

Review of the Clinical Governance of Public Mental Health Services in Western Australia

Final Report

October 2019

Language

The language relating to ‘consumers and support persons’ used in this report is taken from the Mental Health Commission Mental Health and Alcohol and Other Drug Engagement Framework 2018–2025.

Consumers are people with a personal experience of mental health, alcohol and/or other drug issues, irrespective of whether they have a formal diagnosis or have accessed services and/or received treatment. It is acknowledged that some people may prefer to use the words personal or lived experience. It is recognised that in some health settings, the word ‘consumer’ is inclusive of individuals, families and supporters.

Support persons refers to people in caring and supporting roles. It is acknowledged that a large proportion of support persons are support persons as defined in the *Western Australian Support Persons Recognition Act 2004 (WA)*. The term ‘support persons’ includes support persons, friends and significant others.

Clinicians are people who hold positions that require the incumbent to have recognised training that allows them to be members of a professional registration body, for example, nurses, psychologists, psychiatrists, occupational therapists and social workers. They must abide by the National Practice Standards for the Mental Health Workplace 2013.

Recovery – distinctions are made in the report between clinical recovery, which tends to focus on diagnosis and symptom reduction, and personal recovery, which is defined as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. Central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person’s right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination’ (1 p. 11).

Use of the term Aboriginal

Within Western Australia, the term ‘Aboriginal’ is used in preference to ‘Aboriginal and Torres Strait Islander’ or ‘Indigenous’, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. Where referenced documents use the term Aboriginal and Torres Strait Islander or Indigenous, that term is used instead. No disrespect is intended to our Torres Strait Islander colleagues and community.

Glossary

ABF	Activity-Based Funding
ACSQHC	Australian Commission on Safety and Quality in Health Care
AH	Allied Health
AMA	Australian Medical Association
AMHCON	Australian Mental Health Outcomes and Classification Network
AOD	alcohol and other drug
BAU	Behavioural Assessment Unit
CIMP	Clinical Incident Management Policy
CIMS	clinical incident management system
CL	Consultation-Liaison
CMO	community-managed organisation
COAG	Council of Australian Governments
CoMHW	Consumers of Mental Health Western Australia
COP	Community Options Program
CROM	clinically reported outcome measure
CSA	Commission Service Agreements
EBCD	Experience-based co-design
ED	Emergency department
EHR	Electronic health record
FHRI	Future Health Research and Innovation
FIFO	Fly-in fly-out
FTE	Full-time equivalent
GP	General practitioner
HaDSCO	Health and Disability Services Complaints Office
HoNOS	Health of the Nation Outcome Scales
HSA	Health Service Agreement
HSA16	<i>Health Services Act 2016 (WA)</i>
HSP	Health Service Provider
HSPR	Health Services Performance Report
ICT	Information and communications technology
KPI	Key performance indicators
LARU	Licensing and Accreditation Regulatory Unit
MBS	Medicare Benefits Schedule
MHA14	<i>Mental Health Act 2014 (WA)</i>
MHAOD	Mental health, alcohol and other drugs

MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MHED	Mental Health Executive Director
MHN	Mental Health Network
MHOA	Mental Health Observation Area
MHQ-14	Mental Health Questionnaire
MHT	Mental Health Tribunal
MHU	Mental Health Unit
MoC	Models of Care
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NMHSPF	National Mental Health Service Planning Framework
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Services
OCP	Office of the Chief Psychiatrist
PHN	Primary Health Network
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
PSOLIS	Psychiatric Services On Line Information System
PSSU	Patient Safety Surveillance Unit
QMF	Quality Management Framework
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCA	Root Cause Analysis
SHR	Sustainable Health Review
SMI	Severe mental illness
SPA	Special Purpose Account
SQuIS	Safety and Quality Indicator Set
TSD	Treatment, support and discharge
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WAAMH	Western Australian Association of Mental Health
WACHS	WA Country Health Service
WANADA	Western Australian Network of Alcohol and Other Drug Agencies
WAPHA	Western Australia Primary Health Alliance

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1. Executive Summary

This report presents the findings of a review of the clinical governance of public mental health services in WA. Past reports raised issues including the *Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia* (2012) (the Stokes Review) (2) and the Western Australian Auditor General's Report (2014) *Licensing and Regulation of Psychiatric Hostels* (3). System function was reviewed in 2019 by the WA Auditor General in *Access to State Managed Adult Mental Health Services* (4).

The *Review of Safety and Quality in the WA Health System: A strategy for continuous improvement* (2017) (Mascie-Taylor Review) raised concerns with the governance arrangements of WA public mental health services. It reported a complex system, which lacked clarity and was composed of numerous agencies with overlapping roles and in which no one agency had a complete picture. It recommended a review of clinical governance to simplify and clarify organisational arrangements to provide direction, consistency and facilitation across service providers. The *Sustainable Health Review: Final Report to the Western Australian Government* (2019) (5) supported this Recommendation.

The Panel was fortunate to have Professor Bryant Stokes jointly leading this work. The review sought the advice of a number of consumers, support persons and clinicians. Interviews were conducted in the metropolitan area and some regional areas including Kununurra, Karratha, Kalgoorlie and Bunbury. An online survey was conducted and a Lived Experience Forum was held. Department of Health (Department) officers, the MHC, Health Service Providers (HSPs) and other government agencies involved with mental health were interviewed.

Governance arrangements for WA public mental health services have undergone significant change in the past decade. The WA State Government established the first Mental Health Commission (MHC) in Australia in 2010 as the sector leader for mental health services. A key role was to drive reform, with a shift from hospital based clinical services to community based nonclinical services. The MHC is the only budget holding commission in Australia. Another major change was the devolvement of the WA Health system with the *Health Services Act 2016* (HSA16). The Department undertook the role of system manager and purchase services for the WA public from board-governed, statutory Health Service Providers (HSPs).

The Review's Terms of Reference detail areas of enquiry. The current clinical governance structures in WA public mental health services are detailed in Section 3 of the review. The main operational agencies are the Mental Health Commission (MHC) and the Department of Health (Department). Nonoperational statutory entities are the Office of the Chief Psychiatrist (OCP), Mental Health Tribunal (MHT), Mental Health Advocacy Service (MHAS) and the Health and Disability Service Complaints Office (HaDSCO).

Review consultations confirmed ongoing governance issues in WA public mental health services. Leadership of the sector is unclear, with the MHC acting as "sector leader" and Department as "system manager". The structure of WA governance agencies was found to be complex, with numerous agencies with unclear definitions of roles and responsibilities. Communication between governance agencies is limited with evidence of silos. Consultation indicated these issues had a negative impact on clinical oversight and accountability, safety and quality culture and clinical outcomes.

The changes over the past decade have impacted upon the governance of public mental health services. There are splits in the WA governance structure between general and mental health services and a further split between clinical and nonclinical services. This has led to poor service integration and lack of system effectiveness. Duplication at many levels

has resulted in significant administrative costs resulting in poor efficiency and diversion of resources from patient care.

Key findings and patterns observed were:

- **Separation of general health from mental health services**

The formation of the MHC in 2010 resulted in separation of mental health from general health services in WA. The parallel streams appear disconnected, noting that mental health consumers often need to access general health services (e.g. EDs) (4). The separation has also resulted in the need for duplicated processes and additional costs.

- **Two “system managers” of mental health services with unclear leadership**

The devolution of the system with HSA 16 (2016) saw the Department adopting the role of a “system manager”. The MHC as “sector leader” had already adopted a devolved structure with central contracting and oversight of a range of providers. WA public mental health has two “system managers” with no single point of accountability or authority. HSA16 indicates the Department has responsibility for the total health system (as system manager), but it has limited visibility of the nonclinical and accommodation sectors. The MHC has limited insight into the clinical services. Neither agency has whole of system visibility.

- **Two separate clinical and nonclinical systems that integrate poorly**

The two “system managers” lead parallel mental health systems that operate independently with limited integration. The Department oversees clinical services and the MHC provides oversight for nonclinical and accommodation sectors. Clinical services have areas of overlap between the Department and MHC. The lack of integration and coordination between clinical and nonclinical systems has led to services being implemented that do not connect with existing services or each other. HSPs and service providers reported little knowledge of newly commissioned services. The result is poorly integrated services of limited effectiveness.

- **Duplicated monitoring of performance, safety and quality with limited indicators**

There is duplication of many functions, including for planning, performance and safety and quality monitoring. For clinical services, this has resulted in duplicated reporting to both the Department and MHC. Monitoring of some sectors (e.g. hostels) is by multiple agencies using different standards and frameworks. The mental health indicator set is lacking and additional indicators are urgently needed for service demand, patient experience and system flow across the full pathway (ED, hospital, Step Up Step Down, community accommodation, primary-care). The duplication of functions has resulted in higher costs and resources diverted away from consumer care.

- **Two purchasers with a lack of clarity in funding and high costs**

WA has two purchasing agencies and two budgets for mental health services. WA is unique in having an external agency in control of the mental health budget. The MHC purchases the majority of mental health services from Health Service Providers (HSPs). The Department however, also purchases significant mental health activity in EDs, Mental Health Observation Areas (MHOAs), patient transport services and Consultation Liaison services. Separate budgets result in neither the Department nor

MHC having visibility of total system costs. This has also compromised the validity of efficiency indicators with a loss of transparency. The duplication of contracting functions has also resulted in higher costs and decreased efficiency. The complexities of the funding system have also increased burden and costs for provider organisations.

The structural divisions are magnified by issues with governance processes. These are:

- **Lack of clarity in roles, responsibilities and accountability at multiple levels.**

Documentation of governance roles and responsibilities is unclear. A shared statement of roles for governance agencies was only produced after this Review commenced, many years after major system change. A consolidated corporate diagram of lines of reporting for the system has not been produced. This has resulted in minimal transparency of governance arrangements.

- **Disconnection of governance from consumers, supporters and clinicians**

There is limited input into governance from consumers, supporters and clinicians. Consumer and supporters are well engaged by the MHC but have limited engagement with the Department. Clinicians have a good relationship with the Department but have minimal interface with the MHC. Overall, there is a marked lack of clinical and content expertise WA clinical governance. The MHC has a significant staffing footprint – 272 full-time equivalent (FTE) – but does not have any psychiatric staff involved with planning, monitoring or regulation of services. The Department has a small Mental Health Unit (MHU) with limited staff (14 FTE) and no clinical presence. The Office of the Chief Psychiatrist (OCP) does have specialist staff, but it does not have operational responsibilities. Clinical input is via numerous advisory groups that have no formal governance role and limited apparent influence.

- **Lack of a system wide plan that hampers service integration and coordination**

There is a significant gap in integrated system wide planning, which is noted in past reviews (2). There is no detailed system-wide service plan that incorporates all providers and describes service access, models of care or pathways and coordination of services (4). The lack of integration between clinical and non-clinical sectors has led to poorly integrated and ineffective services. Consumers are having difficulties getting the help they need and face a difficult journey through the system. Planning lacks focus on the differing needs of patient groups. The population with severe mental illness (SMI) accounts for only 10 per cent of patients yet consumes 90 per cent of hospital care and 50 per cent of ED and community services but there appears to be few dedicated services that provide for this group (4). There is also an urgent need to improve the viability of the accommodation sector, which is critical to the system.

- **Learning system impairment with limited support for quality and innovation**

This review identified the same issues noted in past reviews, with minimal improvement. Past reviews focused on changes to policy or process and did not suggest changes in governance structure. The inherent structural issues and lack of integration in the governance structure are likely to have blocked meaningful change. This review has therefore recommended structural realignment.

The current difficulties are the unintended result of structural changes and should not reflect negatively on the agencies or those working within the system. The MHC, in particular, has made valuable contributions to mental health in WA through its engagement with consumer organisations, implementation of nonclinical recovery and trauma informed services, Step up Step Down services and its support of the police co-response service. The Panel was also

struck by the commitment of the managers, clinicians and support staff working to improve the system. All are trying to deliver good outcomes but hampered by the system structure.

The Review Terms of Reference requested identification of opportunities for clinical governance improvement through reform of the mental health clinical governance structure to enhance effectiveness and efficiency and embed a quality improvement focus to deliver best practice mental health services for the WA community. The Review has made 10 recommendations for action to improve processes that are displayed in Table (1). These align with those of the Sustainable Health Review and regrettably, also with those made by the Stokes Review in 2012 (2). They address clinical leadership and engagement, consumer leadership and engagement, culture, planning funding and commissioning, standards and performance, safety and quality training and ICT systems. A key area for improvement is clearly documented roles and responsibilities within the system. Adoption of these recommendations will bring some improvement in governance processes.

The Review also recommends structural realignment to address the structural divisions and splits that are causing poor integration and system fragmentation, detailed in Section 6. It is unlikely that any substantial improvement in WA public mental health services will be possible until these issues are addressed.

A core issue is the distribution of responsibilities across the Department and MHC. A single agency structure was considered with allocation of all mental health duties to either the MHC or Department. If MHC assumed all responsibilities, there would be persistent fragmentation from the division between general and mental health services and ongoing duplication of governance processes with inefficiency. There were concerns arising from the Auditor General report of system ineffectiveness and inefficiency under MHC leadership (4). If the Department was to assume all responsibilities, this would lose the valuable contributions of the MHC. It was therefore felt that both should retain roles but with realignment of functions.

Options were considered that kept the existing governance structure but with some modification. The adoption of clear roles and responsibilities will bring some improvement but will not address the core structural issues. This approach was taken in past reviews (e.g. Stokes), and proved not effective. This option was favoured by the consumer and carer representative on the Panel. Another option was to separate the clinical and nonclinical sectors, which would clarify lines of reporting and accountability and decrease overlap, but still leave residual structural issues. As a result, these options were considered not viable.

Governance structures in other states were reviewed. They have a MHC performing strategic functions and providing leadership in mental health prevention, promotion and education. Unlike the WA commission, they do not have operational roles in purchasing or monitoring of safety and quality, which are the responsibility of the Departments of Health. Such a structure in WA would address the structural issues identified with improved governance effectiveness and efficiency. The integration of clinical and nonclinical services would give the WA public better-coordinated services. The majority of the Panel felt this option was viable.

The consumer and carer representative was concerned with the decreased role of the MHC, especially in funding. Further options were then explored based on a standard commission model but with the MHC retaining budget-holding responsibility. Firstly, the MHC could retain strategic control of budget allocation (e.g. determining proportions for prevention, promotion and so forth). The Department would (in accordance with those allocations) purchase and coordinate all services. This would deliver a balance between the need for governance structure change and the concerns of consumer organisations. This option was favoured by two members of the Panel. An alternative was a joint commissioning model, with a shared budget at a strategic level leading to a single contract for providers with operational oversight provided by the Department. This was favoured by the remaining two panel members.

The consumer and carer representative submitted a minority opinion and the contents are detailed in Section 6.5. Key issues are concerns that the Department will not listen to consumer and supporter groups, not support a social model of mental health (rather keep a biomedical focus) and not implement non-clinical recovery-focussed services. Funding was another concern, with potential loss of funding for consumer groups. To address integration, the consumer and carer representative favoured the option (above) of all mental health responsibilities transferred to the MHC. The remaining panel members noted this would not address the divide between general and mental health with ongoing duplication and high costs. The lack of consensus is typical of the polarised viewpoints in WA public mental health sector noted by the SHR (5).

Mental health services across Australia are experiencing issues. The WA Auditor General recently reviewed the WA public mental health services and found a system under significant pressure which was both ineffective and inefficient (4). Reform progress was limited, with completion of only 24 per cent of projects that were expected to be complete by 2017. The review found increasing hospital costs and found that WA people accessing community treatment services in 2017 were actually receiving less care on average than in 2013 (4). The Report on Government Services indicates high readmission rates following discharge in WA, suggesting that community services are not meeting need (6). The Australian College of Emergency Medicine (ACEM) also reports that mental health presentations to WA EDs are increasing and patients are staying longer (7).

These issues are a likely result of poor integration (from a divided system), lack of multidisciplinary services and lack of interface with Commonwealth-funded services. The pressures on the system signal an urgent need to act, with structural realignment of governance arrangements being a critical step to improve mental health services for the WA public (4). Funding drivers for the MHC (e.g. ring fencing), could be achieved through ongoing use of Special Purpose Accounts (SPA's). Reassurance will be needed regarding the funding of NGO, accommodation and consumer groups. Social determinants of mental health have a significant impact and a whole of government approach will also be pivotal to making real change.

The way forward will be challenging but the desire for improvement expressed by all stakeholders was genuine and their commitment real. A balanced direction would be to progress with critical governance reform in concert with attempts to address the concerns of consumer groups. The Department and HSP's must urgently, respectfully and meaningfully engage with consumer organisations. A key outcome is to embed contemporary recovery-based and trauma informed models into new integrated models of care with the help of the lived experience voice. Robust monitoring of the Review implementation is also needed to ensure there is deep engagement of the consumer organisation sector.

Table 1. Ten recommendations for action in the WA mental health system

Number	Recommendation
1. Clinical Governance	<p>1.1 The roles, responsibilities, accountabilities and lines of reporting across mental health governance agencies should be clarified, defined and published.</p> <p>1.2 The WA Clinical Governance Framework should explicitly incorporate cultural safety and partnering with lived experience as essential components of effective clinical governance.</p>
2. Clinical Leadership and Engagement	2.1 The Department of Health should establish a Mental Health Directorate (or equivalent) with responsibility for system-wide clinical service planning, clinical leadership, oversight and system management for all public mental health providers in WA.

	2.2	The Mental Health Directorate in the Department of Health should be led by an Executive Director of Mental Health Services who should report to the Director General.
	2.3	The Executive Director of the Directorate should work in partnership with a Lived Experience Leadership Group with involvement of peak consumer and carer organisations.
	2.4	The Mental Health directorate should develop a leadership and capacity-building framework for clinicians. The Directorate must co-design a leadership and capacity building framework for consumers and support persons.
	2.5	The Mental Health Commission should establish a Senior Clinician role with responsibility to facilitate clinician engagement with strategic planning and assist with mental health reform.
	2.6	Health service provider (HSPs) mental health services should be led by an Executive Director with relevant mental health expertise. Where this position is not a clinician, a Clinical Director should also be appointed to work collaboratively with the Executive Director.
	2.7	The Executive Director should report directly to the CEO of the health service provider and with the Lived Experience Leadership Group, have the opportunity to periodically meet with the Board of the HSP.
3. Culture	3.1	A sustained commitment to cultural change must be made by the Director General, Mental Health Commissioner, Board chairs of health service providers and non-government organisations, peak bodies and oversight bodies, consumers and support persons.
	3.2	Protections for workers and volunteers speaking out on matters of human rights and safety and quality should be reviewed and enhanced to move to an “open” culture in WA health.
4. Planning	4.1	The Mental Health Commission should continue with responsibility for strategic planning and leading the reform of mental health in WA mental health services.
	4.2	The Department should have responsibility for system-wide planning. It should co-design plans in collaboration with consumers, support persons, HSPs, NGOs and peak bodies. Plans should develop Models of Care (MoC) and pathways as part of joint regional planning. Priority should be given to addressing the needs of high-risk groups.
	4.3	The Department, health service providers and NGOs should collaborate with WAPHA to jointly develop regional mental health plans.
	4.4	Support the SHR recommendation for the transfer of custodial health services from the Department of Justice to the WA health system.
5. Funding and Commissioning	5.1	A single agency should undertake contracting with all public mental health providers in WA. The final configuration will be subject to proposed realignment options in Section 6.
	5.2	Mental health should be a key consideration in the implementation of new funding and commissioning models for the WA health system, in line with recommendations made by the Sustainable Health Review.

6. Standards	6.1	Responsibility for the regulation of the physical environment, accreditation and management of all mental health providers should reside with the Licensing and Accreditation Regulation Unit (LARU) in the Department of Health.
	6.2	Responsibility for monitoring the services delivered to assist people with mental health issues should reside with the Office of Chief Psychiatrist (OCP).
	6.3	Monitoring of compliance with the Charter of Mental Health Principles (MHA14) should reside with the Mental Health Advocacy Service (MHAS).
	6.4	Standards should be streamlined and reviewed annually by the regulatory agencies to ensure minimal overlap and currency.
7. Performance, Safety & Quality Monitoring	7.1	The monitoring of performance and safety and quality should be consolidated within a single agency. This includes monitoring of clinical, non-clinical and accommodation services.
	7.2	Data analysis should be performed within a centralised hub with enhanced analytic capability. Results must be provided to all governance agencies as appropriate.
	7.3	Key performance indicators (KPIs) for performance, safety and quality indicators should be reviewed for mental health services. Indicators to monitor consumer access, demand, system flow and consumer experience should be considered.
	7.4	Indicators should be streamlined for consistency and where possible embedded within the ICT systems to progress to real-time reporting.
	7.5	Transparency is a priority and the system should move to public reporting of outcomes consistent with the Recommendations of the Sustainable Health Review.
8. Workforce	8.1	The Department of Health and the Mental Health Commission should work collaboratively to develop a whole of sector workforce plan and build the capacity and capability of the entire workforce within public mental health services. This includes expanding the number of peer workforce positions.
9. Information and Communications Technology	9.1	A searchable centralised service database should be developed as a priority to inform consumers, support persons and clinicians of all public mental health services in WA.
	9.2	All providers should be given tiered access to mental health information systems. This could initially involve improved PSOLIS access with later migration to a shared platform or electronic health record.
	9.3	Workflow process should be reviewed annually to ensure efficiency and avoid duplication. Implementation of standardised documentation across WA should occur in all services.
10. Consumer Leadership and Engagement	10.1	The Department of Health must establish strategies to partner with lived experience. Their voice should be influential in decisions about clinical services policy, planning, priority setting and performance monitoring.
	10.2	Health service providers must establish strategies to partner with lived experience, at the service level and at executive and board level.

2. Review Context

2.1. The broader context of mental health reform

The changes to mental health service delivery in WA have occurred in the context of the mental health reform across Australia since the *National Mental Health Strategy* in 1992 (8). There are many achievements including a stronger focus on human rights, emphasis on engagement of consumers, a focus on recovery, mainstreaming of services and community-based care with an increase in services from non-government and nonclinical agencies. Investment in mental health has increased with funding from Federal and State governments. For all the gains made, much remains to be done and new challenges have appeared. This is reflected by the Royal Commission in Victoria, upcoming federal Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and ongoing work by the National Mental Health Commission.

The *Fifth National Mental Health and Suicide Prevention Plan*, endorsed by the Council of Australian Governments Health Council in 2017, is the most recent plan released under the *National Mental Health Strategy*. It sets out eight priority areas for collaborative government action to progress the reform agenda. A key emphasis is the importance of working at the regional level to achieve integrated care pathways. In WA this will require collaboration of MHC, service providers and the Western Australia Primary Health Alliance (WAPHA).

The National Disability Insurance Scheme (NDIS) launched with trial sites in 2013 and commenced full rollout in 2016 (2018 in WA). It provides support for those with a significant psychosocial disability, including that arising from mental illness. The implementation process has been challenging and not proceeded in the anticipated timelines. This has led to upheaval in the non-government organisation (NGO) sector at the same time as significant changes have occurred in the mental health sector. As a result, a strong sense of uncertainty has prevailed over many consumers, support persons and service providers.

It is on this basis, the MHC has been charged with progressing reform of the mental health sector in WA. The direction is outlined in the 2015 *Better Choices. Better Lives. Western Australian mental health, alcohol and other drug services plan 2015–2025* (The Plan) and its 2019 update (9). The Plan aims to rebalance and shift focus from clinical services to a broader service spectrum that includes community-based, non-clinical services (10). There are significant challenges in attempting to balance investment across the sectors.

The message from consumers and support persons has been consistent - they want service responses which are accessible, responsive, individualised, effective and kind and in which they play a meaningful part in designing, delivering and evaluating. Leadership in this area requires courage, boldness and a deep understanding of what a person-centred, trauma-informed paradigm of mental health looks and feels like to the person experiencing and delivering the service.

The need for a whole of government approach to mental health and alcohol and other drugs was raised by multiple stakeholders, with the need for communication, collaboration and integration with broader government agencies such as Disability, Housing and Justice, as well as between the State and the Commonwealth. Any review of the clinical governance cannot occur without acknowledging these broader undercurrents and the need for a sophisticated engagement with all stakeholders to determine an agreed way forward.

2.2. Past reviews

A number of reports have identified the clinical governance of WA public mental health services as an area requiring review and reform. These include:

Stokes Review (2012)

The *Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in Western Australia* (the Stokes Review) was conducted by Professor Bryant Stokes in 2012 (2). It identified a number of concerns with the governance of WA mental health services. These included an absence of a single point of authority with responsibility and accountability for patient care, deficits in system planning and a lack of consistency in practices. It recommended the Department of Health establish an Executive Director of Mental Health Services to jointly develop a Clinical Service Plan with the MHC and to establish sound linkages between the various mental health governance bodies (2 p. 8).

Western Australian Auditor General's Report *Licensing and Regulation of Psychiatric Hostels* (2014)

The Western Australian Auditor General's Report *Licensing and Regulation of Psychiatric Hostels* (2014) (3) noted difficulties with agency collaboration, noting '*There were some instances where the agencies responsible for monitoring hostels worked together, and some where coordination and cooperation could have been improved*'. Other issues identified included concerns with complaints processes, providers not covered by the standards and duplication of monitoring activities with burden on providers (3 p. 6). It recommended that '*All agencies should take advantage of current initiatives in the monitoring of mental health service provision to improve coordination, efficiency and outcomes*'.

Mascie-Taylor Review (2017)

The *Review of Safety and Quality in the WA Health System: A strategy for continuous improvement* (the Mascie-Taylor Review) was conducted by Professor Hugo Mascie-Taylor in 2017 (11). It reviewed the safety and quality arrangements for the WA health system after introduction of devolved governance arrangements with HSA16. It highlighted responsibility for safety and quality performance lies at many levels, including the boards of the Health Service Providers (HSPs) (Recommendation 2). Governance arrangements for WA public mental health services were found to be complex with a large number of organisations with overlapping roles, leading to 'confusion and concern' (11). No one group had a complete picture of mental health and the sum of the parts did not provide a clear and coherent overall view of safety and quality (11 p. 30).

It concluded '*there is an urgent need to simplify and clarify the organisational arrangements supporting effective clinical governance of mental health services in order to provide direction, consistency and facilitation across service providers. To this end an external review of the overall governance of the mental health system in WA should be initiated as a system priority*' (Recommendation 24).

Sustainable Health Review (2019)

In 2017, the WA State Government commenced the Sustainable Health Review (SHR) to prioritise the delivery of patient-centred, high quality and financially sustainable health care across the State.

The 2018 *Interim Report* (12) made two recommendations for action regarding mental health:

- Recommendation 3: In collaboration with the Mental Health Commission, Department of Health, Health Service Providers, consumers and support persons, immediately develop and then implement, an effective, contemporary clinical needs-based model that enhances or replaces the current patient flow model across all health services.
- Recommendation 4: Support the immediate review of mental health clinical governance as identified by Professor Mascie-Taylor in the 2017 Review of Safety and Quality the WA Health System.

The *Final Report* (5) noted that courage, collaboration and system thinking was needed to change how health care is delivered in WA for a healthier, more sustainable future. Regarding mental health governance, the report noted: *'It is clear from listening to those who work in the system, and more importantly, consumers relying on the system, that the current approach is not working'* (5 p. 60). Two further recommendations were made in relation to mental health.

Recommendation 6 noted:

- Prioritise and invest in capacity to balance early intervention, community, Step Up Step Down, acute and recovery mental health, alcohol and other drug services.
- Immediate transparent public reporting of patient outcomes and experience.
- Ensure clear accountabilities for joint planning, commissioning and service delivery for more integrated services (5 p. 12).

Recommendation 7 noted:

- Implement models of care for people to access responsive and connected mental health, alcohol and other drugs services in the most appropriate setting (5 p. 13).

A priority was for *'Consumer and carer voices [are] embedded into health system governance structures and [to] make consumer/carers/clinician partnerships and co-designed projects a normal part of business'* (5 p. 11).

Access to State Managed Adult Mental Health Services (2019)

This review assessed whether people can access adult State managed mental health services efficiently and effectively (4). The Auditor General noted it was not clear if either the MHC or the Department was responsible for delivering the necessary changes to ensure care was efficient and effective and limited effective coordination between agencies. Whilst the MHC had developed strategies for engagement in service design, it had not developed a system wide implementation plan to promote a coordinated approach. It found the MHC had made limited progress in reform, having finalised only 24 per cent of the projects it expected to complete by 2017.

The Plan had aimed to reduce the proportion of funding the hospital beds from 42 per cent to 29 per cent by 2025. By the end of 2017-18, hospital costs had instead risen to 47 per cent of state mental health funding. A key component of the plan was to shift to nonclinical and community based services. The proportion of funding on community treatment services remained constant at 43 per cent, with reductions in prevention and community support (three per cent to one per cent and eight per cent to five per cent respectively). The Auditor General found that people accessing community treatment services in 2017 were actually receiving less care on average than in 2013.

The report also noted EDs appeared to be used as the major gateway for mental health. From 2013 to 2017, almost half the people seeking care first accessed State-funded mental

health services through an ED. A significant number of people had three or more ED visits in the seven days before being readmitted to hospital. The review found that 10 per cent of people consumed 90 per cent of the hospital care and 50 per cent of ED and community treatment services. It also found high numbers of patients with very long stays in the WA mental health system. From 2013 to 2017, 126 people spent more than 365 consecutive days in an acute hospital bed, with hospital fees totalling an estimated \$115 million. Another 158 people had multiple stays that totalled 365 days or more across the same period. Older adults are overrepresented and comprise 25 per cent of this group.

2.3. Purpose and scope of the review

The purpose and scope of this review is set out in the Terms of Reference, provided in full at Appendix 1. The review aims to ensure the WA public mental health system hasan appropriate and robust clinical governance with clear roles and responsibility, authority and accountability to ensure the delivery of its high-quality mental health services.

2.4. Review methodology

An independent review Panel (the Panel) was appointed by the Minister for Health and Mental Health to conduct the review. The methodology included information gathering, a range of face-to-face interviews, public submissions and online consultations.

The information gathering included a desktop review of past reports and inquiries of the governance of the mental health system in WA; collation of information regarding the current functions, roles and responsibilities of agencies charged with the clinical governance of the public mental health system; an inter-jurisdictional review of comparable models in other Australian states and territories; and a literature review on clinical governance.

The consultation included targeted semi structured interviews with key stakeholders; meetings with regional stakeholders in areas with high rates of mental health issues; a one-day Lived Experience Forum for consumers and support persons; formal submissions from targeted key stakeholder groups; and a public online survey of clinicians, consumers, support persons, organisations and service providers.

The methodology adopted was consistent with the purpose and scope outlined in the Terms of Reference. The review aimed to provide an inclusive opportunity for consumers, support persons, clinicians, community organisations, peak bodies and other key stakeholders to share their insight and experiences with the independent Panel. Further details regarding the methodology are set out in Appendix 2.

3. Mental Health Governance in Western Australia

3.1. Overview

Public mental health services in WA provide a range of hospital and community-based services to individuals and communities across the State. Services are delivered by a mix of providers including public mental health services, private hospital services contracted to provide public services, non-government organisations (NGOs) and contracted private mental health accommodation services.

Clinical governance of the public mental health system in WA is distributed across the Department of Health (the Department) and the Mental Health Commission (MHC). It also involves the statutory entities of the Office of the Chief Psychiatrist (OCP), the Mental Health Advocacy Service (MHAS), the Health and Disability Services Complaints Office (HaDSCO)

and the Mental Health Tribunal (MHT). Each of these agencies has different service provision, regulatory, assurance and facilitation roles and responsibilities.

3.2. History and timelines

The public mental health system in WA has undergone numerous changes in governance over the past decade. An overview of the key changes is set out below.

3.2.1. Minister for Mental Health – 2008

Governance of mental health policy, planning and service monitoring was traditionally the responsibility of the Department through its Mental Health Division, which reported to the Director General and the Minister for Health. In 2008, the portfolio of Minister for Mental Health was established, with responsibility for the distribution of the mental health budget and administration of the *Mental Health Act 2014 (WA)* (MHA14). The creation of this standalone ministerial portfolio for mental health was intended to *'to lead mental health reform throughout the state'* (13).

3.2.2. Mental Health Commission – 2010

The MHC was established in 2010 under section 35 of the *Public Sector Management Act 1994 (WA)* to lead mental health reform across the State and to work towards a system that places the individual and their recovery at the centre of its focus. Resources for the MHC were transferred from the existing Mental Health Division of the Department of Health (13).

The Minister for Mental Health is the 'responsible authority' for the MHC with respect to its functions, performance objectives and budget. The MHC purchases, provides and partners in the delivery of prevention, promotion and early intervention programs; treatment, services and support; and research, policy and system improvements. It has a key role in mental health strategy, planning, budgeting, procurement and administration of the MHA14.

The WA MHC was Australia's first such commission, with subsequent commissions established by the Australian Government and the New South Wales, Queensland and South Australia governments. The ACT Government has more recently established an Office of Mental Health and Wellbeing. The WA MHC is the only commission in Australia responsible for mental health purchasing (14).

Drivers for the decision to give the MHC budget-holding responsibility included a need to protect mental health funds from diversion to general health services and to facilitate reform, particularly towards the shift in focus from clinical services to a broader service spectrum that included community-based, non-clinical services. Others noted the split of general health and mental health services differed from the National Mental Health Strategy, which promoted the integration ('mainstreaming') to improve the management of physical health issues in people with mental illness and to decrease stigma (15).

3.2.3. Amalgamation with the Drug and Alcohol Office – 2015

The MHC and the Drug and Alcohol Office amalgamated in 2015, and the MHC took responsibility for the *Alcohol and Other Drugs Act 1974 (WA)* (AODA). The primary driver for this merger was to achieve an integrated approach to mental health and AOD service delivery for WA, in recognition that drug, alcohol, and mental health problems commonly coexist. Through this amalgamation, the MHC assumed clinical governance responsibilities for the AOD sector. It also became a service provider for the delivery of drug and alcohol treatment services (Next Step) and programs under the AODA, in contrast to its role in mental health where it does not directly provide mental health services.

3.2.4. Devolved governance of the WA health system – 2016

The WA health system adopted a devolved governance model with the implementation of the HSA16. This saw the Department CEO (the Director General) become the system manager responsible for the overall management and strategic direction of the WA health system and the HSPs established as independent board-governed statutory authorities to provide health services as well as teaching, training and research.

The role of the system manager is set out in the HSA16 and is critical to understanding the clinical governance of the public mental health system. The role includes the following functions (HSA16 s. 20):

- (a) advising and assisting the Minister in the development and implementation of WA health system-wide planning;
- (b) providing strategic leadership and direction for the provision of public health services in the State;
- (c) recommending to the Minister the amounts that may be allocated from the monies appropriated from the Consolidated Account to health service providers;
- (d) promoting the effective and efficient use of available resources in the provision of public health services in the State;
- (e) carrying out certain functions of health service providers as specified in service agreements;
- (f) managing WA health system-wide industrial relations on behalf of the State, including the negotiation of industrial agreements, and making applications to make or vary awards;
- (g) commissioning and delivering capital works and maintenance works for public health service facilities;
- (h) classifying, and determining the remuneration of, health executives and their offices, and varying the classification or remuneration;
- (i) establishing the conditions of employment for employees in health service providers;
- (j) arranging for the provision of health services by contracted health entities;
- (k) providing support services to health service providers;
- (l) overseeing, monitoring and promoting improvements in the safety and quality of health services provided by health service providers;
- (m) monitoring the performance of health service providers, and taking remedial action when performance does not meet the expected standard;
- (n) receiving and validating performance data and other data provided by service providers; and
- (o) other functions given to the Department CEO under this or another Act.

Nothing in the HSA16 affects the role of the Minister responsible for the administration of the MHA14. The HSA16 notes the responsibility for maintaining and improving patient safety, quality and care lies with the HSP. The HSA16 is not explicit about the role of the system manager in relation to mental health services.

3.3. Operational agencies

3.3.1. Statement of roles and responsibilities – 2019

There was no shared description of the roles and responsibilities of the governance agencies involved with WA public mental health services. In March 2019 a joint statement was issued by the Department of Health and the Mental Health Commission in consultation with other agencies. The roles of the key operational agencies are briefly summarised below.

3.3.2. Department of Health

- Responsible for strategic leadership, oversight, performance, planning, policy setting and direction of the WA health system.
- Oversees, monitors and promotes improvements in the overall delivery of health services, including the safety and quality of mental health services provided by HSPs.

- May issue binding policy frameworks and directions to HSPs to ensure a consistent approach to a range of matters, including mental health service delivery.
- Enters into service agreements with HSPs setting out the services to be provided by HSPs, funding, performance measures and operational targets. This includes mental health services not purchased by the MHC, including emergency department (ED) mental health care, but excludes services purchased by the MHC through Commission Service Agreements (CSAs).
- Monitors performance of the HSPs and takes remedial action when performance does not meet expected standards.
- May initiate an investigation, inspection or audit to assess the compliance of HSPs with the HSA16 and may conduct an inquiry into the functions, management or operations of HSPs.

Table 2. The functions of the different sections of the Department of Health

Department section	Function
Mental Health Unit	Development of state-wide policies for mental health services. Coordination, review and reform of public mental health.
Patient Safety and Clinical Quality Directorate – Patient Safety Surveillance Unit (PSSU)	Responsible for state-wide patient safety policy and reporting on consumer complaints, clinical incidents, clinical risk management and review of death (including mental health services provided by HSPs).
Information and System Performance	Delivers the performance-related functions of the system manager, supporting the provision of an accountable, sustainable system that delivers better health outcomes.

3.3.3. Mental Health Commission

- Sector leader for mental health, with responsibility for setting strategic directions for public mental health and AOD services and leading mental health reform.
- Responsible for development of mental health planning and strategy, and determining the range of mental health services required for the State, together with responsibility for specifying activity levels, ongoing performance monitoring and evaluation of key mental health programs.
- Coordinates research into causation, prevention and treatment of AOD use problems.
- Provides assessment, treatment, management, care and rehabilitation of persons experiencing AOD use problems or co-occurring health issues (including mental health issues) and, subject to the consent of the Minister for Mental Health, may establish and maintain premises and/or accommodation for those purposes.
- Purchases mental health, AOD health services and support services across the State from the WA health system via CSAs and other non-government health providers.
- Under section 572 of the MHA14, may request disclosure of relevant information about mental health treatment and care and service evaluation by the Department CEO and HSPs. However, HSPs and the Department CEO are not bound to disclose information requested by the MHC under this section.

Additional roles not included in the joint statement but derived during the review.

- Monitors performance, safety and quality and licensing of facilities for the NGO and AOD sectors.
- Monitors standards through its Quality Management Program against the National Standards for Mental Health Services for NGO and AOD sectors.

- Administration of the MHA14.
- Collates system performance data for clinical and non-clinical services. It is the main reporting entity for the National Minimum Data Set regarding mental health.

Table 3. The functions of the different areas of the Mental Health Commission

MHC area	Function
Planning, Policy and Strategy	Leads the development and monitoring of strategy and planning including the implementation of reforms aligned to the <i>Mental Health, Alcohol and Other Drug Services Plan 2015–2025</i> . Supports the administration of the MHA14. Promotes and undertakes community engagement.
Purchasing, Performance and Service Development	Responsible for the commissioning and service development of specialised mental health services in liaison with the Department of Health and HSPs. Leads the overarching management of quality in NGOs. Undertakes performance monitoring, reporting and evaluation of services.
AOD Services and Prevention Services	Develops, implements and coordinates initiatives to reduce the prevalence of mental health, suicide and other impacts of AOD use in the community. Provides an Alcohol and Drug Support Service – a 24/7 telephone and online support service. Responsible for the development of sector capacity. Delivers assessment and treatment services for people experiencing problems with AOD use, including assistance for support persons.

3.3.4. Public Health Service Providers

There are currently five board-governed HSPs, each providing public mental health services:

- Child and Adolescent Health Service
- East Metropolitan Health Service
- North Metropolitan Health Service
- South Metropolitan Health Service
- WA Country Health Service

Health Support Services and Pathwest have been established as chief executive-led HSPs providing state-wide support services. The Quadriplegic Centre is also established as a chief executive-led HSP. The HSPs are legally responsible and accountable for providing safe, high-quality and efficient health services to their local communities, in accordance with expectations set out in Service Agreements with the Department CEO, and CSAs with the Mental Health Commissioner. They must also comply with policy frameworks and directions issued by the Department CEO. It is understood that reviews of Clinical governance arrangements within HSPs have been undertaken following the Mascie-Taylor review and progress is being made regarding reforms (11). There are significant numbers of NGO providers now operating within the WA mental health system.

3.4. Non-operational statutory entities

Non-operational statutory entities include the Office of the Chief Psychiatrist, the Mental Health Advocacy Service, the Mental Health Tribunal and the Health and Disability Services Complaints Office, which provide additional advocacy, regulatory, assurance and facilitation functions.

3.4.1. Office of the Chief Psychiatrist

- Responsible for overseeing the treatment and care of a range of persons within the scope of the MHA14, including involuntary patients, patients suspected to be in need of an involuntary treatment order and those who are mentally impaired accused¹ and to be detained at an authorised hospital (MHA14 s 515(1)).
- Responsible for voluntary patients being treated at a mental health service and licensed psychiatric hostel residents.
- May visit a mental health service at any time, or review the treatment being provided to an involuntary patient.
- Mental health services are required to report certain matters to the Chief Psychiatrist, such as unreasonable use of force by a staff member against a patient or other incidents related to provision of treatment and care that are likely to have an adverse effect on a patient.
- Must prepare an annual report for the Minister for Health, which is tabled in Parliament.
- Must publish guidelines for certain purposes and must publish standards for the treatment and care of certain people as specified under the MHA14.
- Monitors compliance with the published Chief Psychiatrist standards.
- Does not play a role in day-to-day operations of public mental health services.

3.4.2. Mental Health Tribunal

- Undertakes a range of functions to protect the rights of involuntary patients subject to the MHA14. These include conducting periodic reviews of involuntary status and ensuring that clinicians and services comply with certain aspects of the MHA14.
- The Tribunal is constituted by lawyers, psychiatrists and community members. It replaced the Mental Health Review Board, which operated in WA from 1997–2015.

3.4.3. Mental Health Advocacy Service and the Chief Mental Health Advocate

- Created under the MHA14, it replaces the Council of Official Visitors and is composed of approximately 28 mental health advocates across metropolitan and regional WA.
- Advocates for involuntary patients and others within the scope of the MHA14, by ensuring that patients are aware of their rights under the MHA14, and by investigating matters that may adversely impact patient health, safety and wellbeing.
- The MHA14 requires a mental health advocate to contact every involuntary patient within seven days, or 24 hours after an involuntary treatment order is made in the case of a child.

3.4.4. Health and Disability Services Complaints Office

- Provides an impartial resolution service for complaints relating to health, disability and mental health services provided in WA.
- Assists people in making a complaint and supports service providers in resolving complaints.
- Uses information about complaints to identify and provide advice on systemic issues and trends across the health, disability and mental health sectors, and works with all parties to improve service delivery.

¹ As defined by the *Criminal Law (Mentally Impaired Accused) Act 1996 (WA)*.

3.4.5. Licensing and Accreditation Regulatory Unit

- The Licensing and Accreditation Regulatory Unit within the Department is responsible for the licensing and monitoring of private hospitals in WA, including private psychiatric hospitals and hostels.
- Licensing and regulatory functions provided by the Licensing and Accreditation Regulatory Unit (LARU) are conducted under the authority of the *Private Hospitals and Health Services Act 1927 (WA)* and supporting regulations.

3.5. Advisory groups, committees and networks

In addition to the governance entities outlined above, a significant number of advisory groups, committees and networks that have been established to provide advice on specific topics to the Minister for Mental Health, the Department and the MHC. They do not play a direct role in governance and there is no requirement for agencies to involve or consult them in system decision making. There are minimal formal lines of communication between the majority of the groups, committees and networks. The functions and membership of the different advisory groups are detailed in Table 4, and of the committees in Table 5.

Table 4. The functions and membership of the different advisory groups

Advisory group	Function and membership
Co-Leadership Safety and Quality Mental Health Steering Group	<p>The Co-Leadership Safety and Quality Mental Health Steering Group was established to bring a collaborative approach to the management of mental health services between the MHC and Department. The Steering Group seeks to coordinate the strategic governance of safety and quality across all publicly funded mental health services.</p>
Mental Health Network (MHN)	<p>A forum for improving mental health outcomes by enabling engagement and collaboration between consumers, support persons, health professionals, service providers, the MHC and the Department. The MHN's engagement is intended to inform reform and policy development, and improve care coordination. The MHN supports the implementation of the <i>Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–25</i>.</p> <p>Membership of the MHN is wide-ranging, including service providers, consumers, support persons and representatives from respective governance agencies.</p> <p>The MHN is supported by ten sub-networks, which provide and engage with specific expertise across a range of geographic and diagnosis specific areas.</p>
Mental Health Advisory Council	<p>Brings together representatives from the WA community to provide high-level advice and input to the Mental Health Commissioner on significant mental health issues affecting the State.</p> <p>Membership of the Council is required to include people with experience of receiving mental health services, a person or persons of Aboriginal descent, young people (aged 16–25 years), people from regional areas with knowledge or experience of mental health issues, and a member of the Alcohol and Other Drugs Advisory Board.</p>
Alcohol and Other Drugs Advisory Board	<p>Provides strategic advice about the management, care and support services provided to people experiencing AOD use problems.</p>
System-wide Mental Health Policy and Planning Advisory Group	<p>Provides strategic advice to the system manager on issues that impact state-wide mental health policy and planning.</p> <p>Comprises Executive Director or Area Manager for Mental Health from each HSP, the Co-Director Women and Newborn Health Service, and Executive Director Patient Safety and Clinical Quality Directorate. The Group reports to the Mental Health Unit.</p>
System-wide Mental Health Clinical Policy Group	<p>Responsible for developing and reviewing system-wide clinical policies issued within the <i>Mental Health Policy Framework</i>.</p> <p>Comprises Executive Director of Mental Health from each HSP, a representative of the Mental Health Unit, a consumer representative and a carer representative. The Chair of the system-wide Mental Health Clinical Reference Group is also a member of this group.</p>
System-wide Mental Health Clinical Reference Group	<p>Provides clinical advice to the Department, the MHC and other key stakeholders regarding the development and delivery of high quality, comprehensive and contemporary mental health services for WA.</p> <p>Includes representatives from HSPs, specific health services such as the Women and Newborn Health Service, cohort-specific mental health services (youth, adult, older adult, forensic and Consultation-Liaison) and other related specialities (Pharmacy, Social Work and Physiotherapy). The Mental Health Commissioner is also an ex officio member of this group.</p>

Table 5. The functions and membership of the different committees

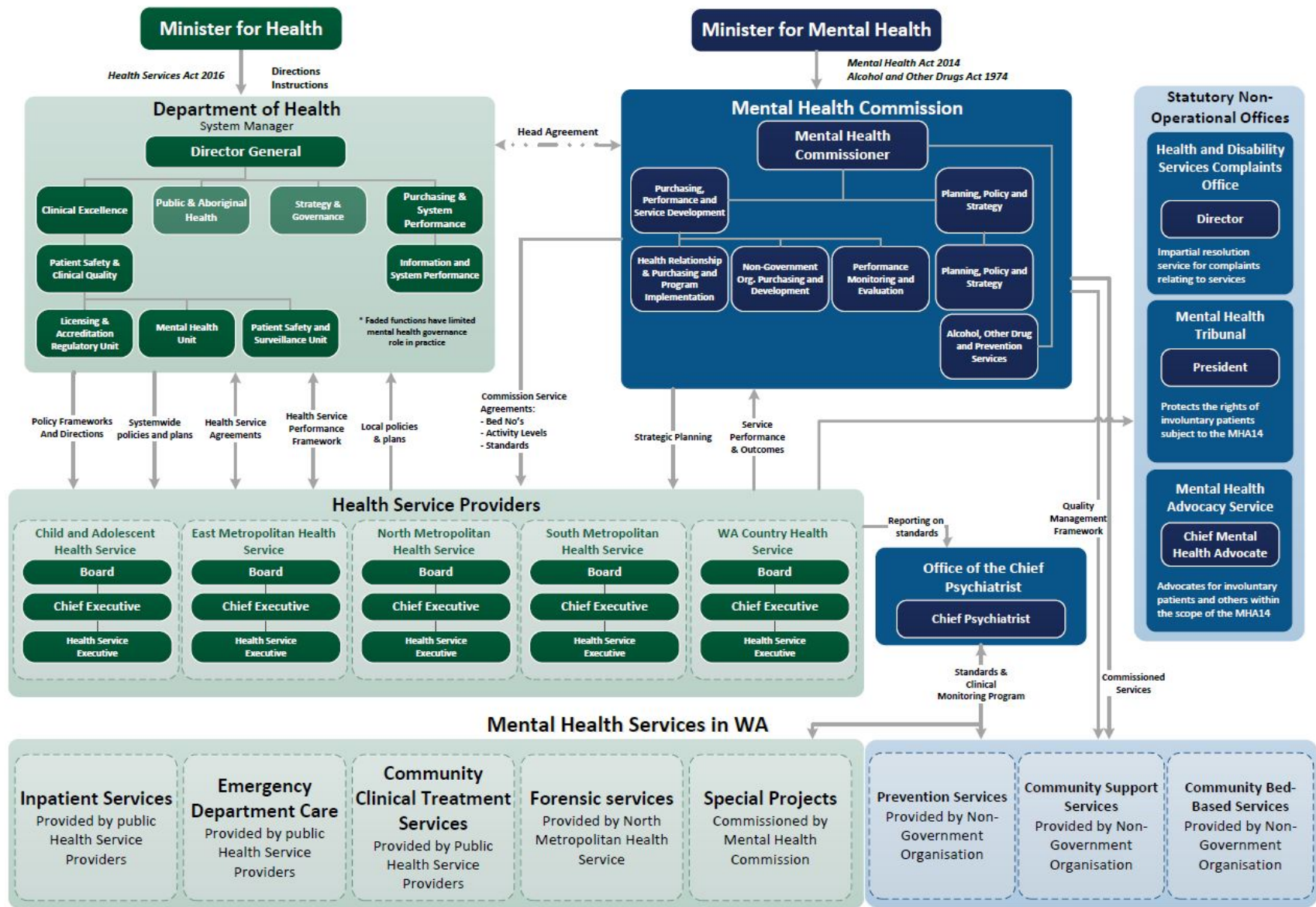
Committee	Function and membership
WA Mental Health Interagency Forum	<p>Advises the Department and the MHC on state-wide mental health policy and planning matters.</p> <p>Membership includes senior staff from WA Police, St John Ambulance, Royal Flying Doctor Service, the MHC, the MHU, the OCP and representatives from HSPs. This group reports to the Executive Director Patient Safety and Clinical Quality Directorate, with issues escalated as required.</p>
Psychiatric Services On Line Information System (PSOLIS) Governance Committee	<p>Carries overall responsibility for driving and supporting the planning, strategy implementation and resourcing decisions required to maintain and develop PSOLIS, the primary mental health clinical information platform in WA. Oversees matters such as meeting ongoing clinical needs, documentation, legislative and reporting requirements, and the delivery of priority projects. Supported by the PSOLIS Management Group, which is responsible for representing users to ensure PSOLIS meets ongoing operational and reporting requirements.</p>
Mental Health Data Management Group	<p>An advisory group to provide expert advice and, where required, make recommendations on information and performance measure development. Membership includes the Department, HSPs, the MHC and the OCP.</p>

3.6. Legislative framework

Mental health services in WA are subject to the legislative requirements of the following Acts and regulations:

- *Mental Health Act 2014 (WA)*
- *Health Services Act 2016 (WA)*
- *Alcohol and Other Drugs Act 1974 (WA)*
- *Guardianship and Administration Act 1990 (WA)*
- *Health and Disability Services (Complaints) Act 1995 (WA)*
- *Criminal law (Mentally Impaired Accused) Act 1996 (WA)*
- *Private Hospitals and Health Services Act 1927 (WA)*
- *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987 (WA)*
- *Hospitals (Licensing and Conduct of Private Psychiatric Hospitals) Regulations 1997 (WA).*
- *Support persons Recognition Act 2004 (WA)*
- *Support persons Recognition Act 2010 (Cmlth)*
- *Health Practitioner Regulation National Law (WA) Act 2010 (WA)*
- *Prisons Act 1981 (WA).*

Legislation relevant to governance is addressed in context in sections of the report.



4. Clinical Governance

Clinical governance was first implemented in 1997 in the National Health Service (NHS) in the United Kingdom (UK) and later adopted by other countries including Australia, Canada and the United States (US) (16). It is 'the set of relationships and responsibilities established by a health service organisation between its state or territory department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes (17).

It aims to ensure that systems are in place to deliver safe, high-quality health care and that all key stakeholders are accountable to patients and the community for services that are effective, integrated, high quality and continuously improving (18) (17 p. 44). Corporate governance is the system of rules, practices and processes by which an organisation is controlled. Clinical governance is an integrated part of a governing body's responsibility to govern the organisation and is a system within a system (17). It should be of equal importance to financial and business governance. Health systems often work in a constrained resource environment and there is a need for transparent and evidence-based resource allocation.

The Lived Experience Forum highlighted that governance should not be limited to clinical knowledge but incorporate other forms of knowledge, such as that held by consumers and support persons (19). The concept of open and closed governance was raised, with open governance systems recognising "critics" as innovators rather than being seen as 'disruptive' (19). Cultural governance ensures culturally secure practices are in place when engaging with Aboriginal populations, ethnic minorities and those who identify as LGBTIQ.

4.1. Health system failures

Clinical governance problems are linked to health system failures and scandals. Reviews note that whilst issues may appear in clinical care problems, the causes lie in problems with organisational governance, systems, procedures and environment (20). Governance failures were evident in the Bristol Royal Infirmary paediatric cardiac surgery case, which involved the deaths of 29 children and left four others with severe brain damage (20).

The Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Review) also identified significant governance failures (21) (22). Australia had issues at Bacchus Marsh Hospital leading to a review of hospital safety and quality in Victoria and the report, *Targeting Zero* (23). Numerous other governance failures have been associated with governance issues in the US, the UK, New Zealand and Canada (24) (25).

4.2. System change and devolvement

Traditional health systems involved large unwieldy health departments that delivered public services as a single entity. Difficulties with managing these structures led to regional models with reporting to a central head office. Safety and quality assurance was based on a system of 'checks and balances' and external accreditation. History has demonstrated the approaches 'simply did not work' with many prominent health system failures (25) (22).

Devolved health systems are used in Australia and other parts of the world. WA moved to such as system with the *Health Services Act 2016* (2016). This saw the Department adopting a central system manager role and purchased health services from a range of on behalf of the public. Key roles for the system manager include leading service direction, planning and coordination. Monitoring of providers is key to providing assurance of safe and high quality services (11). Each provider is also responsible for the monitoring and ensuring safety and quality in their services.

Governance in devolved systems is reliant on linkage between purchasing and safety/quality monitoring. Contracts between the system manager and a provider define expectations for safety and quality and remediation. For whole of system visibility the system manager must have contracts with all providers. Action for improvement is via contract mechanisms for individual providers or changes to planning, policy, standards or legislation.

The major structural changes appear to have affected the governance of WA mental health services. The implementation of the MHC in 2010 led to separation of mental health from general health services and adoption of a partially devolved structure, with the MHC performing a “system manager” role in purchasing of mental health services from a range of providers. Responsibility for safety and quality of clinical services however was split and remained with the Department for clinical services. An unintended consequence was a system with two “system managers” for mental health services.

For clinical services, the MHC determines and purchases activity from “designated” mental health services, including hospitals and community treatment services. The Department also purchases mental health activity in emergency departments (e.g. MHOAs) and other sections. The divided funding results in neither having whole of system visibility. For clinical services, there are split responsibilities for purchasing (MHC) and safety and quality monitoring (the Department). The NGO sector has the MHC serving to purchase and monitor providers with the Department having minimal visibility with resultant poor transparency.

The major structural changes have resulted in splits and fragmentation in the clinical governance framework for WA public mental health services. There is a separation of general and mental health services and in practice, the mental health sector is further split with two “system managers” leading two parallel and separate systems (Department with clinical services and MHC for nonclinical, accommodation and AOD services). For clinical services, there is further division with purchasing (MHC) and safety and quality (MHC). The impact of these structural issues is examined further in this review.

4.3. Frameworks

The *National Model Clinical Governance Framework* describes the principles for Australian health services and serves as a guide for the development of local frameworks to meet local needs, values and context (17). The five key components of the National Model are (a) Governance, leadership and culture; (b) Patient safety and quality improvement systems; (c) Clinical performance and effectiveness; (d) Safe environment for the delivery of care; and (e) Partnering with consumers. The WA Department has recently updated a *Clinical Governance Framework*, which reflects the National Model and also incorporates guidance from local reviews including Mascie-Taylor (11). These resources were used to guide this review with sections following the National model.

5. Review Findings

5.1. Governance, leadership and culture

5.1.1. Governance structure and system leadership

The WA mental health system has undergone major changes in the past decade. Planning for governance arrangements is an essential part of health organisation restructure or expansion (26). The review did not find evidence of planning for the establishment of the MHC or system devolvement. Clear documentation of roles, responsibilities and reporting is also critical for governance (27). A joint statement of functions for the Department and MHC was only agreed in March 2019, many years after major system changes. The HSA16 refers to the purchasing function of the MHC (HSA16 s. 45) but is not explicit about mental health

governance. No corporate diagram was available at the time of this review of the mental health governance system with lines of reporting and accountability. The diagram (pg. 23) was prepared by the secretariat.

Leadership is pivotal in the governance literature, with health system failures often pointing to inadequate leadership with a lack of willingness to accept and tackle known problems (28). The Mid Staffordshire report found failings started at the board level and allowed a negative culture, tolerant of poor care, to pervade the hospital (25). Leadership must start with the governing body if a culture of safety and quality is to be achieved. Review submissions report that overall leadership of the WA public mental health system is unclear. The MHC is described as the 'sector leader' for mental health services. Other documents suggest the Department, as the system manager, under the HSA16 is responsible for strategic leadership of the total WA health system. The review was unable to locate clear distinctions between the 'sector leader' and 'system manager' and their role in mental health.

Governance structure is a focus of the literature. Contemporary models suggest simple systems with clear roles and responsibilities, noting that *'when responsibility is diffused, it is not clearly owned: with too many in charge, no one is'* (27). The Francis Review found the number and complexity of regulatory bodies contributed to system fragmentation and decreased accountability (22) (27). The literature highlights that governance agencies must also have good communication to prevent dysfunction and fragmentation (26) (27). There is encouragement towards integration and moves to a single accountable agency with the exception of statutory agencies for monitoring of human rights (27).

The Stokes Review (2012) found silos and divides between the Department and the MHC (2). Silo formation can lead to information *'distributed across agencies, who all know something about the problem or failure, but don't necessarily know the full picture or have the authority or incentive to act'* (24). The Office of the Auditor General found four agencies monitoring hostels with evidence of inefficiency, duplication, inability to agree on roles and a burden on providers (3). Another WA review found issues with agency communication (29). The Stokes review previously emphasised the need for a single point of accountability and authority (2).

The Mascie-Taylor review found that mental health governance agencies in WA were numerous, complex, unclear and posed a direct risk to safety and quality (11). Respondents in the review online survey (90 per cent) reported the WA mental health structure was fragmented, with multiple layers and streams that were competitive and not collegial (30). They reported issues with the integration, interaction and communication between agencies (99 per cent). Of the survey respondents, 90 per cent identified weaknesses with the interface between WA mental health and AOD and other relevant WA agencies (31). The RANZCP also reported that silos exist in the system with lack of cooperation between providers managing incidents across services (32).

Respondents in the review online survey reported little clarity as to who is accountable or in charge (64 per cent). The RANZCP noted a challenge was to address the lack of clarity and accountability for the integrated mental health, alcohol and other drugs (MHAOD) system (33). The RANZCP called for a single point of accountability with the seniority, data, resources and authority to balance and integrate the mental health and AOD system (33). Respondents reported governance issues had a negative impact on clinical oversight and accountability (71 per cent), safety and quality culture (95 per cent), innovation in safety and quality processes (72 per cent) and clinical outcomes for consumers (64 per cent) (2).

Consumer viewpoints were sought in the Lived Experience Forum (19). Consumers did not put forward a particular governance model but stressed that whatever structure was developed, it should be informed by lived experience voices and have a culture that welcomed diversity. They wanted a system that was transparent and accountable, provided

answers to individuals about their care, reported outcomes and delivered a transparent evidence base for decisions (19).

This review confirmed the findings of previous reports and noted that despite recommendations, major governance issues persisted (11). Key findings include a complex system with multiple agencies with silos and communication issues. While moves to clarify roles and responsibilities are encouraged, the structural issues that remain are a source of ongoing difficulty and will require structural realignment, (covered in Section 6).

Recommendation 1 : Governance	
1.1	The roles, responsibilities, accountabilities and lines of reporting across mental health governance agencies should be clarified, defined and published.
1.2	The WA Clinical Governance Framework should explicitly incorporate cultural safety and partnering with lived experience as essential components of clinical governance.

5.1.2. Clinical and consumer leadership

Clinical leadership is a key determinant for consumer safety and quality in healthcare systems (20) (27). International reviews highlight the need for clinical involvement in the planning, improving and delivery of healthcare services (34). Conversely, a lack of clinical engagement features prominently in health system scandals (20) (27). Listening to the staff is highlighted as a key part of monitoring the safety and quality of care in organisations (27) (18).

Submissions report a lack of effective clinical input in the governance of WA mental health services (31). The Department has a limited Mental Health Unit (MHU) in the Clinical Excellence section of 14 staff with no clinicians. The MHC has a significant footprint with 272 full-time staff (including AOD staff). Despite this, the Australian Medical Association (AMA) notes there are no medical practitioners in the MHC mental health section to assist with governance (36). Overheads in the MHC annual operating budget were \$38 million (35).

Clinical input in WA governance is mainly provided through advisory groups, which do not play a role in governance and appear to have limited impact (Section 3.4) (36). The OCP has specialist psychiatrist expertise but does not play an operational role as it was established as an agency independent of the system to facilitate human rights monitoring (2). Submissions raised concern the WA mental health system is planned and monitored without adequate mental health content expertise (36).

The MHC and the Department co-sponsor the WA Mental Health Network, which is a cooperative of clinicians and administrators who work collaboratively to improve clinical practice and service management. This provides an avenue for knowledge sharing, research translation and innovative practice. While there was evidence during the consultation of high regard for the work of the MHN, it was not apparent that it had been given effective levers to drive much reform.

Concerns were also raised regarding lack of clinical input at the level of providers and HSPs. The RANZCP notes few psychiatrists are in senior leadership and management roles (32). Mental health services were apparently relegated or clustered with unrelated specialities. Structures were also noted in which clinical leaders report to finance managers, carrying a risk that financial issues may take priority over clinical care. Risk management committees sometimes did not have mental health expertise, which is alarming given the risks in the sector. Multilayered management structures were felt to be limiting progress with reform (37).

Peak consumer and carer groups also raised the need to strengthen the governance in HSPs (37). They suggested the appointment of a MHED with overarching responsibility for

the safety, quality and rights of individuals and support persons and requiring mental health treatment and support within the HSP. A Lived Experience Leadership Group was also recommended to ensure that the voice of consumers and support persons is heard.

The RANZCP suggests a need for integrated frameworks of mental health leadership with clinical expertise present at all levels of decision-making (33). Critical areas included representation in areas of safety and quality, planning, policy development, education and research (41). High-performance health models were recommended with *'collaborative and distributed leadership to create a culture within which compassionate care can be created'* (33 p. 4). One HSP reported significant benefits from a Mental Health Executive Director (MHED) directly reporting to the chief executive and Board as required (41).

There are significant barriers to clinicians moving into senior management roles (38). A need for clinician management training was identified in the Stokes Review for WA mental health services (2). The need for greater involvement of clinicians in management has been recognised around the world, with the establishment of centres of excellence such as the NHS Leadership Academy and the Cleveland Clinic (39) (38). Similar programs exist in the Czech Republic, Taiwan, South Korea, Ireland, Germany and the Netherlands (40). Similar opportunities should be made available in WA to improve opportunities.

There is also a critical need to increase input from lived experience perspectives into the system. Recommendation 2 suggests a Lived Experience Leadership Group provide guidance at the level of the Department/MHC and also HSPs. This will allow contributions to planning, clinical training, practice development and performance appraisals. Further improvement can arise from tools such as Patient Opinion and Care Opinion and the use of progressive strategies such as Open Dialogue and the co-design of culturally secure options at a service level. A commitment by services to use this feedback needs to be a priority (1).

Further suggestions to strengthen the genuine representation of people with lived experience were made in the joint submission by WAAMH and CoMWA. This suggested a model of state-wide mental health governance through either new legislation or via amendment of the *Mental Health Act 2014 (WA)*. Key goals of this legislation would be provision of functions similar to the *Disability Services Act 1993 (WA)*. Considerations could include a Ministerial Advisory Council for People with Lived Experience reporting to the Minister for Mental Health, but with a quota to provide for majority lived experience representation (similar to the *Disability Services Act 1993*) and a new Mental Health Commission Board with a quota to provide for majority representation by people with lived experience.

Recommendation 2: Clinical leadership and consumer and supporter engagement

2.1	The Department of Health should establish a Mental Health Directorate (or equivalent) with responsibility for system-wide clinical service planning, clinical leadership, oversight and system management for all public mental health providers in WA.
2.2	The Mental Health Directorate in the Department of Health should be led by an Executive Director of Mental Health Services who should report to the Director General.
2.3	The Executive Director of the Directorate should work in partnership with a Lived Experience Leadership Group with involvement of peak consumer and carer organisations.
2.4	The Mental Health Directorate should develop a leadership and capacity-building framework for clinicians. The Directorate must co-design a leadership and capacity building framework for consumers and support persons.
2.5	The Mental Health Commission should establish a Senior Clinician role with responsibility to facilitate clinician engagement with strategic planning and assist with mental health reform.
2.6	Health service provider (HSPs) mental health services should be led by an Executive Director with relevant mental health expertise. Where this position is not a clinician, a Clinical Director

should also be appointed to work collaboratively with the Executive Director.

2.7 The Executive Director should report directly to the CEO of the health service provider and with the Lived Experience Leadership Group, have the opportunity to periodically meet with the Board of the HSP.

5.1.3. Organisational culture

Organisational culture is the shared values, beliefs and assumptions shared by occupational groups which are translated into repeated patterns of behaviour, that are maintained and reinforced by the rituals, ceremonies and rewards of everyday organisational life (17). Culture plays a role in health system failures (25). Denial and dismissal of issues raised by clinicians and consumers are reported in health failures (20).

Clinical staff reported a number of cultural issues in the review. Bullying was noted by the RANZCP which stated *“There is a perception, and some evidence, that psychiatrists who have spoken out and raised concerns as to the state of WA’s mental health system over a number of years have suffered adverse consequences as a result of their actions”* (33). Service reviews suggest clinicians are reluctant to speak out from fear of retribution or loss of employment (42). A blame culture was reported with health professionals blamed for issues arising from system dysfunction (33). There were also reports of a culture in which the concerns of consumers were not being heard, listened to, or respected (37).

Tensions were also reported between mental health sector groups. The SHR found polarised views and little agreement on system directions. There are views of a perceived dominance of a “biomedical model” and calls for a shift in power to a more social construct of mental health (10). Others note difficulty reforming the system to reflect contemporary values of person-centred, trauma informed, culturally sensitive and recovery focused services that are guided by the voice of lived experience (37). A lack of acknowledgement of the impact of social determinants in mental health (e.g. stable accommodation) was also highlighted (32).

Submissions by consumer and peak bodies are a reminder that cultures of management based on throughput and funding are driven to achieve a goal for the service, rather for consumers and place little value on the importance of the human experience (43). They warn of cultures that have become desensitised to the concerns of individuals, where corporate targets become the primary focus and low expectations of services becomes acceptable.

There is a role for all sectors to work together in an integrated way for consumers. This reflected in Recommendation 2, which encourages the need for collaboration noting that clinical and nonclinical services in WA have limited integration. The Panel supports moves to a culture of excellence, respect, integrity, teamwork and leadership, along with a commitment to continuous learning and improvement (17). There are already moves to improvement with the Minister championing organisation wide culture surveys. Another key step is use of contemporary workplace practice (such as 360 surveys). It is understood that progress is being made with “whistleblowing” protections (37).

Recommendation 3 : Culture

3.1 A sustained commitment to cultural change must be made by the Director General, Mental Health Commissioner, Board chairs of health service providers and non-government organisations, peak bodies and oversight bodies, consumers and support persons.

3.2 Protections for workers and volunteers speaking out on matters of human rights and safety and quality should be reviewed and enhanced to move to an ‘open’ culture in WA health.

5.1.4. Planning

Planning has a central place in governance as a main pathway for system improvement (16). The Stokes Review (2012) found deficiencies in WA clinical services planning (2). The SHR (2019) also identified problems and called for clear accountabilities for joint planning, commissioning and service delivery for more integrated services (5). The Auditor General also noted issues with a lack of system-wide plans in WA mental health (4).

Planning functions for WA mental health reside with the MHC. It has developed a Mental Health, Alcohol and Other Drug Services Plan (the Plan), which was recently updated (9) (46). This serves as the major strategic guide for state mental health and AOD. It uses the National Mental Health Service Planning Framework (NMHSPF), an Australia wide planning tool that provides estimates of service need based on population size (44). The MHC has also developed plans for mental health prevention, interagency collaboration, suicide prevention, and a draft workforce and accommodation strategy (45) (46) (47).

Submissions indicate issues with WA mental health planning. The RANZCP notes; ‘The system lacks detailed and comprehensive plans for clinical models, care pathways, infrastructure, and workforce planning and clinical activity. (33). The Lived Experience Forum raised a need for effective planning and service redesign to address service shortages and access barriers (19). Consultation also noted an absence of clear direction, terminology, KPIs, targets, timeframes, responsibilities, priority groups and unclear funding (32) (37).

The Panel considered these issues from a health planning viewpoint (48). Planning involves a number of interlocking stages and this can lead to confusion (48). Strategic plans are long range (e.g. 10 years), high-level aspirational documents. System-wide (previously clinical service plans) plans are developed centrally, are shorter term (e.g. two years) and subdivided into different patient streams by age (e.g. child and adolescent, youth, adult, older adult) and sub-specialty (e.g. perinatal).

These plans specify what, how and where services will be delivered (Models of Care). Central coordination ensures no service duplication and assures gaps are addressed. Pathways describe how consumers will access the service and journey through the system. Providers are then commissioned to deliver services and expected to develop local service plans.

The MHC Plans meet the requirement of strategic plans. The MHC acknowledges this noting; *‘the Plan is not prescriptive about how programs and services will be delivered but rather provides a guide for investment decisions and priority settings’* (9). The issues noted in submissions indicate there a major lack of clear system-wide plans in WA mental health. There is also lack of clarity as to which agency is responsible for these plans. The lack of a system-wide plan appears to be at the core of many system issues.

Access difficulties were noted by more than 87 per cent of survey respondents, who report issues for consumers in identifying and accessing public mental health and AOD services (30). Stakeholders also reported poor access to service information (43). Clinicians reported difficulties with service access in the AMA survey (36). Providers appear to determine which patients they will accept which may lead to “cherry picking” (only taking less severe or complex cases), and service gaps. Submissions did report significant gaps for at-risk groups (e.g. youth), with patients ‘falling through the cracks’.

Service inconsistency was reported and has resulted in equity issues. Some regions have services and others not (41). Providers appear to develop their own models of care, which has resulted in an array of different and varying services. The “postcode lottery” remains with access to services determined by postcode rather than need. This will also prevent development of clear pathways for the patient journey and result in navigation issues.

Transition between providers was noted as period of high risk by the Stokes Review and the SHR (2). The review online survey found that 74 per cent of respondents reported a poor experience of transitioning between services (30). Discharge process was raised as an area of concern by MHAS (49). Consumer groups reported a *'dangerous default overreliance on individuals, families and support persons to self-manage coordination and follow-up arrangements'* (43).

Provider coordination was found to be lacking. A submission suggested an urgent need to *'improve the referral pathways and integration of care between HSP mental health specific services, GPs and community-based primary care providers'* (50). The AMA reported a complex environment with *'a large number of service providers, differing referral pathways and various exclusion/inclusion criteria to meet'* (36). Coordination is not managed centrally in WA and is based on providers forming relationships, which is not always the case.

Integrated models of care were reported to be lacking in WA. Mental health consumers have a range of needs that require multidisciplinary collaboration. The WA implementation of Step Up Step Down units was noted with the MHC favouring a non-clinical model based on psychosocial support (4). This differs to interstate models, which provide both clinical and psychosocial support. The WA units do not function mainly as Step Down units for acute services, due to lack of clinical input and issues with higher acuity patients. Admission criteria also include a need for the patient to have stable accommodation, which excludes many hospital patients and leaves them stranded.

Systems thinking is vital in planning. This recognises that providers are dependent on each other and that issues in one area will affect other parts. A lack of appropriate community multidisciplinary services may lead to exclusion of those with severe or complex issues. This can block discharge from acute units leaving patients "stranded" in acute inpatient beds (33). This decreases the number of active beds in the system with the result that patients in ED are unable to access admission and may be turned away. To create hospital beds, services then discharge patients early. This places pressure on acute community treatment teams to provide care. Those teams also discharge patients with severe but stable illness who later relapse due to lack of follow-up and present to ED. The end result is a vicious cycle of escalating need.

The Auditor General review of access to mental health services suggests such a pattern is present in WA mental health services (4). The review found that 10 per cent of people consumed 90 per cent of the hospital care and 50 per cent of ED and community treatment services. There were high numbers of patients with very long stay in the WA mental health system. From 2013 to 2017, 126 people spent more than 365 consecutive days in an acute hospital bed, with hospital fees totalling an estimated of \$115 million. Another 158 people had multiple stays that totalled 365 days or more across the same period. Older adults comprise were over overrepresented and represented 25 per cent of this group (4).

The reform direction of the MHC has been provision of standalone nonclinical and community based services for those with lower acuity illness. This group account for only 10 per cent of acute admissions, and it would be expected that this approach will have minimal impact on ED and hospital use. An alternative is to focus initially on meeting the needs of high service users in the community (51). This group with severe mental illness (SMI) includes those with psychotic disorders, severe personality disorders, developmental disability (e.g. autism), and neuropsychiatric syndromes (e.g. head injury or early onset dementia). Effective community services for this group would be expected to decrease the use of ED and hospital services. The savings could then be redirected to increasing the range of community services.

Consumers who are unable to get help or are delayed in accessing care are likely to deteriorate. This leads to an increased risk of the consumer causing harm to themselves, or less commonly, to others (52). Alternatively, consumers can end up in the justice system

where multiple reports have highlighted the inadequacies of mental health treatment. Despite demand projection being unclear in other areas, it is only too clear in the justice area with nearly half of the 7,000 people in the corrections system needing some level of mental health support and more than 200 needing ‘close mental health support’. Many will be reliant on public mental health services when they return to the community. There is a critical need to improve care for consumers in prison and those exiting and requiring care should be prioritised. The Panel supports the transfer of correctional health services from the Department of Justice to the WA health system.

The SHR called for development of models of care, integrated patient flow and clear accountabilities for joint planning, commissioning and service delivery to provide more integrated services (Recommendation 6c and 7). The SHR also encouraged development of joint Regional Mental Health Plans with a strong partnership approach with all stakeholders, including consumers, carers, HSPs, NGOs and Primary health providers.

From a governance standpoint, this review recommends that the MHC continue with development of strategic plans. The Department should assume responsibility for system-wide plans with integration of all services in the sector. Engagement with the full range of providers will also assist in the healing of sector rifts. Assistance from consumers, support persons and clinicians will be provided through the Mental Health Directorate and Lived Experience Leadership Group highlighted in Recommendation 2 of this review. Current planning expertise in the MHC should be transferred across to utilise existing skills.

Recommendation 4 : Planning	
4.1	The Mental Health Commission should continue with responsibility for strategic planning and leading the reform of mental health in WA mental health services.
4.2	The Department should have responsibility for system-wide planning. It should co-design plans in collaboration with consumers, support persons, HSPs, NGOs and peak bodies. Plans should develop Models of Care (MoC) and pathways as part of regional planning. Priority should be given to addressing the needs of high-risk groups.
4.3	The Department, Health service providers and non-government organisations should collaborate with WAPHA to jointly develop regional mental health plans.
4.4	Support the SHR recommendation for the transfer of custodial health services from the Department of Justice to the WA health system.

5.1.5. Funding and commissioning of services

WA’s mental health funding arrangements are complex and unique. The MHC is the only purchasing commission in Australia and is the only example of a budget holding agency external to a health department (14). It purchases mental health activity in designated areas, which includes mental health hospitals, community treatment services, community support and accommodation services.

The Department also purchases significant mental health activity in areas not designated by the MHC. This includes services in EDs, Mental Health Observation Areas (MHOAs), Behavioural Assessment Units (BAUs), Consultation Liaison (CL) services and patient transport services (HSA16 s 20). WA differs from other states with a split in funding for its state mental health services.

The WA commissioning process involves an annual head agreement between the Department and the MHC, which outlines the roles of the MHC and the Department (HSA16 s 44). The MHC purchases clinical services (inpatient and community treatment) from HSPs using Commission Service Agreements (CSAs). The MHC determines the funding allocations for clinical and non-clinical services, and sets the levels of clinical activity for

hospitals (e.g. the number of beds) and clinical community services (the hours of service provided per patient).

Funding for hospital-based services is based on an Activity-Based Funding (ABF) model with provision via Special Purpose Accounts (SPAs) (HSA16 s 45). This prohibits the use of the funds for any other purpose and addresses previous concerns that mental health funds were diverted for general health use. Non-admitted mental health services are generally block funded. Funding for NGO and accommodation providers is provided by the MHC.

State and Commonwealth responsibilities for mental health are noted. The WA State Government expenditure on mental health and AOD has increased 21 per cent over the last five years compared to general government expenditure increase of 10 per cent (53). The WA State Government is now the top-ranking jurisdiction in Australia for per capita expenditure on mental health (6). Commonwealth funding for WA mental health lags behind the rest of Australia, with low rates of use for primary care Medicare Benefits Schedule (MBS) items and the NDIS (6). This inequity was noted by the SHR and specific recommendations made.

A number of issues were raised in consultation. HSPs highlight a separation between control of funding (provided by MHC) and performance and safety and quality (Department). If problems emerge there is no direct link to additional funding to drive improvement. A lack of flexibility was also reported in movement of funds between hospital and community SPAs. Many HSP's reported difficulties in securing funds for innovation or new services, although others reported some success. NGO groups reported poor security of funding with short-term contracts and concerns about precipitous defunding of services. The competitive tendering process was felt to promote division and focussed on low cost rather than service quality.

No single agency in WA has a consolidated view of mental health spending and efficiency indicators are compromised due to the split budgets. Whilst MHC indicators indicate improvements in cost, a recent Auditor General review indicates the opposite, with a rise in WA mental health costs (4). The MHC indicators do not include costs from high growth areas such as EDs and MHOAs. Safe reform is dependent on accurate indicators to monitor the impact of changes. For example well-meaning attempts to decrease community contact hours (MHC budget) could result in higher ED presentations (Department budget). Current indicators are also episodic and indicate cost per episode of care, rather than cost per patient (4). Auditor General reviews also show the same patient presenting multiple times - that appears to be efficient but is actually both inefficient and ineffective (4).

Effectiveness of funding was raised in consultation and noted in past reviews and by the SHR (3). The RANZCP noted *'there is limited public accountability for expenditure'* (33). The WA Auditor General found *'The MHC collects a lot of information but does not analyse it to ensure service effectiveness or value for money'* and that *'It [the MHC] has not conducted a comparative assessment of treatment service providers to understand what services are most effective and give value for money'* (54). The community accommodation sector is generally block funded (i.e. fixed annual sum). Some providers operate with high vacancy rates (up to 20 per cent), which raises questions of value for the State. There is no centralised bed management database for community beds in WA and they are not linked to the hospital bed system (29). These findings are relevant in the context of acute hospitals that cannot discharge patients safely and EDs operating above capacity.

Equity issues were also raised by agencies including the Auditor General (3) (55). There are marked differences in the sector, with funding per person per annum in NGO provided recovery facilities (up to \$185,000 pa) being significantly higher than in psychiatric hostels (approximately \$12,000 pa) (55). While hostels can charge up to 87.5 per cent of an individual's pension in rent, this leads to a total of \$37,000 per annum. Illness severity does not account for differences, with reports of the opposite with higher funded providers

reluctant to accept more complex cases (55). The different MHC funding for Not for Profit (NFP) and private providers – even if they provide the same service – is apparently due to policy and requires review.

The WA mental health commissioning system is complex with two purchasers managing separate budgets. The Department and MHC have both developed contracting functions with significant administrative costs that are diverting resources from patient care. A more typical structure will deliver improvements in effectiveness (in conjunction with improved planning), and efficiency. The Department fulfils this role for all other health services in the WA and is best placed to undertake this role. It will deliver greater accountability and deliver savings that can be redirected to patient care. A key driver for separation of purchasing included “ring-fencing” of the mental health budget, which could be achieved by continuing SPA accounts. This move aligns with SHR drives for enhanced contractual relationships and new commissioning models (Recommendations 6c and 17). The Panel did not reach consensus on this recommendation. This viewpoint was not shared by the consumer and carer representative who recommended that purchasing remain with the MHC, with consideration of also allocating the budget currently managed by the Department to the MHC.

Recommendation 5 : Funding and Commissioning

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|-----|---|
| 5.1 | A single agency should undertake contracting for all public mental health providers in WA. The final configuration will be subject to proposed realignment options in Section 6. |
| 5.2 | Mental health should be a key consideration in the implementation of new funding and commissioning models for the WA health system, in line with recommendations made by the Sustainable Health Review. |

5.2. Patient safety and quality improvement systems

5.2.1. Safety and quality monitoring

The Department sets standards for the performance of the total health system, using service agreements and mandatory policy frameworks under HSA16 (56). The *Clinical Governance, Safety and Quality Policy Framework* aims to ensure patient care that is safe, effective, appropriate to their needs, timely and efficient. The WA Health Clinical Incident Management Policy (CIMP) describes management requirements with reporting using the Datix clinical incident management system (CIMS).

The Department's Patient Safety Surveillance Unit (PSSU) integrates patient safety data across a number of domains (e.g. clinical, complaints and coronial data), maintains oversight of the CIMS process and shares lessons learned at a system level. The Department has implemented a WA Health Quality Surveillance Group and a Quality Coordinators Network. Private licensed healthcare facilities report incidents that have potential for serious harm or death and conduct inpatient mortality reviews. The Department (as system manager), does not have routine access or visibility over NGO, AOD or accommodation data.

The MHC has developed a *Quality Management Framework* for CMOs with a move into operational areas (safety and quality monitoring) that are typically the responsibility of the system manager. The system includes client feedback and complaints, clinical incident reporting, investigation and management systems, and risk management. All MHC funded services, including HSPs, are required to report any notifiable incidents as soon as practicable. The MHC may undertake an investigation (or have an independent investigation) and make a written report of required actions with suggestions of service improvements and timeframes for completion. The MHC can access Datix CIMS and PSOLIS, but has limited access to ED data.

The Chief Psychiatrist under the MHA14 also receives notification of all incidents that pertain to mental health patients via the Datix CIMS. This includes incidents in mental health services, clients of community treatment services and consumers receiving mental health treatment in general health services and AOD services. Private hospitals, NGO services and private psychiatric hostels are required to abide by separate reporting policies.

Reports are also made to the Coroner in circumstances where death occurs from non-natural causes or where the cause of death is unknown, as a death certificate cannot be issued. The Coroner will then investigate and determine a cause of death. For mental health consumers, the responsibility to inform the Coroner rests with hospital staff and authorities.

Administrative burden was noted in consultation. HSPs apparently report clinical incidents to multiple agencies including their Board, Department, MHC and where appropriate, the OCP (41). HSPs also note that agencies often require additional information and, not infrequently, conduct separate investigations of the same clinical incident with varying recommendations (41). Duplication was also noted with audits. HSPs are required to complete overlapping reports and need to ask the same question in different ways to satisfy the different requirements set by the OCP and Stokes Review audits (41). Data collection systems can be resource intensive (especially for smaller providers), and consideration could be given to provision of Datix CIMS (or equivalent) to all providers of WA public mental health services. This will also simplify collection and decrease the burden on smaller providers.

Transparency was a goal set by the Mascie-Taylor Review and the SHR (43). There are currently no publicly reported safety and quality indicators specific to mental health. The Department has moved to increase transparency for general health with an annual report of patient safety. Patient Opinion is a website championed by the current Minister for Health, which provides an online platform for the public to reflect on their experience with the ability for staff to respond. The Chief Psychiatrist has also advanced transparency with publication of data on restraint and seclusion in the system. The option of a safety report card for all publicly funded mental health services was also suggested by peak consumer bodies (43).

This review confirmed the observations of Mascie-Taylor of no single point that has a whole-of-system view of safety and incident data. This has resulted from separate systems for clinical and nonclinical services with neither the Department nor MHC having a full view of the sector. The Chief Psychiatrist is aware of clinical services and has partial awareness of some NGO services (those with a clinical component). At the same time, some sectors (e.g. hostels) have multiple agencies monitoring the same incidents with significant overlap. This has resulted in considerable and unnecessary administrative burden for providers (11).

A clear direction is for one agency to have responsibility for monitoring of all incidents for the WA mental health sector. Advantages would include improvements in oversight, ability to detect safety issues and use of consolidated feedback to drive planning and improvement processes. Efficiency benefits will also arise from a decreased need for duplicated systems with resources redirected to patient care. The Department has responsibility for the rest of the health system and the PSSU is well placed to undertake this function. Transfer of resources from the MHC will allow it to meet the additional roles. Recommendations for safety are included with those for performance monitoring and detailed in Section 5.3.1.

5.2.2. Risk management

Risk management processes include the balancing of financial and clinical drivers. This is reflected in the triple aim of US organisations and the quadruple aim put forward by the SHR for WA (57). Imbalance can compromise patient safety and quality, and reviews of the NHS culture of cost containment demonstrate impacts on patient care (27).

The RANZCP reports that *'innovative clinical models, services, pathways and treatments are commonly undermined and degraded by ill-informed disruptions imposed by decision-*

makers that oversee silos, who are responding to other pressures and don't appreciate the negative impact on the broader system' (33). Examples were provided of services that had been developed, piloted and evaluated but were closed down to meet targets. These included cases of models of integrated acute care that directed flow away from EDs (33).

Franciscan House was a 75-bed hostel that closed in December 2017 with the circumstances addressed in a number of reviews (2) (29). The hostel had ageing infrastructure and provided low cost accommodation for residents with severe and complex mental illness, many of whom had lived there for decades. This form of accommodation is not favoured as it does not reflect contemporary and is based on a "social dependence model".

After introduction of the MHC *Quality Management Framework*, the hostel licensee informed the MHC it could not participate and was subsequently defunded. The outcome for residents was generally positive as they were transferred to better-funded accommodation with higher levels of support. A number of residents, however, required extended admissions. The costs included \$250,000 for project costs and an additional \$3 million per annum in State costs to fund an additional 19 beds (29).

The potential closure of further hostels is a major risk management issue for WA. There are differing views but most agree consumers could benefit by moving to modern facilities. These do not currently exist and will require time and funding for construction, with allowances for increases in recurrent funding. Further closures (e.g. of 75 – 150 beds), carry risk of increased pressure on an already overwhelmed system with risks of resident homelessness. A review of hostel funding practices could immediately improve patient services and support sector viability.

Risk management requires a whole-of-system viewpoint of clinical and financial aspects. The divisions in the WA mental health system can hamper whole-of-system risk management and the drive to sustainability. Reviews of the NHS note a common approach is for managers to cut budgets whilst avoiding clinical or consumer oversight (27). Staff and support persons are left providing care to patients with fewer resources or having to ration care. Responsibility is transferred to clinicians, who are then held accountable for the poor outcomes. The literature and SHR recommend development of better models of care based on integration and partnerships between clinicians, patients and support persons to deliver better care at a lower cost (27). For mental health this will require an integrated and coordinated governance system - which is not currently the case.

5.2.3. Feedback and complaints management

Consultation feedback indicated issues with the complaints process in WA. A complaint about a service is generally first made to the service involved but can may be made to the service provider (HSP or NGO), MHC, OCP, MHAS or HaDSCO. If a complaint to an HSP remains unresolved, it can be escalated to HaDSCO. However, the interface between HaDSCO and HSPs lacks clarity.

There appears to be little understanding of the very real difficulties faced by many consumers and support persons in making a complaint while often still needing to access the service (or practitioner) in question, particularly in a geographic area where options may be limited. This requires services to be much more proactive in welcoming and addressing feedback early in the experience, and also demonstrate willingness to take it on board as part of continuous quality improvement.

The complaints process is not easy for consumers and support persons to navigate, especially for consumers who do not speak English as their first language or who have literacy challenges. CoMHW and WAAMH reported concerns regarding the lack of enforcement powers held by HaDSCO to resolve serious complaints. They also suggested

that there should be the option for a consumer to report directly to HaDSCO, without making a formal complaint to the service first.

CoMHW and WAAMH also suggested possible mechanisms for lived experience representatives to make complaints about services, particularly in relation to the consumer participation activities of a service. A further suggestion was for HaDSCO to establish a board and advisory groups with representative individuals and support persons using mental health services. The Panel noted and wished to highlight the work of the MHAS, the Chief Mental Health Advocate and the MHT. Their ongoing “fearless advocacy” for consumers and support persons documented in reports and findings over the years is exemplary.

5.2.4. Standards and licensing

The National Standards for Mental Health Services (NSMHS) were developed to guide continuous quality improvement in mental health services. There is a focus on rights and responsibilities, safety, consumer and carer participation, responding to diversity, promotion and prevention, consumers, support persons, governance, leadership and management, integration and delivery of care (58). The Chief Psychiatrist has accepted the NSMHS as the standards relevant for MHA14.

The National Safety and Quality Health Services Standards (NSQHS Standards) were developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) (59). All public and private hospitals in Australia must be accredited against these Standards and satisfactory performance is required against all of the Standards for accreditation. The first edition of the NSQHS Standards did not fully align with the NSMHS, meaning that mental health services needed to comply with both sets of standards (41). This was addressed in the second edition of the NSQHS Standards, which came into effect on 1 January 2019 (60). This addresses mental health more effectively but lags behind the NSMHS in the area of Recovery.

The Chief Psychiatrist’s Standards for Clinical Care were developed to meet the requirements of section 547 of the MHA14 (61). These are focussed on clinical practice and include Aboriginal practice, care planning, consumer carer involvement in individual care, physical health care of mental health consumers, risk assessment and management, seclusion and bodily restraint reduction and transfer of care. Compliance with these Standards is assessed independently through the OCP Clinical Monitoring Program. The Department’s Licensing Accreditation and Regulation Unit (LARU) monitors the accreditation status of public mental health services, including mental health services. These include the NSQHS Standards, the NSMHS and Chief Psychiatrist’s Standards, compliance with state-wide policy, local policy and legislative requirements of the MHA14.

The physical environment of public hospitals is regulated by the LARU *Building Guidelines – Western Australian Health Facility Guidelines for Engineering Services* (62). These set out guidelines for building construction, establishment and maintenance. Facilities are also required to meet the Australian Standards and the National Construction Code. Compliance is mandatory for HSPs in the design and operation of public hospitals and community clinics. LARU also has responsibility for licensing and monitoring private hospitals and private psychiatric hostel facilities in WA under the *Private Hospitals and Health Services Act 1927 (WA)* and the subsidiary *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*. The Act empowers the Director General to issue guidelines about the construction, establishment and maintenance of mental health facilities.

For private psychiatric hostels, LARU has developed the *Licensing Standards: Approved Supervisor* (63) and the *Licensing Standards: For the Arrangements for Management, Staffing and Equipment – Private Psychiatric Hospitals* (64) to facilitate the licensing application, renewal and investigations process and to provide clarity regarding requirements for licence holders, applicants and approved supervisors. The LARU *Building Guidelines for*

the Construction, Establishment and Maintenance of Psychiatric Hostels (65) apply to new facilities and existing facilities (if altered or renovated), with a change of function, if there is a written complaint regarding the premises, or a change of ownership. LARU has undertaken annual inspections of hostels since 2004 to ensure compliance with standards reflecting facility functions, as outlined in the LARU-approved Statement of Function.

The MHC *Quality Management Framework* (QMF) requires CMOs to evaluate and monitor service quality against six outcomes based on the NSMHS. Commissioned services are expected to strive towards achievement of the outcomes but not all organisations have to meet all outcomes. The MHAS has a critical role in monitoring agencies' compliance with the Charter of Mental Health Principles (MHA14), which often speaks to the culture of the service and consumers' experiences in, for example, being treated with dignity and respect.

Stakeholders report duplication and overlap in standards from the Chief Psychiatrist, MHAS Charter of Mental principles and MHC are duplicated and overlap. The built environment is addressed by LARU standards, MHAS facility guidelines and MHC quality indicators. For psychiatric hostels the Auditor General found multiple agencies were found to be involved using different standards and with varying interpretations (3).

There will be benefit from streamlining the process with the statutory agencies assuming responsibility for monitoring standards. LARU should continue in its role overseeing standards for the physical environment and support services. The OCP should continue monitoring of inpatient care and service delivery. MHAS should continue in its role monitoring the Charter of Mental Health Principles in areas that are not covered by the above agencies. The role of these agencies should be expanded to areas currently managed by the MHC, which should transfer responsibilities and resources. Further, a joint understanding should be developed by those agencies and published to inform the sector. The goal should be the development of a streamlined set of standards and licensing requirements for WA.

The Panel notes the WA system is reliant on external accreditation mechanisms. Recent reviews note that accreditation is limited to a point in time, static review that is resource intensive for the organisation (66) (67). NGO organisations operating on tight budgets and limited resources may struggle with such processes. There may be merit in moving to more dynamic processes for safety and quality monitoring, such as real time outcome monitoring as discussed elsewhere (Sections 5.2.1. and 5.3.1).

Reform has led to development of a range of new facilities and service models. The *Private Hospitals and Health Services Act 1927* (WA) does not encompass contemporary service models and attempts to classify facilities with existing categories proving problematic. An example is Step Up Step Down services, which were initially classified by LARU under provisions for day hospitals and hostels. There is a need for standards that cover contemporary accommodation models is in place for WA accommodation providers.

Recommendation 6 : Standards	
6.1	Responsibility for the regulation of the physical environment, accreditation and management of all public mental health providers should reside with the Licensing and Accreditation Regulation Unit (LARU) in the Department of Health.
6.2	Responsibility for monitoring the services delivered to assist people with mental health issues should reside with the Office of Chief Psychiatrist (OCP).
6.3	Monitoring of compliance with the Charter of Mental Health Principles (MHA14) should reside with the Mental Health Advocacy Service (MHAS).
6.4	Standards should be streamlined and reviewed on a regular basis by the regulatory agencies to ensure minimal overlap and currency.

5.3. Performance and effectiveness

5.3.1. Performance

Performance monitoring is managed by both the Department and MHC in the WA mental health system. There is a separation of tasks with the Department overseeing clinical services and MHC managing support and accommodation services. There is also an overlap between indicators used for safety and quality and performance monitoring (Section 5.2.1). As a result, the recommendations are considered together in this section.

The Department uses a monthly Health Services Performance Report (HSPR), which contains performance indicators, targets and thresholds that relate to targets in the Department's agreements with HSPs. The MHC uses its Quality Management Framework (QMF) for performance monitoring as part of contract management. The MHC has access to the HSPR data but the Department does not have access to NGO and accommodation data.

The indicators for mental health are (a) the percentage of contacts with community-based public health non-admitted services within seven days post discharge from an acute public health inpatient unit, and (b) readmissions to an acute specialised mental health inpatient unit within 28 days of discharge.

The Auditor General reported issues with the indicators. It notes the seven-day follow-up does not reliably reflect if a person is actually connected to a community service. During the five-year review period, follow-up phone calls increased from 34 per cent to 60 per cent but face-to-face contacts fell from 60 per cent to 30 per cent (4). The 28-day readmission rate reflects the adequacy of community follow-up and treatment. The Report on Government Services (ROGS) shows a marked deterioration with year-on-year increases in readmissions leading to WA having the highest rates of any Australian state (6)

The limited indicator set was noted in Stokes, Mascie-Taylor and the SHR. The SHR also observed *'it has become obvious that WA does not have the right set of measures to really understand if the services provided in mental health are truly making a difference to improving people's health outcomes and experience.'* Stokes recommended an additional 10 indicators covering key inpatient, Hospital in the Home and non-admitted community care (2).

Mascie-Taylor recommended indicators of access, demand, clinically reported outcome measures (CROMs), patient reported outcome measures (PROMs) and patient reported experience measures (PREMs). The Auditor General found issues with current MHC measures which, instead of analysing patient journeys, monitors basic indicator sets tracking the number of times services are delivered rather than who used the service (4). Review submissions suggested indicators linked to patient rights, housing and employment (43). There could also be value adopting systems used in other sectors (e.g. Uber or eBay) to provide real-time consumer feedback.

The Safety and Quality Indicator Set (SQulS) initiative was launched by the Department in January 2019 and allows WA hospital benchmarking, identification of variation and data sharing. Online Patient Safety Dashboards for WA health staff are now available state-wide. These include clinical incident data, complaints and patient feedback. The Department, the MHC and the OCP have been working together to develop mental health specific indicators for SQulS. This will provide an opportunity for all indicators to be reviewed and a single consolidated set introduced to avoid duplication.

Administrative burden was reported in the performance management system. HSPs apparently need to report mental health KPIs on a monthly mental health dashboard along with bimonthly board reporting and reporting via the Department's HSPR and biannually to the MHC. The reporting format varies between the governance agencies, using different

programs, with providers needing to prepare multiple overlapping reports of the same data (41). As noted by Duckett, more regulation by more agencies of the same indicators will only increase burden with no improvement in safety and quality (66).

Consumer access to services was a major theme in consultation. There are limited indicators of demand in the WA system. Other states have encountered similar issues and developed additional indicators including referral acceptance rates, service wait times and consumer-reported experience of service accessibility (68). System navigation issues were also reported during consultation with problems moving between services. Despite this there are no current indicators in WA reflecting these areas.

A standardised electronic referral system could provide insight into data on service inclusion/exclusion, the patient journey through the system and identify groups having difficulty with access. Electronic referral systems are already in place for general health, allow embedding in the ICT system, and form the basis of movement to real-time process. Changing to such a system could promote efficiencies with a move from paper and fax systems.

Data analysis is highlighted in past reviews (4). The Auditor General found issues with MHC data analysis noting *‘information to assess how people use treatment services, the performance of service providers or predict future demand for services’* is not well used (54). Data collection and analysis ideally should lie with one agency for the system to allow triangulation of information across different datasets that will allow greater system understanding. With respect for confidentiality, suitable information should be shared with agencies and providers to drive quality improvement. This will facilitate SHR Recommendation 6 (b) which suggests *“Immediate transparent public reporting of patient outcomes and experience with the Priority for implementation being public reporting of measures of quality and safety, patient experience and outcomes from December 2019”*.

Overall there are similar issues to those in Safety and Quality (Section 5.2.1). Functions are distributed across the Department and the MHC. Neither has a view of whole-of-system performance with data silos in place, with the MHC having partial access to HSP data and the Department having limited visibility of the support and accommodation sector. HSPs have separate contracts with both and therefore report twice on a limited indicator set. The need for duplicated sections for performance management and analysis in both the Department and MHC is inefficient and again diverts resources from patient care.

A clear direction is to have one agency with responsibility for monitoring. This will provide for single point with visibility of the sector, which will allow ready detection of areas of deficiency (e.g. youth services) and action. The Department is enhancing the Patient Safety Surveillance Unit (PSSU), which will integrate data from across the health system. It is therefore well positioned to perform and integrated function for mental health. In order to adopt the additional roles resource should be transferred from the MHC. Efficiency benefits are likely from consolidation of function with further benefits from improved provider efficiency through a single line of reporting.

Recommendation 7 : Performance, Safety and Quality monitoring

7.1	The monitoring of performance and safety and quality should be consolidated within a single agency. This includes monitoring clinical, non-clinical and accommodation services.
7.2	Data analysis should be performed within a centralised hub with enhanced analytic capability. Results must be provided to all governance agencies with public reporting aligned to the WA Open Disclosure Policy.
7.3	Key performance indicators (KPIs) for performance, safety and quality indicators should be reviewed for mental health services. Indicators should include consumer access or exclusion, waiting times, demand, system flow and consumer and support person experience.

7.4	Indicators should be streamlined for consistency and where possible embedded within the ICT systems to progress to real-time reporting.
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7.5	Transparency is a priority and the system should move to public reporting of outcomes consistent with the Recommendations of the Sustainable Health Review.
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5.3.2. Learning culture

A key goal of clinical governance is learning, which should occur at the system and provider level. Ideally, the aim is to develop a “*system devoted to continual learning and improvement of patient care, top to bottom and end-to-end*” (27). A learning system should have the ability to continuously monitor and process feedback and aim to act on this information. This should lead to continuously improving services.

Consumer and carer feedback regarding this review was mixed and a common refrain was ‘*Not another review*’. This in no way reflected an unwillingness to be involved and to participate. However, it did reflect a weariness at being asked similar questions over a number of years and finding that recommendations from previous reviews to which they had contributed, had largely been unaddressed.

The RANZCP also noted that ‘*ongoing cycles of review and reform identify the same issues, with regular restructures providing significant disruption but little resolution of core issues*’ (33). RANZCP members also expressed frustration and distress where effective services had been developed, evaluated and devolved without appreciation of the value lost to the system. Concerns regarding the safety of infrastructure, staffing levels or practices had also been raised multiple times - often over years – and not acted upon. They stated this indicated that the concerns of clinicians were not being heard or addressed (33).

The AMA in its submission quoted the 2016 WA Legislative Assembly Education and Health Standing Committee report *Learnings from the message stick: the report of the Inquiry into Aboriginal youth suicide in remote areas*. This noted a failure to adequately respond to the recommendations made by previous inquiries for more than 15 years, governance structures for suicide prevention that were unclear, and roles and responsibilities that were ill-defined (69).

There appears to be a lack of learning from past reviews, which is a common finding in the international literature (70). The Stokes Review identified the majority of issues that remain problematic. Some recommendations appear to be actioned but only partially implemented or repealed in system restructures. The Panel’s consumer and carer representative highlighted that despite recommendations and mandatory items for accreditation, there was little change in the presence or influence of the consumer and carer voice in mental health organisations.

Learning is also reliant on effective incident management and data collection (Section 5.2.1 and 5.3.1). A system requires whole-of-system integration of clinical governance arrangements to enable “closing of the loop”. The presence of multiple splits and numerous agencies having different functions as well as the varying understanding of recovery and consumer and support person engagement is a major barrier to quality improvement and a culture of continuous learning. Lessons can be learned from initiatives such as Implementing Recovery through Organisational Change, used in the UK since 2011.

5.3.3. Research and innovation

Strong research helps to drive innovation, improve service delivery and achieve better patient health outcomes. The MHC mission statement includes a role in ‘*research, policy and system improvements*’ and coordinating research into causation, prevention and treatment of AOD use problems (35 p. 5). The OCP launched a Research and Strategy Program in 2017

for research and sector development, reviews, investigations and stakeholder engagement. The Department has a well-developed Research Unit within the Clinical Excellence Division. This administers state-funded research programs and develops capacity in WA to participate in national research directions. While the MHC, the Department and the OCP all have roles in supporting research, there appears to be limited coordination.

The WA State Government has demonstrated a strong commitment to research with the establishment of the \$1.1 billion Future Health Research and Innovation (FHRI) Fund. The Department has responsibility for managing the FHRI Fund. Allocated funding for mental health research would allow progress on translational research into service improvements and development of meaningful partnerships with lived experience. Mental health should be included into the system-wide network of innovation units proposed by the SHR in partnership with clinicians, consumers and wide range of partners (Strategy 8).

5.3.4. Workforce

Workforce is a key enabler for achieving clinical performance and effectiveness and hence good clinical governance in health services. The joint statement of roles and responsibilities does not specify or indicate the duties of the Department, the MHC and governance agencies in relation to workforce issues.

The MHC has developed a draft *Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018–2025* (71) in conjunction with WAAMH and the Western Australian Network of Alcohol and Other Drug Agencies (WANADA). The Framework notes the MHC will coordinate workforce planning but does not specify roles, responsibilities, targets or funding. The draft plan consulted widely but focused on non-clinical workforce planning.

The Department also has a role in workforce including responsibility for managing system-wide industrial relations and overseeing workforce planning undertaken by HSPs. The Department employs various officers such as the Chief Medical Officer, the Chief Nurse and the Chief Health Professions Officer (for allied health professions), to provide leadership and strategic advice on issues such as workforce planning. These leaders identify trends in their respective workforces and implement planning and development strategies across WA (53 pp. 2,8).

Providers, including HSPs, NGOs, and private providers of public community-based mental health and AOD services, are also responsible for planning and development of their workforces. This includes facilitating access to appropriate clinical supervision for staff and adequate placements for registrars and students (53 pp. 2,8). Under the HSA16, HSPs are required to provide teaching, training and research to support service provision. HSP chief executives are responsible for the employment, management, supervision, transfer, direction and dismissal of their employees (HSA16 s. 34(1) (b), 107(2) (e)).

Review survey respondents also raised issues with 76 per cent stating that human resources could be used more efficiently to manage and implement clinical governance processes. Common issues included duplication of roles and services, limited contract continuity that impacted on staff security, morale and retention and the need for better performance management. In addition, 74 per cent felt resources could be used more efficiently by investment in senior clinical leadership positions, staff training and capacity building (30).

WA has a chronic shortage of psychiatrists, psychiatric nurses, allied health staff and support workers. The state has one of the lowest ratios of psychiatrists per head of population, with 11.3 psychiatrists (FTE) per 100,000 population, compared to the national ratio of 13 per 100,000 (7). The *WA Health Medical Workforce Report 2015–2016* (72) found that WA had a shortfall in the projected supply of addiction medicine and psychiatric specialists, which are 'critical risk' specialties for 2021–2025 (36).

The RANZCP reported that rather than increasing training positions services had actually reduced training positions, which will carry a long term impact on WA services. The need for a strong collaboration with training colleges and educational institutions was highlighted in consultations (33). Allied Health (AH) stakeholders reported that there did not seem to be an allocated budget for professional development or promoting AH research, despite allied health workers comprising 21 per cent of the workforce.

Nursing constitutes the majority of the professional workforce in WA public mental health services. The Australian College of Mental Health nurses reported that nursing staff were under significant stress as a result of constant system pressure and chronic staff shortages. Of particular note was an increase in pattern of aggression and violence towards staff, which was extremely concerning.

The peer workforce was recognised by *The Fifth National Mental Health Plan* with key roles to advocate, advise, represent and/or support their peers. The Productivity Commission found the level of consumer and carer employees in WA was lower than any other Australian state (6). The Lived Experience forum suggested opportunities for building and supporting the peer workforce with a need for consistent support and training for peer workers, with strategies to support their employment (73). This is important in regional areas, with local peer workers serving as a stable mental health presence.

The Aboriginal workforce is another critical area. Aboriginal peer workers are essential in promoting and delivering culturally appropriate and safe mental health and AOD services. *The Fifth National Mental Health Plan* acknowledges that '*cultural competence should be considered a core clinical competence capability, as it can determine the effectiveness of a service for Aboriginal and Torres Strait Islander peoples*' and that a well-supported Aboriginal mental health workforce is required to deliver culturally competent services (74 pp. 27,32). Workforce attraction and retention process was also raised as an area of difficulty. This was particularly evident in regional and remote areas with lengthy recruitment processes and constant staff turnover affecting patient care, safety and outcomes.

Workforce models were raised in consultation. Patients with severe mental illness will require clinical, nonclinical and accommodation services provided by multidisciplinary teams. Feedback suggested a decreased use of these models in WA with a move to commission individual providers. A move to generic 'case manager' model was also noted, in which all team members perform similar roles. This does not use the professional background of staff (e.g. psychology, social work). Previous models of care saw the same team provide inpatient and community care for greater continuity but reports indicate that WA has moved away from this model resulting in consumers needing to retell their stories and numerous staff handovers.

Supervision and staff development changes were noted by stakeholders. Continuing professional development across all disciplines is important for reflective, evidence-based practice to support innovation and implementation of contemporary models of care. Feedback suggested that resource constraints had led to decreased provision of supervision. Inconsistent terminology was also noted with WA's differing from national categories. Support workers who only work in mental health (and not general health), are classified as 'mental health specialists' in WA. This differs to Commonwealth classifications of a 'specialist' workforce and could distort workforce reporting.

Workforce issues are critical for WA public mental health services. There is a need for careful whole of sector workforce planning to support innovative models of care. There is a lack of clarity with regard to workforce duties and roles between the governance agencies must be addressed as a matter of priority. Recommendations of the SHR regarding culture and workforce to support new models of care (5 p. 8) are readily applicable to mental health services. SHR Strategy 7, Recommendation 25 suggests implementation of contemporary workforce roles and scope of practice if there is a proven record of supporting better health

outcomes and sustainability. Priorities for implementation also include progressing to interdisciplinary models of care rather than only profession-based approaches.

Recommendation 8 : Workforce

8.1 The Department of Health and the Mental Health Commission should work collaboratively to develop a whole of sector workforce plan and build the capacity and capability of the entire workforce (including the peer workforce) within public mental health services.

5.4. Safe environment for the delivery of care

5.4.1. Infrastructure

A number of significant issues were raised during the consultation in relation to some of the infrastructure within mental health services. The ageing and sub-optimal infrastructure of significant facilities such as Graylands Hospital and Selby Hospital was noted. The Panel heard of the real impact of this on patient experience, an example of which is the loss of scarce forensic subacute beds due to the building in which they were housed being unfit for purpose and having to be closed to safeguard agency accreditation.

Plans for decommissioning of Graylands appear not to have progressed as planned. It was suggested that this might relate to frequent restructures, but it suggested the governance of the project is not at an appropriate level. The project has recently been allocated additional funding to progress planning and it is recommended that this occur as a priority.

The hostel sector was also raised as an area of priority as many facilities appear to fall short of national standards. The recent closure of Franciscan House highlights issues involved and the significant impact on consumers and other services (29). Improvements in the sector could be done in conjunction with the Department of Housing and complemented by a model to deliver integrated care from psychosocial and clinical services. There are existing models such as Housing and Accommodation Support Initiative (HASI) in NSW. This would also support efficient bed flow and reduce unnecessary hospital bed days.

From the perspective of governance, there is a separation between oversight of WA public mental health infrastructure, which rests with the Department, and funding of services, which is a responsibility of MHC. This has impacts on planning and monitoring. An audit of the existing infrastructure could inform the development of a capital works plan for future investment. Structural realignment options to address this are addressed in Section 6.

5.4.2. Information and communications technology

Complex healthcare systems are reliant on data to provide 'an accurate, comprehensive picture of organisational and clinical performance' (11). There is 'widespread recognition that the current ICT systems for mental health are not fit for purpose' (41). Key issues include limited integration of ICT systems and a need to use multiple ICT platforms. Sharing of information with private or NGOs is difficult due to protocols. There is no shared database between the WA public mental health services, the MHC and WAPHA funded services (50).

PSOLIS has been used since 2005 for mental health data management. It has basic capability for risk screening, history, mental state examination, care planning and discharge planning. There is no linkage to laboratory investigations and electronic prescription capability is very limited. PSOLIS allows data collection and reporting for the National Minimum Data Set and the National Outcomes and Casemix Collection. A review of PSOLIS was finalised late in 2018, and identified capacity issues with system crashes when used by a large number of users.

Access is a major area of concern. Restrictions in the past were based on concerns that access might lead to stigma. Consumers and clinicians consulted during this review supported improved access to improve patient safety. Tiered access has resulted in most mental health clinicians only able to access data entered from their own service. As a result, community services cannot access hospital information about their patients. Allied health staff and NGO organisations still do not have full access to PSOLIS. These restrictions are likely to impact on provider collaboration, information sharing and service integration.

Private hospitals contracted to provide public sector services have limited read only access. Non-mental health clinicians such as ED services have only received access to PSOLIS this year. Non-mental health services traditionally have not had access but this has improved recently for front-line EDs, emergency response teams and court diversion services. This is a welcome advance because in the past, there were reported cases of patients in EDs, unconscious after overdoses, with ED staff unable to access their medication lists.

Workflow issues are also highlighted. The PSOLIS user interface is cumbersome and layered, with different risk assessment and other tools. Stakeholders reported difficulties with data input that require use multiple screens to capture the same information. Most services also operate parallel paper-based notes leading to dual entry of information. Clinicians reported spending hours each week scanning paper documents to populate fields in PSOLIS. These practices divert scarce resources from consumer care and on a whole-of-system basis, will have a significant impact.

Duplication of process and system inefficiency was reported throughout consultation. Discharge and transfer process (even within the same service), involves a PSOLIS transfer summary, a hospital discharge summary, a medication summary and, in some cases, a nursing discharge summary. Communication between parts of the same service (e.g. transfer of care), is reliant on mail or fax. Stakeholders also reported struggles with the management of the implementation of MHA14, with introduction of electronic forms only completed this year.

WA lacks a centralised consolidated directory of all public mental health services. Service information is distributed across numerous websites and lack clarity as to what services can actually provide. Consumers reported difficulty finding mental health services in their local areas and having to spend days going through websites with limited success. A joint project including the Department, the MHC and the Commonwealth to produce a searchable directory based on patient age, postcode and diagnosis could be useful. This could be supported by enhanced system-wide planning and mapping activities.

The SHR recommends a phased 10-year Digital Strategy to allow *'predictive analytics, big data, and moving towards the real-time use of data'* as *'being essential to unlock the potential benefits of the WA health system's rich information and transform healthcare'*. Mental health should be a priority area within the Digital Strategy. Tiered access should be considered for all providers (clinical, non-clinical and accommodation), to promote integration and collaboration.

E-referral systems for mental health will increase efficiency and form the basis of monitoring of patient demand and flow (Section 5.3.1). A PSOLIS replacement should be considered in line with SHR recommendations for a state-wide electronic health record (EHR). The design process must involve end users such as clinicians, support staff, consumers and carers. Proper design and adequate resourcing (including training), are needed to ensure that clinical staff do not have an increased administrative workload resulting in decreased efficiency and reduced patient care (33).

Recommendation 9 : Information and Communications Technology

9.1 A searchable centralised service database should be developed as a priority to inform

	consumers, support persons and clinicians of all public mental health services in WA.
9.2	All providers should be given tiered access to mental health information systems. This could initially involve improved PSOLIS access with later migration to a shared platform or electronic health record.
9.3	Workflow process should be reviewed to ensure efficiency and avoid duplication. Implementation of standardised documentation across WA should occur in all services.

5.5. Consumer engagement

Partnering with consumers and support persons must occur in relation to their own care, respecting healthcare rights, providing informed consent and sharing decision-making and planning care. It is also essential in implementing clinical governance and applying quality improvement systems. Effective partnerships should also occur with consumers and support persons in governance planning, design, measurement and evaluation (17).

The implementation of lived experience leadership roles in leadership agencies is also critical, particularly in relation to governance. It is notable that many reviews were finally undertaken after persistent attempts by individuals or support persons to highlight the serious problems which service leaders or governments effectively ignored or minimised. However, it is important that there is independent governance of lived experience roles to ensure that their voice 'can be strong without threat of sanctions'.

Consumer and support person involvement remains all too often tokenistic in some health services. In others, consumers and support persons may be involved but relegated to less important decision making. Alternatively, services may select representatives most likely to maintain the status quo (75) which reinforces the power differential between providers and the consumers they should serve, leading to feelings of anguish with the 'medical model' (76).

Underpinning effective partnerships is good communication. Contemporary work focuses on assisting health services to genuinely change the provider – a consumer dynamic to co-create value, including a shift from consumer participation to genuine consumer leadership and involvement based on 'relationships, mutual trust and a win-win exchange' (77).

The importance of the consumer voice should be unquestioned in contemporary health care. The Mascie-Taylor Review suggested the consumer voice required strengthening in WA. He stated '*HSP boards should engage with consumers on their expectations for Safety and Quality*' (11). Despite this, stakeholders reported a major issue with consumer and carer engagement in WA public mental health services.

The Lived Experience Forum identified that 71 per cent of its survey respondents recommended greater use of the lived experience of consumers and support persons in all levels of decision making within the system (30). The Review online survey reported 88 per cent of respondents felt that current governance structures hindered consumers and support persons from getting outcomes they need (30).

The RANZCP noted that engagement and consultation with support persons, consumers and clinicians has been inadequate, and that these critical voices have not been supported to engage productively, which requires the support of management, clinical leaders, relevant data and policy analysis (33). WAAMH and CoMHWA reported that there is clear and major system inertia in rights and safety improvements (43).

The Lived Experience Forum revealed concerns that consumer and carer feedback was not incorporated into service improvements (19). It highlighted concerns about the extent to which they can currently influence safety and quality at the governance level. It suggested value in identifying the current locations of lived experience voices in governance

arrangements and the extent to which those voices are translated into quality and safety improvements, with recommendations made to address any gaps identified, including developing the means by which to provide ongoing monitoring of and opportunities for consumer and support person input (19).

Only 31 per cent of respondents to the Review online survey felt that services worked collaboratively with consumers and support persons, and 60 per cent felt that consumers and support persons were not involved in planning and decision making about their own care. Review submissions suggested widespread concerns about tokenism, with a lack of respectful and genuine partnership between agencies and people with lived experience and little validity given to their views. As a result, consumers and support persons felt disempowered, exploited and ignored (43). Even when clinical and management staff accepted consumer feedback, organisational barriers prevented that information being used to drive safety and quality improvements, leaving some consumer groups without a voice in system governance (19).

Reluctance of service providers to involve support persons was reported, often justified on the basis of patient confidentiality policies or due to legislation (30). The Lived Experience Forum noted that service providers failed to recognise their support persons, despite previous recommendations made by the State Coroner to involve support persons as part of safety and quality issues process (19).

The Lived Experience Forum identified a need for clinical staff to have additional skills for managing consumers with mental health issues (19). Many voiced a need for improved communication skills generally, but specifically raised the need for deeper implementation of a recovery orientation, trauma informed and person-centred approach among staff. This is in line with concerns raised about EDs where many of the skill areas are related to emergency mental health skills, including the ability to triage in a manner consistent with a recovery oriented and suicide prevention approach (19).

The need for staff training to reduce stigma and improve communication with consumers and support persons was repeatedly identified. WAAMH and CoMHWAs highlighted that a culture that routinely listens for 'illness speaking' rather than listening to what people have to say impedes the meaningful inclusion, respect and participation of people with lived experience in safety, feedback and advisory processes (43)

Opportunities identified for collaboration with consumers and support persons include involvement in planning, governance committees, recruitment processes, training development of staff, community engagement activities and focus groups (19). Many participants in the Lived Experience Forum mentioned the potential for cultural change to be driven by the knowledge of people with lived experience who could be engaged in various roles in the mental health system. Stigma reduction and greater understanding of the social determinants of health were considered vital and a key role for consumer and carer advocates (19).

The Lived Experience Forum noted that the Australian Commission on Safety and Quality in Health Care considers the health literacy of consumers to be a vital contribution to safety and quality. It recognises the burden is largely placed on consumers and support persons to understand and make sense of language and processes that are often designed without their input. This makes it difficult for consumers and support persons to participate in service level processes such as using complaints processes within the service or through the HaDSCO, or being aware of the right to ask for escalation of care, request a second opinion or make decisions about treatment options.

Participants mentioned a desire for capacity building to support consumer and lived experience participation in service level and system level governance processes. Additionally, participants stated the importance and need for upskilling of staff to use and

value plain language communication and lived experience knowledge at all levels of the mental health system (19).

Submissions highlighted that consumers and support persons are not being adequately informed about their rights and what to expect when accessing services (43). The Review online survey found that 72 per cent of consumers and support persons were unclear about which agency they should talk to regarding concerns or problems with public mental health and AOD services. Further, 81 per cent felt there were barriers, which made it hard to resolve problems (31). Common themes were experiences of unsympathetic staff, which respondents felt was the result of a culture of silos, stigma, lack of training and discrimination. Others reported concerns that feedback would not be taken seriously or dismissed. Some reported not raising problems due to a fear of a negative impact on their relationship with service providers.

Participants in the Lived Experience Forum commented on the need for additional individual advocacy to be available within the mental health system. Advocates can support people to make and pursue a complaint, to access services and to better understand their rights within the system (19). Stakeholders noted that consumer representatives in services were currently employees of the service and could feel conflicted.

WAAMH and CoMHWA suggested there could be a robust independent state-wide network of consumer representatives to serve in governance roles in mental health services. This would allow independent recruitment, training, coordination, payment, supervision and placement of lived experience representatives. The network would aim to provide state-wide reporting, liaison, networking and consultation between representatives (43).

Stakeholders reported that there was an urgent need to meaningfully engage consumers and support persons into the Department and HSP process, with adoption of the MHC engagement framework across the system. The Department has performed poorly in this capacity and must develop a clear and convincing strategy as to how they will improve their performance going forward. In addition, HSPs also need to continue working to improve their partnerships with consumers as recommended in the Mascie-Taylor Review (11).

Despite the models, frameworks and past recommendations that support partnering with consumers and support persons, there has been little progress in improving recognition of the value and importance of lived experience. There are significant deficits in consumer engagement at all levels in the WA public mental health system, the exception being the MHC.

The MHC has achieved excellent engagement with consumers and support persons through the development of a co-designed, comprehensive engagement framework and its Elders-in-Residence program – the first in the WA Public Sector Strategies. Resources are required to ensure that lived experience voices are able to be heard within all agencies and used to inform service improvements. Adoption of the MHC engagement framework by the Department and HSPs is recommended. Consideration could also be given to establishing a Lived Experience Leadership Group with involvement of peak community agencies.

Tools to support a more collaborative approach are emerging. For example, recent work by the UK-based National Collaborating Centre for Mental Health provides practical resources for co-production in the commissioning of mental health services (78). Practical advice is also offered by the National Mental Health Commission (79) and through the learnings of a number of experience-based co-design (EBCD) projects undertaken in hospital and community mental health services in the UK (19).

The Lived Experience Forum report highlighted that the second most commonly raised issue in relation to safety and quality was the need for clinical staff to be reskilled or have

additional skills in the general area of communication and more specifically in the areas of recovery, trauma-informed and person-centred approaches.

Recommendation 10 : Consumer leadership and engagement

10.1 As a matter of priority, the Department of Health must establish strategies to partner with people with lived experience. Their voice should be influential in decisions about clinical services policy, planning, priority setting and performance.

10.2 Health service providers should establish strategies to partner with people with lived experience, at the service, executive and board level.

6. Summary and Recommendations

6.1. Key findings

The Terms of Reference requests identification of opportunities to improve and reform the mental health clinical governance structure to enhance effectiveness and efficiency and embed a quality improvement focus to deliver best practice mental health services for the WA community. Key findings and patterns are:

- **Separation of general health from mental health services**

The formation of the MHC in 2010 resulted in separation of mental health from general health services in WA. The parallel streams appear disconnected, noting that mental health consumers often need to access general health services (e.g. EDs) (4). The separation has also resulted in the need for duplicated processes and additional costs.

- **Two “system managers” of mental health services with unclear leadership**

The devolution of the system with HSA 16 (2016) saw the Department adopting the role of a “system manager”. The MHC as “sector leader” had already adopted a devolved structure with central contracting and oversight of a range of providers. WA public mental health has two “system managers” with no single point of accountability or authority. HSA16 indicates the Department has responsibility for the total health system (as system manager), but it has limited visibility of the nonclinical and accommodation sectors. The MHC has limited insight into the clinical services. Neither agency has whole of system visibility.

- **Two separate clinical and nonclinical systems that integrate poorly**

The two “system managers” lead parallel mental health systems that operate independently with limited integration. The Department oversees clinical services and the MHC provides oversight for nonclinical and accommodation sectors. Clinical services have areas of overlap between the Department and MHC. The lack of integration and coordination between clinical and nonclinical systems has led to services being implemented that do not connect with existing services or each other. HSPs and service providers reported little knowledge of newly commissioned services. The result is poorly integrated services of limited effectiveness.

- **Duplicated monitoring of performance, safety and quality with limited indicators**

There is duplication of many functions, including for planning, performance and safety and quality monitoring. For clinical services, this has resulted in duplicated reporting to both the Department and MHC. Monitoring of some sectors (e.g. hostels) is by multiple agencies using different standards and frameworks. The mental health indicator set is lacking and additional indicators are urgently needed for service demand, patient experience and system flow across the full pathway (ED, hospital, Step Up Step Down, community accommodation, primary-care). The duplication of functions has resulted in higher costs and resources diverted away from consumer care.

- **Two purchasers with a lack of clarity in funding and high costs**

WA has two purchasing agencies and two budgets for mental health services. WA is unique in having an external agency in control of the mental health budget. The MHC purchases the majority of mental health services from Health Service Providers (HSPs). The Department however, also purchases significant mental health activity in EDs, Mental Health Observation Areas (MHOAs), patient transport services and Consultation Liaison services. The separate budgets means that neither the Department nor MHC has visibility of total system costs. This has also compromised the validity of efficiency indicators with a loss of transparency. The duplication of contracting functions has also resulted in higher costs and decreased efficiency. The complexities of the funding system have also increased burden and costs for provider organisations.

The structural divisions are magnified by issues with governance processes. These are:

- **Lack of clarity in roles, responsibilities and accountability at multiple levels.**

Documentation of governance roles and responsibilities is unclear. A shared statement of roles for governance agencies was only produced after this Review commenced, many years after major system change. A consolidated corporate diagram of lines of reporting for the system has not been produced. This has resulted in minimal transparency of governance arrangements.

- **Disconnection of governance from consumers, supporters and clinicians**

There is limited input into governance from consumers, supporters and clinicians. Consumer and supporters are well engaged by the MHC and but have limited engagement with the Department. Clinicians have a good relationship with the Department but have minimal interface with the MHC. Overall, there is a marked lack of clinical and content expertise WA clinical governance. The MHC has significant staffing footprint – 272 full-time equivalents (FTE) – but does not have any psychiatric staff involved with planning, monitoring or regulation of services. The Department has a small Mental Health Unit (MHU) with limited staff (14 FTE) and no clinical presence. The Office of the Chief Psychiatrist (OCP) does have specialist staff, but it does not have operational responsibilities. Clinical input is via a numerous advisory groups that have no formal governance role and limited apparent influence.

- **Lack of a system wide plan that hampers service integration and coordination**

There is a significant gap in integrated system wide planning, which is noted in past reviews (2). There is no detailed system-wide service plan that incorporates all providers and describes service access, models of care or pathways and coordination of services (4). The lack of integration between clinical and nonclinical sectors has led to poorly integrated and ineffective services. Consumers are having difficulties getting the help they need and face a difficult journey through the system. Planning lacks focus on the differing needs of patient groups. The population with severe mental illness (SMI) accounts for only 10 per cent of patients yet consumes 90 per cent of hospital care and 50 per cent of ED and community services. There appears to be few dedicated services that provide for this group (4). There is also an urgent need to improve the viability of the accommodation sector, which is critical to the system.

- **Learning system impairment with limited support for quality and innovation**

This review identified the same issues noted in past reviews, with minimal improvement. Past reviews focused on changes to policy or process and did not suggest changes in governance structure. The inherent structural issues and lack of

integration in the governance structure are likely to have blocked meaningful change. This review has therefore recommended structural realignment.

6.2. System leadership

The Panel considered a number of roles for the MHC as the sector leader. Fundamentally, it should have a strategic focus and articulate a clear vision for public mental health services. This could encompass the following:

- Promotion of services to maintain the health and wellbeing of the population of WA.
- Prevention and early intervention services to address the needs of those who are at risk or have early signs but do not meet diagnostic criteria (and may be required to do so within a recovery-focussed system).
- Promotion of recovery-focused clinical and community-based services that interface well with the NDIS and other intersectoral agencies.

The sector leader should develop the vision in conjunction with all stakeholders, who must be engaged and on board if the joint vision is to be achieved. The sector leader will need to establish priorities with key stakeholders, including consumers and support persons, to guide use of available funds in a way that is coherent with the vision. This is no easy task, given the widely diverging interests of the different stakeholder groups in the sector, all of which need to be heard. Attempting to progress reform and shift the balance from clinical to non-clinical services without that deep engagement is flawed, and will do little to enhance the governance or integration of the sector.

The system manager role should differ to that of the sector leader. Its role is operational and tasked with translating the vision into services. This will require system wide planning, implementation, purchasing, monitoring and regulation of providers in the system. There are a number of foundational pillars:

- Regional governance and accountability
- Partnerships with consumers and support persons
- Effective cross-sectoral leadership
- Effective safety and quality framework
- Workforce planning to build capacity and capability
- Research, evaluation and innovation
- Comprehensive monitoring and reporting

The elements must involve clinical, nonclinical and accommodation services in an integrated fashion to deliver seamless, person-centred services to consumers and support persons. To a large extent, the current confusion in leadership arises from a lack of clarity between strategic and operational roles, system complexity, confusion of clinical governance with contract management and the lack of effective implementation of the statutory system manager and HSP roles.

6.3. Importance of consumers and support persons

The role of consumers and support persons will be vital and central in efforts to improve. The literature indicates that to have a safe system, the voice of lived experience must be present and heard at every level of a mental health system. The Panel made multiple recommendations to address this (Recommendations 1.2, 2.6, 2.7, 3.1, 4.2, 8.1, 10.1 and 10.2). To be effective, the recommendations must be implemented. Robust oversight of implementation must include consumer.

6.4. Better partnering and integration

Better partnering is needed throughout the whole system. The MHC should have responsibility for engaging with intersectoral agencies at the strategic level. The Department should have responsibility for engaging with intersectoral agencies at an operational level. Consideration could be given to a high-level intergovernmental committee, led by the Premier and Cabinet. The Director General and the Mental Health Commissioner should consider meeting periodically oversight bodies and with the boards of the HSPs and NGOs.

6.5. Governance structure options

The main goal is to achieve high quality and safe mental health services for the WA public. All sectors report concerns that the current WA public mental health services are not meeting need and are ineffective and inefficient (4). Lack of integration at the governance level in planning and commissioning appears to be having flow down impacts on service delivery to patients. The complexities of the system for monitoring of performance and safety and quality also appear to be obscuring some of the evident system issues.

The review identified areas of improvement in processes and governance structure. Ten recommendations have been made to assist with current processes. The review also recognised significant and inherent structural fragmentation within the WA mental health governance structure, requiring structural solutions to improve governance.

An initial consideration is whether one agency having responsibility for WA public mental health services could be of benefit. This would address the fragmentation issues and integrate the sector with provision of a single point of accountability and authority. Options include:

- **Allocation of all responsibility to the MHC**

This would provide a single point of accountability for the system but would result in completely separate mental health and general health systems, which is contrary to aims for integration and National Mental Health Policy. No other state has completely separate general and mental health services. This option is likely to result in ongoing and additional duplication of management functions and lead to further administrative costs. Based on these considerations, this option was not considered viable.

- **Allocation of all responsibility to the Department**

This option would also provide a single point of accountability and would also resolve the split between mental health and general health services with improvements in system effectiveness and efficiency. This structure is used in some other states. It was however recognised that the MHC has made significant improvements in WA. It has deeply engaged with consumer organisations and has most effectively demonstrated an understanding and willingness to support the development of recovery-focussed trauma-informed mental health services with meaningful lived experience engagement in policy and practice co-design and partnership. Therefore this consideration was not considered viable.

The Panel therefore concluded that both the Department and MHC should play important ongoing roles in WA public mental health service governance. The Panel considered a range of governance structures that would resolve the identified issues in WA governance. Six options are detailed below including corporate function diagrams showing lines of reporting and authority (pg. 58-62) and compared in Table (6). There was a lack of panel consensus regarding options with divergent views.

Firstly, options were considered that retained the existing governance structure but with modification. Option (1) involved the adoption of clear roles and responsibilities within the current structure, which would provide some improvement but not address the core structural issues with a likelihood of ongoing difficulties. This approach was taken in past reviews (e.g. Stokes) and proved not effective. This option was favoured by the consumer and carer representative on the Panel. Option (2) involves formal separation of the clinical and nonclinical sectors, which would clarify lines of reporting and accountability and decrease overlap but leave a split between clinical and nonclinical services. Both were considered not optimal or viable for long-term benefit.

Governance structures used in other states were reviewed. These structures have the MHC performing strategic functions and leadership in mental health prevention, and promotion and education. Those commissions do not have operational roles in purchasing, monitoring of safety and quality or regulation, which are the responsibility of the respective Department of Health. Option (3) involves use of such a structure in WA with resolution of the structural issues identified with improvements in governance effectiveness and efficiency. The WA MHC would step back from its operational roles in purchasing, monitoring of performance and safety and quality, regulation and direct service provision. Integration of operations would result in better-coordinated services for the WA public. If all review recommendations are adopted, they would arrive at this structure. The majority of the Panel felt this option was viable.

The consumer and carer representative was concerned with the decreased role of the MHC, especially in funding. Further options were explored by the Panel that were based on a standard commission model but with the MHC retaining budget-holding responsibility. Option (4) sees the MHC retain strategic control of budget allocation (e.g. determining proportions for prevention, promotion and so forth). The Department would (in accordance with those allocations) coordinate and purchase all services. This would deliver a balance between the need for governance structure change and the wishes of consumer organisations. This option was favoured by two members of the Panel. Option (5) proposes a Joint commissioning model, with a shared budget at a strategic level leading to a single contract for providers with operational oversight provided by the Department. This was favoured by the remaining two panel members.

The consumer and carer representative on the Panel raised a number of concerns. These relate to the past relationship between the Department and consumer and support groups, different concepts of mental illness (biomedical and social models with recovery), and control of funding. These are detailed below:

- Structural options are undoubtedly an enabler of good clinical governance but are just that – *an* enabler, not *the* enabler. There are many other enablers such as culture (which consumers and carers continually cite as a key priority to be addressed), leadership, partnerships with a diversity of consumers and carers and their representative agencies which requires culturally secure policies and practices, quality improvement systems, environment and clinical performance and effectiveness.
- The submission by the Consumers of Mental Health WA in the WA Association for Mental Health preferences a strengthening of the MHC's role to capture gains made and build on these for future progress and reform and continue to advocate for lived experience input to meaningfully inform all levels of decision-making. The position includes strengthening the role of the MHC and embedding meaningful lived experience input and leadership at all levels of decision-making, the latter of which is in line with the Sustainable Health Review (2019) recommendations.
- The voices of consumers and carers have been supported and strengthened through the policies and practices of the MHC. However, this progress has not been mirrored

consistently at the level required within public mental health clinical services, led up until 2016 by the Department and since then by HSPs. During the time the Department managed the MHC budget, the consumer and carer voice was managed from a medical rather than a social model of care perspective. There is still little or no evidence that the Department of Health embraces recovery or person-centred mental health care and therefore, there is understandably little confidence in a social model of mental health being progressed under its leadership. In fact, there is great concern that gains made to date in WA would be lost.

- The lack of evidence or current demonstration or leadership by the Department in understanding or supporting the implementation of a recovery-focussed, social model of mental health care in public clinical mental health services, yet now being the entity assigned to undertake the contracting and monitoring of the performance of the agencies assigned to deliver this (in line with national standards and policies).
- The MHC was established to enable the development of a contemporary, social model of mental health care, which requires a balancing of the current system away from acute medical environments to community managed options. It is possible that the gains made towards a social model of mental health care in the past nine years could be lost with a return to the dominance of a model focussed on diagnosis and symptomology similar to other health areas in the Department. In WA, these need to be delivered with a recovery-focused approach in line with national and international standards and policies. This requires a shift away from the dominance of a narrow, biomedical approach (as outlined in the 2017 UN Special Rapporteur Report).
- There has not been a consistent strategy to understand or operationalise a genuine recovery focus by the leadership of the Health Service Providers, which is critical as they hold ultimate responsibility for safety and quality. The Department of Health appears to have negated its role as system manager in mental health. This has led to a lack of leadership and consistency in policy development, an unwillingness to hold HSPs to account and variation of experienced care across HSPs.
- The MHC was established in 2010 partially to provide “ring fencing” to the mental health budget to stop it from being continually subsumed into general health. The raiding of mental health budgets by the Department to fund more acute health services in response to funding pressures was noted in the 2018 Sustainable Health Review Interim Report.
- During the consultation, the MHC reported that the main barrier to the inclusion of clinicians in planning and designing mental health services were written directives from two Directors General of Health, precluding the MHC from contacting clinicians. This left the MHC in an impossible position with respect to clinical engagement. This was not in the best interests of developing a recovery-focused mental health service, which requires clinical engagement, particularly in acute and community settings. In the meantime, it would appear that the MHC has largely been blamed by other parties in the sector for the lack of clinical engagement in mental health without an understanding of this context.

The last point was clarified. It was reported the directive emerged at the time the Office of Mental Health (OMH) was in place in the Department. The MHC was apparently approaching clinicians directly rather than following regular lines of communication. It was requested the MHC contact the OMH to receive clinical input.

Governance structure options

1. Current structure with clarification of roles

The corporate function diagram indicates the current structures and lines of reporting and authority. This demonstrates the current fragmentation and duplication in lines of reporting.

Option 1 proposes retaining the current structure with clarification of roles and responsibilities. This would improve clarity for those in the system.

This option carries the advantage of ease of implementation and low cost. Long-term costs however are likely to be significantly higher due to duplication and inefficiencies.

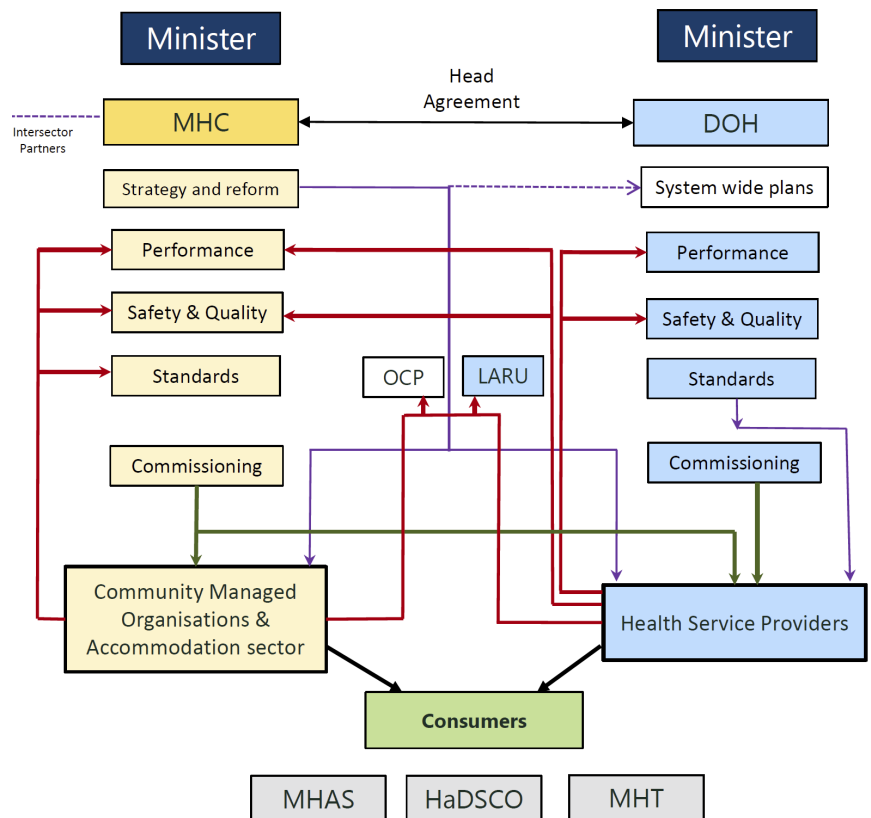
There are no changes to the current system with ongoing structural splits between general and mental health services and between clinical and nonclinical sectors. The issues with lines of reporting would also remain.

The lack of change is likely to result in limited impact on governance ineffectiveness and inefficiency. The governance issues are mainly structural in nature and will require structural change to achieve lasting improvement. This option was therefore not viewed as a viable option by the majority of the Panel.

The carer and consumer representative differed and favoured this option. The joint submission by WA Association of Mental Health and Consumers of Mental Health WA also favoured retention of the current structure. This view appeared to be based on the strong relationship between consumer organisations and the MHC and its support for the development of community-based, nonclinical, recovery-focussed and trauma informed mental health services with meaningful lived experience engagement in policy and practice co-design and partnership. There was also concern that change in funding arrangements could affect consumer organisations.

Most of the Panel did not view this as a viable option.

Option 1 : Current with clarification of roles



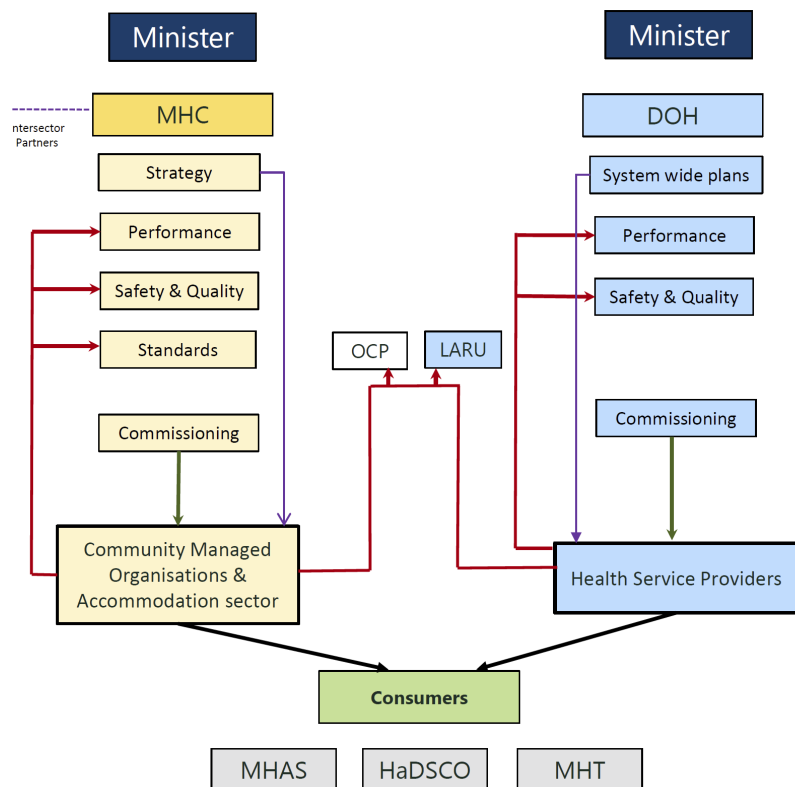
2. Formal separation of clinical and non-clinical governance

This option formalises the current separation of the system into clinical and nonclinical sections.

The corporate function diagram demonstrates a significant improvement in clarity of the lines of reporting. This would provide greater accountability for service delivery with clear responsibilities for the Department and MHC. Therefore this option is likely to result in greater improvement than Option 1.

Purchasing for clinical services would be transferred to the Department. This would allow alignment of funding with safety and quality objectives. Under such an arrangement, the Mental Health Commission would retain responsibility for community support and bed-based services provided by NGOs.

Option 2: Split clinical and nonclinical services



This option would be relatively simple to implement and would only require a shift in budgets. As with Option 1, however administrative costs would remain high as duplicated functions will remain.

This option presents clear advantages and will improve accountability for safety and quality. It does not however address the concerning lack of integration between the clinical and nonclinical and accommodation sectors, which is contributing to system fragmentation and poor system effectiveness. There is also ongoing inefficiency through persistence of duplicated processes. As a result, the Panel did not consider this option viable.

The Panel does not consider this option viable.

3. Standard commission model

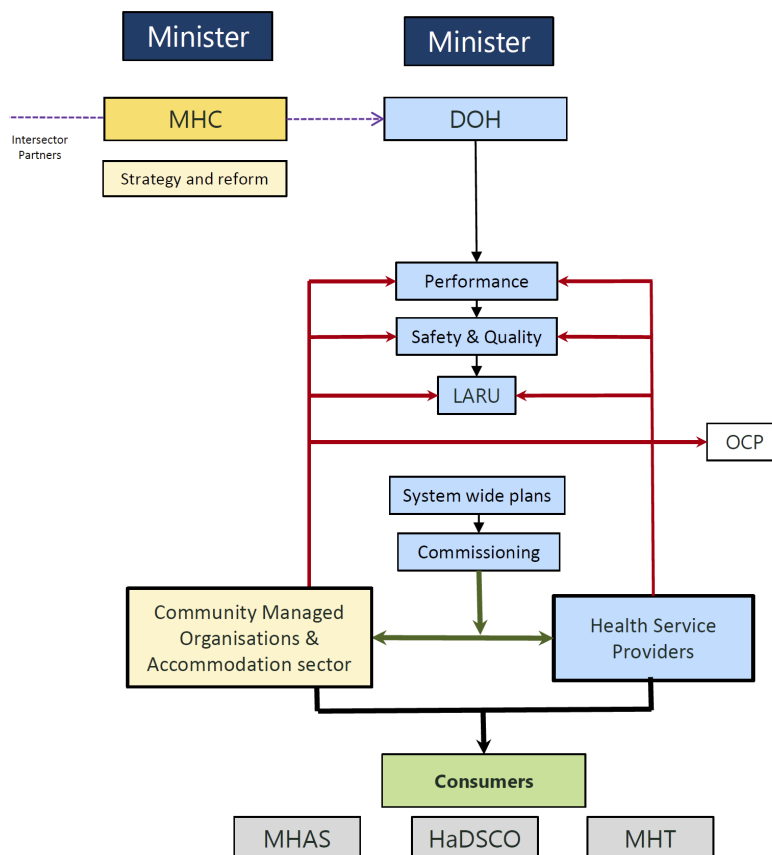
This option would see WA shift to a model similar to that being used in other states such as Queensland, New South Wales and South Australia.

The core functions of those Mental Health Commissions are Strategic and include the development of a strategic plan, and leadership in mental health prevention, and promotion and education across those states.

Operational implementation is undertaken by the relevant government authorities' e.g. Health, Justice, Education, Housing etc.

Such a model in WA would retain the MHC as sector leader. Commissioning of all mental health services would be the responsibility of the Department. The MHC would step back from the operational roles in performance, safety and quality, commissioning and direct service delivery (for AOD services).

Option 3 : Standard (interstate) Model



Operational roles would be undertaken by the Department, which have responsibility as the system manager role for mental health services. This structure provides for a single point of accountability and integrated whole of system oversight of all sector providers (clinical, nonclinical and accommodation). The improved integration should lead to improved services for consumers of WA public mental health services.

The majority of the panel noted this option would address the structural issues in the WA system but may undo gains made by the MHC. Recognising these reservations, the Panel considered additional models with the aim balancing the need for a governance structure that would be effective and efficient, but also meet the view of consumer organisations that the MHC retain a role in funding and purchasing. These are outlined in Options 3.1 and 3.2.

Most of the Panel members considered this option viable but not a preferred model.

4. Separation of strategic and operational functions

This option is based on the standard model described in Option 3.1. The main point of difference is the MHC would retain strategic responsibility for the mental health budget allocation and determine allocations for prevention, promotion, services and so forth.

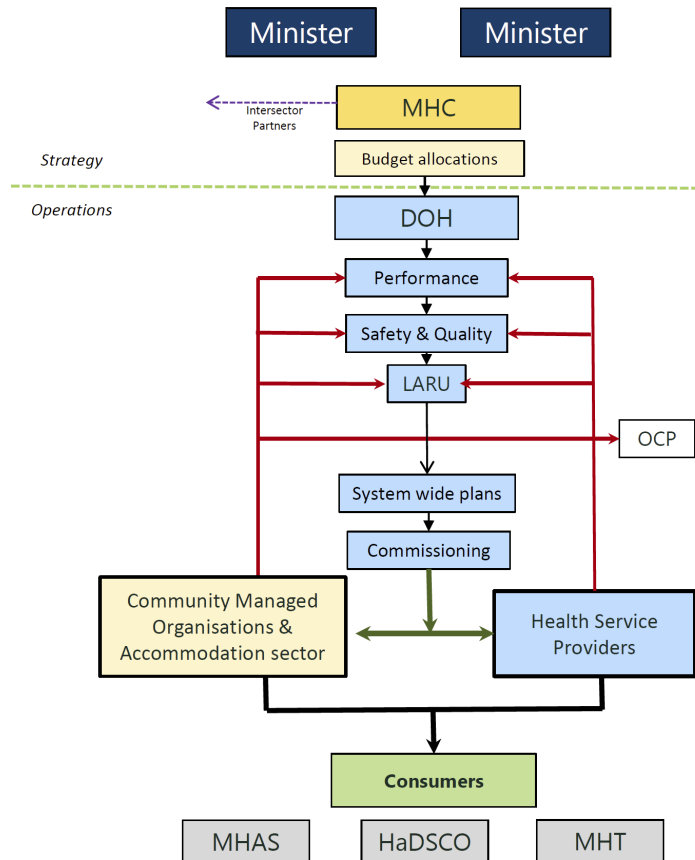
The MHC would have direct ongoing influence in reform. This differs from the model used in other states, as those commissions do not have a budget role. Arrangements would be described in the existing head agreement between the MHC the Department.

The Department (in accordance with those allocations), would purchase services including community support and bed-based services and accommodation from HSPs and NGOs.

This option achieves a balance between the drivers for governance structure change and addresses the concerns of consumer organisations that the MHC should retain a role in funding allocation.

Panel members viewed this option as viable.

Option 4 : Separation of strategic and operational roles



5. Joint commissioning

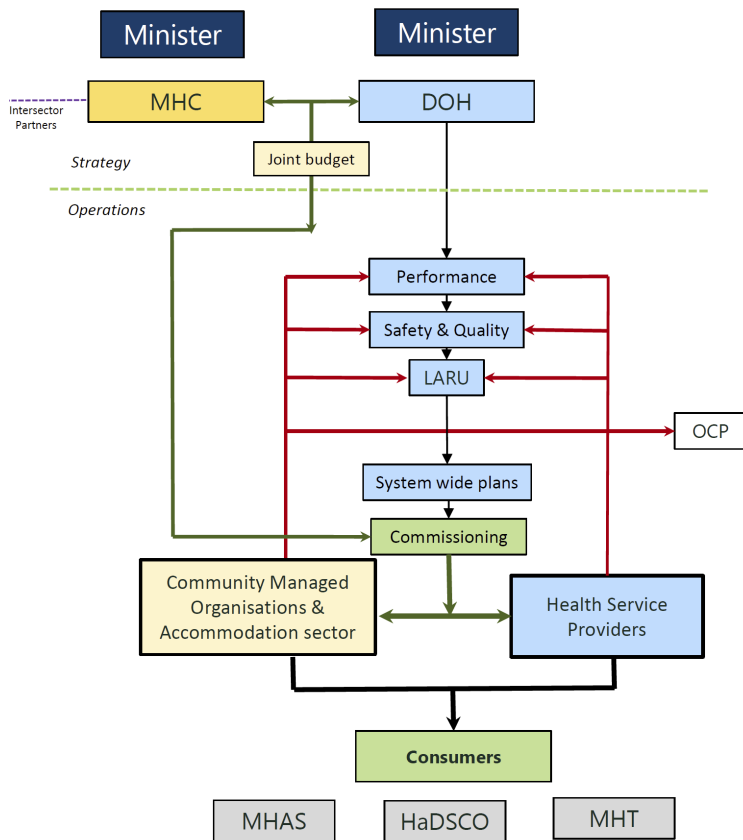
This option also aligns with Options 3.1 and 3.2. In this option the MHC and Department would collaborate to jointly identify their shared contribution to mental health funding.

A single contract would be developed and jointly negotiated by the MHC and Department with HSPs. Contracts would be approved by the MHC.

System management functions for all contracted services would be undertaken by the Department. Likewise the MHC would work with the Department to develop short-term operational priorities, consistent with strategic plans and priorities.

As part of this, it is expected that both parties would work closely together and with service providers to develop priorities for system enablers such as workforce and ICT.

Option 5 : Joint commissioning



Panel members viewed this option as viable.

Table 6. A visual comparison of the five options considered by the Panel

Model	1. Current model with clarification of roles	2. Separation of clinical and nonclinical governance	3. Standard Commission model	4. Separation of strategic and operational functions	5. Joint commissioning
Leadership	Unclear	Unclear	Clear	Clear	Clear
System management	Unclear	Divided	Clear	Clear	Clear
System integration	Fragmented	Fragmented	Integrated	Integrated	Integrated
Planning	Unclear	Unclear	Clear	Clear	Clear
Purchasing and commissioning	Divided	Divided	No role for MHC	MHC strategic budget holder	Joint budget holding
Performance monitoring	Duplicated	Duplicated	Single	Single	Single
Safety and quality monitoring	Duplicated	Duplicated	Single	Single	Single
Governance effectiveness	Limited	Moderate	High	High	High
Governance efficiency	Poor	Poor	High	Moderate	Moderate
Panel support	Not viable*	Not viable	Viable but not preferred	Viable: Panel support	Viable: Panel support

Appendix 1. Terms of Reference



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

TERMS OF REFERENCE FOR A REVIEW OF THE CLINICAL GOVERNANCE OF PUBLIC MENTAL HEALTH SERVICES IN WESTERN AUSTRALIA

Background

Public mental health services in Western Australia provide a range of hospital and community based services to individuals and communities across the State. Services are provided by a mix of providers including public providers, private hospital services contracted to provide public services, contracts with non-government organisations, and private mental health accommodation services.

Clinical Governance of the public mental health system in Western Australia is shared across separate agencies and statutory entities, including Health Service Providers, the Department of Health, the Mental Health Commission, the Office of the Chief Psychiatrist, and other non-operational statutory entities such as the Mental Health Tribunal, Mental Health Advocacy Service and the Health and Disability Services Complaints Office, which have different service provision, regulatory, assurance and facilitation roles and responsibilities.

The definition of the Australian Commission on Safety and Quality in Health Care (2017) (the ACSQH), Clinical Governance is ‘the set of relationships and responsibilities established by a health service organisation between its state or territory department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes.... Clinical Governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.’

The ACSQH also noted that ‘Clinical governance is an integrated component of corporate governance.’

A number of recent reports and recommendations have identified the clinical governance of mental health services as an area requiring review and reform to provide direction, consistency and facilitation across service providers in WA.

The Review of Safety and Quality in the WA health system: A strategy for continuous improvement (Mascie-Taylor/Hoddinott, 2017) (‘HMT Report’), found that the large number of WA mental health system governance organisations with overlapping roles has caused ‘confusion and concern’, and that there is a complexity of safety and quality governance of mental health services with no one group having a complete picture and the sum of the parts not providing a clear and coherent overall view of safety and quality (p. 30). To address these issues, the HMT Report recommends:

Recommendation 24: *There is an urgent need to simplify and clarify the organisational arrangements supporting effective clinical governance of mental health services in order to provide direction, consistency and facilitation across service*

providers. To this end an external review of the overall governance of the mental health system in WA should be initiated as a system priority.

The Sustainable Health Review Panel's *Sustainable Health Review: Interim Report to the Western Australian Government* report (Kruk, 2018) also supported a review of clinical governance - 'The Panel supports a review of mental health clinical governance, to simplify and clarify the organisational arrangements supporting mental health services in order to provide direction, consistency and facilitation across service providers in WA' (p. 35), recommending:

Recommendation 4: *Support the immediate review of mental health clinical governance as identified by Professor Mascie-Taylor in the 2017 Review of Safety and Quality the WA health system.*

The WA Auditor General's Report *Licensing and Regulation of Psychiatric Hostels* (Office of the Auditor General (OAG) WA, 2014), found that 'there were some instances where the agencies responsible for monitoring hostels worked together and some where coordination and cooperation could have been improved', particularly in relation to clarifying complaints processes, identification of '...risks to residents that are not covered by the standards and to make sure that monitoring activities are not duplicated and are spread throughout the year...' (p. 6). The OAG Report recommends:

Recommendation 1: *All agencies should take advantage of current initiatives in the monitoring of mental health service provision to improve coordination, efficiency and outcomes.*

While a number of initiatives were implemented to address the OAG's recommendations (e.g. implementation of an agreed cross-agency complaints process), subsequent changes in the monitoring and oversight of the service standards of psychiatric hostels, have demonstrated the need for continued efforts to improve coordination and cooperation between agencies.

Purpose

An independent review of clinical governance within the WA mental health system will be undertaken to ensure that the system has appropriate and robust clinical governance with clear roles and responsibility, authority and accountability to ensure the delivery of high quality mental health services for the WA community.

In reviewing the clinical governance of the WA mental health system, the reviewers will give particular attention to the following focus areas:

- ***Defining the current clinical governance structures:*** What are the structural components, processes and culture that constitute the current WA mental health clinical governance structures? Are the roles and responsibilities, authority and accountability in the WA mental health system clear? What oversight arrangements are in place and which authority or agency oversees the key clinical governance processes?
- ***Lack of clarity / gaps / duplication:*** Are there specific areas of unclear or absent clinical governance and/or duplication of clinical governance processes and, where these occur, what is the impact on the mental health system?
- ***Fragmentation / Interface:*** To what extent is the system fragmented in relation to clinical governance arrangements, and how well do the relevant governance

agencies / authorities interface, communicate and engage to facilitate appropriate clinical governance and oversight?

- **Effectiveness:** How effectively does the current clinical governance structure facilitate decision making, clinical oversight and accountability, service management, achievement of clinical outcomes and the setting and monitoring of standards, to support the mental health system in delivering mental health services to the WA community?
- **Efficiency:** How efficient is the current clinical governance structure in facilitating timely decision making and optimal use of human and financial resources in managing and implementing clinical governance processes?
- **Support for quality improvement and innovation:** How well does the clinical governance structure support, promote and foster quality improvement and innovation in the delivery of mental health services? What improvements could be made?
- **Learning culture:** How well does the system address and implement recommendations and/or changes from previous reviews and reports that relate to clinical governance? What barriers exist, real or perceived, that inhibit addressing issues and implementing change regarding clinical governance?
- **Opportunities for clinical governance improvement / reform:** What opportunities exist to improve / reform the mental health clinical governance structure to enhance effectiveness and efficiency and embed a quality improvement focus to deliver best practice mental health services for the WA community? For example:
 - Who should best coordinate the clinical governance processes, and, if an issue arises, take the lead in a timely way to resolve the issue? This should include consideration of clinical integrity: clinical judgements regarding clinical care are the remit of clinicians.
 - A clinical governance structure and process that embeds quality improvement within clinical services, and develops a culture amongst clinicians in which quality improvement is the standard modus operandi.
 - A culture and structure that facilitates services and clinicians to talk to each other to improve coordination, care continuity, and issue resolution.

Scope

The scope of the review will include, but is not limited to:

- Current WA public mental health system clinical governance, including clinical oversight processes, staff reporting structures, planning, decision making and approval processes, and resource management (including human resources and funding).
- Overall WA mental health system governance, including both structural and organisational components, where these directly influence or impact on clinical governance.

- WA mental health governance agencies including (but not limited to): Department of Health WA, Health Service Providers (including hospital and community based sites), Mental Health Commission, Office of the Chief Psychiatrist, Mental Health Tribunal, Mental Health Advocacy Service, and the Health and Disability Services Complaints Office.
- Agency/authorities (Department of Health, Mental Health Commission, Office of the Chief Psychiatrist, Mental Health Tribunal, Mental Health Advocacy Service, and the Health and Disability Services Complaints Office) and Health Service Provider level clinical governance structures.
- Mental health governance, advisory and consultation committees and groups to the degree that they directly impact clinical governance.
- Publicly provided services, public mental health services provided via public-private partnerships, publicly contracted NGO services, mental health services contracted to private organisations (eg, mental health ambulance contract), private accommodation services (eg, psychiatric hostels), and private mental health facilities (in relation to the regulatory and assurance functions undertaken for these facilities by public agencies (eg, DoH, OCP)).
- Consideration of the current legislation: *Health Services Act 2016*, *Mental Health Act 2014*, *Criminal Law (Mentally Impaired Accused) Act 1996*, *Private Hospitals and Health Services Act 1927*, and *Health and Disability Services (Complaints) Act 1995*.
- Assessment of the oversight of the following recommendation from the *Review of the admission or referral to and discharge and transfer practices of public mental health facilities/services in Western Australia*, Professor Bryant Stokes AM, July 2012 that explicitly relates to clinical governance in the mental health system: “8.6 Special provisions are made for the clinical governance of the mental health needs of youth (16-25 years of age). The State would benefit from the advent of a comprehensive youth stream with a range of services that do not have barriers to access.”
- Consideration of recent mental health and relevant health governance reviews at Statewide, Health Service Provider and service level, eg, *North Metropolitan Health Service Mental Health Review*, *South Metropolitan Health Service Mental Health Organisational Structure Review*, *East Metropolitan Health Service Mental Health governance review*, *East Metropolitan Health Service City East Review*, and more broadly the CAHS/PMH Review, etc.
- Lessons learnt from other jurisdictional reviews, eg, South Australia’s *The Oakden Report*, and NSW’s *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*.
- Culture of the mental health system (organisational values, interactions with others, behaviours, attitudes).
- Leadership (leading and facilitating achievement of system and local service objectives, staff management, stakeholder engagement).
- Documents / submissions / consultation input provided for the reviewer’s consideration.

Methodology and consultation

The reviewers will be responsible for developing and implementing an appropriate methodology for the review.

Key aims for the methodology and consultation should be to elicit and clarify:

- Roles & responsibilities, authority and accountability, in relation to clinical governance in the WA mental health system.
- Oversight and coordination of clinical governance processes.

Documents / research / evidence recommended for review include the reports referenced in Background of this document, terms of reference and minutes of mental health committees and groups, and national and international best practice mental health service governance models. The reviewers should interview stakeholders from across the WA public mental health system, including:

- Representatives of governing agencies / entities (DoH, MHC, etc), committees and groups.
- Clinicians, consumers, carers and families.
- Representatives from non-governance mental health stakeholder groups such as the Royal Australian and New Zealand College of Psychiatrists, Australian Medical Association, Consumers of Mental Health WA, Health Consumers' Council, Carers WA, WA Police, St John Ambulance, Royal Flying Doctor Service.

Oversight of the review will be jointly provided by the Department of Health and the Mental Health Commission by means of an agreed mechanism, eg, a reference group or key contacts within each agency.

Final report

A final report detailing the reviewers' methodology, analysis, findings and recommendations in relation to all of the areas detailed in the Purpose section of this document will be delivered to the Director General, Department of Health WA, and the Mental Health Commissioner.

Panel Composition

Dr Martin Chapman (Chair)

Dr Chapman (MBBS and FRANZCP) has been active with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) throughout his career. He has previously served as the Psychiatry Discipline Leader at the University of Notre Dame (Fremantle) for seven years, and is currently leading the development of the foundation psychiatry curriculum for the Curtin Medical School and overseeing clinical programs. Dr Chapman was a founder and Chief Executive Officer for the Marian Centre for a 10-year period, which included oversight of all clinical, corporate and governance matters for the organisation.

Dr Chapman has served as the Australian Medical Association (WA) Craft group leader for Mental Health for four years with involvement and advised on Voluntary Assisted dying and Palliative care proposals. He has also served as the psychiatrist for the Doctors Health Advisory Service (WA), and has also served on a number of advisory panels and Boards. He currently works in private practice at Hollywood Private Hospital with a special interest in Mood and anxiety disorders and has a special interest in Defence Health.

Professor Bryant Stokes (Special Ministerial Advisor)

Professor Bryant Stokes is a distinguished neurosurgeon with three professorships at WA universities. A leader in fostering development of the neurosciences in WA, Professor Stokes directed the WA Health Neurosciences and the Neurosciences Health Network and served on the Medical Board of WA for more than a decade. He also served as the WA Health system's acting Director General for two years from 2013, during which he oversaw the commissioning of Fiona Stanley Hospital, and construction of Perth Children's and St John of God Midland Public hospitals. In August 2015 Professor Stokes became the first clinician to receive the AMA (WA) President's award. In recent years Professor Stokes has undertaken a number of health reviews, the most significant of these being the *Review of the Admission or referral to and the Discharge or transfer practices of public mental health facilities/services in Western Australia 2012*.

Dr Peggy Brown AO

Dr Peggy Brown AO is the Director of Limen Health Care Consulting Pty Ltd, and also works part-time as the Director of Quality, Safety and Leadership at Metro South Addiction and Mental Health Service in Queensland, and as a Senior Clinical Advisor to the Australian Commission on Safety and Quality in Health Care. Dr Brown has held multiple clinical and administrative positions in psychiatry and has been a leading participant in national mental health policy and planning in Australia for almost two decades. In January 2018, she was admitted as an Officer in the General Division of the Order of Australia for distinguished service to medical administration in the area of mental health through leadership roles at the state and national level, to the discipline of psychiatry, to education and to health care standards.

Dr Grant Sara

Dr Grant Sara is the Director of InforMH, the unit responsible for data collection, analysis and reporting for NSW Mental Health and Drug and Alcohol Services. Dr Sara is a psychiatrist, with a clinical role in treating young people with early psychosis. He is a Clinical Senior Lecturer in the Northern Clinical School, University of Sydney, and Chair of the National Mental Health Information Strategy Standing Committee. Dr Sara has a PhD in Public Health, and an interest in using large health datasets to support clinical practice, policy and research. His research interests include the epidemiology of cannabis and amphetamine disorders.

Margaret Doherty (Consumer and Carer Representative)

Margaret Doherty has been an educator for over 30 years and is a sought-after conference speaker and consultant/facilitator. While Margaret has a diverse professional background, it was her personal experience of supporting two family members with ongoing mental distress, and drug and alcohol use, which prompted her foray into mental health advocacy. In 2010 she convened Mental Health Matters 2, a grassroots advocacy group aimed at mental health reform, whose current membership is a unique alliance of over 1300 individuals, families and supporters, and people who work in community and public service settings. Margaret is also involved in multiple advisory groups and committees, notably as Co-Chairperson of the Forensic Mental Health sub-network, the Community Advisory Group on Compulsory Treatment Legislation, and the Steering Committee for the development of the Statewide Mental Health, Alcohol and Other Drug Consumer, Carer and Family Engagement policy.

Appendix 2. Methodology and Consultation

The Review was undertaken by an independent panel from January to June 2019. The Review was predominantly a qualitative review, drawing upon the perspectives of multiple stakeholders through a combined approach of evidence gathering and consultation, including a desktop review, interviews, regional consultation, formal submissions, a publicly available survey and a half-day forum for consumers.

This approach was developed with the intent of providing an inclusive opportunity for clinicians, staff and consumers to share their insight and experiences with the Panel, in line with the Terms of Reference and timeframes provided for the Review.

Key stakeholders were identified from the following areas of the WA mental health system.

Governance agencies, entities and authorities:

- Mental Health Commission;
- Department of Health;
- Health Service Providers;
- Office of the Chief Psychiatrist;
- Mental Health Advocacy Service;
- Mental Health Tribunal;
- Health and Disability Complaints Office;
- Office of the Inspector of Custodial Services;
- Office of the Auditor General; and
- WA Police.

Consumer and carer representative organisations:

- Carers Australia WA;
- Consumers of Mental Health WA;
- Mental Health Matters 2;
- Richmond Wellbeing;
- Western Australian Association for Mental Health;
- WA Network of Alcohol and Other Drug Agencies; and
- Young Carers WA.

System advisory and consultation groups or committees

- Co-Leadership Safety and Quality Mental Health Steering Group;
- System-wide Mental Health Policy and Planning Advisory Group;
- System-wide Mental Health Clinical Reference Group;
- PSOLIS Governance Committee;
- WA Child and Youth Health Network
- WA Mental Health Network Executive Advisory Group;
- WA Therapeutic Advisory Drug Advisory Committee; and
- WA Mental Health Interagency Forum;

Aboriginal focused service providers and representative groups:

- Aboriginal Health Council of WA;

Professional representative bodies;

- Australian Medical Association, WA;
- Australian College of Mental Health Nurses, WA;
- Australasian College of Emergency Medicine, WA;
- Royal Australian and New Zealand College of Psychiatrists, WA;
- WA Network of Alcohol and Other Drug Agencies; and
- WA Primary Health Alliance;

Public-Private providers

- St John of God Health Care;
- Ramsay Health Care;
- Royal Flying Doctors Service, WA; and
- St John Ambulance WA.

Not-for-profit and non-government organisations delivering public mental health services.

- St Bartholomew's House; and
- Association of Community Care Facilities.

Desktop Review

A desktop review was undertaken to collate pertinent information regarding:

- the formation of existing governance entities, frameworks and plans; and
- the current defined roles and responsibilities across the public mental health system.

Additionally, an interjurisdictional review was undertaken to conduct a comparative analysis of the WA mental health system in relation to other states in Australia.

Interviews

Formal and informal interviews took place between January and May 2019. Panel members conducted over 100 in-person interviews with stakeholder groups involved in or affected by clinical governance arrangements in the WA public mental health system. Key themes and outcomes from these meetings were provided to the full Panel throughout the Review for consideration.

Regional Consultation

Regional consultation for the Review took place during late April and early May 2019 in the following locations:

- Kalgoorlie (Goldfields region);
- Bunbury (Southwest region);
- Kununurra (East Kimberly region); and
- Karratha (Pilbara region).

Locations selected for consultation were identified based on need, in areas that showed higher rates of mental health occasions of service when compared to the State average.

Formal Submissions

Selected key stakeholder groups were invited to provide a formal submission to the Review. A total of 17 formal submissions were received, and a high-level analysis of the key themes and issues was provided to the Panel for consideration.

The Panel also acknowledges the contribution of the mental health governing agencies (the MHC, MHAS, MHT, OCP and HaDSCO) to the Review process, all of whom met with the Review on multiple occasions and provided supporting information as required.

Public Online Survey

The Review Citizen Space survey was available online from 1 March 2019 to 12 April 2019. The survey invited interested clinicians, consumers and carers, organisations and service providers to answer questions relating to the Review Terms of Reference, with the intent of informing the Review Panel on current issues with the clinical governance of mental health services in WA. Alternative formats were provided on request and a dedicated team member was available to consumers, carers and family members to take survey responses over the phone, to ensure accessibility to all stakeholders.

A total of 113 responses were received, comprised of 76 responses from employees of the WA Health System, private and/or not-for-profit organisations and service providers; and 37 responses from consumers, carers and family members. An analysis of the survey responses was undertaken and provided to the Panel.

Lived Experience Forum

The Lived Experience Forum, held on 29 April 2019 for the purposes of the Review, was a collaboration between the WA Association for Mental Health (WAAMH), Consumers of Mental Health WA (CoMHWA), Mental Health Matters 2, HelpingMinds, Carers WA and the Health Consumers Council. Funding was contributed by the Department of Health.

Participants were people with a lived experience of mental health challenges, accessing mental health services, and/or family members and friends in a supporting role for someone close to them living with a mental health issue. The forum was attended by 68 consumers and carers, and peer supporters and table facilitators from the collaborating organisations.

Participants were provided an opportunity to hear more about the Review, to gain an overview of the structure of the WA mental health system and to share their lived experience. Participants had a choice of providing feedback either by writing comments as a group, writing ideas on sticky notes individually, or completing a paper copy of the *Lived Experience Feedback Survey: Improving Safety and Quality of Mental Health Services*.

Acknowledgements

The Panel wishes to acknowledge those people with a lived experience of mental health, their carers and family members who generously shared their stories and provided input into the Review process. The Panel also recognises the many organisations and individuals across the public mental health sector who contributed their professional knowledge, insights and expertise.

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Minority opinion supplied by panel member Margaret Doherty of the Review of the Clinical Governance of Public Mental Health Services in Western Australia.

Margaret Doherty

Perth, Western Australia |

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Honourable Minister Roger Cook
Deputy Premier; Minister for Health; Mental Health
13th Floor,
Dumas House
2 Havelock Street
West Perth WA 6005

Dear Minister Cook,

Minority Opinion as a Panel Member of the Review of the Clinical Governance of Public Mental Health Services in Western Australia (the Review).

Thank you for the invitation and opportunity to provide a consumer and carer perspective as a Panel Member of the Review of the Clinical Governance of Public Mental Health Services in Western Australia (the Review).

Reason for the Minority Opinion

I write this Minority Opinion to highlight some significant concerns I hold regarding some of the processes of the Review, the end outcome of which is to provide independent advice to you to enable decisions to be made which will ensure that consumers and carers who use mental health and alcohol and other drug services in Western Australia consistently receive care which is contemporary, safe and of the highest possible quality. By its very nature, effective recovery-focussed mental healthcare requires strong, supported and diverse consumer and carer voices at all levels of decision-making, including in clinical governance processes.

It is also critical that frontline staff in particular are enabled to provide recovery-focussed care in workplaces that are free from bullying and where their work is supported by commissioning agencies, management and Boards who understand the concept and operationalisation of Recovery and the co-design and delivery of contemporary mental health and alcohol and other drug treatment and care as per the WA Mental Health and Alcohol and Other Drugs Services Plan 2015-2025 (the Plan).

I am aware that there is significant expectation and some concern in the sector about the outcomes of the Review and what that might mean in the commissioning, managing and delivery of recovery-focused mental health care in WA despite the Review being titled as focused on clinical governance. This was initially exacerbated by the lack of easily available information about the review, including the Terms of Reference and a lack of proactive early engagement with the agencies representing consumers and carers. These concerns also arise in the context of significant changes in the sector in recent years with the establishment of the Mental Health Commission (MHC) (2010), a new Mental Health Act (2014), amalgamation of the MHC and the Drug and Alcohol office (2015) and devolved governance with the establishment of Health Service Providers (HSPs) under the Health Services Act (2016) which saw the Department of Health (the Department) assume the role of System Manager. The context also includes significant national initiatives such as the establishment of Primary Health Networks and WAPHA (2015) and the ongoing roll-out of the National Disability Insurance Scheme (NDIS). Consumers, carers and clinicians have approached me directly to share their concerns and a common theme is that they are weary of reviews

and changes which do not directly contribute to core business – the experience or delivery of safe, quality mental health care.

A predetermined agenda that has influenced the process

My main concern is that a strong prevailing view about the perceived best outcome and this was present from the beginning and has continuously pervaded the review process. For me, this was evidenced by the very first comment made to me in my first meeting with the WA panel members that what we needed to do was 'get the money back into the Department of Health' (from the Mental Health Commission). I refuted that then and wondered how it was centrally related to the issue of clinical governance. I refute it now. The dogged pursuit of this outcome has, in my opinion, influenced the process of the Review, as an inordinate amount of time and energy has been spent on examining what is fundamentally a contract management issue rather than a core clinical governance issue. As a result, taxpayers' funds have not been well spent because this has meant the focus has been spent on pursuing an agenda much broader than clinical governance.

It is abundantly clear that by law, the HSPs have a statutory responsibility to address safety and quality across all of their services irrespective of contractual or structural reporting requirements. This was also repeatedly highlighted in the Mascie Taylor Report (2017)ⁱ. If the HSPs deliver a service, they are responsible for clinical governance in the first instance.

This focus on which agency (MHC or the Department) should hold the mental health funding and contract services has resulted in a disproportionate amount of time and energy being spent on developing and reviewing structural options. Structural options are undoubtedly an enabler of good clinical governance but are just that – *an* enabler, not *the* enabler. There are many other enablers such as culture (which consumers and carers continually cite as a key priority to be addressed), leadership, partnerships with a diversity of consumers and carers and their representative agencies which requires culturally secure policies and practices, quality improvement systems, environment and clinical performance and effectiveness. In WA, these need to be delivered within a recovery-focused approach in line with national and international standards and policies. This requires a shift away from the dominance of a narrow, bio-medical approach (as outlined in the 2017 UN Special Rapporteur Reportⁱⁱ).

Consumer and carer perspective

The consumer and carer perspective on the issue of structure is clear and has been consistent through consultations including those for the Plan, the Mental Health Act 2014 and more recently for the Sustainable Health Review. That position includes strengthening the role of the MHC and embedding meaningful lived experience input and leadership at all levels of decision making, the latter of which is in line with Sustainable Health Review (2019) recommendationsⁱⁱⁱ.

The MHC was established in 2010 partially to provide 'ring-fencing' to the mental health budget to stop it from being continually subsumed into general health. The raiding of mental health budgets by the Department to fund more acute health services in response to funding pressures was noted by in the 2018 Sustainable Health Review Interim Report^{iv}. The establishment of the MHC was also to enable the development of a contemporary, social model of mental health care which requires a balancing of the current system away from acute medical environments to community-managed options. It is likely that while this occurs, 'hump' funding may be required to support acute settings while an appropriate mix and quantity of community services is developed with an intention to make dollar savings in the medium / long term as well as, more importantly, enable people to recover their lives more quickly and effectively. This is particularly true for the cohort of people who, for a variety of reasons, find it difficult to identify or access suitable services and who have the distressing revolving-door experience of frequent Emergency Department presentations;

acute care (if admitted) with discharge to homelessness or a backpackers or perhaps ending up in prison which various reports have shown to be wholly deficient in the care of people with mental health issues. This is a group whose lives and care needs to be urgently prioritised.

In the view of consumers and carers, their voices have been supported and strengthened through the policies and practices of the MHC. However, this progress has not been mirrored consistently at the level required within public mental health clinical services, led up until 2016 by the Department and since then by the HSPs. During the time that the Department managed the MHC budget, the consumer and carer voice was managed from a medical rather than a social model of care perspective. There is still little or no evidence that the Department of Health embraces Recovery or person-centred mental health care and therefore, there is understandably little confidence in a social model of mental health being progressed under its leadership. In fact, there is grave concern that gains made to date in WA would be lost.

This is not to say that there are not areas of good practice led by progressive and caring clinicians and managers who reported during consultations that they are often carrying out this work in spite of the system in which they work, rather than because of it. There has not however, been a consistent strategy to understand or operationalise a genuine recovery-focus by the leadership of the Health Service Providers which is critical as their Boards hold ultimate responsibility for safety and quality. The Department of Health appears to have negated its role as System Manager in mental health which has led to lack of leadership and inconsistency in policy development, an unwillingness to hold HSPs to account and variations of experience of care across HSPs.

The submission by the Consumers of Mental Health WA and the WA Association for Mental Health therefore preferences a strengthening of the MHC's role to capture gains made and build on these for future progress and reform as well as to continue to advocate for lived experience input to meaningfully inform all levels of decision-making.

Resistance by the Department to actively engage in mutual discussions

There is no doubt that clinical input and leadership requires to be strengthened. There is little input from mental health clinicians at an executive level within HSPs nor within the Department. During the consultation, the MHC reported that the main barrier to the inclusion of clinicians in planning and designing mental health services were written directives from two Director Generals of Health (one while in an Acting position) precluding the MHC from contacting clinicians. This left the MHC in an impossible position with respect to clinical engagement and this action was not in the best interests of developing a recovery-focused mental health sector which requires clinical engagement, particularly in acute and community treatment settings. In the meantime, it would appear that the MHC has largely been blamed by other parties in the sector for the lack of clinical engagement in mental health without an understanding of this context.

The process of preparing the report

Another concern I have regarding process was the apparent sidelining of the Project Team whose role I had understood to include the recording of meetings through Minute-taking and distribution, drafting of the report and general Panel support. I have been supported by the team and commend the officers involved. However, there is no formal record of meetings via Minutes which means that there is no record of issues which have been consistently raised but left effectively unaddressed (such as bias in preferred outcome, questioning and report drafting). I understand that significant work has been put into preparing drafts however, the competent public servants employed to do so appear to have been largely marginal to this process. The drafts are often made available with insufficient time (24-48

hours over a weekend) for reading or detailed feedback or decision-making prior to important panel decision-making meetings. I have not been alone in consistently raising this issue over the distribution of essential paperwork, including the five drafts of the report.

An example is the fact that as I finalise this Minority Opinion at 10pm on Tuesday 30th July 2019, I have not yet received a copy of the final report for endorsement, which is due to you tomorrow (31st July 2019), following a one-month extension. Therefore, I am unaware if any or all of the amendments I have made to the most recent draft report and recommendations have been included in the final copy. I am also, therefore, unable to comment on the final report and recommendations.

While these administrative delays may seem unimportant, they may also be viewed as a strategy to curtail robust feedback, minimise the opportunity for detailed reading and response and frankly, wear people down as they navigate multiple copies of large draft documents and an unduly protracted process. The extension of the work has also resulted in panellists navigating the significant final part of the project while continuing with existing workloads and moving onto new financial year projects.

I am happy to discuss any of the issues mentioned if required.

Again, I thank you for the opportunity to be involved in this important piece of work which contains the possibility of strengthening the clinical governance and delivery of recovery-focused, person-centred, contemporary mental health services in Western Australia which can ultimately change and save lives.

Yours sincerely,



Margaret Doherty
30th July 2019

ⁱ Professor Hugo Mascie Taylor. (2017). *Review of Safety and Quality in the WA Health System*.

ⁱⁱ United Nations General Assembly Special Rapporteur. (2017). *Report on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*.

ⁱⁱⁱ Final Report to the Western Australian government. (2019). *Sustainable Health Review*.

^{iv} Interim Report to the Western Australian government. (2018). *Sustainable Health Review*.