced in 1996 to facilitate the adoption of appropriate and safe practices within mental health services (MHS). The Standards were revised in 2006 to apply to a broader range of government and non government services. The key principles are consistent with national policy and requirements for the delivery of mental health services in Australia and are embedded in the Standards. The principles include:

- Mental health services should promote an optimal quality of life for people with mental health problems and / or mental illness.
- Services are delivered with the aim of facilitating sustained recovery.
- Consumers should be involved in all decisions regarding their treatment and care, and as far as possible, the opportunity to choose their treatment and setting.
- Consumers have the right to have their nominated carer(s) involved in all aspects of their care.
- The role played by carers, as well as their capacity, needs and requirements as separate from those of consumers is recognized.
- Participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services.
- Mental health treatment, care and support should be tailored to meet the specific needs of the individual consumer.
- Mental health treatment and support should impose the least personal restriction on the rights and choices of consumers taking account of their living situation, level of support within the community and the needs of their carer(s).

The Standards are embedded in to the methodology developed for this review with the relevant standards presented before the findings of each of the aspects of clinical care.

Findings of the Thematic Review

This section begins with a presentation of demographic data, followed by the results associated with each of the six clinical areas:

1. Initial Psychiatric Assessment
2. Initial and Ongoing Risk Assessment and Management
3. Individual Management Plans
4. Outcome Measures
5. Use of the Mental Health Act 1996
6. Discharge Planning

Recommendations are presented at the end of each section with a list of overall recommendations following presentation of the data for each of the six clinical areas. This is followed by a section on limitations and finishes with a section of future directions.

Demographic Information

Clinical Record Reviews

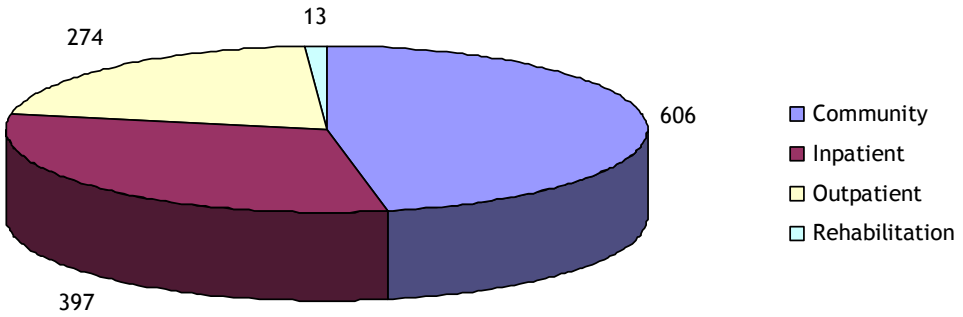
A total of 1,248 Clinical Records were reviewed across the four streams including Adult, Older Adult, Child and Adolescent Mental Health Services (CAMHS) and Youth. Table 1 provides a breakdown by Stream.

Table 1: Number of Clinical Records Reviewed by Stream

Stream	Number of Clinical Records Reviewed
Adult	856
Older Adult	223
CAMHS	127
Youth	42
Total	**1,248**

The clinical records reviewed were across multiple settings within the mental health services, as indicated in Figure 2 below. It should be noted that consumers may have had admissions in multiple settings, and where those admissions were within of the review timeframe, both admissions were reviewed.

Figure 2: Number of Clinical Records Reviewed by Type of Admission



The length of consumer admissions of the clinical records reviewed ranged from 1 day to 24 years. The average length of stay was 508 days (1.4 years), and the median was 160 days (22 weeks)

Consumer Questionnaires

1,500 Consumer Questionnaires (Appendix A) were sent to a random sample of mental health consumers across all four streams. A total of 207 questionnaires were completed and returned (14% return rate). The questionnaires were in relation to the aspects of clinical care under examination. In addition to the questionnaire, a consumer reviewer formed part of the thematic review team, and interviewed 99 consumers across multiple sites. In total, 306 consumers provided feedback to the review team.

Initial Psychiatric Assessment

It is imperative that all patients receive an initial psychiatric assessment for each episode of care. This should be completed as soon as is practicable following acceptance of the referral. Standards 9 and 10 of the NSMHS are relevant to this area of review.

NATIONAL STANDARD FOR MENTAL HEALTH SERVICES

Standard 9 – INTEGRATION

The MHS collaborated with and develops partnerships within its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Specific Criteria:
9.2 – The MHS has formal processes to support and sustain interdisciplinary care teams.

Standard 10 – DELIVERY OF CARE

10.4 - ASSESSMENT AND REVIEW
Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Specific Criteria:
10.4.2 Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.

The Clinical Record criteria used by the Reviewers to assess this aspect of clinical care are outlined in the shaded box below.

- A full psychiatric assessment has been conducted
- An examination of the consumer has been undertaken, including a comprehensive risk assessment.
- A **Brief Risk assessment (BRA)** has been completed on initial entry to the MHS – *data for this criterion is presented in the following section.*

As is outlined in the NSMHS, MHS are expected to complete a comprehensive psychiatric assessment for all patients entering their service. Although not all MHS utilise standardized initial assessment forms the Chief Psychiatrist recommends that the following information be routinely collected:

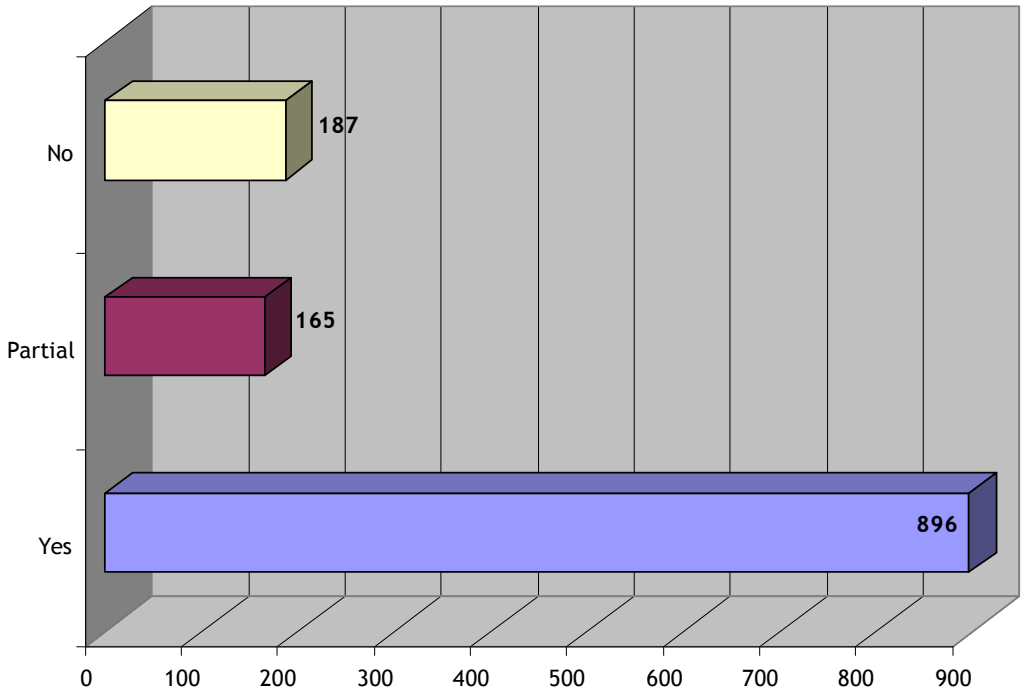
- Alerts/Risks
- Assessment Details
  - Date, time, location
  - Referred by
  - Reason for Referral
  - Sources of information
  - Communication Issues
- History of Presenting Problems
- Past Psychiatric Mental Health History
- Legal Issues
- Drug and Alcohol History
- Family Medical/Mental Health History
- Patient Medical History
  - Allergies/adverse drug reactions
- Current Treatments
  - Current Medications
  - Dose/Frequency/route
- Additional Information
- Other Treatments

- Developmental and Personal History
- Current Functioning and Supports
- Parental Status and/or other Carer Responsibilities
- Details of Children and/or Dependents
- Personality
- Mental State Examination
- Physical Examination Summary
- Risk Assessment
- Outcome Measures (National Outcomes and Case Mix Collection)
- Formulation/ Overall Clinical Impression
- Provisional Diagnosis
- Initial Management Plan
- Contacts

While this information may initially be collected by one clinician within the MHS (Triage or Duty Officer), once collected the information should be reviewed by a multidisciplinary team prior to acceptance of the referral and the development of a comprehensive individual management plan.

Of the 1,248 clinical records reviewed, 72% contained evidence of an initial psychiatric assessment with 13% assessed as having a partially completed assessment and the remaining 15% containing no evidence of an initial assessment having been conducted.

Figure 3: Comprehensive Psychiatric Assessment on Entry to the Mental Health Service



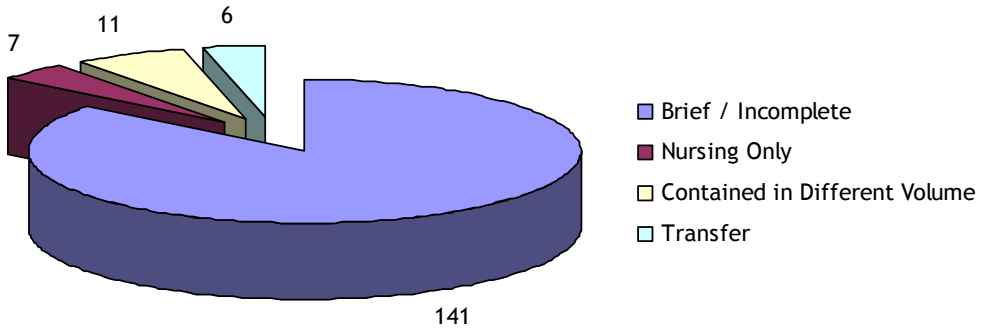
The 165 clinical records that contained a partial initial assessment were assessed as such for a number of reasons including:

- The initial assessment was limited to a nursing assessment only
- The assessment was incomplete or brief. These assessments lacked detail (ie. Mental State Exam only, risk assessment only, lack of formulation and subsequent diagnosis and plan)
- The initial assessment was filed in a different volume of the clinical record. This happens when the patient has a long standing relationship with the MHS and as such has multiple volumes of clinical notes. The MHS do not always conduct a comprehensive assessment for each episode of care but rather rely on the information contained in the patient's previous records.

- The patient was transferred from another MHS and the clinicians, at the new MHS, relied on the details in the discharge summary rather than completing their own initial assessment.

As is depicted in Figure 4, of the 165 records assessed as 'Partial' the majority were due to incomplete or brief initial assessment documentation. This was followed by a nursing assessment only, the patient having multiple volumes and the MHS relying on the discharge summary from another MHS.

Figure 4: Reasons for 'Partial' Initial Psychiatric Assessments



Recommendations – Initial Psychiatric Assessment

1. All patients, regardless of how well they are known to the MHS, should receive a comprehensive psychiatric assessment on entry to the MHS for each specific episode of care including patients transferred from other facilities.

2. The MHS should utilise a standardised psychiatric assessment form to ensure consistency of data collection within and between MHSs.

Initial and Ongoing Risk Assessment and Management

As part of the initial psychiatric assessment clinicians are required to complete a brief risk assessment which will identify if a subsequent more in depth risk assessment is required and a related risk management plan is to be generated.

NATIONAL STANDARD FOR MENTAL HEALTH SERVICES

Standard 2 – SAFETY

The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Specific Criteria:
2.11 - Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Standard 10 – DELIVERY OF CARE

10.3 - ENTRY
The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

Specific Criteria:
10.3.3 The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and / or response to all those referred, at the time of assessment.

The Clinical Record items used by the Reviewers to assess this aspect of clinical care are outlined in the shaded box below.

Risk Assessment
- An examination of the consumer has been undertaken, including a **Brief Risk assessment**
- Is a more comprehensive risk assessment warranted from initial assessment
- The MHS uses a standardised risk assessment tool (ie. CRAM as endorsed by the Mental Health Division).
- A comprehensive risk assessment is completed on admission/ intake to the service.
- The risk assessment tool provides **Level of Risk**
- The risk assessment tool provides **Formulation of Risk**
- The risk assessment tool provides **Risk Management Plan (as appropriate to identified risk(s))**
- Evidence on the file of risk being reviewed at any of the following:
- At clinical team reviews
- When discharged or transferred
- If there is a significant change in the consumer's status
- When there are clinical concerns about risk

Risk Management
- Documented risk management plan including **Types of risk and to whom**
- Documented risk management plan including **Triggers for identification of escalating risk and de-escalation of risk**
- Documented risk management plan including **Strategies for reducing risk**
- Documented risk management plan including **Review data**
- Documented risk management plan including **Clinician responsible**
- Evidence of risk being revised as per assessments

The Brief Risk Assessment (BRA) is a standardised risk assessment tool which should be completed on entry to the MHS. The BRA contains the following fields:

- Patient demographics
- Source of Information
- Suicidality - Static (historical) and Dynamic (current) Risk Factors
- Protective Factors
- Level of suicide
- Aggression/Violence - Static (historical) and Dynamic (current) Risk Factors
- Level of Violence
- Other Risks indentified
- Risk Management Issues
- Designation, Signature of Clinician completing
- Date of assessment

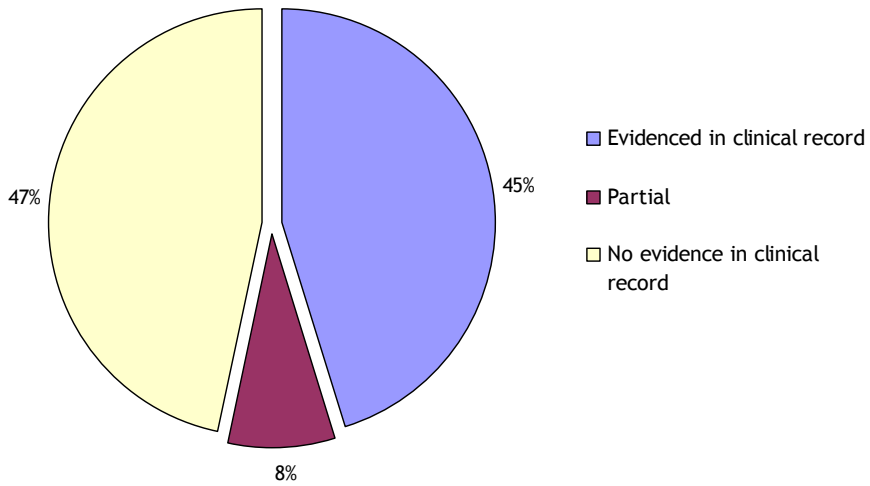
Of the 1,248 records 600 records (48%) provided evidence of a BRA having been completed on entry to the MHS. Reviewers also identified a total of 685 clinical records which warranted an in depth risk assessment. Although 85 patients had not received an initial BRA the reviewers were able to ascertain that an in depth risk assessment was warranted from entries in the integrated progress notes.

A more in depth risk assessment includes those items addressed in the BRA plus sections on:

- General Risk Factors
  - Background Factors (e.g. Personality Disorder, Alcohol/drug abuse, intellectual disability)
  - Current Factors (e.g. disinhibition, physical pain, disorientation)
- Other Vulnerabilities
  - Background Factors (e.g. History of absconding, sexual vulnerability, falls, harm to children)
  - Current Factors (e.g. current delusional beliefs, self neglect, poor self care, non compliance with medication, access to dependents)
- Overall Assessment of Risk (formulation)
- Specific Risk issues to be addressed in the IMP

Of the 1,248 records 559 (45%) had evidence of a standardised risk assessment tool with 100 (8%) being rated as partial and 579 (47%) having no evidence of a standardised tool being utilised. This data varies from the data relating to the BRA as it relates to ongoing risk assessments being in a standardised format.

Figure 5: Use of Standardised Risk Assessment Tool – In depth Risk

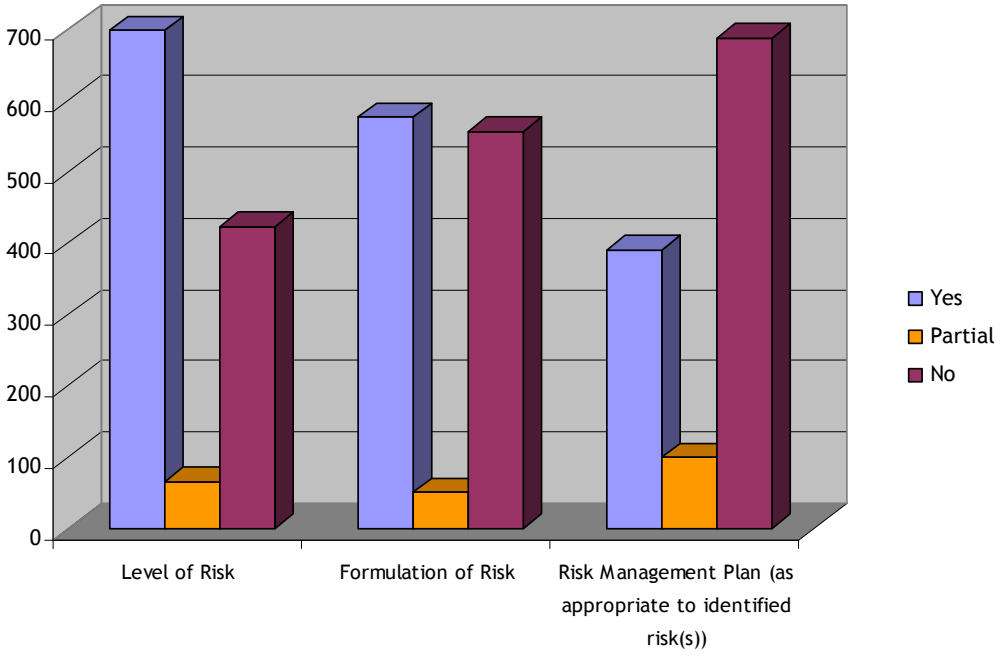


Examples of reasons why records were assessed as 'Partial' include:

- There is evidence of a comprehensive risk assessment tool, but it is incomplete
- Additional assessments (i.e. Suicide risk) were completed but not a comprehensive risk assessment.

While not all records contained a standardised risk assessment tool reviewers were asked to rate what aspects of risk were assessed within the clinical record, including hand written documentation within the integrated progress notes. Figure 6 below shows which specific risk issues have been assessed and documented in the clinical record. 56% of records contained a documented level of risk, 46% provided a formulation of risk and 31% had a documented risk management plan.

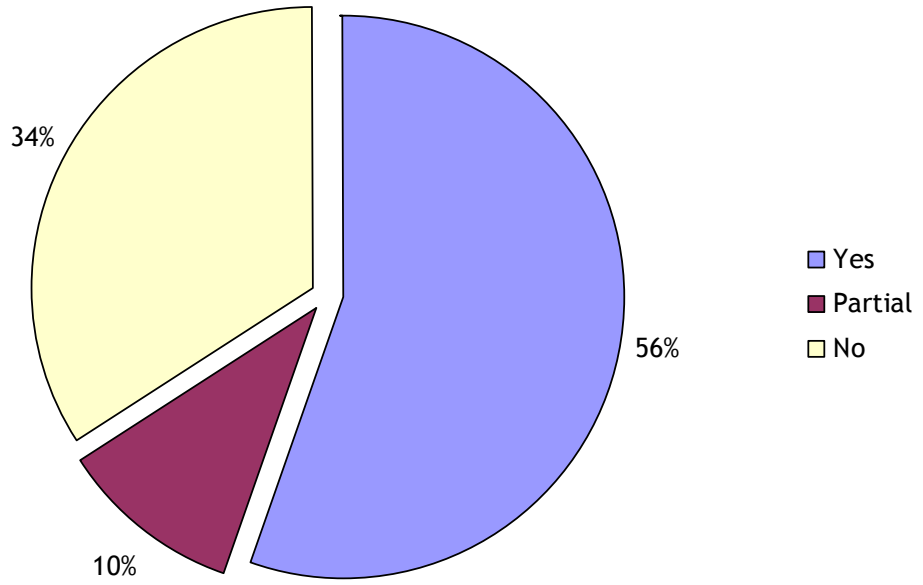
Figure 6: Aspects of Risk Assessed
Note: N/A records have been removed



There are a significant number of clinical records that did not contain evidence of a formulation of risk. A review of the comments made by Reviewers indicates that some clinicians completed the tick box aspects of the tool but then failed to formulate risk overall and develop an associated risk management plan.

CRAM indicates that risk should be reviewed at clinical team reviews, when a patient is discharged or transferred, if there is a significant change in the patient's status or when there are clinical concerns about risk. Examination of the data indicated that 34% (N=405) of clinical records provided no evidence of risk being reviewed with another 10% (N=123) rated as partially meeting the criteria. A total of 656 (56%) clinical records provided evidence of risk being reviewed at the appropriate times.

Figure 7: Evidence of Risk Being Reviewed



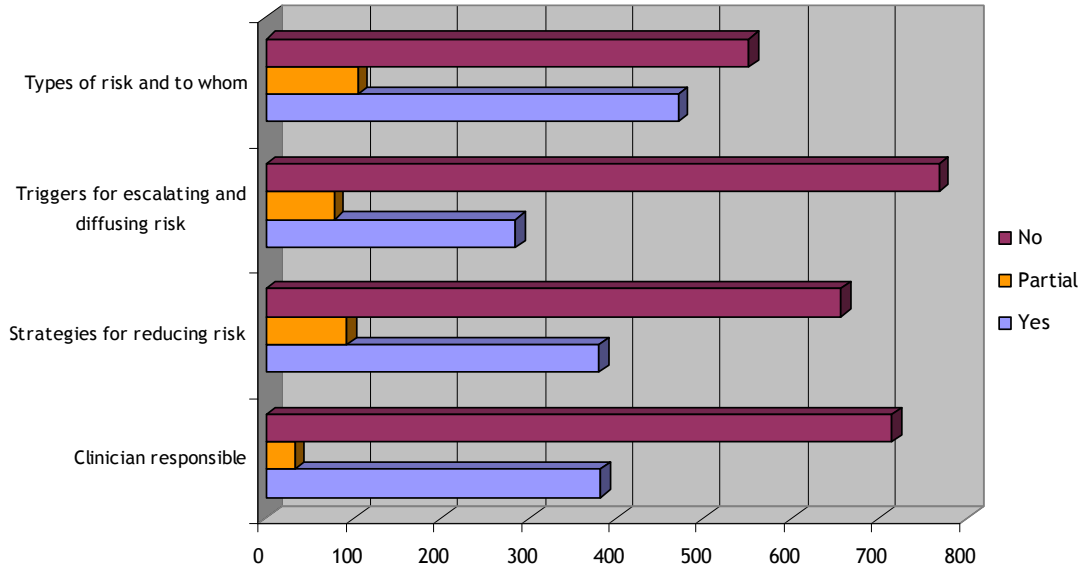
In addition to risk being reviewed on a regular basis the Clinical Risk Assessment and Management Policy and Standards document (CRAM) requires that "in managing risk, the immediate safety of consumers, carers and staff is prioritised and a CRAM risk plan is generated".

The CRAM Plan contains the following fields:

- Patient demographics
- Risk Evaluation and Formulation
  - Types of risk – specific to one person or situation – include identified victims
  - How serious, imminent or immediate is the risk?
  - Is the risk currently increased, lowered or stable? Why is that?
  - What situations or factors might increase the risk? What might decrease it?
  - What specific treatment options can best reduce the risk? What might stop the management plan from being effective?
- Risk Management
  - Steps taken to reduce risk
  - By whom
  - By When
- Communication and Consultation
  - Steps taken to communicate risk and risk management
    - About extreme or high risk with senior clinicians /medical staff
    - About extreme or high risk at team review (including handover)
    - Advanced Statements – mental health completed and on file
    - Family/carer provided with copy (within confidentiality)
    - Family/carer notified about CRAM Plan (within confidentiality)
    - Relevant Parties notified of CRAM Plan:
      - GP
      - MHERL/CERT
      - ED Liaison/Inpatient Unit
      - Intermediate Care/CSRU/Hostel
      - Community Mental Health Service
      - Police/Ambulance/Alternative Transport Support
      - Other (specify)
- Monitoring and Review
  - Risk to be assessed and plan reviewed
    - At next Clinical Team Review _____ date

- When there is significant change in mental state or circumstances or life events
- On discharge, referral or transfer between settings or
- On refusal or non attendance at outpatient appointment (which ever comes first).

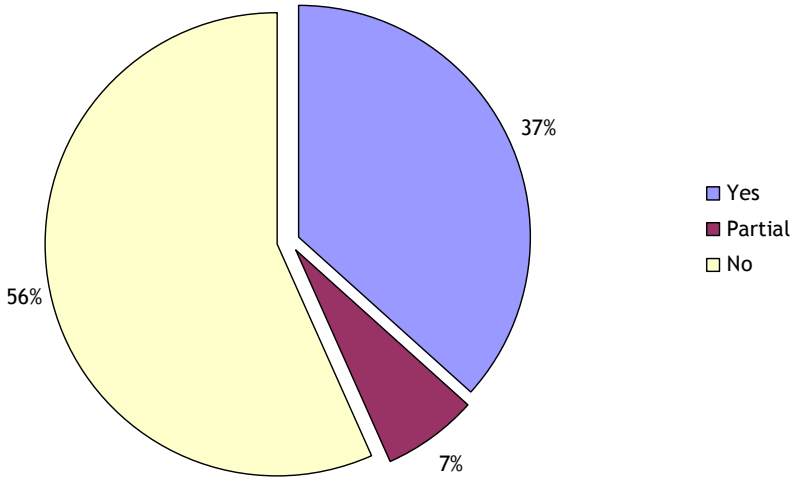
Figure 8: Documented Risk Management Plan
Note - 'Not Applicable' responses have been removed from dataset



As is illustrated in Figure 8 above a significant number of clinical records did not contain evidence of clinically appropriate risk management plans in relation to the 5 criteria. 42% of files contained a risk management plan which identified the type of risk and to whom, only 25% contained specific triggers for escalating and diffusing risks, 34% had strategies for reducing risk, and 34% contained the signature and designation of the clinician developing the plan.

The CRAM policy also recommends that the risk management plan is reviewed to reflect the ongoing risk assessments. The data indicates that 37% of clinical records provided evidence that the risk plan was reviewed, 56% provided no evidence of review and 7% provided partial data. When comparing the 37% of clinical records that provided evidence of the risk plan being reviewed to the 56% of clinical records that provided evidence of risk being reviewed at the appropriate times it indicates that the risk management plan did not routinely get updated as a result of the review of risk.

Figure 9: Evidence of Risk Plan Being Revised as per Assessments



The area of risk is a significant one in effectively managing acute mental health patients. It is imperative that documentation is completed in its entirety and consistently throughout the patient's episode of care. Given the data collected during the review the Chief Psychiatrist makes the following recommendations in relation to Risk Assessment and Management.

Recommendations – Initial and Ongoing Risk Assessment and Management

3. The MHS should ensure that a BRA is completed for all patients on entry to the MHS.
4. The MHS adopt the CRAM policy as mandatory practice
5. The MHS utilises the CRAM audit document to ensure compliance with the policy.
6. The MHS ensures that where indicated patients have a current risk management plan (separate from the IMP)

Individual Management Plans (IMP)

IMPs are an essential piece of documentation in the patients' clinical record. The IMP is a plan that is designed to meet the specific needs of the patient and is developed in conjunction with the patient's treating team and the patient, where possible and appropriate. The IMP should be reviewed on a three monthly basis and revised as necessary. The IMP should be entered into PSOLIS with a copy printed off and placed on the clinical record. Where appropriate and possible both the patient the patient's case manager should sign the IMP.

NATIONAL STANDARD FOR MENTAL HEALTH SERVICES

Standard 6 – CONSUMERS

Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Specific Criteria:

6.7 Consumers are partners in the management of all aspects of their treatment, care and recovery planning.

Standard 10 – DELIVERY OF CARE

10.3 – ENTRY

The entry process of the MHS meets the ongoing needs of its community and facilitates timeliness of entry and ongoing assessment.

Specific Criteria:

10.3.5 Entry to the MHS minimises delay and the need for duplication in assessment, treatment, care and recovery planning and care delivery.

10.4 – ASSESSMENT AND REVIEW

Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and carer(s).

Specific Criteria:

10.4.5 The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer:

- Requests a review
- Declines treatment and support
- Is at significant risk of injury to themselves or another person
- Receives involuntary treatment or is removed from an involuntary order
- Is transferred between service sites
- Is going to exit the MHS
- Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.

10.4.6 The MHS conducts assessment and review of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, at least every three months (if not previously required for reasons stated in criteria 10.4.5)

10.4.8 There is a current individual interdisciplinary treatment, care and recovery plan which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.

10.5 – TREATMENT AND SUPPORT

The MHS provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

Specific Criteria:

10.5.11 The treatment and support provided by the MHS is developed and evaluated with the consumer and their carer(s). This is documented in the current individual treatment, care and recovery plan.

Reviewers used the following Clinical Record items to assess this aspect of clinical care.

- There is an individual management plan (IMP) which is **in a standardized proforma (eg. PSOLIS care plan)**
- There is an individual management plan (IMP) which is **multidisciplinary**
- There is an individual management plan (IMP) which is **developed with the consumer**
- **(place for consumer to sign) or alternatively there is documented evidence of the consumer's involvement**
- There is an individual management plan (IMP) which is **current (within the last 3 months)**
- There is an individual management plan (IMP) which is **relevant (has relationship to the areas identified by outcome measures)**
- There is an individual management plan (IMP) which is **readily accessible**
- There is an individual management plan (IMP) which is **clearly documented**
- The IMP addresses **the consumer's current situation, goals, strategies and responsibilities**
- The IMP addresses **medication and psychological treatments**
- The IMP addresses **collaborative education about the illness and medication**
- The IMP addresses **liaison with carers and significant others (unless otherwise indicated)**
- The IMP addresses **accommodation needs**
- The IMP addresses the **consumer's social skills and wider social network**
- The IMP addresses **work opportunities**
- The IMP addresses **collaborative service arrangements**
- The IMP addresses **review of treatment for its effectiveness**
- Treatment and care reflect the goals and strategies contained in the IMP reflect the problem area(s) identified in the HoNOS, HoNOS65+ or HONOSCA
- The IMP is reviewed at least six monthly, revised as necessary and the outcome recorded.

Subsequent to the completion of the initial psychiatric assessment the multidisciplinary treating team is required to develop, in conjunction with the patient and carer (the latter where consent is provided), an IMP. The IMP should contain a series of patient focused goals and include strategies for how the patient's progress, in conjunction with the MHS and any other relevant agencies, will meet the goals. The goals should have a direct connection to the scores generated from the National Outcome and Case Mix Collection (NOCC) which is collected on entry to the MHS.

The NOCC Measures traditionally utilised in MHS are the Health of the Nation Outcome Scale (HoNOS), the Life Skills Profile (LSP) and the Kessler 10, the latter being a patient generated measure. The outcome measures are completed on entry to the service, every three months and on discharge. In addition the outcome measures may be re administered should the treating team decide it is clinically indicated. The scores on the HoNOS should be reflected in the patient's IMP with those areas receiving a high score having a related goal in the IMP or documentation stating why the particular area is not included in the plan. Additional data regarding outcome measures is presented later in the report in the section entitled outcome measures.

The findings from the clinical record reviews of IMPs are below. The data relating to the IMPs has been separated into two figures. The first figure relates to accessibility and relevance of the IMP with the second figure focusing on the content.

Figures 10 and 11reflect the percentage of clinical records assessed as 'Yes', 'Partial' and 'No' to each of the criteria, where applicable.

Figure 10: Individual Management Plans

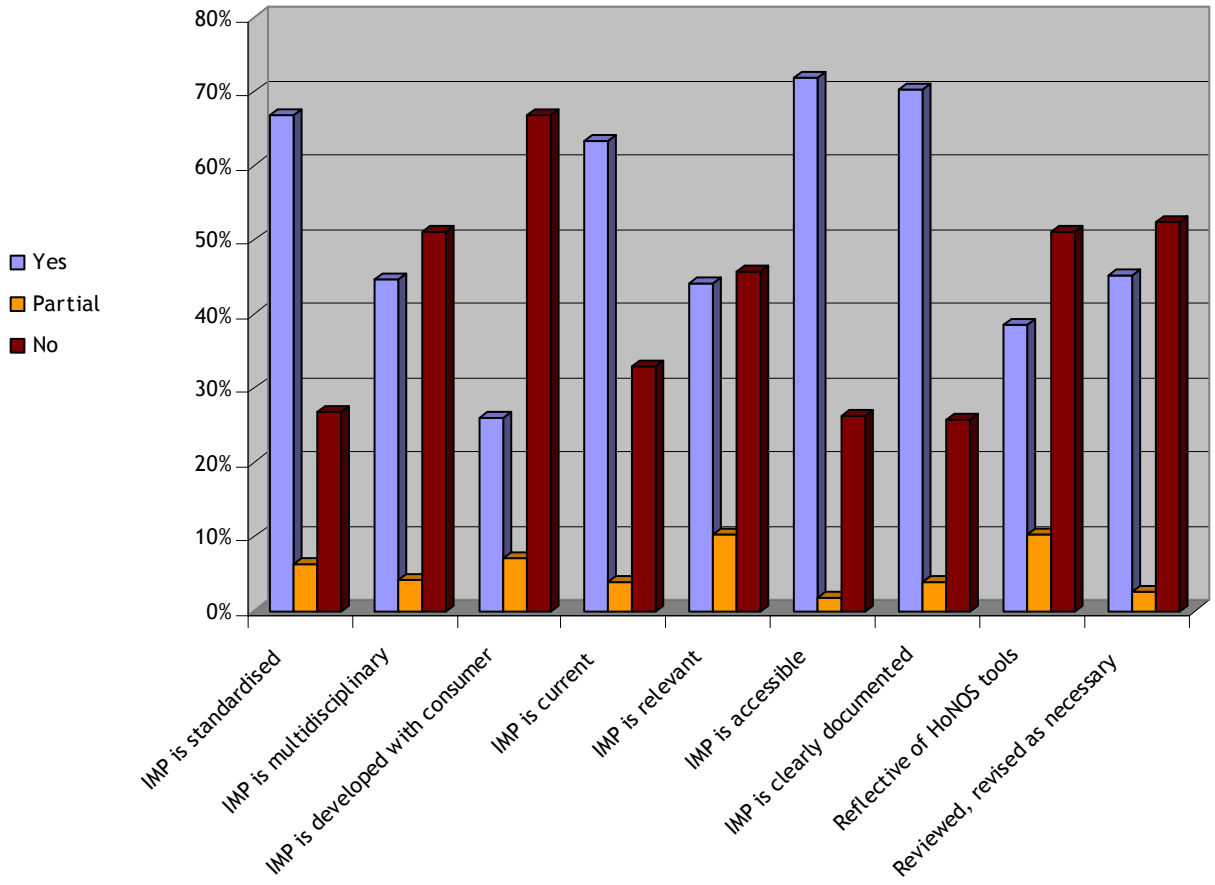


Figure 10 illustrates four significant clinical issues that require attention including the IMP being:

- multidisciplinary (MDT)
- relevant (IMP has a relationship to the areas identified by assessments)
- reflective of the HoNOS scores
- reviewed and revised as necessary

Of the 630 clinical records that did not have a MDT IMP, comments from reviewers highlighted:

- IMP initially written and updated by the Case Manager only
- Nursing plans evident in file, but no MDT plan
- Those patients that only see a Consultant Psychiatrist in an outpatient setting are less likely to have an MDT IMP.

Less than half of the IMPs (N=545) had goals that were rated as relevant. A number of the IMPs contained goals that were MHS goals regarding the management of the patient rather than patient generated goals to assist the patient in recovery. 127 clinical records were rated as partially relevant indicating a mix of MHS and patient centred goals.

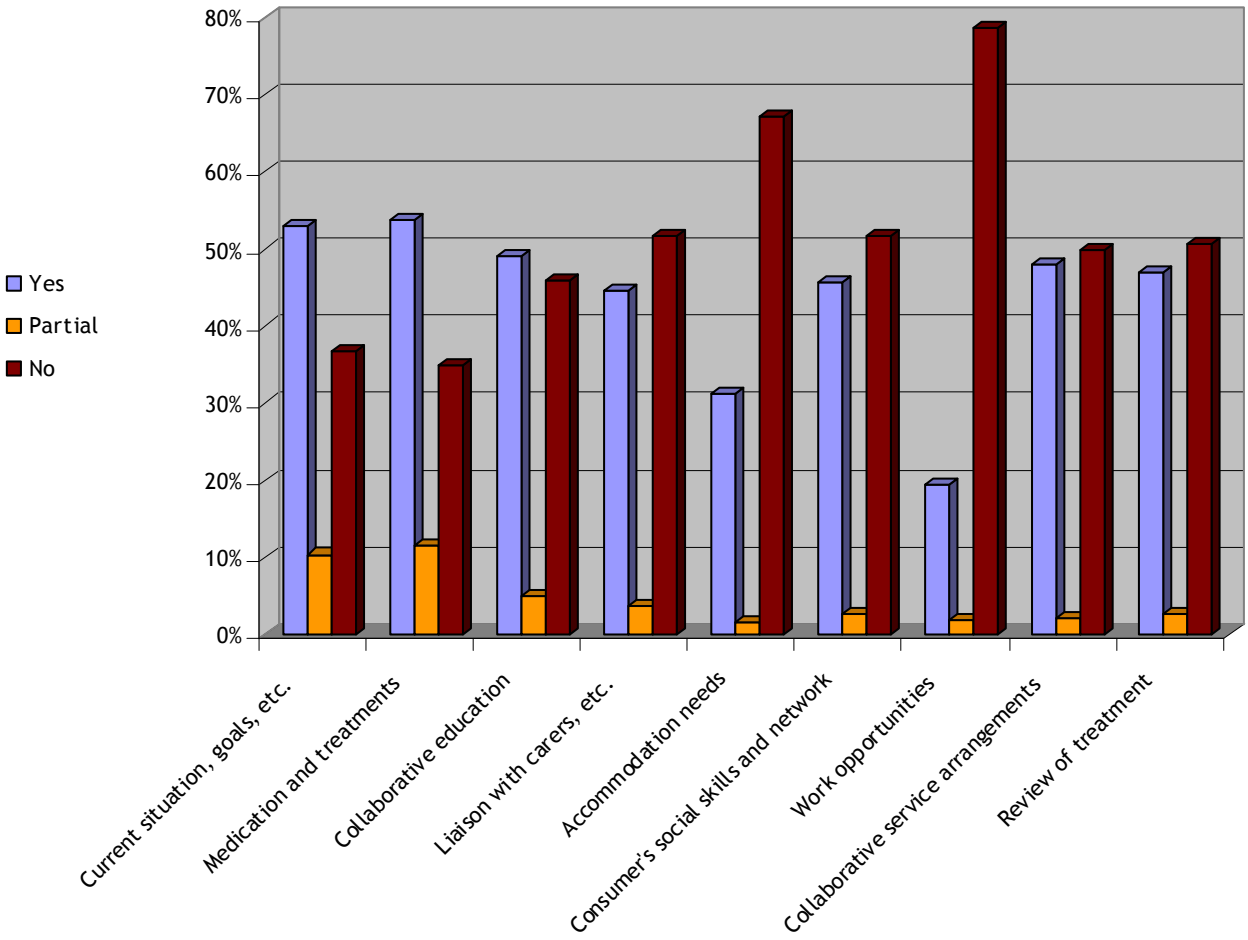
Similarly, a significant number of IMPs (N=626) did not contain goals and strategies that reflected those issues identified in the HoNOS. Not all clinicians utilise the HoNOS as a clinical tool but rather see the process as simply a data collection exercise for the Mental Health Commission. Where scores and graphs are generated and placed on the patient's clinical record the IMP is more likely to be reflective of the issues highlighted by the HoNOS.

The fourth clinical area requiring attention relates to the review of the IMP as required. MHS are required to review patients once every three months. This review is MDT based and should include the readministering of the HoNOS and LSP and updating of the patient's IMP. Just over 50% (N=587) of the clinical records reviewed showed no evidence of the IMP

having been reviewed or revised within the time frame or any entries to suggest why the IMP had not been updated. Clinicians identified a number of logistical issues relating to the IMP being updated every three months including:

- Large case loads make a three monthly review impractical
- Geographic location (access to the patient) may impact on the ability to complete within the three months
- The goals and strategies for chronic patients often remain stable for periods of time and hence a three monthly review is not justified.

Figure 11: Content of the IMP



In addition to the significant clinical issues the figures also highlight priority areas that should be an integral component of best practice IMPs. These priority areas include:

- IMP development in conjunction with the patient (Figure 10)
- Accommodation needs
- Work Opportunities

While only 26% of clinical records provided evidence that the IMP was developed with the consumer, 43% of consumers who provided feedback (N=306) confirmed that they were involved in drawing up their IMP. The discrepancy in the figures may relate to consumers being included in discussions regarding their IMP but not subsequently being offered an opportunity to sign the plan or being provided with a copy of the plan. 40% of consumers also reported that their families had been invited to be involved in their treatment. When asked how good staff members are at including their carers/family members 78% of respondents indicated staff were very good or good.

Table 3: Patient Feedback - How good are staff members at this service at including your family in your care?

Response	Frequency
Very Good	43%
Good	35%
Fair	12%
Poor	11%

27% of patients reported that they have not seen a copy of their IMP. However, of those who reported to have seen their IMP, 78% agreed with the content.

In relation to accommodation needs and work opportunities only 31% and 19% respectively IMPs contained any reference to either criterion. Accommodation is a particularly important aspect given its direct link with effective discharge planning. It is imperative that patients that are returning home have strategies in place to manage this transition and to minimise any potential relapses.

In addition to examining the clinical records reviewers also examined entries on the Psychiatric Services Online Information System (PSOLIS) to establish if, in the cases where there was no evidence on the file there was an electronic version on PSOLIS. Although the Business Rules relating to PSOLIS indicate that the IMP must be entered onto PSOLIS and then printed off for the consumer and clinician to sign it became evident, during the review, that this practice is inconsistent.

Table 4: Individual Management Plans on PSOLIS

IMP on PSOLIS	Number of Records	Comments
Yes	711	70 of these were in draft form on PSOLIS
No	486	16 files had no admission on PSOLIS for the MHS at which the hard copy clinical record was reviewed
Not Applicable	8	Consultation - Liaison patients
Unable to Determine	43	Unable to locate the clinical record on PSOLIS

A review of the hard copy clinical records indicated 829 records had evidence of a standardised care plan. The difference between the number of electronic IMPs (711) and the hard copy IMPs (829) relates to those MHS that utilise an alternative standardised IMP proforma other than the PSOLIS one.

The 43 clinical records that were unable to be located on PSOLIS are related to patients that have only accessed MHS and have not ever presented to a general hospital for treatment and hence have not been allocated a Unit Medical Record Number (UMRN).

There are a number of criteria within this clinical area that require attention. The Chief Psychiatrist recommends the following.

Recommendations – Individual Management Plans

7. The MHS ensures that all patients have a current multidisciplinary IMP on their clinical record and on PSOLIS.

8. The MHS ensures that all patients IMPs are reviewed within a time frame that is practicable for the MHS and appropriate for interval reviews.

9. The MHS ensures that all patients that are "Medical only" have a current IMP on the clinical record and on PSOLIS.

10. The MHS ensures that the goals and strategies in the IMP are reflective of the scores on the outcome measures.

Outcome Measures

In 1992, Australian Health Ministers endorsed the National Mental Health Strategy. An important factor contributing to the Strategy was recognition of the lack of quality information and the absence of a consistent data collection set for mental health. The National Outcome and Casemix Collection commenced in all jurisdictions in Australia in 2004 following a commitment made in June 1999 by Australian Health Ministers.

The accurate entry of all data collected after completing outcome measures is a critical success factor for the NOCC. This will enable clinicians to make:

- Meaningful interpretation of change scores - Where clients and clinicians will be able to determine if and how client outcomes as measured by the instruments change over a period of time.
- Cross sectional comparisons - Where outcomes for clients with the same case complexity and diagnosis can be compared.

The relevant NSMHS is Standard 10 Delivery of Care.

NATIONAL STANDARD FOR MENTAL HEALTH SERVICES

Standard 10 – DELIVERY OF CARE

10.4 - ASSESSMENT AND REVIEW
Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Specific Criteria:

10.4.1 Assessments conducted and diagnoses made are evidence based and use accepted methods and tools, as well as internationally accepted disease classification systems.

10.4.2 Assessments are conducted during the consumer's first contact with the MHS by appropriately qualified staff experienced and trained in assessing mental health problems, and where possible in a consumer's preferred setting with consideration of safety for all involved.

10.4.5 The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer:
- Requests a review
- Declines treatment and support
- Is at significant risk of injury to themselves or another person
- Receives involuntary treatment or is removed from an involuntary order
- Is transferred between service sites
- Is going to exit the MHS
- Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.

10.4.8 There is a current individual interdisciplinary treatment, care and recovery plan which is developed in consultation with and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.

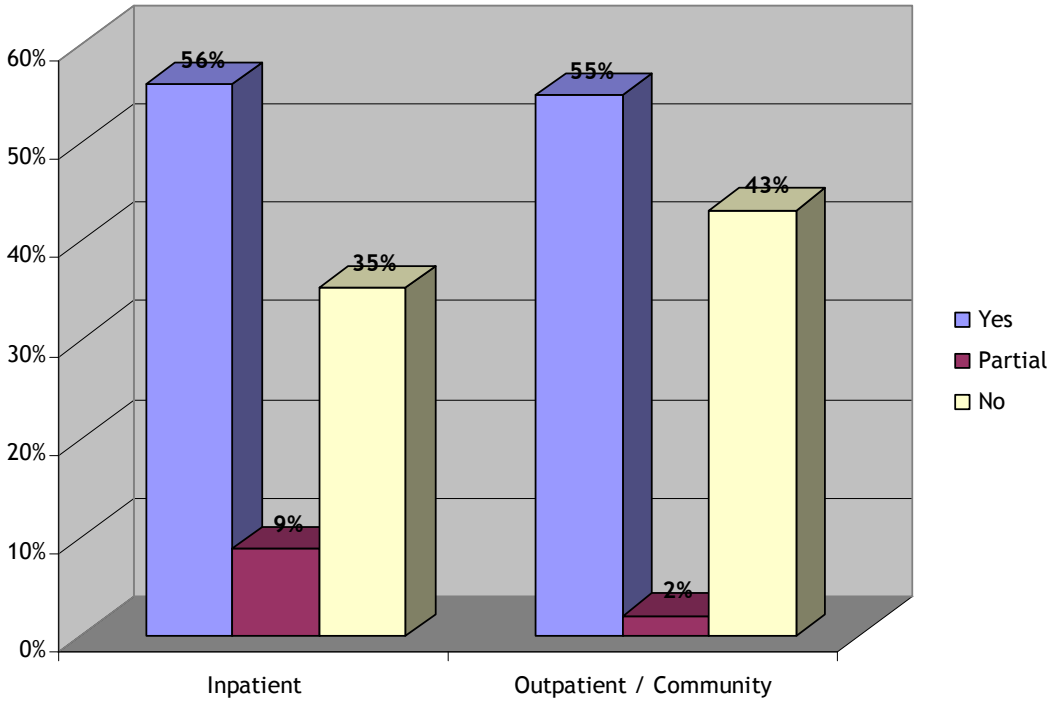
The Clinical Record items used by the Reviewers to assess this aspect of clinical care are outlined in the shaded box below.

- The consumer's intake assessment has included the completion of the HoNOS, HoNOS 65+ or HoNOSCA
- There is evidence in the file of additional collections (3 monthly) of the HoNOS, HoNOS 65+ or HoNOSCA
- Treatment and care reflect the goals and strategies contained in the IMP reflect the problem area(s) identified in the HoNOS, HoNOS65+ or HONOSCA

- The IMP is reviewed at least six monthly, revised as necessary and the outcome recorded.

Of the 1248 clinical records reviewed 56% of inpatients had evidence of outcome measures being completed on entry to the MHS, 35% had no evidence of admission measures being completed and 9% were rated as partial.

Figure 12: Admission - Outcome Measures by Setting
Note - 'Not Applicable' responses have been removed from dataset

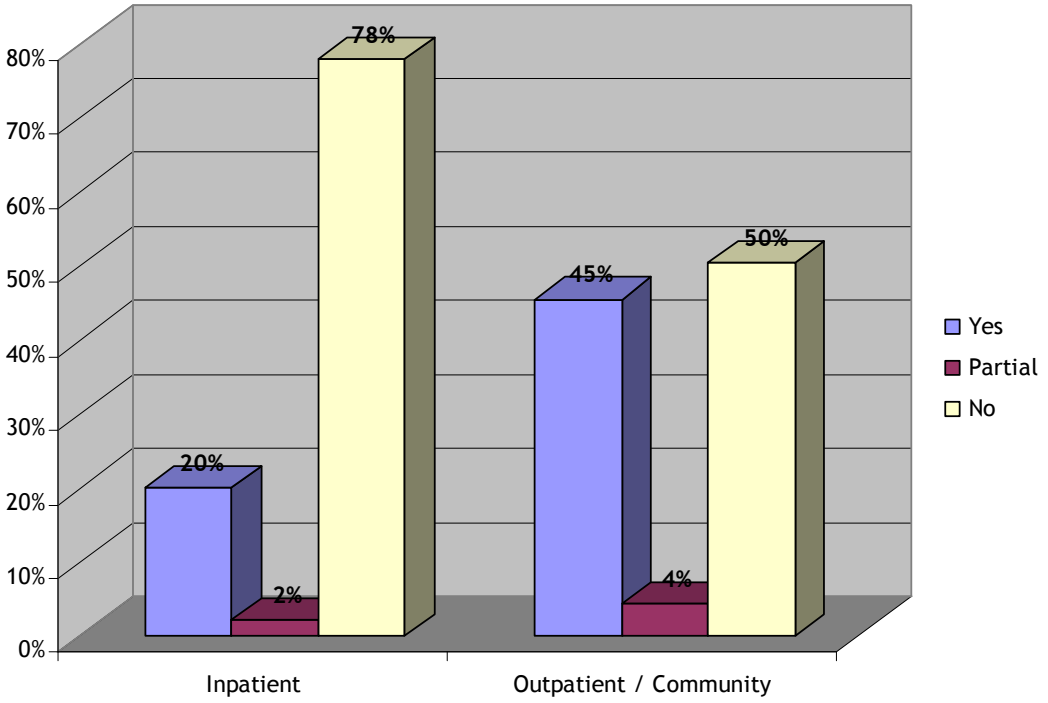


As demonstrated in Figure 12 above, there is very little difference between outcome measure completion rate on admission to inpatient or outpatient / community services (56% and 55% completed respectively).

The HoNOS data is captured on the Psychiatric Services on Line Information System (PSOLIS). As per the PSOLIS Business Rules Clinicians are required to enter the HoNOS data collected into PSOLIS and then generate a summary score sheet and the associated graphs. Although in contrast to the Business Rules the Chief Psychiatrist requires that clinicians file the summary score sheet on the consumer's file and utilise the scores in developing the patient's individual management plan. Of the 35% (N= 131) inpatient and 43% (N=372) outpatient/community that did not contain evidence of outcome measures having been completed, on entry, it is unclear how many of these have been completed on PSOLIS and have simply not been printed out and put on the file.

In addition to reviewing files to find evidence of outcome measures being completed on entry to the MHS the reviewers also examined the files to find evidence of review outcome measures being completed. As Figure 13 indicates a significant number 78% (N=257) of inpatient files and 50% (N=426) of outpatient/community files reviewed did not contain evidence of review outcome measures being conducted. 20% of inpatients and 50% outpatient/community patient records contained documented evidence of review outcome measures being conducted and 2% and 4% respectively had partially completed reviews.

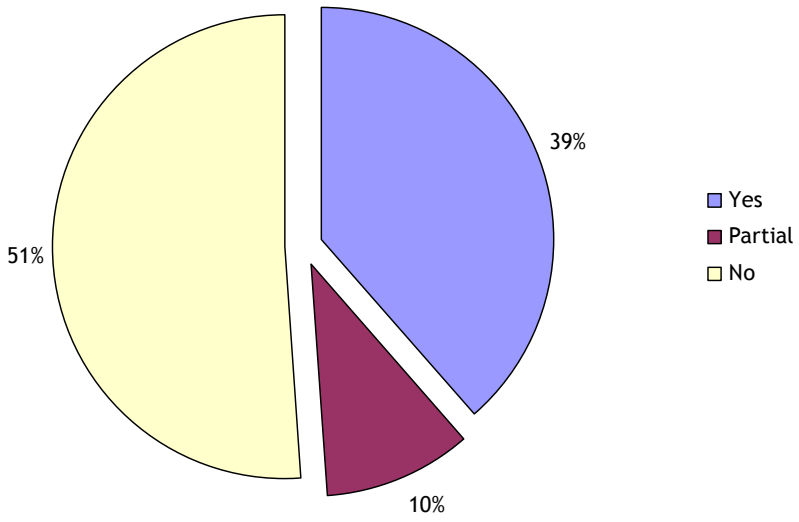
Figure 13: Review - Outcome Measures - by Setting
Note - 'Not Applicable' responses have been removed from dataset



When examining the difference between review outcome measure completion rates in an inpatient setting compared to outpatient/community, there are some notable trends. Review outcome measures are completed more frequently in the outpatient/community setting than in an inpatient setting, as demonstrated in Figure 13. 45% of files reviewed in the outpatient/community settings contained evidence of review outcome measures being completed compared to only 20% in the inpatient setting.

Reviewers were also required to assess if the HoNOS scores were reflected in the goals and strategies identified in the IMP. 39% of IMPs reflected the HoNOS scores. 51% of IMPs did not contain evidence of the HoNOS scores being reflected in the IMP and 10% partially reflected the HoNOS scores.

Figure 14: HoNOS Scores reflected in the IMP
Note - 'Not Applicable' responses have been removed from dataset



In addition to reviewing the clinical records patients were also asked to provide feedback in relation to outcome measures. The Kessler 10 is a self administered measure which MHS should offer to patients on presentation to the MHS. Of the 211 consumers who provided feedback in relation to outcome measures, only 53 respondents (25%) reported ever having been asked to complete a Kessler-10.

The Chief Psychiatrist makes the following recommendations:

Recommendations – Outcome Measures

11. MHS must ensure that outcome measures are collected on entry to the MHS, at three monthly intervals and on discharge.

12. MHS must ensure that the outcome measures summary score sheets are printed off and filed on the consumers' clinical record.

Use of the Mental Health Act (1996) (MHA)

The aim of the MHA is:

- To ensure that persons having a mental illness receives the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity.
- To ensure the proper protection of patients as well as the public and
- To minimize the adverse effects of mental illness on family life

It is imperative that the requirements of the MHA are met. This section of the report relates to Community Treatment Orders, Involuntary admissions, emergency psychiatric treatment, seclusion and mechanical bodily restraint.

The relevant NSMHS is Standard 10 Delivery of Care.

NATIONAL STANDARD FOR MENTAL HEALTH SERVICES

Standard 10 – DELIVERY OF CARE

10.1 - SUPPORTING RECOVERY
The MHS incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

10.2 - ACCESS
The MHS is accessible to the individual and meets the needs of its community in a timely manner.

10.3 - ENTRY
The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

10.4 - ASSESSMENT AND REVIEW
Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

10.5 - TREATMENT AND SUPPORT
The MHS provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

10.6 - EXIT AND RE ENTRY
The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

The Clinical Record items used by the Reviewers to assess this aspect of clinical care are outlined in the shaded box below.

- Reviews by the Mental Health Review Board are recorded
- Any restrictions applied have been recorded (eg. phone, visitors, letters)

Community Treatment Orders (Forms 10, 11, 12, 13, 14)

- Forms completed correctly
- Forms sent to the Mental Health Review Board
- Copy of Forms provided to patient
- Patient and / or carer informed of Rights
- Consent discussed with consumer (allowable without consent, but this should be recorded in the notes)

Involuntary admission
- Forms completed correctly
- Forms sent to the Mental Health Review Board
- Copy of Forms provided to patient
- Patient and / or carer informed of Rights
- Consent discussed with consumer (allowable without consent, but this should be recorded in the notes)

Emergency Psychiatric Treatment
- Record is made of any treatment given
- Record of treatment given is provided to the Mental Health Review Board

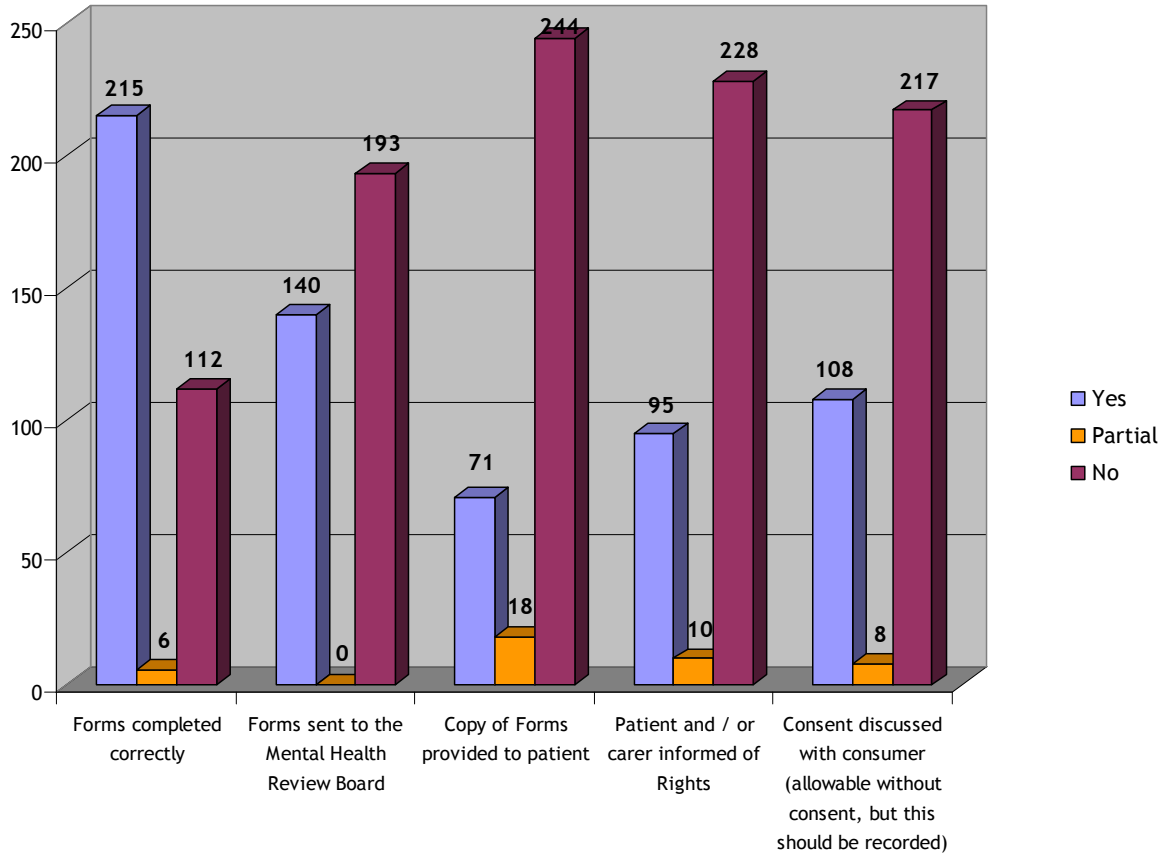
Seclusion
- Record is made of any intervention given
- Record of intervention given is provided to the Mental Health Review Board

Mechanical Bodily Restraint
- Record is made of any intervention given
- Record of intervention given is provided to the Mental Health Review Board

Community Treatment Orders

Figure 15 depicts the criteria relating to the use of Community Treatment Orders (CTOs). Of the 1,248 clinical records reviewed 333 clinical records had evidence of Community Treatment Orders being used. Four of the five criteria require attention and include:
- Evidence of the CTO being sent to the Mental Health Review Board (MHRB)
- A copy of the CTO form being provided to the patient
- Patients and carers are informed of their rights
- Consent is discussed with the patient

Figure 15: Community Treatment Orders
Note - 'Not Applicable' responses have been removed from dataset



58% of files did not have evidence of the MHRB being informed of the patient being placed on a CTO. 73% of clinical records provided no evidence of a copy of the CTO being provided to the patient. 68% of the clinical records did not reflect the patient or carer being informed of their rights and 65% of clinical records did not have evidence of consent being discussed with the patient.

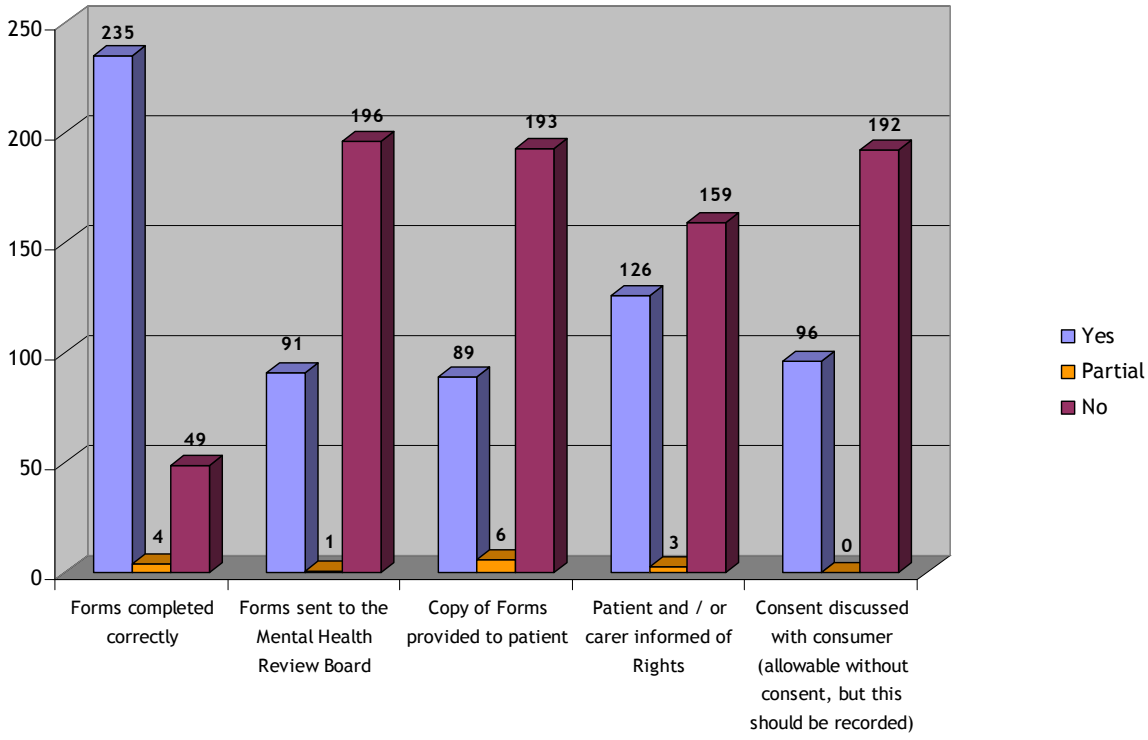
Involuntary Inpatient Admission

Of the 1,248 clinical records reviewed, 288 had evidence of an involuntary inpatient admission. Similar to the patients on the CTO four of the five involuntary admission criteria require attention including:

- Evidence of the forms being sent to the Mental Health Review Board (MHRB)
- A copy of the form (where applicable) being provided to the patient
- Patients and carers are informed of their rights
- Consent is discussed with the patient

196 clinical records provided no evidence of forms being faxed to the MHRB, 193 (67%) records had no evidence that a copy of the form (where applicable) was provided to the patient, 126 (44%) of the 288 involuntary admissions provided evidence of the patient and their carer being advised of their rights and 96 (33%) had evidence of the decision to admit involuntary was discussed with the consumer.

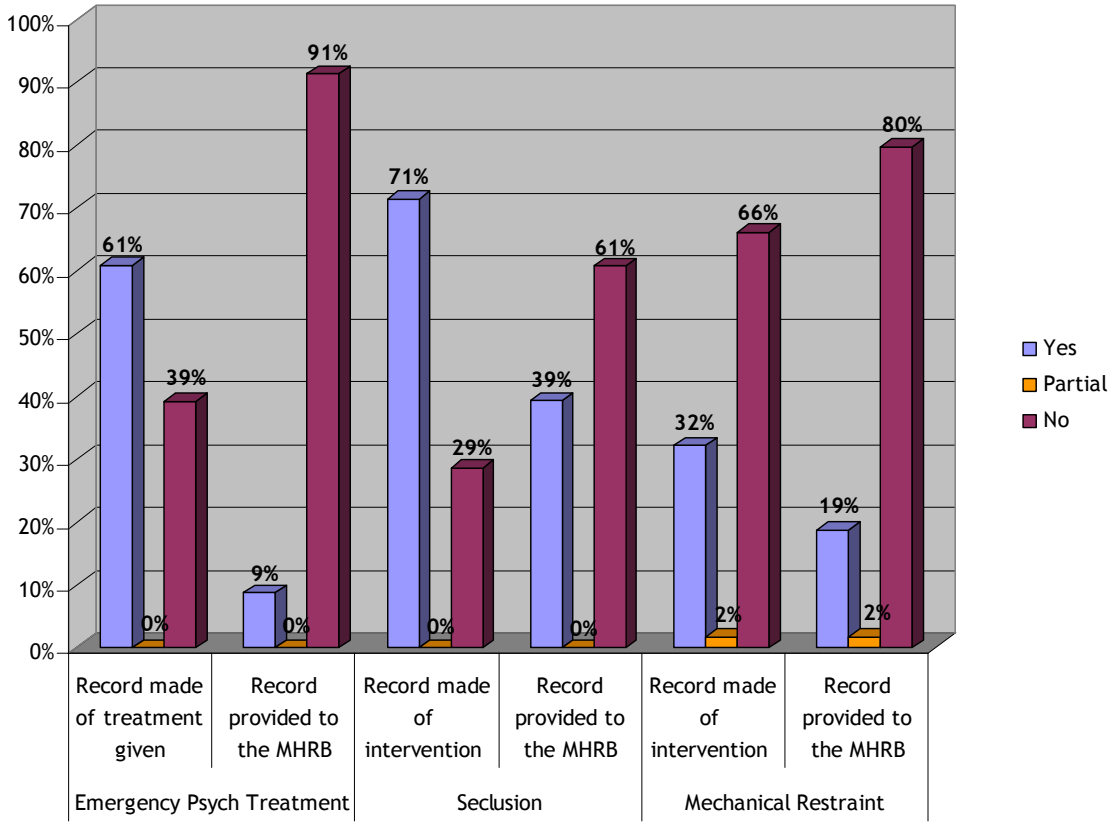
Figure 16: Involuntary Inpatient Admission
Note - 'Not Applicable' responses have been removed from dataset



Emergency Psychiatric Treatment, Seclusion and Mechanical Bodily Restraint

In the files reviewed there were 23 recorded cases of Emergency Psychiatric Treatment (EPT), 28 incidences of seclusion and 58 recorded cases of Mechanical Bodily Restraint (MBR) being performed. Figure 17 below represents how these incidences were recorded in the clinical records.

Figure 17: Emergency Psychiatric Treatment, Seclusion and Mechanical Bodily Restraint
Note - 'Not Applicable' responses have been removed from dataset



As is illustrated in Figure 17, reporting to the MHRB is an issue in all three of the clinical areas under review. The Reviewers also found that there was inconsistent documenting in the clinical record of when Mechanical Bodily Restraint was being used.

In addition to the Clinical Reviewers examining the clinical records, patients also provided feedback with regard to the use of the MHA.

Patient Feedback

Of the 227 patients who responded to the 'Mental Health Act' section of the questionnaire, 107 reported being made involuntary and admitted to a secure inpatient ward, and 21 reported being made involuntary and placed on a Community Treatment Order. 14 of these respondents reported being both admitted involuntarily and being placed on a CTO.

Table 5: Patient Feedback - Explanation of Involuntary Status

Criteria	Yes	No	Not sure	Not Answered
Was it explained to you why you were being made involuntary?	78	56	0	172

Consumers reported that it is usually a doctor that explains why they were being made involuntary.

Table 6: Patient Feedback - Mental Health Act Forms

Criteria	Yes	No	Not sure	Not Answered
If you were put on a CTO, did you receive a copy of your CTO form?	36	44	1	225
If your CTO was extended, did you receive a copy of the CTO Extension form?	17	63	1	225
Have you received a copy of any other MHA forms?	47	103	0	156

Of those who responded 'Yes' to the questions above, they reported receiving not only copies of MHA forms, but also pamphlets and information on rights.

While the number of files and clinical records reviewed for this section was small the results highlighted a number of issues that could potentially lead to a breach of the MHA. The Chief Psychiatrist makes the following recommendations.

Recommendations – Use of the MHA (1996)

13. The MHS must ensure there is a process in place for consistent reporting to the MHRB

14. The MHS must ensure that there is a documented record of Seclusion and Mechanical Bodily Restraint if it is utilised, consistent with the requirements of Mental Health Regulations.

15. The MHS must ensure that patients and their families/carers are provided with documentation regarding their rights and copies of MHA forms where appropriate.

Discharge Planning

Discharge Planning presents a structured and standardised process for ensuring safe and successful transition of people with a mental illness from time of admission to hospital to post-discharge. It supports patient safety, reduced adverse events and aims for improved patient, family and carer outcomes. Discharge planning recognises that mental illness may impair many aspects of a patient's life, often for extended periods of time. Effective discharge planning recognises the importance of engaging other agencies, service providers, carers and the patient. Improved discharge planning has been shown to have a positive impact on length of stay (LOS), follow up care within the specified 7 day time frame and unplanned readmissions within 28 days (National Key Performance Indicator for Mental Health Services).

The relevant NSMHS is Standard 10 Delivery of Care.

NATIONAL STANDARD FOR MENTAL HEALTH SERVICES

Standard 10 – DELIVERY OF CARE

10.4 - ASSESSMENT AND REVIEW
Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and carer(s).

Specific Criteria:

10.4.4 The MHS actively plans as early as possible in the course of psychiatric inpatient admission, for the discharge of the consumer from inpatient care.

10.4.6 The MHS conducts a review of a consumer's treatment, care and recovery plan when the consumer:
- Requests a review Declines treatment and support
- Is at significant risk of injury to themselves or another person
- Receives involuntary treatment or is removed from an involuntary order
- Is transferred between service sites
- Is going to exit the MHS
- Is observed through monitoring of their outcomes (satisfaction with service, measure of quality of life, measure of functioning) to be in decline.

10.6 - EXIT AND RE ENTRY
The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs

Specific Criteria:

10.6.3 The MHS has a process to commence development of an exit plan at the time of the consumers enters the service.

10.6.4 The consumer and their carer(s) and other service providers are involved in developing the exit plan. Copies of the exit plan are made available to the consumer and with the consumers' informed consent, their carer(s).

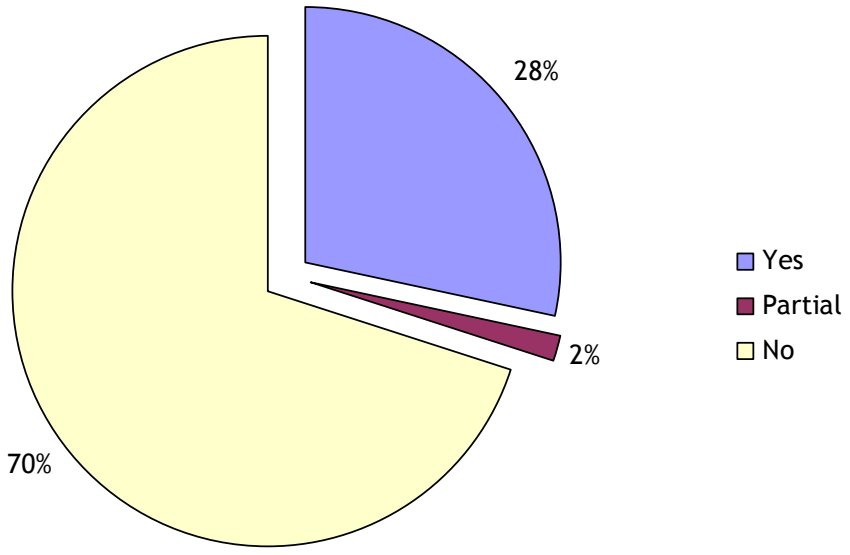
10.6.7 Staff Review the outcomes of treatment and support as well as ongoing follow –up arrangements for each consumer prior to their exit from the MHS.

10.6.8 The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow – up within 7 days after discharge from inpatient care wherever possible, and has a follow-up procedure for those consumers who do not keep the planned follow-up arrangements.

The Clinical Record items used by the Reviewers to assess this aspect of clinical care are outlined in the shaded box below.

- The service has a documented policy on discharge planning and case closure
- There is evidence that discharge planning commenced on the person's admission to the inpatient unit
- The record demonstrates that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) has been undertaken prior to discharge
- There is evidence that the discharge decision has been reviewed by the treating team
- The service ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow up are, wherever possible, satisfactory to the consumer, their carers and other relevant service providers prior to discharge from the service.
- Necessary follow up has been undertaken within a reasonable timeframe for the consumer's condition.
- Discharge has been formalised in writing
- The consumer, carers (unless otherwise indicated) and any relevant service provider has been advised on how to re-access the service if necessary in the future, and has been provided with emergency contact numbers
- The service provides consumers, carers and other agencies involved in ongoing care to identify early warning signs of relapse that indicate thee mental health service should be contacted.
- The service attempts to re-engage with consumers who do not adhere to the planned follow up arrangements.

Figure 18: Evidence that Discharge Planning commenced on Admission to Inpatient Unit



Discharge planning beginning on admission is a concept fraught with challenges, as is supported by the 70% of clinical records that did not contain evidence of discharge planning commencing on admission to the inpatient unit. Discharge Planning policies were collected from each MHS with a total of 83% of having a documented policy. While theses policies stated that discharge planning should begin on entry to the MHS, discussion with clinicians indicated that there are a number of additional variables that will impact on whether a patient's discharge planning begins on entry. Discussions with clinicians have reported the following issues associated with naming a projected discharge date on entry to the MHS:

- The information may be used to alleviate the bed pressures with patients identified as being ready for discharge on a particular date when in fact they are not well enough for discharge.
- The expectation of being discharged on a particular may not be in the best interest of patients who may expect to be discharged despite not being well enough.
- It is impractical to have a projected discharge date for those patients, with accommodation issues, who are long stay patients.

From these comments it can be suggested that the process for discharge planning on entry to the MHS may vary depending on the type of patient (long stay (rehabilitation or accommodation issues), short stay or forensic).

Table 7: Evidence of Discharge Planning
Note - 'Not Applicable' responses have been removed from dataset

Criteria	Yes	Partial	No
The record demonstrates that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) has been undertaken prior to discharge	23%	1%	76%
There is evidence that the discharge decision has been reviewed by the treating team	16%	1%	83%
The service ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow up are, wherever possible, satisfactory to the consumer, their carers and other relevant service providers prior to discharge from the service.	79%	2%	18%
Necessary follow up has been undertaken within a reasonable timeframe for the consumer's condition	84%	2%	14%
Discharge has been formalised in writing	73%	4%	24%
The consumer, carers (unless otherwise indicated) and any relevant service provider has been advised on how to re-access the service if necessary in the future, and has been provided with emergency contact numbers	66%	2%	32%
The service provides consumers, carers and other agencies involved in ongoing care to identify early warning signs of relapse that indicate thee mental health service should be contacted. The service attempts to re-engage with consumers who do not adhere to the planned follow up arrangements.	64%	2%	35%
The service attempts to re-engage with consumers who do not adhere to the planned follow up arrangements	72%	2%	27%

Table 7 presents the eight criteria used to assess effective discharge planning. The two clinical aspects that require attention include:

- A comprehensive clinical review prior to discharge and consultation with the patient and their carer
- Evidence that the treating team is supportive of the discharge decision.

As can be seen in Figure 19 overleaf, 124 of the patient respondents indicated that discharge planning had not been discussed with them. A sample of patient comments has also been provided to highlight some of the patient concerns.

Although not collected in this review, data from previous Clinical Governance Reviews indicates that carers with whom mental health patients reside are often not advised about their discharge, and that discharge occurs with no support from other agencies. It would appear from the data collected in relation to criteria 3 that this has improved with 79% of clinical records providing evidence of other service providers having been contacted in relation to ongoing follow up with the knowledge of the patient and their carer. Similarly, 84% clinical records provided evidence of follow up being timely and 73% had a formal discharge letter on file.

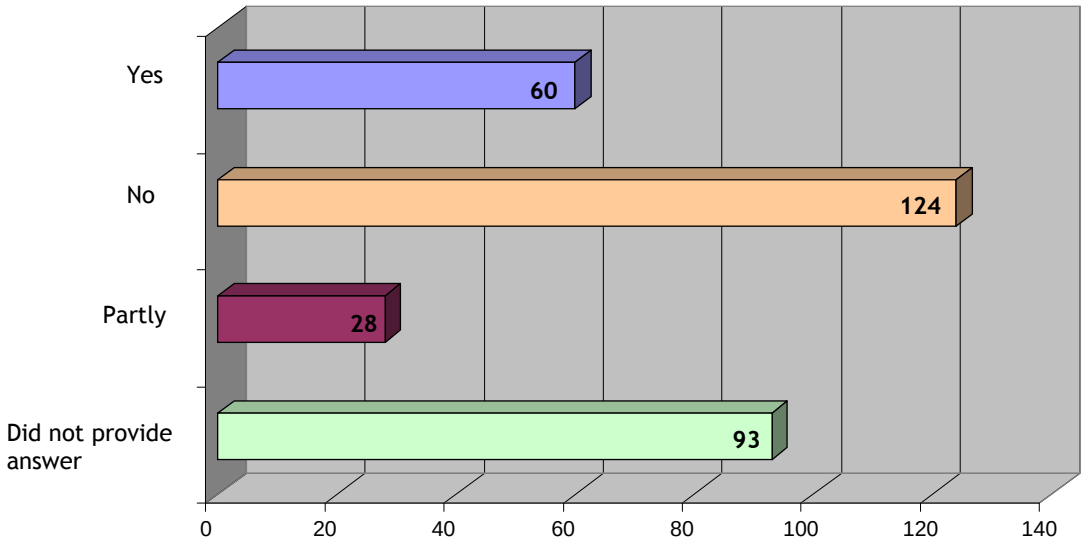
There was slightly less evidence found in relation to patients and their families being provided with information about how to re-access the MHS and being provided with emergency contact numbers (66%). Similarly, 64% of files provided evidence of the MHS assisting to re-engage those patients who do not adhere to the planned follow up arrangements.

Discussions with clinicians regarding the effectiveness of discharge planning has indicated that the decision to discharge a patient is often made solely by the Consultant Psychiatrist, without reference to the treating team, especially in the case when there are pressures on the system to vacate a mental health bed. Comments from Reviewers also indicates that if the most recent medical review was within two weeks prior to discharge there is less likely to be a comprehensive review conducted prior to discharge.

Further comments from the Reviewers suggests that there are a significant number of cases in which the case manager, who is likely to be most aware of the patients mental health state, has a contrary opinion to the Consultant Psychiatrist in relation to the patient's readiness for discharge. Further discussions with Clinicians suggested that large case loads and the pressure on mental health beds are the two main reasons contributing to such decisions.

Patient Feedback

Figure 19: Patient Feedback - Has Discharge Planning Been Discussed with You?



28% of consumer respondents said that a staff member had discussed possibility discharge with them.

When asked what was discussed, an example of some of the comments made are below:

- *Nothing - I was asked a week ago by my inpatient doctor if I would be prepared to be discharged tomorrow, as triage was asking when my bed would be available. So I had no choice but to say yes, even though I'm not ready, not well*
- *Doctor said I need to settle down then I can be discharged*
- *That I need to stabilise my medication first but it doesn't seem to be working*
- *Can't be because of Clozapine - need monitoring*
- *I connected with other services I have used before. They ordered me to community MH. Discharge plan was for Monday but it changed and nothing was organised*
- *Making sure I have the right support from my family and friends*
- *Getting support in the community, what I need to do to stay well*
- *When I was planned to leave the ward the staff helped me meet the community mental health nurse. They organised housing. I was meeting my counsellor after I left*

hospital. Community mental health nurse helped me into Centrelink, linked me into the community

- *A daily plan on what I'm going to do each day*
- *What community support I'll receive and how to make the transition from hospital to home*
- *My future, how I am feeling*
- *Leaving - and I don't want to*

As there are a number of previously mentioned positives to starting discharge planning on entry to the MHS, it can be suggested that the definition of discharge planning on entry to the MHS be further defined to ensure that each of the criteria are able to be met regardless of anticipated length of stay.

Recommendations – Discharge Planning

16. The MHS ensures that all patients receive a Multidisciplinary Team (MDT) comprehensive review prior to discharge.

17. The MHS ensures there is documented evidence in the file that the treating team is in agreement with the decision to discharge the patient. Alternatively, evidence is documented in the file as to why the decision was made that may have been different from the treatment team plan for discharge.

18. The MHS ensures that carers, where consent is provided and where appropriate, are involved in the patient's discharge planning.

Limitations of the Review

One of the main limitations to this Thematic Review was the low response rate from Consumers in relation to the Consumer Questionnaire sent out. 1,500 Consumer Questionnaires (Appendix A) were sent to a random sample of mental health Consumers across all four streams. A total of 207 questionnaires were completed and returned (14% return rate) despite including a self addressed, stamped envelope to assist consumers in returning their forms. In addition to the questionnaire, a consumer reviewer formed part of the thematic review team, and interviewed 99 consumers across multiple sites.

The following highlights the factors that impacted on the completion of patient questionnaires.

Consent Form Distribution

The decision was taken by the OCP to allow the service to decide how to distribute their consent forms. This was to ensure the most appropriate form of distribution for their client group.

The OCP suggested:

> *"The forms can be left at reception, or maybe handed out at appointments, groups, home visits, etc. For inpatient wards, we suggest including it as part of an admission pack. It's really up to the service as to how you think it best to reach as many of your patients as possible - across each of your sites"*

Problems that arose with distribution included:

- Not all programs within the service being included
- Some services chose to mail consent forms to their clients and received little to no response

The OCP also responded to a number of queries from liaison people who were unclear on how to distribute their consent forms. They were advised to discuss it with their clinical teams as to the most appropriate method for their service.

Involvement of Clinical Staff

It appears that some MHS chose to leave the consent forms in patient areas for patients to pick up, with little or no follow up. This means that no forms were filled in or handed back to the service.

Other services asked their clinicians to hand out the forms, along with an explanation to their patients. Where this happened, there was an excellent uptake from patients.

Where the clinical teams were informed and involved in distribution of the forms, there was a much higher rate of consent forms being signed.

Further reviews should consider asking the MHS to document the number of consumers that the information is sent to. While it may not increase the uptake, it would allow a more accurate presentation of the uptake.

Choice of Liaison Person

Each service was asked to nominate a liaison person to assist the OCP in preparing for the thematic review.

> "In order to assist with this, can you please identify a person at your service for my Office to liaise with. This person will work with representatives from my Office in order to:
> - Arrange for the distribution of consent forms to consumers of your service for the review of their clinical records.

- Compile all complete consent forms and arrange for those clinical records to be available to our reviewers when they are on site
- Meet with the reviewers when they arrive at your service

Past experience indicates that the most appropriate person to fill this role is not necessarily a Manager, but rather an administrative staff member who has a good knowledge of the working of the service."

Problems that arose due to choice of liaison person:

- Where the liaison person did either not have a good understanding of their service, or was not in a position to liaise with the clinical teams, consent forms were not distributed to all areas of the service, or little follow up was undertaken to ensure forms were being signed.
- High level Managers, while in principal are a good choice, sometimes do not have the time to be able to dedicate to ensuring appropriate distribution and collation of the forms. This contributes to a limited number of consent forms being signed.

Timing of Consent Distribution

The OCP began distributing the consent forms in May 2011 (two and a half months before the review start date of 01/08/11) when advised by the services of their liaison person.

Some services did not provide details of their liaison person, and were followed up by the OCP on 13/06/11. The final liaison person was contacted on 30/06/11, giving that service only a one month lead in time to get consents distributed, signed and returned.

Other services were provided with their consent forms, but did not distribute them upon receipt. Some services only distributed their forms 1 - 2 weeks prior to the site visit, leading to only a small number of consents being signed.

This suggests that a three month lead time may be more appropriate.

Lack of Clarity of Service Structures

Despite previous reviews, the OCP was unaware of a number of services when organising this Thematic Review. The OCP was informed of these omissions either by another service, or by Regional Management in the late planning stages, and while we were able to make contact with these services and involve them in the Thematic Review, they did not have the lead-in time that other services had. We believe the list of services is now complete, with 48 services included in this review.

The reporting structures of the CAMHS services also presented a problem, with each individual CAMHS program needing to be contacted separately (even those based on the same site as other programs and services). This is due to the new structure of CAMHS under CAHS, and the different reporting lines within that structure. The review organisers were not aware of these reporting lines until the end of review planning.

Data Integrity

The final limitation relates to data integrity. Although this was not a common occurrence the issue of having multiple reviewers at one MHS site and asking them to respond to an item in the record review form that related to the MHS as a whole (not specifically to each record) lead to some data inconsistency. An example relates to question 54 in the Discharge Planning section in which Reviewers were asked to rate the following item "The service has a documented policy on discharge planning and case closure YOU WILL NEED TO ASK A STAFF MEMBER ABOUT THIS" as Yes, No, Partial or Not Applicable. Reviewers at the same MHS provided conflicting results. This is likely to relate to the knowledge of the particular staff member that they spoke with at the MHS.

The author overcame this discrepancy by requesting a copy of the discharge planning policy from all MHS. As is noted previously in the report a total 83% of MHS were able to provide a copy of the policy.

Conclusion

This extensive review of six clinical areas across all Western Australian MHS has provided the Chief Psychiatrist with an understanding of the areas of statewide gaps in quality processes that support care and aspects of comprehensive care that is provided to patients. 18 recommendations have been made with the expectation that all MHS will implement the recommendations within a six month time frame. In addition to implementing the recommendations the Chief Psychiatrist has an expectation that MHS will build in an internal monitoring system (audit process) to ensure that changes identified as important and necessary are maintained over time.

It is intended that the Chief Psychiatrist will develop guidelines in relation to each of the six clinical areas. These guidelines will be disseminated to MHS to facilitate the adoption of the recommendations. The Chief Psychiatrist will conduct an audit of the recommendations six months post the release of the guidelines.

References

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Office of the Chief Psychiatrist, Department of Health (2009). *Clinician's Guide to the Mental Health Act (Fourth Edition – 2009)*. Department of Health Western Australia

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Appendix A

Chief Psychiatrist's Clinical Record Review Tool

Clinical Record Review Recording Sheet

Review Information

Service: _____ **Unit:** _____

File Number: _____ **Volume:** _____

Reviewer: _____ **Review Date:** _____/_____/_____

Record Information

Gender: ☐ Male ☐ Female **Date of Birth:** _____/_____/_____

Date of Admission: _____/_____/_____

Service	Stream	Setting
☐ Metro	☐ CAMHS	☐ Inpatient
☐ Rural	☐ Adult	☐ Outpatient
☐ State-wide	☐ Elderly	☐ Community Program
	☐ Youth	☐ Rehabilitation

ENTRY & ASSESSMENT – WITHIN 12 MONTHS	COMPLIANCE	EVIDENCE/COMMENTS
Intake and Assessment		
1. A full psychiatric assessment has been conducted	☐ Yes ☐ Partial ☐ No ☐ N/A	Brief Risk Assessment: ☐ Yes ☐ No
2. An examination of the consumer has been undertaken, including comprehensive **Risk assessment**	☐ Yes ☐ Partial ☐ No ☐ N/A	
3. The consumer's intake assessment has included the completion of the HoNOS, HoNOS 65+ or HoNOSCA.	☐ Yes ☐ Partial ☐ No ☐ N/A	
4. There is evidence in the file of additional collections (3 monthly) of the HoNOS, HoNOS 65+ or HoNOSCA	☐ Yes ☐ Partial ☐ No ☐ N/A	
TREATMENT AND SUPPORT	**COMPLIANCE**	**EVIDENCE/COMMENTS**
Individual Management Plans	☐ **Section N/A**	
5. There is an individual management plan (IMP) which is **in a standardized proforma (eg. PSOLIS care plan)**	☐ Yes ☐ Partial ☐ No ☐ N/A	
6. There is an individual management plan (IMP) which is **multidisciplinary**	☐ Yes ☐ Partial ☐ No ☐ N/A	
7. There is an individual management plan (IMP) which is **developed with the consumer (place for consumer to sign) or alternatively there is documented evidence of the consumer's involvement**	☐ Yes ☐ Partial ☐ No ☐ N/A	
8. There is an individual management plan (IMP) which is **current (within the last 3 months)**	☐ Yes ☐ Partial ☐ No ☐ N/A	
9. There is an individual management plan (IMP) which is **relevant (has relationship to the areas identified by outcome measures)**	☐ Yes ☐ Partial ☐ No ☐ N/A	
10. There is an individual management plan (IMP) which is **readily accessible**	☐ Yes ☐ Partial ☐ No ☐ N/A	
11. There is an individual management plan (IMP) which is **clearly documented**	☐ Yes ☐ Partial ☐ No ☐ N/A	

12. The IMP addresses **the consumer's current situation, goals, strategies and responsibilities**	☐ Yes ☐ Partial ☐ No ☐ N/A	
13. The IMP addresses **medication and psychological treatments**	☐ Yes ☐ Partial ☐ No ☐ N/A	
14. The IMP addresses **collaborative education about the illness and medication**	☐ Yes ☐ Partial ☐ No ☐ N/A	
15. The IMP addresses **liaison with carers and significant others (unless otherwise indicated)**	☐ Yes ☐ Partial ☐ No ☐ N/A	
16. The IMP addresses **accommodation needs**	☐ Yes ☐ Partial ☐ No ☐ N/A	
17. The IMP addresses the **consumer's social skills and wider social network**	☐ Yes ☐ Partial ☐ No ☐ N/A	
18. The IMP addresses **work opportunities**	☐ Yes ☐ Partial ☐ No ☐ N/A	
19. The IMP addresses **collaborative service arrangements**	☐ Yes ☐ Partial ☐ No ☐ N/A	
20. The IMP addresses **review of treatment for its effectiveness**	☐ Yes ☐ Partial ☐ No ☐ N/A	
21. Treatment and care reflect the goals and strategies contained in the IMP reflect the problem area(s) identified in the HoNOS, HoNOS65+ or HONOSCA	☐ Yes ☐ Partial ☐ No ☐ N/A	
22. The IMP is reviewed at least six monthly, revised as necessary and the outcome recorded.	☐ Yes ☐ Partial ☐ No ☐ N/A	
Risk Assessment	☐ **Section N/A**	
23. Is a more comprehensive risk assessment warranted from initial assessment	☐ Yes ☐ Partial ☐ No ☐ N/A	

24. The MHS uses a standardised risk assessment tool (ie. CRAM as endorsed by the Mental Health Division).	☐ Yes ☐ Partial ☐ No ☐ N/A	
25. A comprehensive risk assessment is completed on admission/ intake to the service.	☐ Yes ☐ Partial ☐ No ☐ N/A	
26. The risk assessment tool provides **Level of Risk**	☐ Yes ☐ Partial ☐ No ☐ N/A	
27. The risk assessment tool provides **Formulation of Risk**	☐ Yes ☐ Partial ☐ No ☐ N/A	
28. The risk assessment tool provides **Risk Management Plan (as appropriate to identified risk(s))**	☐ Yes ☐ Partial ☐ No ☐ N/A	
29. Evidence on the file of risk being reviewed at any of the following: • At clinical team reviews • When discharged or transferred • If there is a significant change in the consumer's status • When there are clinical concerns about risk	☐ Yes ☐ Partial ☐ No ☐ N/A	
Risk Management	☐ **Section N/A**	
30. Documented risk management plan including **Types of risk and to whom**	☐ Yes ☐ Partial ☐ No ☐ N/A	
31. Documented risk management plan including **Triggers for escalating and diffusing risk**	☐ Yes ☐ Partial ☐ No ☐ N/A	
32. Documented risk management plan including **Strategies for reducing risk**	☐ Yes ☐ Partial ☐ No ☐ N/A	
33. Documented risk management plan including **Review data**	☐ Yes ☐ Partial ☐ No ☐ N/A	
34. Documented risk management plan including **Clinician responsible**	☐ Yes ☐ Partial ☐ No ☐ N/A	

35. Evidence of risk being revised as per assessments	☐ Yes ☐ Partial ☐ No ☐ N/A	
USE OF THE MENTAL HEALTH ACT	**COMPLIANCE**	**EVIDENCE / COMMENTS**
36. Reviews by the Mental Health Review Board are recorded	☐ Yes ☐ Partial ☐ No ☐ N/A	
37. Any restrictions applied have been recorded (eg. phone, visitors, letters)	☐ Yes ☐ Partial ☐ No ☐ N/A	
Community Treatment Orders (Forms 10, 11, 12, 13, 14)	☐ **Section N/A**	
38. Forms completed correctly	☐ Yes ☐ Partial ☐ No ☐ N/A	
39. Forms sent to the Mental Health Review Board	☐ Yes ☐ Partial ☐ No ☐ N/A	
40. Copy of Forms provided to patient	☐ Yes ☐ Partial ☐ No ☐ N/A	
41. Patient and / or carer informed of Rights	☐ Yes ☐ Partial ☐ No ☐ N/A	
42. Consent discussed with consumer (allowable without consent, but this should be recorded in the notes)	☐ Yes ☐ Partial ☐ No ☐ N/A	
Involuntary Admission	☐ **Section N/A**	
43. Forms completed correctly	☐ Yes ☐ Partial ☐ No ☐ N/A	
44. Forms sent to the Mental Health Review Board	☐ Yes ☐ Partial ☐ No ☐ N/A	
45. Copy of Forms provided to patient	☐ Yes ☐ Partial ☐ No ☐ N/A	

46. Patient and / or carer informed of Rights	☐ Yes ☐ Partial ☐ No ☐ N/A	
47. Consent discussed with consumer (allowable without consent, but this should be recorded in the notes)	☐ Yes ☐ Partial ☐ No ☐ N/A	
USE OF THE MENTAL HEALTH ACT	**COMPLIANCE**	**EVIDENCE / COMMENTS**
Emergency Psychiatric Treatment	☐ **Section N/A**	
48. Record is made of any treatment given	☐ Yes ☐ Partial ☐ No ☐ N/A	
49. Record of treatment given is provided to the Mental Health Review Board	☐ Yes ☐ Partial ☐ No ☐ N/A	
Seclusion	☐ **Section N/A**	
50. Record is made of any treatment given	☐ Yes ☐ Partial ☐ No ☐ N/A	
51. Record of treatment given is provided to the Mental Health Review Board	☐ Yes ☐ Partial ☐ No ☐ N/A	
Mechanical Restraint	☐ **Section N/A**	
52. Record is made of any treatment given	☐ Yes ☐ Partial ☐ No ☐ N/A	
53. Record of treatment given is provided to the Mental Health Review Board	☐ Yes ☐ Partial ☐ No ☐ N/A	
DISCHARGE AND CASE CLOSURE	**COMPLIANCE**	**EVIDENCE/COMMENTS**
Discharge and Case Closure	☐ **Section N/A**	
54. The service has a documented policy on discharge planning and case closure **YOU WILL NEED TO ASK A STAFF MEMBER ABOUT THIS**	☐ Yes ☐ Partial ☐ No ☐ N/A	

55.	There is evidence that discharge planning commenced on the person's admission to the inpatient unit	☐ Yes ☐ Partial ☐ No ☐ N/A	
56.	The record demonstrates that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) has been undertaken prior to discharge	☐ Yes ☐ Partial ☐ No ☐ N/A	
57.	There is evidence that the discharge decision has been reviewed by the treating team	☐ Yes ☐ Partial ☐ No ☐ N/A	
58.	The service ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow up are, wherever possible, satisfactory to the consumer, their carers and other relevant service providers prior to discharge from the service.	☐ Yes ☐ Partial ☐ No ☐ N/A	
59.	Necessary follow up has been undertaken within a reasonable timeframe for the consumer's condition.	☐ Yes ☐ Partial ☐ No ☐ N/A	
60.	Discharge has been formalised in writing	☐ Yes ☐ Partial ☐ No ☐ N/A	
61.	The consumer, carers (unless otherwise indicated) and any relevant service provider has been advised on how to re-access the service if necessary in the future, and has been provided with emergency contact numbers	☐ Yes ☐ Partial ☐ No ☐ N/A	
62.	The service provides consumers, carers and other agencies involved in ongoing care to identify early warning signs of relapse that indicate thee mental health service should be contacted.	☐ Yes ☐ Partial ☐ No ☐ N/A	
63.	The service attempts to re-engage with consumers who do not adhere to the planned follow up arrangements.	☐ Yes ☐ Partial ☐ No ☐ N/A	

Appendix B

Chief Psychiatrist's Consumer Questionnaire

Thematic Review of Mental Health Services - 2011

Consumer Questionnaire

Instructions

Please complete the questions and return the completed questionnaire in the envelope provided.

The questions relate to the following areas:

- Your involvement in your treatment
- Physical Health

Interview Details

What is the name of Mental Health Service you are currently attending?

_____

Date: _____ Type of interview: ☐ Face to Face Interview

☐ Telephone Interview

☐ Questionnaire

Involvement – Decision about Treatment and Support

Please think about your current episode of care and answer the following questions. Please tick the appropriate boxes and make comments in the spaces provided.

1. Are you (please tick all that apply):

☐ Inpatient - Voluntary ☐ Inpatient - Involuntary

☐ Outpatient (seen at clinic only)

☐ Community services (seen in your home)

2. Do you know who your key worker or case manager is? (A case manager is a person within the Mental Health Service who is responsible for your care. This is the person you contact if you need support)

☐ Yes
☐ No

3. Have you got an individual management plan? (a piece of paper where the staff have written down the treatment and support you are to get).

☐ Yes
☐ No (If **No**, go to Question 4)

3.a) Were you involved in drawing up your individual management plan?

- ☐ Yes
- ☐ No
- ☐ Partly
- ☐ I don't have a Management Plan

3.b) Do you agree with what is in your individual management plan?

- ☐ Yes
- ☐ No
- ☐ Partly
- ☐ I have not seen my Management Plan

3.c) Have you been provided with a copy of your individual management plan?

- ☐ Yes
- ☐ No
- ☐ I don't have a Management Plan

4. Have you ever been asked to complete a 'Kessler 10' form?

- ☐ Yes
- ☐ No

5. Have other members of your family been invited to be involved in your treatment?

- ☐ Yes
- ☐ No
- ☐ Partly

6. How good are the staff members at this Service at including your family in your care?

- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

7. Has anybody discussed your possible discharge plan with you?

- ☐ Yes
- ☐ No
- ☐ Partly

7.a) What have they talked about?

_____

_____

Mental Health Act

8. Have you ever been made an involuntary patient under the Mental Health Act (1996)?

(Please tick all that apply)

☐ Yes - made an inpatient and admitted to hospital
☐ Yes - put on a Community Treatment Order
☐ No

9. Was it explained to you why you were being made involuntary?

☐ Yes
☐ No

9.a) If yes, who explained to you:

_____

_____

10. If you were put on a Community Treatment Order, did you receive a copy of your Community Treatment Order form?

☐ Yes
☐ No

11. If your Community Treatment Order was extended, did you receive a copy of the Community Treatment Order Extension form?

☐ Yes
☐ No

12. Have you received a copy of any other Mental Health Act Forms?

☐ Yes
☐ No

12.a) If yes, which ones:

_____

Physical Health

13. When you first entered the service (for your current admission) did you receive a physical health check?

☐ Yes
☐ No

13.a) If yes, who checked your physical health? (please tick all that apply)

☐ Doctor
☐ Nurse
☐ Other _____

13.b) What, of the following, did they check? (please tick all that apply)

- ☐ Height
- ☐ Weight
- ☐ Blood pressure
- ☐ Temperature
- ☐ Blood test
- ☐ Other _____

14. Is your physical health checked on an ongoing basis?

- ☐ Yes
- ☐ No

14.a) If yes, who checks your physical health on an ongoing basis? (please tick all that apply)

- ☐ Doctor
- ☐ Nurse
- ☐ GP
- ☐ Other _____

14.b) What, of the following, do they check? (please tick all that apply)

- ☐ Height
- ☐ Weight
- ☐ Blood pressure
- ☐ Temperature
- ☐ Blood test
- ☐ Other _____

15. How often does the Service check on your physical health?

_____

_____

Any Other Comments

Is there anything else you would like to tell us about your treatment at the mental health service?

_____

_____

_____

Thank you for completing this questionnaire.

Please place the questionnaire in the envelope provided and return it to the person who gave it to you - or you can post directly to the Chief Psychiatrist