Informing the Development of a Quality Assurance Framework for Mental Health in Western Australia

Interim Report May / June 2011

1. Background

In April 2011, the Mental Health Commission on behalf of the Government of Western Australia commissioned a team of external experts to provide advice to help inform the development of a Quality Assurance Framework for Mental Health in Western Australia. (Appendix 1 gives information on the team of experts and the role and remit of the work). This work is taking place as part of the Western Australian Government’s commitment to modernize, streamline and improve quality assurance across the mental health system and improve outcomes for the public through improved and modernised public sector management (Economic Audit Committee 2009)

‘The potential of the public sector is constrained by multiple layers of regulatory scrutiny. The resulting culture of the public sector is excessively compliance-driven and risk averse. Changing this culture will be essential to the achievement of Government priorities’. (EAC October 2009)

In considering this task, it is important to note that there has been significant attention to quality assurance in health generally, and mental health in particular, at both the State and National levels in Australia. An outline of the roles and responsibilities in the existing mental health system at the State level was provided to us (see Appendix 2). Sensible and planned reform must build on the existing strengths, skills, expertise and experience of the current system.

There is no doubt that this is a very complex system and in moving forward it is important to ensure that any proposed changes do not have unintended negative consequences elsewhere in the system.

This interim report marks the end of the first stage of the project. A final report with recommendations will be produced towards the end of July 2011. This interim report is based on desk-based research into the current mental health system in Western Australia and in Australia more generally and into approaches to quality assurance and mental health internationally. Profiles of approaches to quality assurance taken in a selection of other countries can be found in Appendix 3. The work has also been richly informed by a visit to Perth in May 2011 during which the team met with and were informed by a wide range of stakeholders who provided invaluable information about the current system, its qualities, strengths, challenges, shortcomings and their aspirations and hopes for the future. The people we met responded with great openness about how to improve the current situation and the possibilities and ambitions for real change, not just in improving quality assurance for mental health care in Western Australia but in significantly adding to the ambitions already underway to transform the mental health system across the State.
We noted that in the feedback to the Statewide consultations undertaken by the Mental Health Commission in 2010, many people identified quality assurance, and avenues to provide feedback and express concern, as matters that needed to be strengthened. This also permeated the earlier consultations when the Mental Health Act was first reviewed in 2002 and reflected in the report of Professor Holman.

We were humbled by the commitment and hard work of the people we met and the aspirations they share to improve the lives of people living with and recovering from mental illness and those of their carers and families and the wider community. There is a real desire to create something better for the people of Western Australia. The clamour for change and for much greater collaboration was palpable and the enthusiasm for grasping the moment to create an improved quality assurance system and wider system and human transformation was impressive.

We were tasked with developing an approach to improve quality assurance for the Western Australian mental health system. However, we have been convinced by the views of stakeholders and evidence from other countries that quality assurance alone will not achieve the kind of system transformation that you told us you want to achieve and which is already underway in the State. As one family carer told us, “a quality assurance system cannot guarantee that the services that are needed will be there, however, it can be a driver for helping to improve the system”. For this reason, we have gone beyond quality assurance in this report to address wider questions of system reform, of which quality assurance is a key component part. In our view, the two are best pursued in parallel.

This report draws on the enthusiasm and expertise of the people we met to help provide a starting point for debate and discussion on the future direction of quality assurance for mental health in Western Australia as part of a wider process of system transformation. It is not intended to be a blueprint. Rather, it has been written to help inform ongoing consultations and discussions at a series of further meetings and events to be held in Western Australia from 4-12 July 2011.

Prior to this next consultation and discussion visit with stakeholders we are keen to generate a wide range of responses, views and thoughts on this report, and other issues you feel are relevant but not addressed here. We will take note of these views and will use them to prepare for our visit in July. We look forward to working with you then and to hearing and discussing in more detail your views on whether the approaches we have put forward in this report are the right ones to achieve your aspirations to improve quality assurance in mental health and help underpin and accelerate change in the Western Australian mental health system for the benefit of all Western Australians.
2. International Context

We thought it would be helpful to set our proposals on quality assurance and system transformation in Western Australia in the context of current strands of thinking about mental health reform internationally. A lot of what is emerging internationally is also evident in what is taking place across Australia and Western Australia. This section presents a brief overview of international trends.

Recovery
Internationally there is a growing focus on updating and improving mental health care for people living with significant mental illness in line with the principles of recovery which emphasise supporting and enabling people to lead flourishing and fulfilling lives independently in their local communities.

Human rights
In addition there is also considerable attention being paid to ensuring equal human rights for people living with and recovering from mental illness. The recent United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) is a key driver of this along with wider human rights and equalities issues.

Social determinants of mental health and a whole-life focus
Coupled with this is the desire for greater social and community inclusion, a new focus on wellbeing and fairness and equality in terms of access to housing, employment, education, healthcare, family support, debt and financial advice. This recognises that mental illness and mental health are in large part socially created and socially destroyed.

Stigma and discrimination
There is significant work being pursued internationally to address and counteract discrimination against persons with a mental illness and the desire for greater public understanding and awareness about both mental illness and mental ‘health’.

Mental health, not just mental illness
There is a desire emerging internationally not only to tackle the modernisation and improvement of mental health care services along recovery principles but a desire to promote and improve wider population mental health or wider social, emotional and mental wellbeing. A good recent example of this is the new English mental health strategy, No Health Without Mental Health (February 2011), which also calls for ‘parity of esteem’ between mental and physical health.

Choice and personalisation
Other emerging issues include a move to enhance choice and greater ‘personalisation’ of services and supports. Here there is a desire to bring mental health care and support onto a level playing field with wider disability services and the significant gains and improvements made for people living with physical disabilities. Some of this is present in the growing debate for extending the use of individual budgets to also include people living with and recovering from mental illness.
In terms of quality assurance there are a number of emerging trends:

- There is an emerging challenge to the convention of having separate mental health care legislation. Although no country or jurisdiction has gone down the route of extending legislation on guardianship, health and criminal justice instead of creating separate legislation, some countries, notably Norway, are beginning to look into this in more depth in the belief that having separate legislation compromises the notion of equal human rights.
- Where mental health care legislation is being updated, law makers are placing greater emphasis on only using legislation to restrict people’s freedoms where there is a clear treatment and care reason, including issues of safety and appropriate management of risk, and that this is done with the least restriction possible for the shortest period possible with strong external reviews and checks on legal process.
- Alongside this are moves to help provide a sense of reciprocity in the system. Where if individual freedoms are taken away or restricted for a period of time, there needs to be a reciprocal benefit to the person. This is most evident in Scotland (see Appendix 3).
- Countries are also beginning to consider or move to a system where there are rights to independent advocacy to support people, and not just those subject to involuntary status.
- The issue of addressing serious complaints and challenges is pursued in some countries through an independent, mental health specific organisation and in others as part of a wider public ombudsman’s roles or indeed through an independent ‘Commissioner’ role.
- In terms of quality improvement, a number of countries have moved to having mental health care quality improvement as one part of their overall system of quality improvement in healthcare. These moves do not seek to downplay the specific needs of mental health care services and specialist knowledge and skills but to integrate mental health into the wider healthcare system.

3. The Current System of Quality Assurance in Western Australia

People told us that the current system of quality assurance in mental health is complex and difficult for many people, families, practitioners and agencies to understand. They also said it does not have sufficient transparency and independence to give providers, consumers, families and communities the confidence they require to enable people to feel that positive outcomes for patients, carers and the public will be achieved. There were also a number of strengths identified by stakeholders within the current system and there is in our view considerable potential to build on the experience, skills, roles and functions currently being performed.
It was also hard for people to disentangle their desires for an improved quality assurance system from their desires to have improved services, supports and positive outcomes for people’s lives.

Through a series of meetings with stakeholders, a number of shared aspirations were consistently articulated. These included:

- The desire to have a quality assurance system that is able to judge all providers fairly, in a way that is seen as independent and where real sanctions can be brought to ensure improvements and compliance.
- An ability to respond to significant adverse events, where each event is investigated and acted upon, enabling real improvements to be made.
- Having a quality assurance system that supports collaboration and improved relationships across the system in a positive way that builds sharing, learning and improving together across the system.
- Where the use of legislation that restricts people’s rights, is only used to help meet specific treatment and care needs and is used for the shortest period possible, in the least restrictive setting and with consent, where possible. It should not be used because there is a lack of appropriate services in the community (housing and accommodation were people’s key concerns).
- Having a responsive system that acts to protect people’s rights in a more timely and equal way, with a requirement that actions are taken are in line with a holistic plan for care, treatment and the promotion of a person’s wellbeing, social development and social inclusion.
- Mental health should not be subject to separate and different forms of quality assurance, as this can breed separatism and fuel misunderstanding and further increases stigma.
- Addressing the overrepresentation in the mental illness system (and especially in the use of involuntary treatment orders) of indigenous people’s and especially young men from indigenous communities.
- Improving the ability of all parts of a quality assurance system to be culturally competent and to demonstrate an understanding of, respect for and ability to support indigenous cultures, beliefs and practices and those of other diverse ethnic communities and groups.
- Having an accessible Advocacy network that can respond to a range of people’s support needs, and one not just restricted to people under involuntary status.
- Developing a wider system of ‘quality assurance’ that links with and is part of wider issues such as guardianship, criminal justice, generic health care, housing, employment, education etc
- An ability to focus on individual needs, aspirations and to give choice based on principles of personalisation and increased autonomy.
- Having a place in the system where serious complaints are acted upon and when shortcomings are found, changes and improvement are made that are owned by the system.
- An approach to risk that focuses on safety and does not restrict opportunity or ambition more than is absolutely justified.
People were naturally focused on the elements of the system that through their experiences were not working in ways that they wanted or in ways that met their aspirations and expectations. There are also good features that people identified that they wished to see built on going forward and current functions that people feel are fundamental to retain and improve going forward. However, there was a feeling that changes were already taking place, and that mental health was experiencing a period of greater investment and interest politically and publically, and that this brings with it a need and opportunity to improve and update quality assurance going forward from here.

There was also a real desire to see any future changes in a wider context where issues of basic social and human needs were acted upon to help underpin improvements in care and treatment. Time and time again we were told of the importance of housing, links to employment, education and to better overall health. People were especially keen to see the wider picture drawn in to any future quality assurance system, otherwise there may be a danger that the new system continues to be ‘uncoupled’ from people’s lives, experiences and communities.

4. Vision and principles

The focus on mental health in parts of this report in isolation, or separate from, other parts of the health and disability system should be taken as a sign of the times. Given current efforts in Western Australia to transform the mental health system, there is a strong case for singling out mental health and treating it separately to provide the focus required to achieve the desired changes. However, over time, as a singular focus on mental health moves it towards parity of funding and also of ‘esteem’ with physical health and disability services, treating mental health separately, differently or ‘exceptionally’ will no longer (and should no longer) be necessary. On the contrary, mental health will benefit from greater integration and mainstreaming into the wider health and disability system. Indeed that should be one of the principle goals of the transformation process. For the moment, however, shining a spot light on mental health transformation has a clear purpose and until that parity of esteem is reached, specialised but connected structures and roles will be necessary in Western Australia as they are elsewhere.

If the central purpose of transforming the Western Australian mental health system is to put people at its heart and to ensure that the services it provides support people to move on in their lives – to find meaningful things to do, a place to live and to be socially connected - not just to manage their symptoms, then getting the functions of quality assurance right may not be enough. A well designed system can still disregard the voices of those who depend on it. For people to be at the centre of the system, it is not just a question of having the right functions. It is critically important what those functions do, how they do it, with whom, and how they are held to account. Is the performance of providers judged on how successful they are at getting people into employment or only on how many assessments they do in a year? Do service-users and families play a
meaningful role in co-producing the strategy, policies, legislation and co-designing new services or are they part of an advisory group that is consulted but not listened to? Are carers meaningfully engaged? And are community and public attitudes and behaviours challenged when they run counter to human rights and equal opportunities?

We are not sure that, put together, the quality assurance functions described in this interim paper will go far enough to transform the Western Australian mental health system into a truly person-centred system that improves people’s lives not just their mental health. That is why we wish to suggest these initial ways to improve the quality assurance system and get your views on these suggestions, but also go further with you to explore the vision and principles that will underpin the system and its continuing improvement.

We suggest that to transform the mental health system into one that supports individuals to achieve a full and meaningful life, it may be necessary to consider some new or additional forms of legislation or statutory change, for example:

- Develop legislation that adheres to the principles and articles of the UN Charter for Human Rights and the recently ratified UN Convention on the Rights of Persons with Disabilities (UN CRPD) in state wide legislation.
- Create a statutory body or council to support and drive system transformation by providing independent oversight, identifying gaps in existing services and holding other actors in the system to account. Without independent monitoring and oversight, real transformation is unlikely to be achieved solely from within the system.
- Create a statutory right for all individuals receiving care to have an individualised care and support plan and to choose who advises them and supports them in developing it. We note that South Australia for instance provides that the treatment and care of patients must, as far as practicable, be governed by a treatment and care plan directed towards recovery. This will help tip the balance of power in the system in favour of individuals and their carers and families and support a more integrated whole-life approach to addressing mental health.
- In time, consideration might be given to creating a statutory right for all individuals receiving care to choose self-determination and provide personalised budgets to allow them to do so. This will give individuals and their supporters greater power to reshape the system according to their needs and preferences, ensuring a stronger focus on the social determinants of mental health. In doing this, Western Australia would leapfrog all other western jurisdictions. In the short to intermediate term, the Commission needs to ensure it has all the levers it requires to increase access to personalised budgets.

These and other changes could be encompassed in the development of the new Mental Health (Care and Treatment) Act – we have added ‘Care and Treatment’ to the title of the draft legislation to emphasise the fact that this legislation is largely about the care and treatment of people who have a mental illness rather than mental health more broadly. We will return to that later in the report. These are options for discussion at this stage. There could be other ways to ensure that the system you build creates a real
transformation for individuals, their families, communities and the wider public. This will form a core part of further considerations.

5. **Defining Quality Assurance**

Our approach to quality assurance has two core functions:

- **Rights and protections**

Rights and protections includes protecting the human rights of those who are involuntarily detained and treated and who are at greatest risk of having their rights violated and neglected. It also includes protecting the rights of individuals who use mental health services, as part of a wider set of ‘consumer’ rights for users of health and disability services. Rights protection in both contexts would be underpinned by access to independent advocacy for any individual who requests it.

- **Quality improvement**

Quality improvement includes accreditation and licensing, standard setting, monitoring and inspection of providers and continuous quality improvement to ensure that the systems improve year on year.

Each of these functions can be underpinned by legislation, although they do not all have to be and each is dependent on securing adequate funding and the required authorisation, governance, leadership and political support to operate. Furthermore, effectively achieving each of these key objectives and functions to a standard of excellence requires clinicians, practitioners, administrators, managers, community groups and others within the mental health system and beyond to have permission to do things differently. Without permission to act and adopt a learning culture without fear of sanction, system transformation will not be achieved. Ultimately, the functions of quality assurance have to be underpinned by values and principles to ensure that they support the kind of system transformation stakeholders wish to see.

We understand that the immediate challenge for the Mental Health Commission is ensure the new Mental Health legislation includes the necessary statutory underpinnings to support the on-going development and refinement of the broader quality framework.

These elements, summarised in Table 1 are discussed in the following section.
Table 1: Defining Quality Assurance

Our approach to quality assurance has two core functions:

1. Rights and protections
   — Protecting the human rights of individuals receiving involuntary treatment
   — Protecting the rights of users of mental health services
   — Advocacy

2. Quality improvement
   — Licensing and accrediting providers
   — Setting standards and key performance indicators
   — Regular and ad hoc inspections
   — Continuous quality improvement.

A Rights and Protection

i. Protecting the human rights of individuals receiving involuntary treatment

When individuals are detained under the (any) Mental Health (Care and Treatment) Act, we have a clear duty to ensure that their human rights are respected and that they are treated with respect and dignity. This applies to those detained in hospital or in the community.

Ensuring that this legislation works in the interests of patients, carers, families and communities will fall to a body that performs an external and independent review function. This function requires adequate resourcing and support to carry out this vitally important role. In some jurisdictions this body is known as a ‘tribunal’.

As part of developing this function, we believe it is critical for the Western Australian Government to move forward with drafting, consulting on and passing a new Act which will provide the basis for the work of this function or tribunal, building on the experience to date in Western Australia, on past and more recent reviews and on growing international evidence of what works and why.

As a first principle, the Act should be rooted in the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) (see Appendix 5 for the key articles of this convention).
In addition, people told us the Act should embody the following principles:

- An external review function that is independent from the service system
- Where automatic reviews take place much more promptly
- Where the onus is on the provider to demonstrate clear treatment aims and plans
- Length of stay – that involuntary detention should be for the shortest possible time and in the least restrictive setting possible;
- Individual planning – Individuals who are involuntarily detained should be supported to develop an individual plan of care with a strong focus on therapeutic interventions, advance directives and on building towards improving their life once they leave hospital.
- A right to independent advocacy
- A right to legal representation
- Reciprocity – having restricted their freedom, that the mental health system has a duty to promote the well being and social development of individuals who have been detained and to ensure that they have appropriate care and support in the community when they are discharged

These principles draw on best international practice, most notably from Scotland where a new Mental Health (Care and Treatment) Act 2003 was introduced in 2005 based on the principle of reciprocity. With a key focus on an individual care plan, a right to independent advocacy and a duty on local statutory agencies to ensure that a person’s wellbeing and social development, i.e. housing, employment status, educational opportunities and inclusion are properly supported in the care planning process.

If the Act were to have a strong focus on social development and well being, it would appear necessary for that body to have access to wider expertise related to these issues alongside the tradition legal and psychiatric expertise of Mental Health Tribunals. The body set up to adjudicate over the Act would in our view be part of the judicial system to ensure independence from healthcare providers. We do note however that in Australia there has been trend to maintain dedicated Mental Health Tribunals separate from the broader administrative tribunals. There may be good reasons for this.

In addition to these high level issues, a few major impediments or improvements were consistently raised. These included:

- The need for tri-state or interstate agreements so that transfers across and between different state jurisdictions can be effectively managed in the interests of patients
- Where there is a need for transportation this is done in a manner that puts care and welfare first and where all possible attempts are made to manage risk and safety in a local and consensual way.
- That where there are blocks to releasing someone from involuntary care, that these are not due to a lack of services or supported accommodation. These will need to be developed through effective care planning across the system.

Not all of this requires legislative change to enable it to happen.
A few thoughts on ‘risk’ - Serious harm, to self or others, is very rare but when it occurs it causes severe and widespread personal and systemic distress. Historically, mental health systems have addressed risk and the avoidance of risk in such a way as to unreasonably restrict the lives and opportunities of the many who have severe mental illness. There is a growing move in England and elsewhere to reframe risk through the lens of safety. At a time of increasing choice and control for those receiving services, clinicians, the public and politicians have to feel confident that risks are mitigated. Through a new, more inclusive and more holistic approach, the responsibility for achieving safe outcomes is beginning to be shared by the person who is ill, their family/close friends, and the psychiatrist and other professionals involved. These more inclusive processes move away from the fantasy that all risks can be prevented and seek to develop a more mature approach to managing it.

ii. Protecting the rights of users of mental health services

There is a need over and above the external review of involuntary treatment orders to protect the rights of all users of services to ensure they are well treated and get a good service, including those receiving voluntary treatment.

As in New Zealand, this could be pursued through a code of consumer rights in regulation. This would require a legal basis which could be under the Mental Health Act or other legislation. This function undertakes monitoring, information provision and support for consumers, conducts investigations and reports on standards of care; and establishes and conducts an independent complaints mechanism. In some jurisdictions this role is performed by a separate mental health body, such as in Scotland through the role of the Mental Welfare Commission. In others this is part of wider generic responsibilities. i.e. New Zealand and England. In New Zealand, the role of the Health and Disability Commissioner is to promote and protect the rights of health and disability services consumers, as set out in the Code of Health and Disability Services Consumers’ Rights, and to facilitate the resolution of complaints.

Having a set of rights that apply to all users of health and disability services, including users of mental health services, can provide a powerful check on the system and drive further transformation. If these rights are written to include a focus on recovery, on wider social determinants of mental health, as well as on effective care and treatment, a code of consumer rights coupled with a mechanism to ensure proactive monitoring and promotion of those rights could accelerate the kind of system transformation that is desired in Western Australia. This is an issue that needs further consideration.

iii. Advocacy

We would propose that advocacy be available to all users of mental health services through a state-wide network of advocates that is independent from service providers. As a first step, we would suggest that it is written into the new Act that involuntary status
comes with the right to advocacy. Given that many individuals who are voluntary patients are vulnerable and require support to ensure that their rights are upheld, we would propose extending the right to advocacy in law to all inpatients, whether voluntary in involuntary as well as to those on community treatment orders. Access to advocacy for all users of mental health services should be taken as a second step, once a network of state-wide advocates is better developed.

Given that the Act is rooted in the UN Convention on the Rights of Persons with Disabilities, we would argue that advocacy should be cross-disability as its role is to protect individual human rights not specific mental health-related rights. New Zealand has a cross-health and disability advocacy service that was created in 1996 under the Health and Disability Commissioner legislation. Consumers are protected in law by a set of consumer rights and can make complaints about any service to the Health and Disability Commissioner whose role it is to ensure that consumer rights are upheld. Anyone who makes a complaint is entitled to advocacy to support them in going through the complaints process.

**B  Quality Improvement**

Internationally, quality improvement is moving away from separating mental health from other health services. Mental health is integrated into the wider quality improvement system. For example, in England, the creation of the CQC (Care Quality Commission) in 2009 brought together all health and adult social care regulation, including the Mental Health Act Commission. The CQC now applies a generic approach to mental health providers with an overlay of interest in issues unique to mental health. This approach has led to the regulation and monitoring functions applying holistic tests to mental health services without diluting the specific mental health function. This holistic route would address those incidents of serious short-comings in primary care that we were advised of, including the higher rates of morbidity and mortality among those with long term mental illnesses.

We have listened to what people have told us and measured it against international best practice. We see no reason for a separate quality improvement system for mental health. In our view this will only marginalise and further stigmatise mental health. We do, however, recognise that specific mental health care, support, treatment and clinical expertise will need to be developed within this generic quality improvement function. That is, the quality improvement system for mental health should be customised, to the extent necessary, within the broader health quality improvement system.

Looking internationally, quality improvement organisations have four core functions:

1. **Licensing and accrediting providers**
   Licensing and accreditation sets the floor for quality in the system. Whether, public, private or an NGO, providers have to meet certain basic standards in order to operate
within the system. Removing a provider’s license to operate for failure to meet basic standards ensures minimum standards.

ii Setting standards and key performance indicators
The development of appropriate standards for licensing and accreditation is an important function of quality improvement organisations. In addition, they have an important role in developing key performance indicators and identifying best practice against which providers can be judged and their performance constantly improved.

For the inspection function to deliver real transformation, it will be critical for standards and KPIs to be set in line with the values and principles identified for the system. If the intention is to create a mental health system in Western Australia that improves people’s quality of life as effectively as it deals with the psychiatric condition, this needs to be embedded in the measures for which providers are held accountable. A system that measures performance according to the bio-medical model of mental health only will deliver services that neglect important facets of people’s lives.

iii Regular and ad hoc inspections
Monitoring the performance of providers according to published standards and key performance indicators ensures that quality is maintained within the healthcare system. Regular cycles of inspection are important alongside the ability to perform ad hoc inspections in response to complaints or incidents. The ability to apply effective sanctions where breaches in quality are identified is critical to an effective inspection system.

iv Continuous quality improvement.
As well as judging providers against published standards, quality improvement organisations have an important role to play in supporting providers to improve year on year. Continuous quality improvement needs to reflect and be in line with the values and priorities for the system.

Central to these functions is creating a level playing field for all providers, whether public, NGO or private and developing accountability. One of the important challenges for the Western Australian mental health system is to hold providers to account for their performance, irrespective of whether they are in the public, NGO or private sectors. The system currently appears to lack accountability. Time is spent recording complaints, serious incidents and other problems but the public perception is that little is done with that information. It appears to external observers that there is little or no sanction for organisations or chief officers, such as losing their license to operate on the basis of poor performance. Accreditation and re-accreditation needs to be robust, transparent and fair. It needs to be driven not by historical models but by the demands of the strategic direction chosen for the system. Providers are usually willing to change to more appropriate individual based models when fully involved in the process of change and development. The desire to be involved and to work collaboratively was a key feature of all the providers we met.
6. Mental Health System Transformation

Going back to where we started at the beginning of this paper, in developing the functions of quality assurance and setting a framework for their future development, it became clear that they are only functions that operate as one part of a transformed system. The rest of this interim report looks at the functions required to achieve the reform agenda that is already underway in Western Australia.

The desire is to help create a way of moving beyond a system that focuses on individual treatment and care to one that encompasses wider social and community issues, and a whole of life focus that supports wider wellbeing and mental health.

A lot is already in place or developing. The creation of the Mental Health Commission is a bold first move, one which gives the system a strong strategic and operational commissioning basis under the policy and strategic direction of the Minister for Mental Health. There is already a commitment to address issues such as housing, employment, recovery, individualised care and parity with physical health and disability services.

The main functions of the Mental Health Commission in relation to quality and accountability are currently described as the following:

- Policy, legislation and strategy
  Within the broader framework of Government policy, the Commission will play the lead role in developing policy and strategy for mental health across government. This will need to be supported by the appropriate legislative framework and complement work at the national level. The Commission must ensure that policy is informed by stakeholder input, particularly consumers and carers, so that it remains responsive to their particular needs, preferences and circumstances. The creation and funding of a Consumer body is arguably one important component part of this.

- Purchasing and contracting
  Purchasing and contracting will play a critical role in delivering the strategy by translating strategic priorities such as person-centred care or prevention into financial flows within the mental health system. Contracting needs to be flexible for contracts to be transferred from providers when priorities change or when providers underperform and to reflect the choices of individuals and communities. Therefore, there should be a preference for framework contracts and other flexible arrangements over block contracts. The use of performance-based and outcomes-based contracting should be encouraged.

- Information and data
  A system cannot become more efficient and effective without good data and information, including on inpatient services and, crucially, data on finance and costs across the service system and beyond. It is important that data are collected and analysed so as to be useful to decision-makers involved in purchasing and contracting or policy and strategy. To deliver the vision of a mental health system that addresses people’s whole lives, a wider set of data will need to be collected. This may require agreements across government
departments to share back office functions. There is also a need to deal with the egregious retention of information behind the personal confidentiality caveat.

- **Service development**
  
The function of Service Development is the hands on work required to support providers to change the ways in which they provide services, to develop new providers in the market offering alternative services and to support the development of service user-led organisations. It is an essential part of continuous improvement. Service development functions also need to be able to go beyond limited mental health service issues to address issues such as employment, housing, education and wider issues of inclusion and community participation.

Part of a future service development function that people called for was the ability to provide opportunities for ongoing collaborative work and learning through improved networks of practice and engagement where a wide range of stakeholders are brought together on a regular basis to discuss and debate issues and work out actions to support and imbed change.

This is an excellent start but the system also needs independent oversight and external challenge to accelerate transformation and ensure that the vision and principles are achieved. At present, there is no body that plays this role in the system although the recently announced Mental Health Advisory Council can certainly play a role.

This independent oversight and external monitoring and accountability function for wider system change is one that we feel has considerable merit and should be explored. Attempts have been made internationally to develop this function. New Zealand comes to mind. But nowhere has yet devised this function in ways that embody a set of important characteristics. These could include (Adapted from Rosen, Goldbloom and McGeorge 2010):

- A system wide mandate to promote mental health transformation
- Independence from policy, strategy, operations and quality assurance
- A focus on wide stakeholder engagement and demonstrating true stakeholder collaboration and representation and influence.
- A focus on recovery, holistic care and human rights
- A wider focus on prevention and the promotion of good mental health (social, emotional and psychological wellbeing) at a wider population level to ensure a better balance between individualised treatment responses and addressing key social determinants for good mental health and wellbeing
- Monitoring and reporting on progress.
- Encouraging and evaluating new innovations
- Making the evidence base available
- Being a positive yet critical friend in the on-going challenge of transformation.
- Embodying principles of shared and open learning and learning by doing and experience. The phrase ‘walking together’ with Government and stakeholders has been used.
‘Despite all the policies, plans, strategies, reports and proposals released over recent years on mental health reform in various nations, on the whole we still have not seen a consistent and stable roll-out of evidence-based and recovery oriented system building that might drive some of the tangible improvements so desperately needed’ (Rosen et al, 2010)

Many of these of these, along with its purchasing, are roles of the Mental Health Commission and appropriately so. However, we believe that with independent oversight, Western Australia can go further still and develop a system of improved quality assurance and at the same time move to a wider framework of system reform that improves not just the lives of people living with and recovering from mental illness, but that begins to move the mental health agenda more centre stage and better integrated with wider wellbeing and quality of life for families and communities.

7. Interim Conclusions

In this interim report we have attempted to set out a suggested direction of travel, at a deliberately ‘high’ level without much detail. This is because we wish to establish some high level suggestions that can be debated, discussed, critically appraised and further developed. The detail will follow with further discussions and reflections. We have sought to describe an outline framework that concentrates on the core functions of quality assurance alongside some suggestions as to how wider system transformation may be supported by a series of strategic, operational and oversight functions.

Below, we summarise the key points raised in this interim paper:

- We recognise and acknowledge the significant enthusiasm for system transformation in Western Australia and the commitment to creating a mental health system that improves the lives of those who use services, their families and the public.
- We heard from many of you that you are unhappy with certain aspects of the current system but are also aware of its strengths and what can be built on, especially the bold decision in Western Australia to create a Mental Health Commission with a purchasing capacity.
- A strong set of values and principles that could underpin system transformation in the interests of people are emerging but need to be articulated, consulted on and agreed.
- Our research into international approaches to quality assurance and the conversations we had with you have highlighted that quality assurance cannot be easily separated from wider system transformation. The two are mutually reinforcing.
- The approach to quality assurance we propose here has two principal functions: protecting the human and ‘consumer’ rights of individuals using the mental health system; and quality improvement to ensure that the system meets certain standards and achieves better quality year on year.
• Through the creation of the Mental Health Commission, Western Australia is developing a strong strategic and operational commissioning entity under the policy and strategic direction of the Minister for Mental Health.

• To accelerate transformation, the system also needs independent oversight and external challenge. At present, there is no one that plays this role in the system and transformation is likely to be slower without such a function in place. It will be a major challenge for the Mental Health Commission to do this at the same time as it develops a strategic and commissioning role. This needs to be balanced against the costs and layers of bureaucracy that can be created when there are too many parts to a system.

Our next set of stakeholder discussions and meetings on developing a quality assurance framework for mental health in Western Australia are planned for the first week in July from 4 - 12. To prepare for our visit, we look forward to receiving your feedback, thoughts and views on this interim paper. Tell us what we have got wrong and also what you like about our proposals in this paper. Tell us whether the existing systems as described in Appendix 2 can embody greater confidence in the quality of services with minor changes to structures and processes, or are there approaches we can adopt from other health, wider disability arena(s) that will enhance confidence in the quality assurance of mental health services?

We would like to get your feedback on the general direction of travel set out here and on specific points of detail you would like to raise. We can digest these before we come out and be prepared to debate and discuss with you in July. We would like to thank you in advance for your ideas and ongoing collaboration with this project and we look forward to the next stage of work.

To submit feedback please go to [http://tinyurl.com/WAQAFMHinterim](http://tinyurl.com/WAQAFMHinterim)

_Vidhya Alakeson, Gregor Henderson, Kevin Lewis, 10 June 2011_
References


Appendices

Appendix 1 - Information on Expert Team and Role and Remit of Project.

Appendix 2 – Towards a Comprehensive and Coordinated Quality Framework for Mental Health in Western Australia. Background Information. (Mental Health Commission, Government of Western Australia)

Appendix 3 – Country Profiles (England, New Zealand, Ireland, Scotland)

Appendix 4 – Stakeholder Meetings 9-13 May 2011

Appendix 5 - Key Articles from the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)
Appendix 1

Provision of Advice to Inform the Development of a Quality Assurance Framework for Mental Health in Western Australia

Background, Remit and Expert Project Team

The Mental Health Commission of Western Australia has commissioned a group of external mental health experts to provide advice to help inform the development of a Quality Assurance Framework for Mental Health in Western Australia. (For further information see Appendix 2)

This work is taking place as part of the Western Australian Government’s commitment to update, modernize, streamline and improve quality assurance across the mental health system.

The experts involved are Gregor Henderson, Kevin Lewis, Vidhya Alakeson and Tony Jameson Allen from the UK.

The work will take place over the next four months in two stages.

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

Stage two will take the interim report and use this as a consultation paper to form the basis for further discussions with stakeholders to help canvas a broad range of opinions, views and experience. Consultation meetings and discussions will take place in Western Australia from 4 – 12 July. Following this, a final report with suggested recommendations for a new quality assurance framework will be produced by the end of July.

Background

The Mental Health Commission is seeking advice to inform the development of a new Quality Assurance Framework for Mental Health in Western Australia that reflects the opportunity to modernize, streamline and improve quality assurance mechanisms across the sector.

The goals of quality improvement (as set out by the World Health Organisation in 2003) are to,

‘respect the rights of people with mental disorders, to ensure that they are provided with the best available evidence-based care, to increase self-reliance and to improve quality of life’.
‘……. quality assurance activities should ensure that people receive the care they require and have their aspirations for personal recovery supported’.

The Mental Health Commission has identified three key objectives underpinning mental health system reform and the way forward, these are:

- Person centred services and support
- A connected whole of Government and community approach
- Balanced investment in a full range of services.

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

As mental health systems develop, change, respond and adjust to new advances in evidence, technology, practice and the advancement of human rights and equalities, the ability of quality assurance services, systems and processes to keep pace with these changes becomes crucially important. The opportunity to take stock and reflect, look at what is happening and emerging elsewhere nationally and internationally, engage in meaningful discussion, dialogue and debate with and between stakeholders is one helpful part of the process in developing a modern quality assurance framework for Western Australia.
External Experts – Project Team

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

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

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

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

Background information
1 Introduction

The ultimate goals of quality improvement are to respect the rights of people with mental disorders, to ensure that they are provided with the best available evidence-based care, to increase self-reliance and to improve the quality of life.1

From the perspective of a person with a mental disorder quality assurance activities should ensure that they receive the care they require and that their aspirations for personal recovery are supported.

However, as systems become more complex and community expectations are raised there can be a tendency for the quantity of ‘quality’ activities to increase. Whilst this may lead to the more scrutiny, there can be risk that the positive outcomes sought are not forthcoming as the focus trends towards undertaking the process rather than improving the outcomes.

2 Western Australian Context

2.1 Mental Health Commission

2.1.1 Establishment

Western Australia’s first Mental Health Commission came into effect on 8 March 2010. This is a key step in creating a modern effective mental health system that places individuals and their recovery at the centre of its work.

The Commission will focus on mental health strategic policy, planning, procurement and performance monitoring and evaluation of services. It will promote social inclusion, raise public awareness of mental wellbeing and address stigma and discrimination surrounding mental illness.

Collaborative partnerships will be established with other government agencies, the community sector and business. It will operate in the context of the national mental health reform agenda.

The Commission will not provide specialist mental health services directly to individuals with mental health problems. These will continue to be provided by government, not-for-profit and private sector organisations.

The Mental Health Commission has identified three key reform objectives underpin the way forward and should therefore be reflected in the design of the quality assurance system. These are.

- PERSON CENTRED services and support—because the consumer must come first always
- CONNECTED whole of government and community approach—because we can only achieve the vision by working together and building on strengths
- BALANCED investment in a full range of services—because mental health crosses a broad spectrum and we need a strong system from promotion and prevention to treatment and recovery

2.1.2 Functions of the Commission

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1 World Health Organisation in their Mental Health Policy and Service Guidance Package - Quality Improvement for Mental Health (2003)
The functions of the Commission include:

- the development and provision of mental health policy and advice to the Government;
- leading the implementation of the Mental Health Strategic Plan;
- responsibility for articulating key outcomes and determining the range of mental health services required for defined areas and populations across the state;
- responsibility for specifying activity levels, standards of care and determining resourcing required;
- identification of appropriate service providers, benchmarks and the establishment of associated contracting arrangements with both government and non government sectors;
- provision of grants, transfers and service contract arrangements
- ongoing performance monitoring and evaluation of key mental health programs in Western Australia;
- ensuring effective accountability and governance systems are in place; and
- promoting social inclusion, public awareness and understanding of matters relating to the wellbeing of people with mental illness to address stigma and discrimination

Specialised mental health services will continue to be provided by a range of providers including:

- WA Health Area Health Services will continue to provide inpatient and community based services.
- Private hospitals will continue to be funded to provide specialised mental health inpatient care
- Non government mental health service providers will continue to be funded to provide a range of support and residential services.

3 National Context

3.1 Australian Commission on Safety and Quality in Health Care

The National Health and Hospitals Network (NHHN) Agreement (WA not a signatory) outlines structural reforms as well as additional investment in the health sector. Included in the structural reform will be development of new clinical safety and quality standards developed by the Australian Commission on Safety and Quality in Health Care (ACSQ). The ACSQ are in the process of finalising 10 National Standards that are clinically (hospital) focussed.

Australian Health Ministers endorsed the ACSQ developed Australian Safety and Quality Framework for Health Care in 2010. The framework sets out 21 areas for actions that all people in the health system can take to improve safety and quality of care provided in all healthcare settings over the next decade.

Also included in the structural reform is the establishment of an independent National Performance Authority to provide transparent information about national, state and local performance of the health system and report against the standards developed by the ACSQ.
3.2 National Standards for Mental Health Services

National Standards for Mental Health Services were first introduced in Australia in 1996 to assist in the development and implementation of appropriate practices, to inform consumers and carers about what to expect from mental health services and to guide quality improvement in the public specialised mental health sector. Much has changed since then with increased service provision in the community, expansion of the non-government and private sectors and greater focus on the primary care sector in mental health. New services have been developed and funded through all levels of government.

In response to these changes a review of the National Standards was commenced in 2006 in consultation with the sector and with consumers and carers. The revised National Standards for Mental Health Services have been endorsed by Australian Health Ministers (see Attachment 1).

The inclusion of a Recovery Standard in the revised National Standards is a welcome addition.

The scope for the revised National Standards has broadened to include a diverse range of mental health services, private and non-government organisations, including drug and alcohol services, community based mental health services, private office based practices and primary care.

Over the next 12 to 18 months the Mental Health Commission will assist agencies to transition to the revised National Standards, in accordance with sector specific Implementation Guidelines. The Commission will set up a steering committee tasked with guiding implementation of the revised National Standards to ensure that the process is completed to the maximum benefit of the clients of all mental health services. Mental health services funded by the Commission will be required to report on the National Standards and the Commission is looking forward to working with the sector to implement this important initiative.

3.3 Fourth National Mental Health Plan

The Fourth National Mental Health Plan 2009-2014 endorsed by Health Ministers is underpinned by eight key principles with 34 actions and 24 performance indicators embedded within five priority areas.

The Fourth National Plan articulates that developing a clear performance and benchmarking framework across the service system will enable comparison between services and within services over time and is a key tool for promoting quality improvement in mental health care. Benchmarking will be undertaken utilising the National Mental Health Performance Framework which is based on the National Health Performance Framework that was developed in 2001. The Framework outlines three tiers: Health Status and Outcomes, Determinants of Health and Health System Performance. There are nine domains and currently 15 agreed national performance indicators within the Health System Performance tier.

4 Quality Assurance roles

Prior to the establishment of the Commission, quality assurance roles in mental health were spread across a number of areas, with both legislative and administrative mandates. Most are
enshrined in the Mental Health Act 1996\textsuperscript{2}. A review of that Act and some recommendations for change, particularly in relation to complaints management was undertaken by Prof Holman in 2004\textsuperscript{3}. However, this review preceded the establishment of the Commission and some of its recommendations which have not yet been enshrined in legislation require reconsideration.

### 4.1 Roles transferred to the Commission

#### 4.1.1 Contract Management (non-government sector)

Structures and processes for purchasing of specialised mental health services from the non-government were transferred directly from the Department of Health to the Mental Health Commission when it was established. The Commission monitors performance of NGO contracts through the General Provisions for the Purchase of Community Services by Government Agencies and the NGO Services Agreements with Government Agencies (2008 ed).

This requires service providers to:

- (a) Comply with all appropriate legislative, statutory and health standards;
- (b) If requested, provide the Purchaser with a list of all legislation covering the Provider;
- (c) If applicable, demonstrate progress towards meeting the requirements of all relevant Disability Services legislation;
- (d) Ensure that all counselling and training is undertaken by appropriately trained or experienced staff, and provide advice to the Purchaser as to the nature of the training and qualifications; and
- (e) Ensure that all staff are aware of all policies and procedures developed by the Provider; and
- (f) The Service Provider must, in providing the services, comply with the Quality Standards.

When assessing service providers’ performance the MHC requires its contracted service providers to respond with:

- Six monthly financial reports base on income and expenditure, plus annual audited accounts
- Six monthly activity reports (hours of service provided) reviewed by MHC against contracted of service purchased
- Self assessment against meeting the requirements of the Carers Recognition Act
- Self assessment against meeting the requirements of the WA Department of Health’s Disability Access and Inclusion Plan

Service evaluations have been undertaken on an Ad hoc basis and are subject to appropriate funding allocations.

The General Provision for the Purchase of Community Services by Government Agencies requires Services Providers are required to notify the MHC of the details of serious incidents that occurring there service.

A serious incident is defined as being events that involve the Service Provider and their employees or contractors that relate directly to clients of the service that are negligent or

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\textsuperscript{2} \url{http://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtile_580_homepage.html}

\textsuperscript{3} \url{http://www.health.wa.gov.au/mhareview/reports/report/government-response.pdf}
unlawful or is likely to result in a breach of the Service Agreement and which could result in adverse public comment or media criticism.

Incidents included are the death or serious physical illness and injury of clients, neglect, abuse or exploitation of clients by an employee or contractor of the service, the charging or criminal conviction regarding an offence, including any sexual offence, relating to a client by an employee, serious complaints regarding the service, any matter that the service provider needs to refer to their insurer and any matter or complaint that is referred to a statutory or investigative body.

4.1.2 Contract Management (WA Health)

The Mental Health Commission commenced funding WA Health for the provision of specialised mental health services (inpatient and community-based) from 2010-11. The Commission will progressively develop and implement the full contract management framework, quality assurance, performance monitoring and reporting frameworks.

4.1.3 Performance and Reporting

Structures and processes for performance and reporting functions for specialised mental health services were transferred directly from the Department of Health to the Mental Health Commission when it was established. These include obligations for state and national mandatory reporting and mental health system performance monitoring. Currently the Commission reports on 11 of the 15 nationally agreed Key Performance Indicators (Attachment 3) and 11 State specific indicators. With the creation of the Mental Health Commission a new Outcome Based Management framework is being developed.

4.1.4 Complaints

As the Mental Health Commission becomes known as being responsible for ensuring that mental health services are appropriately provided it is likely that the number of complaints will increase. Currently where complaints relate to the delivery of clinical services they are referred to the Chief Psychiatrist whilst complaints regarding services contracted by the Commission are managed by the Commission.

Increasingly however concerns about services or lack of access come directly to the Commission or are referred by the Minister’s Office. Protocols are being established to manage these.

4.2 Chief Psychiatrist

The Mental Health Act 1996 prescribes that the Chief Psychiatrist has responsibility for monitoring the standards of psychiatric care provided throughout the State of Western Australia. In order to meet this responsibility the Chief Psychiatrist has established the Clinical Services Monitoring Program whereby the clinical services delivered by public mental health services are systematically reviewed. The Office of the Chief Psychiatrist is currently part of the Department of Health.

4.2.1 Clinical Governance Reviews

These reviews are undertaken to evaluate the consistency of mental health service’s clinical governance practice and procedure with the requirements of the:

- Mental Health Act 1996,
- National Mental Health Policy 1992,
- National Mental Health Plan 2003-2008
- National Standards for Mental Health Services 1996
- Complaints Management Policy
- Clinical Governance Framework for Mental Health Services

The review team provides the Chief Psychiatrist with a written report. This is not a public document.

The Office of the Chief Psychiatrist has recently refocused the Clinical Services Monitoring Program from a whole of service monitoring to ‘thematic’ reviews that focus on a targeted area. The first of these thematic reviews targeted the physical health of patients of the mental health services.

4.2.2 Psychiatric Hostels and Non-Government Organisations

In further exercising the responsibility for monitoring psychiatric care the Chief Psychiatrist monitors the Service Standards for Non Government Providers of Community Mental Health Services and the Standards of Care provided to residents of accommodation licensed as Psychiatric Hostel under the provisions of the *Hospital and Health Services Act 1927*

To meet these responsibilities the Chief Psychiatrist has instituted a monitoring program for non-government organisations that consists of a self assessment process, whereby agencies provide an assessment of their performance in relation to each of the services standards and commenced a program of on-site review of standards of care in the psychiatric hostels that were undertaken by a team of assessors, using a process similar to that used by the Commonwealth to assess Nursing Homes. It is understood that this process is currently under review.

4.2.3 Serious Incidents/Complaints

In monitoring mental health services the Chief Psychiatrist has responsibilities for the investigation and reporting of both Serious Incidents and Unexpected Deaths. As a consequence Mental Health Services, Psychiatric Hostels and Non Government Agencies monitored by the Chief Psychiatrist are expected to report:

- The unexpected death of patient / resident in any mental health service/facility.
- Serious Incidents and associated issues that will or are likely to reflect on the standards of mental health care in Western Australia.

The Chief Psychiatrist will also investigate complaints made about the standard of care received by people accessing mental health services or drawn to his attention by the Council of Official Visitors.

4.3 Area Health Services (public sector)

4.3.1 Accreditation

Accreditation is used as a formal process by which a recognised accreditation body assesses if a health care organisation meets a set of agreed healthcare standards. It is suggested that by meeting accreditation standards assurance can be provided to consumers and health service management that those services are safe and of a high quality.

Participation in an accreditation program is voluntary for public hospitals in Western Australia. However, the majority of services have engaged in an accreditation program as part of a commitment to quality improvement.

The Australian Council of Healthcare Standards (ACHS) accreditation program is the Evaluation and Quality Improvement Program (EQuIP) with the focus of the accreditation program being to provide a framework for continuous improvement. The ACHS web page states “ACHS accreditation is not quality assurance”.

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As part of whole of health site accreditation, mental health services can also be subject to what is described as an “external in-depth review against the National Standards for Mental Health Services”.

4.3.2 Complaints Management

A Department of Health Operational Directive (O/D0262.10 January 2010) requires Area and local health services to respond to complaints as described in WA Health Complaints Management Policy 2009 (3rd edition) Appendix 2 Mental Health Specific guidelines. In most instances complaints are managed within the local health services and the outcomes not referred elsewhere.

4.4 Other Bodies

4.4.1 Mental Health Review Board

The Mental Health Review Board (the Board) is an independent quasi-judicial review body established under Part 6 of the Mental Health Act 1996 (the Act).

The Board's primary statutory role is to review involuntary patients, in accordance with the Act. Involuntary patients are those people who have been placed by a psychiatrist on an involuntary order under the Act.

a. The Minister for Health may direct the Board to enquire into any matter to do with the administration of the Act. (s.147) The Board is to report to the Minister on the results of an enquiry that it is directed by the Minister to carry out, and may report to the Minister on any other matter that it thinks should be considered by the Minister. (s.148)

b. The Board is required to enquire into any complaint made to it concerning any failure to recognise the rights given by the Act to an involuntary patient or any other matter to do with the administration of the Act. (s.146)

c. The Chief Psychiatrist may report to the Board on matters concerning the medical care or welfare of involuntary patients. (s.10(d)).

Primary focus of MHRB is the review of the status of people subject to involuntary treatment under the provisions of the MHA 1996.

4.4.2 Council of Official Visitors

The Council of Official Visitors has a statutory role with respect to involuntary patients and those people residing in licensed psychiatric hostels. It undertakes, at the direction of the Minister, inspections of authorised hospitals and private psychiatric hostels.

As advocates for involuntary patients and residents, the council can raise concerns with the service managers or operators directly or through the Chief Psychiatrist or other statutory body. It reports annually to Parliament.

4.4.3 Licensing Standards and Review Unit (LSRU)

The LSRU in the Department of Health has a statutory responsibility under the Hospital and Health Services Act to ensure that operators of private health facilities and psychiatric hostels are appropriately licensed and meet the relevant standards. This process in usually undertaken as part of the licence application process and subsequently during the annual re-licensing process. LSRU have the legal authority to investigate complaints about breach of the legislation or relevant regulations.
LSRU have issued standards against which the various licensed facilities are monitored. These standards include the Standards for the Management Staffing and Equipment of Psychiatric Hostels.

4.4.4 Health and Disability Services Complaints office

The Health and Disability Services Complaints Office (formerly the Office of Health Review) is an independent State Government agency established by legislation to deal with complaints about health and disability services. It provides a free service to all users of health and disability services in Western Australia.

The Office has the power to deal with health and disability complaints, of which the majority are handled through a conciliation process. The Office also has formal powers of investigation, with the Director having the power to make recommendations following an investigation, however, there is no power to enforce compliance with these recommendations.

4.4.5 Office of Safety and Quality

The Department of Health Office of Safety and Quality developed the WA Strategic Plan for Safety and Quality in Health Care 2008-2013 in consultation with a wide range of key stakeholders to provide direction and guidance over the next five years for the delivery of safe, high quality health care. The Plan is available at:


5 Some Proposed Reforms

A 2003 review of the Mental Health Act 1996 (The Holman Review) made several recommendations to strengthen responses to complaints management. These include:

- There is to be a new part of the Act dealing with complaints.
- Complainants should be able to make a complaint directly to a mental health service provider who must have a documented set of local complaint procedures.
- Anyone dissatisfied with the outcome of a local complaints procedure may refer their complaint to the Director of the Office of Health Review.
- The Council of Official Visitors (COV) may take complaints to the Chief Psychiatrist. The Chief Psychiatrist must then advise the COV of any directions made as a consequence of investigations. The COV should be able to include communications with the Chief Psychiatrist in its Annual Report to Minister for Parliament.
- The Chief Psychiatrist may request in writing information on complaints from authorised hospitals, the COV, the Office of Health Review or any other mental health service.
- The role of the Chief Psychiatrist is to be expanded to include the preparation of an Annual Report with information on complaints.
- The Act should clarify that complaints may be made to the MHRB by a patient, past patient, carer or official visitor.
- The Act should clarify that complaints against a police officer exercising power under the Act should be directed to the Commissioner for Police.

More recent proposals have included the establishment of an independent body dedicated to dealing with complaints from mental health consumers or their representative. The President of the Mental Health Review Board (MHRB) has expressed the view that the power of the MHRB to inquire into complaints should be removed.
The 2009 proposal for a *Commissioner* for Mental Health and Wellbeing Bill proposed that one of the functions of the Mental Health Commission should be to monitor and review complaints arising from (i) services, policies, practices or procedures; and (ii) written law, proposed law or reports, but that it should not deal with individual cases. This proposed legislation did not proceed and the current Commission was established administratively. In many international jurisdictions, the Chief Psychiatrist and community visitor functions are performed by independent commissions with multidisciplinary expertise, or by lawyers employed for this purpose. In New Zealand, the Mental Health Commission employs district inspectors who are lawyers appointed by New Zealand’s Minister of Health. They have specific statutory functions to advise involuntary patients of their rights, support them in exercising their rights, and receive and investigate complaints of breaches of their rights.

Similar to district inspectors in New Zealand, Commissions in England, Wales and Scotland perform complaints and advocacy functions. They employ staff from a variety of disciplines, including clinical experts. These specialist mental health monitoring bodies visit services on a frequent and unannounced basis. The aim of these visits is to improve the experience for individual patients and to check for patterns that may indicate the need for service improvement or systemic change. A wide range of powers are used to help resolve issues at a local level, investigate unresolved complaints, ensure compliance with legislation and investigate breaches of patients’ rights.
National Standards for Mental Health Services

1. **Rights and Responsibilities**
The rights and responsibilities of people affected by mental health problems and/or mental illness are upheld by the mental health service and are documented, prominently displayed, applied and promoted throughout all phases of care.

2. **Safety**
The activities and environment of the mental health service are safe for consumers, carers, families, visitors, staff and the community.

3. **Consumer and Carer Participation**
Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

4. **Diversity Responsiveness**
The mental health service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

5. **Promotion and Prevention**
The mental health service works in partnership with its community to promote mental health and address prevention of mental health problems and/or mental illness.

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

7. **Carers**
The mental health service recognises, respects, values and supports the importance of carers to the wellbeing, treatment and recovery of people with mental illness.

8. **Governance, Leadership and Management**
The mental health service is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

9. **Integration**
The mental health service collaborates with and develops partnerships within its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

10. **Delivery of Care**
   10.1 **Supporting Recovery**
The mental health service incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

   10.2 **Access**
The mental health service is accessible to the individual and meets the needs of its community in a timely manner.

   10.3 **Entry**
The entry process to the mental health service meets the needs of the community and facilitates timeliness of entry and on-going assessment.

   10.4 **Assessment and Review**

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ATTACHMENT 1
Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

10.5 Treatment and Support
The mental health service provides access to a range of evidence-based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promote their recovery.

10.6 Exit and Re-Entry
The mental health service assists consumers to exit the services and ensures re-entry according to the consumer’s needs.

Key Principles that have informed the development of the National Standards include:

- Mental health services should promote an optimal quality of life for people with mental health problems and/or mental illness.
- Services are delivered with the aim of facilitating sustained recovery.
- Consumers should be involved in all decisions regarding their treatment and care, and as far as possible, the opportunity to choose their treatment and setting.
- Consumers have the right to have their nominated carer(s) involved in all aspects of their care.
- The role played by carers as well as their capacity, needs and requirements as separate from those of consumers is recognised.
- Participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services.
- Mental health treatment, care and support should be tailored to meet the specific needs of the individual consumer.
- Mental health treatment and support should impose the least personal restriction on the rights and choices of consumers taking account of their living situation, level of support within the community and the needs of their carer(s).
Appendix 3 Country Profiles

ENGLAND

Overview

The twin functions of protecting the rights of mental health service users and monitoring the quality of mental health services fall under the remit of two organisations: The Mental Health Review Tribunal (MHRT) and the Care Quality Commission (CQC). The provision of services to people with mental illness is further informed by the Mental Health Strategy, ‘No Health Without Mental Health’, published in February 2011.

The MHRT sits within the ambit of HM Courts and Tribunals Service, part of the Ministry of Justice. It is an independent judicial body operating under the provision of the Mental Health Act 1983 (as amended by the MHA 2007). All the Secretariat staff are civil servants and are completely independent of the hospital authorities. The panel members (Judge, medical and lay) are appointed by the Lord Chancellor.

The CQC was established in April 2009 out of the merging of three statutory bodies: the Health Care Commission, Mental Health Act Commission and the Commission for Social Care Inspection. As the independent regulator of all adult health and social care in England its aim is to ensure better care is provided for everyone whether in hospital, in care homes, in people’s own homes or elsewhere. The Commission takes a holistic approach.

Protecting the rights of individuals

The Law

The Mental Health Act 2007 enshrines the following rights for mental health service users, voluntary and involuntary:

- Anyone detained must be told their rights, including the right to appeal and the right to the assistance of an IMHA (independent mental health advocate)
- You have a right to free legal representation at a Tribunal
- An appeal to the Hospital Managers or the MHRT must be arranged within a reasonable time
- When discharged from hospital, individuals should receive aftercare.

Organisations involved in upholding individual rights

Both the MHRT and CQC have roles to play in the protection of rights.
The MHRT has an interest in compulsorily detained patients and judges within narrow parameters whether detention is lawful with remedies should detention be found unlawful. In some cases the Tribunal also has discretion to discharge patients who do not meet statutory criteria. These cases involve a balanced judgment on a number of serious issues: freedom of the individual; protection of public and best interest of patient. The Tribunal sits firmly within the Justice Department.

The CQC has a generic interest in all adult patients, and human rights underpin its work. It also carries the responsibilities late of the Mental Health Act Commission, primarily to be proactive in assuring that the rights of detained patients are upheld. The functions include:

- to keep under review the operation of the Mental Health Act in respect of patients detained or liable to be detained under that Act
- to visit and interview, in private, patients detained under the Mental Health Act in hospitals and mental nursing homes
- to consider the investigation of complaints where these fall within the Commission’s remit
- to review decisions to withhold the mail of patients detained in the High Security Hospitals
- to appoint registered medical practitioners and others to give second opinions in cases where this is required by the Mental Health Act
- to publish and lay before Parliament a report every year
- to ensure staff are applying the MHA Code of Practice correctly.

Complaints about in-patient care can be submitted to CQC.

Regulating and Improving the Quality of Services

The Law

The CQC is charged with Licensing, Monitoring and Improving the standards of health and social care provided to adults. Within this, MHAC commissioners test services visited to satisfy themselves that the reported quality and approach is borne out in practice. The CQC may be alerted to issues of concern by the MHRT.

Organisations involved in statutory regulation

The CQC now fulfils the role across all sectors to Licence provider organisations regardless of scale or sector: state, private, Third sector. The CQC has a range of sanctions culminating in the withdrawal of license to operate. In the state sector, formal notification of failure on a given metric has a direct impact on the overall risk-rating for the breaching organisation which in turn can have a direct impact on facility to borrow from commercial lenders. CQC takes a specific interest in the rights of those from the BME community and for all groups described in the Equality Act 2010.
Organisations involved in quality improvement

The direction of development is set by Ministers and the licensing and regulation of mental health services is shaped by the Strategy. That described three principles for a modern approach to mental health:

1. Freedom – reach our potential; personalisation and control
2. Fairness – equality, justice and human rights
3. Responsibility – everyone playing their part and valuing relationships

The CQC has a remit for the development of services through inspection and the publication of bench-marked and detailed data. Service improvement is also achieved through the finessing and lifting of the demands made of organisations providing services. NICE and a variety of non-governmental organisations also play a significant informal, but influential role in driving up standards.

Observations

- The consolidation of functions into one, authoritative body has removed confusion, created a level playing field and prevented issues slipping between jurisdictions
- Bringing the mental health function into a generic system has begun to ensure a much more holistic approach that supports Recovery
- Having the Licensing and regulation/monitoring in one body confers coherence and potency
- The intensive and growing use of data is allowing a more predictive and proactive approach with compliant organisations subject to much lighter touch.
NEW ZEALAND

Overview

In addition to protecting the rights of individuals receiving involuntary treatment under a Mental Health (Treatment and Care) Act, New Zealand has a strong code of ‘consumer’ rights for users of health and disability services, including mental health services. As part of its system of rights protection, all users of health and disability services who make a complaint have access to independent advocacy through a national network of independent advocates.

Quality improvement in mental health services is integrated into the wider quality improvement structures of the healthcare system, although a framework of key performance indicators for mental health services is under development. In addition, the New Zealand Mental Health Commission acts as an independent adviser to government on the extent to which services are meeting the needs of individuals, families and communities. It monitors progress in meeting the goals of the national strategy, Te Tāhuhu – Improving Mental health 2005-2015: The Second New Zealand Mental Health and Addiction Plan, and advocates for system transformation.

Protecting the rights of individuals

The Law

The Mental Health (Compulsory Assessment and Treatment) Act 1992 covers individuals who are placed under compulsory treatment orders in the community or in hospital. The Act includes 11 patient rights, including the right to treatment, the right to culturally appropriate care and an interpreter and the right to company. Patients who feel that their rights have been violated can complain to the District Inspector. If the issue is not satisfactorily addressed, individuals can take the violation to the Review Tribunal.

In addition, the rights of individuals using health and disability services are protected by regulation under the Health and Disability Commissioner Act 1994. The Code of Health and Disability Services Consumers' Rights grants a number of rights to all consumers of health and disability services in New Zealand, and places corresponding obligations on providers of those services.

Organisations involved in upholding individual rights

The Mental Health Review Authority was established under the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Review Authority reviews the legal status of individuals subject to compulsory treatment orders under civil commitment, 'special patient' orders for service users also subject to criminal justice
legislation and ‘restricted patient’ orders for a small number of service users who require additional restrictions which reflect concern for the public safety.

The role of the Health and Disability Commissioner is to promote and protect the rights of health and disability services consumers and to facilitate the resolution of complaints. The Commissioner has a Consumer Advisory Group whose role it is to provide timely advice regarding the handling of consumer complaints about health and disability services; how to improve the quality of health and disability services; public interest issues where the Health and Disability Commissioner can take a lead; and policy issues raised by the Commissioner.

A national network of advocates exists to assist people with making sure their rights are respected. They help consumers to resolve complaints about health or disability services. They operate independently of government agencies, the Health and Disability Commissioner, and the funders of health and disability services.

**Regulating and Improving the Quality of Services**

**The Law**

The New Zealand Public Health and Disability Act 2000 establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes District Health Boards, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations. The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand.

The Health and Disability Services (Safety) Act 2001 promotes the safe provision of health and disability services to the public. It enables the establishment of consistent and reasonable standards for providing health and disability services and encourages providers of health and disability services to continuously improve the quality of the services they provide. Mental health standards are published under the Act.

**Organisations involved in statutory regulation**

HealthCERT is responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001. HealthCERT’s role is to administer and enforce the legislation, issue certifications, review audit reports and manage legal issues.
Organisations involved in quality improvement

The Health Quality and Safety Commission was established in 2010 under the New Zealand Public Health and Disability Amendment Act 2010. The Commission is responsible for assisting all types of providers across the whole health and disability sector to improve service safety and quality and therefore outcomes for all who use these services in New Zealand. The Commission advises the Minister of Health on quality improvement, leads improvements in safety and quality in health care, identifies data sets and key indicators and reports publicly on the state of safety and quality.

The New Zealand Ministry of Health has funded the development and testing by District Health Boards of a Key Performance Indicator Framework for Mental Health and Addiction Services. The framework is intended to allow providers to benchmark themselves against each other and encourage quality improvement. The framework is intended to be operational within the entire sector from 2012.

The New Zealand Mental Health Commission acts as an independent advisor to government, monitors existing services and advocates for system transformation. It has a fixed term which runs out in 2015 and provides an independent, external challenge to the mental health system.

Observations

- New Zealand is unusual by international standards in having a strong system of rights protection for users of health and disability services in general, not just those who are receiving involuntary treatment.
- New Zealand has a national network of independent advocates. However, their role is restricted to complaints. The Health and Disability Commissioner plays a more proactive role in monitoring system performance.
- The New Zealand Mental Health Commission acts as a strong independent check on the mental health system and the extent to which it is meeting people’s needs.
- The system is in the process of developing KPIs for the mental health which will be act as an important driver of continuous quality improvement.
- New Zealand has recently moved to an integrated approach to quality improvement with the creation of the Health Quality and Safety Commission.
IRELAND

Overview
The twin functions of protecting the rights of mental health service users and monitoring the quality of mental health services fall under the remit of the Mental Health Commission (MHC). The MHC was created by the Mental Health Act 2001 as an independent, statutory body. The Commission has 13 members from a range of backgrounds including medicine, social work, psychology, the voluntary sector and general public and has a six member executive. Commission members are appointed by the Minister of Health and Children.

The Mental Health Act was followed by a national mental health policy in 2006 entitled *A Vision for Change*.

Protecting the rights of individuals

The Law

The Mental Health Act enshrines the following rights for mental health service users, voluntary and involuntary:

- Individuals have the right to receive good quality mental health care
- Mental health services must be properly run and properly regulated
- People working in the mental health services have to make sure that individuals are treated in a way that respects their rights as individuals
- Individuals should be treated with respect and dignity.

The Mental Health Act also gives individuals the right to have their involuntary admission automatically reviewed.

Organisations involved in upholding individual rights

The Mental Health Tribunals Division of the Mental Health Commission is responsible for establishing mental health tribunals for patients admitted on an involuntary basis. A Mental Health Tribunal made up of a psychiatrist, a lawyer and a lay person is automatically established to review the recommendation for involuntary admission or the renewal of involuntary detention. The decision of the Mental Health Tribunal can be challenged through the Circuit Court. A Mental Health Tribunal is also formed if a recommendation for psychosurgery is made. Approval for psychosurgery is based on patient consent and the approval of the Tribunal.

Complaints about mental health services that are being used voluntarily can be submitted to the Inspector of Mental Health Services.
Regulating and Improving the Quality of Services

The Law

Under the Mental Health Act 2001, the Mental Health Commission must appoint an Inspector of Mental Health Services who must be a consultant psychiatrist. The Act also allows for the appointment of Assistant Inspectors with other professional backgrounds. The Mental Health Inspectorate is separate from the Health Information and Quality Authority that regulates the quality of all other health and social services.

Organisations involved in statutory regulation

The Inspectorate of Mental Health Services is required by law to visit and inspect every approved centre annually. Approved centres are inpatient settings where individuals who are involuntarily detained are treated. They are registered by the MHC and the MHC determines the standards and codes of practice against which they are inspected. Codes of practice exist for the use ECT and for the use of seclusion and restraint. Annual reports are published for every approved centre and include an assessment of whether the previous year’s recommendations have been adequately addressed.

In addition, the Act allows the Inspector of Mental Health Services to visit and inspect any other premises where mental health services are being provided.

Organisations involved in quality improvement

One of the core functions of the Mental Health Commission under the Mental Health Act, 2001 is “to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services”. The main responsibility of the Standards and Quality Assurance Division is to work closely with all relevant stakeholders to ensure that high standards and best practices are achieved in Ireland’s mental health services.

In 2007, the Mental Health Commission published a Quality Framework for Mental Health Services in Ireland. It includes the statutory requirements placed on approved centres but goes further. The framework is intended to support quality improvement by services and to inform service users and carers. The standards and criteria included in the Framework will also be used by the Mental Health Commission to monitor the delivery of mental health services in the public, independent and voluntary sector, including through the work of the Inspector for Mental Health Services.
Other information

As well as the functions described above, the Mental Health Commission funds research, conducts surveys of service user experiences as part of its inspection and quality improvement role and is responsible for developing and disseminating public information related to mental health.

Observations

- The Mental Health Commission brings together independent regulation for quality with protection of individual rights which could involve conflicts of interest.
- The system is heavily oriented towards basic statutory regulation for those who are involuntarily admitted.
- The rights of other service users are not well protected and there is no clear mechanism for accountability beyond inpatient settings.
- The system continues to place a strong emphasis on psychiatry in terms of governance i.e. the role of the Inspector of Mental Health Services, and does not include a statutory role for other professional groups, service users or carers. However, the Quality Framework does have a strong focus on recovery and does mention the importance of housing and employment.
- The system segregates the inspection and improvement of mental health services from other health and social services which is unusual by international standards.
SCOTLAND

Overview

Over the last 12 years Scotland has developed a range of new and updated legislation covering incapacity, guardianship and mental health care and treatment. The development of the new Mental Health (Care and Treatment) Act 2003 which started from 1999 also helped drive a number of other key developments in mental health including the development of a national anti-stigma campaign, a national public mental health improvement programme, work on addressing social inclusion and the development of new policies and strategies designed to modernise mental health care services. Scotland has also recently developed a more integrated approach to quality improvement in health care by bringing a range of functions together under one organisation, Healthcare Improvement Scotland. This body came into effect in April this year. In addition to new legislation and quality care improvement regulations, Scotland also has an independent body with a mandate to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. This body is known as the Mental Welfare Commission.

Protecting the rights of individuals

The Law

The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in April 2005. The Act covers when a person can be taken into hospital for care and treatment against their will or given treatment in the community against their will, within a series of safeguards, protections and rights. There are 10 key principles of the Act covering: Non-discrimination, equality, respect for diversity, reciprocity, benefits arising from an (Act) intervention, informal care, participation, respect for carers, use of least restrictive alternative and child welfare.

There are three kinds of compulsory powers: emergency detention, short term detention and compulsory treatment order. The Act gives the right for each person to have a ‘named’ person to provide support, the right of access to independent advocacy (applied to all users of mental health services), the ability for people to make ‘advance statements’ setting out how they would like to be treated if they become unwell or unable to express their views clearly at some point in the future.

There are also a number of other safeguards in the Act, some of which apply to all users of services and not just those who are treated under the Act. These include: a right to request an assessment of needs which must be responded to in 14 days; a duty on local authorities to provide ‘care and support services’ and ‘services designed to promote the wellbeing and social development’ for people who have, or have had, a mental disorder; the provision of services for those under 18 that are appropriate to their needs; the provision of mother and baby services; the right of review for patients placed in higher levels of security.
Organisations involved in upholding individual rights

The new Mental Health Tribunal has replaced the Sheriff Court as the forum for hearing cases. The Tribunal aims to provide a responsive, accessible, independent and impartial service when making decisions on compulsory care and treatment. The Tribunal considers care plans, decides on compulsory treatment orders and carries out reviews. Each Tribunal has three members, a legally qualified person, a doctor with experience in mental health and a third person with other more general skills and experience (can be people with experience of using services and carers). The Tribunal is sponsored by and reports to the Scottish Government.

The Mental Welfare Commission is an independent body that acts to safeguard the rights and welfare of all persons with a mental illness, learning disability or other mental disorder. It reports to Parliament on its findings. It has the right to visit and inspect, monitor the operation of any relevant legislation, investigate abuse, neglect, deficient or unlawful care, provide advice and promotion of best practice and seek to influence and challenge service providers and policy makers. Members of the Commission include service users, carers, mental health practitioners and others.

Regulating and Improving the Quality of Services

The Law

The Public Services Reform (Scotland) Act 2010 sets out how quality, safety and quality improvement across all public sector and publically funded services are to be achieved. Healthcare Improvement Scotland is legislated through this Act to support healthcare providers in Scotland to deliver high quality, evidence based, safe, effective and person centred care; and to scrutinise those services to provide public assurance about the quality and safety of that care. Responsibility covers both public, voluntary and independent private providers of services.

Organisations involved in statutory regulation and quality improvement

The work programme of Healthcare Improvement Scotland covers the provision of advice and guidance, the setting of standards (to International standards), providing improvement and development support, assuring quality, providing scrutiny (visiting and inspection), measurement and reporting on findings and progress.
Mental health is one of a number of special ongoing programmes. The Board of Healthcare Improvement Scotland reports to the Scottish Government, Health and Wellbeing Department.

Healthcare Improvement Scotland also works closely with Social Care and Social Work Improvement Scotland in ensuring quality across health and social care agencies and providers.

**Observations**

- The system has been recently updated and improved across human rights and quality assurance. It is too early to evaluate the benefits of the new system. However Scotland’s mental health care and treatment Act is considered by many to be a good international benchmark.
- The principles of reciprocity and having elements of the Act cover all persons with a mental illness are considered extremely helpful.
- Having a separate Mental Welfare Commission reporting directly to Parliament is also a strong signal in upholding rights. However there are some criticisms that the Welfare Commission has insufficient powers to ensure changes and improvements are made.
- The shift to a generic health care quality assurance body is in line with international practice.
- Scotland also continues to develop national policies and strategies that cover the full range of mental health from promotion, to prevention, to care and treatment to equality and inclusion. This integrated approach to policy and national strategy is a key strength in the Scottish system.
- Service development is largely left to local health and social care bodies and there is not a national agency devoted to service development in mental health.
- There is also not an independent body charged with overseeing the continuing development of the mental health system across Scotland. This is largely done by the Scottish Government’s Mental Health Division, part of the Scottish Government’s civil service.
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<th>Individual Meetings</th>
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<tr>
<td>Hon Helen Morton MLC</td>
<td>Minister for Mental Health</td>
<td>Minister for Mental Health</td>
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<tr>
<td>Debora Colvin</td>
<td>Head</td>
<td>Council of Official Visitors</td>
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<tr>
<td>Dr Dorothy Jones</td>
<td>Executive Director</td>
<td>Performance Activity &amp; Quality Department of Health</td>
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<tr>
<td>Eddie Bartnik</td>
<td>Commissioner</td>
<td>Mental Health Commission</td>
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<tr>
<td>Rowan Davidson</td>
<td>Chief Psychiatrist</td>
<td>Chief Psychiatrist, Department of Health</td>
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<tr>
<td>Murray Allen</td>
<td>President</td>
<td>Mental Health Review Board</td>
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<tr>
<td>Richard Menasse</td>
<td>Director</td>
<td>WA Country Health Services, Mental Health</td>
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<tr>
<td>Stephen Hall</td>
<td>Executive Director</td>
<td>WAAMH (WA Association for Mental Health)</td>
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<td>Judith Balfe and colleagues</td>
<td>President</td>
<td>Hostels Association</td>
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<tr>
<td>Rebecca Brown</td>
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<td>Dept of Premier and Cabinet</td>
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<tr>
<td>Michael Mitchell</td>
<td>Director</td>
<td>Statewide Indigenous Mental Health Services, Department of Health</td>
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<tr>
<td>Danuta Pawelek</td>
<td>Director - Performance and Reporting</td>
<td>Mental Health Commission</td>
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<tr>
<td>Eric Dillon</td>
<td>Director - Services Purchasing and Development</td>
<td>Mental Health Commission</td>
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<tr>
<td>Dr Judy Edwards</td>
<td>Deputy Chair</td>
<td>Mental Health Advisory Committee</td>
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<tr>
<td>Dr Stephen Proud</td>
<td>Psychiatrist</td>
<td>Abbotsford Private Hospital</td>
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<tr>
<td>Rose Moroz</td>
<td>Carer</td>
<td>Abbotsford Private Hospital</td>
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<tr>
<td>Ross Keesing</td>
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<td>Consultant</td>
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<tr>
<td>Michelle Wolstenholme</td>
<td>Senior Legal Advisor</td>
<td>Legal and Legislative services, Dept of Health</td>
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<tr>
<td>Dr Steve Patchett</td>
<td>Psychiatrist</td>
<td>Frankland Centre, Department of Health</td>
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<tr>
<td>Dr Nathan Gibson</td>
<td>Psychiatrist</td>
<td>North Metropolitan Area Health Services, Department of Health</td>
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<tr>
<td>Dr Helen McGowan</td>
<td>Psychiatrist</td>
<td>North Metropolitan Area Health Services, Department of Health</td>
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<tr>
<td>Dr Lesley van Schoubroeck</td>
<td>Director, Organisational Reform</td>
<td>Mental Health Commission</td>
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<td>Group meetings</td>
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<td>1. Representatives from the Department of Health - Mental Health Operational Review Committee (MHORC)</td>
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<td>2. Representatives from Non-government Services hosted by WA Association for Mental Health</td>
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<td>3. Representation of Graylands Specialist Staff</td>
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<td>2. Representation from Non-government Services hosted by WA Association for Mental Health</td>
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Appendix 5
The United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) – Key Articles

Introduction

This international Human Rights Instrument of the UN is intended to promote and protect the rights and dignity of persons with disabilities (physical and mental). It was adopted by the UN on the 13 December 2006, opened for signature on 30 March 2007 and came into force on 3rd May 2008.

The purpose of the UN CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedom by all persons with disabilities, and to promote respect for their inherent dignity. Includes persons with disabilities and those with long term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full participation in society on an equal basis with others.

The Convention is based on:
- Respect for inherent dignity, individual autonomy and independence
- Non-discrimination
- Full and effective participation in society
- Accepting people with disability as part of human diversity and humanity
- Equality of opportunities - Accessibility - Equality between men and women

The key points set out below under each of the articles are adapted from a seminar held by Mental Health Europe in Brussels on 20 May 2011, which explored the UN CRPD and its implementation.

Key Articles

Article 12 Equal recognition before the law
Creates a real challenge for states to revise their legislation on guardianship
UN CRPD foresees ‘supported decision making’ and no transfer of rights to another person
Persons with mental health problems cannot be deprived of their legal capacity on the sole ground of mental health problems

Article 14 Liberty and Security of the Person
The rules regarding forced or involuntary treatment should be the same for all patients, irrespective of whether they have mental health problems or not.
The recognition of legal capacity requires abolishing a defense based on the negation of criminal responsibility because of mental or intellectual disability.
The UN CRPD forbids: deprivation of liberty based on disability (also mental health
problems)
Freedom has to be applied without discrimination.
Health care has to be identical for everybody on the base of free choice and informed consent.

Article 15 Freedom from torture or cruel, inhuman or degrading treatment or punishment.
This article addresses the situation of many persons with disabilities who are living secluded in closed institutions, deprived of their liberty, often for ‘public safety’ or other ‘social’ reasons.
The use of coercive measures in seclusion rooms, ECT, forced medication etc. should be forbidden.
No scientific or medical experimentations without informed consent.
State parties have to take all effective measures to prevent this torture or inhuman treatment or punishment.

Article 16 Freedom from exploitation, violation and abuse
This Article obliges states to take appropriate measures to protect persons with mental health problems from exploitation, violence, abuse.
Ombuds services and independent authorities are required to monitor all forms of exploitation, violence and abuse.

Article 17 Protecting the integrity of the person
The physical and mental integrity of people with disabilities must be respected, as it would in the case of persons without disabilities.
Abuse by professionals, harassment, punishment and lack of privacy can be denounced.
Compulsory treatment without consent to be excluded, as it could create discrimination between persons with mental health problems and other patients.

Article 19 Living independently and being included in the community
Persons with mental health problems should have the right to live where they want, with whom they want, on an equal basis to the general population.
State parties have to take all effective measures to fulfill these rights and create a range of housing, in-home, residential, community based services, including personal assistance and support to live independently in the community. Prevention from isolation and segregation is obligatory.

Article 25 Health
Persons with mental health problems should be provided with the same range of quality health care services as other people.
Health professionals are requested to provide care on the basis of the free and informed consent of patients, and respecting the human rights, dignity and autonomy of the person
Article 33 Implementation and Monitoring
This Article provides the framework under which States can implement human rights provisions in their own jurisdictions.
Each state can establish a framework (mechanism) to promote, protect and monitor the implementation of the convention.
Civil society and people with disabilities should be involved in the monitoring process.