Mental health and addiction quality improvement programme
New projects announcement 1 December 2017
Q&A

Q. What are the new projects being introduced by the Commission?

Two new national projects are being introduced to improve the quality and safety of mental health and addiction (MHA) services:

1. The *Pathways to Eliminate Seclusion by 2020* collaborative will be led by the Health Quality & Safety Commission and Te Pou o te Whakaaro Nui (Te Pou), with the goal of eliminating the use of seclusion in New Zealand.

2. The *Improving Service Transitions* initiative will support providers to achieve successful transitions for consumers of MHA services.

Q. How have the two new projects been chosen?

Stakeholder consultation began in 2016, to help identify the five priority action areas for the MHA sector. Further consultation with the sector, consumers and their families and whānau, took place in workshops around New Zealand during 2017, where attendees were able to share their experiences and learnings to help identify opportunities for making improvements in each area.

The information was then reviewed by the leadership group of the Commissions' MHA quality improvement programme and a project focus and approach was agreed. This process confirmed that improving service transitions and the elimination of seclusion was a priority for consumers, their families and whānau, and service providers in New Zealand.

Q. What are the issues with seclusion as a practice?

Seclusion is when someone is confined to a room, alone, for a period of time, from which they cannot independently exit. Globally there is evidence that seclusion causes harm to consumers who receive it. Seclusion events can traumatise, and for some consumers, it can trigger trauma and abuse experiences of the past.

Seclusion and restraint practices both impact 'participation'. The United Nations Convention on the Rights of Persons with Disabilities calls on governments to remove barriers to enable all people to participate fully in society. We believe consumers deserve care that is pain-free and without isolation, and that means the elimination of seclusion.

Q. How are Māori represented in seclusion statistics?

Māori are more likely to be secluded than non-Māori and are over-represented in other restrictive practices. For example, in 2015 Māori were 3.3 times more likely to be subject to an inpatient treatment order under the Mental Health Act (Ministry of Health 2016). Experts say a strong cultural response is needed to better meet the needs of Māori. This could include Māori peer support models, access to cultural advisors and culturally specific interventions.

Q. What has been happening to date to reduce the practice of seclusion by providers in New Zealand?

Since 2009, Te Pou has been focused on reducing the practice of seclusion. We acknowledge and welcome the 65 percent reduction in the use of seclusion that has been achieved to date, and a continued focus will assist in sustaining these reductions, and accelerating progress further, towards the elimination of seclusion.

Q. Why do providers use seclusion for people with MHA issues?

The main reasons cited by staff are concerns for consumer and staff safety. However, the programme will look at other strategies that will ensure consumer and staff safety, without needing to use seclusion.

Q. What about forensic services?

The New Zealand Forensic Services are expected to eliminate forensic night orders by 2022. This is consistent with respecting human rights under the United Nations Convention of the Rights of Persons with Disabilities. Efforts to eliminate seclusion in acute inpatient units would complement the efforts in forensic services.

Q. How will the new collaborative work to eliminate seclusion?

The Commission will work in partnership with Te Pou, the national KPI programme and DHBs to create a national collaborative from March 2018.

A collaborative approach using quality improvement methods will help clinicians, consumers and families and whānau, to share experiences and learnings with each other, and to design pathways of care that will help DHBs to eliminate seclusion.

A working group of subject matter experts will be set up to support the collaborative. New national networks will also help ensure that quality improvement methodology is well supported by sector leaders, that staff are equipped to deliver the methodology and that learnings are easily shared across DHBs. A strong focus will be on ensuring safer environments for consumers and staff.

Q. What strategies help reduce the use of seclusion?

There are several strategies that might support an organisation to reduce the practice of seclusion, whilst ensuring safety. For example, we know that organisational leadership plays a vital role in driving the culture change that is needed to reduce the practice of seclusion. Structured risk-assessments for each consumer, and effective staff communication, especially between shifts, are both factors that can support its reduction. The collaborative will look at how initiatives, such as these, can help DHBs to maximise their chances of achieving the elimination of seclusion aspirational goal.

Q. Will the reduction in seclusion just mean more people receive chemical restraint?

The use of seclusion is just one tool in a toolkit of strategies that providers can use to work with consumers with MHA issues. We will be looking at what other strategies providers can utilise, to help them ensure consumer safety, and creating pathways of care that minimise seclusion but maximise patient care. It's about ensuring the right course of action for each situation. As part of this we will be monitoring the impact of the programme on the use of both chemical and physical restraint, including rates of assault, so that we can directly see the impact the programme is having.

Q. How feasible is the aim of zero seclusion?

We appreciate that zero seclusion by 2020 is an ambitious goal, yet our collective aim is to have a consistent national approach, over the next two years, that will help us to achieve as close as we can to zero seclusion by that time.

Q. How are consumers being involved in the project?

We will involve consumers, their families and whānau at all levels of the planning and development process. Training sessions will be run in March 2018 and April 2019 to help providers work effectively with consumers and use their feedback to understand and improve their patient experience (also known as co-design). The Commission's national consumer engagement advisor will also be assisting providers through this process.

Improving Service Transitions

Q. Why is it important to improve service transitions?

A service transition is when a consumer has their care transferred between different health care providers and/or locations. For example, a consumer may be moved from a residential service to independent living with support, or from specialist services to the care of their GP. When somebody has extra health challenges then they may need to access other health providers and this will involve a transfer of care from their existing provider.

Service transitions are recognised as a potential risk to consumers, and their families and whānau, and we know that some serious adverse events are thought to be linked to a failed service transition, or lack of discharge planning.

Q. What is happening currently?

A recent Office for the Auditor General report highlighted a number of variations in the way that DHBs manage service transitions from inpatient to community services, and this impacts on consumers and their families and whānau (OAG, 2017).

We need to improve services to ensure that transitions are successful for consumers. The Ministry of Health is looking for DHBs to improve this practice. DHBs are now required to report against an annual target for transition plans including audits of quality.

Q. Which groups are particularly vulnerable during service transitions?

Different groups of people may be vulnerable in different ways. For example, transition between adolescent and adult MHA services occur at a particularly vulnerable time for consumers, because this coincides with the age of onset of many serious mental disorders.

Māori are more likely to be affected by poverty than Non-Māori and may be sent to addresses that do not provide adequate food, warmth, safety and shelter. These factors must be considered in discharge planning and effective planning, support and review processes are needed to ensure that providers meet the particular needs of Māori consumers.

Q How will the project work?

The Commission will begin work with stakeholders across the MHA sector from June 2018, to support a quality improvement approach to improving service transitions.

There will be an in-depth look at the many issues that affect service transitions, to help us identify the best approach.

Working closely with consumers and their families and whānau, will help us gain a richer understanding of the challenges consumers and providers face in this area and their input will help drive the programme design.

An evidence review is already underway to confirm what is known nationally and internationally on improving service transitions, and this information will also be shared with stakeholders.

We plan that the quality improvement work on transitions will involve a 'cluster' approach, which means that DHBs will collaborate on specific project initiatives that address their most significant transition issues.

Q. How will these new programmes help reduce the national suicide rate?

We know from reviews that some serious adverse events are thought to be linked to a failed service transition, and this may include events of suicide or self-harm. Supporting providers to improve service transitions will result in better quality and safety of care for consumers of MHA services.

Q. What is the Commission's MHA programme?

The Health Quality & Safety Commission is leading a five-year quality improvement programme to improve the quality and safety of mental health and addiction services.

Working in partnership with providers, consumers and their whānau and families, the programme will identify and implement quality improvement initiatives to improve the quality and safety of MHA services and build quality improvement capability in the sector. The programme is based on the successful Scottish Patient Safety Programme: Mental Health and work undertaken by the Institute for Healthcare Improvement.

The programme, which is funded by DHBs, will run for the next five years at a cost of around $7.5 million, with a review after three years. These are the first two projects to be announced by the MHA quality improvement group.

For more information about the programme visit the Commission's website.

References

Ministry of Health. 2016. *Office of the Director of Mental Health Annual Report 2015*. Wellington: Ministry of Health.

Office of the Auditor General (2017). Mental health: Effectiveness of the planning to discharge people from hospitals. https://oag.govt.nz/2017/mental-health