Chief Psychiatrist's

Review

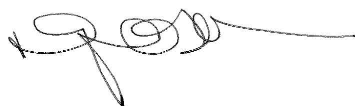
Trends in the Standards of Psychiatric Care in Western Australian Mental Health Services: 2003 to 2011

March 2015

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 confidence to Mental Health Services to assist in their continuing quality improvement of clinical service delivery.

This document is not intended for public release.



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23 March 2015

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

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Executive Summary

The Mental Health Act 1996[1] (MHA 1996), stipulates that the medical care and welfare and the standards of psychiatric care of all involuntary patients across Western Australia (WA) are the responsibility of the Chief Psychiatrist. The Chief Psychiatrist's role has been expanded in the Mental Health Act 2014[2] (MHA 1996) to include oversight of the care and treatment of voluntary patients and referred persons. The Chief Psychiatrist's mandatory reporting responsibilities will also increase markedly under the MHA 2014 and when combined with monitoring the standards of psychiatric care will result in more routine and rigorous evaluation of mental health services (MHS).

In 2011, three reviews of the care of Western Australian mental health patients were conducted, two by the Chief Psychiatrist and the Stokes review[3]. These reviews highlighted a number of gaps in the standard of psychiatric care provided by WA MHS. Improving the standard of psychiatric care across all WA MHS and addressing the recommendations set out in the three reviews and the national standards set by the Australian Commission on Safety and Quality in Health Care,[4] is a priority.

The aim of this report is to provide MHS with evidence of how well they have met the recommended standards for psychiatric care between 2003 and 2011. This report uses the data collected during the Chief Psychiatrist's Clinical Governance reviews conducted between 2003 and 2009 and data from the 2011 Chief Psychiatrist's Thematic Review of MHS (risk assessment, Individual Management Plans, Health of the Nation Outcome Measures (HoNOS), use of the MHA 1996, psychiatric assessment and discharge planning processes in WA MHS) to examine performance with five aspects of clinical care; completion of individual management plans (IMP), Health of the Nation Outcome Scales, risk assessment and management, psychiatric assessment and discharge planning, are examined. It is acknowledged that there are some limitations with these data as they do not cover all MHS and some of the early Clinical Governance reviews did not collect data on each of the outcomes. These limitations are over-ridden by the value in having an historical perspective both to encourage and leverage MHS engagement and to provide a benchmark from which to progress.

Overall, there were marked improvements in the standards of psychiatric care provided to mental health patients in the 2011 Thematic review, compared with the early Clinical Governance reviews. For example, of the five MHS with Clinical Governance and Thematic review data, 80% showed improvement in the provision of written discharge summaries to patients. However, fewer than half of MHS achieved the 70% benchmark set by the Chief Psychiatrist for each of the items reviewed, even for completion of key documents such as IMPs, psychiatric and risk assessments, and discharge plans. Consistent application of the State-wide Standardised Clinical Documentation will assist mental health staff to adhere to national standards and to meet the Stokes recommendations.

Chief Psychiatrist's reviews are always accompanied by recommendations to assist MHS identify areas requiring development. Recommendations have not been included in this report since recent reviews, such as the Stokes mental health review, have captured the issues identified in this report. It is recommended that services consider their local results in light of the Stokes recommendations.

Public sector MHS are experiencing significant duress in the context of resource re-allocation. While there has been some improvement in documented standards of care through the care planning process, there is a signficant risk that benchmarks relating to care planning may deteriorate without appropriate resources to engage in this best practice.

Introduction

The Chief Psychiatrist has responsibility under the Mental Health Act 1996[1] for the medical care and welfare of all involuntary patients and for monitoring standards of psychiatric care across Western Australia. In order to discharge these statutory responsibilities, the Office of the Chief Psychiatrist (OCP) has conducted Clinical Governance, targeted and thematic reviews of mental health services since 2003.

The Mental Health Act (MHA) 2014[2] expands the role of the Chief Psychiatrist to include oversight of the care and treatment of voluntary patients and referred persons. The new MHA mandates increased monitoring responsibilities for the Chief Psychiatrist, which was passed in November 2014 and will come into effect late 2015 or early 2016. This expanded role includes increased requirements for reporting to the Minister for Mental Health in an annual report, which must include details of the mandatory reporting functions of the Chief Psychiatrist. In addition to these statutory requirements, the Chief Psychiatrist is required to report to the Mental Health Commission and the Department of Health on the quality and safety of mental health service provision across Western Australia.

The increased reporting requirements of the Chief Psychiatrist will in turn have implications for the monitoring and reporting workload of staff in MHS across Western Australia.

This report uses data collected during the Clinical Governance reviews conducted between 2003 and 2009 and data from the 2011 Thematic review. A total of 19 Clinical Governance reviews were completed between 2003 and 209, with 500 recommendations generated. The 2011 Thematic review commenced in October 2010 and covered compliance with six aspects of clinical care of which five will be examined in this report; completion of individual management plans (IMP), Health of the Nation Outcome Scales (HoNOS), risk assessment and management, psychiatric assessment and discharge planning. The sixth area of clinical care, 'use of the MHA 1996', will not be examined. These data provide important historical information for services to use as a baseline reference point. It is acknowledged that these data do not cover all MHS and that some of the early Clinical Governance reviews did not collect data on each of the outcomes. However, these limitations are over-ridden by the value in having an historical perspective both to encourage and leverage MHS engagement and to provide a benchmark from which to progress.

The aim of this review is to provide mental health services with an overview of performance over a nine-year period, against the standards of psychiatric care set out in the Stokes Review[3] and the national standards set by the Australian Commission on Safety and Quality in Health Care.[4] Recommendations were provided in the original reports relating to the Clinical Governance and 2011 Thematic reviews and are not repeated here. This report provides a baseline to assist in identifying areas requiring targeted interventions and from which to measure changes in compliance with expected standards of psychiatric care.

Methodology

Data used in this Report

The data for this report were generated through a series of Clinical Governance reviews conducted between 2003 and 2008 and through a Thematic Review of the standards of clinical care provided by Western Australian (WA) MHS in 2011. The state-wide results for the 2011 Thematic Review of MHS (risk Assessment, IMPs, HoNOS, use of the MHA 1996, psychiatric assessment and discharge planning processes in WA Public MHS) were published in December 2011 and the report includes a full description of the review methodology and limitations of the study.[5]

The report published by the Chief Psychiatrist for the 2011 Thematic review described the overall results for WA and did not present data for individual MHS. In this report the findings from the Clinical Governance reviews conducted between 2003 and 2008 and the Thematic review published in 2012[5] are presented individually for 13 MHS. It should be noted that not all items were examined in the Clinical Governance reviews 2003-2008 for each MHS and in these cases, the denominator used for the percentages is the number of MHS with the item reviewed.

The data in this report are presented for 13 individual MHS, five from North Metro Health Service, three from South Metro Health Service, four from WA Country Health Services and one private hospital. For this report, a random number from 1-13 was given to each MHS. Each Area Health Service Director will receive the numbers and corresponding names of the services within their region and release of the identifying information is at their discretion.

Benchmark

The Chief Psychiatrist aspires to have all MHS achieve 100% compliance with the recommendations and standards outlined in the Stokes Review[3] and the National Standards for MHS.[4] However, it is recognized that quality improvement requires time and will require changes in the culture, knowledge, and expectations of staff within MHS. To this end, a benchmark of 70% has been selected as the target to be achieved for monitoring standards of psychiatric care. The results of the Clinical Governance and 2011 Thematic reviews will be assessed using the 70% target as the benchmark and the number of MHS achieving the national standards for between 50% to <70% of the patients is also reported.

Results

1. Individual Management (Care) Plans

Stokes Recommendations

2.2 Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan, the carer is also involved, as appropriate.

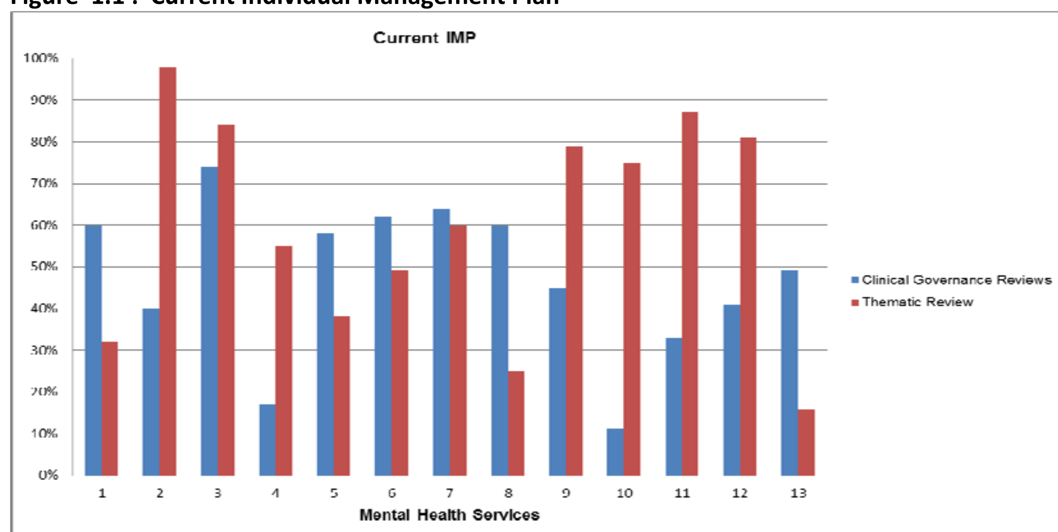
National Standards for Mental Health Services

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

Individual Management Plans (IMP) are used to enhance the continuity of care for people with mental illness ensuring that the patient receives timely and effective services.[6] The IMP should identify the strengths, needs, and goals of the patient and clearly identify the aims, stategies and services to assist them to achieve their goals, and individuals responsible for actions. The IMP is a tool that enables service providers to monitor the patient's progress towards achieving their goals. The Stokes Review recommends that every patient must have a care plan, which is signed off by the patient.[3] However, this report was unable to examine whether the patient had signed the care plan as the Clinical Governance and Thematic reviews did not capture this information.

1.1. Current Individual Management Plan

Figure 1.1 : Current Individual Management Plan



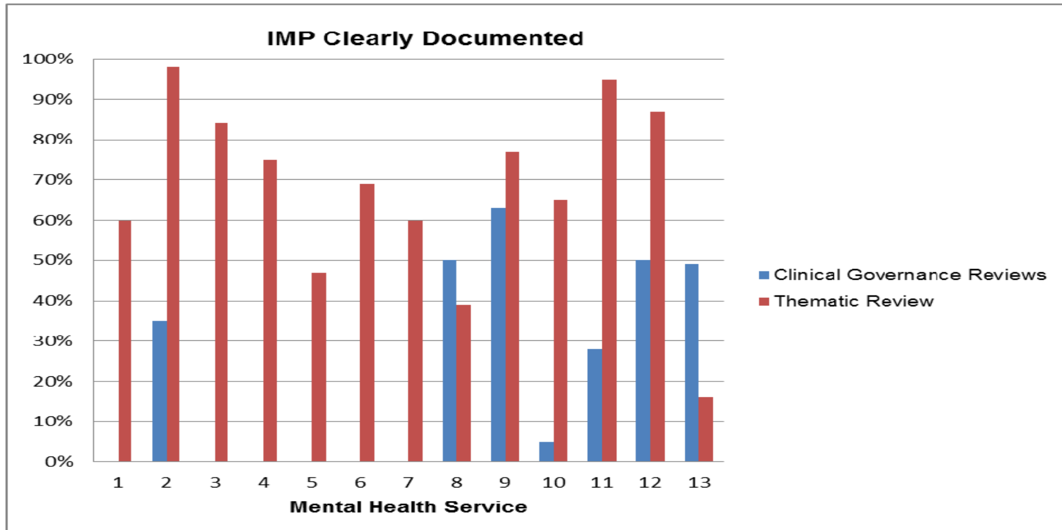
Review Findings:

IMPs are required for all patients, however none of the services had a current IMP for all patients reviewed. In the Clinical Governance reviews, only one MHS (8%) (service 3) had a current IMP for 70% or more of patients and just over one-third (38%) had a current IMP for 50%-<70% of patients. The percentage of patients with an IMP increased to 46% in the 2011 Thematic Review (services 2, 3, 9-12) and two MHS (15%) had an IMP for 50%-<70% of patients (Figure 1.1). However, in six (46%) of MHS (services 1,5-8,13) the proportion of patients with a current IMP was lower in the 2011 Thematic review than in the earlier Clinical Governance review.

1.1.1. Clear Documentation

The Clinical Reviewers examined if the IMP was clearly documented, in particular that the plan was easy to find in the patient's medical record and written in a way that the information was understood by the Reviewer.

Figure 1.1.1: Individual Management Plans Clearly Documented



Review Findings:

There was marked improvement in the clarity of documentation of the IMP. In the Clinical Governance reviews, none of the MHS reviewed achieved the 70% benchmark compared with 46% of MHS in the 2011 Thematic review (services 2-4,9,11,12) (Figure 1.1.1). Of the seven MHS that had this item assessed for both the Clinical Governance and Thematic review, 71% showed improvement in the clarity of documentation over time.

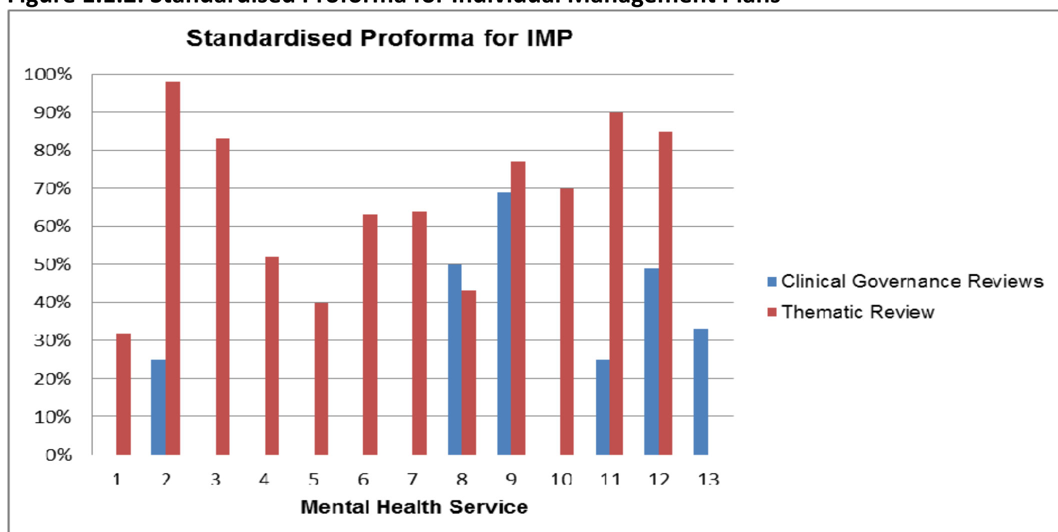
1.1.2. Standardised Proforma

Review Findings:

In the Clinical Governance reviews, none of the six MHS (46%) who had used a standardised proforma for the IMP, had achieved the 70% benchmark, and two (33%) services (services 8,9) used an IMP proforma for 50%-<70% of the IMPs reviewed (Figure 1.1.2).

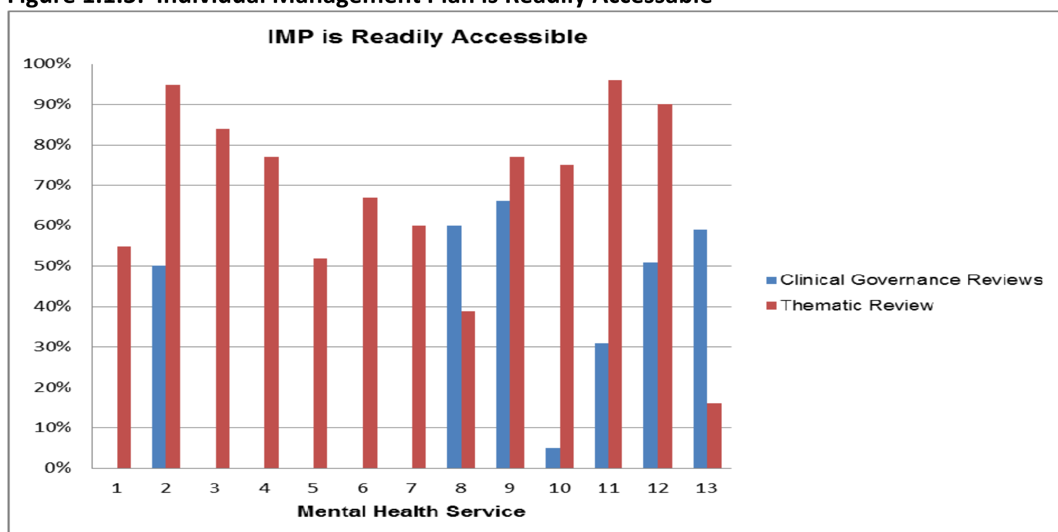
In the 2011 Thematic review, 12 out of the 13 MHS (92%) reviewed had used a standardised IMP proforma, with six MHS (46%) (services 2,3,9-12) achieving the benchmark of 70% or greater and three (23%) MHS (services 4,6,7) using the proforma for 50%-<70% of the patients reviewed.

Figure 1.1.2: Standardised Proforma for Individual Management Plans



1.1.3. Accessibility

Figure 1.1.3: Individual Management Plan is Readily Accessable



Review Findings:

In the Clinical Governance reviews, none of the 7 MHS reached the 70% benchmark in relation to accessibility of the IMP and 4 MHS had a readily accessible IMP for between 50%-<70% of patients (Figure 1.1.3). A marked improvement was seen in the 2011 Thematic review with just over half (54%) of MHS (services 2,3,4,9-12) achieving the benchmark and four MHS (31%) (services 1,5,6,7) had the IMP readily accessible in 50% - <70% of patients' medical records.

1.2. Six-Monthly IMP Review

Stokes Recommendations

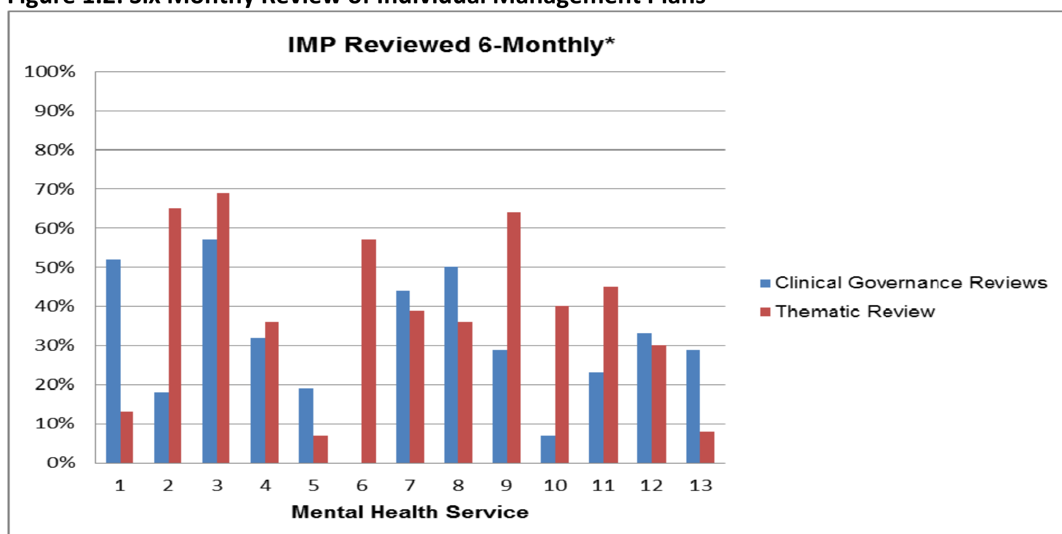
7.11.3a There is a current individual multidisciplinary treatment, care and recovery plan, which is developed in consultation with, and regularly reviewed with, the patient and, with the patient's informed consent, their carer(s).

National Standards for Mental Health Services

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.
Evidence of regular assessment and review should be recorded in the consumer's individual health record.

The IMP is not a static document, requiring updating in response to regular patient reviews and the findings of ongoing ad hoc reviews of the patient's progress. The Stokes Review recommends that IMPs are reviewed regularly but does not stipulate how frequenty the review should be conducted.[3] In contrast, the National Standards for MHS stipuate that a review of the patient's care and recovery plan should occur at least every three months and that this information should be documented in the patient's health/medical record. However, previous clinical reviewers examined six months for reviews as the standard. Irrespective of the frequency of the review period, regular review of the IMP is accepted best practice.[3, 4, 7]

Figure 1.2: Six Monthy Review of Individual Management Plans



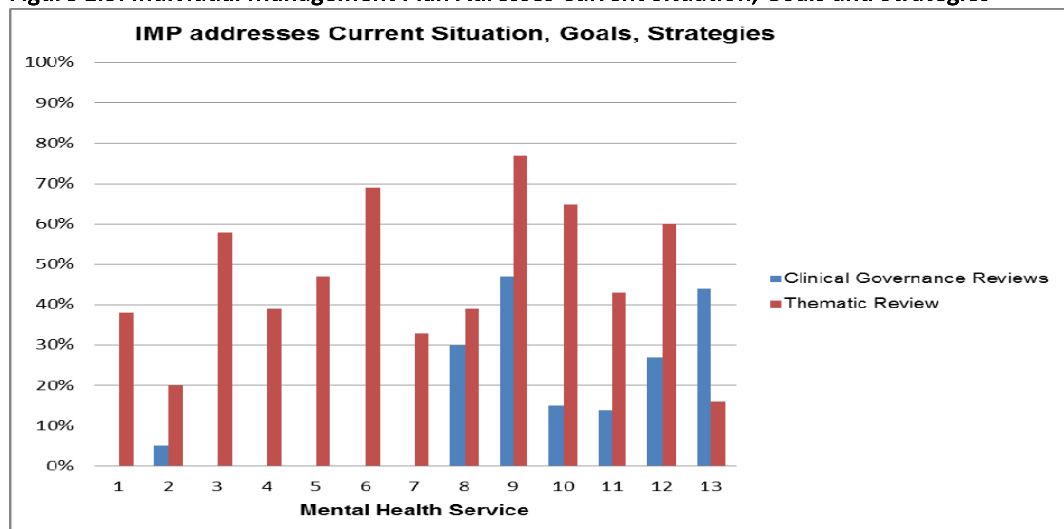
**Review conducted at least six-monthly, revised as necessary and outcome recorded*

Review Findings:

The Clinical Governance and Thematic reviews examined patient's medical records for evidence of at least a six-monthly review of the IMP. None of the MHS achieved the 70% benchmark for a six-monthly IMP review (Figure 1.2). In the Clinical Governance reviews, six-monthly IMP reviews were evident in 50%-<70% of the records at three MHS (23%) (services 1,3,8) and at four MHS (31%) (services 2,3,6,9) in the 2011 Thematic review. These findings indicate that none of the MHS would have achieved the National Standards for MHS requirement of three-monthly reviews.

1.3. IMP Encompasses Current Situation, Goals and Strategies

Figure 1.3: Individual Management Plan Adresses Current Situation, Goals and Strategies



Review Findings:

The medical records were reviewed for evidence that the patient's situation, their goals, and the strategies to achieve their goals reflected their current situation as documented in their IMP. Overall, these were not addressed well within the IMP (Figure 1.3). None of the MHS in the early Clinical Governance reviews addressed these issues in 50% of the IMPs of the patient's reviewed. There was some improvement in the 2011 Thematic review. One MHS (service 9) achieved the 70% benchmark and with four MHS (31%) (services 3,6,10,12) adequately addressing this information in 50% - <70% of IMPs.

1.4. *Collaborative Service Arrangements*

National Standards for Mental Health Services

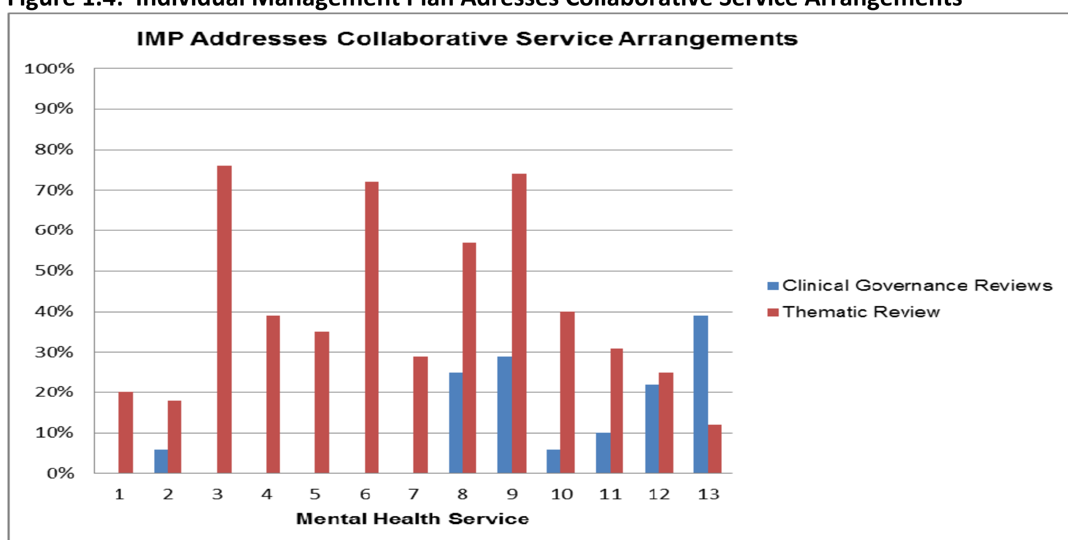
10.5.12 The Mental Health Service facilitates access to an appropriate range of agencies, programs, and/or interventions to meet the consumer's needs for leisure, relationships, recreation, education, training, work, accommodation and employment in settings appropriate to the individual consumer.

10.5.13 The Mental Health Service supports and/or provides information regarding self-care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.

10.5.16 The Mental Health Service endeavours to provide access to a range of accommodation and support options that meet the needs of the consumer and gives the consumer the opportunity to choose between these options.

A range of services are often required in order to provide the patient with the necessary interventions and supports to help them achieve their goals. Involving service providers in the development of the IMP will promote collaboration between the services ultimately assisting the patient in accessing timely, relevant, and effective services.

Figure 1.4: Individual Management Plan Adresses Collaborative Service Arrangements



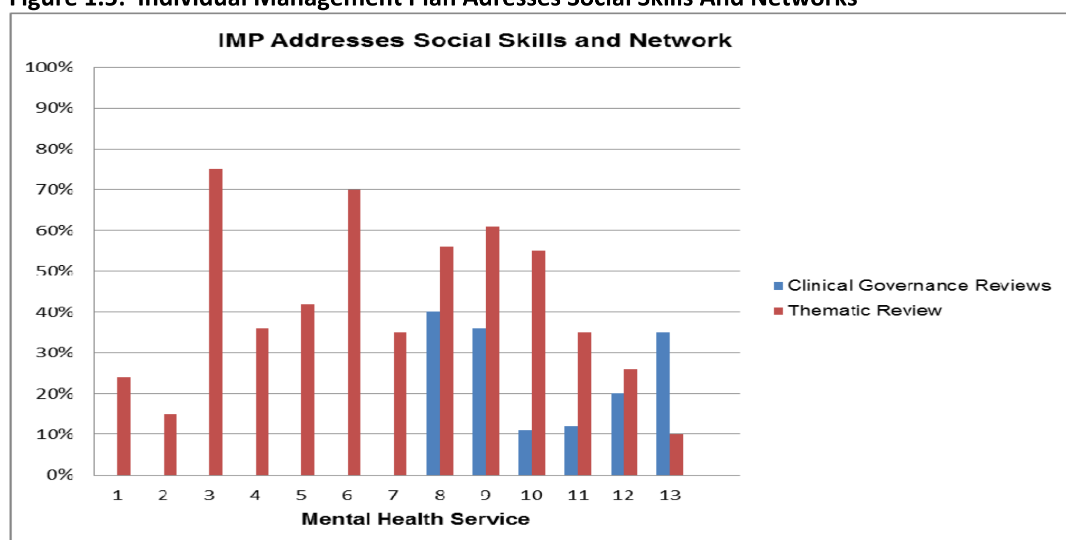
Review Findings:

None of the 7 MHS in the Clinical Governance reviews with information on collaborative service arrangements had this information included in more than 40% of the IMPs reviewed (Figure 1.4). There was a marked improvement in the 2011 Thematic review with three MHS (23%) (service 3,6,9) achieving the 70% benchmark for including collaborative service arrangements in the IMP. However, the majority of the MHS (69%) in the 2011 Thematic review had this information in fewer than 40% of the IMPs examined.

1.5. Social Skills and Network

Individuals with mental illness are at risk of social isolation, often reporting difficulty with making and sustaining relationships and social networks and managing daily living tasks.[8] People with mental health issues often have few close friends and no one to turn to for support within the community. Patients discharged without adequate community support are more likely to relapse and be readmitted to hospital. Community support increases the likelihood of a better quality life, improved functioning, and social connections thereby preventing a cycle of relapse. Indicators of social inclusion or exclusion include the presence or absence of social security, employment, housing, education, community services and participation in the wider social environment.

Figure 1.5: Individual Management Plan Adresses Social Skills And Networks



Review Findings:

The proportion of MHS that included information about the patient's social skills and networks in the IMP (Figure 1.5) showed a similar pattern to collaborative service arrangements (Figure 1.5). In the early Clinical Governance reviews just under half (46%) of MHS addressed social skills and patient networks in the IMPs, with none of the MHS having this information in more than 40% of the records reviewed. In the 2011 Thematic review two MHS (15%) (services 3, 6) achieved the 70% benchmark and three MHS (23%) (services 8-10) had information about these social factors included in the medical records of 50%-<70% of the IMPs reviewed.

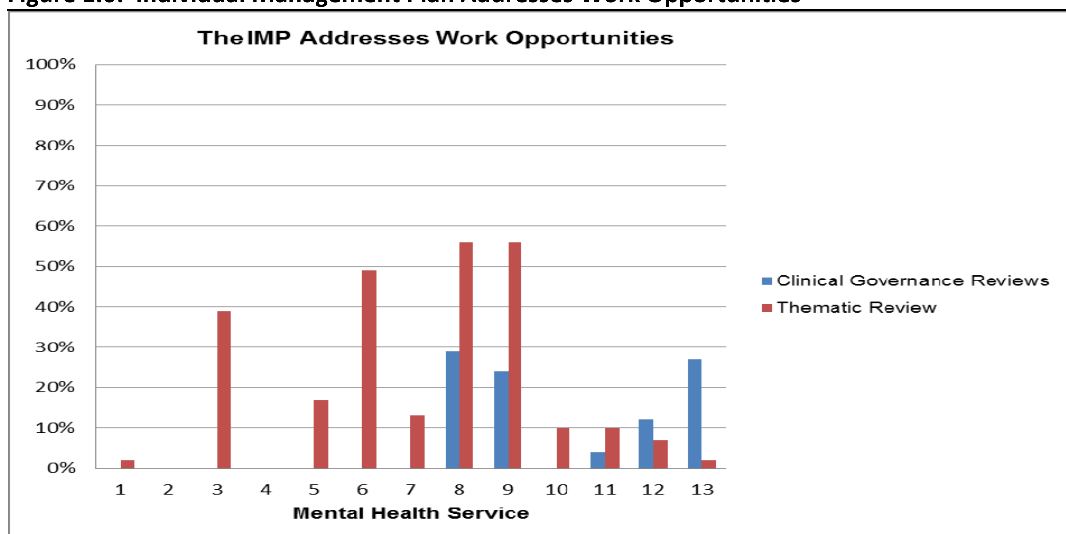
1.6. Work Opportunities

Employment is considered to be a basic human right and unemployment is a key indicator of social exclusion.[8] Employment promotes positive mental health, higher functioning, and improved social skills.[9] However, employment rates and the salaries of psychiatric patients are considerably lower than the general population, which in turn leads to economic disadvantage thereby limiting participation in community leisure activities.[8] Participation in community activities that interest the patient helps to maintain a sense of purpose and enjoyment to life.[9]

Review Findings:

Information about work opportunities was not well documented in patient IMPs in either the early Clinical Governance review or the 2011 Thematic review (Figure 1.6). None of the MHS in either review achieved the benchmark of 70% and in the 2011 Thematic review only two MHS (services 8, 9) had this information documented in at least half of the IMPs reviewed.

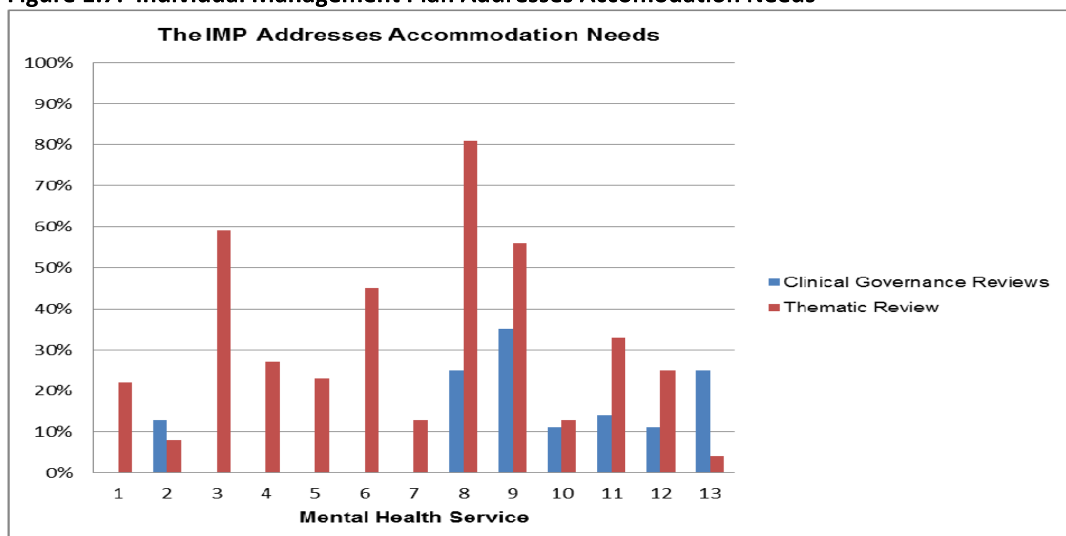
Figure 1.6: Individual Management Plan Addresses Work Opportunities



1.7. Accommodation

Stable and appropriate housing conditions support improved outcomes for people with mental illness.[9] There is some evidence that health professionals have a role to play in assisting mental health patients to gain or retain housing.[8]

Figure 1.7: Individual Management Plan Addresses Accomodation Needs



Review Findings:

Relatively few IMPs in either the Clinical Governance review or the 2011 Thematic review addressed the accommodation needs of the patient (Figure 1.7). In the early Clinical Governance reviews, none of the MHS had this information included in more than one-third of the IMPs reviewed. In the 2011 Thematic Review, one MHS (service 8) achieved the 70% benchmark with 80% of the patients reviewed having information about accommodation included in their IMP and two MHS (service 3, 9) addressed this in 50%-<70% of the IMPs reviewed.

1.8. *Patient Medication, Psychological Treatment, and Treatment Effectiveness*

Stokes Recommendations:

2.5 A detailed explanation of the advantages and side effects of psychiatric drugs is given to patients and the need to maintain medication regimes is comprehensively discussed.

National Standards for Mental Health Services

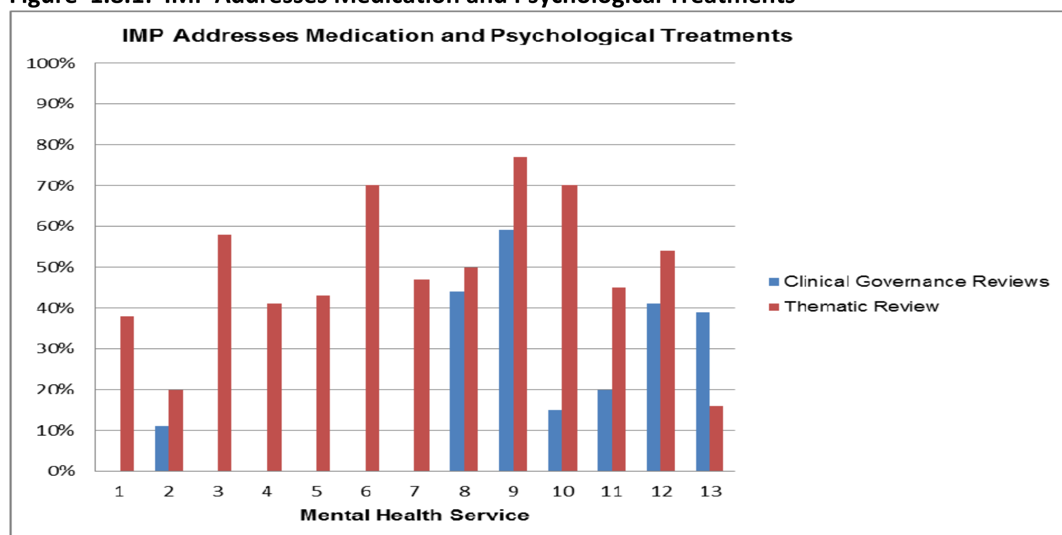
4.14.1 An agreed medication management plan is documented and available in the patient's clinical record.

4.15.1 Information on medicines is provided to patients and carers in a format that is understood and meaningful.
Patient clinical records that show patient and carer information was provided for any changes to medicines during the episode of care.

Many patients with a mental illness require long-term medication and treatment so ensuring patients maintain compliance with these is a key clinical issue. Research indicates that non-compliance with treatment is high, with estimates ranging from 40%[10] to over 50%[11] of patients decreasing to a low of 20% when patients take 13 or more medications on a daily basis.[10] Non-compliance with medication and treatment increases the risk of health problems such as relapse and suicide. In some cases clinicians may erroneously conclude that a patient requires a change in their medication and/or dosage, which may lead to further complications.

A number of strategies have been identified to improve patient compliance with their treatment. One strategy contributing to improving compliance is patient education about their illness, their medication (including drug interactions and side effects), and the importance of continuing their medication and treatment regime.[12]

Figure 1.8.1: IMP Addresses Medication and Psychological Treatments



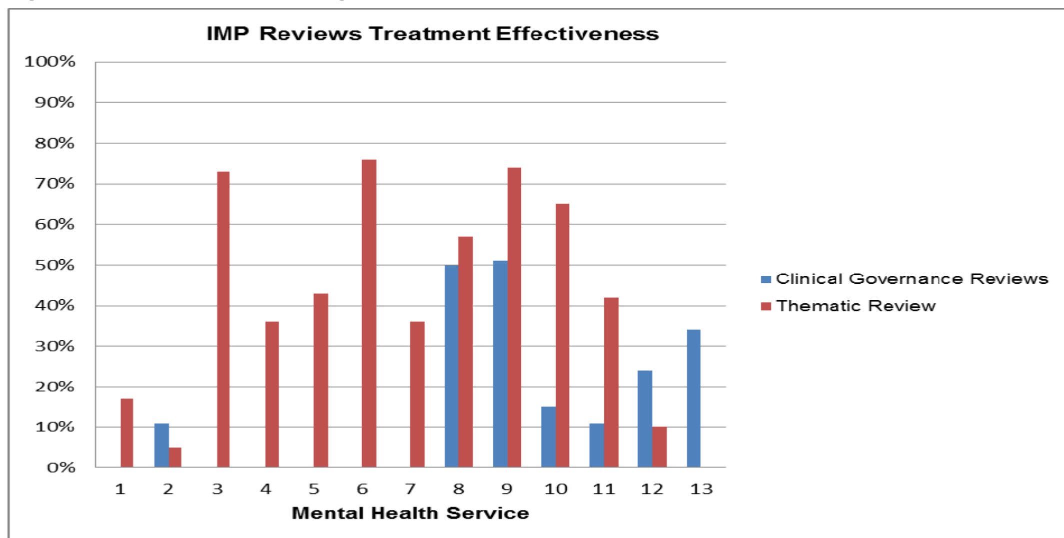
Review Findings:

There have been marked improvements over time in the proportion of patients with details of their medications and treatments included in their IMP (Figure 1.8.1). In the early Clinical Governance reviews none of the MHS achieved the 70% benchmark and only one service (service 9), had this information included in over half (59%) of IMPs reviewed. In the 2011 Thematic review, three MHS

(services 6,9,10) achieved the benchmark with 70% of patients in those services having their medication and treatment information included in their IMP. However, the majority of MHS in both the Clinical Governance (86%) and the Thematic (54%) reviews had this information included in fewer than half of patient IMPs.

Treatment Effectiveness

Figure 1.8.2: Individual Management Plan Reviews Treatment Effectiveness



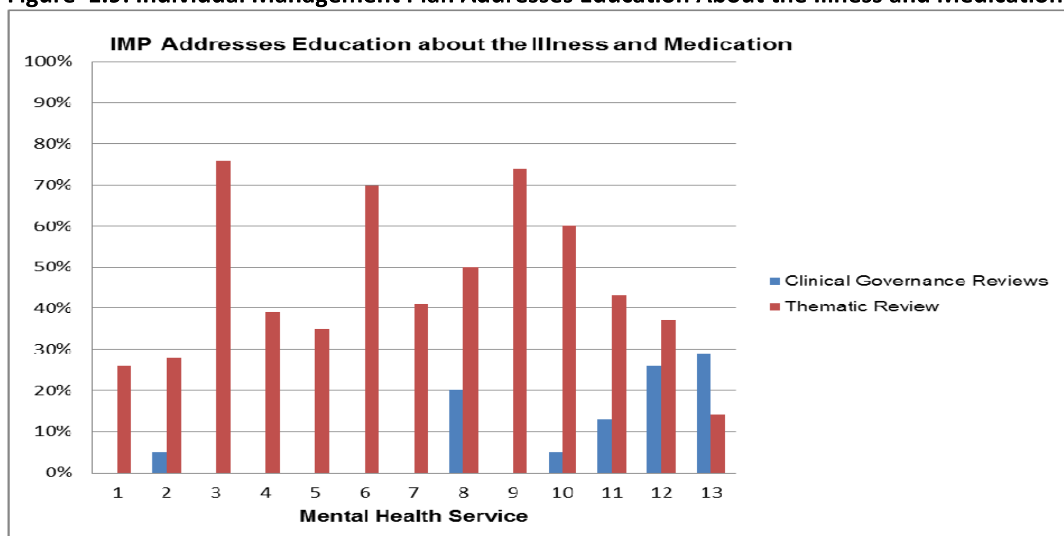
Review Findings:

Improvement in the documentation of treatment effectiveness in patient IMPs was evident over time. In the early Clinical Governance reviews no MHS acheived the 70% benchmark for including infromation in the IMPs about treatment effectiveness, increasing to three (25%) MHS (services 3,6,9) in the 2011 Targeted review (Figure 1.8.2). Two services had this information in 50%-<70% of IMPs in both the Clinical Governance (29%) and 2011 Thematic (17%) reviews.

1.9. Patient Education about their Illness and Medication

Patient education, involvement, and participation in their care enhances patient satisfaction and promotes adherence to treatment,[10] as discussed in section 1.8.1 above. It is essential that patients are provided with sufficient information about their prescribed medication and treatment, including benefits and risks, in order to make an informed decision whether to consent to, or refuse, the treatment.

Figure 1.9: Individual Management Plan Addresses Education About the Illness and Medication



Review Findings:

The provision of education to the patient about their illness and medication (Figure 1.9) improved in the 2011 Thematic review from a very low baseline in the early Clinical Governance reviews. All of the MHS reviewed in the Clinical Governance reviews had fewer than 30% of the patient IMPs with this information. In the 2011 Thematic review three (25%) MHS (services 3, 6, 9) achieved the benchmark with 70% of patients' IMPs having documented evidence that they received education about their illness and medication. However, the majority of MHS (58%) had fewer than 50% of IMPs with this information.

2. Consumer and Carer Involvement

Meaning of Carer

Mental Health Act 2014 – part 17; Division 1; s280

(1) For this Act, a carer of a person is a person who is that person's carer under the Carers Recognition Act 2004 section 5.

Western Australian Carers Recognition Act 2004 -

(1) Except as provided in subsection (2), a person is a carer for the purposes of this Act if he or she is an individual who provides ongoing care or assistance to –

b. A person who has a chronic illness, including a mental illness as defined in the *Mental Health Act 1996* section 3.

Mental Health Act 2014 Part 17, Division 2:

In cases where a voluntary or involuntary patient has the capacity to consent, the carer is entitled to information only with the patient's consent (s286, 288). Where a voluntary or involuntary patient does not have the capacity to consent, the the carer or close family member is entitled to information relating to the patient's condition (s.287, 289) unless the patient's psychiatrist reasonably believes it is not in the best interest of the patient (s292).

Stokes Recommendations

2.1:	The new Executive Director of Mental Health Services mandates the policy development of a patient-focused service that insists every patient is involved in care planning and discharge planning.
7.11.3(b)	The treatment and support provided by the MHS is developed and evaluated collaboratively with the patient and their carer(s). This is documented in the current individual treatment, care and recovery plan.
3.2	Carers must be involved in care planning and most significantly in a patient's discharge plan, including the place, day and time of discharge. *Unless otherwise indicated
3.3	The carers of patients need education, training and information about the 'patient's condition' as well as what are the signs of relapse and triggers that may cause relapse.

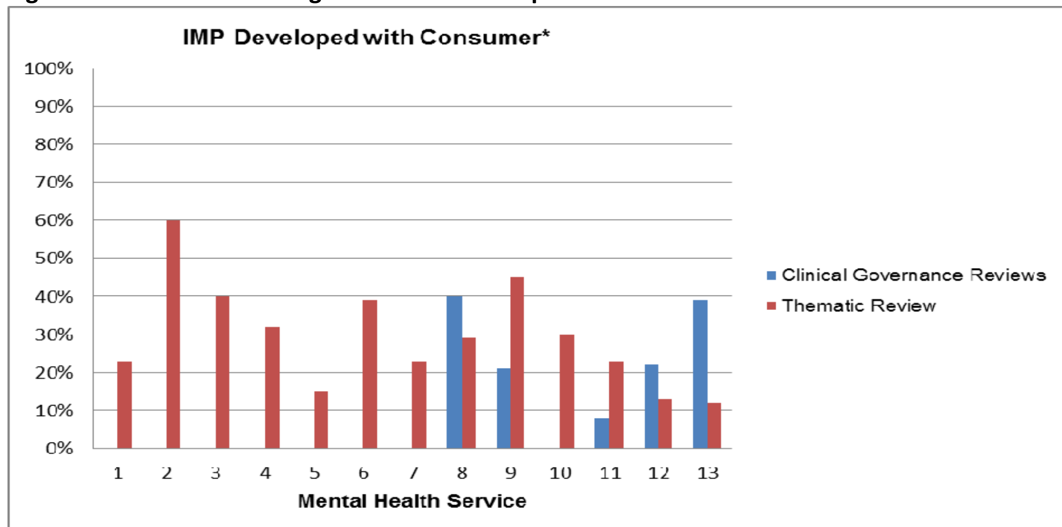
National Standards for Mental Health Services

6.7	Consumers are partners in the management of all aspects of their treatment, care and recovery planning.
7.2	The Mental Health Service implements and maintains ongoing engagement with carers as partners in the delivery of care as soon as possible in all episodes of care. Documentation in progress notes that staff have involved carers in care-planning meetings.
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 the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.

2.1. *Consumer Involvement*

Involving the Consumer in the development of the IMP and the regular review of the IMP are accepted best practice.[3, 4, 7] The nature and severity of the person's illness will affect the degree to which this can occur. Information about their treatment should be given to the patient irrespective of their capacity or willingness to participate, to the extent that this is possible.[7]

Figure 2.1: Individual Management Plan Developed with Consumer



Review Findings:

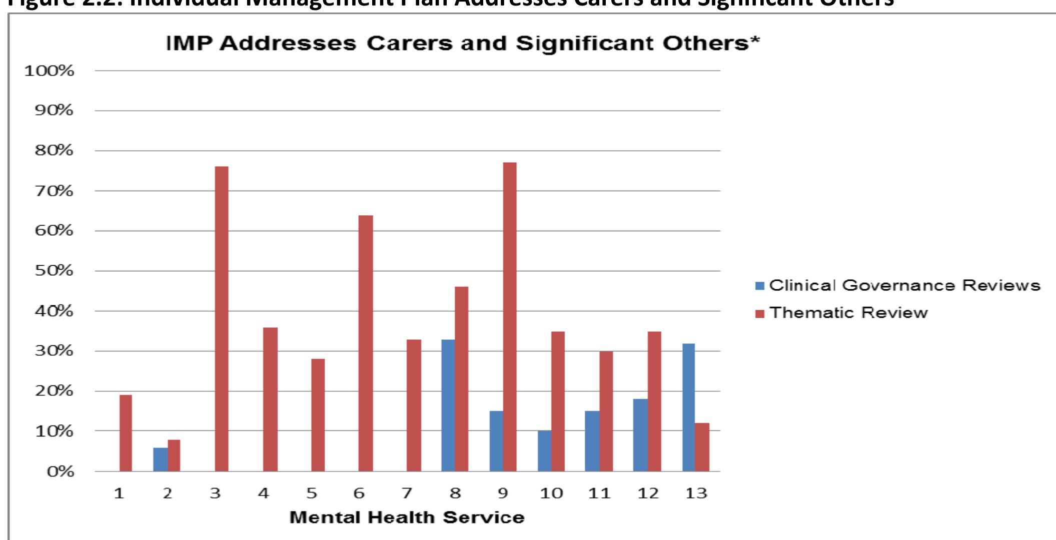
There was limited evidence of consumer involvement in the development of their IMP recorded in the patients' medical records in either the Clinical Governance or 2011 Thematic reviews. None of the MHS reviewed in either of the reviews reached the benchmark of 70% for documenting consumer involvement in the development of their IMP and only one MHS (service 2) achieved 50-<70% in the 2011 Thematic review (Figure 2.1).

It is possible that many staff in MHS may have engaged with the consumer but not documented this in the patient's IMP. Clinical Reviewers need to sight written documentation of consumer engagement and staff should be encouraged to routinely record this in the patient's medical records as part of their ongoing treatment plan.

2.2. Information on Carers and Significant Others

Professor Holman, in his 2004 review of the Mental Health Act 1996, highlighted the significant role that Carers play in the lives of people with a mental illness.[13] He recommended expanding carer involvement in treatment through a partnership model of care and that consultation with carers regarding decisions about treatment/care of the patient and discharge planning should occur. The Mental Health Act 2014 (MHA) recognises the rights of carers and families and in part 17, provides a definition of 'carer' and details the entitlements of carers and close family members in relation to information about the patient's treatment and care.

Figure 2.2: Individual Management Plan Addresses Carers and Significant Others



**Unless otherwise indicated*

Review Findings:

Including information about carers and significant others was limited in the the early Clinical Governance reviews, with fewer than one-third of patients having this information in their IMP (Figure 2.2). In the 2011 Thematic review, information about carers and significant others was documented in 70% of the IMPs of patients in two MHS (services 3, 9), while a third MHS (service 6) had this information recorded in 50%-<70% of their patients' medical records. However, the majority of the MHS (62%) reviewed in 2011 Thematic Review had this information included in the IMPs of less than one-third of their patients.

This documentation only reflects communication with carers and does not reflect the level of engagement. As with consumer involvement, this information should be routinely recorded in the patient's notes as part of the ongoing treatment plan.

3. Health of the Nation Outcome Scales (HoNOS) data collection

The National Outcome and Casemix Collection (NOCC) was implemented across Australia in 2002 and Western Australia has reported annually to the Australian Government Department of Health and Ageing annually since 2002-03.[14] The NOCC was developed to routinely assess the impact of MHS on consumer outcomes in order to improve practice and service management and to support the development of an informed mental health sector in which benchmarking is the norm and performance reporting informs a quality improvement cycle. The three measures are the Health of the Nation Outcome Scales (HoNOS), the consumer-rated outcome measure Kessler-10 Plus, and the Strengths and Difficulties Questionnaire.

HoNOS data are collected for inpatient, community residential, and ambulatory patients. However, the National Minimum Data Set for the HoNOS pertains only to separations where the length of stay was more than 3 days. The Mental Health Information System (MHIS) reports data nationally on a yearly basis, on the proportion of inpatient separations from a specialised mental health unit with a completed HoNOS at both admission and discharge. The MHIS provided the 2011 HoNOS results for seven (services 1,4,6,7,9,11,12) of the 12 MHS examined in these reviews and these are compared with the review results for the intake HoNOS assessment, section 3.1.

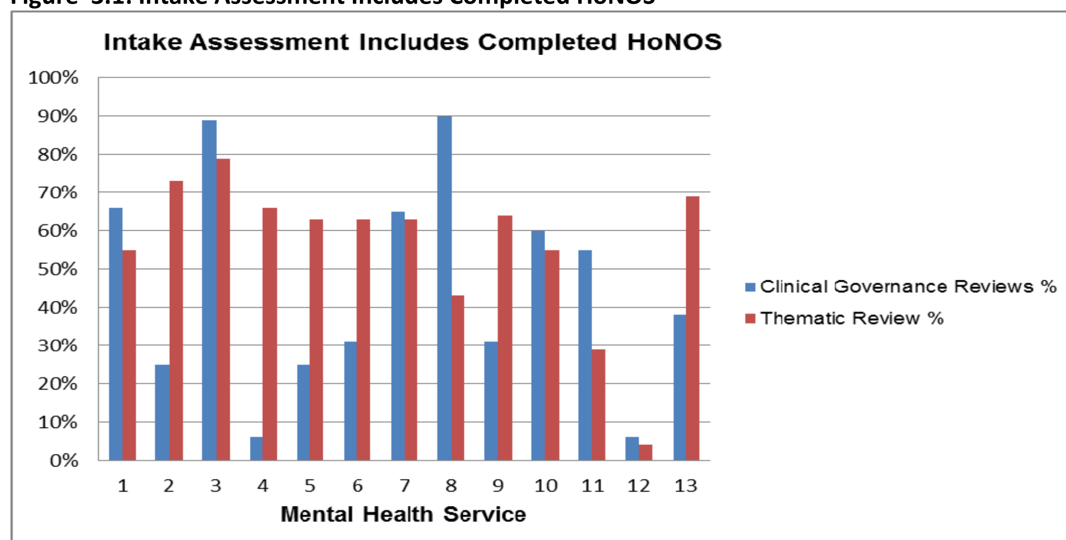
Stokes Recommendation

4.4 Mental health clinicians must comply with reporting requirements for National Outcome and Casemix Collection (NOCC) and Health of the Nation Outcome Scales (HoNOS) data collection.

3.1. Intake Assessment Includes the HoNOS

The HoNOS is one of the three outcome measures in the NOCC[14] and has the highest collection rates. There is strong support from clinicians for the HoNOS measures measure.

Figure 3.1: Intake Assessment Includes Completed HoNOS



Review Findings:

In the early Clinical Governance reviews two MHS (15%) achieved the 70% benchmark for completion of the HoNOS and four MHS (31%) had completion rates of between 50%-<70%. Improvement in completion of the HoNOS was evident in the 2011 Thematic review with two MHS (15%) (services 2,3) achieving the 70% benchmark and eight MHS (62%) (services 1,4-7,9, 10,13) achieving 50%-<70%. Conversely, the proportion of patients with a HoNOS completed dropped over time for five MHS (38%) (services 1,3,7,10,11) (Figure 3.1).

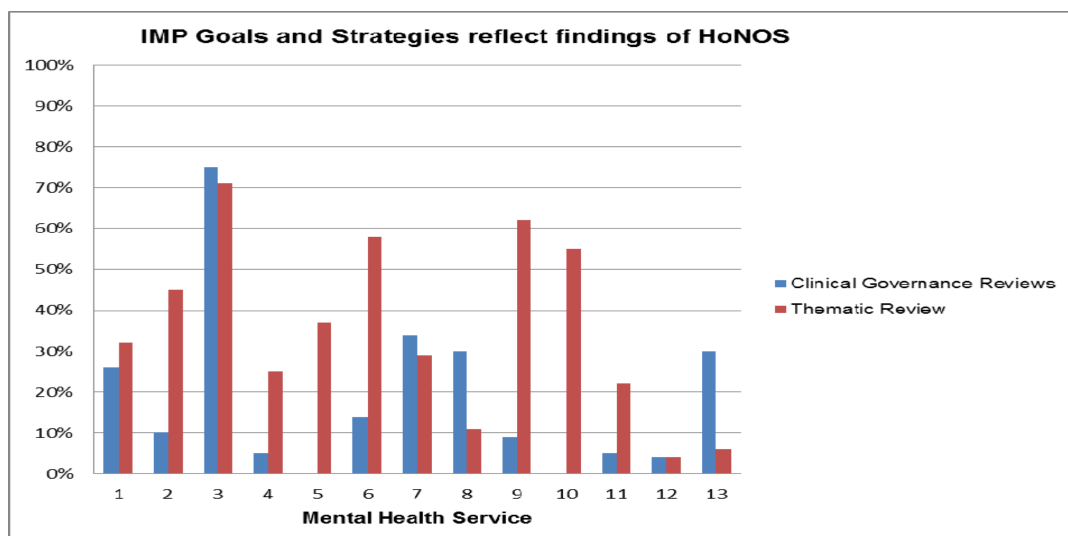
Comparison between the Mental Health Information System (MHIS) HoNOS data and 2011 Thematic review HoNOS results:

The MHIS data for HoNOS were within 10% of the results obtained in the 2011 Thematic review for three MHS (services 1, 6, 9). The proportion of patients with the HoNOS reported in the MHIS was 20% higher than in the 2011 Thematic review for two MHS (services 7, 13) indicating that the HoNOS was not included in the medical records of all patients. Conversely, the MHIS HoNOS results were 30% to 60% lower for two MHS (services 4, 11) than in the 2011 Thematic review. This is likely to reflect differences in the definitions used for collection of HoNOS data by the MHIS and the 2011 Thematic review. The MHIS HoNOS reflects completion of the HoNOS at both the admission and discharge of the patients. In contrast, the 2011 Thematic review examined only completion of the HoNOS on admission. The results therefore indicate that a higher proportion of patients had the admission HoNOS completed than both the admission and discharge HoNOS.

3.2. IMP Reflects HoNOS

One of the key objectives outlined in the NOCC Strategic Directions 2014-2024 is to increase the translation of the NOCC assessments to promote improved clinical practice.[14] This item also seeks to ensure that if a particular issue is identified as high-risk for a patient as part of their NOCC assessment, that there is a correlating goal in the IMP to address the issue. The clinical reviewers examined the inclusion of high-risk issues identified through the NOCC assessment as specific goals in the patient's IMP.

Figure 3.2: Individual Management Plan Goals and Strategies reflect HoNOS findings



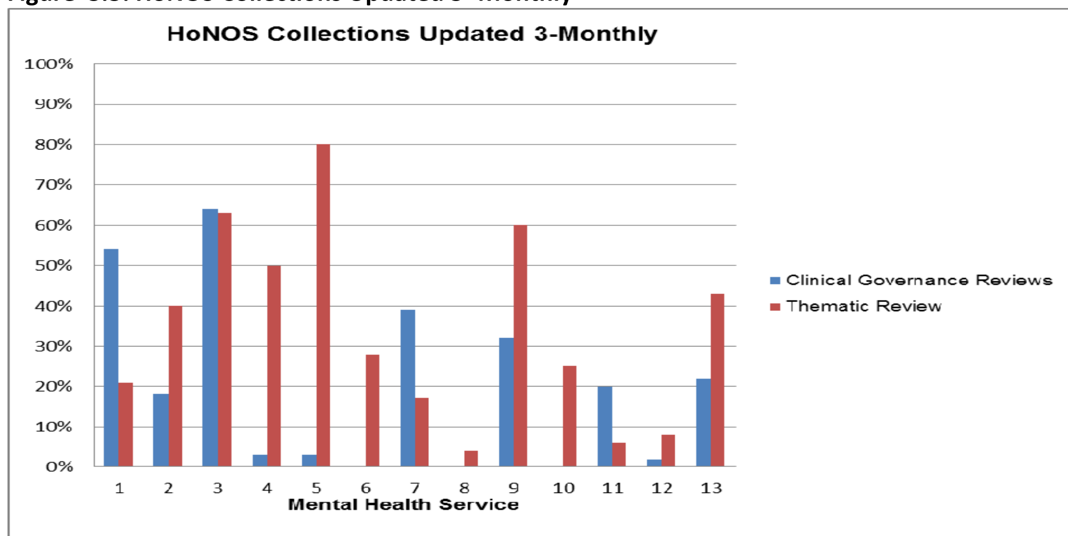
Review Findings:

One MHS (service 3) achieved the 70% benchmark for addressing the findings of the HoNOS in the IMP goals and strategies in both the early Clinical Governance and the 2011 Thematic reviews (Figure 3.2). Improvement over time was evident for six of the eleven (55%) of MHS (services 1,2,4,6,9,11) with both a Clinical Governance and 2011 Thematic review.

3.3. Regular HoNOS Updates

The report of the NOCC Strategic Directions 2014-24 indicates continued support for the current protocol requiring a minimum three-month HoNOS review cycle in order to maintain consistency with national standards.[14]

Figure 3.3: HoNOS Collections Updated 3- Monthly



Review Findings:

Figure 3.3 shows that there is poor compliance with the HoNOS being updated at least 3-monthly in the IMP. In the early Clinical Governance review no MHS achieved the 70% benchmark for the HoNOS being updated at least every three months and one (8%) MHS (service 5) attained the 70% benchmark in the 2011 Thematic review (Figure 3.3). Just under half of MHS (46%) (services 2,4,5,9,12,13) demonstrated improvement over time. However, the majority of MHS had three-monthly updates of the HoNOS for fewer than 50% of patients reviewed; 62% of the MHS in the early Clinical Governance review and 69% of MHS in the 2011 Thematic review.

4. Risk Assessment

The Chief Psychiatrist has mandated that a risk assessment is undertaken for all mental health patients when they enter a MHS. This standard is aligned to the National Mental Health Standards[4, 15] and supported by the Stokes review (2012)[3]. The National Mental Health Standards (2002) state that mental health professionals are expected to *"demonstrate an ability to conduct assessments, in line with expertise and training and in consultation with relevant others, using accepted methods and/or tools in order to prioritise referrals according to risk, urgency, distress, dysfunction and disability"* (page 26).[15]

The Clinical Risk Assessment and Managment Policy was developed under the Western Australian Mental Health Strategy 2004-2007 and published in 2008.[16] The CRAM policy recognizes that *"effective risk assessment and management is part of, and synonymous with, effective treatment"* (page 32). The Policy sets out a guideline for MH staff to use for identifying risks that have a high probablility of resulting in severe (negative) consequences, such as risks to self (e.g. self-harm and suicide, self-neglect, absconding), risk to others (e.g. harassment, violence, aggression), and risks by others (physical, sexual, or emotional harm/abuse). The policy endorses a five-step process for use within mental health settings:

- Establish the context;
- Identify the risks;
- Analyse the risks;
- Evaluate and prioritise the risks;
- Treat the risks.

Stokes Recommendations

7.10.1 Risk assessments should always follow those guidelines published jointly in 2000 by the Australasian College for Emergency Medicine and the Royal Australian College of Psychiatry and as subsequently endorsed as policy by the WA Department of Health in 2001 as a minimum standard.

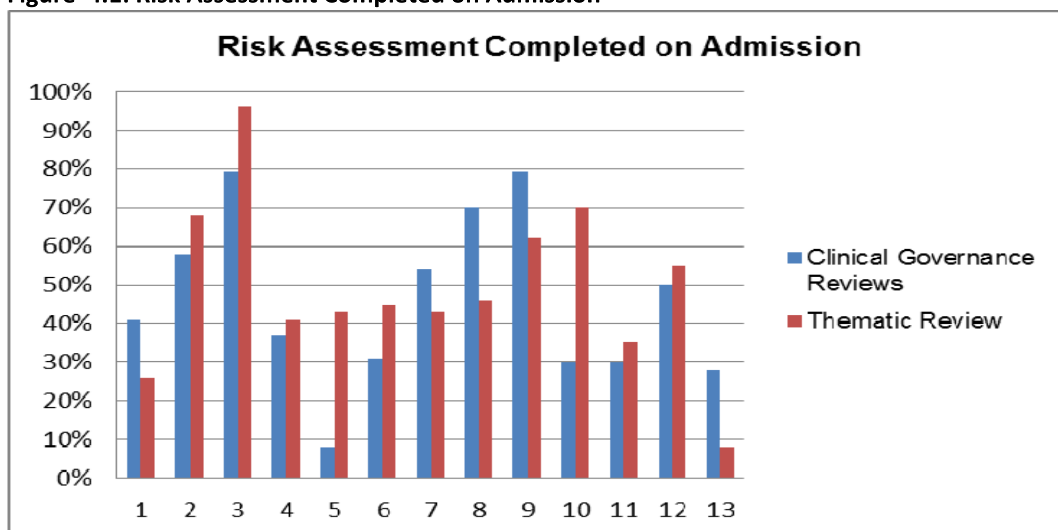
7.11.2(b) The MHS ensures that, where indicated, patients have a current risk management plan, separate from the Individual Management Plan (IMP).

National Standards for Mental Health Services

1.8.1 Mechanisms are in place to identify patients at increased risk of harm

2.1 The MHS promotes the optimal safety and wellbeing of the consumer in all MH settings and ensures that the consumer is protected from abuse and exploitation e.g. Risk management plans

Figure 4.1: Risk Assessment Completed on Admission



Review Findings:

Over half (62%) of the MHS showed improvement in the completion of risk assessments on admission between the early Clinical Governance reviews and the 2011 thematic reviews (services 2-6, 10, 11) (Figure 4.1). In the Clinical Governance reviews, three MHS (3, 8, 9) review achieved the 70% benchmark for risk assessment reducing to two (17%) of MHS (services 3, 10) in the 2011 thematic review. Two of the three MHS that achieved 70% in the early Clinical Governance reviews did not achieve the benchmark in 2011 (services 8, 9), while compliance with risk assessment improved over time for service 3, increasing to 95%.

5. Psychiatric Assessment

All patients presenting to a mental health service are required to receive a psychiatric assessment by qualified staff as soon a practicable following admission.[3, 15] One clinician may collect the initial information, however a multidisciplinary team should review the infromation prior to development of the IMP.[5]

Stokes Recommendations

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

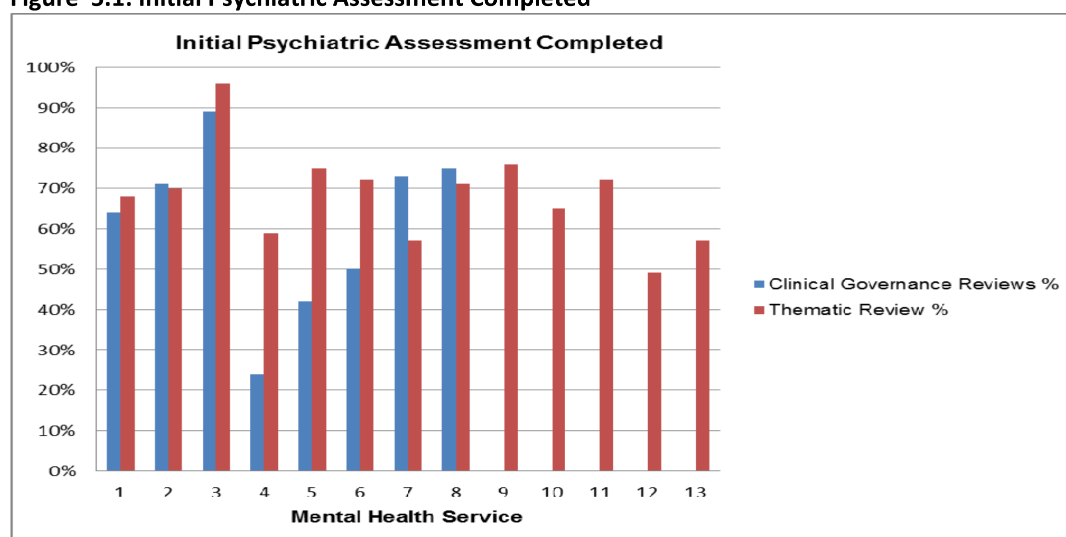
7.11.1(b) The MHS should use a standardised psychiatric assessment form to ensure consistency of data collection within and between mental health services.

National Standards for Mental Health Services

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.

5.1. Psychiatric Assessment

Figure 5.1: Initial Psychiatric Assessment Completed



Review Findings:

In the MHS that had both a Clinical Governance and Thematic review, improvements in the completion of the initial psychiatric assessment were observed over time for just under two-thirds (63%) (Figure 5.1). Half (50%) of the MHS (services 2, 3, 7, 8) with a Clinical Governance review achieved the benchmark of 70% and 58% of the 12 MHS reviewed in the 2011 Thematic review (services 2, 3, 5, 6, 8, 9, 11).

5.2. Comprehensive Psychiatric Assessment

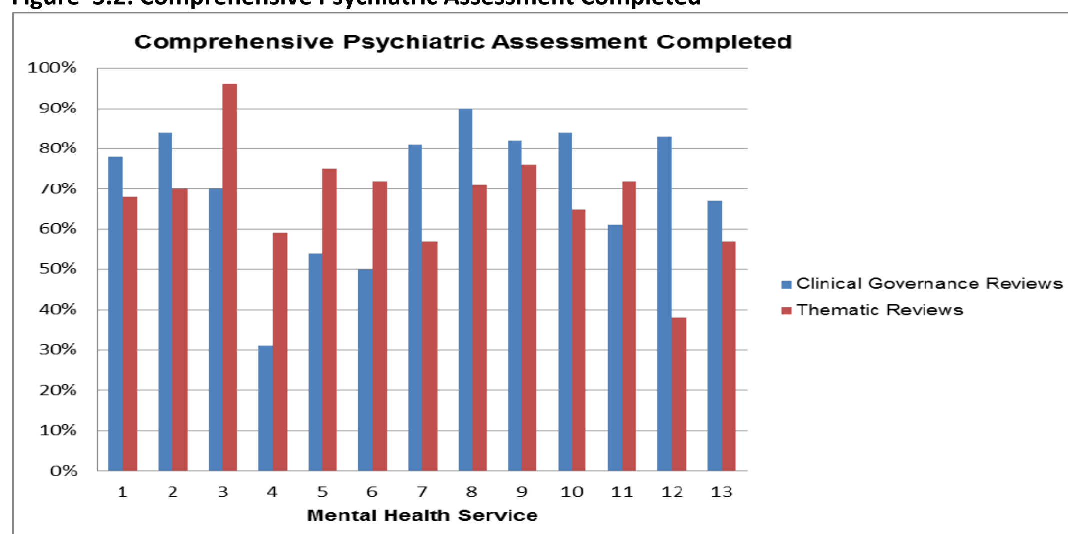
The list of information that the Chief Psychiatristrecommends to be collected in the psychiatric assessment is detailed in Table 5.1.[5]

Table 5.1: Information required in the Psychiatric Assessment[5]

Alerts/Risks	Current treatments:
Assessment Details:	Medications and dose/frequency/route
Date, time, location	Other treatments
Referring clinician	Additional information
Reason for referral	Physical examination summary
Sources of information	Risk assessment
Communication issues	Mental State Examination
History of:	Outcome measures (NOCC)*
Presenting problem	Parental status and/or other carer responsibilities
Psychiatric mental health	Details of children and/or dependents
Drug and alcohol use/abuse	Formulation / Overall clinical impression
Patient medical history	Provisional diagnosis
Family medical/mental health	Initial Management Plan
Development	Contacts
Personal	Personality
Current functioning and supports	Legal issues

*National Outcomes and Case Mix Collection such as the Health of the Nation Outcome Scales (HoNOS)

Figure 5.2: Comprehensive Psychiatric Assessment Completed



Review Findings:

Compliance with the requirement for patients to have a comprehensive psychiatric assessment was very high in both the early Clinical Governance reviews and the 2011 Thematic reviews, with seven MHS achieving the benchmark of 70% in both of these reviews (Figure 5.2). However, four (57%) of the seven MHS that achieved the benchmark in the Clinical Governance reviews did not achieve the benchmark in the 2011 Thematic review (services 1, 7, 10, 11). Conversely, five (38%) MHS showed marked improvement in compliance over time with completion of the comprehensive psychiatric

assessment (services 3, 4, 5, 6, 11), of which 80% achieved the 70% benchmark. One MHS (service 3) had both the comprehensive psychiatric assessment (Figue 5.2) and the initial psychiatric assessment (Figue 5.1) completed for 95% of their patients.

6. Discharge Planning

Stokes Recommendations

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

7.11.4(b) The MHS provide patients, their carers and other service providers involved in follow-up with information on the process for facilitating re-entry to the MHS if required and other resources such as crisis supports are provided.

7.11.4(c) 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 plan for discharge.

7.11.4(d) The MHS ensures, as far as possible, that the next agency or clinician to support or provide care for the patient is made aware of the discharge date, the urgency of review and a specific contact within the services to manage issues of urgency or failure of follow-up contact.

National Standards for Mental Health Services

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.

10.6.3 The MHS has a process to commence development of an exit plan at the time the consumer 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 consumer's informed consent, their carer(s).

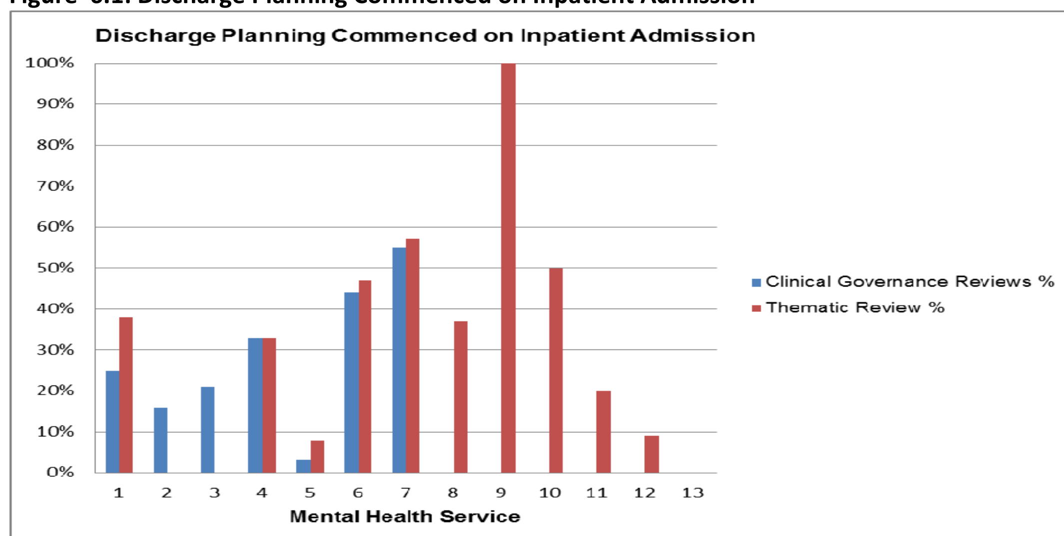
10.6.7 Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

Discharge planning for patients with a mental illness is an important part of psychiatric care. Discharge planning should be commneced as soon as possible after the patient is admitted to hospital and address the patient's current needs and goals.[5] Prior to discharge, a comprehensive clinical review and consultation with the patient and carer (if indicated) should be undertaken.

The aim of discharge planning is to provide the patient and future treating teams with information vital for ensuring comphrensive care such as medication, follow-up community and physical health care, activities of daily living, education, accommodation, financial assistance and other information as required.[6] Discharge planning supports the patient and their carer and/or family, reduces the length of hospital stay, promotes engagement across MHS and access to community MHS within 7 days and has been shown to reduce the rate of unplanned readmissions within 28 days.[5] Given the importance of discharge planning, it is of concern that the Clinical Governance and the 2011 Thematic reviews found poor compliance with discharge planning across all MHS.

6.1. Discharge Planning Commenced on Admission

Figure 6.1: Discharge Planning Commenced on Inpatient Admission

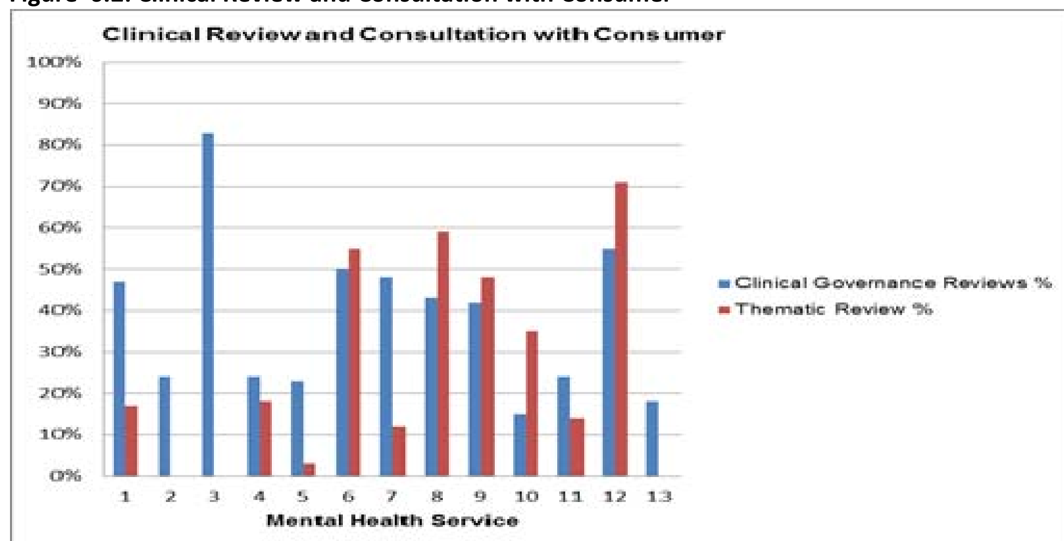


Review Findings:

The two reviews showed that few MHS were compliant with the requirement for discharge planning to commence on admission to the service (Figure 6.1). The exception was MHS 9, which achieved 100% compliance with this standard in the 2011 Thematic review. There was minimal improvement in discharge planning in the five MHS with data from both a Clinical Governance and 2011 Thematic review.

6.2. Comprehensive Clinical Review and Consulation with Consumer Prior to Discharge

Figure 6.2: Clinical Review and Consultation with Consumer



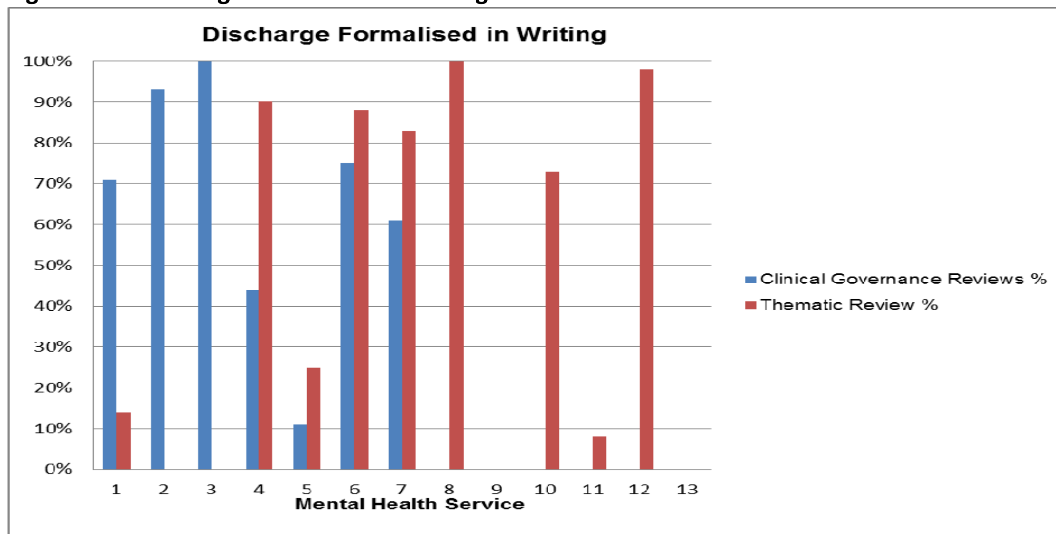
Review Findings:

Clinical review and consultation with the consumer prior to their discharge was either inconsistently undertaken or if it was undertaken, it was not documented within the patients' medical records (Figure 6.2). Only one MHS in each of the two reviews achieved the 70% benchmark; service 3 in

the early Clinical Governance Reviews and service 12 in the 2011 Thematic review with two MHS in each review period achieving 50% to 60%. In the Clinical Governance Reviews three-quarters of MHS (77%) had fewer than half of patients receiving a clinical review and consultation prior to their discharge decreasing slightly to 70% in the 2011 Thematic review.

6.3. Written Discharge Documentation

Figure 6.3: Discharge Formalised in Writing

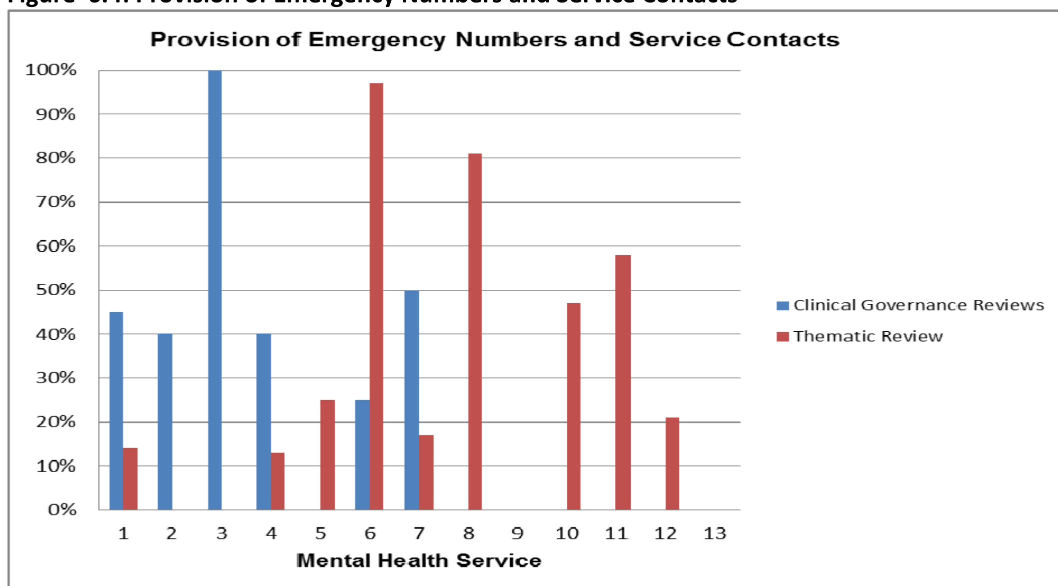


Review Findings:

Of the seven MHS Clinical Governance review where this item was reviewed, four (57%) (services 1, 2, 3, 6) achieved the benchmark with written discharge provided to the patient for 70% or more of the discharges (Figure 6.3). In the 2011 Thematic review, six of the nine (67%) MHS (services 4, 6, 7, 8, 9) with data on this standard achieved the benchmark of 70% or higher. Of the five MHS with data from both a Clinical Governance review and the 2011 Thematic review, 80% showed improvement in providing written discharge summaries.

6.4. The Consumer and Carers (if indicated) have been advised how to reaccess the service and provided with emergency contact numbers

Figure 6.4: Provision of Emergency Numbers and Service Contacts



Review Findings:

The reviews indicated that patients are not routinely provided with discharge information for emergency numbers and service contracts, or if they are this information is not being documented in the patient medical records. One MHS (17%) (service 3) provided this information to all of the patients reviewed in the Clinicial Governance review (Figure 6.4). However, the other five MHS with data from the Clinical Governance review provided this information to less than half of their patients. Of the nine MHS with data from the 2011 Thematic review, two (22%) (services 6,8) achieved the benchmark of 70% with the majority (67%) having this information in fewer than 50% of patients' medical records.

7. Patient Follow-Up

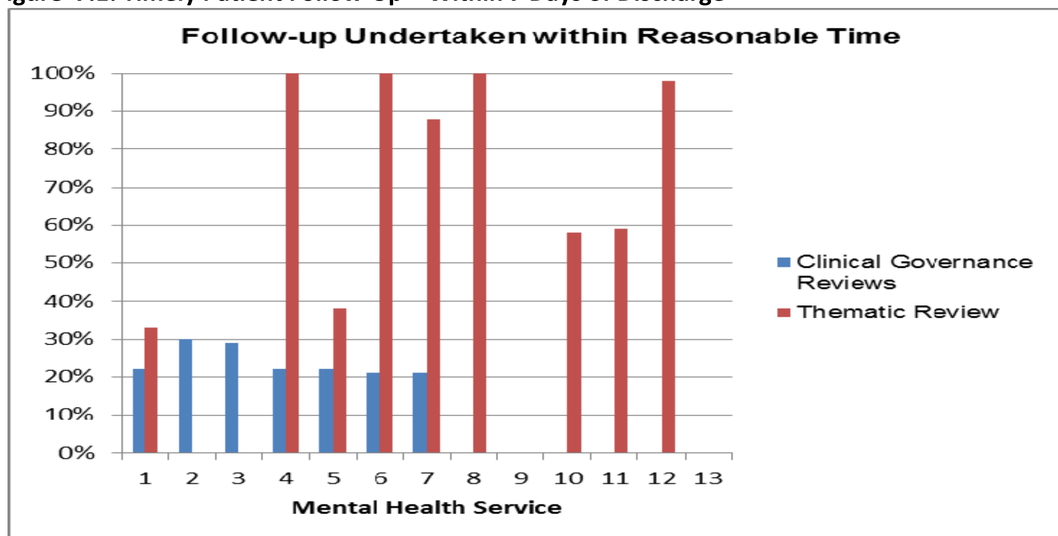
Stokes Recommendation:

7.11.4 (d) The MHS ensures, as far as possible, that the next agency or clinician to support or provide care for the patient is made aware of the discharge date, the urgency of review and a specific contact within the services to manage issues of urgency or failure to follow-up contact.

National Standards for Mental Health Services

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.

Figure 7.1: Timely Patient Follow-Up – Within 7 Days of Discharge



Review Findings:

None of the MHS reviewed in the early Clinical Governance reviews demonstrated evidence that there was timely follow-up of patients after discharge, defined as within 7 days of discharge from an inpatient unit. All of the five MHS (services 1,4,5, 6,7) that had data on the timeliness of patient follow-up from both the Clinical Governance and Thematic reviews showed marked improvement in the provision of timely follow-up of the patient following discharge (Figure 7.1). In particular, services 4, 6, and 7 improved from 20% of their patients receiving timely follow-up in the early Clinical Governance reviews to between 85% and 100% of patients in the 2011 Thematic review. Of the eight MHS with data from the 2011 Thematic review, five (56%) had achieved the 70% benchmark for timely follow-up and 22% achieved 50% to 60%..

Table 8.1 Summary Results: Percentage of items achieving the 70% Benchmark for each Mental Health Service

	Mental Health Service												
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Clinical Governance Review													
Number of Items Reviewed	13	23	13	13	11	11	13	21	20	16	21	21	21
Outcome													
70% +	0	9%	69%	0	0	17%	15%	14%	5%	6%	0	5%	0
50% <70%	30%	4%	15%	0	18%	36%	46%	29%	25%	6%	10%	19%	10%
2011 Thematic Review													
Number of Items Reviewed	26	20	21	25	26	26	26	26	23	26	26	26	19
Outcome													
70% +	0	35%	52%	16%	8%	38%	8%	23%	52%	23%	23%	27%	0
50% <70%	19%	15%	29%	24%	12%	35%	31%	27%	35%	35%	8%	15%	16%

8. Overall Results

There have been marked improvements over time in the proportion of MHS achieving the benchmark of 70% (Table 8.1). In the early Clinical Governance reviews conducted between 2003 and 2008 only one MHS (service 3) had achieved the benchmark of 70% for more than half of the items reviewed with the remaining services achieving the benchmark for fewer than 20% of the items. The majority of patient medical records did not comply with the Stokes review recommendations and the National Standards for MHS.

Compliance with these standards increased markedly in the 2011 Thematic review with two MHS (services 3, 9) achieving the 70% benchmark for around half (52%) of the items reviewed, two MHS (services 2, 6) achieving the benchmark for over one-third (35%-38%) of items and three MHS (services 8, 10, 11) for a quarter of the items reviewed (Table 8.1)

9. Summary

Notwithstanding that the Chief Psychiatrist was not consistently measuring the same outcomes for each MHS over time, there appeared to be marked improvements in the standard of psychiatric care provided to mental health patients in the 2011 Thematic review, compared with the findings of the early Clinical Governance reviews. However, many gaps in standards of psychiatric care remain.

IMP, Psychiaric and Risk Assessment

Key components of psychiatric care include having a current IMP, psychiatric assessment, and risk assessment commenced or completed for every patient on admission. However, few MHS achieved the 70% benchmark for these items in the 2011 Thematic review. The benchmark was achieved by 42% to 54% of MHS for having a current IMP that was accessibile, clear, and used a standardized proforma and 54% of MHS had achieved the 70% benchmark for initial psychiatric assessment. However, only two MHS (17%) in each of the review periods achieved the benchmark for completing a risk assessment on admission.

The IMP is expected to have a wide range of details about the patient, their treatment and medications, their current situation and goals, and items relating to their life in the community. Overall, the number of MHS that had included these items in the IMP was very low. The proportion of MHS achieving the 70% bennchmark for including items such as regular 6-montly reviews (0%) and information relating to the patient's current situation and their care, goals, and strategies (8%), work opportunities and 6-monthly review (0%), social skills (17%) and accommodation (8%) and treatment and medications including treatment effectiveness (25%) indicates the need for the implementation of policy and guidelines to ensure the standards of psychiatric care expected by the Stokes review and the National Standards for MHS are achieved for all mental health patients. Regular audits should be conducted by the MHS to ensure and promote compliance.

Consumer and Carer

None of the MHS achieved the 70% benchmark for having evidence that the consumer was involved in the development of the IMP and only 17% achieved the benchmark for having information about carers and significant others.

Health of the Nation Outcome Scales (HoNOS)

The NOCC data collection was established with the aim of improving clinical practice and engendering a cycle of quality improvement. Although the HoNOS is a key performance indicator with strong support for continuing with this data collection, in the 2011 Thematic review only two MHS achieved the 70% benchmark and one MHS in the earlier Clinical Governance reviews. In the 2011 Thematic review the majority of MHS (67%) reported the HoNOS for 50% to <70% of patients, which is consistent with the MHIS data for 71% of the MHS. This provides a solid baseline from which MHS can monitor improvements in future national HoNOS data reports.

Discharge and Patient Follow-Up

Performance in discharge planning was equally concerning with only one MHS (8%) in the 2011 Thematic review achieving the 70% benchmark for commencing discharge planning on admission to the service and none of the MHS achieving this in the early Clinical Governance reviews. One area of strength in the 2011 Thematic review was provision of written discharge documentation, with two-thirds of the MHS (67%) with this item reviewed achieving the 70% benchmark. There was a marked improvement in the timely review of patients within 7 days following discharge, with just over half (56%) of the MHS with data on this item achieving the 70% benchmark.

10. Conclusions

The Mental Health Bill 2013 and the Stokes review[3] in 2012 have increased the emphasis on monitoring and reporting the standards of psychiatric care being delivered in Western Australian MHS. The improvements in the standards of psychiatric care over the past decade are promising, but in most areas they continue to fall short of the national standards.[4] With only two MHS achieving the 70% benchmark for half of the items examined in this report, MHS have considerable work to do to ensure all mental health patients are receiving the standard of psychiatric care expected by the Chief Psychiatrist.

Patient medical records provide vital clinical information for clinicians involved in the care of a patient and ensure that patient details and the medical treatment delivered to the patient are communicated to all clinical staff to inform care decisions. The lack of compliance with documentation of patient assessments and other information is therefore very concerning. State-wide Standardised Clinical Documentation (SSCD) have been developed to promote consistent recording, retrieval and sharing of patient clinical information throughout their admission across all WA MHS. Use of the SSCD has the potential to lead to improvement in many of the areas reviewed in this report. The WA Department of Health SSCD Operational Directive (OD 0526/14), published in May 2014, states that use of the SSCD is mandatory for all MHS. However, anecdotal evidence indicates that implementation of the SSCD by MHS staff remains inconsistent.

The Chief Psychiatrist will be repeating the 2011 Thematic Review following the commencement of the Mental Health Act 2014 and improvements in the standards of psychiatric care are expected, particularly in relation to the relevant areas where services have worked hard to implement the SSCD into their everyday practice.

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