

ACT AUDITOR–GENERAL’S REPORT

**MENTAL HEALTH SERVICES –
TRANSITION FROM ACUTE CARE**

REPORT NO. 6 / 2017

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The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to forward to you a Performance Audit Report titled 'Mental Health Services – Transition from Acute Care' for tabling in the Legislative Assembly pursuant to Subsection 17(5) of the *Auditor-General Act 1996*.

Yours sincerely

Dr Maxine Cooper
Auditor-General
23 June 2017

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SUMMARY

Mental health care and treatment is a journey, often occurring over a long period of time. People living with enduring and episodic illnesses or disorders may spend extended periods in the community, with periodic readmission to acute care as an element of their long term care. The Canberra Hospital and Calvary Public Hospital provide acute inpatient care services for people with mental illnesses and disorders.

Given the long term nature of mental health care and treatment, continuity in care is critical in managing a person's journey and it is important to have effective transition processes from acute mental health care. Each year, about 1,000 people in the ACT are discharged from acute mental health services, usually into the care of their family and friends. They are assisted by the ACT Health Directorate's five Adult Community Mental Health Teams and other mental health programs, non-government community organisations, General Practitioners and other care providers.

Effective transition processes from an acute care setting should be underpinned by the principles of:

- consultation, participation and collaboration between the person and mental health service provider, where there is open communication and consultation with the person and their views and preferences are recognised; and
- early and effective discharge and recovery planning, where there is an early emphasis on planning for the person's discharge from the acute care service and subsequent recovery.

Conclusions

Overall conclusion

An integrated, comprehensive and contemporary framework, encompassing the ACT *Mental Health Act 2015* (the Act), for managing the transition of people from acute care services to community-based services is lacking. Not all the requirements of the Act are captured in policies and procedures, and many are outdated. This compromises the ability of public health practitioners and carers to effectively manage a person's transition.

In developing the framework it will be important for policies and procedures to be harmonised so that services are delivered seamlessly regardless of where they are provided. To reinforce this, the Director-General needs to examine whether section 217 of the Act needs to be invoked for key administrative policies and procedures.

The ACT has prudently implemented a single record-keeping system (MHAGIC) across all public mental health services which can facilitate the effective sharing of information, and continuity in care, regardless of where a person receives treatment. However, many of the recovery planning

and related records in MHAGIC are poor. There are plans to upgrade MHAGIC but this will be futile unless there are significant positive changes in the way staff, at all levels, use MHAGIC and the information it produces.

Outdated performance reporting processes limit the availability and quality of information for operational staff and executives. A review of these processes is needed to enable monitoring and reporting on key performance indicators, compliance measures and patient outcome measures.

Notwithstanding these issues, it was apparent from clinical records that there is a focus on providing quality and compassionate care.

Chapter conclusions

LEGAL AND POLICY FRAMEWORK

There is a need to review, rationalise and re-issue mental health services policies and procedures as many are outdated or were drafted before the passage of the *Mental Health Act 2015* (the Act). These do not give full effect to the Act, notably the different treatment regimes for people with mental illnesses and mental disorders.

In order to achieve consistency in services and continuity of care for patients there is merit in aligning mental health services policies and procedures across all public health services, including those delivered directly by the ACT Health Directorate and Calvary Public Hospital. A mechanism by which consistency in service and continuity of care may be achieved is through the issuing of key administrative policies and procedures under the authority of section 217 of the Act and there is merit in the ACT Health Directorate giving consideration to this option. The Calvary Public Hospital could then be requested to adopt these, or align their activities.

RECOVERY PLANNING

While a review of case file records showed a high degree of care and compassion for those in acute care, documentation in MHAGIC could not be relied on to demonstrate consultation and collaboration in the delivery of services, or early and effective planning for discharge and recovery from acute care.

For the records reviewed, clinical notes in MHAGIC were repetitive, poorly structured and did not provide comprehensive information on the course of treatment, discharge and recovery planning. This does not facilitate efficient or effective administration or recovery-oriented service delivery. Although MHAGIC includes a suite of documents and templates designed to assist in promoting consistency in record-keeping and service delivery, these are infrequently used.

MENTAL HEALTH SERVICES INFORMATION MANAGEMENT

A substantial number of performance reports are produced to monitor and improve operational performance. However, the current suite of reports is complex and needs to be reviewed to identify

and eliminate duplication and ensure coverage of key performance indicators. In addition, a number of reports require substantial manual processing. To improve controls in relation to the preparation of these reports, the report preparation process should be documented.

MHAGIC is designed to capture a wide range of information covering a person's involvement with the mental health system. This important information on patient outcomes could be used better to monitor patients' progress and outcomes.

The Health Directorate requires that the Suicide Vulnerability Assessment Tool (SVAT) be completed every three months for each patient. Compliance with this requirement is significantly below the target rate. A review of processes to identify why this occurs and to improve the completion rate is needed.

An upgrade of MHAGIC is planned. It will not deliver its intended outcomes unless there is a significant, positive change in the way staff at all levels use the system and the information that it produces.

Key findings

LEGAL AND POLICY FRAMEWORK

Paragraph

Section 217 of the *Mental Health Act 2015* provides a mechanism for the Director-General of the ACT Health Directorate to make administrative policies and operating procedures that have a legal and mandatory force. The use of section 217 could reinforce which administrative policies and procedures are critical. Calvary Public Hospital could then be requested to adopt the same policies and procedures or align their activities.

2.39

The ACT Health Directorate has developed a *Draft Adult Community Mental Health Services Model of Care* and a *Draft Mental Health Short Stay Unit Model of Care* and there is evidence that these draft models of care are addressing functional recovery and discharge planning. However, the *Adult Mental Health Unit Model of Care* (April 2012), which has not been updated for over five years, does not explicitly address functional recovery and discharge planning. Overall, the model of care expresses principles and intentions that are consistent with the *Mental Health Act 2015* and the *Human Rights Act 2004*, but it does not integrate fundamental innovations within the *Mental Health Act 2015* relating to treatment and consumer choice and does not set out an approach to ensuring recovery planning is a routine part of ensuring continuity of care.

2.64

None of the relevant models of care developed by the ACT Health Directorate, including those in draft form, give full effect to important aspects of the *Mental Health Act 2015*, including: the rights of people to communication, to nominate another person to assist in their care, and the right to make advance agreements and advance consent directions; the distinction between mental disorder and mental

2.65

illness and the different treatment orders they entail; and the distinct roles and responsibilities of the Chief Psychiatrist and the Care Coordinator set out in legislation.

The *Collaborative Planning Standard Operating Procedure* and related templates cover all key elements of planning, including staying well. The procedure and templates reflect the *Mental Health Act 2015* and the focus on collaborative planning that actively involves the person, their treatment and support network. A further improvement would be the inclusion of a 'nominated person' template. The role of a nominated person is to help a person with a mental illness or mental disorder by making sure their interests are respected if they require treatment, care or support for their condition. Having this document template included in MHAGIC reflects the importance of this role. 2.72

The ACT Health Directorate has developed policies, procedures and systems to support collaborative planning for recovery at the operational level. Among them are policies and procedures that encourage planning from the very beginning of care, review at regular intervals (including clinical review and review at the end of an episode of care) and the involvement of family and carers, along with tools for measuring outcomes. Key to this process is the development of a *recovery plan* which identifies treatment, care and ongoing recovery and wellbeing requirements. 2.97

The procedures for collaborative planning are well articulated and staff are supported with a clinical record system, MHAGIC, that provides a full suite of recovery planning documents available for use by the Community Mental Health Teams and in all acute care facilities. MHAGIC also allows users to record important events (including people being advised of their rights and obligations). The ACT Health Directorate has also developed a comprehensive set of audit tools that are suitable for monitoring and reviewing compliance with the requirements. 2.98

However, the procedures may be found within a large body of policies and procedures that exist without a system of indexing or inquiry that would allow users to quickly find and apply the appropriate policy at the appropriate time. In addition, among this large body of guidance are policies and procedures that: 2.99

- mix policy and work instructions, without being clear which is which;
- do not provide clear, detailed and comprehensive work instructions;
- do not provide copies of relevant forms or cross references to them;
- do not clearly specify the responsible staff;
- are not stand alone references; and
- overlap – for instance triaging is addressed in two Standard Operating Procedures.

There are numerous references to the *National Standards for Mental Health Services 2010* in the ACT Health Directorate's policy and procedural documentation. Taken as a whole their provisions are broadly consistent with the thrust of the standards but there is little specificity in terms of reference to them or working instructions which reinforce/embed/enforce them. Areas where strengthening ACT Health Directorate 2.106

policy and procedural documentation would better implement the *National Standards for Mental Health Services 2010* include:

- strengthening the procedures for follow-up after discharge (standard 10.6.8 follow-up within 7 days);
- implementing a formal quality improvement program incorporating evaluation of services (standard 8.11); and
- making explicit the requirement to ensure compliance with all relevant laws (standard 8.4).

RECOVERY PLANNING

Paragraph

Records do not always show that every person's rights were communicated and observed. Though MHAGIC is the ACT Health Directorate's primary medical record of a person's mental health care, it includes fewer primary and contemporaneous records of consultation, participation and collaboration than would be expected. This is important given the rights and obligations set out in Chapter 3 of the *Mental Health Act 2015*. Nor are there many records showing communications with General Practitioners. There were no standard practices for recording the transmission of hospital discharge summaries to General Practitioners.

3.32

In only 5 percent of cases were records found that showed that planning commenced during the initial phase of hospitalisation for discharge and the support required after inpatient care.

3.48

Recovery plans were found in only one third of the records examined. There is evidence that mental health staff have not regularly and systematically recorded discharge and recovery planning in MHAGIC. Records have similarly not been made of clinical meetings that involve the sharing of information and clinical decision making about a person's care and treatment.

3.60

This failure of practice means that the MHAGIC records of recovery planning are incomplete. Reliable and complete records of recovery planning are not available to be given to the person, their family or to other carers. Neither are they available to other staff or other support organisations to help in their care of the person, including after discharge from acute care. The responsibility for creating, reviewing and maintaining a person's discharge and *recovery plan* is not clearly assigned.

3.61

The ACT Health Directorate sets a schedule for following people up after discharge, and the records showed that two thirds were followed-up within a week; this is a high level of achievement.

3.70

Apparent low rates of referral to alcohol and drug services, according to advice from the ACT Health Directorate, are due, in part, to staff not always recording instances in which people in acute care decline referral to alcohol and drug services. In addition, the ACT Health Directorate advised that the low rates of referral to the alcohol and drug facilities at the Canberra Hospital during acute care are due, in part, to the facilities being unsafe for people at high risk of harming themselves. This means that acute care mental health beds are frequently occupied by people

3.74

recovering from intoxication for a period of some days before effective mental health care can begin.

Nevertheless, the ACT Health Directorate has advised that people can still be referred to alcohol and drug services through clinicians' in-reach into the mental health in-patient facility. Furthermore patients would only be transferred directly to an alcohol and drug service withdrawal facility from an in-patient mental health unit where their mental health episode has stabilised and an acute detoxification was still required. 3.75

A number of community organisations interviewed identified that there are benefits to be gained from a common, systematic approach to referring people to appropriate community organisations on discharge from acute care. 3.78

The MHAGIC notes examined were repetitive and poorly structured and did not clearly provide information on the course of treatment, recovery and discharge planning for the person. This does not aid efficient or effective administration or recovery-oriented service delivery. Clinicians did not make use of the full set of modules and documents available to record their observations and clinical notes in MHAGIC. 3.81

The prevalence of cut-and-paste practices for MHAGIC notes results in records containing inaccurate, irrelevant or outdated information. They simultaneously reduce accountability while increasing the risk that individuals could be held responsible for records made by others. 3.84

MENTAL HEALTH SERVICES INFORMATION MANAGEMENT Paragraph

The ACT Health Directorate is yet to put in place detailed policy or procedural guidance with respect to making mental health records and recording and maintaining them in MHAGIC. The review of clinical files shows a diverse and inconsistent range of practices for documentation and record-keeping and the use of MHAGIC. 4.8

Where reports require manual input there is a potential conflict of interest whereby a manager is amending performance data that directly relates to their area of responsibility. There are no controls in place, whether written procedures, a division of duties, or a process for independent checking to address this potential conflict. 4.33

Current ACT Health Directorate policy requires the Suicide Vulnerability Assessment Tool (SVAT) to be completed for every person at least every three months. Records of completion are significantly below this and it may be interpreted that the current level of performance is below the level of achievement the ACT Health Directorate management expects. Notwithstanding an expected performance level of 100 percent, as at December 2016 completion of the SVAT was reported as 62 percent. Suicide (along with potential to harm others) is self-evidently the most significant risk, in terms of consequences, to be addressed in the transition from acute care to 4.53

other forms of support. Non-compliance with the procedure for assessing suicide vulnerability is inconsistent with the risk to life that suicide vulnerability represents.

Through daily operational reporting it is possible to identify mental health service patients who need to have tasks completed for them. This level of reporting also usefully flags whether key support people of some kind have been identified and by extension people who need to be identified. Outcomes reporting compliance is aligned with the Mental Health National Outcomes and Casemix Collection (NOCC) down to operational level, and can be assessed by facility and also by staff member. These reports together provide a useful tool for identifying present levels of performance and compliance. 4.66

Overall, there is a great deal of useful information in the current suite of performance reports that is available to improve operational performance. However, the current performance information suite is complex, having grown over time without the benefit of systematic review: for instance, the same measures appear in different reports and in different formats. Potential improvements could include: 4.71

- including new reporting items in line with the new *Mental Health Act 2015* and to strengthen focus on collaborative planning;
- expanding reporting to better track outcomes measure compliance; and
- active use of the information to improve performance, including through evaluation.

In relation to outcomes measures and compliance, there is merit in more use being made of the Health of the Nation Outcome Scale (HoNOS), and an increased level of attention to person self-assessment. This is merited for the purposes of reporting at the national level, and in view of the *Mental Health Act 2015's* focus on collaborative planning. In particular the HoNOS can readily provide longitudinal data that could be used to examine and evaluate the outcomes of cohorts of people engaged with mental health services. 4.72

There is also a case to develop measures of the use of the provisions of the *Mental Health Act 2015* for advance agreements, advance consent directions and nominated persons. Such measures would give strong indications of the level of support provided to people under the Act. Related measures that demonstrated the involvement of carers, General Practitioners, clinical managers and community organisations would form a sound basis from which to gauge the strength of collaborative planning and transition planning. 4.73

Recommendations and response to the report

In accordance with subsection 18(2) of the *Auditor-General Act 1996*, the Health Directorate was provided with a:

- draft proposed report for comment. All comments were considered and required changes were reflected in the final proposed report; and
- final proposed report for further comments. As part of this process, the Directorate was offered the opportunity to provide a statement for inclusion in the Summary chapter.

In accordance with subsection 18(3) of the *Auditor-General Act 1996*, Calvary Health Care ACT was provided with a:

- draft proposed report for comment. All comments were considered and required changes were reflected in the final proposed report; and
- final proposed report for further comments. As part of this process, Calvary Health Care ACT was offered the opportunity to provide a statement for inclusion in the Summary chapter.

ACT Health Directorate overall response

[The ACT Health Directorate] would like to take this opportunity to thank the Auditor General's Office for undertaking this Performance Audit, and for engaging so positively with ACT Health throughout the audit and the report writing process.

Calvary Health Care ACT overall response

Calvary Public Hospital Bruce welcomes the opportunity to cooperate and assist ACT Health Directorate in the development of an integrated, comprehensive and contemporary mental health services framework.

Calvary Public Hospital Bruce will continue to collaborate with ACT Health Directorate in order to improve mental health service provision across the Territory, improve coordination and documentation of care to include all relevant parties, and improve visibility and transparency of performance information reporting.

RECOMMENDATION 1 MENTAL HEALTH SERVICES POLICIES AND PROCEDURES

The ACT Health Directorate should:

- a) develop an integrated, comprehensive and contemporary framework governing mental health services capturing all requirements for the effective and efficient implementation and documentation of discharge and recovery planning under the *Mental Health Act 2015* (and the *National Standards for Mental Health Services 2010*);
- b) work cooperatively with Calvary Health Care ACT to harmonise and align policies and procedures; and
- c) investigate reinforcing key administrative policies and procedures by issuing these under section 217 of the Act.

ACT Health Directorate response

Supported.

ACT Health is currently developing a Territory Wide Health Services Framework 2017-2027 to identify the ACT's health service requirements for the next decade. The Framework will provide the foundation for Specialty Service Plans for individual services and Models of Care for clinical areas. Mental Health and Suicide Prevention have been flagged as key service plans for development.

Further, the specific requirements contained within the Mental Health Act 2015 will be considered and incorporated into this planning process.

ACT Health currently operates collaboratively with Calvary Health Care ACT to deliver Mental Health Services. Where practicable, ACT Health will develop joint policies and procedures with Calvary Health Care ACT to standardise mental health care across the ACT.

Timeframe: 6-9 months.

Calvary Health Care ACT response

Supported.

Calvary Public Hospital Bruce (CPHB) welcomes the opportunity to cooperate and assist ACT Health Directorate in the development of an integrated, comprehensive and contemporary mental health services framework.

CPHB support the review and alignment of policies and procedures, in accordance the Mental Health Act 2015 (the Act) and National Standards for Mental Health Services 2010, in order to standardise mental health service delivery across the Territory, where practicable.

CPHB notes that current discordance in policy between services may be partly attributable to the fact that clinical staff at CPHB mental health units do not have access to ACT Health Directorate policy and procedures. In order to effectively contribute to the review, harmonisation and implementation of aligned policy and procedures, CPHB requests that all staff are granted access to ACT Health Directorate's policy and procedure register.

CPHB recognises the enforcement power of s217 of the Act in relation to administrative functions under the Act. CPHB notes that this power does not expressly apply to clinical management but commits to working with ACT Health Directorate in order to standardise clinical services, where practicable.

RECOMMENDATION 2 RECORDS OF COMMUNICATION WITH RELEVANT PARTIES

The ACT Health Directorate should review and promulgate processes for recording communications with relevant parties, including carers, government agencies and General Practitioners so that all communications are documented on a patient's record in MHAGIC.

ACT Health Directorate response

Supported.

ACT Health's current Clinical Records Documentation Policy requires staff to document relevant clinical communication with external parties in the patient's Clinical Record.

As a Directorate wide Policy, it is generic in nature and principle based. ACT Health acknowledges that the Directorate wide policy does not specifically articulate procedures for the electronic record (MHAGIC). ACT Health will review that current Policy and ensure that policy documents ensure compliance with documentation standards.

Timeframe: 4 months

Calvary Health Care ACT response

Supported.

CPHB appreciates the importance of recording all communications with relevant parties in the clinical record. It is hoped that the forthcoming upgrade of the MHAGIC electronic record will incorporate clear labels for all file entries in order to facilitate rapid identification and ease of access to relevant information.

CPHB welcomes standardised processes aiding consistent documentation.

RECOMMENDATION 3 RECOVERY PLANNING

The ACT Health Directorate should clearly assign responsibility for creating, reviewing and maintaining a person's recovery plan.

ACT Health Directorate response

Supported.

Existing ACT Health Procedures clearly articulate that the primary responsibility for completing Recovery Planning documentation lies with Clinical Managers in community mental health settings. However, ACT Health acknowledges that several other procedural documents require further clarification and will review these to ensure consistency across all program areas.

Timeframe: 4 months

Calvary Health Care ACT response

Supported in principle.

CPHB agree there is merit in clearly assigning responsibility by creating, reviewing and maintaining a person's recovery plan.

CPHB note that there is currently a recovery plan incorporated in MHAGIC which is utilised by CPHB Older Persons Mental Health Unit (OPMH).

CPHB acute adult inpatient unit, Ward 2N, currently utilize the 'Tidal Model', an internationally recognised consumer driven model of recovery planning. Multi-disciplinary team (MDT) meetings are based on the consumer's documented plan of care, with multi-disciplinary treatment roles and discharge planning added to the care plan. The completed Tidal Model document is then uploaded (scanned) into MHAGIC and referred to at each subsequent MDT meeting, effectively acting as a living care plan. CPHB 2N intend to continue to utilise the Tidal Model.

RECOMMENDATION 4 ELECTRONIC CLINICAL RECORDS

The ACT Health Directorate should review policy and procedural guidance for the use of MHAGIC so that guidance:

- a) identifies MHAGIC as the single electronic record for each patient provided with mental health services in the ACT; and
- b) clearly outlines the mandatory requirements for using MHAGIC to record patient nursing and clinical notes.

ACT Health Directorate response

Supported.

ACT Health acknowledges that clear reference material for staff is important in ensuring that the standard of documentation within clinical records is appropriate. ACT Health is currently upgrading the electronic clinical record, MHAGIC. The new system is anticipated to go-live in November 2017. As part of the implementation, ACT Health will ensure that Policy, Procedure and Guidance Manuals support the changes to the electronic records.

ACT Health will ensure that this documentation forms the basis for the initial and on-going training of staff.

Timeframe: 4 months.

Calvary Health Care ACT response

Supported.

CPHB Mental Health services request clinician inclusion, via consultation and/or participation, in the review of policy and procedural guidance for the use of MHAGIC.

RECOMMENDATION 5 MANUAL REPORTING PROCEDURES

The ACT Health Directorate should document the procedures for manual reports to identify appropriate controls and separation of duties to prevent errors and manage conflict of interest.

ACT Health Directorate response

Supported.

ACT Health acknowledges that good governance regarding data and reporting is essential. ACT Health will rectify the absence of the documented process highlighted by this Audit.

Timeframe: 4 months.

Calvary Health Care ACT response

Supported in principle.

It is unclear if this recommendation relates to CPHB.

CPHB wishes to highlight that current performance reporting practices, relating to CPHB service provision, are conducted external to CPHB. There is currently no visibility of data reporting for CPHB for service delivery at CPHB. CPHB is not afforded the opportunity to review, or confirm accuracy of, current performance reports.

CPHB Mental Health clinical staff and/or management do not manually audit and/or edit data and are therefore not placed in a position of potential conflict.

CPHB would welcome an opportunity to review the processes for the capture and reporting of data relating to mental health service provision at CPHB.

RECOMMENDATION 6 SUICIDE VULNERABILITY ASSESSMENT TOOL

The ACT Health Directorate should enforce their own policy that the Suicide Vulnerability Assessment Tool be completed every three months for all patients and address areas of non-compliance (or amend the policy if the ACT Health Directorate considers it inappropriate).

ACT Health Directorate response

Supported.

ACT Health acknowledges that a Suicide Vulnerability Assessment Tool (SVAT) is a vital component of good mental health care.

ACT Health is currently reviewing the policy, data collection and documentation requirements for use of this assessment tool. The current data collection methodology around this target does not account for:

- services where a SVAT may not specifically required;*
- where suicide vulnerability assessment has been documented in the body of a clinical record rather than specifically using the SVAT Form; and*
- where the SVAT has actually been completed, but outside of the 3 month period.*

ACT Health will make adjustments to the SVAT Policy to account for Clinical variations.

Timeframe: 4 months.

Calvary Health Care ACT response

Supported.

CPHB agree that compliance with completion of a Suicide Vulnerability Assessment Tool (SVAT), at least quarterly, should be a service priority.

CPHB have identified a need for training for clinical staff, particularly in inpatient units. CPHB clinical staff, in particular nursing and allied health, currently do not have uniform access to the ACT Health's learning management system to enable them to complete the mandated eLearning or face-to-face education.

CPHB requests that all appropriate staff have this access to facilitate access to relevant eLearning modules and education sessions.

RECOMMENDATION 7 PERFORMANCE REPORTING

The ACT Health Directorate should review and rationalise its performance information reports by:

- a) reporting the performance of provisions of the *Mental Health Act 2015* that are intended to support collaborative planning (e.g. the number of people accessing mental health services that have an advance agreement in place);
- b) including outcome and outcome compliance measures (e.g. person outcomes from HoNOS and LSP-16 mental health well-being assessments or 28 day unplanned readmissions);
- c) including exception reports identifying outliers;
- d) including time series, including of outcome measures;
- e) having it relate to management actions taken to achieve targets, including compliance targets; and
- f) aligning reporting to the relevant day-to-day reporting requirements of adult mental health operational managers.

ACT Health Directorate response

Supported.

ACT Health has acknowledged in various data reviews, including the 2016-17 Price Waterhouse Coopers review, that there is a lack of documentation and linkages to data definitions and standards for performance reporting.

ACT Health will ensure various components of this recommendation are addressed under the Service Wide Review during the second half of 2017.

Calvary Health Care ACT response

Supported.

CPHB wishes to highlight that current performance reporting practice, relating to CPHB service provision, are conducted external to CPHB. There is currently no visibility of data reporting for CPHB for service delivery at CPHB. CPHB is not afforded the opportunity to review, or confirm accuracy, of current performance information reports.

CPHB notes that commentary on CPHB related performance data is provided by ACT Health Directorate staff, without consultation with CPHB service providers. CPHB requests the opportunity to provide comment on performance reports.

CPHB notes that historically, data generated by ACT Health Directorate relating to services provided at CPHB often shows significant variances to CPHB data (e.g. length of stay, unplanned readmission rate).

CPHB requests consideration of the development of data standards, including data definitions/dictionary, in order to standardise and promote transparency for Territory-wide Mental Health services data collection and reporting.

1 INTRODUCTION

Mental health care and services in the ACT

- 1.1 Within the ACT Health Directorate, the Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division is responsible for mental health services provided in a range of settings. In relation to these services, the ACT Health Directorate's 2016-17 Budget Statements state:

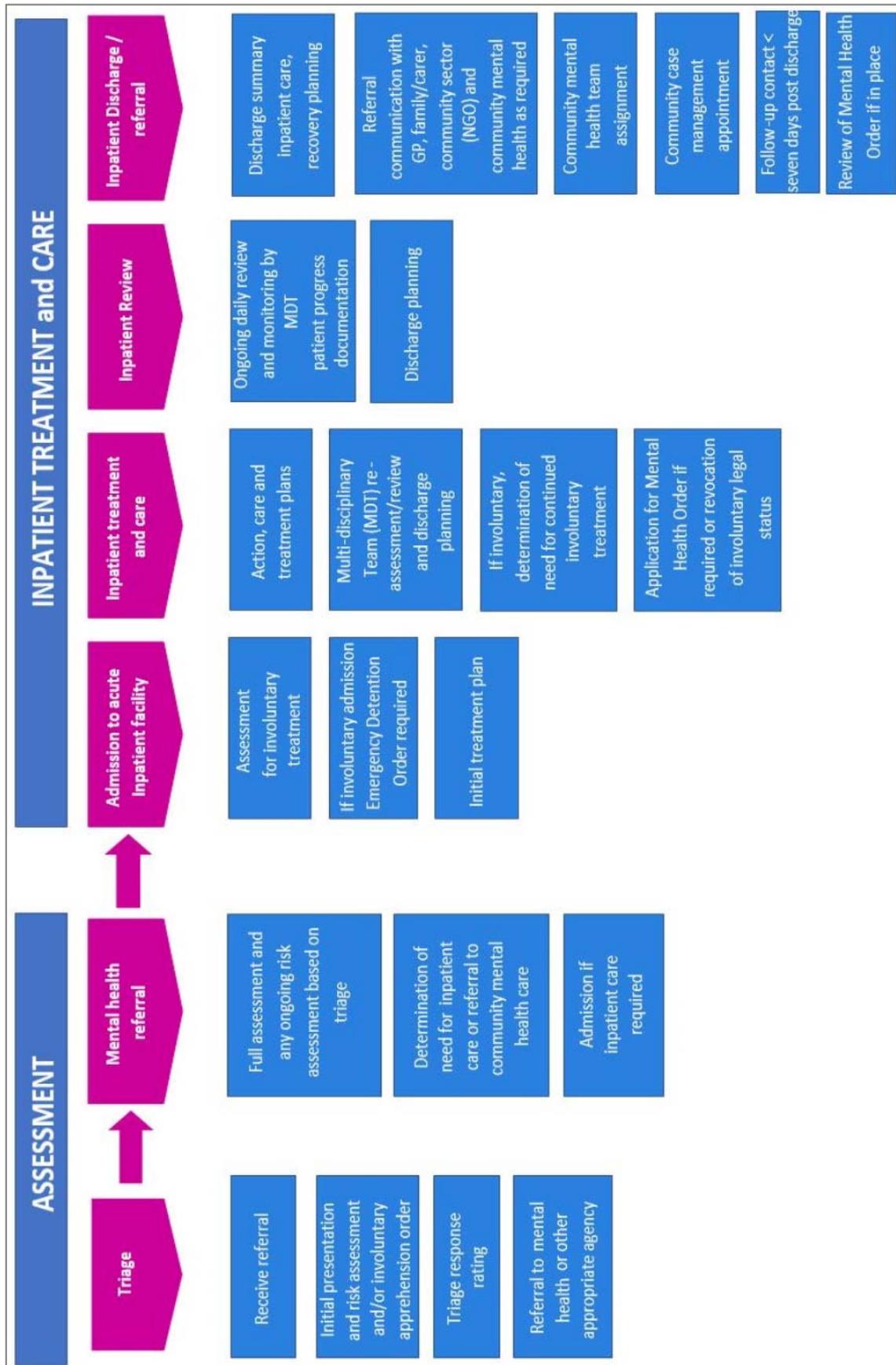
The Health Directorate provides a range of Mental Health, Justice Health and Alcohol and Drug Services through the public and community sectors in hospitals, community health centres and other community settings, adult and youth correctional facilities and peoples' homes across the Territory. These services work to provide integrated and responsive care to a range of services, including hospital based specialist services, and therapeutic rehabilitation, counselling, supported accommodation services and other community based services.

- 1.2 The total estimated cost of the ACT Health Directorate's mental health, justice health and alcohol and drug services was \$151.8 million in 2016-17, or 11.5 percent of the ACT Health Directorate's total estimated expenses. Of this, \$12.4 million is allocated to adult acute mental health services and \$13.04 million is allocated to adult community mental health services.
- 1.3 The ACT Government purchases acute mental health services from Calvary Public Hospital under the auspices of the ACT Local Hospital Network. The Calvary Public Hospital is operated by Calvary Health Care ACT Ltd, a subsidiary entity of the Little Company of Mary Health Care Ltd. Calvary Health Care ACT Ltd delivers public health and hospital services on behalf of the ACT Government as a member of the ACT Local Hospital Network. The Calvary Network Agreement formalises this arrangement, and an annual Calvary Performance Plan is negotiated to determine the services to be provided over the financial year. These governance arrangements are subject to ongoing review.
- 1.4 On 1 March 2016, the *Mental Health Act 2015* (the Act) came into effect, replacing the *Mental Health (Treatment and Care) Act 1994*. The Act provides those in the ACT living with a mental illness, or their carers and family members, greater opportunity to contribute to decisions on their treatment, care and support.

Acute Mental Health Services

- 1.5 The Canberra Hospital and Calvary Public Hospital provide inpatient acute care services for people with mental illnesses and disorders. As at 20 March 2017 the Canberra Hospital and Calvary Public Hospital offered a total of 89 acute care beds:
- 37 beds in the Adult Mental Health Unit (AMHU) (Canberra Hospital);
 - 21 beds in the Mental Health Unit Ward 2N (Calvary Public Hospital);
 - 6 beds in the Mental Health Short Stay Unit (Canberra Hospital);
 - 15 beds in the Older Persons Mental Health Service (OPMHS) (Calvary Public Hospital); and
 - 10 beds at the Dhulwa secure mental health facility at Symonston.
- 1.6 In general, people are admitted to acute care when their mental state presents a risk to the person and/or to other people. The risk may be immediate, or it may be assessed as highly likely to worsen without prompt treatment and assistance. Figure 1-1 sets out in general terms processes for assessment, treatment and care in inpatient facilities in the ACT.

Figure 1-1 Acute care assessment, care and discharge process



Source: Audit Office, based on ACT Health Directorate records

- 1.7 People usually present at the hospital Emergency Department where their condition will be assessed. Many people arrive in the company of family, carers or health professionals. In other cases, the person may be brought to the hospital by (for example) members of the ACT Health Directorate's Crisis Assessment and Treatment Team (CATT), by ambulance staff, or the Australian Federal Police.
- 1.8 At the Canberra Hospital, adults presenting at the Emergency Department with an acute mental health episode are initially assessed by mental health clinicians in the Emergency Department. There are six short-stay beds available at the Mental Health Short Stay Unit and a further 37 beds available in the Adult Mental Health Unit (AMHU).
- 1.9 The Calvary Public Hospital provides 21 adult mental health beds in Mental Health Unit Ward 2N, with a further 15 beds available for people 65 years of age and older at the Older Persons Mental Health Service (OPMHS).
- 1.10 Dhulwa is a secure mental health facility at Symonston, which provides 24-hour treatment and care for adults with complex mental health needs in the ACT region. Dhulwa commenced operation in November 2016 with 10 acute beds.

Community Mental Health Services

- 1.11 The ACT Health Directorate has five multidisciplinary Adult Community Mental Health Teams. They are located in the City, Woden, Tuggeranong, Belconnen and Gungahlin. These teams provide mental health assessment, treatment, clinical management, crisis management, family support and referral pathways for people with mental health issues.
- 1.12 People who are discharged from acute care at the Canberra Hospital or Calvary Hospital, will usually be referred to one of the Adult Community Mental Health Teams for mental health support and assistance in integrating back into the community. People discharged from acute care may also receive support and assistance from other ACT Health Directorate mental health services, including the Mobile Intensive Treatment Team North and the Crisis Assessment and Treatment Team. Support for the children of parents with mental illness is provided by the Adult Community Mental Health Teams. The ACT Health Directorate's community program of Rehabilitation and Speciality Mental Health Services includes Aboriginal and Torres Strait Islander Services, Intellectual Disability Neuropsychology, Mental Health Dual Diagnosis, Brian Hennessy Rehabilitation Centre, the Adult Mental Health Day Service and the Older Persons Mental Health Community team.

Community organisations and General Practitioners

1.13 In the community sector, there are a number of government funded services for people with mental health issues. The services are mostly provided by non-government organisations and range from supported accommodation services to outreach services. Two examples of these services are:

- the Adult Step Up Step Down Program - a residential mental health program that operates as a partnership between Mental Illness Fellowship Victoria and the ACT Health Directorate. People 'step-up' from the community into a highly supportive environment when they are becoming unwell to prevent further relapse and people 'step down' from the hospital setting to enable a more graduated return to the community; and
- the Transition to Recovery Program (TRec) - an intensive community outreach mental health program provided by Woden Community Services. People can be referred to the program by Community Mental Health Teams for assistance in transitioning to the community following an acute episode of mental illness. The aim is to prevent relapse and maximise the potential for recovery and independence.

1.14 People can also receive assistance with mental health services provided by General Practitioners and other medical health practitioners through a mental health plan. Mental health plans outline the support and services a person with a mental disorder or illness requires and explains the support provided by each of those services and when treatment should be provided. The plan helps a person set goals and decide on the best treatment options. Assistance provided under these plans can provide important support to people as they transition from acute to community care.

The recovery framework and consumer-centric care

1.15 The principles of empowerment and focus on recovery are set out in sections 5 and 6 of the *Mental Health Act 2015*. The practical expression of those principles is in collaborative planning and review involving consumers, carers, families, mental health clinicians and other providers of support (including support to meet psycho-social needs) in an ongoing process of defining the care and treatment people need to recover and stay well. The ACT Health Directorate *Draft Adult Community Mental Health Services Model of Care* sets out the aim of recovery as follows:

Optimising recovery - Making the most of every opportunity to collaboratively engage a person in strengths based quality of life goals that engender hope, maximise self-determination, and improve functioning and social inclusion.

1.16 Times of transition between forms of care represent key points in a person's journey to recovery, and the transition from acute care to the community in particular needs to be managed carefully. Collaborative planning and review prior to discharge and after discharge is important to ensure optimal outcomes for people living with mental illness and conditions.

Collaborative planning

1.17 Collaborative planning is important for a person's treatment and recovery. Collaborative planning is intended to occur throughout a person's journey through mental health care and treatment, including after discharge from acute care into community care. The ACT Health Directorate *Draft Adult Community Mental Health Services Model of Care* states:

Consumers will have the right to timely and ongoing information about their health status, treatment options, changes to treatment and services available to them. Collaborative relationships are guided by respect for each consumer and their family/carer, recognition of and building on the strengths of each consumer and supporting and facilitating choice about approaches to assist their recovery.

1.18 The intensity of a person's involvement in collaborative planning will vary according to the person's needs and their ability to participate. At admission to acute care, the person is often quite unwell and their ability to participate in planning is likely to be compromised. At this stage, staff typically assemble the person's history, review any earlier treatment or recovery plans, and commence observations and assessments to inform the current treatment plan.

1.19 As the journey of care and treatment progresses, the person in care usually becomes more involved in treatment and planning for recovery. That planning can involve:

- the acute care clinical team and nursing staff;
- the person's family and carers;
- consumer advocacy services and consumer consultants;
- allied health professionals (such as occupational therapists and social workers);
- the Community Mental Health Teams;
- community organisations (including those providing accommodation and other support services); and
- private medical practitioners, including psychiatrists, psychologists and General Practitioners.

1.20 The aim is to involve the person in a collaborative effort to build a network of support that will aid their recovery, and support them as they resume their life in the community with refreshed priorities and aims. The ACT Health Directorate's *Collaborative Planning Standard Operating Procedure* states:

The process should be a supportive one that builds confidence and a sense of control. It may be appropriate to make use of an advocate, act as a mediator between relevant parties or use other strategies for planning other than a large meeting where the person may feel overwhelmed, uncomfortable or intimidated.

1.21 Collaborative planning is focused on the development of a treatment, care and recovery plan that identifies treatment required from health professionals, care from health service staff; and personal recovery goals and actions. In ACT Health Directorate policies and

procedures this document is alternatively referred to as either *The Plan* or the *Recovery Plan*. In this report, the term *Recovery Plan* is used.

- 1.22 Regular review of progress against the *Recovery Plan* should be undertaken with the person at least every three months to ensure a comprehensive approach that supports a person's ongoing recovery and wellbeing. Entering or leaving acute care also requires review of the *Recovery Plan*.

Recovery and discharge planning

- 1.23 When a person enters acute care, a *discharge plan* should also be documented on the *recovery plan*. In addition to plans for care and treatment, including the prescription of medicines, a *discharge plan* can identify additional transition requirements including referrals to other service providers, arrangements to support carers, and treatment and therapeutic care from General Practitioners and other health professionals.
- 1.24 The intention is that transition from acute care into community-based care occurs when the person is no longer acutely unwell and has regained their capacity to safely and effectively resume their life in the community. Prior to this transition, assessments will be repeated to confirm the person's wellbeing and to gauge the risk they pose to themselves and others.
- 1.25 On leaving acute care, the person usually moves into the care of family or other carers, including community service providers and other medical practitioners. The collaborative planning model supports the continuation of treatment in a community setting. In many cases, recovery planning will still be underway at the time of transition from acute to community-based care, after which time the ACT Health Directorate's Community Mental Health Teams usually take on the responsibility for follow-up and planning. In many cases, the Community Mental Health Team will assign a Clinical Manager to the person. They will be involved in planning for the transition to community-based care and in follow-up after care.

Service delivery outcomes

- 1.26 People living with enduring and episodic illnesses or disorders may spend extended periods in the community, with periodic readmission to acute care as an element of their long term care. Collaborative planning for supportive, effective community care helps people anticipate and manage their re-admission. The Commonwealth Department of Health and Ageing's *National Mental Health Report 2013* states:

Internationally, readmission rates are often used as a litmus test of the performance of mental health systems. High rates may point to deficiencies in hospital treatment or community follow up care, or a combination of the two. Of course, other factors may also be implicated in rapid readmissions, with some reflecting the episodic nature of mental illness. Notwithstanding the complexity of the indicator, it is used by many countries to monitor health system performance.

It has special relevance to areas of health care that involve provision of services to people with longer term illnesses who need a combination of hospital and community-based treatment. The underlying standard is that, while multiple hospital admissions may be necessary over the

course of a lifetime for some people with ongoing illness, a high proportion of unplanned readmissions occurring shortly after discharge largely reflects failures in the care system.

- 1.27 The standard metric of performance is the proportion of unplanned readmissions within 28 days of discharge. The ACT Health Directorate reports annually on this metric as a Strategic Indicator to the Legislative Assembly. Commenting on national trends, the *National Mental Health Report 2013* noted:

Two states had readmission rates lower than 10% in 2010-11: the Australian Capital Territory (5%) and South Australia (9%) ... There has been little movement over time in almost all states and territories, except in the Australian Capital Territory where the rate has more than halved since 2005-06.

- 1.28 Maintaining and improving on this level of performance places a premium on collaborative planning that is developed, maintained and recorded so that, no matter where a person is in their journey of care, their plan stands ready to be used and improved by them and their carers to ensure continuity of care.

Audit objective and scope

- 1.29 The objective of this audit is to provide an independent opinion to the Legislative Assembly on the effectiveness of the ACT Health Directorate's management of the transition process for adult clients (clients aged 18 or more years) who move between acute mental health services and community mental health services, as well as the transition from acute mental health services into the primary health and community sector.
- 1.30 The ACT Government's implementation of the National Disability Insurance Scheme (as it affects mental health services) was not within the scope of the audit. Dhulwa, the secure mental health facility at Symonston, was not in scope as it had only recently opened at the time of commencement of the audit.

Audit criteria, approach and method

- 1.31 The following three criteria were used to test the audit objective:
- Transfer and management of clients - are there effective transfer and management arrangements in place for clients transitioning between acute and community mental health services and those transitioning from acute care into the primary health and community sectors?
 - Information management systems and data collection and management - are there effective data collection and management arrangements in place to effectively manage the risks and support improved outcomes for clients transitioning between acute and community mental health services and from acute care into the primary health and community sectors?

- Monitoring, review and evaluation mechanisms - are monitoring, review and evaluation mechanisms in place to effectively manage the risks and support improved outcomes for clients transitioning between acute and community mental health services and from acute care into the primary health and community sectors?

1.32 The audit adopted the Office's Performance Audit Methods and Practices and related Policies, Practice Statements and Guidance Papers. These policies and practices have been designed to comply with the requirements of the *Auditor-General Act 1996* and relevant professional standards (including *ASAE 3500—Performance Engagements*). This performance audit process is distinct from a clinical quality of care audit which focuses on the improvement of patient care processes through the review of care against clinical criteria.

1.33 The audit involved:

- a review and analysis of the ACT Health Directorate's policies and procedures and other control frameworks for the efficient and effective handling of the transition of people with mental health conditions from acute care back into the community;
- analysis of a random sample of 40 records relating to discharges from acute care services during the period July 2015 to June 2016, which were drawn from the ACT Health Directorate's medical records management system for mental health consumers (MHAGIC);
- review and analysis of current data structures and change proposals for the MHAGIC medical records system;
- review and analysis of performance information, management reports and risk management documentation;
- discussions with the managers of the ACT Mental Health Team and a number of non-government organisations on how people with mental illnesses and disorders are being transitioned from acute care back into the community; and
- seeking legal advice from the ACT Government Solicitor on the application of the *Mental Health Act 2015*.

1.34 Audit fieldwork was undertaken by Stret Pty Ltd on behalf of the ACT Audit Office. A subject matter expert, Mr Andrew Clark, was used to support assessment of policies and procedures, medical records and design of community consultations. Mr Clark has extensive experience in data collection, monitoring and evaluation of the outcomes of the supports provided for people with severe and persistent mental illness and complex needs. Specifically, Mr Clark was engaged to assist in the examination of a sample of client records covering the post discharge period. This examination informed the evaluation of the effectiveness of discharge and transition processes and identified potential areas for improvement.

2 LEGAL AND POLICY FRAMEWORK

- 2.1 This chapter discusses the legislation, policy and procedures relating to recovery planning and transition between acute mental health care and non-acute care.

Summary

Conclusions

There is a need to review, rationalise and re-issue mental health services policies and procedures as many are outdated or were drafted before the passage of the *Mental Health Act 2015* (the Act). These do not give full effect to the Act, notably the different treatment regimes for people with mental illnesses and mental disorders.

In order to achieve consistency in services and continuity of care for patients there is merit in aligning mental health services policies and procedures across all public health services, including those delivered directly by the ACT Health Directorate and Calvary Public Hospital. A mechanism by which consistency in service and continuity of care may be achieved is through the issuing of key administrative policies and procedures under the authority of section 217 of the Act and there is merit in the ACT Health Directorate giving consideration to this option. The Calvary Public Hospital could then be requested to adopt these, or align their activities.

Key findings

Section 217 of the *Mental Health Act 2015* provides a mechanism for the Director-General of the ACT Health Directorate to make administrative policies and operating procedures that have a legal and mandatory force. The use of section 217 could reinforce which administrative policies and procedures are critical. Calvary Public Hospital could then be requested to adopt the same policies and procedures or align their activities.

Paragraph

2.39

The ACT Health Directorate has developed a *Draft Adult Community Mental Health Services Model of Care* and a *Draft Mental Health Short Stay Unit Model of Care* and there is evidence that these draft models of care are addressing functional recovery and discharge planning. However, the *Adult Mental Health Unit Model of Care* (April 2012), which has not been updated for over five years, does not explicitly address functional recovery and discharge planning. Overall, the model of care expresses principles and intentions that are consistent with the *Mental Health Act 2015* and the *Human Rights Act 2004*, but it does not integrate fundamental innovations within the *Mental Health Act 2015* relating to treatment and consumer choice and does not

2.64

set out an approach to ensuring recovery planning is a routine part of ensuring continuity of care.

None of the relevant models of care developed by the ACT Health Directorate, including those in draft form, give full effect to important aspects of the *Mental Health Act 2015*, including: the rights of people to communication, to nominate another person to assist in their care, and the right to make advance agreements and advance consent directions; the distinction between mental disorder and mental illness and the different treatment orders they entail; and the distinct roles and responsibilities of the Chief Psychiatrist and the Care Coordinator set out in legislation. 2.65

The *Collaborative Planning Standard Operating Procedure* and related templates cover all key elements of planning, including staying well. The procedure and templates reflect the *Mental Health Act 2015* and the focus on collaborative planning that actively involves the person, their treatment and support network. A further improvement would be the inclusion of a 'nominated person' template. The role of a nominated person is to help a person with a mental illness or mental disorder by making sure their interests are respected if they require treatment, care or support for their condition. Having this document template included in MHAGIC reflects the importance of this role. 2.72

The ACT Health Directorate has developed policies, procedures and systems to support collaborative planning for recovery at the operational level. Among them are policies and procedures that encourage planning from the very beginning of care, review at regular intervals (including clinical review and review at the end of an episode of care) and the involvement of family and carers, along with tools for measuring outcomes. Key to this process is the development of a *recovery plan* which identifies treatment, care and ongoing recovery and wellbeing requirements. 2.97

The procedures for collaborative planning are well articulated and staff are supported with a clinical record system, MHAGIC, that provides a full suite of recovery planning documents available for use by the Community Mental Health Teams and in all acute care facilities. MHAGIC also allows users to record important events (including people being advised of their rights and obligations). The ACT Health Directorate has also developed a comprehensive set of audit tools that are suitable for monitoring and reviewing compliance with the requirements. 2.98

However, the procedures may be found within a large body of policies and procedures that exist without a system of indexing or inquiry that would allow users to quickly find and apply the appropriate policy at the appropriate time. In addition, among this large body of guidance are policies and procedures that: 2.99

- mix policy and work instructions, without being clear which is which;

- do not provide clear, detailed and comprehensive work instructions;
- do not provide copies of relevant forms or cross references to them;
- do not clearly specify the responsible staff;
- are not stand alone references; and
- overlap – for instance triaging is addressed in two Standard Operating Procedures.

There are numerous references to the *National Standards for Mental Health Services 2010* in the ACT Health Directorate's policy and procedural documentation. Taken as a whole their provisions are broadly consistent with the thrust of the standards but there is little specificity in terms of reference to them or working instructions which reinforce/embed/enforce them. Areas where strengthening ACT Health Directorate policy and procedural documentation would better implement the *National Standards for Mental Health Services 2010* include:

- strengthening the procedures for follow-up after discharge (standard 10.6.8 follow-up within 7 days);
- implementing a formal quality improvement program incorporating evaluation of services (standard 8.11); and
- making explicit the requirement to ensure compliance with all relevant laws (standard 8.4).

Requirements of the *Mental Health Act 2015*

2.2 The *Mental Health Act 2015* (the Act) came into effect on 1 March 2016, replacing the *Mental Health (Treatment and Care) Act 1994*. The Act is described by the ACT Health Directorate as:

... not just a change in law, this is a change in culture [that] creates a fresh approach to service delivery and brings the ACT's mental health legislation into line with the United Nations Convention on the Rights of People with a Disability and the ACT Human Rights Act.

2.3 The *Mental Health Act 2015* (the Act) provides for a range of mental health service supports for people suffering from a mental illness or mental disorder, including the right to nominate a person to make decisions on their behalf (Part 3.2) and the right to enter into an advance agreement or make an advance consent direction for their treatment (Part 3.3). The Act also provides for a range of orders to be made, and the effect of those orders, including assessment orders (Chapter 4), mental health orders (Chapter 5) (including psychiatric treatment orders (Part 5.4) and community care orders (Part 5.5)) and forensic mental health orders (Chapter 7).

Objects and principles of the Act relating to transition

2.4 While there are no specific provisions in the Act relating to transition of patients from acute care, it includes objects and principles of care that are relevant to a range of mental health

service delivery activities, including those that establish a framework for transition. For instance, section 5 paragraph (f) includes as an object of the Act facilitating:

... access by people with a mental disorder or mental illness to assessment and treatment, care or support as far as practicable in communities of their choice

2.5 With that object in mind, the Act provides at section 6 paragraph (j) that:

services provided to a person with a mental disorder or mental illness should—

- (i) respect the informed consent of the person to the person's assessment and treatment, care or support including consent as expressed in an advance consent direction; and
- (ii) support and allow the person to make the person's own decisions; and
- (iii) be provided in a way that considers and respects the preferences of the person, including those expressed in an advance agreement
- (iv) promote a person's capacity to determine the person's recovery from mental disorder or mental illness; and
- (v) seek to bring about the best therapeutic outcomes for the person and promote the person's recovery; and
- (vi) be therapeutic or diagnostic in nature for the benefit of the person, and never administered as punishment or for the benefit of someone other than the person; and
- (vii) be delivered in a way that takes account of, and continues to build on, evidence of effective assessment and treatment, care or support; and
- (viii) be provided in a way that ensures that the person is aware of the person's rights; and
- (ix) facilitate appropriate involvement of close relatives, close friends and carers in treatment, care or support decisions in partnership with medical professionals; and
- (x) acknowledge the impact of mental disorder and mental illness on the close relatives, close friends and carers of people with a mental disorder or mental illness; and
- (xi) recognise the experience and knowledge of close relatives, close friends and carers about a person's mental disorder or mental illness; and
- (xii) promote inclusive practices in treatment, care or support to engage families and carers in responding to a person's mental disorder or mental illness; and
- (xiii) promote a high standard of skill and training for the people providing treatment, care or support.

2.6 In summary, key principles associated with the *Mental Health Act 2015*, include:

- respect for the informed consent of the person to the person's assessment and treatment, care or support;
- support for, and allowance of, the person to make their own decisions;
- respect for the preferences of the person;
- ensuring that the person is aware of the person's rights; and
- facilitation of appropriate involvement of close relatives, close friends and carers in treatment, care or support decisions in partnership with medical professionals.

Participation and control

2.7 The Act includes a number of important provisions to support and promote the participation of people in their own care, and to give them significant control as to how they will be cared for and treated. This object is set out at section 5 paragraph (b) which provides that the Act is to:

... promote the capacity of people with a mental disorder or mental illness to determine, and participate in, their assessment and treatment, care or support, taking into account their rights in relation to mental health under territory law

2.8 Significant provisions that put this into effect are at sections 19 and 20 (the power to nominate someone to help ensure that the interests, views and wishes of the person are respected), at section 26 (allows a person to identify and set out matters the person considers relevant to their treatment and care) and section 27 (allows a person to specify those treatments and medicines they consent to receive and those that they do not).

2.9 Sections 19 and 20 of the Act state:

19 Nominated person

- (1) A person with a mental disorder or mental illness, who has decision making capacity, may, in writing nominate someone else to be the person's nominated person.

20 Nominated person—functions

- (1) The main function of a nominated person for a person with a mental disorder or mental illness is to help the person by ensuring that the interests, views and wishes of the person are respected if the person requires treatment, care or support for a mental disorder or mental illness.
- (2) The other functions of a nominated person include—
 - (a) receiving information under this Act; and
 - (b) being consulted about decisions in relation to treatment, care or support; and
 - (c) other functions given to the nominated person under this Act.

2.10 Section 26 of the Act states:

26 Entering into advance agreement

- (1) A person with a mental disorder or mental illness who has decision making capacity may enter into an agreement (an advance agreement) with the person's treating team that sets out—
 - (a) information the person considers relevant to their treatment, care or support for the mental disorder or mental illness (but not information more appropriate to include in an advance consent direction); and
 - (b) any preferences the person has in relation to practical help the person may need as a result of the mental disorder or mental illness.

2.11 Section 27 of the Act states:

27 Making advance consent direction

- (1) A person with a mental disorder or mental illness may make a direction (an advance consent direction) about 1 or more of the following:
- (a) the treatment, care or support that the person consents to receiving if the mental disorder or mental illness results in the person not having decision-making capacity;
 - (b) particular medications or procedures that the person consents to receiving if the mental disorder or mental illness results in the person not having decision-making capacity;
 - (c) particular medications or procedures that the person does not consent to receiving if the mental disorder or mental illness results in the person not having decision-making capacity;
 - (d) the people who may be provided with information about the treatment, care or support the person requires for a mental disorder or mental illness;
 - (e) the people who are not to be provided with information about the treatment, care or support the person requires for a mental disorder or mental illness.

2.12 The *Mental Health Act 2015* includes provisions to promote a person's capacity to determine their own recovery from mental disorder or mental illness. A person's rights to participate in, and control, their treatment and care are supported by explicit provisions to nominate people to assist in planning and delivering care and treatment, and provisions to make advance agreements and directions in case of illness and disorder.

Mental disorders and mental illnesses

2.13 Sections 9 and 10 of the Act distinguish between mental disorders and mental illnesses. The meaning of a mental disorder is set out at section 9 and is associated with a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion. It does not include a mental illness.

2.14 The meaning of a mental illness is set out at section 10 which states:

mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in 1 or more areas of thought, mood, volition, perception, orientation or memory, and is characterised by-

- a) the presence of at least 1 of the following symptoms:
 - (i) delusions;
 - (ii) hallucinations;
 - (iii) serious disorders of streams of thought;
 - (iv) serious disorders of thought form;
 - (v) serious disturbance of mood; or
- b) sustained or repeated irrational behaviour that may be taken to indicate the presence of at least 1 of the symptoms mentioned in paragraph (a).

- 2.15 The distinction between mental disorder and mental illness gives rise to different provisions under the Act, which can be seen most clearly where the person poses risks to themselves or to others. When a person is assessed as having a mental disorder and is doing, or is likely to do, serious harm to themselves or someone else, a community care order can be made. The Act assigns responsibility for the care of these people to the Care Coordinator appointed by the Minister.
- 2.16 When a person is assessed as having a mental illness and is doing, or is likely to do, serious harm to themselves or someone else, a psychiatric treatment order can be made if there is an assessment that the person does not have decision making capacity. The Act assigns responsibility for the care of a person subject to a psychiatric treatment order to the chief psychiatrist appointed by the Minister.
- 2.17 Some key aspects of responsibilities relevant to the treatment of mental disorders and mental illnesses (including references to the relevant section of the Act) are summarised in Table 2-1.

Table 2-1 Arrangements applying to mental disorder and mental illness

Mental disorder	S9	Mental illness	S10
The Minister must appoint a public servant as Care Coordinator.	S204(1)	The Minister must appoint a public servant as Chief Psychiatrist.	S196(1)
Relevant official for a community care order—the Care Coordinator	S50(b)	Relevant official for a psychiatric treatment order—the Chief Psychiatrist	S50(a)
Community care order if person has mental disorder	S66(2)(a)	Psychiatric treatment order if person has mental illness	S58(2)(a)
The Care Coordinator is responsible for coordinating the provision of treatment, care or support for a person to whom a community care order applies.	S70(1)	The Chief Psychiatrist is responsible for the treatment, care or support of a person to whom a psychiatric treatment order applies.	S62(1)
A restriction order on a community care order may state that the person must (i) live (but not be detained) at a stated approved community care facility or another stated place; or (ii) be detained at a stated approved community care facility	S69(1)(a)	A psychiatric treatment order may state an approved mental health facility to which the person may be admitted	S59(1)(a)
The Care Coordinator may detain the person at the facility in the custody that the Care Coordinator considers appropriate	S73(2)(a)	The Chief Psychiatrist may detain the person at an approved mental health facility	S65(2)(a)
Community care facility approved by the Minister	S262	Mental health facility approved by the Minister	S262

Source: ACT Audit Office

- 2.18 The ACT Health Directorate has developed a suite of materials that is available on the ACT Health Directorate website to provide plain language information and guidance in relation to the new *Mental Health Act 2015*, and to provide further information around the general principles for the new Act, including the rights of people living with a mental illness or mental disorder regarding their assessment, treatment, care or support. The guidance sets out the approaches to consultation and collaboration for persons subject to community care orders and psychiatric treatment orders. A summary of the guidance provided to the public is below.

Mental disorder

- 2.19 If a person has a mental disorder and a community care order is in place, the Care Coordinator (or their delegate) must consult with the person to try to find out their opinions and views on where and when they will have to go to receive treatment, care or support or to do a counselling, training, therapeutic or rehabilitation program. The person's views must be taken into account as the Care Coordinator consults the service providers that would be responsible for providing treatment, care or support (including 'professional carers', and allied health professionals).

Mental illness

- 2.20 If a person has a mental illness and a psychiatric treatment order is in place, the Chief Psychiatrist (or their delegate) must consult with that person to find out the person's opinions and views on whether or not they should be treated, where treatment is to occur, whether the person must be admitted for treatment, and the types of treatment the person might be given. The Chief Psychiatrist must consider the person's opinions and views, though that will not necessarily mean that the treatment, care or support will be provided according to the person's wishes.
- 2.21 To support the Chief Psychiatrist in the execution of their duties, the Act provides for the appointment of mental health officers under section 201. The Minister may appoint a nurse, authorised nurse practitioner, psychologist, occupational therapist or social worker as a mental health officer to undertake duties directed by the Chief Psychiatrist. This includes the administration of psychiatric treatment orders in approved mental health facilities.

Approved facilities

- 2.22 At the time of this audit, the approved mental health facilities under section 261 of the *Mental Health Act 2015* were:
- the Canberra Hospital (Mental Health (Facility) Approval 2016 (No 1));
 - the Brian Hennessy Rehabilitation Centre (Mental Health (Facility) Approval 2016 (No 2));
 - the Calvary Public Hospital Bruce (but not the Emergency Department) (Mental Health (Facility) Approval 2016 (No 3)); and

- Dhulwa Mental Health Unit (Mental Health (Facility) Approval 2016 (No 4)).

2.23 Approved community care facilities under section 262 of the *Mental Health Act 2015* were:

- the Canberra Hospital (Mental Health (Community Care Facility) Approval 2016 (No 1));
- the Brian Hennessy Rehabilitation Centre (Mental Health (Community Care Facility) Approval 2016 (No 2));
- the Calvary Public Hospital Bruce (Mental Health (Community Care Facility) Approval 2016 (No 3)); and
- Dhulwa Mental Health Unit (Mental Health (Community Care Facility) Approval 2016 (No 4)).

2.24 All the acute care facilities that are the focus of this audit, are therefore approved facilities.

Official visitors

2.25 Under section 208 of the *Mental Health Act 2015*, the Attorney-General must, after consulting the Minister for Mental Health, appoint at least one official visitor under the *Official Visitors Act 2012*.

2.26 At the time of this audit, four official visitors had been appointed. They have rights of entry to mental health facilities and community care facilities (among other places), where they may assess (among other things) the adequacy of services, facilities and treatment and report to the Minister for Mental Health on their findings.

ACT Health Directorate policy and procedural guidance

Recognition of the *Mental Health Act 2015*

2.27 The ACT Health Directorate has issued a number of policies and procedures in relation to the delivery of mental health services, in the form of clinical guidelines and standard operating procedures, including models of care and other operational guidance. These are discussed in paragraphs 2.40 to 2.99.

2.28 A number of existing clinical guidelines and standard operating procedures provided by the ACT Health Directorate were developed prior to the *Mental Health Act 2015* and reference the former *Mental Health (Treatment and Care) Act 1994*. They cite neither a specific authority, nor authorisation as an instruction.

2.29 Some new instructions were provided to staff when the *Mental Health Act 2015* took effect, including *Advance Agreements*, *Advance Consent Directions*, and *Nominated Persons*, *CHHS16/028* and *Mental Health Officer CHHS16/023* and these set the practical steps for

putting these important elements of the Act into effect. However, other instructions are not so well formed, for instance:

- *Consent and Treatment CHHS16/026*, which refers to the new Act but gives the Care Coordinator responsibilities for mental illness that properly lie with the Chief Psychiatrist; and
- *ACT Civil and Administrative Tribunal (ACAT) Ordered Mental Health Assessments CHHS16/027*, which addresses the psychiatric treatment orders that might result from a mental health assessment but not community care orders.

2.30 Accordingly, there are opportunities to make the links between the new Act and policy and procedure stronger and more transparent by reviewing and revising existing policies to:

- recognise the different treatment of mental disorder and mental illness, especially in the administration of community care and psychiatric treatment orders; and
- align staff roles and responsibilities with the responsibilities of the Care Coordinator and the chief psychiatrist.

2.31 This could help mitigate risks of non-compliance with the Act and improve consumer outcomes. In particular, the Act provides that an advance agreement, advance consent direction and nomination of a responsible person have force until terminated in clearly defined ways that are not related to episodes of acute care and transition. It is therefore essential to ensure that records of agreements, directions and nominated people are all readily accessible and available to the treating team to ensure that there is no unintended violation of these legal arrangements, and to ensure control is maintained by the person in care. This issue is also raised in Chapter 4, dealing with electronic clinical records.

Application to Calvary Public Hospital services

2.32 The ACT Health Directorate's policy and procedural guidance, in the form of clinical guidelines and standard operating procedures, are intended to apply to staff in the ACT Health Directorate, but are not intended to apply to staff employed at the Calvary Public Hospital.

2.33 Calvary Health Care ACT advised that the clinical directors who supervise the mental health staff in the Calvary Public Hospital facilities were employees of the ACT Health Directorate, as were consultant psychiatrists and registrars. These staff are appointed by the Mental Health, Justice Health Alcohol and Drug Service. Accordingly, at present, ACT Health Directorate employees in mental health acute care facilities are subject to different policies and procedures depending on where they work.

2.34 More specifically, the ACT Health Directorate advised that it does not govern the clinical guidelines and standard operating procedures used by Calvary Health Care ACT Ltd. While Calvary Public Hospital staff were welcome to use the ACT Health Directorate clinical guidelines and standard operating procedures, they were not required to adhere to them.

Issuing of policies and procedures under the *Mental Health Act 2015*

- 2.35 Subsection 217(1) of the *Mental Health Act 2015* provides that the Director-General ACT Health Directorate may make policies and operating procedures, consistent with the Act, for the effective and efficient management or operation of any administrative function under the Act. Subsection 217(2) of the Act provides that a person exercising an administrative function under this Act must comply with policies and operating procedures.
- 2.36 The ACT Health Directorate has advised that no policies and procedures have been issued pursuant to subsection 217(1) of the Act.
- 2.37 While the Act does not require the Director-General make administrative policies and procedures under the Act, the fact that the Act provides for them and specifies that they must be complied with indicates their importance as a way of giving effect to the provisions of the Act. Making key policies and operating procedures in this way would provide the specificity needed to implement aspects of the Act, protect people exercising administrative functions under the Act, and support the achievement of the objects of the Act.
- 2.38 Having consistent administrative practices and treatments across public health services delivered directly by the ACT Health Directorate and Calvary Public Hospital could facilitate the continuity of care for patients.
- 2.39 Section 217 of the *Mental Health Act 2015* provides a mechanism for the Director-General of the ACT Health Directorate to make administrative policies and operating procedures that have a legal and mandatory force. The use of section 217 could reinforce which administrative policies and procedures are critical. Calvary Public Hospital could then be requested to adopt the same policies and procedures or align their activities.

ACT Health Directorate policy and procedural guidance

- 2.40 The ACT Health Directorate has prepared an extensive suite of policy and procedural documentation to guide the delivery of mental health services in the ACT Health Directorate. These policies and procedures were reviewed to assess whether they effectively addressed:
- the *principles and purposes of care* (*who is being assisted and what is to be achieved?*); and
 - provided clear *instructions* that set out what is to be done, by whom, when, how and to what standard.
- 2.41 The ACT Health Directorate's policy and procedural guidance is a logical hierarchy of general policies accompanied by specific procedures, typically arranged as policies and procedures, with the policies clearly linked to legislation and standards of care. In the documentation provided by the ACT Health Directorate:
- the *principles and purposes of care* are partly reflected in 'Model of Care' documents and 'Policy' documents; and

- the *instructions* are represented by 'Standard Operating Procedure' documents.

2.42 The majority of these documents do not contain an authorisation from a senior responsible person or otherwise reflect documentation control practices.¹ An exception is the risk management policy and risk management guidelines.

Models of care

2.43 The ACT Health Directorate provided three models of care for consideration as part of the audit:

- *Adult Mental Health Unit Model of Care* - final version dated April 2012.
- *Mental Health Short Stay Unit Model of Care* - draft; and
- *Adult Community Mental Health Services Model of Care* - draft.

Adult Mental Health Unit Model of Care

2.44 The *Adult Mental Health Unit Model of Care* (April 2012) includes:

... information on the final governance structures, policies, protocols, business rules, staffing, job specifications, information and communication technology, equipment and security requirements needed to operationalise the [Adult Mental Health Unit].

2.45 The *Adult Mental Health Unit Model of Care* (April 2012) also states 'It is acknowledged that following an operational review process the model will be revised and amended over time'.

2.46 The *Adult Mental Health Unit Model of Care* (April 2012) sets out the framework within which policy and protocols and business rules are to be developed, rather than defining them. A key feature of the model is recovery, which is described as:

... the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from illness, its treatment and personal and environmental conditions. An acute inpatient service with an orientation toward recovery is an important component of a system of care.

2.47 The *Adult Mental Health Unit Model of Care* (April 2012) includes principles of care (summarised below) that should inform the development of policies and procedures for transition and recovery:

Protection of consumer rights – treatment should be provided in the least restrictive environment and guided by recovery principles. People with a mental illness are entitled to the same human and legal rights as any member of the community as required under the *Human Rights Act 2004*, the *Mental Health (Treatment and Care) Act 1994* and related legislation.

Recovery focused and integrated services – a system that facilitates the links between consumers and the services they require. All health professionals, community agencies and nominated support people are to be involved in planning and implementation, with clear communication with the Adult Mental Health Unit, the consumer and their family, other

¹ The ACT Health Directorate has advised that it is not Health Directorate practice to include the name of a senior responsible person on policies and procedures.

inpatient services, community mental health teams, consumer and carer organisations and community based services to ensure continuity of care and quality collaboration.

Recovery-Focused Acute Inpatient Services – with a recovery based philosophy to engage families and carers in respectful collaboration to help people optimise their wellbeing and determine their path towards living a meaningful life.

2.48 The *Adult Mental Health Unit Model of Care* (April 2012) places the Adult Mental Health Unit within an integrated mental health service, with clinical governance to drive the continuous improvement of service quality and to safeguard high standards of care. The model provides that this requires:

- effective organisational and clinical leadership, strategy and service planning, change management, accountability, performance review and community partnerships;
- information from consumers and carers to help staff to deliver the kind of services that consumers and the general community want;
- quality care and treatment that is consistent with good practice and based on sound evidence; and
- involving people in decision-making because they are the experts on receiving health care and are integral to determining if the services provided are “fit for purpose” in terms of accessibility, acceptability, effectiveness and equity.

2.49 Among the benefits expected from applying the *Adult Mental Health Unit Model of Care* (April 2012) are ‘improvements to discharge planning and facilitating a return to the community with appropriate supports which are in place when the consumer no longer requires acute services in an inpatient facility’. The intention is to build better links to the community based mental health teams and other community agencies to improve the co-ordinated treatment interventions provided to consumers between the in-patient unit and the community.

2.50 Overall, the *Adult Mental Health Unit Model of Care* (April 2012) expresses principles and intentions that are consistent with the *Mental Health Act 2015* and the *Human Rights Act 2004*. However, the model does not integrate fundamental innovations within the Act relating to treatment and consumer choice, including:

- the rights of people to communication, to nominate another person to assist in their care, and the right to make advance agreements and advance consent directions;
- the distinction between mental disorder and mental illness and the different treatment orders they entail; and
- the distinct roles and responsibilities of the Chief Psychiatrist and the Care Coordinator.

2.51 Furthermore, the *Adult Mental Health Unit Model of Care* (April 2012) does not set out an approach to ensuring recovery planning is a routine part of ensuring continuity of care by specifically requiring staff to:

- retrieve any existing recovery plans for guidance and, where appropriate, re-negotiation with the person in care;
- ensure that essential elements of care are in place prior to discharge (such as suitable accommodation, a safe and supportive care environment, and basic supplies of food, energy and means of communication);
- evaluate and assess wellbeing (via HoNOS) or risk (via the SVAT) as supporting criteria for discharge; and
- make use of the discharge and recovery planning suite of templates and documents supported by the medical record system, MHAGIC.

2.52 The *Adult Mental Health Unit Model of Care* (April 2012) does not distinguish between mental illness and mental disorder, or give effect to key provisions of the *Mental Health Act 2015* relating to the duties of the Chief Psychiatrist and the Care Coordinator. It is not apparent who has authorised the model, or how it is to be used to effectively direct the staff of the Unit, or any other ACT Health Directorate staff, or any other person working in an approved mental health or community care facility.

2.53 The *Adult Mental Health Unit Model of Care* (April 2012) does not take full account of the passage of the *Mental Health Act 2015* (it is five years since it was issued, and it refers to the repealed *Mental Health (Treatment and Care) Act 1994*). A review of the model of care is warranted from an operational perspective, as the status of the model is unclear - it is neither a policy/procedure issued by the Director-General under the *Mental Health Act 2015*, nor a clearly authorised instruction. It also lacks key features of document management control, including:

- a statement of authorisation;
- a document owner;
- details of its intended users; and
- information on its ongoing maintenance and administration, including arrangements for review.

Draft Mental Health Short Stay Unit Model of Care

2.54 At the time of the audit, the ACT Health Directorate was drafting a model of care to apply to the Mental Health Short Stay Unit at the Canberra Hospital. The Short Stay Unit evolved from the Mental Health Assessment Unit established in 2010 within the Canberra Hospital Emergency Department. It is:

... a standalone 6-bed inpatient unit adjacent to the ED. It is staffed with appropriately trained MHJHADS medical and nursing staff. The unit design is intended to support brief therapeutic

intervention including the establishment of pharmacological treatments, recovery focussed interventions and psycho-education.

2.55 The *Draft Mental Health Short Stay Unit Model of Care* has been in development since early 2015. It sets out treatment pathways, including for discharge and transfer and notes that effective discharge planning promotes continuity throughout the health care continuum and contributes to a person's engagement with health care services once they leave the unit, reducing the likelihood that the person will need to re-present to the hospital environment. The draft treatment pathway for transfer and discharge is as follows:

Discharge planning will commence as soon as a person is admitted to the MHSSU consistent with least restrictive care and to ensure planning is coordinated and comprehensive in order to facilitate people in returning home in the most timely and supported manner.

The MHSSU team will involve relevant stakeholders including clinical managers, families and carers and the extended care team including GPs, Private Counsellors, Psychologists, Psychiatrists and other health professionals or community agencies as a core element of discharge planning. Discharge summaries will be completed for all people admitted to MHSSU within a timely manner.

2.56 As with the *Adult Mental Health Unit Model of Care* (April 2012), the *Draft Mental Health Short Stay Unit Model of Care* expresses general principles to be followed with little operational guidance or development of procedures. For instance, there is no reference to:

- the distinction between mental disorder and mental illness and the different treatment orders they entail;
- the distinct roles and responsibilities of the Chief Psychiatrist and the Care Coordinator;
- identifying advance agreements and advance consent directions that may be in place; and
- the role of a nominated person.

2.57 Similar to the *Adult Mental Health Unit Model of Care* (April 2012) the *Draft Mental Health Short Stay Unit Model of Care* does not set out an approach to ensuring recovery planning is a routine part of ensuring continuity of care by requiring staff to:

- retrieve any existing recovery plans for guidance and, where appropriate, re-negotiation with the person in care;
- ensure that essential elements of care are in place prior to discharge (such as suitable accommodation, a safe and supportive care environment, and basic supplies of food, energy and means of communication);
- evaluate and assess wellbeing (via HoNOS) or risk (via the SVAT) as supporting criteria for discharge; and
- make use of the discharge and recovery planning suite of templates and documents supported by the medical record system, MHAGIC.

Draft Adult Community Mental Health Services Model of Care

2.58 At the time of this audit, the ACT Health Directorate was preparing to brief the Minister for Mental Health on progress putting in place an *Adult Community Mental Health Services Model of Care*. The model has been in development for approximately three years (commencing in 2014) with an external consulting team commissioned to inform a process of redesign to improve effectiveness and efficiency based on contemporary and evidence-based service delivery models. By early 2017, a *Draft Adult Community Mental Health Services Model of Care* had been developed, a Project Governance committee structure established and a project officer employed to develop the framework of practices, process and structures necessary to deliver the quality of care documented in the *Adult Community Mental Health Services Model of Care*. In June 2017, the ACT Health Directorate advised that:

The new *Adult Community Mental Health Services Model of Care* is designed to enable the principles and objectives of the new *Mental Health Act 2015*.

2.59 The *Adult Community Mental Health Services Model of Care* envisages the redesign of existing ACT Health Directorate services of the Crisis Assessment & Treatment Team (CATT), Mobile Intensive Treatment Team (MITT) and the Community Mental Health Teams of City, Woden, Belconnen, Tuggeranong and Gungahlin. With some augmentation and staff restructuring, services would be delivered via:

- Access Assessment Triage - 24 hours a day, 7 days a week, with centralised intake;
- Acute Response & Intensive Home Treatment - brief crisis intervention (2-6 weeks duration) in a person's home or community setting as an alternative to inpatient admission and/or to facilitate discharge;
- Community Recovery Service - clinical case management (long or short term);
- Assertive Community Outreach Service - clinical case management for people with longer term complex service engagement needs; and
- Individual Therapies - structured therapy sessions as an adjunct to clinical case management.

2.60 No changes are envisaged to inpatient, child and adolescent, forensic, and rehabilitation services, as reflected in the ACT Health Directorate's service delivery arrangements set out in Figure 2-1. The span of the re-designed services (those under the heading of 'ACMH Services') shows the proposed shift to community based and recovery oriented care, with intensive home treatment an option for diversion from acute care in a hospital setting. The effectiveness of the proposed changes will depend on (among other things) quality person-centred recovery planning conducted and recorded consistently across all the proposed care domains.

2.61 The *Draft Adult Community Mental Health Services Model of Care*, as with the other models, supports the recovery model and its principles. It also supports important provisions of the Act, including nominated persons, advance agreements and advance consent directions. However, as can be seen in Figure 2-1, the focus of the care is mental illness and not mental disorder. In that respect, the model does not refer to:

- the distinction between mental disorder and mental illness and the different treatment orders they entail; and
- the distinct roles and responsibilities of the Chief Psychiatrist and the Care Coordinator.

Figure 2-1 Draft Adult Community Mental Health Services Model of Care

Primary Health, private psychologists, community agencies, counselling centres, self help, social systems	ACMH Services					Inpatient Admission Inpatient
	Access Assessment and Triage (AAT)	Community Recovery Service (CRS)	Individual Therapies	Assertive Community Outreach Service (ACOS)	Acute Response and Intensive Home Treatment (ARIT)	
First contact point with assessment and referral follow up as per triage rating	Moderate intensity (weekly, fortnightly or monthly) multidisciplinary interventions	Weekly structured sessions as per mode of therapy or one off specialist assessment session	moderate to high intensity (2-3 times weekly) multidisciplinary interventions	high intensity (twice daily, daily, 2-3 times weekly) multidisciplinary treatment safely managed without hospital admission	Person's Home	high intensity multidisciplinary treatment in contained hospital facility
Phone or Community Health Centre	Person's Home or community health centre appointments	Community Health Centre	Person's Home or community health centre appointments	Person's Home	Canberra Hospital & Calvary MH Units	
Triage line 24 hrs 7 days, Assessment appointments 9am-5pm Mon-Fri (rapid 24 hr assessment response referred into ARIHT) Assessment period	9am-5pm Mon-Fri	9am-5pm Mon-Fri	extended hours 7 days	Outreach 24hrs 7 days	Operates 24hrs 7 days with on site 24hr medical and nursing support	
	Longterm	Short or long term	12-24 months	2-6 weeks		
All other presentations of mental illness	Signs of at least moderate mental illness requiring further assessment. Complexity of mental health presentation is unknown and triaged at this point.	Complex, severe and persistent mental illness with significant psychosocial functional impairment and/or risks associated with complex needs	Complex, severe and persistent mental illness with significant psychosocial functional impairment and/or risks associated with complex needs	Complex, severe and persistent mental illness with significant psychosocial functional impairment and/or risks associated with complex needs	Complex, severe and persistent mental illness with significant psychosocial functional impairment and/or risks associated with complex needs	Complex, severe and persistent mental illness with significant psychosocial functional impairment and/or risks associated with complex needs
			Requiring structured discipline specific therapy sessions or assessments	requiring assertive service engagement strategies	requiring assertive service engagement strategies	requiring assertive service engagement strategies
				An acute exacerbation of the mental illness and/or severe psychological or emotional distress	An acute exacerbation of the mental illness and/or severe psychological or emotional distress	Immediate risk self harm or harm to others that cannot be safely managed without contained hospital environment and 24 hr medical care

Source: Health Directorate.

- 2.62 Similar to the other models of care, the *Draft Adult Community Mental Health Services Model of Care* does not set out an approach to ensuring recovery planning is a routine part of ensuring continuity of care by requiring staff to:
- retrieve any existing recovery plans for guidance and, where appropriate, re-negotiation with the person in care;
 - ensure that essential elements of care are in place prior to discharge (such as suitable accommodation, a safe and supportive care environment, and basic supplies of food, energy and means of communication);
 - evaluate and assess wellbeing (via HoNOS) or risk (via the SVAT) as supporting criteria for discharge; and
 - make use of the discharge and recovery planning suite of templates and documents supported by the medical record system, MHAGIC.
- 2.63 At the time of the audit, the implementation plan for the *Draft Adult Community Mental Health Services Model of Care* was not settled, including key implementation issues. The document stated:
- The analysis, planning, consultation and implementation of any possible changes to workforce, infrastructure and locations, training, culture and operational procedures as a result of the ACMHS MoC are not in scope for the purpose of this current document and will instead be addressed after the endorsement of the key facets proposed in the AMCH MoC.
- 2.64 The ACT Health Directorate has developed a *Draft Adult Community Mental Health Services Model of Care* and a *Draft Mental Health Short Stay Unit Model of Care* and there is evidence that these draft models of care are addressing functional recovery and discharge planning. However, the *Adult Mental Health Unit Model of Care* (April 2012), which has not been updated for over five years, does not explicitly address functional recovery and discharge planning. Overall, the model of care expresses principles and intentions that are consistent with the *Mental Health Act 2015* and the *Human Rights Act 2004*, but it does not integrate fundamental innovations within the *Mental Health Act 2015* relating to treatment and consumer choice and does not set out an approach to ensuring recovery planning is a routine part of ensuring continuity of care.
- 2.65 None of the relevant models of care developed by the ACT Health Directorate, including those in draft form, give full effect to important aspects of the *Mental Health Act 2015*, including: the rights of people to communication, to nominate another person to assist in their care, and the right to make advance agreements and advance consent directions; the distinction between mental disorder and mental illness and the different treatment orders they entail; and the distinct roles and responsibilities of the Chief Psychiatrist and the Care Coordinator set out in legislation.

Collaborative planning policy and procedural guidance

2.66 The principles, approach and aim of collaborative planning are set out in the ACT Health Directorate's *Collaborative Planning Standard Operating Procedure*:

Fundamental to promoting recovery and wellbeing for people managed by Mental Health, Justice Health and Alcohol & Drug Services are the principles of participation, choice, self-determination, partnership and collaboration.

2.67 The approach to be taken is person and family centred, encompassing all the key people and supports that might come together to develop the plan:

The ACT Government Health Directorate is committed to person and family centred approaches that encourage people to be actively involved in the planning, implementation and evaluation of services. People experiencing mental disorder or mental illness, staff and, where appropriate, their families, other identified supports and service providers are encouraged to collaborate on the development and implementation of the person's treatment/care/recovery plan (The Plan).

2.68 The ACT Health Directorate's *Collaborative Planning Standard Operating Procedure* clearly states its objective with respect to improving outcome for people. It aims to improve outcomes for people through:

- Taking a person-centred and holistic approach to treatment and recovery, making full use of the strengths, expertise and experience of the person and their treatment and support team/network.
- Promoting the acquisition of skills and confidence in managing health conditions, goal setting and action planning, wellbeing and relapse prevention planning.
- Improved communication between the parties involved in supporting an individual's recovery and wellbeing.
- Defining the roles and responsibilities of those involved in the plan and being accountable for actions in the plan.
- Coordination of care to reduce any duplication or contradictions.

Procedures for collaborative planning

2.69 The *Collaborative Planning Standard Operating Procedure* also specifies 13 steps in the procedure to be followed to meet the stated aims, which are summarised as follows:

1. Ask the person about their carers, Nominated Person, family and friends, general practitioner and other health and support services that they use.
2. With the person, identify people to be included in the planning process and check they consent to being involved.
3. Ensure the person has signed their consent to the ACT Health Directorate sharing relevant information with those who are to be involved.
4. After making sure of the views of the person, arrange meetings or other means of communication, keeping the person central to the process.
5. Where appropriate, involve the party that referred the person to the ACT Health Directorate to collaborate in planning.
6. Arrange a planning meeting with the relevant members of the treating and support network.

7. Develop a plan from collaborative discussions and, with the person, determine their priorities. Invite the person to sign sections of the plan, such as the Personal Recovery Plan, the Keeping Well Plan, or an Advance Agreement. Copies are to be provided to the person and those nominated to receive copies in the plan. Any changes will be communicated to all relevant parties.
8. The person and their families will be provided with appropriate information and education to assist them in the planning process.
9. Offer options for planning services in advance, including Advance Consent Directives and Advance Agreements.
10. Reduce duplication of the planning process so that, as far as possible, the person and their treating and support network work from a single plan.
11. Regularly review progress with the person at least every three months, more often if indicated. This review should involve consultation with the treatment and support network.
12. Reviews should occur if the person requests a review, declines treatment and support, is at significant risk of injury to themselves or another person, is observed to have a condition that is deteriorating, is transferred between services, or has a change in their voluntary/involuntary status, or is exiting the service.
13. Regular contact with all parties is to be maintained to ensure a comprehensive and holistic approach that supports the person's ongoing recovery and wellbeing.

Collaborative planning documentation

2.70 MHAGIC provides a suite of eight collaborative planning templates for use by staff and practitioners. They are intended to record the development and agreement of a *Recovery Plan* and other aspects of care and wellbeing. The template documents listed below (coded as 'RP1-Information Sheet' through to 'RP8-Information checklist') are available on MHAGIC).

- RP1 – Information Sheet v1-1.doc
- RP2 - Personal Recovery Plan v1-1.doc
- RP3 - Other Recovery Issues v1-1.doc
- RP4 - Keep well prevent relapse respond early v1-1.doc
- RP5 - Advance Agreement Template v1-1.doc
- RP6 – Children and Young People's Support Plan v1-1.doc
- RP7 – Independent Assessment of FamilyCarerNeeds v1-1.doc
- RP8 – Information checklist v1-1.doc

2.71 Each document is a Word™ template that can be downloaded and filled in electronically, or printed and completed by hand. The completed documents can be stored on MHAGIC, either as Word™ files or as scanned Portable Document Files (PDF files). Copies can then be provided to the person, their carers and/or other supports, with the electronic copies available to authorised staff via MHAGIC. The plans form part of the person's medical record.

2.72 The *Collaborative Planning Standard Operating Procedure* and related templates cover all key elements of planning, including staying well. The procedure and templates reflect the *Mental Health Act 2015* and the focus on collaborative planning that actively involves the person, their treatment and support network. A further improvement would be the inclusion of a 'nominated person' template. The role of a nominated person is to help a person with a mental illness or mental disorder by making sure their interests are respected if they require treatment, care or support for their condition. Having this document template included in MHAGIC reflects the importance of this role.

Transition management policy and procedural guidance

2.73 The policies and standard operating procedures provided by the ACT Health Directorate contain instructions relating to the management of all people admitted to acute care in the Adult Mental Health Unit. The instructions establish a process for transition management which begins at the time people are admitted and continues until after they are discharged. They also make provision for risk management and systems/records relevant to all parts of the mental health care process.

Seventy Two Hour Assessment

2.74 The *Seventy Two Hour Assessment in the AMHU Standard Operating Procedure* states that within the first 72 hours of a person's admission to the Adult Mental Health Unit, a *Recovery Plan* for each person admitted is required to be commenced (if one does not already exist). A *Discharge Plan* is to be completed in the *Recovery Plan* and an estimated discharge date is to be specified. The *Recovery Plan* is then meant to be reviewed (and by inference adjusted if necessary) at each care plan review or Ward Round. The *Discharge Plan*, as part of the *Recovery Plan*, is also to be reviewed and updated.

Episode of Care Closure

2.75 Prior to a person's transition from acute to community-based care, and for each episode of care, there are a number of activities to be completed. The Clinical Manager (or other staff member) is required to:

- discuss and document the process with the team leader and multidisciplinary team as well as the person (or guardian) and carer/s;
- (wherever possible) ensure the person and carer/s understand the Episode of Care Closure process and that they have been consulted and their views obtained regarding closure so that any specific needs that this might generate are addressed;
- consider whether a person with a long term disabling illness has remained clinically stable for a period of at least six months without significant medication changes (as indicated by standard instruments from the National Outcomes Casemix Collection, including Basis32, HoNOS and/or LSP16);
- consider whether the person has acquired a level of functioning that does not indicate an ongoing need for intensive mental health intervention;

- consider other issues that should possibly contraindicate or defer Episode of Care Closure at that time, including:
 - people with active, unmanaged substance use problems;
 - people with two or more admissions in a twelve month period;
 - people with imminent stressors in their lives (such as significant life events); and
 - complete the required documentation to ensure that all components of the comprehensive assessment and recovery plan are finalised.
- 2.76 The multidisciplinary team is to discuss each episode of care closure formally at the team case review or other multidisciplinary team meeting. The review is required to assist in identifying relevant people and the key agencies to which the person will be discharged/transferred.
- 2.77 Following this review the Clinical Manager is expected to make initial contact with the respective people/agencies after discussions with the person with mental disorder or mental illness and their carer/s.
- 2.78 Following consultation with and agreement by the person, a collaborative planning meeting or discussions between the Clinical Manager, the person, carer/s and GP/agency should occur to negotiate an agreed Episode of Care closure plan.
- 2.79 Clearly documented strategies need to be developed prior to Episode of Care closure to address any potential difficulties that may arise in the future. These strategies should be mutually satisfactory for all parties involved and should be congruent with the relapse prevention strategies. This process may also include setting a date for a formal psychiatric review.
- 2.80 The Clinical Manager and the multi-disciplinary team are to complete the required documentation to ensure that all components of the comprehensive assessment and recovery plan are finalised.

Clinical case review

- 2.81 Procedures for recovery planning are also set out in the ACT Health Directorate's *Clinical Case Review in Mental Health Services Standard Operating Procedure*. The responsibility for initiating regular (3-monthly) clinical reviews for people in community-based care is assigned to Community Mental Health Team leaders. They are to ensure that all people experiencing mental illness or mental disorder are reviewed every three months at a minimum, whether or not the person is involved on a voluntary or involuntary basis. Among other things, the *Recovery Plan* is to be reviewed, including:
- risks, inclusive of risk of suicide (past and present), risk of self harm, risk of harm to others be they adult or child, risk of relapse inclusive of drugs, alcohol, life debilitating stressors and noncompliance with treatment.
 - issues associated with the person's recovery and support systems in the community, including people's:

- carer systems and their fundamental living needs (such as income, housing, transport, and shopping etc);
- level of community support, connection and participation (for instance, activities, groups and help required);
- needs, goals, responsibilities, aspirations, interest in work and other meaningful activity, as well as options;
- plans to address these (e.g. rehabilitation plan) made in consultation and collaboration with family and carers; and
- review of all outcome measures.

2.82 In particular, all reviews are to develop options to facilitate independence from specialist services.

2.83 The *Seventy Two Hour Assessment in the AMHU Standard Operating Procedure* assigns nursing staff the responsibility for commencing recovery planning. This includes completion of the *Other Recovery Issues* document (referred to above) within 72 hours of admission to the unit. There is no subsequent responsibility assigned for carriage of the plan, or specification of the personnel who are to undertake the Ward Round or the timing of it. Furthermore, the *Seventy Two Hour Assessment in the AMHU Standard Operating Procedure* does not include references to related legislation or policies, including the *Recovery Planning within the Mental Health Unit Standard Operating Procedure* which outlines additional procedures to be completed within the first 72 hours of care. In respect of these procedures, the ACT Health Directorate advised in June 2017 that:

There are significant resource implications in terms of the consistency and clinical diligence required in order to meet the requirements of the Episode of Care as reflected in the 3-Monthly Clinical Case Review.

Risk Management policy and procedural guidance

2.84 The ACT Health Directorate has a risk management policy and procedures that apply to all parts of the organisation. The ACT Health Directorate's *Risk Management Policy* provides that:

Risk management is regarded by the ACT Health Directorate as essential for achieving its business objectives.

2.85 Risk management is aligned with the ACT Health Directorate's organisational, business planning, performance and reporting structure and provides for the management of risks to be managed across the ACT Health Directorate at four levels defined as follows:

- Tier 1: Organisational Level – this is the ACT Health Directorate as a whole. It includes all aspects of the organisation and any partnerships with external parties.
- Tier 2: Group Level - this represents the Director-General's office and the Deputy Directors Generals of Canberra Hospital and Health Services, Strategy and Corporate, Health Infrastructure & Planning and Population Health.
- Tier 3: Divisional Level – this includes Canberra Hospital and Health Services' Divisions, Strategy and Corporate Branches and branches from within the Director-General's office.

Tier 4: Team Level – includes all sections, units, programs, teams, and projects.

- 2.86 Risks must be adequately documented to deliver the level of detail and clarity required by all parts of the organisation and by external stakeholders. Both the risk assessment template and the risk register template are available from the ACT Health Directorate risk management intranet page.
- 2.87 In risk management, accurate and reliable records are important for ensuring that there is sufficient evidence that the ACT Health Directorate's risks are being effectively and efficiently managed. It is important that the records are accurate to facilitate ongoing review, monitoring and management.
- 2.88 Risk registers are maintained at a team level using the ACT Health Directorate templates. The risk registers show that risks are being monitored and recorded on a regular basis. The risk registers are reviewed at Team Work Health and Safety meetings and Quality and Safety Committee meetings, and, where required, are escalated to the Divisional Level Work Health and Safety meetings for management and treatment.

Measuring outcomes policy and procedural guidance

- 2.89 The *Collaborative Planning Standard Operating Procedure* specifies five outcome measures:
- Treatment, care and recovery planning reflects a person centred and holistic approach, promoting choice and participation and making full use of the strengths, expertise and experience of the person and their treatment and support team/network.
 - People are encouraged to participate in planning for improved wellbeing, relapse prevention and access to services when needed.
 - Communication between the parties involved in supporting an individual's recovery and wellbeing is enhanced.
 - Those involved in treatment and support of the person and their roles and responsibilities are defined in the plan.
 - Services are well coordinated to reduce any duplication or contradictions.
- 2.90 The *Collaborative Planning Standard Operating Procedure* specifies the method of evaluation of outcome measures, with the results to be communicated up to the Divisional level:
- Monitor completion rates for Treatment/Care/Recovery plans (e.g. in Mental Health services, Personal Recovery Plans, Keeping Well Plans and Advance Agreements etc.).
 - Audit for evidence of participation and collaboration with people, families and other service providers (e.g. Consent to share/release of information documents, documentation of planning meetings and other communication).
 - Through People Satisfaction Surveys or experience of care tools seek feedback from person's on their satisfaction with the level of participation, inclusion and self-determination in Treatment/Care/Recovery Planning.
 - Survey satisfaction of families, community partners, GPs on the level of communication and collaboration regarding The Plan.
 - Data to be reported to the service level and divisional Quality and Safety Committees.

Clinical records management policy and procedural guidance

- 2.91 The ACT Health Directorate's *Clinical Records Management Policy* requires that complete and accurate clinical records be kept for all people. It also indicates the ACT Health Directorate's intention to establish a single, integrated, on-line clinical record for all people. For people receiving mental health care this record is maintained in MHAGIC. The policy emphasises the important role that effective information management plays in the provision of care and collaborative planning for people receiving mental health care.
- 2.92 The structure and functions of MHAGIC (described in more detail in Chapter 4) are designed to support nurses and clinicians to record observations and tasks, including *Recovery Plans*. MHAGIC is used across the ACT Health Directorate's mental health services, including in acute care facilities and the Community Mental Health Teams, as well as for alcohol and drug services and for administrative purposes.
- 2.93 In addition to supporting practitioners, MHAGIC records the elements of the minimum data required to contribute to the national mental health reform process, and the outcomes measures of the National Outcomes Casemix Collection (NOCC) adopted by all States and Territories for national reporting and reform purposes. MHAGIC is routinely interrogated to deliver management reports to business units up to the Divisional level. These reports can include rates of completion of plans and other related activities.
- 2.94 Auditing of mental health service practices is given effect via the ACT Health Directorate's internal *In-Depth Clinical Documentation Audit Tool* (the Audit Tool). The Audit Tool was intended to be applied monthly to acute care facilities:
- All Service Sites ... are to be audited monthly using the In-Depth Clinical Document Audit Tool ... The episode of care to be audited is as follows:
- Acute Inpatient Units: Most recent admission. Please note, audits should be carried out on the files of people who have been discharged from the unit in the preceding month.
- 2.95 The coverage of the Audit Tool relevantly includes worksheets to assess compliance with:
- Recovery Plan ;
 - Carer Participation and Assessment;
 - Relapse Prevention Strategies; and
 - Acute Inpatient Discharge.
- 2.96 The audit worksheets for each heading include (among other things) the collection of evidence of compliance against all 13 procedures set out in the *Collaborative Planning Standard Operating Procedure*.
- 2.97 The ACT Health Directorate has developed policies, procedures and systems to support collaborative planning for recovery at the operational level. Among them are policies and procedures that encourage planning from the very beginning of care, review at regular intervals (including clinical review and review at the end of an episode of care) and the

involvement of family and carers, along with tools for measuring outcomes. Key to this process is the development of a *recovery plan* which identifies treatment, care and ongoing recovery and wellbeing requirements.

- 2.98 The procedures for collaborative planning are well articulated and staff are supported with a clinical record system, MHAGIC, that provides a full suite of recovery planning documents available for use by the Community Mental Health Teams and in all acute care facilities. MHAGIC also allows users to record important events (including people being advised of their rights and obligations). The ACT Health Directorate has also developed a comprehensive set of audit tools that are suitable for monitoring and reviewing compliance with the requirements.
- 2.99 However, the procedures may be found within a large body of policies and procedures that exist without a system of indexing or inquiry that would allow users to quickly find and apply the appropriate policy at the appropriate time. In addition, among this large body of guidance are policies and procedures that:
- mix policy and work instructions, without being clear which is which;
 - do not provide clear, detailed and comprehensive work instructions;
 - do not provide copies of relevant forms or cross references to them;
 - do not clearly specify the responsible staff;
 - are not stand alone references; and
 - overlap – for instance triaging is addressed in two Standard Operating Procedures.

National Standards for Mental Health Services 2010

- 2.100 The *National Standards for Mental Health Services 2010* are a resource for all Australian mental health care services ‘to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services’. The *National Standards for Mental Health Services 2010* were first issued in 1996 and were revised and re-issued in 2010.
- 2.101 The *National Standards for Mental Health Services 2010* include a focus on recovery oriented mental health practice, which are consistent conceptually with the principles underpinning the *Mental Health Act 2015*. According to the standards, recovery means ‘gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self’. A key element of recovery oriented service provision is evaluation, the principle of which is set out as follows:
- Recovery oriented mental health practice:
- ensures and enables continuous evaluation of recovery based practice at several levels
 - individuals and their carers can track their own progress

- services demonstrate that they use the individual's experiences of care to inform quality improvement activities
- the mental health system reports on key outcomes that indicate recovery including (but not limited to) housing, employment, education and social and family relationships as well as health and well being measures.

2.102 The *National Standards for Mental Health Services 2010* are not mandatory, and the ACT Health Directorate has not sought accreditation against them. However, the ACT Health Directorate uses the standards to inform its policies and to measure performance, including in the in monthly performance scorecards provided to the Executive. The standards are extensively referenced in the policy documents examined in the course of this audit, including where they are listed as a relevant reference for the policy or procedure. In addition, the ACT Health Directorate refers to the standards as being consistent with Health's clinical practice and philosophy of care in the case of (for instance) receiving a second opinion for psychiatric review or choosing from the available range of treatments offered by MHJHADS.

2.103 Though it is not anywhere stated that the policies and procedures have to be consistent with the national standards, such a specification may be merited and, if realised, would help ensure that policies and procedures are complete, relevant and appropriate. Regardless, reference to the standards may be taken to mean (at a minimum) that they are considered relevant and are to be taken into account in policy and practice. Compliance with the standards can also reasonably be viewed as an element of good risk management practice.

2.104 Furthermore, the underlying recovery oriented approach of the *National Standards for Mental Health Services 2010* is fully consistent with the aims of the *Mental Health Act 2015* and the Open Door (or 'no wrong door') philosophy of the ACT Health Directorate, as expressed in the ACT Health Directorate's *Triaging of Initial Presentations Standard Operating Procedure*, which:

... supports the National Standards for Mental Health Services and underpins the endorsed service expectation to support all persons who make contact with ACMHT to either receive a direct response or to be linked to the appropriate service.

2.105 Table 2-2 illustrates the way in which the standards relevant to this audit were applied to the policies and procedures provided by the ACT Health Directorate. The table illustrates how the audit assessment was conducted by reference to specific policies and procedures. In the table:

- the term 'the procedure' used in the Comment column refers to all relevant prescriptions in all policy documents taken collectively;
- the comments note where *National Standards for Mental Health Services 2010* criteria do not require processes to be in place and cannot, therefore, be assessed against administrative procedures; and
- the relevant *National Standards for Mental Health Services 2010* are cross-referenced to the National Safety and Quality Health Service Standards (NSQHSS, in brackets adjacent to the reference for the relevant standard).

Table 2-2 Elements of the *National Standards for Mental Health Services 2010* and their relationship to selected the ACT Health Directorate policies and procedures

NSMHS 2010 criteria (NSQHSS Criteria cross references in brackets)	Reference in policies	Comment
2.11 (1.8) The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and / or are transferred to another service.	MHJHADS SOP Episode of Care Closure	The procedure addresses risks of stability, level of function, contraindications and lack of awareness of person and carer. However, it does not refer to a specific risk assessment approach.
3.1 (2.1, 2.2, 2.4, 2.5) The MHS has processes to actively involve consumers and carers in planning, service delivery, evaluation and quality programs	MHJHADS SOP Episode of Care Closure	The process requires that people and carers be actively engaged in the EOC closure element of service delivery.
6.7 (n/a) Consumers are partners in the management of all aspects of their treatment, care and recovery planning.	MHJHADS SOP Episode of Care Closure	Not an assessable criterion, but note comment in relation to 3.1 above.
6.8 (n/a) Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.	MHJHADS SOP Episode of Care Closure	Not an assessable criterion, but note that informed consent in relation to EOC Closure is not specifically addressed in the procedure.
6.12 (n/a) Consumers have an individual exit plan with information on how to re-enter the service if needed.	MHJHADS SOP Episode of Care Closure	Individual exit plan provided for in procedure, not clear if information on re-entry included.
6.13 (n/a) Consumers are actively involved in follow-up arrangements to maintain continuity of care.	MHJHADS SOP Episode of Care Closure	The procedure touches on active involvement, in that it requires development of strategies which engage the person, but it is not specific on this point.
7.12 (6.5) The MHS engages carers in discharge planning involving crisis management and continuing care prior to discharge from all episodes of care.	MHJHADS SOP Episode of Care Closure	The procedure engages carers in discharge planning, and while the wording of the procedure does not include 'crisis management and continuing care' it does seem that these are covered off (refers to 'potential difficulties' and 'relapse prevention strategies').

NSMHS 2010 criteria (NSQHSS Criteria cross references in brackets)	Reference in policies	Comment
8.4 (1.1) The MHS has processes in place to ensure compliance with relevant Commonwealth, state/ territory mental health legislation and related Acts.	No reference.	Procedure does not specify means to achieve compliance
8.9 (1.9) The MHS manages and maintains an information system that facilitates the appropriate collection, use, storage, transmission and analysis of data to enable review of services and outcomes at an individual consumer and MHS level in accordance with Commonwealth, state/ territory legislation and related Acts.	Clinical Records Management Policy Standard Operating Procedure Clinical Record Documentation	The clinical records procedures are consistent with standard. As noted separately references to MHAGIC are far less clear.
8.10 (1.2, 1.5) The MHS has an integrated risk management policy and practices to identify, evaluate, monitor, manage and communicate organisational and clinical risks.	Risk Management Policy Risk Management Guidelines	Procedures institute the Australian risk management standard and reflect Act Health management and operational structures. This approach consistent with standard.
8.11 (1.2, 1.6) The MHS has a formal quality improvement program incorporating evaluation of its services that result in changes to improve practice	No reference	No procedures provided that address evaluation and quality improvement.
10.6.2 (n/a) The consumer and their carer(s) are provided with understandable information on the range of relevant services and support available in the community.	MHJHADS SOP Episode of Care Closure	The procedure does not specify the kind of information to be provided in EOC closure planning for people and carers.
10.6.3 (n/a) The MHS has a process to commence development of an exit plan at the time the consumer enters the service.	MHJHADS SOP Episode of Care Closure AMHU SOP Recovery Planning within the Adult Mental Health Unit AMHU SOP Seventy Two Hour Assessment in the AMHU	The procedure specifically addresses this requirement, setting a 72 hour timeframe on development of a recovery plan which is to include a discharge plan.

NSMHS 2010 criteria (NSQHSS Criteria cross references in brackets)	Reference in policies	Comment
10.6.4 (6.5) 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).	MHJHADS SOP Episode of Care Closure	The procedure provides for the involvement of people and carers in developing the exit plan and also requires that copies are made available.
10.6.5 (n/a) The MHS provides consumers, their carers and other service providers involved in follow-up with information on the process for re-entering the MHS if required.	MHJHADS SOP Episode of Care Closure	The procedure uses the language of 'emphasising' which is not the same as providing information.
10.6.6 (n/a) The MHS ensures ease of access for consumers re-entering the MHS.	MHJHADS SOP Episode of Care Closure ACMHT SOP Triaging of Initial Presentations	The procedure emphasises the importance of access but has little specificity.
10.6.7 (n/a) 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.	MHJHADS SOP Episode of Care Closure	The procedure requires staff review of proposed exits.
10.6.8 (n/a) The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers 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.	MHJADS SOP Transitional Clinician	The procedure requires the Transitional Clinician to follow up within 7 days but does not specify a follow up procedure for consumers who do not keep the planned follow-up arrangements.

Source: ACT Audit Office analysis of National Standards for Mental Health Services 2010, and the ACT Health Directorate policy and procedures.

2.106 There are numerous references to the *National Standards for Mental Health Services 2010* in the ACT Health Directorate's policy and procedural documentation. Taken as a whole their provisions are broadly consistent with the thrust of the standards but there is little specificity in terms of reference to them or working instructions which reinforce/embed/enforce them. Areas where strengthening ACT Health Directorate policy and procedural documentation would better implement the *National Standards for Mental Health Services 2010* include:

- strengthening the procedures for follow-up after discharge (standard 10.6.8 follow-up within 7 days);
- implementing a formal quality improvement program incorporating evaluation of services (standard 8.11); and
- making explicit the requirement to ensure compliance with all relevant laws (standard 8.4).

RECOMMENDATION 1 MENTAL HEALTH SERVICES POLICIES AND PROCEDURES

The ACT Health Directorate should:

- a) develop an integrated, comprehensive and contemporary framework governing mental health services capturing all requirements for the effective and efficient implementation and documentation of discharge and recovery planning under the *Mental Health Act 2015* (and the *National Standards for Mental Health Services 2010*);
- b) work cooperatively with Calvary Health Care ACT to harmonise and align policies and procedures; and
- c) investigate reinforcing key administrative policies and procedures by issuing these under section 217 of the Act.

3 RECOVERY PLANNING

- 3.1 This chapter presents the results of an examination of a random sample of records of people who transitioned from acute care in 2015-16. The records were examined for evidence of collaborative recovery planning, in accordance with relevant ACT Health Directorate policies and procedures and the *Mental Health Act 2015*.
- 3.2 Where appropriate, the results are illustrated with anonymous case studies, and the comments of community based organisations that support people after discharge from acute care.

Summary

Conclusion

While a review of case file records showed a high degree of care and compassion for those in acute care, documentation in MHAGIC could not be relied on to demonstrate consultation and collaboration in the delivery of services, or early and effective planning for discharge and recovery from acute care.

For the records reviewed, clinical notes in MHAGIC were repetitive, poorly structured and did not provide comprehensive information on the course of treatment, discharge and recovery planning. This does not facilitate efficient or effective administration or recovery-oriented service delivery. Although MHAGIC includes a suite of documents and templates designed to assist in promoting consistency in record-keeping and service delivery, these are infrequently used.

Key findings

Records do not always show that every person's rights were communicated and observed. Though MHAGIC is the ACT Health Directorate's primary medical record of a person's mental health care, it includes fewer primary and contemporaneous records of consultation, participation and collaboration than would be expected. This is important given the rights and obligations set out in Chapter 3 of the *Mental Health Act 2015*. Nor are there many records showing communications with General Practitioners. There were no standard practices for recording the transmission of hospital discharge summaries to General Practitioners.

Paragraph

3.32

In only 5 percent of cases were records found that showed that planning commenced during the initial phase of hospitalisation for discharge and the support required after inpatient care.

3.48

Recovery plans were found in only one third of the records examined. There is evidence that mental health staff have not regularly and systematically recorded discharge and recovery planning in MHAGIC. Records have similarly not been made of clinical meetings that involve the sharing of information and clinical decision making about a person's care and treatment. 3.60

This failure of practice means that the MHAGIC records of recovery planning are incomplete. Reliable and complete records of recovery planning are not available to be given to the person, their family or to other carers. Neither are they available to other staff or other support organisations to help in their care of the person, including after discharge from acute care. The responsibility for creating, reviewing and maintaining a person's discharge and *recovery plan* is not clearly assigned. 3.61

The ACT Health Directorate sets a schedule for following people up after discharge, and the records showed that two thirds were followed-up within a week; this is a high level of achievement. 3.70

Apparent low rates of referral to alcohol and drug services, according to advice from the ACT Health Directorate, are due, in part, to staff not always recording instances in which people in acute care decline referral to alcohol and drug services. In addition, the ACT Health Directorate advised that the low rates of referral to the alcohol and drug facilities at the Canberra Hospital during acute care are due, in part, to the facilities being unsafe for people at high risk of harming themselves. This means that acute care mental health beds are frequently occupied by people recovering from intoxication for a period of some days before effective mental health care can begin. 3.74

Nevertheless, the ACT Health Directorate has advised that people can still be referred to alcohol and drug services through clinicians' in-reach into the mental health in-patient facility. Furthermore patients would only be transferred directly to an alcohol and drug service withdrawal facility from an in-patient mental health unit where their mental health episode has stabilised and an acute detoxification was still required. 3.75

A number of community organisations interviewed identified that there are benefits to be gained from a common, systematic approach to referring people to appropriate community organisations on discharge from acute care. 3.78

The MHAGIC notes examined were repetitive and poorly structured and did not clearly provide information on the course of treatment, recovery and discharge planning for the person. This does not aid efficient or effective administration or recovery-oriented service delivery. Clinicians did not make use of the full set of modules and documents available to record their observations and clinical notes in MHAGIC. 3.81

The prevalence of cut-and-paste practices for MHAGIC notes results in records containing inaccurate, irrelevant or outdated information. They simultaneously 3.84

reduce accountability while increasing the risk that individuals could be held responsible for records made by others.

Random sample analysis

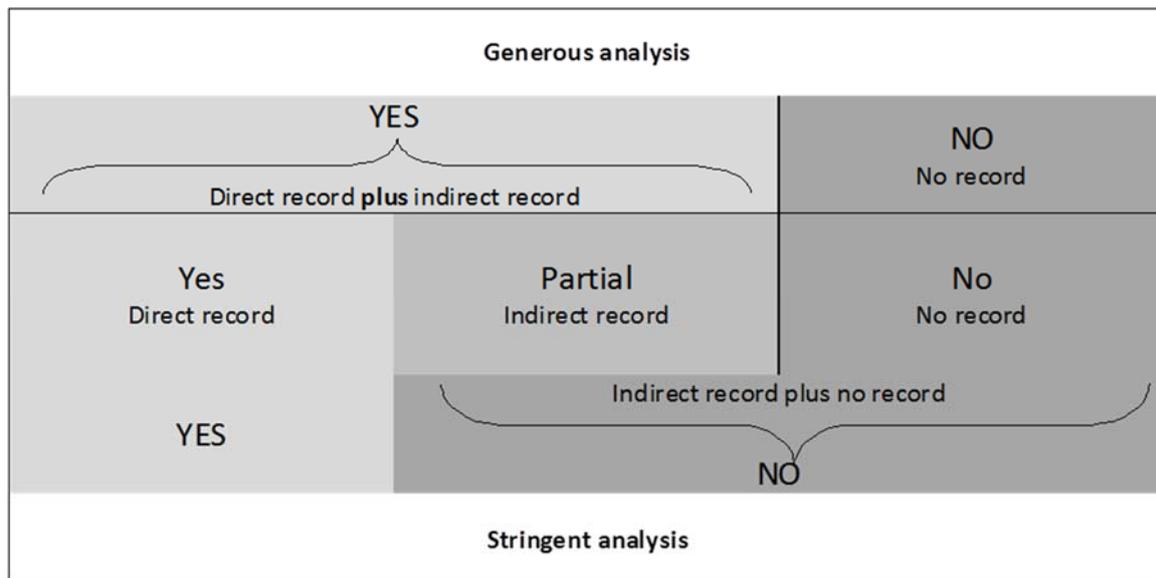
- 3.3 A random sample of 40 records was made for adults who transitioned from acute care in the Canberra Hospital or from Calvary Hospital into community-based care in 2015-16 (refer to Appendix A for the processes used to form the random sample for analysis). The sample adequately covered both campuses, noting that most people over 65 years of age are admitted to Calvary's Older Persons Mental Health Service (OPMHS).
- 3.4 The random sample records were examined for evidence of collaborative recovery and transition planning, in accordance with relevant ACT Health Directorate policies and procedures and the *Mental Health Act 2015*. The criteria for assessment, which are set out in Appendix B, relate to a requirement or standard set out in one or more of:
- legislation, including the *Mental Health Act 2015*;
 - ACT Health Directorate policy, guidance or Standard Operating Procedures, including the *Collaborative Planning Standard Operating Procedure*;
 - the *National Standards for Mental Health Services 2010*; and
 - the *In-Depth Clinical Documentation Audit Tool* (discussed in Chapter 2).
- 3.5 The results of the random sample analysis are set out below under key headings:
- **Consultation, participation and collaboration** – including records that clearly showed consultation with the person and other relevant parties, including that people were informed of their rights and obligations;
 - **Recovery planning** – including records of admission and subsequent steps taken to commence discharge and recovery planning, including documented recovery plans;
 - **Treatment, discharge and follow-up** – including documented risk assessments, discharge summaries and records of contact with the person after transitioning to community-based care, and arrangements to refer them to services to support recovery; and
 - **Record-keeping and the use of MHAGIC** – including documented observations and clinical notes and the use of MHAGIC.

Generous analysis and stringent analysis

- 3.6 Where a primary record could be found to satisfy the criteria (for instance, a *Personal Recovery Plan*, MHAGIC document RP2) a positive result was recorded. Where a primary record could not be located and secondary records existed indicating that, for instance, some elements of discharge and recovery planning had occurred, a partial result was recorded.

- 3.7 Two grades of analysis are therefore possible from the random sample analysis:
- generous analysis; and
 - stringent analysis.
- 3.8 A generous analysis combines positive results (where there is a primary record) and partial results (where there is only a secondary record) to indicate the highest feasible rate of satisfaction of a criterion.
- 3.9 In the more stringent analysis, the positive results based on primary records stand alone, to indicate the lowest feasible rate of satisfaction of a criterion. The two analyses are illustrated in Figure 3-1.

Figure 3-1 Composition of the two analyses applied to the random sample



Source: ACT Audit Office

- 3.10 The results of both generous and stringent analyses are shown where they help understand the results.

Consultations with community groups

3.11 The audit included structured interviews with community organisations involved in supporting people after discharge from acute care. Community organisations consulted for the purpose of the audit included Carers ACT, CatholicCare, the Mental Health Foundation, ACT Mental Health Coalition, the Mental Health Consumer Network, Richmond Fellowship, Wellways, Winnunga Nimmitiyah Aboriginal Health Service and Woden Community Service.

3.12 Services provided by community groups include:

- clinical and medical services;
- accommodation support services;
- assistance with day to day living;

- suicide prevention services;
 - Step-Up-Step-Down programs;
 - transition to recovery services; and
 - outreach services.
- 3.13 The focus of consultation with community organisations was their experience of involvement in recovery and transition planning, which included:
- involvement in the process of transition from acute care;
 - the processes by which referrals are made;
 - how the community organisation is involved in planning for recovery; and
 - contact with community mental health teams.
- 3.14 Where appropriate, observations from consultation with community organisations are included to emphasise the results of the random sample examination.

Consultation, participation and collaboration

- 3.15 As the *Collaborative Planning Standard Operating Procedure* states, 'Fundamental to promoting recovery and wellbeing for people managed by Mental Health, Justice Health and Alcohol & Drug Services are the principles of participation, choice, self-determination, partnership and collaboration'. The review of records showed instances where this was apparent, an example of which is shown in Figure 3-2.

Figure 3-2 Collaborative planning case study

Case study
This woman has a personal recovery plan in place after a long stay in acute care. This is an excellent outcome with clinical staff, including the Social Worker, Occupational Therapist and Clinical Manager establishing a working relationship with the patient, and with the housing and other support agencies that provide her with support and assistance.

Source: ACT Audit Office, analysis of MHAGIC records – comment from subject matter expert

Records demonstrating consultation, participation and collaboration

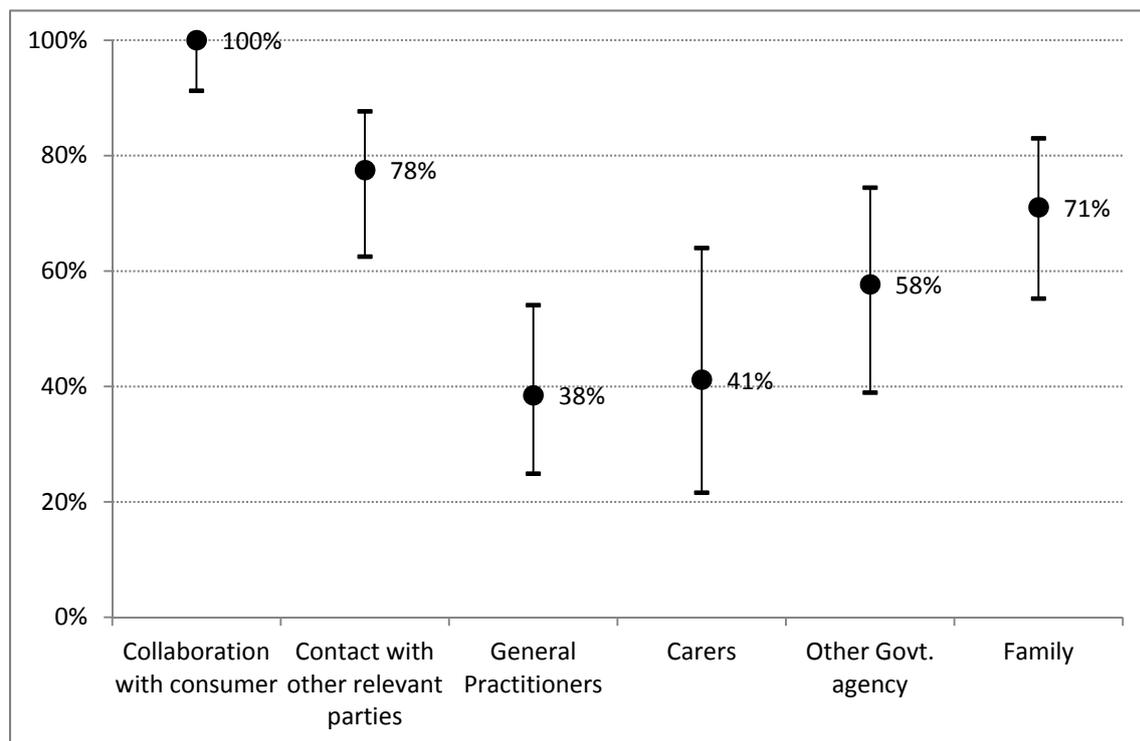
- 3.16 Records that were considered to be relevant to assessing satisfaction of the criteria for consultation, participation and collaboration covered a wide range of circumstances. They included clinical notes indicating that, for instance, at admission, people were informed of their rights. In a number of cases, the admission was involuntary. In these cases, evidence was sought that showed, for instance, the person was offered an explanation of the decision to detain them and an explanation of their rights in the circumstances, including the right to legal aid.

- 3.17 Other relevant records demonstrated consultation with the person as to which members of their family, and/or which friends and other people could, with the permission of the person in care, be informed or included in consultations while they were in care.
- 3.18 As the period of care progressed, it was usual to see records showing family information being sought from the person in care, along with details of other supports in their life. Records also showed family meetings, along with consultations with clinicians and other practitioners in which the desires and plans of the person in care were recorded and reflected. In addition to family contact, records also indicated contact and consultation with carers, General Practitioners, and other government agencies (for instance Centrelink and the National Disability Insurance Agency).

Generous analysis

- 3.19 Where records showed direct contact and consultation (e.g. a nursing note recording that the person had been advised of their rights and that legal aid was being sought at their request, or a record of their consenting to staff contacting friends or family, or an email to a general practitioner) a positive result was recorded. The results of a generous analysis are shown in Figure 3-3.
- 3.20 By way of example:
- the proportion of records showing contact with a General Practitioner was 38 percent, which is indicated by a black dot alongside the percentage;
 - the dot is bracketed by bars that show the 95 percent confidence interval for the sample of records – if 100 different samples of 40 records had been examined, 95 of them would have been likely to have shown a rate inside the bracket; and
 - the result is a rate (38 percent) and a range of likely rates (from 25 percent to 54 percent). On that basis, it is plausible that the recorded rates of contact might be as high as 54 percent, but not much higher, and certainly not very much higher.
- 3.21 Applying a generous analysis, the records indicate very high rates of contact and collaboration with the person in care (close to 100 percent). At the aggregate level, records indicated high rates of contact with all other relevant parties (General Practitioners, carers, government agencies and family) giving a rate of 78 percent. Closer examination suggests that the bulk of the recorded contact was with families, at a rate of 71 percent.

Figure 3-3 Collaboration and contact – generous analysis



Source: ACT Audit Office, analysis of random sample

3.22 At 41 percent, the rate of contact with carers was lower than for families, noting that it was calculated only where the records showed a non-familial primary carer.² The relatively small number of such carers (10 out of the total of 40 records) reduces the reliability of the estimate (the 95 percent confidence interval is quite wide) but it remains safe to conclude that recorded rates of contact are significantly lower for non-familial carers than for families.

Rate of contact with carers

3.23 A low rate of contact with carers is consistent with comments made by community service providers during the course of this audit. In general, given that they take on significant responsibilities, community organisations advised that the role of carers was not sufficiently taken into account in transition and recovery. Community organisations asserted:

- the involvement of carers in the transition process varies. Some people do not want their carers to be advised of their whereabouts. The hospitals can take this literally and not explore with the person other avenues for releasing information that can help carers; and
- transition often occurs without a carer being adequately informed beforehand. A minimum of least a day's notice should be given, along with the details of the

² Throughout this analysis, rates are calculated as a proportion of the relevant population. In this case, carers were nominated in only 10 records - the contact rate and confidence interval were calculated strictly against the population of 10, rather than the total sample of 40.

transition arrangements, the person's medications, and an explanation of the risks facing the carer.

Rate of contact with government agencies

3.24 The rate of contact with government agencies (notably Centrelink, the National Disability Insurance Agency and the Commonwealth Department of Veterans' Affairs) was 58 percent, higher than for carers or General Practitioners. This may be explained, in part, by the fact that 40 percent of the sample of people admitted to acute care were receiving a Centrelink income support payment (usually the Disability Support Pension, as well as one Newstart recipient) and were applying for and/or had been granted eligibility for the National Disability Insurance Scheme.

Rate of contact with General Practitioners

3.25 The rate of recorded contact with General Practitioners (38 percent) was lower than for families. This is surprising, as almost all available hospital discharge summaries showed the name of a General Practitioner, and some of the people in acute care may have a Medicare rebatable Mental Health Plan in place with a General Practitioner. At a minimum, the result indicates that contact with General Practitioners is not always recorded.

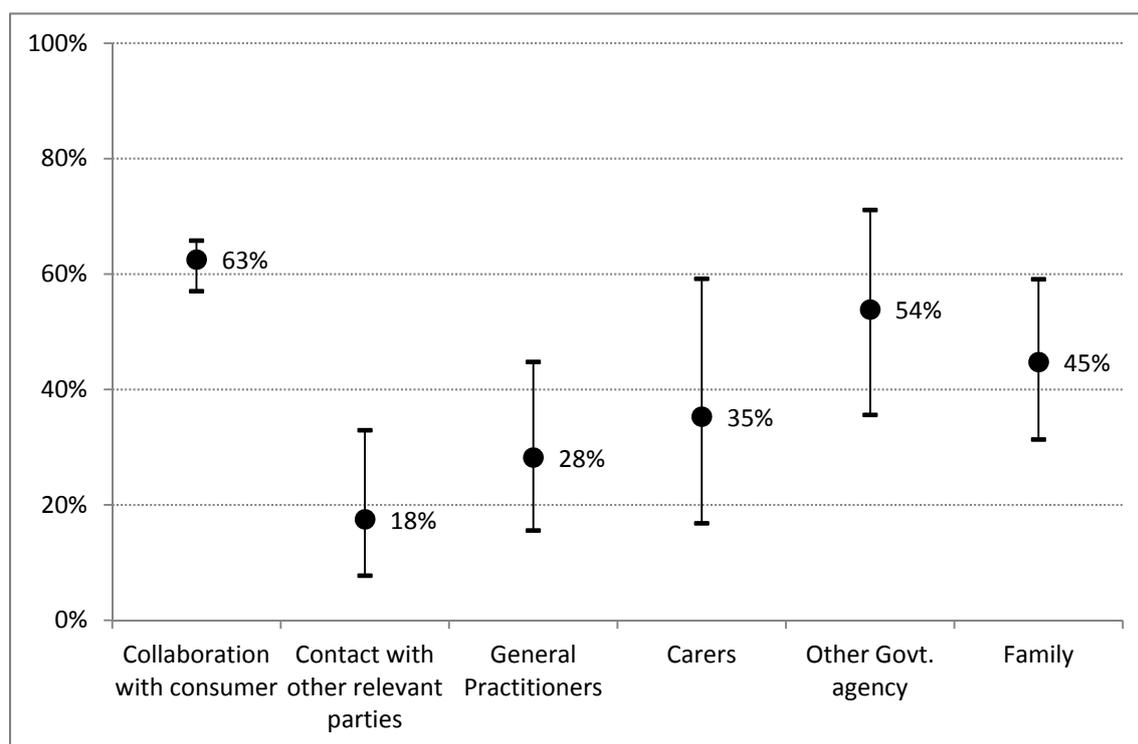
Stringent analysis

3.26 Some insight into the meanings of the reported rates can be gained by interpreting the data more stringently, when only a direct record of contact and collaboration is recorded as a "yes". Such records include but are not limited to:

- a record that the person was informed of their rights as set out in Chapter 3 of the *Mental Health Act 2015*;
- a facsimile or email record of transmission to a General Practitioner;
- an email record from CentreLink or the Commonwealth Department of Veterans' Affairs;
- an application form for assistance from the National Disability Insurance Agency; or
- the records of a family meeting or a meeting with a primary carer.

3.27 All the rates of contact and collaboration are lower under a more stringent analysis, especially the combined rate for all relevant parties as seen in Figure 3-4. This reflects a particular feature of the MHAGIC records examined - most records of contact are secondary rather than primary records made at the time of the event, i.e. they are not contemporaneous records.

Figure 3-4 Collaboration and contact – stringent analysis



Source: ACT Audit Office, analysis of random sample

- 3.28 The lack of contemporaneous records is marked when it comes to communication with General Practitioners. ACT Health Directorate staff confirmed that there is no systematic method of recording in MHAGIC the communication of hospital discharge summaries to General Practitioners or other relevant parties. Furthermore, evidence of a systematic approach to seeking, obtaining and or recording the existence of Medicare Mental Health Plans in the MHAGIC records for the benefit of recovery planning was not found.
- 3.29 The rates of contact with government agencies reduced by the least amount, reflecting practices of communicating via email, and requirements for documented applications, both of which are primary records. The rate of contact with carers reduced to 35 percent.
- 3.30 Of greatest significance in the stringent analysis is the fall in the rate of recorded contact with the person themselves (from 100 percent to 63 percent). This category includes contemporaneous records showing that people were informed of their rights under the *Mental Health Act 2015*.

Outcomes of a lack of collaboration and communication

- 3.31 There is evidence that the impact of a lack of collaboration and communication is more substantial than simply a failure to make records, as illustrated by the case study at Figure 3-5 from the review of the random sample of files. The case study shows an example where there is little evidence of working collaboratively with the person to develop a *recovery plan*.

Figure 3-5 Collaborative planning case study

Case study
This man presents with an episode exacerbated by cannabis and alcohol used and the registrar complies a very good psychiatric history. There is no record of a prior recovery or discharge plan. From that point, aside from establishing a medication regime, it is difficult to discern the treatment plan. There is no record of referral to drug and alcohol workers, and no record of recovery or discharge planning. He is discharged without a recorded clinical manager, or recorded follow up until a home visit by a nurse almost two weeks after discharge.

Source: ACT Audit Office, analysis of MHAGIC records – comment from subject matter expert

- 3.32 Records do not always show that every person’s rights were communicated and observed. Though MHAGIC is the ACT Health Directorate’s primary medical record of a person’s mental health care, it includes fewer primary and contemporaneous records of consultation, participation and collaboration than would be expected. This is important given the rights and obligations set out in Chapter 3 of the *Mental Health Act 2015*. Nor are there many records showing communications with General Practitioners. There were no standard practices for recording the transmission of hospital discharge summaries to General Practitioners.

RECOMMENDATION 2 RECORDS OF COMMUNICATION WITH RELEVANT PARTIES

The ACT Health Directorate should review and promulgate processes for recording communications with relevant parties, including carers, government agencies and General Practitioners so that all communications are documented on a patient’s record in MHAGIC.

Recovery planning

- 3.33 The prompt commencement of recovery planning is provided for in the *National Standards for Mental Health Services 2010* and in policies and procedures drafted by the ACT Health Directorate, such as the Adult Mental Health Unit *Seventy Two Hour Assessment in the AMHU Standard Operating Procedure* (April 2012). The intention is to engage the person and their supports as soon as practicable.
- 3.34 The *National Standards for Mental Health Services 2010* state:
- The process of discharge planning should commence at the time of admission, when barriers to discharge should be identified (such as anticipated difficulties in finding suitable accommodation) and specific planning initiated to address them.
- 3.35 The aim is to put in place a *recovery plan* in a collaborative fashion, so that the person and all their supports are coordinated in the best way possible to support them. This includes ensuring that, when difficulties and problems arise, there are strategies for preventing relapse and/or seeking assistance when it is needed, including access to services and re-admission to acute care if necessary.

3.36 This process was set out in more detail in the *Adult Mental Health Unit Canberra Hospital and Health Services Operational Model of Care* (April 2012) as follows:

Planning for discharge and the support required after inpatient care should commence during the initial phase of hospitalisation. Factors that may exacerbate a consumer's needs may include lack of stable housing, poverty, poor physical health, lack of employment and social networks. The need for a comprehensive assessment is crucial to maintaining the consumer's place in the community and to prevent inappropriate lengths of stay in inpatient care. It is important that community services and resources are engaged and mobilised at the earliest stage. This will involve community mental health team [Clinical Managers] at the earliest opportunity in facilitating early discharge. Integrated care pathway documentation must be agreed to enhance care delivery and communication and specific alternatives and options for further acute admission.

3.37 For those people having their first contact with the mental health system in an acute care setting, no prior *recovery plan* will exist. It is important that it is begun, so that its completion and maintenance can be part of the person's recovery journey, including when they are supported by ACT Mental Health Community Mental Health Teams. The April 2012 *Adult Mental Health Unit Recovery Planning within the Adult Mental Health Unit Standard Operating Procedure* requires:

The recovery plan is to be reviewed at all care plan review rounds (Ward Round). A discharge plan is required to be documented on the recovery plan.

3.38 For those people whose admission to acute care is the most recent episode of care in their mental health journey, an existing *recovery plan* is a useful tool. It can provide important information about the person's aspirations, circumstances and important supports, including family and carers. It can form the basis of a discharge plan for those working in acute care and, after transition, can be jointly reviewed and adjusted with the assistance of others, including Clinical Managers and other members of Community Mental Health Teams. In general, it is the Community Mental Health Teams that are likely to play the greatest role in a person's recovery after they leave acute care – the Community Mental Health Teams can be regarded as the trustees of the person's *recovery plan*.

Documents for recovery planning

3.39 Records designed to show the early commencement of recovery planning include:

- the *Treatment and Care Plan*, a paper record completed for all patients admitted to the Canberra Hospital; and
- the *Other Recovery Issues* document provided in the MHAGIC suite of recovery planning templates.

Treatment and Care Plan

3.40 A *Treatment and Care Plan* is required for all admissions to the Canberra Hospital. It is not specific to mental health services. The first section of the *Treatment and Care Plan* is headed Discharge Planning. The information to be provided under this section includes a nomination as to whether the management of care is likely to be complex and the requirement to estimate a discharge date.

3.41 The ACT Health Directorate provided the ACT Audit Office with copies of all the *Treatment and Care Plans* for those people whose records were in the audit sample and who were admitted to the Adult Mental Health Unit of the Canberra Hospital. The ACT Health Directorate was unable to provide an equivalent document for those people admitted to Calvary Ward 2N or the Older Persons' Mental Health Service. In this respect, The ACT Health Directorate advised that:

ACT Health does not hold copies of Calvary Public Hospital clinical forms.

3.42 Without exception, the Discharge Planning section of the *Treatment and Care Plan* form had not been completed. In every instance it was blank or annotated 'TBA'.

3.43 The ACT Health Directorate advised that unless there were particular medical elements of the person's care requiring attention, the *Treatment and Care Plan* was of little use to the staff or the person during their period of care in the Adult Mental Health Unit:

This is a Canberra Hospital and Health Services wide document that was developed for all inpatient areas in 2015. [While it] has great application in acute medical and surgical wards...mental health specific parameters aren't necessarily included, whereas less relevant ones take precedence (such as skin integrity); it is a hard-copy form [used alongside] an electronic record (MHAGIC) that results in [the risk of] overlaps and omissions; and [while] 'Expected Discharge Date' has strong efficacy in acute medical and surgical wards...the predictability of discharge date for acute mental illness is less clearly defined.

Other Recovery Issues Document

3.44 The *Recovery Planning within the Adult Mental Health Unit Standard Operating Procedure* requires that:

The "Other Recovery Issues" document is to be completed within 72 hours of admission to the unit. The completion of this document is to be initiated by nursing staff. This document can be accessed on MHAGIC under word documents.

3.45 In the sample of 40 records examined, only two contemporaneous *Other Recovery Issues* forms were found, both for people admitted to the Older Persons' Mental Health Service at Calvary Hospital. No forms were found in the 23 records of admissions to mental health facilities at the Canberra Hospital. It is not clear that Calvary Ward 2N has adopted the use of the form (none were found in 2N records) but neither was any equivalent early planning document to be found in the MHAGIC records from Ward 2N.

- 3.46 As detailed in Appendix A, the records examined exclude those people who were discharged less than 48 hours after admission to acute care. Discharge and recovery planning records were sought only for people with longer stays in acute care.
- 3.47 The ACT Health Directorate advised in June 2017 that ‘Short stays make the fidelity criteria for recovery planning very difficult to meet in all circumstances’.
- 3.48 In only 5 percent of cases were records found that showed that planning commenced during the initial phase of hospitalisation for discharge and the support required after inpatient care.

Records of recovery planning

- 3.49 Records that were directly relevant to recovery planning included *recovery plans* made using the MHAGIC template, and other MHAGIC forms (such as the *Keep Well, Prevent Relapse, Respond Early* MHAGIC template). MHAGIC forms were found to be used at the Canberra Hospital and the Older Persons’ Mental Health Service at Calvary Hospital.
- 3.50 *Recovery plans* from Calvary Public Hospital’s Ward 2N acute facility, although in a different format, included goal plans completed by the person, complemented by post discharge arrangements for care and support usually set out in correspondence between 2N clinicians and the person for whom they had been caring.
- 3.51 A broad range of documents were considered to offer secondary, supporting evidence of recovery planning. These included records such as psycho-social needs assessments, the *Other Recovery Issues* document available through MHAGIC, elements of the records of Multi-disciplinary Team Meetings, and elements of clinician’s notes recorded in MHAGIC. Hospital discharge summaries were consulted, and evidence looked for in communications recorded with other service providers and carers. The records reviewed included any recovery plans made before admission or during the 28 days after discharge from acute care.
- 3.52 The case study below indicates how the full range of records was considered in reviewing recovery planning for a person.

Figure 3-6 Recovery planning recorded in a range of records

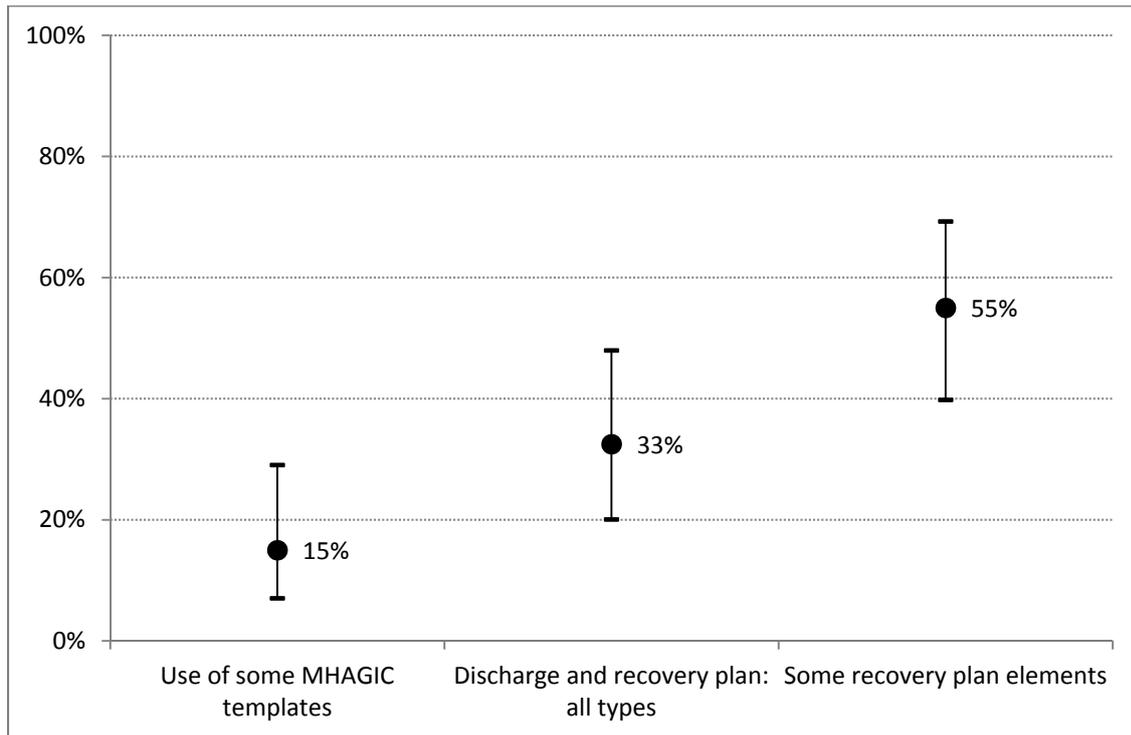
Case study
<p>This record shows excellent compassionate care of a young woman who is very unwell, physically and mentally. The records show excellent coordination of her treatment and active problem solving to manage her care. The file shows treating clinicians sharing notes in a concise and structured way, with little repetition, to build up a coherent clinical picture and intervention strategy. This was achieved almost in spite of the constraints imposed by different forms, different disciplines and different perspectives and shows how information shared occurred while remaining mindful of this young woman’s concerns and privacy. This patient is an example of continuity care across a range of disciplines.</p>

Source: ACT Audit Office, analysis of MHAGIC records – comment from subject matter expert

Generous analysis

3.53 The full range of records was examined in the assessment of all the files in the random sample: in effect, any evidence of recovery planning was noted and considered in the analysis, whether or not it was set out in a template or pro-forma. It was on this basis that the assessment of all records was conducted, the results of which are shown below. In this case, a generous analysis considers any evidence of recovery planning as a positive result.

Figure 3-7 Recovery plans – generous analysis



Source: ACT Audit Office, analysis of MHAGIC records

3.54 The data showed records of discharge and recovery planning in 55 percent of cases at best. This rate was arrived at by acknowledging any elements of planning, be they just a few dot-points in the person’s hospital discharge summary. Better developed plans were found in a third of cases (33 percent) including those recorded in one or more recovery planning documents. The rate of use of MHAGIC documents was very low at 15 percent. Actual recorded plans were uncommon, as illustrated by the following case studies.

Figure 3-8 Two case studies showing little recorded recovery planning

Case study - 1
The records do not show a systematic approach to discharge and recovery planning. The Personal Recovery Plan created for this patient some 18 months earlier is not referred to or review during this episode of care. Given her recorded strengths and her connection to family, a review of her plan could have started in hospital and been followed up after discharge. The high likelihood of her receiving NDIA assistance could have been integrated into planning.

Case study - 2

There is no recovery plan for post discharge. A Tidal Model form was filled out but there was no record of subsequent development. Given treatment in hospital and the patient's history, it was potentially a very powerful tool for her.

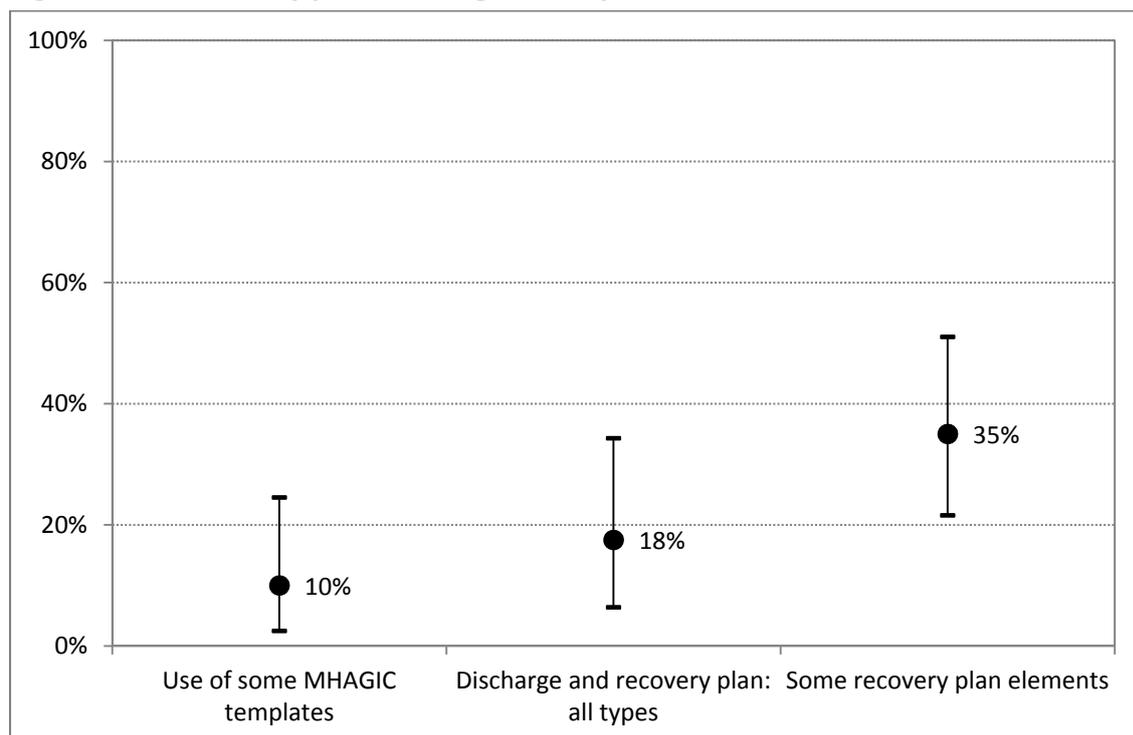
Source: ACT Audit Office, analysis of MHAGIC records – comment from subject matter expert

Stringent analysis

3.55 The stringent analysis (when only recorded *recovery plans* give a positive result) shows even lower rates of recorded recovery planning. The total rate of recovery planning was approximately 18 percent and the use of the MHAGIC *Personal Recovery Plan* was as low as 10 percent. In particular:

- there were no records that showed any person's MHAGIC record was reviewed to discover any previous *recovery plan*, or related documents; and
- while six records were found of *recovery plans* put in place prior to admission to acute care, there is no record of those plans being referred to or reviewed during the period of acute care or in the 28 days after discharge.

Figure 3-9 Recovery plans – stringent analysis



Source: ACT Audit Office, analysis of MHAGIC records

Community organisation feedback

3.56 The low rates of recorded recovery planning is consistent with the comments of community organisations involved in the care of people following periods of acute care. Community organisations advised:

- they saw little evidence of *recovery plans* being in place for transition from acute care. Getting a hospital discharge summary can be a challenge, and there is a lack of information/data sharing from acute care units to General Practitioners and community service organisations;
- there was high variability in the quality of documentation provided by acute care and health professionals to community service organisations, with *recovery plans* the exception rather than the rule, though occasionally a hospital discharge summary may be provided;
- they had less concerns with the transition processes from Calvary Hospital's Ward 2N as opposed to the Canberra Hospital's Adult Mental Health Unit, while acknowledging that the people at 2N have less acute conditions and so are less challenging; and
- they saw variable management in the transition process from acute care, depending on the individual staff members of the Community Mental Health Teams.

3.57 Community organisations advised that they had little concern with the ACT Health Directorate's policies, noting that in general, the ACT Health Directorate has good policies in place for the effective transfer of people from acute to community care and that, at times good work was done including involving community organisations. However, community organisations advised of their concerns with respect to shortcomings in the implementation of policies.

Accountability for recording of *recovery plans*

3.58 It is common practice for recovery planning (including estimated date of discharge) to take place in direct conversation, including with acute care staff and clinicians. Video conferencing is also used. Documentation of the results of these planning sessions is less frequent. As recently as February 2017 key issues with the documentation of recovery planning processes have been raised by the ACT Health Directorate with the managers of the Community Mental Health Teams and instructions issued noting the requirement to record the following in MHAGIC:

- attendance and outcomes of Transition Clinicians and/or Clinical Managers at ward reviews and discharge meetings;
- results of ward reviews and clinical decision making in relation to care and treatment;
- weekly visits to the inpatient unit by the Clinical Manager;
- results of 7 day post hospital discharge reviews; and
- arrangements for 14 days post discharge appointment.

- 3.59 In the absence of clearly assigned responsibility for creating and maintaining the *recovery plans* however, accountability is unclear. If the practices to be corrected are of long standing, it would explain the very low rates of satisfaction of the criteria tested, since it indicates that it has not been the practice to record on MHAGIC (or elsewhere) a range of matters, including discharge and *recovery plans*, clinical decisions and recovery planning outcomes.
- 3.60 *Recovery plans* were found in only one third of the records examined. There is evidence that mental health staff have not regularly and systematically recorded discharge and recovery planning in MHAGIC. Records have similarly not been made of clinical meetings that involve the sharing of information and clinical decision making about a person's care and treatment.
- 3.61 This failure of practice means that the MHAGIC records of recovery planning are incomplete. Reliable and complete records of recovery planning are not available to be given to the person, their family or to other carers. Neither are they available to other staff or other support organisations to help in their care of the person, including after discharge from acute care. The responsibility for creating, reviewing and maintaining a person's discharge and *recovery plan* is not clearly assigned.

RECOMMENDATION 3 RECOVERY PLANNING

The ACT Health Directorate should clearly assign responsibility for creating, reviewing and maintaining a person's recovery plan.

Treatment, discharge and follow-up

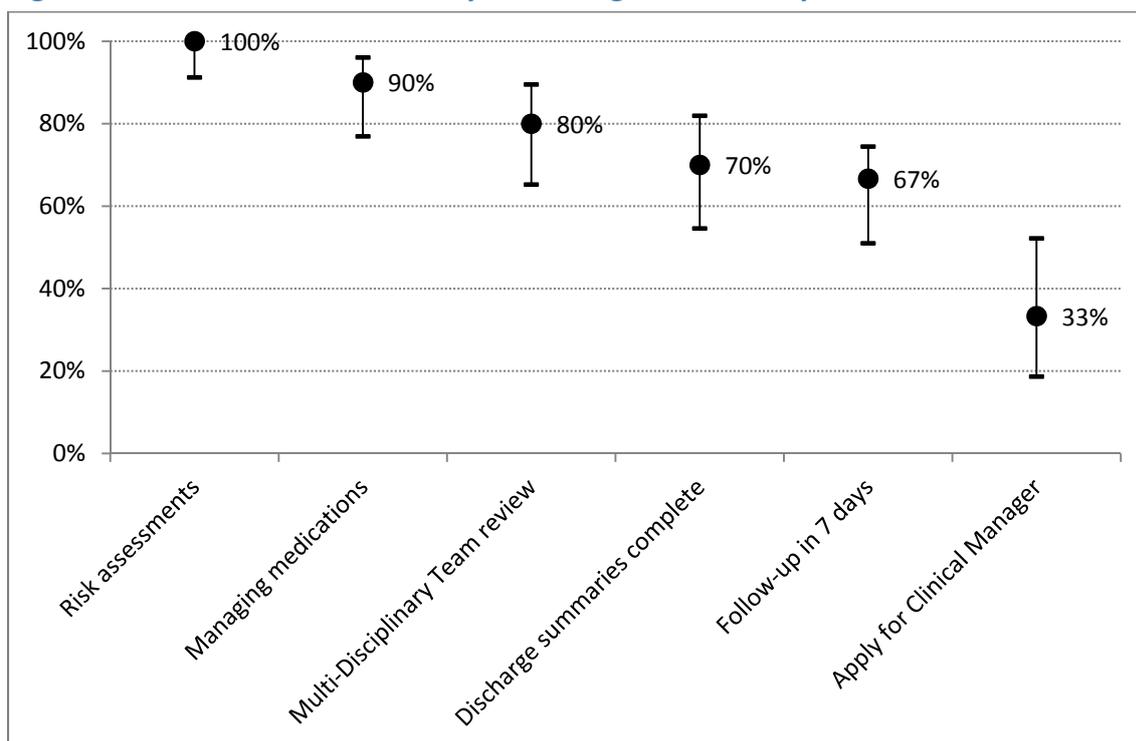
- 3.62 Records were examined for evidence of continuous care, during the period of acute care, through to discharge and follow-up in the community. The elements of care examined included evidence of:
- the conduct of risk assessments;
 - the management of medications;
 - the convening of multi-disciplinary teams;
 - the completion of discharge summaries;
 - follow-up in 7 days; and
 - referrals to Community Mental Health Teams for the allocation of a Clinical Manager, where one was not already in place.

Elements of continuity of care

- 3.63 While a person is in acute care, staff should regularly assess their mental state, the degree of risk they pose to themselves and others, and their general wellbeing. As discharge

approaches, the aim is that the care team has coordinated and put in place a care plan, including plans for any medications.

- 3.64 At discharge, the treating doctor should compile a summary of the treatment and care undertaken during the time in acute care. The discharge summary should identify what was done to treat the person while in care, and the immediate steps taken at discharge to establish post-discharge care. It includes important information for other clinicians who will be involved in the person's care after discharge, including General Practitioners, members of the community mental health teams, and other service providers.
- 3.65 The time immediately after discharge is often very challenging for a person leaving acute care. To help in that period, the ACT Health Directorate's *Transitional Clinician Standard Operating Procedure* specifies arrange prompt follow-up within 7 days and a consultation with a clinician for psychiatric review, ideally within 14 days. This is consistent with the *National Standards for Mental Health Services 2010*:
- 10.6.8 The [Mental Health Service], in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers 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.
- 3.66 People's MHAGIC records showed that, during their stay in hospital, there were regular checks on their risks, including of harm to themselves and to others. These were recorded in daily nursing notes and observations, along with the results of instruments to measure well-being and capacity. The risk assessment instruments administered to people included the *Suicide Vulnerability Assessment Tool*.
- 3.67 The standard instrument used to measure well-being was the *Health of the Nation Outcome Scale* (HONOS). Other *National Outcomes Casemix Collection* instruments found in the records included the *Life Skills Profile* (LSP-16), the *Behaviour and Symptom Identification Scale* (BASIS-32™) and the *Resource Utilisation Groups - Activities of Daily Living* (RUG-ADL). In no case were there contemporaneous notes in MHAGIC recording the analysis of the results of these instruments or incorporating the results and analysis into plans for treatment or discharge.
- 3.68 The MHAGIC records showed that a good deal of attention was paid to managing medication, and to multi-disciplinary team meetings to coordinate care. The rate of completion of discharge summaries was as high as 70 percent and follow-up within seven days of discharge was indicated in two thirds of the records reviewed. The generous analysis is shown below - the more stringent analysis is not shown, as it is very similar.

Figure 3-10 Elements of continuity of care – generous analysis

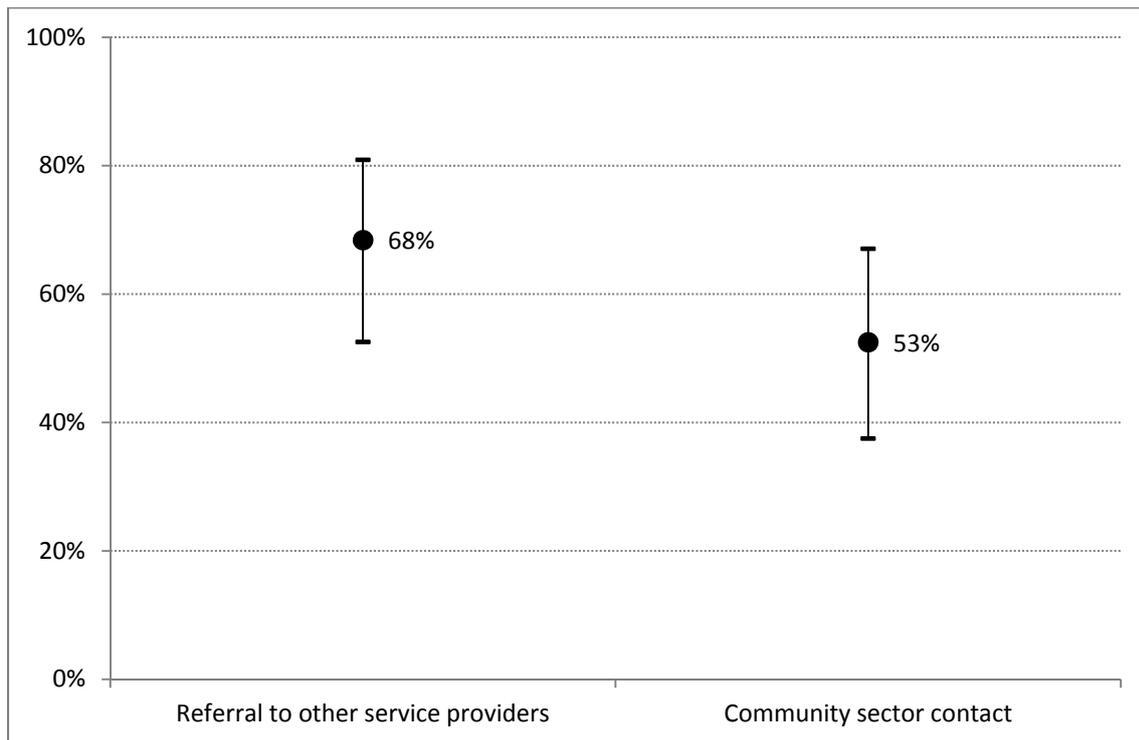
Source: ACT Audit Office, analysis of MHAGIC records

- 3.69 The records showed that a third of those discharged were referred for Clinical Management by a Community Mental Health Team. A Clinical Manager participates in ward rounds and conferences with acute care staff, and is usually responsible for follow-up once a person is discharged. One third of the people in the sample already had a Clinical Manager when they entered acute care. The rate of referral is calculated only for the other two thirds who did not already have a Clinical Manager.
- 3.70 The ACT Health Directorate sets a schedule for following people up after discharge, and the records showed that two thirds were followed-up within a week; this is a high level of achievement.

Referral and community sector contact

- 3.71 The records showed limited use by acute care facilities of the available referral form by which a person transitioning from acute care can be referred to a Clinical Manager in the Community Mental Health Team
- 3.72 Figure 3-11 shows the recorded rates of referral and contact with community sector organisations for the records in the random sample. Referrals were typically made to other government agencies and to mental health services in other states or territories' alcohol and drug services.

Figure 3-11 Referral and community sector contact – generous analysis



Source: ACT Audit Office, analysis of MHAGIC records

- 3.73 The records for 45 percent of people in the sample showed alcohol and drugs as a significant feature of their presentation at admission or subsequent treatment. However, the rate of referral to drug and alcohol services is low, with only a third of those people receiving drug and alcohol services during their treatment and/or being referred for follow-up after discharge. The ACT Health Directorate advised that this was due, in part, to referral to alcohol and drug services being voluntary - if the person did not wish to engage, a referral was unlikely, and the event may not be recorded in the person’s records.

- 3.74 Apparent low rates of referral to alcohol and drug services, according to advice from the ACT Health Directorate, are due, in part, to staff not always recording instances in which people in acute care decline referral to alcohol and drug services. In addition, the ACT Health Directorate advised that the low rates of referral to the alcohol and drug facilities at the Canberra Hospital during acute care are due, in part, to the facilities being unsafe for people at high risk of harming themselves. This means that acute care mental health beds are frequently occupied by people recovering from intoxication for a period of some days before effective mental health care can begin.

- 3.75 Nevertheless, the ACT Health Directorate has advised that people can still be referred to alcohol and drug services through clinicians’ in-reach into the mental health in-patient facility. Furthermore patients would only be transferred directly to an alcohol and drug service withdrawal facility from an in-patient mental health unit where their mental health episode has stabilised and an acute detoxification was still required.

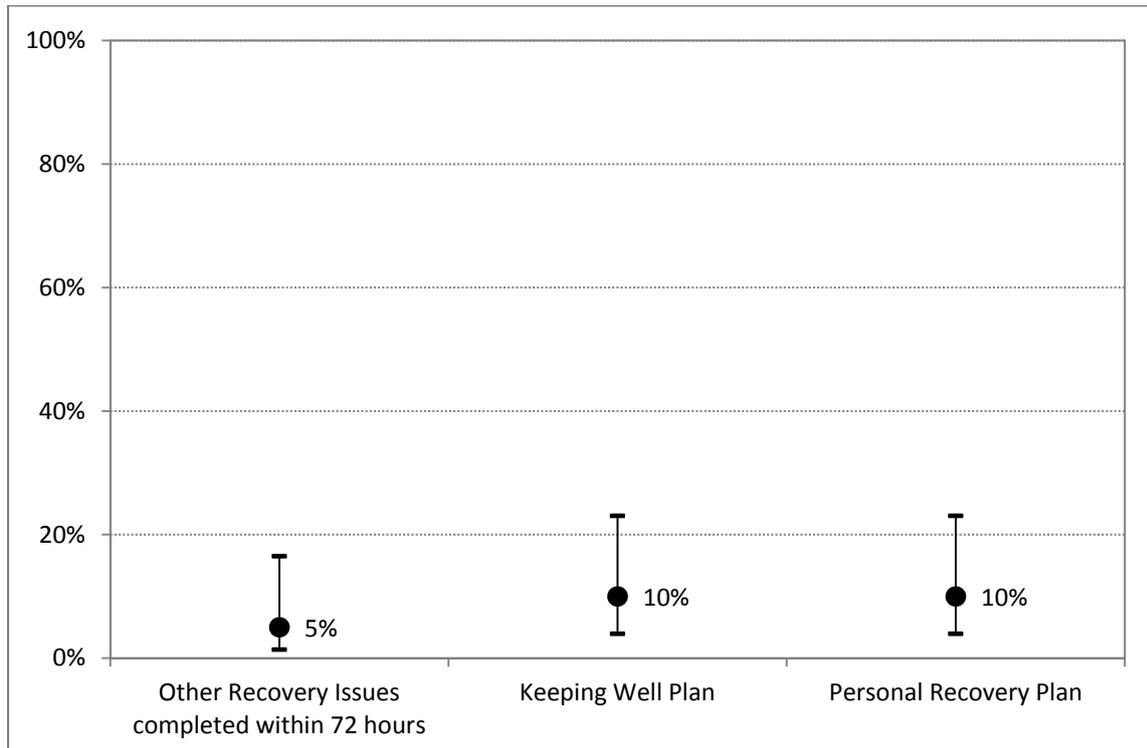
Community organisation feedback

- 3.76 Contact with and referral to appropriate community organisations can be of great assistance, including for people with diverse cultural backgrounds and people from Aboriginal and Torres Strait Islander (ATSI) communities. In this regard, the Winnunga Nimmityjah Aboriginal Health Service advised that improved communications with Mental Health services would be of benefit since:
- presently there was no formal arrangement with the Winnunga Nimmityjah Aboriginal Health Service for exchanging information on people in care or for referring people from ACT Mental Health services;
 - there was little contact with the Community Mental Health Teams and the level of engagement with acute care facilities is less than needed;
 - Aboriginal Mental Health Liaison officers were not always available; and
 - while the documentation provided on discharge is considered adequate, Winnunga Nimmityjah Aboriginal Health Service receives little notice of imminent discharge and advised that frequently the person presented to the service without prior warning and communication.
- 3.77 The ACT Health Directorate advised in June 2017 that the Aboriginal and Torres Strait Islander Mental Health Service is co-located with Winnunga Nimmityjah Aboriginal Health Service and includes a senior clinical nurse consultant with access to MHAGIC and a psychiatric registrar placement.
- 3.78 A number of community organisations interviewed identified that there are benefits to be gained from a common, systematic approach to referring people to appropriate community organisations on discharge from acute care.

Record-keeping and the use of MHAGIC

- 3.79 The review of the random sample of files identified that acute care staff did not make use of the full set of modules and documents available to record their observations and clinical notes. The low use of the facilities of MHAGIC is most relevantly illustrated in Figure 3-12, which shows the rate of recorded use of three relevant templates in the recovery planning document suite. No examples were found of the other four relevant documents in the suite.

Figure 3-12 Rates of use of three key MHAGIC recovery planning documents – stringent analysis



Source: ACT Audit Office, analysis of MHAGIC records

3.80 In general, rather than use the available modules and document suites, staff made their MHAGIC records as a string of nursing and clinical notes, interspersed with correspondence to Courts, the ACT Civil and Administrative Tribunal (ACAT) and other agencies, with infrequent summaries or evidence of validation. The records were characterised by:

- repetitive nursing and clinical notes incorporating whole sections clearly copied from previous notes (complete with errors of fact, structure and grammar), augmented with observations that were sometimes at odds with other contemporaneous records;
- nursing notes (and at least one clinical note) that reported events on the ward that could not be reconciled with other records indicating that the person was on leave from the ward; and
- a lack of regular recorded reviews and validation of the records and notes to ensure that they accurately reflected the most up-to-date diagnostic information, along with an updated history and currently identified risk factors.

3.81 The MHAGIC notes examined were repetitive and poorly structured and did not clearly provide information on the course of treatment, recovery and discharge planning for the person. This does not aid efficient or effective administration or recovery-oriented service delivery. Clinicians did not make use of the full set of modules and documents available to record their observations and clinical notes in MHAGIC.

Use of cut-and-paste

3.82 The prevalence of cut-and-paste medical records is a well-known problem. The practice is intended to improve efficiency but brings attendant risks, as noted by the Office Of Inspector General of the United States Department of Health and Human Services in December 2013:

Copy-paste is most useful with facilitating data entry of physicians' progress notes; however, few hospitals had fully implemented that function. Only 4 percent of hospitals reported they had fully implemented electronic progress notes. Most hospitals (73 percent) reported having a combination of electronic and handwritten or dictated physician progress notes. Although this feature may enhance efficiency, it is vulnerable to fraudulent use.

3.83 Safeguards are required to achieve efficiency and manage the risks. These might include:

- making copy and paste material easily identifiable;
- ensuring that the provenance of copy and paste material is readily identifiable;
- ensuring that adequate staff training and education is provided on the appropriate and safe use of copy and paste; and
- ensuring that copy and paste practices are regularly monitored, measured, and assessed.

3.84 The prevalence of cut-and-paste practices for MHAGIC notes results in records containing inaccurate, irrelevant or outdated information. They simultaneously reduce accountability while increasing the risk that individuals could be held responsible for records made by others.

Lack of information on treatment personnel

3.85 In MHAGIC, the risks of poor record-keeping are amplified when notes do not clearly identify all personnel involved in treatment, care and decision-making. While MHAGIC clearly records the name of the person who entered the record (along with their designated position) it was frequently the case that the notes would record those involved only with a first name. Notes did not always identify all the people involved, their positions or their roles. It was therefore difficult to determine which personnel were authorised or responsible for undertaking the actions ascribed, including for recovery and discharge planning.

Separate nursing and clinical notes

3.86 MHAGIC often included separate sets of nursing and clinical notes without cross-reference or periodic alignment to ensure that all parties had a common understanding of treatment, care and risks.

3.87 Table 3-1 shows a case study of a person admitted to acute care who had a history of sexual misconduct and/or assault and posed a potential threat to practitioners and other people in care. The case study shows successive nursing notes assigning low levels of risk, which do

not appear to be informed by historical information in the clinical notes identifying significant risks of sexual misconduct and/or assault.

Table 3-1 Case study – risks posed when nursing and clinical notes are not aligned

	Risk in Nurse notes	Risk in Clinical notes
Day 1	Misadventure	
Day 2	Low medium risk harm to others, low harm to self, low risk of absconding	Psychiatric review assesses low medium risk harm to others, low harm to self, low risk of absconding
Day 4	Low medium risk harm to others, low harm to self, low risk of absconding	Family conference reports person likely sexually abused as child
Day 5	Low medium risk harm to others, low harm to self, low risk of absconding	
Day 6	Low medium risk harm to others, low harm to self, low risk of absconding	
Day 7	<ul style="list-style-type: none"> • Low medium risk harm to others, low harm to self, low risk of absconding • Visited by partner – no observations recorded of this visit 	
Day 8	Low medium risk harm to others, low harm to self, low risk of absconding	<ul style="list-style-type: none"> • Clinical report cites a nurse report of wife feeling scared of patient on Day 7 visit • Psych history shows previous sexual assault of female • Psych history shows previous female patient complaint of inappropriate sexual behaviour when person in earlier episode of acute care • Report notes both mother and wife scared of him
Day 9	Deterioration	
Day 10	Deterioration	Low risk of absconding, low risk of non-compliance with treatment
Day 11	Deterioration	Leave with wife and mother doesn't go well. Both scared.
Day 12	Risk of harm to others, low risk of harm to self	
Day 13	Deterioration, risk to reputation	
Day 14	Discharged	Low risk of harm to self Low risk of harm to others Low risk of non-compliance with treatment Discharged

Source: ACT Audit Office, analysis of MHAGIC records.

- 3.88 This case study demonstrates the difficulties and problems of team coordination across service system to inform decision making in a collaborative and informative way. The two streams of notes exist in parallel on the file, with limited evidence of cross referencing between the two. There was no recorded consideration of the person's previous behaviour and whether it was likely to recur, or records of instructions to staff to be aware of behaviours that might indicate earlier behaviours might recur.

RECOMMENDATION 4**ELECTRONIC CLINICAL RECORDS**

The ACT Health Directorate should review policy and procedural guidance for the use of MHAGIC so that guidance:

- a) identifies MHAGIC as the single electronic record for each patient provided with mental health services in the ACT; and
- b) clearly outlines the mandatory requirements for using MHAGIC to record patient nursing and clinical notes.

4 MENTAL HEALTH SERVICES INFORMATION MANAGEMENT

- 4.1 This chapter discusses information management practices that the ACT Health Directorate uses to support the provision of mental health care. It focuses on the Mental Health Assessment Generation and Information Collection system (MHAGIC), which is the primary information system used to support mental health care. It also examines the performance information produced from MHAGIC and other sources to support the management of mental health care services.

Summary

Conclusion

A substantial number of performance reports are produced to monitor and improve operational performance. However, the current suite of reports is complex and needs to be reviewed to identify and eliminate duplication and ensure coverage of key performance indicators. In addition, a number of reports require substantial manual processing. To improve controls in relation to the preparation of these reports, the report preparation process should be documented.

MHAGIC is designed to capture a wide range of information covering a person's involvement with the mental health system. This important information on patient outcomes could be used better to monitor patients' progress and outcomes.

The Health Directorate requires that the Suicide Vulnerability Assessment Tool (SVAT) be completed every three months for each patient. Compliance with this requirement is significantly below the target rate. A review of processes to identify why this occurs and to improve the completion rate is needed.

An upgrade of MHAGIC is planned. It will not deliver its intended outcomes unless there is a significant, positive change in the way staff at all levels use the system and the information that it produces.

Key findings

The ACT Health Directorate is yet to put in place detailed policy or procedural guidance with respect to making mental health records and recording and maintaining them in MHAGIC. The review of clinical files shows a diverse and inconsistent range of practices for documentation and record-keeping and the use of MHAGIC.

Paragraph

4.8

Where reports require manual input there is a potential conflict of interest whereby a manager is amending performance data that directly relates to their area of responsibility. There are no controls in place, whether written procedures, a division of duties, or a process for independent checking to address this potential conflict. 4.33

Current ACT Health Directorate policy requires the Suicide Vulnerability Assessment Tool (SVAT) to be completed for every person at least every three months. Records of completion are significantly below this and it may be interpreted that the current level of performance is below the level of achievement the ACT Health Directorate management expects. Notwithstanding an expected performance level of 100 percent, as at December 2016 completion of the SVAT was reported as 62 percent. Suicide (along with potential to harm others) is self-evidently the most significant risk, in terms of consequences, to be addressed in the transition from acute care to other forms of support. Non-compliance with the procedure for assessing suicide vulnerability is inconsistent with the risk to life that suicide vulnerability represents. 4.53

Through daily operational reporting it is possible to identify mental health service patients who need to have tasks completed for them. This level of reporting also usefully flags whether key support people of some kind have been identified and by extension people who need to be identified. Outcomes reporting compliance is aligned with the Mental Health National Outcomes and Casemix Collection (NOCC) down to operational level, and can be assessed by facility and also by staff member. These reports together provide a useful tool for identifying present levels of performance and compliance. 4.66

Overall, there is a great deal of useful information in the current suite of performance reports that is available to improve operational performance. However, the current performance information suite is complex, having grown over time without the benefit of systematic review: for instance, the same measures appear in different reports and in different formats. Potential improvements could include: 4.71

- including new reporting items in line with the new *Mental Health Act 2015* and to strengthen focus on collaborative planning;
- expanding reporting to better track outcomes measure compliance; and
- active use of the information to improve performance, including through evaluation.

In relation to outcomes measures and compliance, there is merit in more use being made of the Health of the Nation Outcome Scale (HoNOS), and an increased level of attention to person self-assessment. This is merited for the purposes of reporting at the national level, and in view of the *Mental Health Act 2015's* focus on collaborative planning. In particular the HoNOS can readily provide longitudinal data that could be used to examine and evaluate the outcomes of cohorts of people engaged with mental health services. 4.72

There is also a case to develop measures of the use of the provisions of the *Mental Health Act 2015* for advance agreements, advance consent directions and nominated persons. Such measures would give strong indications of the level of support provided to people under the Act. Related measures that demonstrated the involvement of carers, General Practitioners, clinical managers and community organisations would form a sound basis from which to gauge the strength of collaborative planning and transition planning. 4.73

Mental Health Assessment Generation and Information Collection system

- 4.2 The Mental Health Assessment Generation Information Collection (MHAGIC) was originally developed in 1996 and most recently updated in 2010. MHAGIC supports clinical data capture from triage/referral, registration and ongoing care documentation through to discharge from mental health services.
- 4.3 MHAGIC is widely used across a range of ACT Mental Health, Justice Health and Alcohol and Drug Services for the purpose of data capture and record keeping including:
- Child and Adolescent Mental Health Services (Southside and Northside Community Mental Health);
 - Adult Acute Mental Health Services (AMHU and MHSSU at the Canberra Hospital);
 - Adult Community Mental Health Services (at Belconnen, Woden, City, Gungahlin and Tuggeranong Community Mental Health services);
 - Rehabilitation and Specialty Mental Health Services (at Brian Hennessy Rehabilitation Centre, and Older Persons Mental Health Community Team); and
 - Justice Health Services - forensic mental health services.
- 4.4 The ACT Health Directorate advised that, with the planned upgrade of MHAGIC, it will become available to Alcohol and Drug Services and to Justice Health Services - primary health services. MHAGIC is also used at Calvary Public Hospital in the Calvary Mental Health inpatient Ward 2N and Calvary Older Persons Inpatient Service.

Information management policy and procedural guidance

- 4.5 The ACT Health Directorate's overarching *Clinical Records Management Policy* requires that complete and accurate clinical records be kept for all consumers. The policy also demonstrates ACT Health Directorate's intention to establish a single, integrated, on-line clinical record for all consumers. For people receiving mental health care this record is maintained in MHAGIC. The Policy emphasises the important role that effective information management plays in the provision of care and collaborative planning for people receiving mental health care.

- 4.6 The ACT Health Directorate's policy and procedural guidance relating to mental health services were examined for guidance on record-keeping. Some policies included references to MHAGIC; for example the *Recovery Planning within the Adult Mental Health Unit Standard Operating Procedure* states:

The "other recovery issues" document is to be completed within 72 hours of admission to the unit. The completion of this document is to be initiated by nursing staff. This document can be accessed on MHAGIC under word documents.

- 4.7 While broad principles-based guidance was available from Mental Health ACT's *Guiding Principles for Documentation*, at the time of this audit no guidance was available to mental health staff on the status of MHAGIC records, or how they relate to other electronic records (including those in CRIS and ACTPAS) and other paper records, such as the *Treatment and Care Plan* created at admission to the Canberra Hospital. During the course of the audit the ACT Health Directorate advised that MHAGIC records were likely to be health records under the terms of the *Health Records (Privacy and access) Act 1997*. In June 2017, the ACT Health Directorate advised that:

ACT Health can confirm that MHAGIC records are health records, and, as such ACT Health has a statutory obligation under the Health Records (Access and Privacy) Act to maintain the records. The guidance for staff is included in ACT Health Clinical documentation policy and the MHAGIC user manual.

- 4.8 The ACT Health Directorate is yet to put in place detailed policy or procedural guidance with respect to making mental health records and recording and maintaining them in MHAGIC. The review of clinical files shows a diverse and inconsistent range of practices for documentation and record-keeping and the use of MHAGIC.

Current use of MHAGIC

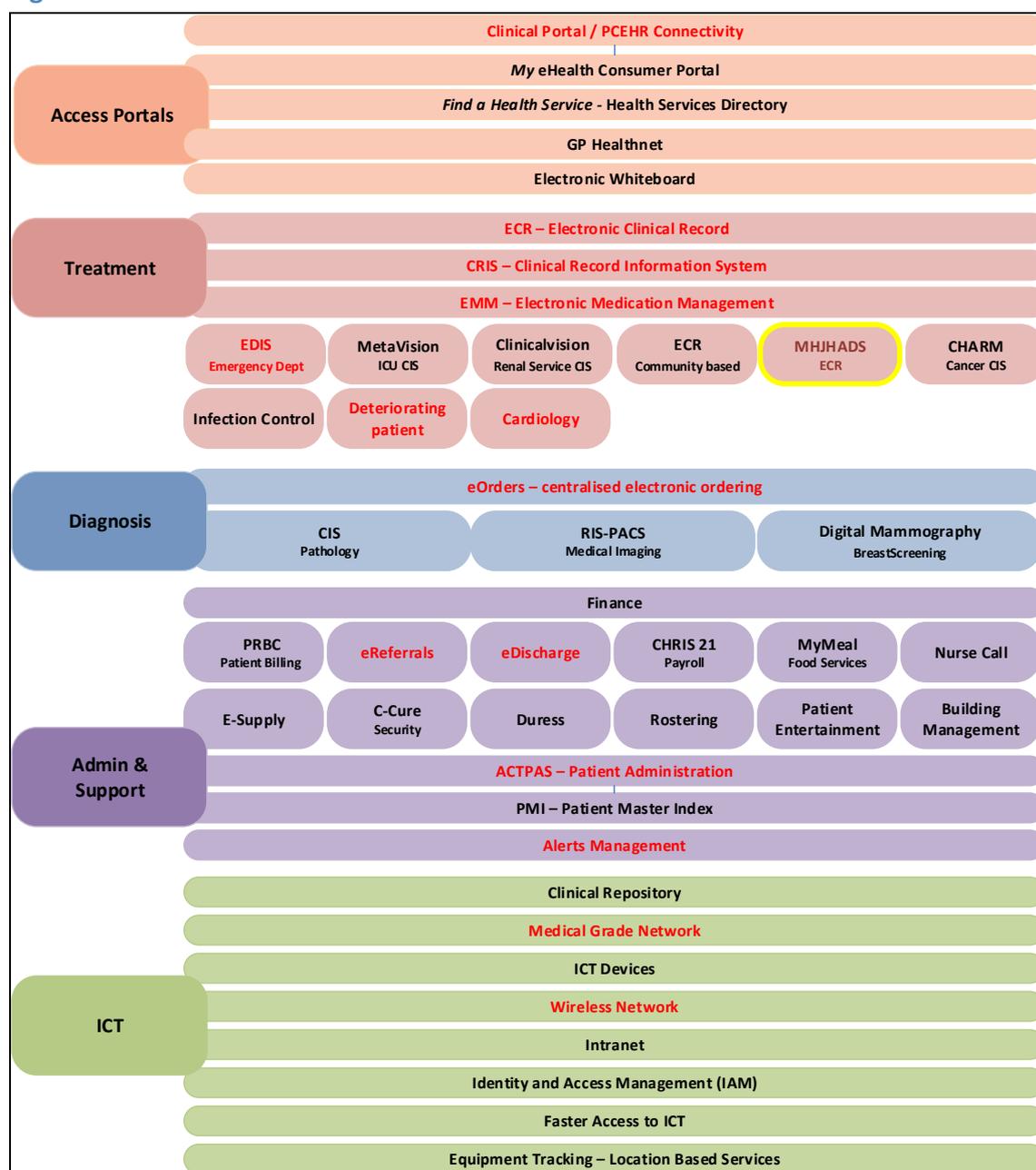
- 4.9 There are approximately 600 current users of MHAGIC who can be grouped into the following job roles:
- Operational Director;
 - Team Leader;
 - Senior Clinician;
 - Clinician;
 - Clinical Nurse;
 - Allied Health (psychologist, occupational therapist and social worker);
 - Psychiatrist;
 - Duty Officer;
 - Administrative Officer; and
 - Allied Health Assistant.

- 4.10 The random sample analysis confirmed that many clinicians do not use the available functionality of the MHAGIC electronic clinical record system appropriately. Rather than enter data in designated fields, records are usually entered as file notes in free text format. This achieves a basic level of compliance, but impairs the usefulness and usability of MHAGIC as there is an impact on the completion of structured data available in the standard MHAGIC modules and accessibility to information within a record. The completion rates for *recovery plans* are low, and effectively recording other information that is valuable to supporting the persons' journey across a range of services is often given a lower priority, including recording collaboration with the community services sector.
- 4.11 As hard copy file notes are completed in preference to the available modules or forms, compiling and analysing client information becomes a manually intensive process of identifying the relevant file note and reading the text to identify what actions were taken/planned. Key data that could have been recorded in modules (including *recovery plans*) can be buried in detailed text, and important information (such as advising people of their rights) may not be recorded at all. The content of the file notes is often inadequate to comply with all policy guidelines. In June 2017, the ACT Health Directorate advised that:
- In reality there are significant practical functionality issues with MHAGIC leading to...a basic level of compliance. This was identified in 2014 and was one of the drivers for the MHAGIC upgrade project.

E-Health Strategy

- 4.12 Announced in the 2009-10 financial year, E-Health is a program to develop (among other things) the electronic management and transmission of health records to the ACT Health Directorate services and facilities. A key objective of the E-Health strategy is to fully integrate MHAGIC with a number of other key health systems used within the ACT Health Directorate's Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division. The revised and integrated system will be known as the MHJHADS Electronic Clinical Record (ECR). Figure 4-1 shows how the revised and integrated system is expected to fit into the overall e-Health strategy.

Figure 4-1 E-Health architecture overview



Source: Health Directorate

4.13 Other key ACT Health Directorate systems in place include:

- The Clinical Portal, which provides a single point of access to clinical information. The Portal:
 - presents a summary of key person data with links to related information such as pathology and radiology results, inpatient, outpatient and emergency department encounter history for persons attending services at both The Canberra Hospital and Calvary.
 - provides for all orders for imaging and pathology requests.
 - supports referrals between divisions and from external providers.

- supports inpatient discharge and generation of Discharge Summary documentation.
 - provides an Electronic Whiteboard: Inpatient ward details including demographics and other features which provide clinicians with an immediate ‘at a glance’ view of the person’s status.
 - supports Medication Integration: Inpatient medication administration details.
 - provides a fully integrated electronic alerts management solution which enables clinicians to view, add, review and close person alerts.
- ACTPAS: Person demographic information, referral, admission and appointment scheduling will be managed through the central patient administration system ACTPAS.
 - Electronic Medication Management (EMM) system, person prescription and medication management.
 - CRIS: Clinical Records Information System (CRIS), used for electronic document storage and retrieval. Allows simultaneous access to a person’s medical record on computer.
 - ACT Health Directorate Data Warehouse(reporting): provides a framework for sharing of information between systems, and will support the development of a clinical information repository.
 - My e-Health Consumer Portal: People will be able to view their ACT Health Directorate clinical records via a portal.

Future directions for MHAGIC

Revised and updated MAJICER

4.14 The revised and updated MHAGIC (referred to as the MHJHADS Electronic Clinical Record (ECR)) has since been referred to as the Mental Health, Alcohol and Drug Services, Justice Health, Integrated Care Electronic Record (MAJICER) in recent planning documents. The intended purpose of MAJICER is to maintain a comprehensive person centred record which supports all the activities of the multi-disciplinary service (i.e. single electronic clinical record). Further development of MHAGIC into MAJICER is expected to enable:

- a single source of clinical information for the Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division;
- improved cross-service clinical handover and communication within the Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division;
- improved complex multidisciplinary care planning and service delivery for people accessing services provided by the Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division;

- improved communication pathways for referrals and clinical handover to other Canberra Hospital and Health Services divisions and services; and
 - improved access to data and reports to support Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division staff in managing daily operations and in the planning of services.
- 4.15 MAJICER will be designed to provide access to all information held for the person receiving treatment including:
- episodes of care;
 - medical, drug and alcohol, counselling and treatment, carer, service, clinical risk, and suicide risk assessments undertaken across the Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division;
 - medications prescribed;
 - clinical notes taken;
 - demographic data (e.g. CALD and ATSI);
 - status of carer, housing, employment, financial and personal relationships;
 - legal events;
 - requests for transport;
 - leave details whilst an in-patient at the unit;
 - details of Electroconvulsive Therapy (ECT) and Forcible Giving of Medication;
 - letters (general and specific) to be sent electronically/faxed;
 - reports (e.g. Short Term Action Plan, Discharge Summary, and *recovery plan*);
 - Occasions of Service (OoS); and
 - mental and justice health, and alcohol and drug history.
- 4.16 It is intended that each person is expected to have one clinical record with multiple services providing care to that person within an episode of care, depending on service setting and service provided. A person could therefore have multiple episodes of care captured against their clinical record, with each episode assigned a unique identifier. An episode of care would relate to the treatment a person receives within a service setting that may include a single service area/specialist. The broader ACT Patient Administration System (ACTPAS) is expected to generate the inpatient episode number which is the unique identifier.
- 4.17 MAJICER is expected to facilitate the clinician user to refer the person to any of the internal services offered within the Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division. It is also intended that staff will be able to create reminder notifications at any time in relation to the person and all notifications including any system generated alerts will be presented on the staff member's 'dashboard' (i.e. display a summary of the staff member's referrals, alerts (notifications) and incomplete work to date).

- 4.18 It is expected that MAJICER will maintain an audit log whenever a person's clinical record has been accessed to comply with the ACT Health Directorate's Clinical Records Policies and meet the statutory requirements of the *Health Records (Privacy and Access) Act 1997*. In doing so, it is expected that MAJICER will adhere to the ACT Health Directorate 'Approved Abbreviations and Symbols Policy' when using abbreviations and symbols, and will support local ACT Health Directorate Data Set standards.

Timing of implementation

- 4.19 MAJICER is scheduled to go live in October 2017. The timing of the implementation will require the current version to operate for the first few months of the 2017-18 financial year, and a data migration process to ensure the new system has the full year data.

MHAGIC version 4.15 is reaching its end of life with increasing costs of ownership and has some significant legacy limitations that restrict future development and planned improvements being made.

The alternative product MasterCare/EMR is a clean build that has removed most of the legacy limitations while maintaining and enhancing existing functionality.

There will still remain some legacy issues even with MasterCare(EMR) as the vendor have incorporated the exact functionality as originally designed for MHAGIC for areas that have not yet been developed further, some of this functionality has not been explored for limitations by the vendor. To note the vendor relies on its clients for most research and future development of the product and for changes to remaining limitations not yet explored at the clients' cost. For the significant reporting issues, these have been identified and corrected in MasterCare (EMR).

Implementation considerations

- 4.20 MAJICER is intended to be based on the software vendor's flagship product and is expected to have an improved front end user interface. The basic functionality and back end data structure of the existing MHAGIC system will not change as a result of the system upgrade and it is expected that there will be some additional functionality to improve how the system meets business requirements, both in supporting clinical practice and gathering data for reporting.
- 4.21 A key issue is finding an acceptable balance between tailoring the standard processes in MHAGIC to cater for the specific work practices of clinicians, making it easier for them to use, and changing work practices to meet an industry standard approach (i.e. electronic clinical record). The recommended approach is to make the system easy to comply with, easy to access information, and reduce data entry through automatic population of data fields. However, clinical work practices will need to be addressed to ensure information is documented in a meaningful and accessible way that adheres to an industry standard approach.
- 4.22 ACT Health Directorate staff working on the upgrade project identified that a key objective of the upgrade of MHAGIC to MAJICER is to transition to a future state where effective information management practices are regarded as 'the way we do things around here'. The target level of performance is that 100 percent of the mandatory requirements are

completed (i.e. support performance and accountability reporting, workflow, and information sharing). The timeframe to achieve a significant step improvement in performance is 12 months.

4.23 To facilitate the improvement in practice, the ACT Health Directorate has advised that components of the current change management strategy for the upgrade of MHAGIC to MAJICER include:

- training to be provided to all staff on the new system highlighting changes and re-focusing on job roles, clinical scenarios and the end to end process (i.e. the person's journey to recovery from crisis contacts, intake to exit in acute care units and ongoing rehabilitation and support in the community);
- modifying the standard operating procedures to incorporate the MHAGIC functions to be performed for each step in the end to end process;
- increasing awareness of the importance of information management and capturing data in a structured format so that it can be shared between users and support reporting processes;
- the use of standard naming conventions for file note entries and other titled documents to support searching, data analysis and improve the accuracy of reporting;
- conversion of standard forms into PDF format to reduce the ability of users to manipulate the structure of the template and change data fields;
- disabling the current MS WORD template *recovery plan* and utilising the planning module which allows multiple approaches to action planning and creation of reports to promote a multi-disciplinary and collaborative approach inclusive of the person, their families and other agencies; and
- clearly defining the mandatory fields that must be completed within each screen and do not accept data entry until complete (e.g. ISBAR handover process, SVAT, HoNOS, contact with carers, GP and the community sector, follow up within seven days, Discharge Summaries, and *recovery plans*).

4.24 The implementation of a number of enhancements to the functionality and useability of MHAGIC, and updating the procedures for using the system will address the clinical record documentation issues identified.

Mental health services performance reporting

Internal performance reporting

4.25 The ACT Health Directorate produces a range of internal performance reports, which are summarised in Table 4-1.

Table 4-1 Summary of ACT mental health services internal performance reporting

Report type	Users	Report
Daily automated	Operational level managers i.e. those with direct responsibility for staff operating in the area and services	Program Summary Demographics and Psychiatric Treatment Orders Important Items Outcome Measures
Monthly automated	Senior policy and program managers	Monthly Program Report CATT Program Report Neuropsych Program Report Post 7 Day Community Contact NDIS Team Registrations
Monthly manual	Senior policy and program managers	Monthly 28 Day Unplanned Readmission Reports Monthly Outcomes Data Reports Monthly Seclusion and Restraint Data Monthly Suicide Vulnerability Assessment
Monthly Executive scorecard	Executive level, head of branch	MHJHADS Scorecard

Source: ACT Audit Office, analysis of ACT Health Directorate performance information

External performance reporting

4.26 The ACT Health Directorate also produces performance reports for several national level governance forums that receive performance information for review including:

- MHDAPC (Mental Health Drug and Alcohol Principle Committee);
- MHISSC (Mental Health Information Strategy Standing Committee);
- National MH NMDS Sub-Committee;
- National Mental Health Performance Sub-Committee (NMHPSC); and
- Safety and Quality Partnership Standing Committee (SQPSC).

Performance report preparation

4.27 Internal and external performance reports are prepared by the Business Performance Information and Decision Support Branch from data drawn from the ACT Health Directorate databases. Most data is drawn from MHAGIC. Other sources of data include ACTPAS and RISKMAN. Information for performance reports are derived from systems such as MHAGIC by the processes of:

- extraction, transformation and loading (ETL) of data from the “live” work system into a data warehouse;

- running structured queries (in Structured Query Language – SQL) against the data in the warehouse, which can come from other sources (such as ACTPAS); and
 - producing reports in the desired format (including spreadsheets).
- 4.28 MHAGIC (and other clinical record systems) are structured to record information at the level of the individual person in care, including individual Occasions Of Service – OOS for all reportable clinical activity. These can then be strung together to see all clinical activity in an episode of care.
- 4.29 The Business Performance Information and Decision Support Branch identifies reports as automated or manual. Automated reports are those produced exclusively using automated scripts. Manual reports are produced by staff, using output from automated scripts. The definition includes reports that involve minor work, such as copying and pasting automated query output into a spreadsheet, as well as those requiring more extensive work, such as compilation of information from various sources. These practices are usual in the context of producing internal management information. While manual intervention creates a risk that data will be changed erroneously or otherwise, these risks can be adequately managed by skilled and experienced staff implementing appropriate control procedures.
- 4.30 To assess the level of risk to data, the ACT Audit Office examined the process for developing one manual report which required a high level of staff input: the *28 Day Unplanned Readmission Report*. The key steps in the process are as follows:
- the Business Performance Information and Decision Support Branch produces an automated report which identifies all cases of re-admission within 28 days in the relevant period. The report produced does not identify whether cases of re-admission are planned or unplanned;
 - the Business Performance Information and Decision Support Branch prepares a spreadsheet which includes the results of the automated report, and which marks all cases of re-admission as unplanned. It forwards the report via email to the Operations Manager, Acute Mental Health Services;
 - the Operations Manager reviews each case in the spreadsheet and reviews the case data to determine whether it is an unplanned or planned re-admission;
 - the Operations Manager includes a brief text note alongside each case to explain why a determination is made; and
 - the Operations Manager sends the modified spreadsheet via email back to the Business Performance Information and Decision Support Branch for dissemination.
- 4.31 When the level of manual input to a report is high, as in this case, it is especially important to implement controls that ensure the report is free of erroneous information. There are no such controls in place to manage the risk of error in the manual part of the process. The process for producing the report is not written down and there is no review of the Operations Manager's activities. Review is particularly important in this case as the indicator in question relates to the performance of the Operations Manager's area of responsibility.

- 4.32 It is noted that, in this instance, the manual work is required because a field in MHAGIC is not completed to indicate if a re-admission was planned or not. Updating procedures to require staff to complete this field would eliminate much of the manual work required for this report.
- 4.33 Where reports require manual input there is a potential conflict of interest whereby a manager is amending performance data that directly relates to their area of responsibility. There are no controls in place, whether written procedures, a division of duties, or a process for independent checking to address this potential conflict.

RECOMMENDATION 5 MANUAL REPORTING PROCEDURES

The ACT Health Directorate should document the procedures for manual reports to identify appropriate controls and separation of duties to prevent errors and manage conflict of interest.

Mental health services outcomes reporting

- 4.34 A number of internal reports are produced for the purpose of providing internal stakeholders with information relevant to assessing outcomes of care and ongoing support for people. These internal reports include:
- Executive Scorecard reporting;
 - monthly reporting; and
 - daily reporting.
- 4.35 A key element of internal outcome reporting is compliance with the Mental Health National Outcomes and Casemix Collection (NOCC) requirements.

The Mental Health National Outcomes Casemix Collection

- 4.36 The Mental Health National Outcomes and Casemix Collection (NOCC) is a performance information framework which specifies data to be collected by states and territories on mental health outcomes and classification of mental health care cases.
- 4.37 The Mental Health National Outcomes and Casemix Collection (NOCC) data collection requirements are built on several sets of clinical and people self-rating measures. The requirements differ for adults, older people and children and adolescents. For adults, the group being considered in this audit, the measures included in the Mental Health National Outcomes and Casemix Collection (NOCC) are:
- Health of the Nation Outcomes Scales (HoNOS), which is a 12 item clinician-rated measure designed by the Royal College of Psychiatrists specifically for use in the

assessment of people outcomes in mental health services. Ratings are made by clinicians based on their assessment of the consumer;

- *Abbreviated Life Skills Profile* (LSP-16) is a version of the Life Skills Profile developed for use in conjunction with HoNOS which is designed to be a brief, specific and jargon free scale to assess a person's abilities with respect to basic life skills. It is capable of being completed by family members and community housing members as well as professional staff;
- *Focus of Care*, which is a clinician's assessment of a consumer's primary goal of care. It is a single item requiring selection of one of four options: *Acute*; *Functional Gain*; *Intensive Extended*; and *Maintenance*;
- *Behaviour and Symptoms Identification Scale* (BASIS-32), which is a consumer self-rated measure and is one of the options for person self-rating available to states and territories under the Mental Health National Outcomes and Casemix Collection (NOCC) that can be selected following consultations with consumers within their jurisdictions;
- *Principal and Additional Diagnoses* (PAD) which is the diagnosis established after study to be chiefly responsible for occasioning the person's care in the period of care preceding the Collection Occasion. Up to two Additional Diagnoses may be recorded; and
- *Mental Health Legal Status* (MH Legal), which is an item used to indicate whether the person was treated on an involuntary basis under the relevant State or Territory mental health legislation.

4.38 The Mental Health National Outcomes and Casemix Collection (NOCC) specifies the points in a person's experience at which data should be collected. It defines three 'episode service settings', as follows:

- psychiatric inpatient service;
- community residential mental health service; and
- ambulatory care mental health service, which can 'include community-based crisis assessment and treatment teams, day programs, psychiatric outpatient clinics provided by either hospital or community-based services, child adolescent outpatient and community teams, social and living skills programs, psychogeriatric assessment services and so forth'.

4.39 The Mental Health National Outcomes and Casemix Collection (NOCC) also defines 'collection occasions' within each episode service setting, as follows:

A collection occasion is defined as an occasion during an Episode of Mental Health Care when the required dataset is to be collected in accordance with a standard protocol. The broad rule is that collection of data is required at both episode start and episode end.

4.40 Table 4-2 summarises National Outcomes and Casemix Collection reporting requirements for adults.

Table 4-2 National Outcomes and Casemix Collection reporting requirements for adults

Service setting	INPATIENT			COMMUNITY RESIDENTIAL			AMBULATORY		
	A	R	D	A	R	D	A	R	D
Collection Occasion									
HoNOS	●	●	●	●	●	●	●	●	●
LSP-16				●	●	●		●	●
BASIS32	●	●	●	●	●	●	●	●	●
PAD		●	●		●	●		●	●
FoC								●	●
MH Legal		●	●		●	●		●	●

Source: ACT Audit Office, adapted from the NOCC Technical Specifications, page 40

4.41 The suite of performance reports prepared address the reporting requirements for the National Outcomes and Casemix Collection identified above. In addition, the reports contain a number of indicators relevant to assessing outcomes of care which are not specified in the Mental Health National Outcomes and Casemix Collection (NOCC) requirements. These measures are:

- compliance with the SVAT;
- 28 Day unplanned readmission, which is collected for all in-patient services; and
- follow up within 7 days of discharge, demonstrating active engagement with people in the critical period immediately following discharge.

4.42 The reports also provide performance information on accountability indicators for mental health services. The Mental Health, Justice Health, Alcohol and Drug Services Division has a number of accountability indicators outlined in the ACT Health Directorate Budget Statements. The accountability indicators reflect the number of contacts made to the various services. Information against the accountability indicators is updated quarterly.

Executive Scorecard reporting

4.43 The Executive Scorecard is a monthly report which provides performance information against both national and internal targets. The report is prepared for the executive of the ACT Health Directorate's Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) Division as well as for review by the ACT Health Directorate executive more broadly. Table 4-3 shows Executive Scorecard targets relevant to the provision of mental health services.

Table 4-3 Executive Scorecard mental health services targets

Indicator	Target for 2016-17
Post discharge reporting	
Proportion of mental health clients contacted by a Health Directorate community facility within 7 days post discharge from inpatient services	75%
Outcome measures	
Percentage of clients with outcome measures completed	65%
Unplanned readmissions to hospital within 28 days of discharge	10%
Suicide vulnerability assessment tool attached to clinical file for ALL consumers in past three months.	-

Source: ACT Audit Office, analysis of ACT Health Directorate MHJHADS Scorecard, December 2016

Gaps in reporting

4.44 There was a five month gap in Executive Scorecard reporting between July 2016 and November 2016. The break in reporting of the Executive Scorecard during this period diminished the performance information made available to ACT Health Directorate decision-makers.

Exclusion of historical information

4.45 Following the July 2016 to November 2016 break in reporting, the ACT Health Directorate introduced a revised format for Executive Scorecard reporting. The main substantive change is the removal of historical performance data for periods prior to May 2016.

4.46 Monthly Executive Scorecard reports that had been prepared up to June 2016 included monthly data for some indicators back to May 2015 and for others back to July 2014. Time series data is a valuable resource which supports the examination of performance over time, not only in terms of performance standards but also the identification of contributing factors, notably cyclical and seasonal variations. There may be some benefit in the ACT Health Directorate considering the presentation of two years of data on the scorecard to capture cyclical and seasonal factors.

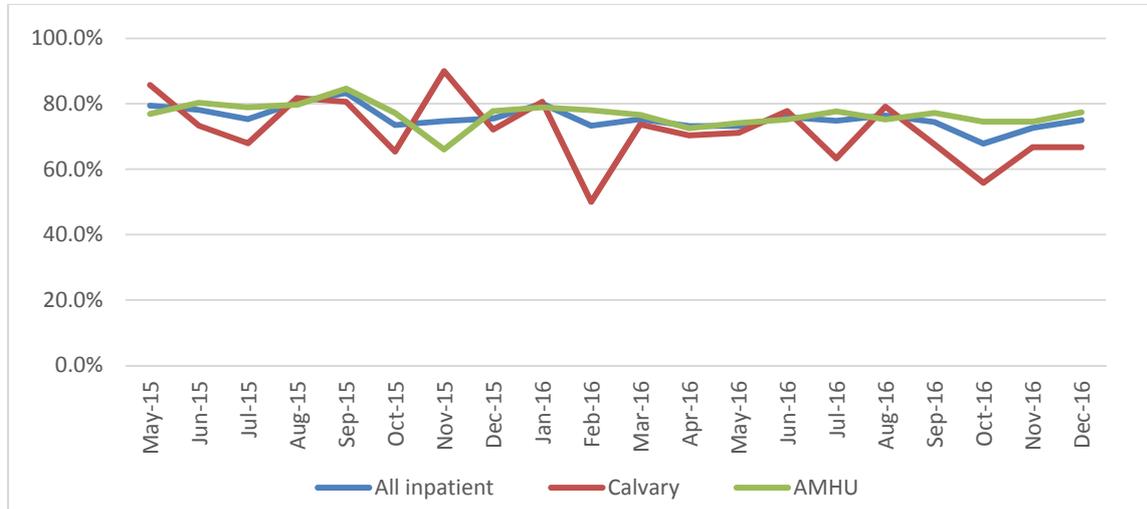
4.47 The structure and coverage of the ACT Health Directorate's outcomes reporting, including Executive Scorecard reporting, monthly and daily reporting, taken as a whole, has a focus on information relevant to considering the success of a person's transition, within a recovery and customer focussed framework. Reporting also includes references to relevant standards.

Reporting results

4.48 Using data in the monthly Executive Scorecard reports provided by the ACT Health Directorate, the Audit Office has developed times series for the indicators: 7-day post discharge contact and outcome measures reporting. Time-series data was available for

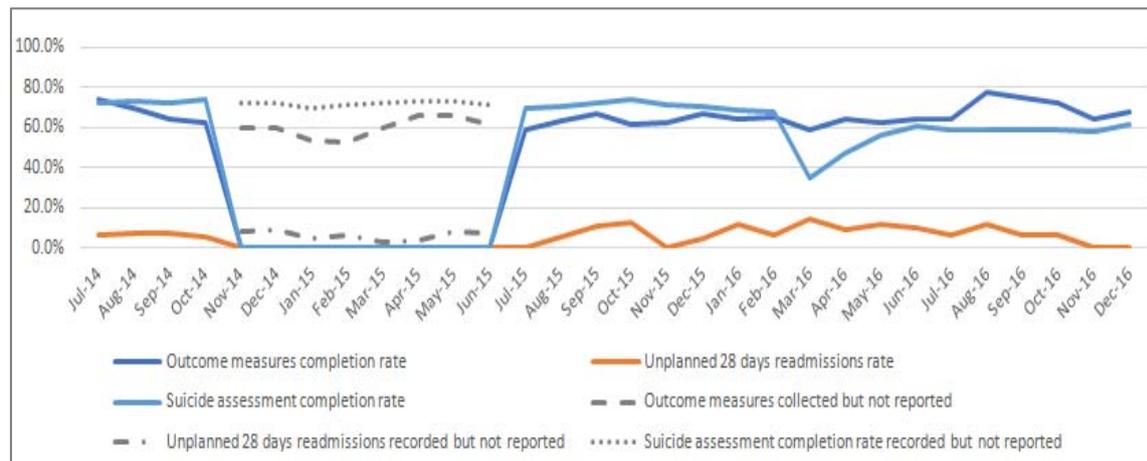
7-day post discharge reporting from May 2015 while time-series data was available for completion of outcome measures reporting from July 2014 (albeit with a six month gap between November 2014 and June 2015). These are represented in Figures 4-2 and 4-3.

Figure 4-2 7-day post discharge reporting



Source: ACT Health Directorate performance reporting data

Figure 4-3 Completion of outcome measures



Source: ACT Health Directorate performance reporting data

4.49 There is a distinct period in which data for some measures was not included in Executive Scorecard reporting, notwithstanding that the data was being collected during this period, as evidenced by the review of monthly performance reports. This gap in reporting, along with the five month gap in scorecard reporting in 2016, means that in the last two years there has been inconsistent performance reporting on mental health services at the ACT Health Directorate Executive level. During the periods of gaps in reporting, Executive management was not provided with the totality of reports used for assessing performance and taking actions to improve it.

4.50 Notwithstanding the gaps in reporting, Audit Office collation and analysis of the data contained in the Executive Scorecard reports provided indicates that the Executive

Scorecard report may be useful for assessing performance over time. The time series in the figures above show that the level of performance in respect of the selected indicators has remained largely static over time, except in relation to the suicide assessment indicator, which shows a decline in performance over time.

Suicide assessment indicator

- 4.51 The SVAT indicator reflects the requirement that the SVAT be completed for all mental health persons, as follows:

Suicide vulnerability assessment tool attached to clinical file for ALL persons in past three months.

- 4.52 The level of performance can be readily addressed with management attention and through existing operational processes, for example daily shift handovers, ward rounds and multidisciplinary team meetings. In service training and on the job support for staff to reinforce the requirement is also an option. In June 2017, the ACT Health Directorate advised that the policy, data collection and documentation requirements for the SVAT were under review:

While 100% is a reasonable policy position for a mental health service, the current data collection methodology around this target does not account for: services where the SVAT may not be specifically required (eg some consultation teams which provide only consultation and liaison input into clinical care); where the suicide vulnerability assessment has been documented in the body of a clinical record rather than specifically using the SVAT form; and where the SVAT has actually been complete but outside of the 3 month period. [ACT Health] is considering adjusting the SVAT policy to account for these clinical variations where they are reasonable.

- 4.53 Current ACT Health Directorate policy requires the Suicide Vulnerability Assessment Tool (SVAT) to be completed for every person at least every three months. Records of completion are significantly below this and it may be interpreted that the current level of performance is below the level of achievement the ACT Health Directorate management expects. Notwithstanding an expected performance level of 100 percent, as at December 2016 completion of the SVAT was reported as 62 percent. Suicide (along with potential to harm others) is self-evidently the most significant risk, in terms of consequences, to be addressed in the transition from acute care to other forms of support. Non-compliance with the procedure for assessing suicide vulnerability is inconsistent with the risk to life that suicide vulnerability represents.

RECOMMENDATION 6 SUICIDE VULNERABILITY ASSESSMENT TOOL

The ACT Health Directorate should enforce their own policy that the Suicide Vulnerability Assessment Tool be completed every three months for all patients and address areas of non-compliance (or amend the policy if the ACT Health Directorate considers it inappropriate).

4.54 Targets for two other measures are set at significantly less than 100 percent when the operational target is 100 percent. These are the *7 day post discharge contact* and *outcome measures* completion indicators. This approach to setting targets is justifiable if the target relates directly to a step improvement sought from specific management actions, however there is no evidence to hand that the targets are set in this way. In June 2017, the ACT Health Directorate advised that:

There are clear rationales and practical considerations for why targets, such as 7 day follow-up, are not set at or even closer to 100%. For example, data is collected at jurisdictional level. It is not uncommon that a person will be admitted to an inpatient unit in the ACT and then be discharged interstate which means 7 day follow-up will be conducted by an interstate service and its completion will be unknown to ACT Health.

Alternatively, some people may be discharged from inpatient units and refuse follow-up from public mental health services or prefer follow-up with their own private practitioners. To set targets at 100% would require data systems which could reliably ensure that such cases are excluded from analysis.

Monthly reporting

4.55 As noted in Table 4-1 a number of monthly reports are prepared which are provided to senior managers in the Division. These reports include information on compliance with outcomes measures collection and other measures related to transition. Key reports considered for the purpose of the audit are:

- *Monthly Outcomes Data Report*;
- *Monthly Program Report*;
- *Post 7 Day Community Contact* report;
- *Suicide Vulnerability Assessment* report; and
- *28 Day Unplanned Readmission* report.

Monthly Outcomes Data Report

4.56 This report provides information on the collection of outcomes measures data. It presents information for each operational unit within the Mental Health, Justice Health and Alcohol and Drug Services Division (for example, Adult Acute Mental Health Services and Older Persons Mental Health Services), going back to 2006 or to the commencement of operations in units established after that date. The documentation for the report states:

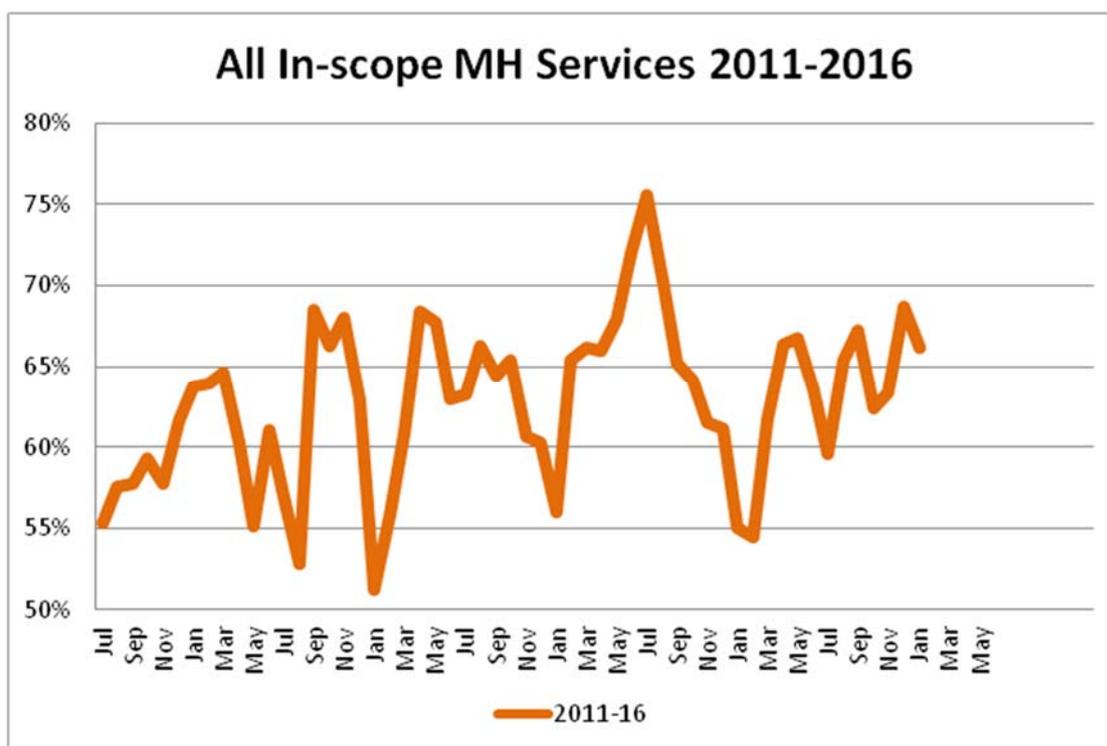
The outcome measure specifically counted for this report is completion of the HoNOS/CA/65+ for each person as this outcome measure is required to be collected in all settings and at all key collection points as per the outcome measure protocol.

It is expected that the other outcome measures required to be collected according to the protocol are collected as relevant to the collection point (admission/review/discharge) in the relevant service setting (inpatient/community/ residential).

What the figure represents is compliance with the minimum required collection of the basic outcome measures collected as standard. This is also a reflection of the degree of ... improvement, staying the same or deterioration.

4.57 Figure 4-4 shows the aggregated completion rate of HoNOS/CA/65+ outcome measures for each person current receiving mental health services at all key collection points.

Figure 4-4 Aggregate performance to June 2016



Source: ACT Health Directorate MHJHADS Monthly Report, January 2017.

4.58 The ACT Health Directorate has set a target figure of 75 per cent compliance with the completion of HoNOS/CA/65+ at the required collection points. Figure 4-4 indicates that this was achieved for a brief period in 2015. This target is inconsistent with the requirement set out in the documentation in the report, which in effect establishes a target of full compliance in line with the National Outcomes and Casemix Collection (NOCC) requirements.

Monthly Program Report

4.59 The Monthly Program Report provides a snapshot of compliance with outcomes measures included in the Mental Health National Outcomes and Casemix Collection (NOCC). It presents data in line with the age cohorts specified in the NOCC. It includes data on compliance with LSP16 and BASIS 32 as well as HoNOS. Figure 4-5 presents an excerpt from the January 2017 report.

Figure 4-5 Monthly performance report – outcomes measures snapshot

DAILY OUTCOME MEASURES SUMMARY					
Adult Primary Team Name	Number of Clients	HoNOS	LSP16	BASIS32	
FMHS AMC Assertive Response	32	68.8%	0.0%	6.3%	
Forensic AMC MH Service	49	59.2%	16.3%	24.5%	
Forensic CA Service	12	16.7%	0.0%	8.3%	
Forensic CL Service	4	100.0%	25.0%	50.0%	
Forensic CO Service	12	50.0%	33.3%	16.7%	
Total	109	57.8%	11.9%	17.4%	
Older Persons Primary Team Name	Clients	HoNOS65+	LSP16	RUGADL	BASIS32
Total	0	N/A	N/A	N/A	N/A
Child and Adolescent Team Name	Clients	HoNOSCA	SDQYr	SDQPY	SDQPC
Forensic Bimberl MHS	8	75.0%	37.5%	37.5%	0.0%
Total	8	75.0%	37.5%	37.5%	0.0%

- This table is a snapshot for the date this report is run and reflects data in the daily reports in the directory Q:\MH\Team Leader Reports\Automated\
- Client counts are for clients who have that team listed as their primary team.
- If the team should never be a primary treatment team then they should have 0s across the board (and therefore not appear in this list), if not it indicates that data needs to be fixed. Please open one of the relevant daily files to identify the client then log into Mhagic and put the correct primary treatment team at the top of the clients team list.
- Completion of these measures are mandated for the National Outcomes Casemix Collection that is reported nationally.

Please Note: Calculation Method is simple and does not take into account complexities of the NOCC outcome measure completion chart, it simply indicates whether each measure has been completed in the last 90 days.

Source: ACT Health Directorate performance information, January 2017, dated 8 February 2017

4.60 The Monthly Program Report also presents a snapshot of completion rates by unit of the Suicide Vulnerability Assessment Tool, as at the date of the report. Figure 4-6 presents an excerpt from the January 2017 report (dated 8 Feb 2017).

Figure 4-6 Monthly performance report – important items snapshot

DAILY IMPORTANT ITEMS SUMMARY					
Primary Team Name	Number of Clients	Number of Clients on a PTO	Clients with Diagnosis recorded	Clients with GP Recorded	Clients with Suicide Vulnerability Assessment in last 90 days
FMHS AMC Assertive Response	32	0	46.9%	31.3%	81.3%
Forensic AMC MH Service	49	2	79.6%	55.1%	53.1%
Forensic Bimberl MHS	8	0	75.0%	87.5%	87.5%
Forensic CA Service	12	0	25.0%	66.7%	25.0%
Forensic CL Service	4	2	25.0%	100.0%	75.0%
Forensic CO Service	12	8	100.0%	83.3%	66.7%
Total	117	12	65.0%	56.4%	62.4%

- This table is a snapshot for the date this report is run and reflects data in the daily reports in the directory Q:\MH\Team Leader Reports\Automated\
- Client counts are for clients who have that team listed as their primary team.
- If the team should never be a primary treatment team then they should have 0s across the board (and therefore not appear in this list), if not it indicates that data needs to be fixed. Please open one of the relevant daily files to identify the client then log into Mhagic and put the correct primary treatment team at the top of the clients team list.

Source: ACT Health Directorate performance information, January 2017, dated 8 February 2017

4.61 Compared to the Executive Scorecard reporting of outcomes, which is at an aggregate level and covers HoNOS only, this is a more informative report and better reflects minimum data collection standards. It would be useful and appropriate for information on the indicators at the top level (i.e. for all mental health services) to be included in the Executive Scorecard reporting. To illustrate why, the Audit Office notes one aspect of performance which stands out in this reporting is the disparity between levels of compliance with HoNOS, LSP16 and BASIS32. Collection rates of LSP16 and BASIS32 are far lower than HoNOS collection rates, which are themselves well below the required rate of collection. This fact is presently not

visible to management in context of monthly executive meetings, but deserves consideration in that forum.

Post 7 Day Community Contact report

4.62 This report presents a breakdown of contacts in the seven days immediately after discharge.

Figure 4-7 Post 7 Day Community Contact report

Mental Health, Justice Health, Alcohol and Drug Services																							
Seven Day Post Discharge Contact Indicator																							
Discharge Ward		2016-17												1st QTR	2nd QTR	3rd QTR †	4th QTR	YTD 2016-17	YTD 2015-16				
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun										
Hospitals Total	Separation	151	144	129	145	135	161	164									424	441	164		1029	635	
	7 Day Post	113	110	96	99	98	121	109									319	318	109		746	488	
	%	74.8	76.4	74.4	68.3	72.6	75.2	66.5									75.2	72.1	66.5		72.5	76.9	
Canberra Hospital	AMHU	Separation	73	67	55	57	71	85	84														
		7 Day Post	60	49	44	46	53	65	60														
		%	82.2	73.1	80.0	80.7	74.6	76.5	71.4														
	PSS	Separation	48	34	37	36	31	39	41														
		7 Day Post	34	27	27	24	23	31	23														
		%	70.8	79.4	73.0	66.7	74.2	79.5	56.1														
	Total	Separation	121	101	92	93	102	124	125									314	319	125		758	413
		7 Day Post	94	76	71	70	76	96	83									241	242	83		566	321
		%	77.7	75.2	77.2	75.3	74.5	77.4	66.4									76.8	75.9	66.4		74.7	77.7
Calvary Hospital	2N	Separation	26	32	28	37	28	27	30														
		7 Day Post	15	24	16	21	19	16	18														
		%	57.7	75.0	57.1	56.8	67.9	59.3	60.0														
	OPMH-IU	Separation	4	11	9	15	5	10	9														
		7 Day Post	4	10	9	8	3	9	8														
		%	100	90.9	100	53.3	60.0	90.0	88.9														
Total	Separation	30	43	37	52	33	37	39									110	122	39		271	222	
	7 Day Post	19	34	25	29	22	25	26									78	76	26		180	167	
	%	63.3	79.1	67.6	55.8	66.7	67.6	66.7									70.9	62.3	66.7		66.4	75.2	

Source: ACT Health Directorate performance information, January 2017, dated 8 February 2017

Suicide Vulnerability Assessment report

4.63 The *Suicide Vulnerability Assessment* report breaks down completion of the Suicide Vulnerability Assessment Tool for each person by unit, and can be further broken down by clinician. It is useful for identifying where compliance needs to be most improved.

28 Day Unplanned Readmission report

4.64 This report is not a requirement of the Mental Health National Outcomes and Casemix Collection (NOCC), however the percentage of unplanned readmissions within 28 days of discharge from acute services is a Strategic Indicator for the ACT Health Directorate. It provides useful information as to the operations of mental health services in the ACT.

Daily operational reporting

4.65 At this level, outcomes reporting is directed to supporting the work of teams, highlighting matters which require attention as well as summarising levels of activity. In relation to transition, these reports provide useful outcome measure compliance information and also information which supports collaborative planning. Figures 4-8 to 4-10 show some examples of information that is available.

Figure 4-8 Important items, primary team AMHU

Clients important items with primary team AMHU at approximately 9pm 7 March 2017				
Team	Number of Clients	With Current Diagnosis	Within 90 days SRA	With GP Assigned
AMHU	16	7 (44%)	8 (50%)	8 (50%)
Case Managers				
No Case Manager	12	4 (33%)	7 (58%)	6 (50%)
x	1	1 (100%)	0 (0%)	1 (100%)
x	1	0 (0%)	1 (100%)	1 (100%)
x	1	1 (100%)	0 (0%)	0 (0%)
x	1	1 (100%)	0 (0%)	0 (0%)
Case Manager Name	Patient Name	Diagnosis	Most Recent Suicide Vulnerability Assessment	GPName
x	x	F31.7	29-November-2016	x
x	x		04-February-2017	x
x	x		22-February-2017	x
x	x		01-March-2017	x
x	x	F60.31	26-October-2016	x
x	x		26-February-2017	x
x	x	F32.3	28-February-2017	x
x	x		09-February-2017	x
x	x			x
x	x			x
x	x		04-March-2017	x
x	x	F20.0	03-May-2016	x
x	x	F20.9	27-July-2016	x
x	x		09-February-2017	x
x	x	F20.0		x
x	x	F20.9		x

Source: ACT Health Directorate Performance information, March 2017

Figure 4-9 Completed and overdue 7-day follow-ups

Mental Health, Justice Health, Alcohol and Drug Services					
Seven Day Follow-up Completion					
PSS	27 Feb 2017	210401	2530	Woden	Completed
PSS	28 Feb 2017	17005817	65555	Forensic AMC MH Service	Completed
PSS	28 Feb 2017	20314437	80049	CATT	Completed
PSS	01 Mar 2017	505134	52330	CATT	Completed
PSS	01 Mar 2017	18139646	!	PMI URN not registered in Mhagic	Completed
PSS	03 Mar 2017	20295671	76329	CAMHS Northside	Completed
PSS	03 Mar 2017	18144964	55683	NDIS Funded	Completed
PSS	06 Mar 2017	20221510	78754	CATT	Completed
PSS	06 Mar 2017	768672	80140	AMHU	Completed
PWA	01 Mar 2017	18125456	79939	CAMHS Northside	Completed
Calvary Hospital					
2N	24 Feb 2017	662736	77780	Belconnen	overdue: 03 Mar 2017
2N	28 Feb 2017	11347699	79936	CAMHS Northside	overdue: 07 Mar 2017
OMH	28 Feb 2017	188	!	PMI URN not registered in Mhagic	overdue: 07 Mar 2017
2N	02 Mar 2017	633739	37786	Belconnen	due by: 09 Mar 2017
2N	07 Mar 2017	17010597	78529	Calvary Consultation Liaison	due by: 14 Mar 2017
OMH	07 Mar 2017	11312650	24551	OPMHS	due by: 14 Mar 2017
2N	23 Feb 2017	20223398	68398	Belconnen	Completed
2N	23 Feb 2017	763989	35591	Belconnen	Completed
2N	24 Feb 2017	738693	4816	Gungahlin	Completed
2N	27 Feb 2017	20205853	77781	Tuggeranong	Completed
2N	28 Feb 2017	11032807	!	PMI URN not registered in Mhagic	Completed
2N	01 Mar 2017	20297834	79304	Woden	Completed
2N	03 Mar 2017	20166008	80138	Calvary Consultation Liaison	Completed
2N	06 Mar 2017	18073054	6556	Gungahlin	Completed
2N	06 Mar 2017	739255	79453	Belconnen	Completed
OMH	02 Mar 2017	11031491	79185	OPMHS	Completed

Report displays for the last 14 days the status of Client separations with a follow-up Occasion of Service within the required seven days.

Due by date and Overdue date is the seventh day after Separation.

! PMI URN not registered in Mhagic: The Mhagic Client ID is not linked to its PMI ID and therefore the Client's Mhagic data is inaccessible for reporting purposes.

Source: ACT Health Performance information

Figure 4-10 Outcome measures with primary team AMHU

Clients last Outcome Measures with primary team AMHU at approximately 9pm 7 March 2017				
Outcome measures should be done for each client regularly. They should be done on Admission to the service, 90 day review (prior to 91 day deadline) and on Discharge. They should be done as a set. If you are not aware of the requirements please speak with your director. Colour highlighting: Yellow - last measure done 81-90 days ago - please do new set now, Red - last measure done more than 91 days ago or not at all - overdue!				
Team	Number of Clients	With HoNOS	With LSP16	With BASIS32
x	16	8 (50%)	1 (6%)	0 (0%)
Case Manager Name				
x	12	7 (58%)	0 (0%)	0 (0%)
x	1	0 (0%)	0 (0%)	0 (0%)
x	1	1 (100%)	1 (100%)	0 (0%)
x	1	0 (0%)	0 (0%)	0 (0%)
x	1	0 (0%)	0 (0%)	0 (0%)
Case Manager Name	Patient Name	HoNOS	LSP16	BASIS32
x	x	3 June 2016	9 April 2012	3 June 2016
x	x	1 March 2017		
x	x	27 February 2017		
x	x	13 March 2017		
x	x	14 November 2016	21 April 2016	21 April 2016
x	x	5 March 2017		
x	x	12 June 2013	12 June 2013	12 June 2013
x	x	3 February 2017		26 February 2016
x	x			
x	x			
x	x	5 March 2017		
x	x	27 December 2016	10 June 2016	16 January 2013
x	x	24 November 2016	10 September 2016	26 September 2016
x	x	14 February 2017	3 February 2017	8 December 2016
x	x	21 November 2016	14 March 2016	12 April 2016
x	x	15 August 2016	15 August 2016	15 August 2016

Source: ACT Health Directorate Performance information, March 2017

4.66 Through daily operational reporting it is possible to identify mental health service patients who need to have tasks completed for them. This level of reporting also usefully flags whether key support people of some kind have been identified and by extension people who need to be identified. Outcomes reporting compliance is aligned with the Mental Health National Outcomes and Casemix Collection (NOCC) down to operational level, and can be assessed by facility and also by staff member. These reports together provide a useful tool for identifying present levels of performance and compliance.

Use of information to improve performance

4.67 The Executive Scorecard reports provided to the ACT Health Directorate executives include measures of outcomes and measures of compliance with outcomes. However, there is no evidence that the information is analysed or considered as a driver for change. For instance:

- reported levels of completion of outcomes measures have been flat for some time without recorded comment or suggested actions to improve completion and recording; and
- reported levels of completion of the Suicide Vulnerability Assessment Tool (SVAT) have been declining, without recorded comment on possible causes and potential remedies.

4.68 A range of steps could be taken to make better use of the currently available suite of reports. For instance:

- the data is available on a monthly basis – exception reporting could identify outliers for immediate attention;
- time series data is readily constructed, enabling trends to be identified and changes in performance to be assessed in proper context;
- outcome compliance measures are sufficiently important and sufficiently indicative of the level of risk to deserve more prominence in reporting; and
- target levels of outcomes and compliance could be related to specific management actions taken to achieve improvements.

4.69 The ACT Health Directorate may want to consider a review of the performance information provided at the operational level to identify if it is well targeted and useful. Potential improvements could include:

- re-casting performance information to better align with operational management, so that it includes information that they will use as well as information they ought to use; and
- reinforcing the importance of outcome measures and aligning them with the important indicators of administrative milestones.

4.70 Overall, it appears possible to use the current performance information and the data warehouse to gain insight into the reasons underpinning current levels of performance so as to identify the kinds of steps that might generate improvements and where the effort needs to be applied. It is important to consider that it is as beneficial to identify good practice as poor practice, so that effective methods of working can be shared and poor practices minimised or eliminated.

4.71 Overall, there is a great deal of useful information in the current suite of performance reports that is available to improve operational performance. However, the current performance information suite is complex, having grown over time without the benefit of systematic review: for instance, the same measures appear in different reports and in different formats. Potential improvements could include:

- including new reporting items in line with the new *Mental Health Act 2015* and to strengthen focus on collaborative planning;
- expanding reporting to better track outcomes measure compliance; and
- active use of the information to improve performance, including through evaluation.

4.72 In relation to outcomes measures and compliance, there is merit in more use being made of the Health of the Nation Outcome Scale (HoNOS), and an increased level of attention to person self-assessment. This is merited for the purposes of reporting at the national level, and in view of the *Mental Health Act 2015's* focus on collaborative planning. In particular

the HoNOS can readily provide longitudinal data that could be used to examine and evaluate the outcomes of cohorts of people engaged with mental health services.

- 4.73 There is also a case to develop measures of the use of the provisions of the *Mental Health Act 2015* for advance agreements, advance consent directions and nominated persons. Such measures would give strong indications of the level of support provided to people under the Act. Related measures that demonstrated the involvement of carers, General Practitioners, clinical managers and community organisations would form a sound basis from which to gauge the strength of collaborative planning and transition planning.

RECOMMENDATION 7 PERFORMANCE REPORTING

The ACT Health Directorate should review and rationalise its performance information reports by:

- a) reporting the performance of provisions of the *Mental Health Act 2015* that are intended to support collaborative planning (e.g. the number of people accessing mental health services that have an advance agreement in place);
- b) including outcome and outcome compliance measures (e.g. person outcomes from HoNOS and LSP-16 mental health well-being assessments or 28 day unplanned readmissions);
- c) including exception reports identifying outliers;
- d) including time series, including of outcome measures;
- e) having it relate to management actions taken to achieve targets, including compliance targets; and
- f) aligning reporting to the relevant day-to-day reporting requirements of adult mental health operational managers.

APPENDIX A: RANDOM SAMPLE FORMATION

A stratified random sample of MHAGIC files of people discharged from Canberra Hospital and Calvary Hospital acute care facilities was selected for the period 1 July 2015 to 30 June 2016. The period was chosen on the basis of the ACT Health Directorate advice that aggregate performance information would be available for comparison.

After excluding people under 18 years of age, data for 1,676 recorded discharge separations was provided by the ACT Health Directorate. These records were filtered to account for serial separations within a continuous period of acute care. These occur when (for instance) a person leaves the Mental Health Short Stay Unit at the Canberra Hospital (the first separation) and is transferred to the Adult Mental Health Unit in the Canberra Hospital, which they then leave (a second separation) to be transferred to the acute care facility at ward 2N at Calvary Hospital, from which they are subsequently discharged (the third serial separation). The population included only those instances of separation that amounted to a discharge from acute care.

From the resulting population of 947 records, 47 individual records were drawn showing the chief characteristics listed below. The sample was accepted as a good match for sex and age. The over-representation of Aboriginal and Torres Strait Islander people was accepted as consistent with the audit focus.

Closer examination of the sample showed that

- one person had not in fact been discharged and remained in acute care as at 30 June 2016;
- one person had been remanded to custody of the Australian Federal Police after assaulting a staff member after a short period in acute care;
- one person had absconded within six days of admission; and
- four people spent 48 hours or less in acute care.

Table A.1 Characteristics of stratified random sample of person separations 2015-16

Population	947			Expected count in random sample of 47	Actual count in random sample of 47
Females	479	50.6%		24	25
Males	466	49.2%		23	22
Indeterminate	2	0.2%		0	0

Population	947			Expected count in random sample of 47	Actual count in random sample of 47
Aboriginal	45	4.8%		2	5
Under 20	26	2.7%		1	2
20-29	241	25.4%		12	12
30-39	216	22.8%		11	10
40-49	210	22.2%		10	13
50-59	123	13.0%		6	4
60-69	70	7.4%		3	4
70+	61	6.4%		3	2

Excluding these cases, the remaining 40 records were printed out by the ACT Health Directorate and provided to the ACT Audit Office in a secure environment for examination to verify the presence of records demonstrating collaborative discharge and recovery planning. The records included appropriate numbers from each of Canberra and Calvary Hospitals, noting that people over 65 years of age are treated at the OPMHS at Calvary Hospital. To ensure that the examination encompassed the relevant period of discharge and recovery planning immediately after acute care, the printed records ran from admission to acute care up until 28 days after discharge from acute care into the community.

To ensure the completeness of records, ACT Audit Office requested that the ACT Health Directorate conduct its own search of MHAGIC for relevant documents relating to the period of care – the resulting documents were provided for examination. Health also provided copies of the paper Treatment and Care Plans that are completed for admission to the Canberra Hospital (including admissions to the mental health facilities) in order to examine the very first phase of planning for discharge. These records are not included in MHAGIC.

APPENDIX B: RANDOM SAMPLE ASSESSMENT

Table B1. Discharge planning test criteria and sources, as applied to a random sample of MHAGIC files with discharge dates in 2015-16

Test item	Source of each criterion (detailed in endnotes)				Test criteria
	National Standards ¹	Health P&P ²	Health audit tool ³	Other	
1	Yes ⁴	Yes ⁵	Yes ⁶	MH Act 2015 ⁷	Evidence of consultation, participation and collaboration with the person (including informed consent for treatment, care, recovery planning and continuity of care)
2		Yes ⁸	Yes ⁹	MH Act 2015 ¹⁰	Are family/carer needs addressed in the Discharge Plan
3		Yes ¹¹	Yes ¹²		Does the client record identify strategies for managing any medication issues
4	Yes ¹³	Yes ¹⁴	Yes ¹⁵		Were risk assessments of the person conducted throughout all stages of the care continuum
5	Yes ¹⁶	Yes ¹⁷	Yes ¹⁸		Does the discharge plan promote wellness, prevent relapse (identification of early warning signs), and early response (how to re-enter the service if needed)
6	Yes ¹⁹	Yes ²⁰			Was the person readmitted within 28 days
7	Yes ²¹	Yes ²²	Yes ²³		Was there contact with the person, GP, family, carer, community sector, and other government agency - collaborative planning, service delivery, discharge planning etc
8		Yes ²⁴	Yes ²⁵		Is there evidence of a multi-disciplinary team review
9	Yes ²⁶	Yes ²⁷	Yes ²⁸		Was there follow up with the person within 7 days
10		Yes ²⁹	Yes ³⁰		Was there community sector contact (integrated care across programs, sites and other related services)
11		Yes ³¹	Yes ³²		Was an application submitted to the Clinical Manager for Case Management prior to discharge

Test item	Source of each criterion (detailed in endnotes)				Test criteria
	National Standards ¹	Health P&P ²	Health audit tool ³	Other	
12	Yes ³³	Yes ³⁴	Yes ³⁵		Referral to other service providers prior to discharge
13		Yes ³⁶	Yes ³⁷		Were discharge summaries completed (commenced planning at the time of entering the service) and provided to the person and carer on discharge.
14	Yes	Yes ³⁸	Yes ³⁹		3 days (commence from date of admission) to start the file note and 3 days to finish the note
15				ACTAO ⁴⁰	Was the standard functionality of MHAGIC used
16				ACTAO ⁴¹	Were the standard MHAGIC document templates used
17				ACTAO ⁴²	Is the Discharge Plan easy to comprehend and at an acceptable standard
18				ACTAO ⁴³	Were other plans in the client record (e.g. Treatment Plan, Episode of Care - closure, and Exit Plan)

1. Refers to the Australian Government's *National Standards for Mental Health Services 2010*, hereafter referred to as NSMHS.
2. Refers to operating procedures and guidelines issued by the ACT Health Directorate.
3. Refers to relevant criteria of the ACT Mental Health *In-Depth Clinical Documentation Audit Guidelines, FlowCharts and Tools*, Running Version 2009, referred to hereafter as the 'audit tool'.
4. *National Standards for Mental Health Services 2010* Criterion 6.8 requires that:

'Informed consent is actively sought from consumers prior to any service or intervention provided or any changes in care delivery are planned, where it is established that the consumer has capacity to give informed consent.'
5. The Adult Mental Health Unit Canberra Hospital and Health Services *Operational Model of Care* (AMHUMoC) provides at page 38 that:

'Consumers must be informed and regularly advised of their legal rights and status regarding treatment choices and consents under the *Mental Health (Treatment and Care) Act 1994*.'
6. Audit tool criterion 2.12:

'There is evidence that the Consumer has been informed of his/her Rights and Responsibilities.'

7. Section 6 of the *Mental Health Act 2015* provides that:

‘In exercising a function under this Act, the following principles must be taken into account: (a) a person with a mental disorder or mental illness has the same rights and responsibilities as other members of the community and is to be supported to exercise those rights and responsibilities without discrimination; (b) a person with a mental disorder or mental illness has the right to—(i) consent to, refuse or stop treatment, care or support; and (ii) be told about the consequences of consenting to, refusing or stopping treatment, care or support.’

Section 6(j) provides that:

‘services provided to a person with a mental disorder or mental illness should— (i) respect the informed consent of the person to the person’s assessment and treatment, care or support including consent as expressed in an advance consent direction.’

8. See AMHUMoC page 32, which provides that:

‘The views of any guardian, family member or primary carer who is involved in the ongoing care or support of the consumer should also be sought as early as possible, consistent with the privacy and confidentiality requirements and the need to work collaboratively with the consumers support systems.’

9. *National Standards for Mental Health Services 2010* Part 6 provides that

‘Carers have the right to participate in treatment planning where the consumer has given consent, and to provide information to the treating team where this has not been given. Carers also have the right to an assessment of their needs.’

10. Section 6j(ix) of the *Mental Health Act 2015* requires that services be provided that:

‘facilitate appropriate involvement of close relatives, close friends and carers in treatment, care or support decisions in partnership with medical professionals.’

11. See AMHUMoC page33, which provides that:

‘Consumers and carers should be provided with written and verbal information on medications prescribed for them. The effects of medication and side effects should be discussed with consumers and carers and closely monitored.’

12. See audit tool criterion 2.4.

13. *National Standards for Mental Health Services 2010* Criterion 2.11 requires that:

‘The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.’

14. See AMHUMoC ‘Clinical Risk Assessment’, page 35.

15. See audit tool criterion 1.3.

16. *National Standards for Mental Health Services 2010* Criterion 10.6:

‘Exit and re-entry: The MHS assists consumers to exit the service and ensures re-entry according to the consumer’s needs.’

17. See AMHUMoC page 35, which provides that:

‘Integrated care pathway documentation must be agreed to enhance care delivery and communication and specific alternatives and options for further acute admission. In order to access the services required by consumers (to meet their complex needs), these teams need to co-ordinate the activities of many different agencies including health, social services, housing, education, transport, criminal justice and employment.’

18. See audit tool criteria 5 and 7.

19. The 28 day measure is a national standard applying to data supplied to the Commonwealth by all States and Territories for the purposes of National Mental Health reporting – see *National Mental Health Report 2013*, page 186.

20. See AMHUMoC KPI’s on page 44, which include the Australian Council on Health Care Standards KPI of:

‘Unplanned readmissions to hospital within 28 days of discharge’

21. *National Standards for Mental Health Services 2010* criterion 10.5.11 requires that:

‘The treatment and support provided by the MHS is developed and evaluated collaboratively with the consumer and their carer(s). **This is documented in the current individual treatment, care and recovery plan.**’ [Emphasis added.]

22. See Mental Health, Justice Health, Alcohol & Drug Services *Collaborative Planning Standard Operating Procedure*

23. See audit tool criterion 9.1.

24. See AMHUMoC Treatment and Recovery Planning, page 31:

‘Working from an interim treatment and recovery plan, [*Multi-Disciplinary Team’s*] first task is to formulate a comprehensive plan that includes a ‘time frame, goals and aims, strategies and resources to achieve the desired outcomes and clear criteria for assessing consumer satisfaction. The plan will outline achievable collaboratively developed goals. These goals need to be reviewed daily by nursing staff and other members of the clinical team and by the full MDT during ward rounds.’

25. See audit tool criterion 9.1.

26. See *National Standards for Mental Health Services 2010* criterion 10.6 Exit and Re-Entry, particularly 10.6.8 which requires that:

‘The MHS, in conjunction with the treating clinician, has a procedure for appropriate follow-up of all consumers 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.’

27. See Mental Health Justice Health Alcohol and Drug Services (MHJHADS) Adult Mental Health Service (AMHS) Adult Community Mental Health Teams (ACMHT) *Transitional Clinician Standard Operating Procedure* which provides that:

‘For hospital consumers, the Transitional Clinician will; engage with the person whilst they are in hospital and make decisions as to which people would benefit from continued Transitional Clinician engagement; Participate in discharge planning in consultation with inpatient staff, the person and carers; contact the consumer within 7 days post discharge and follow up as per Medical

Discharge Summary (medications and PLAN); schedule a Psychiatric review ideally within 14 days post discharge.'

28. See audit tool criterion 9.3 – note that this criterion does NOT specify follow-up within 7 days, but rather that follow-up has been planned and documented.

29. See AMHUMoC principles of recovery focus and integrated services set out at page 10:

'Recovery focused and integrated services refer to a system which facilitates the links between consumers and the services they require. All health professionals, community agencies and nominated support people involved with a consumer during their recovery journey participate in planning and implementation. There will be clear communication pathways between the AMHU, the consumer and their family, other inpatient services, community mental health teams, consumer and carer organisations and community based services to ensure continuity of care and quality collaboration.'

30. See audit tool criterion 9.1.

31. See AMHUMoC page 34, which provides that, in respect of discharge:

'Planning for discharge and the support required after inpatient care should commence during the initial phase of hospitalisation. Factors that may exacerbate a consumer needs may include lack of stable housing, poverty, poor physical health, lack of employment and social networks. The need for a comprehensive assessment is crucial to maintaining the consumer's place in the community and to prevent inappropriate lengths of stay in inpatient care. It is important that community services and resources are engaged and mobilised at the earliest stage. This will involve community mental health team [*Clinical Managers*] at the earliest opportunity in facilitating early discharge. Integrated care pathway documentation must be agreed to enhance care delivery and communication and specific alternatives and options for further acute admission.'

32. See audit tool criterion 9.2.

33. See *National Standards for Mental Health Services 2010* criterion 10.5.12 which provides that:

'The MHS 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.'

34. See AMHUMoC page 34, which provides that, in respect of discharge:

'In order to access the services required by consumers (to meet their complex needs), these teams need to co-ordinate the activities of many different agencies including health, social services, housing, education, transport, criminal justice and employment.'

35. See audit tool criterion 9.3.

36. See AMHUMoC KPI's on page 44, which include the Australian Council on Health Care Standards KPI of:

'Percentage of Inpatients who have a discharge summary/letter on file at discharge'

37. See audit tool criteria 9.4 and 9.5.

38. See AMHU SOP Seventy Two Hour Assessment in the AMHU which requires that:

'Within the first 72 hours in the AMHU, a recovery plan for each person admitted is to be commenced. A discharge plan is to be completed/identified in the recovery plan and an estimated discharge date is to be specified. This is a responsibility for medical staff.'

In practice, this is first indicated by the completion of the form 'Other Recovery Issues' mandated by the Adult Mental Health Unit which requires that:

'The "other recovery issues" document is to be completed within 72 hours of admission to the unit. The completion of this document is to be initiated by nursing staff. This document can be accessed on MHAGIC under word documents. FDAR documentation is to be used when completing this document (please see SOP FDAR Documentation). The Recovery plan is to be reviewed at all Care plan review rounds (Ward Round). A Discharge plan is required to be documented on the recovery plan.'

MHAGIC operational standards require that all notes that are opened in MHAGIC are to be completed within 72 hours.

39. See audit tool criteria 8.8 and 8.9.
40. ACT Audit Office testing as to whether notes and observations recorded in relevant MHAGIC modules, or simply concatenated within a single module.
41. ACT Audit Office testing as to whether the MHAGIC "Personal Recovery Plan", "Keeping Well" plan and "Other Recovery Issues" templates were used or were present in some other form.
42. ACT Audit Office testing of ease of understanding and the relevant coverage of the plan (such as whether it included the general practitioner and other identified carers).
43. ACT Audit Office testing as to whether other relevant records could be found to indicate discharge planning or that could stand in lieu of a formal discharge plan.

APPENDIX C: THE ACT HEALTH DIRECTORATE CLINICAL RECORDS POLICY (2014)

The ACT Health Directorate's *Clinical Records Policy (2014)* states:

Health Directorate staff to keep full and accurate records of care provided to consumers.

A clinical record must be created and maintained for every consumer accessing a Health Directorate service.

The Health Directorate supports a centralised strategy for the management of clinical records and progression towards a single, integrated clinical record, accessible on-line, to all relevant members of the treating team, under a single unique consumer identifier.

Where centralised storage or digitisation of some parts of the hard copy record is not yet feasible due to clinical or resourcing requirements, these volumes may be managed as decentralised records, under approval by the Director-General.

Clinical records should be accurate, complete and up to date. Documentation within the record should comply with the requirements outlined in the Clinical Record Documentation SOP, be on approved clinical record forms and should include only approved Abbreviations.

All Canberra Hospital inpatient episodes, regardless of length of stay or discharge outcome, require a Discharge Summary, or an acceptable alternate discharge document, with the exception of day-only dialysis admissions. The Discharge Summary or discharge documentation should be completed on transfer/discharge, or within 48 hours of discharge, to facilitate a smooth transition of care to the general practitioner (GP) and/or other facility and to finalise the inpatient clinical record documentation requirements.

Ultimate responsibility for completing the Discharge Summary or discharge documentation lies with the discharging consultant and/or discharging clinical unit and is usually delegated to a Junior Medical Officer.

All Discharge Summaries are to be completed before the Clinical Record Service will sign the Medical Officers Staff Clearance forms.

For community based services, discharge documentation such as a Case Closure Summary, Discharge Letter, or an equivalent should be completed within 48 hours of discharge and faxed/despached to the GP and/or other health professionals involved in the consumer's ongoing care.

For inclusion in the clinical record, forms must be approved by the Clinical Record Forms Committee

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