

**Clinical Accountability
Within The Mental Health Sector**

**The Results Of A Review
Conducted On Behalf Of The
Mental Health Commission**

March 1998



DISCLAIMER

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This is an important subject. It is hoped that the goodwill and generosity of the people who gave up their time to participate in “yet another review process” will be rewarded by the development of improved systems of clinical accountability within the mental health sector.

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(1) EXECUTIVE SUMMARY

Accountability within mental health services has been thrust to the forefront as an issue for the mental health sector over recent years, largely within the context of the move from institutional to community based care for people with serious mental illness. Very little information has been available regarding the range of issues seen as needing attention within the sector. This review of clinical accountability within mental health services has occurred as part of a wider process of information gathering undertaken by the Mental Health Commission to facilitate accurate strategic planning for the national development of mental health services.

A project team representative of the major stakeholder groups within mainstream mental health services was commissioned and given the brief to undertake a “snapshot” review of practice regarding clinical accountability, identify key issues which are highlighted during the review and make recommendations regarding developments which might be necessary to improve accountability of mental health services. In approaching its task, the project team soon realised that clinical accountability is an elusive concept, and that there is a lack of shared definition and of a framework for understanding both clinical accountability and the wider accountabilities within the health sector. A review of the literature regarding accountability in health services was thus undertaken. To canvas opinion within the range of stakeholder groups, two complementary questionnaires were developed – one for providers of services, and one for people receiving services (consumers and family members). These questionnaires were designed to be used in a semi-structured interview format, and sought respondents’ views regarding a range of issues and aspects of clinical accountability. Visits were then made to one urban and one rural health area in each region of New Zealand, and interviews conducted with the range of stakeholder groups of mental health services.

The literature review revealed that the lack of shared definitions and frameworks for understanding accountability in the health sector is a universal phenomenon, and a number of suggested frameworks and models were found in the literature. An excellent review of accountability in health care (1) outlined three components of accountability (Who – the locus of accountability, What – the domains of accountability, and How – the procedures of accountability), which interact to create a matrix of accountability. The three dominant models of accountability which prevail are then outlined – the professional model (which equates to clinical accountability), the economic model (the accountability of the market place), and the political model (the accountability of the political sphere). The fact that these models cannot readily be integrated and in fact may be in conflict with one another is highlighted. The three components of accountability suggested helped to frame the analysis of data, and have been used in reporting the findings and outlining the conclusions of the project.

The findings of the project affirmed the elusiveness of the concept of accountability, and the need for development of shared definitions and frameworks for understanding and debate within the sector. While there was a notable diversity of viewpoints and opinions expressed, a number of important trends were evident. It was apparent that while all services visited had some structures and processes to support accountable practice, there was significant variation in the extent to which these were developed, and how helpful and effective they were found to be by those working in and those using services. Overall it was clear that whilst all of the services visited had some systems in place to address issues of clinical accountability, there is a great need for development in this area, and for resolution of a number of important areas of differing opinion which are likely to compromise accountability of practice.

(1.2) KEY FINDINGS AND RECOMMENDATIONS

Key Findings–

- ◆ Clinical accountability is an elusive concept – there is no commonly held view regarding clinical accountability within the mental health sector
- ◆ Clinical accountability cannot be viewed in isolation without consideration of other factors such as managerial, economic and political accountability
- ◆ Most mental health sector staff interviewed expressed a desire to ensure that they themselves and the systems that they work in are accountable but many did not have a clear understanding of the boundaries of their own accountability
- ◆ Mental Health clinicians are feeling increasingly vulnerable in relation to issues of clinical accountability and often feel forced to practice in a defensive manner
- ◆ Clinicians experience conflict between the increasing demands for consumer empowerment and community safety
- ◆ Issues of leadership within the mental health sector remain unclear, with no one person or agency able to exert overall influence or positive direction.
- ◆ Resource issues impact on clinical practice and accountability

Recommendation 1 –

That a group representative of the major stakeholders in the mental health sector is convened to adapt the frameworks in the literature into a national model of accountability with the intent that this serve to clarify the reasonable accountabilities of all parties and assist the process of debate regarding issues in health sector accountability. This group should as part of its task seek to develop a “new set of rules” to assist the sector to resolve the tension in attempting to be accountable for provision of empowering but safe services.

Key Findings–

- ◆ Services where management was perceived as accessible, supportive and empowering had staff who had a broader view of accountability yet felt clearer and more comfortable with their own accountability
- ◆ The greater the lack of co-ordination between services accessed by an individual the greater the uncertainty regarding who holds accountability for service provision and outcomes
- ◆ A profile of service characteristics which support optimal clinical accountability was developed

Recommendation 2 –

That the profile of “optimal clinical accountability” outlined in section 7.3.8 of this report is circulated widely throughout the mental health sector and feedback sought as to the ways in which it can be further developed as a tool for helping to improve systems of (clinical) accountability within the mental health sector.

Key Findings–

- ◆ Providers' views of clinical accountability were generally focused on accountability to systems where as both consumers and families felt that there should be some accountability directly to them.
- ◆ Both Consumers and Families often had a great sense of responsibility with respect to their own actions
- ◆ Very few services have active consumer or family involvement in either service management or individual clinical care decision-making processes.

Recommendation 3–

That mechanisms are put in place to ensure consumer and family representation at all levels within the mental health sector particularly in relation to systems of clinical accountability.

Key Findings –

- ◆ Most people interviewed were unclear about the overall structure of accountability within the mental health sector
- ◆ There was general agreement across all stakeholder groups that there is a need for systems of accountability to be more explicit
- ◆ Systems for reporting concerns within the sector are often informal and are not made explicit to consumers and families
- ◆ Information regarding complaints and advocacy services is not always made available to consumers - those consumers who were aware of these services often did not have confidence that they could adequately address their needs.
- ◆ The statutory role of the DAMHS and Director of Mental Health require further clarification and definition

Recommendation 4 –

That mechanisms are developed to ensure that systems of clinical accountability are made explicit at all levels within the mental health sector, including:

- .. *Ensuring issues relating to clinical accountability are addressed within THA (HFA)service contracts*
- .. *Ensuring all mental health services have transparent and effective structures and processes to address issues of clinical accountability.*

Key Findings –

- ◆ This report does not address issues of accountability from a Maori perspective

Recommendation 5 –

That a separate review is undertaken to consider issues of clinical accountability from a Maori perspective.

Key Findings –

- ◆ Most CHE staff interviewed identified uncertainty regarding the roles and responsibilities within the multidisciplinary team as a key issue which required clarification. In particular there was a great deal of uncertainty relating to the accountability of the key worker/case manager in relation to the psychiatrist.

Recommendation 6 –

That consideration is given at a national level to clarification of accountability issues in relation to the specific issue of the roles and responsibilities within the multidisciplinary team, in particular the key worker/case manager in relation to the psychiatrist. Gathering key individuals to debate the issues in this regard would be a useful starting point.

Key Findings:

- ◆ Both consumers and families continue to experience the Mental Health Act being interpreted in such a way that people in need of assessment and treatment are denied it and families also experience the Privacy Act being used to exclude them from care processes

Recommendation 7

That a programme of “case -based” training in the interpretation of legislation relevant to the mental health sector be initiated and continued - in particular regarding the Mental Health and Privacy Acts - as a follow-on to the guidelines based training which has occurred up to the present.

(2) LANGUAGE

As with any report regarding an aspect of the mental health field, there is a need to clarify the use of language within this report. Where abbreviations are used, the full word/term is followed by the abbreviation in brackets, and this is repeated for every new section in which the abbreviation appears. The only abbreviations used are those which are in wide use within the sector.

Within this report the meaning of the following words/phrases is as described below –

Consumer – the word consumer is used to refer to **groups** of people who have issues of serious mental illness and use mental health services.

Client – the word client is used to refer to **individuals** who have issues of serious mental illness, and is used most often in the context of the individual person – individual provider relationship.

Receivers of services – this phrase is used to refer to all those who receive aspects of mental health services – **consumers and their families**.

Providers of services – this phrase is used to refer to all those who provide aspects of mental health services – Crown Health Enterprise (**CHE**) and Non-Government Organisation (**NGO**) **services**.

Multi-Disciplinary Team – a group comprising the full range of traditional mental health profession groups, who share the provision of a range of clinical services to an individual client and have processes for joint decision-making regarding the care provided. In most areas the multi-disciplinary team is the core of CHE clinical services

Non-doctor clinician - clinicians from the range of professional groups other than doctors e.g. psychologists, nurses, social workers, occupational therapists

Clinician - CHE clinical staff from all of the professional groups interviewed including doctors and “non doctor clinicians”

Case Manager - while this term is unsatisfactory, in that people with serious mental illness are not “cases” to be “managed”, it is used in this report in the absence of any widely used alternative which has the same shared meaning attributed to it. It is used in combination with the term **Key Worker** to recognise the fact that in many areas people who undertake a “case management” role have this title; however, the term “key worker” is used in a variety of other contexts, so cannot be used alone.

Clinical - within different service contexts in Mental Health Services, different meanings are ascribed to the term "clinical". These meanings range from narrower definitions relating to diagnosis and treatment (biological aspects of care), through to broader definitions encompassing the range of activity from diagnosis/treatment through to support (bio-psycho-social aspects of care). **For the purposes of this project, the broader definition is used.**

(3) INTRODUCTION

Health Services in New Zealand, as around the world, are increasingly being called on to be accountable for provision of "best care" within available resources. The people who work in these services are expected to be accountable to patients, as the receivers of services; professional bodies, as the regulators of standards; and to the community, as the funder of public services. Two particular trends over recent decades have contributed to this development. One has been the rise of "consumerism", with the resulting challenge to the paternalistic model of professional accountability, and increased involvement of "consumers" in defining health and well-being and in decision-making processes. The other has been the increasing dominance (within the health arena and the wider world) of the economic model of accountability, which among other changes has seen the administration and thus control of resources in health shift from senior health professionals to career managers, who may have limited background in the complexities of health service provision.

These changes are in stark contrast to the pre-existing ethos of "the professional knows best", and come at a time when health care is also increasingly subject to "rationing" processes in response to the rapid increase in costs of health care and the associated technology. Health Professionals increasingly talk of the tension which results between these forces - the demand to demonstrably provide "best care" in an accountable fashion on the one hand, and the perceived increasing inability to do so in the face of health resource constraints on the other.

Within the mental health sector there has been additional tension resulting from the increasing emphasis on human rights on the one hand and the community expectation for protection from acts of violence attributable to mental illness on the other. Given the low rate of acts of violence by people with mental illness, and the lack of any means to determine with certainty those people who will commit an act of major violence as a result of mental illness, these expectations are incompatible. Viewing the reports of both the media and formal enquiries regarding some of the very public disasters which have beset the field in recent years, it is hard to escape the conclusion that clinicians are struggling to resolve this conflict. This seems particularly true in the face of the at times competing needs of the three parties with most at stake - the consumer, the family and the community. Clearly all three parties feel that the sector is letting them down.

For mental health services, the "call to account" resulting from the above trends has come most often in response to these "disasters" - if one were to use the media as the means to make judgements about levels of accountable and quality practice in mental health services one could only conclude that these are abysmally low, and that Mental Health Professionals are largely intransigent in the face of numerous calls to address the problem.

While this is unlikely to be an accurate reflection of the situation, there is in fact very little information available about how well mental health services in this country perform in maintaining adequate levels of accountable practice, what is working well in this regard, what "best practice" exists, and what issues and problems are perceived. The project team are aware of only one (as yet unpublished) New Zealand study, conducted shortly after the introduction of the 1992 Mental Health Act, which sought the views of a range of mental health professionals and managers regarding accountability issues.

Looking to national guideline and policy documents, and the various enquiry and commission reports available, it is apparent that there are a number of key documents which highlight issues and establish expected standards which are of relevance to any consideration of clinical accountability. These documents in general come from the Ministry of Health, and include the Guidelines to the use of the Mental Health Act, the Discharge Planning Guidelines, the “Mason Report”, the National Mental Health Standards, and the National Acuity Review. The National Acuity Review, which is the most recent of these, documents the lack of progress in implementing the Discharge Guidelines, which were published in 1993 – highlighting that there is a gap between established standards of practice, and actual practice in the sector. There is however no document which devotes specific attention to the issue of accountability in the mental health sector

This project was thus commissioned as part of a broader information gathering process which the Mental Health Commission has undertaken over the first year of its tenure. The project was undertaken by a team (Appendix I) recruited by the Commission to seek information regarding clinical accountability within the mental health sector. Terms of reference (Appendix II) were developed during the initial period of the team thinking through how to best approach the task of gathering information regarding this important subject.

In approaching its task the project team rapidly reached the realisation that accountability is an elusive concept. There is no commonly accepted definition within the sector despite the widespread use of the word, and there is no shared model or framework for discussion and debate of issues regarding accountability. There was thus a need to look to the available literature for guidance in this regard – in particular to find some model or framework to inform both the project, and any future debate and development regarding accountability processes in the sector

This report summarises the aims of the project, the methodology used to obtain information from the literature and the range of stakeholders of mental health services, and then presents the findings. Conclusions are drawn from these findings, and a set of recommendations made.

(4) AIMS

The aims of the project were as follows -

- ◆ To review the international psychiatric literature regarding clinical accountability
- ◆ To conduct an initial “snapshot” review of practices, viewpoints, and expectations of different stakeholders within the mental health sector in relation to clinical accountability
- ◆ To develop a written report which summarises the major themes and issues raised in the course of this review
- ◆ To develop a set of recommendations regarding development of clinical accountability processes and procedures nationally

(5) METHOD

In approaching the task of developing a methodology for the project, it was apparent that aspects of qualitative research methodology were ideally suited to this exercise. It was decided to conduct either individual or focus-group interviews, and to use open-ended questions to elicit views about a range of issues related to clinical accountability. The major themes could then be extracted and form the basis of a report and recommendations. The resources available to undertake the project did not allow for any formal qualitative analysis of data; individual team members would need to rely on a process of summarising the main findings of each set of interviews, and compiling these into an overall summary of important issues. Following the interview phase of the project the group could then compare and contrast individuals' findings, and develop the major themes and areas of difference as a result of this process.

Two complementary questionnaire formats were thus developed – one for providers of services, and one for people receiving services (consumers and family members). The provider format of the questionnaire included the addition of a number of clinical scenarios, and a rating-ranking exercise regarding the weighting given to safety, empowerment, and service integration issues in decision-making processes. Both versions of the questionnaire are contained in appendix III.

Stakeholder groups consulted were mental health consumers, family members, Crown Health Enterprise (CHE) and Non-Government Organisation (NGO) providers of mental health services, the four Transitional Health Authority regional Mental Health Managers, and the Ministry of Health Mental Health Directorate.

Interviews were conducted in eight CHE areas; one urban and one rural in each region.

Individual interviews were conducted with –

- 22 Psychiatrists (including area Clinical Directors, and the Ministry of Health Mental Health Directorate)
- 17 Non-Doctor Clinicians
- 8 CHE Mental Health Managers

Group interviews were conducted with –

- 60 NGO Staff – in 15 groups
- 4 THA Regional Mental Health Managers – each of whom filled out individual questionnaires later; 3 were returned

Focus group interviews were conducted with –

- 89 Consumers – in 18 groups
- 46 Family Members – in 8 groups

A detailed outline of the methodology, including the processes used to develop the questionnaires, who was interviewed, and the methods of data analysis are included in Appendix IV.

Limitations of the Methodology

A number of important limitations in the process used need to be acknowledged. First, and perhaps most importantly, clinical accountability is a Pakeha/Western concept, and as such relatively meaningless from a Maori perspective which encompasses a different set of philosophical constructs for health care and thus a different set of accountabilities. This project has explored the mainstream aspects of accountability, and while Kaupapa Maori Trusts, Maori Mental Health Workers, and other Mental Health Professionals who are Maori have been interviewed, this report does not address issues of accountability from a Maori perspective. However, given the uniformly poor outcome for Maori with serious mental illness (particularly when treated by mainstream services), this is a very important area, and the project team were of the strong opinion that consideration should be given to addressing this in a future project.

Similarly, Pacific Island Peoples were not well represented in the review process, this report therefore does not address the views and beliefs of Pacific Island Peoples with respect to clinical accountability.

Available time and resources limited the capacity of the project team to ensure a truly representative view was obtained – both in terms of the number of services which could be visited, and the number of people interviewed within each service. Provider staff interviewed were nominated by the service manager (though with clear instructions to ensure reasonable representation). The NGO groups interviewed were comprised mostly of Managers and Team Leaders (we had asked to interview a “group of staff”); the NGO view obtained may have thus been biased towards positive accounts. Family interviews (conducted in a focus group format) were arranged through local family support/advocacy groups and as such may not have been representative of the range of views. Likewise, most consumer interviews were arranged through local consumer groups, though in some cases (in rural areas) there was no consumer organisation and consumer groups were arranged through provider-run services. The consumer and family groups were thus highly “self-selected” which may have resulted in bias. However, within these limitations the project team attempted to ensure that they did gain a representative view, and in some instances return visits were arranged to interview further individuals in provider organisations.

(6) LITERATURE REVIEW

A review of the international literature was conducted by undertaking a search of the Medline, Psychlit, and Cochrane Library Databases from the last 10 years, using the search terms “clinical”, “accountability”, and “mental health services”. A modest number of references were found, most addressing issues of accountability in relation to Managed Care approaches in the United States. Few of these were of any relevance to this project. It was also notable that most focused on more organisational aspects of accountability, few on accountability to consumers of services – references regarding consumer perspectives on accountability were thus separately sought. In addition, the literature search did not identify many references relating to specific topic areas of relevance to clinical accountability – for instance peer review processes or consumer satisfaction surveys – so references regarding these areas were also separately sought.

Within this literature, accountability is defined as "...about individuals who are responsible for a set of activities and for explaining or being answerable for their actions. Accountability therefore entails procedures and processes by which one party provides a justification and is held responsible for its actions by another party that has an interest in the actions" (1). Clinical accountability is thus where the focus of the "activities" is on delivery of clinical services to another individual.

Accountability has become a major issue in health care, with development of adequate accountability processes and procedures having been a considerable focus of activity in the US since the early 1970's, but within the Australasian health arena only over the past 8 to 10 years (2). In the US, this activity has paralleled the development of Managed Care approaches, and contributed to much of the controversy surrounding Managed Care: "...much of the conflict surrounding managed care plans can be viewed as a debate about what constitutes the appropriate form of accountability for them" (3). This controversy is nevertheless along similar lines to those debated locally - who are the parties in health care that can be held accountable, what can they be held accountable for, to whom are they accountable, and what are the appropriate mechanisms for accountability in health care.

In an excellent review of accountability in health care, Emanuel and Emanuel (1,4) outline three components of accountability (Who - the locus of accountability, What - the domains of accountability, and How - the procedures of accountability), which exist within a matrix of accountability ("the different parties that interact on matters of accountability over many different domains and mechanisms create...a complex matrix of accountability"). They proceed to outline the three dominant models of accountability - the professional model (which equates to "clinical accountability"), the economic model (the accountability of the marketplace applied to health care), and the political model (the mechanisms of accountability found in the political sphere adapted to health care).

These models, in their view, cannot readily be integrated, and may actually undermine each other - a factor which could be readily seen as relevant in terms of the current stage of the New Zealand health reforms. As an example, the professional model relies on trust, collaboration, and shared interest between the health care provider and the client, based on the premise that the provider should be motivated to improve the client's well-being. This is incompatible with the focus of the economic model on maximising financial success as the provider's primary motivating force and on the hope that market forces - the need to retain and attract consumers - will ensure high quality.

In the face of the increasingly complex and expensive nature of modern health care, all three models offer important parts of the solution while none is a solution in it's own right - the authors in fact state their view that attempting to apply one model of accountability to all of health care would be a mistake with "devastating implications". While rationing and identification of "best value for money" are a necessary part of modern health care, consumers and the community seem to be clearly saying they value health care primarily as a "non-market good" indicating that the economic model of accountability is inappropriate at the level of those directly involved in clinical activity - the provider, client, and family.

When viewed in this way, it is clear that while the scope of this project has been restricted to Clinical Accountability, it is important to view this one aspect of health service accountability in the broader context of the other accountabilities which exist in the health arena, and of the three models outlined above. The authors present a stratified model of accountability in which different types of accountability govern different interactions - with professional (clinical) accountability within the provider-client relationship "nested" within economic and political strata of accountability. They configure the model around the managed care/integrated care network approach which prevails in the US, but it could readily be modified to the NZ situation.

In the editorial to a recent issue of the managed care industry journal "Behavioural Healthcare Tomorrow" devoted to the issue of accountability, Freeman (5) states "To make accountability a meaningful objective for the entire system – not only providers – all parties in the equation must be accountable to one another for their fair share and not 'toss the hot potato' of responsibility and blame to someone else". He goes on to outline a "road map to build a shared quality and accountability framework for (the) field" comprised of levels of accountability for the various parties, which is similar to the stratified model suggested by Emanuel and Emanuel, and is also relevant to the NZ situation. Of note, he suggests that all parties in this framework can hold other parties accountable as well as be held accountable for their activities; and that this should apply to consumers, who must be "...held accountable for understanding and managing their own behavioural health risks".

In reviewing the literature regarding consumer perspectives of accountability it is apparent that there is a need for an increased sophistication of thinking and shared models in this arena also. Particularly in the mental health field, there is increasing recognition of the importance of consumer choice, participation in decision-making processes, and empowerment as aspects of ethical and accountable practice. However parallel to this has been the increasing expectation that the mental health system in general and psychiatrists in particular should be able to prevent adverse outcomes such as suicide and violence. Undoubtedly quality services can and do prevent many such events, but equally cannot prevent all. A number of important questions are increasingly challenging traditional views within the sector regarding ethical and accountable practice – Does consumer choice always supercede other considerations? At what point is individual choice superceded by prevailing community standards and the need for social regulation? What is the responsibility of the mental health system when consumer choice results in tangible reduction in safety for the consumer or the community? How is consumer preference reconciled with conflicting family needs? In considering such questions, Curtis and Hodge (6) have proposed that a new set of rules and models of thinking need to be developed to guide mental health practice within an environment which increasingly recognises the importance of true accountability to consumers.

Regarding specific topic areas relating to accountability, two tools which are often used in development of systems of clinical accountability are peer review processes, and consumer satisfaction surveys. In a local paper reporting a survey of group peer review (2), the author concludes "it is clear that group peer review significantly contributes to professional accountability for participants, when the review is conducted within a well-functioning group after establishment of sufficient trust through the repeated exposure of complex and difficult clinical issues. Participation can be expected to have a ripple effect on the broader body (of professionals), raising general awareness of appropriate professional standards and clarifying the boundaries of acceptable practice".

In a review of the literature on use of consumer satisfaction instruments in the mental health field, Ruggeri (7) concluded “the original motivation behind satisfaction surveys was to introduce an element of consumerism and accountability to healthcare. However, through high levels of relatively meaningless expressions of satisfaction an illusion of consumerism is created which seldom does anything but endorse the status quo”. While in a separate review (8) the opposite view is expressed with reservations – that progress can be made by developing and spreading the use of validated instruments and discouraging the use of other measures – it is clear that the usefulness of consumer satisfaction surveys is somewhat controversial, and that further work is required in this area.

In considering the New Zealand situation in the light of this literature, it is clear that there is a need to develop among the range of stakeholder groups and levels of organisation within the Mental Health Sector shared definitions and models of accountability. This will allow for informed debate regarding the issues, assist in the development of robust processes and procedures to allow the building of a “shared quality and accountability framework” as described by Freeman (5), and allow the sector to move beyond the current situation where most parties respond to any challenges to their accountability by “tossing the hot potato of responsibility and blame to someone else” Such a framework would also assist the process of shared attempts to find accountable solutions to the human rights - community safety dilemma.

(7.0) FINDINGS

The findings of this project are outlined using the framework of accountability outlined by Emanuel and Emanuel (1,4). That is:

**“WHAT - the domains of accountability
WHO - the locus of accountability
HOW - the systems of accountability”**

(7.1) WHAT IS CLINICAL ACCOUNTABILITY?

The key issues identified in this section are:

- **Clinical accountability is an elusive concept - there is no commonly held view regarding clinical accountability within the mental health sector.**
- **Providers' views of clinical accountability were generally focused on accountability to systems whereas both consumers and families inferred that there should be some accountability directly to them.**
- **Clinical Accountability can not be viewed in isolation without consideration of other factors such as managerial, economic and political accountability.**

It was evident from the responses received that there is no commonly held view of clinical accountability within the mental health sector. Most people had difficulty answering the question “what is clinical accountability” and those that gave a clear definition of the concept tended to view clinical accountability from a narrow perspective without reference to the varying layers and complexities which were highlighted by others.

All of the groups highlighted the difficulty of considering the concept of clinical accountability in isolation from broader issues of accountability such as the accountability of managers, funders and politicians. For most people a lack of clarity regarding the boundaries between clinical accountability and these other spheres of accountability made it difficult for them to clearly define clinical accountability.

The results showed significant variation in the way that clinical accountability was interpreted both within and across the different stakeholders groups. The major differences in this area were that the provider perception of clinical accountability was focused on accountability to systems whereas consumers and families inferred that there should be some accountability to them.

There were also differences within groups. Crown Health Enterprise (CHE) clinicians varied from having narrow definitions of clinical accountability which related purely to safety to broader viewpoints which encompassed issues of competence, legal and ethical conduct.

Whilst there was no correlation between the level of seniority of clinicians and their ability to provide clear and detailed responses to this and other questions, there was some evidence that clinicians in the organisations where there was clear leadership and effective working relationships between managers and clinicians were those who were able to discuss the concepts with greater depth and clarity.

The Non government Organisation (NGO) group also varied in their ability to provide clear and detailed definitions of clinical accountability. In this instance it was the people who worked in organisations which provided a broader range of services who appeared to have spent the most time considering the issues relating to accountability and consequently were able to give more detailed responses.

Consumers' definitions of accountability included the need for clinicians to be accountable for providing effective treatment and also for the way they interacted with their clients. For consumers whose family were involved in their treatment the issue of how the clinician interacted with the family was also important. However few CHE clinicians spoke of having any sense of accountability to consumers. Most clinicians related clinical accountability to organisational and professional accountabilities i.e. they were accountable for their actions regarding consumers but the accountability was to their organisation or professional body not to the consumers themselves. Amongst NGO staff approximately half believed they had some accountability to consumers. For consumers, clinicians being accountable to them was seen as important because so much of the treatment is on a one to one basis.

Families linked clinical accountability to effective treatment, sound decision making and a presumption of overall responsibility for clinical outcomes experienced by the family member with mental illness. Families expressed the view that the best possible treatment could only happen when families were consulted and involved in the decision making process. Most often they linked accountability to the role of the doctor and in many cases felt that doctors failed to deliver in terms of the level of clinical accountability expected by family groups.

(7.2) WHO IS ACCOUNTABLE

The key issues identified in this section are:

- ◆ **Most staff interviewed expressed a desire to ensure that they themselves and the systems that they work in are accountable but many did not have a clear understanding of the boundaries of their own accountability**
- ◆ **The greater the lack of co-ordination between services accessed by an individual, the greater the uncertainty regarding who holds accountability for service provision and outcomes**
- ◆ **Both Consumers and Families often had a great sense of responsibility with respect to their own actions**
- ◆ **Most CHE staff interviewed identified uncertainty regarding roles and responsibilities within the multidisciplinary team as a key issue which required clarification. In particular there was a great deal of uncertainty relating to the accountabilities of the key worker/case manager in relation to the psychiatrist.**
- ◆ **The statutory roles of the DAMHS and Director of Mental Health require further clarification and definition.**
- ◆ **Issues of leadership within the mental health sector remain unclear, with no one person or agency able to exert overall influence or positive direction.**

(7.2.1) Who Is Accountable Within and Across Services?

All of the staff interviewed expressed a desire to ensure that they as individuals and the systems they work in are accountable for the outcomes of their actions. However, many did not have a clear understanding of what they were accountable for, and the boundaries of that accountability. Consumers also expressed the belief that they too needed to be accountable and responsible for their individual actions. However many felt that inadequacies within current systems results in consumers being left to “shoulder” more than their fair share of responsibility.

Whilst all of the CHE and NGO staff acknowledged that they were responsible for their own actions there were a variety of opinions expressed regarding who holds accountability with respect to the overall outcomes for consumers, with many people unclear about this issue.

Within CHE services the most noticeable differences were in relation to roles and responsibilities within the multidisciplinary team. Most psychiatrists felt that they had some degree of overall accountability for the provision of clinical practice within their service. This ranged from the more traditional viewpoint where individuals felt they were accountable for all aspects of clinical decision making in the service to those who felt that whilst all health professionals were accountable for their own practice they as the psychiatrist held overall accountability for clinical outcomes for consumers. There were however psychiatrists who were adamant that they could only be accountable for their own actions, and could hold no accountability for the actions of others involved in the care of their clients, or for outcomes for clients. In general these were individuals who felt unsupported by the systems in which they worked, and acknowledged having adopted an increasingly defensive approach to their practice, and narrow definition of what they were responsible for.

These views were in contrast to those expressed by most of the “non-doctor clinicians”, the majority of whom believed that they were responsible and accountable for the clinical decisions which they made, including decisions about when to consult with other members of the multidisciplinary team. In organisations where there was a well defined key worker or case management system most of the “non-doctors” believed that the key worker/case manager held overall accountability with respect to outcomes for individual consumers.

Often there was an awareness of the differences in perception but there had been little debate or attempt to resolve these differences. Most CHE staff interviewed identified uncertainty regarding accountability within the multidisciplinary team as a key issue which required clarification.

Variations also occurred in opinions expressed by CHE staff regarding who was accountable for outcomes for consumers who used more than one CHE mental health service e.g. inpatient, crisis, and other community services. In some CHE’s the key worker/case manager was clearly identified as the person who held “overall accountability”, this was particularly so in instances where the key worker/case manager role was both clearly defined and transcended service boundaries i.e. the key worker/case manager was involved in treatment planning decisions across the range of services that an individual accessed.

In other CHE’s there was little or no co-ordination between services with staff unsure about who held overall accountability for consumer outcomes. In some areas people were discharged from inpatient units and had to wait several weeks before an appointment could be offered at the community service. The staff in these areas were not able to identify who was responsible for what happened to that person in the interim period or who held overall accountability for the outcomes. This confusion about “who is accountable” was even more marked in small rural areas which relied upon larger neighbouring CHE’s to provide some of the services to the area. Often the rural CHE felt that they were left to account for decisions made by clinicians in another organisation.

The majority of CHE mental health managers gave a clear account of what they believed they were accountable for. In most instances they described themselves as being accountable for ensuring that the “tools and systems” were in place to enable clinicians to do their job. Thus whilst they accepted that they held overall accountability for the services which were delivered, they also saw individual clinicians as having to be accountable for their day to day decision making in relation to the provision of services to individuals.

Clinicians were not always clear regarding the roles and responsibilities of managers and clinical directors. In general the greater the degree of restructuring which had occurred within a CHE the greater the staff were confused regarding who was accountable for what. In areas where psychiatrists felt unsupported by management, they tended to define their own accountability narrowly; and as outlined above described a greater tendency to practice defensively, and to resist any sense of being accountable for the actions of others or for any overview of other’s contribution to care provision.

When responses to the clinical scenarios were compared to responses to the questions, it was apparent that staff who perceived management as accessible and helpful tended to feel accountability was able to be appropriately shared; those who perceived management as distant/unhelpful felt clinicians held full accountability but shouldn’t - highlighting the impact of management style on accountable practice.

A number of clinicians stated the view that within mental health services no one has direct accountability and power/mandate to establish and ensure standards of care and “best care” - mental health services are full of people and bodies with advisory roles but no power to directly influence practice. The only real power is the retrospective disciplinary powers of professional bodies and the courts. No one is able to exert overall influence and positive direction only to weed out those practising below a (somewhat arbitrarily defined) minimum standard.

All NGO staff interviewed believed that they were accountable for their own actions in providing support services to individuals, with the CEO’s of organisations having the overall accountability for the quality of service provision. Those NGO services which developed individual development plans in partnership with consumers often used these to identify the boundaries of accountability.

There were differences in the way in which NGO staff viewed their accountability outside of the support role, with some believing that they were responsible for monitoring clinical issues such as whether or not clients were taking their medications and others believing that they had no responsibility in this respect.

NGO staff often felt that they were placed in the position of having to accept “defacto responsibility” for treatments and support in instances where CHE clinical services were unable to respond to a consumers needs. Whilst they did not feel professionally accountable for any negative events that may result they felt morally responsible for any consequences which arose from not being able to access appropriate treatment on behalf of the client. In contrast CHE staff often saw NGO staff as much less likely to be held accountable. A number of CHE clinicians commented that there is no organisation or professional body regulating the NGO sector.

Consumers expressed a strong sense of personal responsibility with a number commenting that the fluctuating nature of mental illness meant that a person’s sense of their own responsibility could vary. As one person described “it is part of the illness that you do not realise your own responsibility”. The process of recovery was seen to be about “realising your own responsibilities and taking ownership”.

The types of things that consumers believed they were responsible for included:

- ◆ building partnerships with clinicians
- ◆ seeking treatment and support when needed
- ◆ actively participating in treatment and support processes
- ◆ trying to gain an understanding of what precipitates illness
- ◆ respecting other people, including clinicians, family and other consumers

Equally, families expressed a great sense of their own responsibility both in terms of their relationship with service providers and with the family member. A number of family members believed that they had a responsibility to “do what ever it takes” they clearly saw that the “buck stopped” with them.

The types of things that family members felt responsible for included:

- ◆ developing good communication with clinicians
- ◆ keeping the family intact
- ◆ seeking information
- ◆ building support networks for themselves and their family member
- ◆ co-ordination across services
- ◆ to be well informed with respect to monitoring the course of illness/ wellness
- ◆ to advocate on the family member's behalf

For some CHE clinicians there was a perceived tension between consumer empowerment, and safety issues, with clinicians concerned about where to draw the line between consumer responsibility for decision making and safety. This raised a number of questions for clinicians about “who is accountable” for the consequences of decisions which have been made by consumers.

The Transitional Health Authority (THA) respondents divided their roles and responsibilities with respect to clinical accountability into three main areas. These were:

- ◆ to ensure that the services they fund have sufficient resources to provide the level of skill and competence required to meet contractual responsibilities
- ◆ to clearly specify services
- ◆ to monitor the effectiveness of systems of clinical accountability within services

The THA view regarding the boundaries of accountability between themselves and the Ministry of Health was that the Ministry was responsible for setting policy and guidelines for practice and the THA was responsible for funding and monitoring services according to those guidelines. This view was consistent with that of the Ministry of Health Mental Health Directorate, who saw their overall role as being one of policy development and promulgation. However, the issue of leadership within the sector was also raised as an expected role of the Directorate; their clear view was that while provision of leadership “through influence and credibility” was clearly a Directorate role, this had to be exercised in a way that was compatible with the prevailing Government policy direction of “hands-off” decentralisation. Thus, while seeing some level of “hands-on” control as being desirable, the extent of this needed to be limited. The issue of the continuum of view about this important issue was also raised, with the Mason Report reflecting the “hands-on” position, Government policy reflecting the “hands-off” position, and the Mental Health Commission and Directorate lying between.

(7.2.2) The Mental Health Act

With respect to the Mental Health Act, in general clinicians believed that responsibilities were clearly defined within the act, and that it provided greater clarity about who was accountable and what they were accountable for than was evident for people who were not “under the act”. The overall view of clinicians was that apart from some fine tuning the act is a workable piece of legislation, and that initial difficulties with interpretation have now been resolved. This opinion was somewhat contradicted by the consumer and family perspectives, which were that the act is still being interpreted in such a way that people who need assessment and treatment are sometimes denied it. The irony that “people subject to the Mental Health Act have better protection of their rights than those who are not” was also highlighted by a number of consumers and family members.

Several issues pertaining to statutory roles defined within the Mental Health Act were commented on. The first of these was regarding the Duly Authorised Officer (DAO) function. Some DAO's felt that at times there was a conflict between their function in relation to the Mental Health Act and their role as a health professional. This was seen as a particular problem where clinicians were required to perform their DAO role in relation to people with whom they had an ongoing professional relationship e.g. they were their key worker. For some exercising their obligations as a DAO had a detrimental impact on their capacity to maintain good rapport and trust with clients. This concern was not supported by consumers who most often expressed a desire to have someone familiar to them involved with Mental Health Act assessments because of concerns regarding "rapid decisions being made by someone who did not know you".

The other issue raised by all groups was the need to clarify the roles and responsibilities of crisis workers who were also DAO's. In some areas these people viewed their DAO function as their primary role, therefore they saw the limit of their responsibilities as deciding whether or not someone required further assessment or treatment under the Mental Health Act. This was at times causing people to be denied crisis intervention because they were not "committable". Who was accountable in these situations was not clear to consumers, families or clinicians.

The responses to the questionnaire indicated that clinicians believed the role of the "responsible clinician" to be clearly defined and agreed, however the comments made in relation to the clinical scenarios indicate that the clear statutory accountability of the responsible clinician when a person is on a Compulsory Treatment Order is not fully understood across the sector.

An issue which drew comment from clinicians in senior positions was that of the powers and accountability incumbent in the roles of Director of Area Mental Health Services (DAMHS) and the Director of Mental Health (DMH). While the powers and accountability of the Duly Authorised Officer (DAO) and Responsible Clinician are clearly defined in the act, it was felt that the lines of accountability stop there and that accountability beyond that point was an "unsatisfactory mess". The DAMHS and DMH were described as having minimal authority to ensure standards or influence practice – one person described the roles as "all responsibility, no ability". These concerns were much more evident amongst people in senior roles, most others perceived the powers of the DAMHS and DMH to be clearly defined. Clinicians in general saw the DAMHS and DMH as having overall accountability in relation to the Mental Health Act, most felt this was the one area where accountability was clearly defined.

These views were echoed by the Mental Health Directorate, who felt that the statutory roles needed to be clarified "one way or the other". The view was expressed that "...as outlined in the Taggart Report, the accountability process for DAMHS needs clarifying and strengthening...".

(7.3) _HOW DO SYSTEMS OF CLINICAL ACCOUNTABILITY WORK

The key issues identified in this section are:

- ◆ Most people interviewed were unclear about the overall structure of accountability within the mental health sector
- ◆ Very few services have active consumer or family involvement in either service management or individual clinical care decision-making processes
- ◆ Mental Health clinicians are feeling increasingly vulnerable in relation to issues of clinical accountability and often feel forced to practice in a defensive manner
- ◆ Clinicians experience conflict between the increasing demands for consumer empowerment and community safety
- ◆ There was general agreement across all stakeholder groups that there is a need for systems of accountability to be more explicit
- ◆ Services where management was perceived as accessible, supportive and empowering had staff who had a broader view of accountability yet felt clearer and more comfortable with their own accountability
- ◆ Information regarding complaints and advocacy services is not always made available to consumers - those consumers who were aware of these services often did not have confidence that they could adequately address their needs.
- ◆ Both consumers and families continue to experience the Mental Health Act being interpreted in such a way that people in need of assessment and treatment are denied it and families also experience the Privacy Act being used to exclude them from care processes
- ◆ Systems for reporting concerns are often informal and are not made explicit to consumers or families
- ◆ Resource issues impact on clinical practice and accountability

(7.3.1) What Structures are in place to ensure Clinical Accountability

There was a general lack of clarity across all stakeholder groups regarding the overall structure of accountability within the mental health sector. In particular people were unsure of the boundaries of accountability between organisations such as the MOH, THA and providers of services.

This lack of clarity regarding overall accountability within the mental health sector lead clinicians to feel increasingly vulnerable regarding what they could be held accountable for. Whilst all of the clinicians interviewed accepted a need to be accountable for their actions many felt that increasingly they were being held to account for inadequacies within the mental health sector as a whole. As a result of this a significant number of clinicians reported that they felt forced into a mode of “defensive practice”. Thus their clinical decisions were becoming increasingly conservative and were based more on a need to “cover themselves” than to meet consumers’ needs.

Consumers felt frustrated with what they described as a current lack of effective accountability mechanisms and the reluctance of the sector to address this issue, particularly in terms of determining “which agency in the sector is accountable for what”. This frustration was not just with service providers but also included the THA, MOH and government.

Most commonly families did not understand the relative roles of the Minister, Ministry of Health, the Mental Health Commission or the THA relative to the CHE's. They therefore tended to use a broad brush approach to getting their issues heard and would send letters to all positions of perceived influence within and outside the mental health system.

Most CHE's were able to provide an organisational chart which identified the lines of accountability within their mental health service. Whilst most CHE managers and senior clinicians thought that the lines of accountability within their organisation were clearly understood by all staff a number of the clinicians were either unsure of what the actual lines of accountability were or had a different interpretation of them from those who were in senior positions within their organisation.

A variety of management structures were in place within CHE services. At either end of the spectrum were models of management that were solely manager or clinician lead. Other services had a partnership model with a General Manager and Clinical Director having overlapping but shared accountability for service provision. In some services this manager - clinician partnership was mirrored at all levels of service delivery. It was in the organisations where there was evidence of a strong partnership between clinicians and managers at all levels throughout the service that clinicians were most clear about the lines and structures of accountability within the service.

A number of the CHE services visited had either just restructured their services or were in the process of doing so, some were restructuring for the second or third time in as many years. The greater the degree of restructuring which had occurred the less clear staff were regarding the lines and systems of accountability.

Most NGO managers reported that their service had clear lines of accountability with set structures. These structures were somewhat ordained by the Deeds of Trust under which NGO's operated. Frequently the CEO's identified themselves as having the overall accountability and not their Board of Trustees. Representatives from Boards of Trustees were not interviewed and it is therefore not possible to comment on whether or not their views concurred with this opinion.

Most often consumers had not been informed of the lines of accountability or the structures in place to address issues of clinical accountability within the organisations that they were in contact with. Only one of the eighteen groups interviewed had any knowledge of the organisational structure or lines of accountability within their services, this group were consumer representatives who had been informed of these issues during their training. There was a strong view amongst those working as consumer representatives within services or on consumer advisory boards that their presence helped to keep "systems honest" and thus increase accountability. This was echoed by one clinician who stated "accountability is intrinsic in services which are truly consumer focused".

Family Members often felt frustrated by the lack of information available to them regarding the structure and function of the organisations which they had contact with. Many felt that their frustration would be lessened if clear information about the roles and responsibilities of staff involved with their family members care was readily accessible at all points of contact with mental health services. Suggestions from families to improve the situation included the establishment of family liaison staff or family advocates who would be accessible at the initial point of family contact with mental health services

Few of the services had active consumer or family involvement in service planning and management processes. The degree to which consumers were included in individual clinical care decisions varied from service to service and clinician to clinician.

(7.3.2) How explicit are the systems of clinical accountability

Very few CHE clinicians or managers considered that the systems of clinical accountability within their organisations were explicit enough. Most clinicians felt that there needed to be more open discussion regarding issues of accountability and a clarification of roles and responsibilities at all levels within the sector.

Most NGO's were attempting to make the issue of accountability more explicit within their service. In many cases this was being externally driven by the THA through either the contracting process or quality monitoring of services. Several larger NGO's were working towards "accreditation" which was forcing them to develop clearer systems and controls within their organisation. Nonetheless, there were still a number of organisations in which decisions were based on individual judgement rather than policies or guidelines. Consumers who had experienced their organisations working towards accreditation reported that they had seen a focused energy to develop procedures prior to the accreditation but afterwards a "slackening off" of this energy.

Consumers and families were generally of the opinion that clinical accountability was something which required greater definition and to be made more explicit to the people who used the service. There was a strong sense of there needing to be greater transparency in the way that issues of accountability were dealt with within CHE and NGO services. A number of consumers expressed concerns that the system acted to protect staff and that there should be some way of ensuring that clinicians were fit to practice. There was a general sense that professional bodies were "overprotective" and that something serious had to happen before a person's practice was reviewed.

Many families reported that they depended heavily on the support of carer organisations to help them make sense of the mental health system they were reliant upon. Families felt that they were often excluded from systems of accountability. Whilst most providers expressed the view that the Privacy Act did not stand in the way of good clinical practice, most family members believed that the Privacy Act was used by clinicians as a means of minimising their accountability to families.

(7.3.3) What Support Is Provided To Support Staff In Maintaining Optimal Accountability?

The greatest factor influencing whether or not CHE clinical staff felt supported by their organisations was the way in which communication within the service was addressed. The more open and inclusive the communication processes the more supported clinicians felt. There was also a perception amongst staff that there was greater support from managers who had experience of working as a clinician themselves. In general the services where staff perceived managers to be accessible, supportive and empowering were those which had staff who felt clearer and more comfortable with their own accountability.

A number of clinicians reported that they feel increasingly vulnerable in relation to issues of clinical accountability. Some of this vulnerability was a result of the conflict between increasing demands for consumer empowerment and community safety.

There was considerable variation as to whether or not CHE mental health managers felt supported by their organisations. Few had access to formal supervision and some expressed the belief that their CEO or Board did not have a full understanding of the complexity of issues associated with providing mental health services.

In general most NGO staff felt that their organisations were supportive of them. Supervision for staff was common place as were regular performance appraisals. Maintaining optimal accountability, however, was seen to be compromised by the lack of appropriate training opportunities for support staff.

The issue of indemnity for staff was not always clear. Many NGO's, particularly small or recently established NGOs, did not have indemnity insurance cover for the organisation or the staff. Whilst in CHE services indemnity cover for the organisation was commonplace there was often uncertainty about how this applied to individuals working within the service.

Most CHE's did offer legal support to staff in circumstances where a clinical decision made by an individual was being challenged in some way. The level of access to this support varied and in most instances was not well defined. Information for clinicians regarding indemnity matters was not readily available and consequently they were often not well informed on this issue.

Consumers were of the opinion that there was little support for staff resulting in a high staff turnover rate with most often the "good staff" moving on. This was particularly emphasised in rural locations where people felt that doctors were often professionally isolated and pressured by regular 'on call' responsibilities. The stressful work environment for staff was seen by consumers as impacting on morale and straining goodwill which was the ingredient they thought was crucial in determining how staff acted towards them.

Families echoed this opinion and also added that the frequent turnover of clinical staff denied them the opportunity to build the familiarity and continuity necessary for trust and effective communication.

None of the CHE's visited had initiated training or forums for discussion in relation to accountability issues. Generally issues of accountability were only discussed in response to an "incident" which had occurred with the perception of many clinicians being that these types of review were too often carried out as an exercise in "finger pointing".

Of the CHE's that had orientation programmes for new staff none had included a component which explicitly addressed the systems of accountability within the service.

(7.3.4) What Clinical Management Systems Are In Place To Support Optimal Clinical Accountability?

A number of services had started to develop clinical policies and guidelines for practice. In areas where clinicians had had input into the development of these policies they were viewed positively and were incorporated into clinical practice. In areas where policies were in place but had been developed in isolation by a manager or quality improvement person they were often seen by clinicians as having little relevance to their practice and were seldom referred to. Some services had done very little in the way of developing clear clinical policies or procedures. There was a general sense that clinical policies and guidelines helped to define roles and responsibilities and therefore added to accountability within services.

There was a divergence of opinion amongst psychiatrists regarding the usefulness of clinical guidelines and policies, some seeing them as the only way to ensure accountability of practice and others expressing the view that policies and guidelines limit the clinician's ability to respond to individual's needs.

Few clinicians made comment regarding the national guidelines, of those that did some expressed a belief that whilst reflecting "best practice" they had been developed without attention to resource implications.

In most CHE services there were systems in place to ensure that clinicians working in community mental health services received clinical supervision. There was some variation in the frequency of the supervision and the degree to which it could be accessed externally. Few services had instigated similar systems in inpatient units. Clinical supervision for Psychiatrists was rare particularly for those in senior positions.

Systems for clinical review were in place in a number of services. Most clinicians acknowledged that this form of routine peer and multidisciplinary review of treatment planning invoked, affirmed and enforced professional standards and therefore supported optimal clinical accountability. A number of clinicians and managers reported that these processes could be improved if peer and multidisciplinary review was conducted in a more open and honest manner i.e. they felt that the current culture within mental health services does not always create a safe environment for clinicians to frankly and honestly review their colleagues practice. One CHE manager commented that he believed a "culture shift" was required in this respect and that it was necessary for clinicians to develop a culture of "reflective practice". He saw it as his role as a manager to "empower people so that they feel responsible for their own actions and the actions of the service as a whole." There were still some services which did not have any formal multidisciplinary or peer review and a few clinicians who were resistant to the concept.

One suggestion for facilitating discussion and debate regarding issues of accountability was to use "hypothetical scenarios" as a teaching tool for staff. It was felt that it may be less threatening for clinicians to debate issues in a hypothetical context than those related to "real situations"

(7.3.5) What Systems Exist For Reporting Concerns?

Systems for identifying and reporting concerns within CHE services were most commonly focused on "incident review" procedures in response to problems that had arisen. Very few services had systems in place to identify issues before problems arose. Whilst the aim of incident review procedures is to improve clinical management systems and prevent similar incidents occurring in the future they are predominantly a reactive rather than proactive means of addressing issues of accountability.

This reactive mode of operation was a concern to consumers who felt that accountability issues were only responded to when something went wrong. Many consumers saw the mental health sector as needing to change this practice and proactively work towards ensuring optimal clinical accountability.

In most CHE services the identification of concerns relating to systems of clinical practice was reliant on informal networks and good clinician/manager relationships. One CHE manager did hold monthly meetings with representatives from each service which were aimed at identifying what was working well and what needed improvement with respect to service provision.

In some services staff believed that people who identified issues of concern would be “punished for their dissent”. These staff perceptions were not always consistent with those of the managers, most of whom said that they had an “open door” for any clinicians to come to them with concerns about clinical matters. One manager reported that the level of mistrust of management amongst clinicians was so high that any initiatives to improve communication and develop systems for identifying and reporting concerns were met with resistance and scepticism.

As with CHE services NGO systems for identification and reporting of concerns were based more on informal relationships than formal systems or process. Few NGO services had internal quality improvement procedures in place. Although most NGO services conducted some form of client satisfaction survey few had well tested consumer complaints procedures. Systems for reporting concerns to the THA were not always clear. One of the THA divisions identified that they do include in their service contracts a requirement for services to report any major incidents.

The Mental Health Directorate described the system for reporting concerns to the Ministry as “informal”, and expressed the view that this system worked better than it ought to due to the perceived authority of the Ministry in the sector. Again, this issue was particularly commented on with regard to the statutory requirements of the mental health act; while in the case of the act there are clear lines of reporting outlined, there is no authority to act on information obtained, merely the capacity to advise. The need to clarify this situation “one way or the other” was again commented on.

Most consumers found it very difficult to discuss concerns or complaints with staff. The comment was made that “mostly you do nothing because you are either too ill or don’t have the sense of power to challenge”. As with the consumers, families often felt a fear of “punishment” if they dared to complain, comments such as “I’m too scared to criticise” and “if parents make a fuss they lose effective treatment” were not uncommon. For consumers there was also a fear that they would be treated worse or receive no treatment. This concern was accentuated amongst consumers and families in small towns and small organisations.

Amongst consumers interviewed there was limited knowledge of complaints procedures. Whilst most had some idea of where they would address a complaint few had any knowledge of what the “complaints process” would involve or of how to get assistance to make a complaint. Those that knew of the Health and Disability Advocates were not very optimistic about their ability to meet the needs of the mental health community.

Whilst most consumers were familiar with the Health and Disability Code of Rights in that they had previously seen the poster or pamphlet outlining these rights, few were able to talk specifically about what their rights were.

Rights were also a significant issue for family members who believed that a code of rights for families should be developed. Most family members were not familiar with the complaints procedures at their local services and did not know who to contact for support in having a concern addressed. Many parents felt that their time was better spent trying to cultivate a position of trust with clinical staff rather than criticising the main avenue of support for their family member. Those families who had lodged complaints frequently felt that the service had been unresponsive to their concerns.

(7.3.6) How Do Systems Of Clinical Accountability Operate Across Service Boundaries?

There were marked differences within CHE services as to the degree to which accountability issues across service boundaries had been addressed both in relation to boundaries within CHE services and across the CHE / NGO interface.

The CHE services which had clear key worker or case manager systems were the ones where the accountabilities within CHE services were better defined and staff were more able to articulate how the interface between CHE services worked. This was also the case in CHE's where there were strong links between inpatient and community services with community based clinicians having input into inpatient treatment planning.

In a number of CHE's there was a lack of clarity regarding the internal boundaries of accountability. In the more extreme examples community and inpatient services functioned almost independent of one another with no system in place to address issues of accountability across the service boundaries. In some CHE's community services provided by doctors and non doctors operated quite separately, with doctors working in a hospital outpatient base and non-doctors in a community base; there was little communication between the groups and no consensus amongst staff regarding how the systems of accountability worked across these services.

Boundaries across CHE services were a particular issue in rural areas with smaller rural CHE's dependent on their larger urban neighbours for the provision of some services to the people in their area. This resulted in confusion regarding accountability for service provision with the rural CHE's feeling that they were placed in the vulnerable position of having to be accountable for the outcomes of decisions made by clinicians from another CHE.

There were clear differences between medical and non-medical clinicians' perceptions of the interface between CHE and NGO services. Psychiatrists tended to have a negative view of how well the boundaries between services had been defined whereas their colleagues from other professional groups saw the interface in a more positive light and at times reported that the boundaries of accountability between CHE and NGO services were clearer than they were within CHE services. These perceptions were consistent with reports from NGO's who felt that they often had effective working relationships with "key workers" from CHE services but had infrequent contact with Psychiatrists and consequently the relationships were poorer.

There was a perception amongst NGO staff that their opinions were not always valued by CHE staff and that in some instances it had been difficult to get CHE services to begin to work towards clarifying service interface issues. A number of NGO and CHE services had developed or were developing Memorandums Of Understanding (MOUs) in an attempt to build clearer expectations about their respective roles and responsibilities. In the areas where these were in place they were viewed positively, both because they provided some written clarity regarding roles and responsibilities, and also because the process of developing them had helped to build relationships between the services. There was a perception that in the past MOU's had been too vague and they were most effective where the roles and responsibilities of each agency were clearly defined.

One development which NGO staff viewed positively was the CHE-NGO liaison positions which were in place in some areas. It was felt that these positions led to a greater understanding of the role of each service and therefore helped to clarify the boundaries of accountability. This was further assisted where staff from both CHE and NGO services had established regular cross-training workshops.

Several NGO's suggested that the interface issues between CHE and NGO services should be addressed in THA contracts. Specifically they believed that the parameters of the relationships and mutual responsibilities should be clearly articulated in service contracts and the effectiveness of these relationships actively monitored by the THA.

The responses from the THA indicated that in most instances service contracts do require providers to demonstrate effective linkages across services.

Consumer comments confirmed the inadequacy of communication between NGO and CHE services, with consumers often experiencing a lack of certainty about what the different services were responsible for. Some consumers made the assumption that the CHE was "in charge" and therefore the CHE should be accountable for overall service delivery.

Family members also had difficulty understanding what different services did and therefore were unaware of the boundaries between them and consequently who would be accountable for what. Families also were most concerned about the safety and well being of their family member and often indicated that the path to achieving this was through appropriate medication and treatment rather than associated support.

(7.3.7) How Do Resource Issues Impact on Systems of Clinical Accountability?

The gap between the level of need in the community and the amount of service currently available was an issue for most CHE and NGO staff, the majority feeling that their practice was compromised by the current gaps in service availability.

In most instances CHE clinicians felt that this resulted in sub-optimal practice rather than serious threats to safety. The example most frequently given was that clinicians could identify what was required to meet the needs of an individual but if it wasn't available they would then have to compromise their treatment planning. This raised issues of who was then accountable if something went wrong. Some clinicians had begun documenting in clinical notes the treatment plan for what they believe should happen and then the plan for what had actually been put in place based on what was available. The clinicians believed that if they were then held to account for their actions they could demonstrate that their clinical decision making had been compromised by the lack of appropriate services or resources.

A few clinicians felt the problem lies with the way that resources are used. There was felt to be an issue related to purchasing/contracts - more flexible use of money would mean that services could be more appropriately tailored to individual need. A few spoke of the need to fundamentally review the ways that mental health services are organised and delivered and felt that if this could be achieved, the resources to do the job well were available. This was a view also expressed by NGO staff who felt that there needed to be greater flexibility in the way that services are funded and contracted.

Some clinicians and managers expressed the opinion that it was necessary to have a period of consolidation before further service expansion was made. The reason for this was that the recent increases in the range of mental health services available (e.g. home based support and crisis respite services) and the numbers of new providers within the sector had resulted in some confusion regarding roles and responsibilities with providers feeling some uncertainty as to the boundaries of their accountability.

Particular problems with resource gaps were described in some of the rural areas, both in terms of absence of critical elements of mental health services for which larger urban CHE's had to be relied on (with problems being perceived in ensuring these services could be accessed when necessary), and in terms of absence of other necessary social services resulting in inappropriate use of mental health services because "someone had to take responsibility". A rural psychiatrist spoke of having to send troubled suicidal adolescents to a large urban psychiatric hospital because of the lack of any facility to contain them and ensure safety, and having them return with all their original problems plus the trauma of the experience at the hospital. He felt that the level of skill and experience of staff in his service enabled them to cope with most situations, but that without this the situation would be untenable.

Consumer opinion was that the "gaps" in service availability were mostly related to lack of resources. Accountability for this was mostly seen to be beyond the domain of the provider, with a wide divergence of views about whether accountability in this instance was a funder, ministry or government issue.

Some family members felt they played the role of unpaid service co-ordinators. In particular they struggled with the gaps created by the lack of meaningful activity and employment opportunities which created a situation of chronic boredom at home. Families often expressed that access to community services was often not addressed by any provider and so parents met this need.

(7.3.8) What Is Needed To Ensure Optimal Clinical Accountability Within Mental Health Services

Responses to questions regarding the systems and structures needed to ensure optimal clinical accountability within the mental health sector have been collated and presented over the page in Table 1. Whilst this profile is not intended to be a prescription for all services it is hoped that it will be a useful guide for developing and improving systems of clinical accountability within the mental health sector.

Table 1 Service Characteristics Which Support Optimal Clinical Accountability

<p>Organisational Structure and Systems:</p>	<ul style="list-style-type: none"> ◆ An overall framework of shared understanding regarding the varying layers of accountability within the mental health sector ◆ Clearly defined organisational structures which are known and understood to all staff families and consumers ◆ A management model which facilitates manager-clinician partnerships at all levels of service provision ◆ Consumer and family representation in service planning and management ◆ Effective consumer advocacy services ◆ Clear definitions of the roles and responsibilities within the multidisciplinary team ◆ A robust case management/key worker system which co-ordinates access to needed services and ensures continuity of follow-up ◆ Safe and effective complaints procedures ◆ Safe and accessible systems which monitor the rights and satisfaction of families and consumers
<p>Clinical Management Systems</p>	<ul style="list-style-type: none"> ◆ Clinical policies and guidelines which are meaningful and are used as a tool to guide clinical practice ◆ Clear policies and guidelines for addressing legislative issues such as the Privacy and Mental Health Acts ◆ Treatment planning which is undertaken in partnership with consumers/families ◆ Relapse prevention planning is considered a routine part of treatment planning ◆ Systems are in place to ensure the routine review of the needs of all consumers ◆ Peer review and clinical supervision are provided for all staff at all levels within the service
<p>Culture and Environment</p>	<ul style="list-style-type: none"> ◆ Clear Leadership is evident ◆ A culture of “reflective practice” ◆ Safe environment where staff, consumer and families can raise issues or concerns ◆ Issues of clinical accountability are addressed proactively rather than reactively ◆ Managers who have knowledge of or an openness to understand clinical issues ◆ Managers and senior clinicians are accessible to staff and responsive to their concerns
<p>Staff Development</p>	<ul style="list-style-type: none"> ◆ “Best Practice Forums” are held regularly ◆ All clinical staff have regular performance appraisal - with consumer representation in this process ◆ Orientation programmes for new staff which address issues of clinical accountability ◆ Workshops and forums for the debate and discussion of issues in relation to clinical accountability ◆ Inter-sector training occurs
<p>Service Integration</p>	<ul style="list-style-type: none"> ◆ Memoranda of Understanding which clearly define roles and responsibilities are in place between services ◆ Integrated care planning is a routine practice ◆ Forums for interagency communication are in place ◆ Key worker roles which transcend service boundaries

(8) CONCLUSIONS

What Is Clinical Accountability

The findings of this project indicate that there is a lack of shared definition of clinical accountability within the Mental Health sector and no commonly agreed framework or model to guide thinking regarding this important issue. Clinical Accountability is an elusive concept which is commonly referred to but difficult to define. Often the broader the view of accountability held by an individual the more difficulty they experienced in defining it.

Clinical accountability sits within a broader framework which includes economic accountability, managerial accountability and political accountability. The findings outlined in this report show that there is no commonly agreed model by which these differing components are viewed. Thus there is no clear picture of the overall structure of accountability, which makes it difficult to examine and define specific issues such as clinical accountability. **There is clearly a need to develop between the range of stakeholders a shared model/framework for understanding and debating the issues regarding both clinical accountability and the wider accountabilities. Only then will it be possible for groups and individuals to be clear about what they might reasonably be held accountable for, and might reasonably hold others accountable for. This process will in particular need to address the conflict between human rights and community safety needs.**

Who Is Accountable?

There was clearly a strong desire across all of the stakeholder groups to ensure that individuals and systems within the mental health sector are accountable. It was striking that the majority of individuals from all groups – both providers and users of services – expressed in some form the view that “the buck stopped with them”. To many clinicians this resulted in a feeling of vulnerability and for some a tendency to adopt an increasingly narrow and defensive position regarding their own accountability. Whilst consumers mostly expressed a strong sense of personal responsibility a number raised the issue that the level of individual responsibility which can reasonably be expected from an individual varies with the fluctuating nature of mental illness. Many consumers felt that currently they were being left to “shoulder more than their share of the responsibility”. As people feel increasingly vulnerable they begin to “toss the hot potato of accountability” resulting in a culture which is blaming and defensive rather than one in which is accepting and inclusive. **This again highlights the critical need to develop shared models of accountability as the basis for individuals to be able to comfortably accept their own accountabilities and feel assured that others will also.**

A critical issue within services was the lack of clarity regarding the roles and responsibilities within the multidisciplinary team. Confusion regarding the boundaries of accountability were particularly noticeable in relation to the roles of key workers/case managers and psychiatrists. This was an issue which was highlighted in every area as one which required further debate and resolution. **The striking consistency with which this issue was raised indicates that further national debate and review regarding the boundaries of clinical accountability within the multidisciplinary team is required.**

The issue of the need for some form of leadership to effect positive change in the sector was raised in different ways by a variety of people. While the individuals and groups canvassed in the course of this project who commented on these issues almost without exception stressed the need to preserve local decision-making processes and autonomy, there was a clear view expressed that there is a need for some level of national leadership to set direction regarding some to the less tangible needs of the sector. One individual commented “**...in order to provide ‘healthy’ services to people in need of them, we need to develop a ‘healthy and functional culture’ of mental health service provision...**”. **This process will require effective national leadership.**

The tensions between issues of empowerment, responsibility, and safety were apparent from the responses offered by the different stakeholder groups to many parts of the questionnaire. This highlighted the difficulties in the parties being able to enter into dialogue regarding these increasingly important accountability issues. Consumers and families highlighted the importance for them of being informed and involved in decisions regarding the care provided to them or their family member; clinicians highlighted issues to do with their shouldering the responsibility for ensuring safety first and foremost; and all groups reflected different aspects of the need to ensure individual and community safety. What was apparent however was that there has been minimal dialogue between the groups regarding how to resolve some of the tensions inherent in these differing perspectives. As highlighted by Curtis and Hodge (6) **there is a need to develop dialogue and move towards shared understandings – to develop a “new set of rules” regarding issues of empowerment, responsibility, and safety – between provider groups; providers and users of services; and between consumers and family.**

How Do Systems of Clinical Accountability Work Within the Mental Health Sector?

Whilst all services have in place some systems to address issues of clinical accountability the nature and extent to which they had been developed varied considerably. There was no one service which had in place all of the features of optimal accountability identified by the varying stakeholder groups and outlined earlier in this report.

Very few services have active consumer or family involvement and participation in either service management or individual clinical care decision-making processes; yet as one respondent highlighted “accountability is intrinsic in services which are truly consumer focused”. Most clinicians identified their own accountability in terms of accountability to organisations and professional bodies whereas consumers inferred that clinicians should have some accountability to them. **A key element in developing optimal systems of accountability will be the establishment of an environment in which providers, consumers, and family feel safe to challenge and debate issues relating to clinical practice and accountability. Such debate needs to be fostered on both a local and national level, and in particular needs to focus on ways of ensuring genuine partnerships between providers and service users.**

A recurring theme which though expressed in different ways was present across all groups, was that of the impact of the perceived “style” of management of services on both clinical practice

and accountability. Services where managers were perceived as accessible, supportive and empowering, had staff who felt clearer and more comfortable with their own accountability. These were services where managers were seen as balancing the fiscal and service need imperatives, and often this was also reflected in a balance of authority and greater co-operation between managers and senior clinicians/staff. These services also had structures and processes for ensuring accountable practice which were more likely to be owned by and found useful in everyday practice by most staff. **Development of structures and processes to ensure “accountable management” of mental health services is critical to the development of optimal clinical accountability. This development must include means for consumers and family to be involved in service planning, decision making and monitoring.**

There is considerable variation in the extent to which services have clear policies, protocols and guidelines addressing issues of clinical practice and accountability, and in the degree to which these are known to staff and consumers/family. There was general agreement that when these had been developed by those who were to use them, they were useful guides to practice and were in everyday use. There is little evidence that national guidelines are being used to guide clinical decision making. **It is important that all mental health services have systematic and transparent approaches to the development of structures and processes which aim to optimise clinical accountability.**

The lack of integration of services was a difficulty which was voiced (albeit in a variety of different ways) across all groups, and seen as compromising quality and accountability of services. There was a significant level of confusion among consumers and family about who was responsible for what among the array of services, and a general acknowledgement from providers that this area is poorly attended to. **Two particular areas of best practice which were identified were the development of (i) interagency memoranda of understanding and forums for liaison/CHE-NGO liaison positions; and (ii) shared approaches to integrated planning of care and development of “relapse prevention plans”, with active involvement of the client and their family. Such practices need to be developed across all mental health services in all areas, and by themselves have the potential to greatly improve the quality and accountability of clinical practice.**

Another recurring theme across most groups was related to aspects of what purchasers and government are accountable for. Among the examples presented were issues such as the need for improved specification regarding service integration in contracts, the absence or inadequacy of processes to monitor standards of care delivery by contracted providers, the range of service gaps in many areas, and the “prescriptive” nature of purchasing which may not always fit with local need. These and other issues were seen as affecting the capacity of providers to deliver quality care in an accountable fashion. **Attempts to improve quality and clinical accountability of MHS will only be effective if they are “nested” within clearly developed and defined accountability mechanisms at the level of mental health services management, purchasers, and funders/government. This will be facilitated by the development of shared models of accountability for service providers, service managers, purchasers, and funders.**

Resource limitations were commonly seen as compromising standards of care, and in a small percentage of cases as resulting in unsafe care. This was seen as having a major impact on the

capacity of people to deliver quality care in an accountable fashion. Whilst there was an almost universal agreement regarding the need for additional funding to develop new services the impact of additional funding on issues of clinical accountability was also noted, with the development of both new types of services and new service providers enhancing the confusion regarding boundaries of clinical accountability. There was a widely held view that issues to do with the way services are funded impact directly on accountability of clinical practice. **It is important to ensure that systems of clinical accountability are developed in accordance with the level of resource and service availability within the sector.**

One area of best practice identified but not developed across all areas was the use of clinical review systems such as multidisciplinary team client reviews, and profession-based peer review. Whilst a number of issues such as the reluctance of some clinicians, pressure of work and a lack of open and honest debate were seen as limiting the effectiveness of these systems, there was a general view that such forums were very helpful and fostered improved accountability of practice. Access for all staff to quality individual supervision was also viewed as a critical factor in ensuring accountable practice. Whilst most services have systems in place to ensure that clinicians working in community services received clinical supervision, similar systems were much less common in inpatient services and were rare for psychiatrists. **All staff working in mental health services should regularly participate in inter-organisation, team and peer review forums, and should have access to individual supervision.**

Particular issues were raised in regard to the Mental Health Act. Despite the overall provider view that initial uncertainty regarding interpretation of the act was now resolved and that the act is being consistently and accurately interpreted and used, there remains a clear view from consumer and family groups that this is not the case, and that the act is being used in some instances to deprive people of needed assessment and treatment. The issue of needing to see the Duly Authorised Officer (DAO) function as part of a service response was also raised – not meeting the criteria for “mental disorder” does not imply that mental health service staff who are DAO’s can then abdicate responsibility for undertaking any further assessment or action that is clinically indicated. There was also concern expressed regarding the lack of authority and power accorded to Directors of Area Mental Health Services (DAMHS) and the Director of Mental Health. The ongoing issues in being able to ensure consistent application of the Mental Health Act in accord with both its spirit and statute would seem to suggest that there may need to be clearer powers to influence practice accorded to both roles, along with the need for stronger leadership from both. **There is a need for wider debate regarding the powers and roles of DAMHS and the Director of Mental Health. There clearly is also still a need for ongoing training and education of ALL staff involved in the use of the Mental Health Act.**

There was a consistent theme running through the consumer and family interviews relating to their need for information regarding both local service accountability processes, and

national/statutory ones. For instance few people were sufficiently informed regarding local complaints procedures, or their rights under the Health and Disability Code of Rights. Consumers were generally concerned about the ability of health and disability advocates to adequately serve the mental health sector. A number of family members believed consideration should be given to the development of a “family member code of rights”. **The rights of service users including the right to have concerns or complaints addressed in a fair and safe manner are issues which are intrinsically linked with issues of clinical accountability. There is a need to ensure that service users are adequately informed regarding issues of accountability and that processes for reporting concerns or complaints are safe, transparent and effective.**

In finishing it is clear that there is a strong desire amongst the stakeholder groups within the mental health sector to improve systems of clinical accountability. The great majority of people interviewed wish to move from the “hot potato model” of accountability to one in which clinical accountability is embedded within a framework which encompasses shared understanding and practices regarding the “what” the “who” and the “how” of accountability. In order for this to happen there is a great need for development in this area, and for resolution of a number of important areas of differing opinion and perspective which compromise accountability of practice. There exists the opportunity to debate these issues and develop systems to ensure quality, accountable Mental Health Service delivery both locally and nationally; it is our hope that this report and set of recommendations will serve to catalyse and guide this process.

(9) RECOMMENDATIONS

- 1. That a group representative of the major stakeholders in the mental health sector is convened to adapt the frameworks in the literature into a national model of accountability with the intent that this serve to clarify the reasonable accountabilities of all parties and assist the process of debate regarding issues in health sector accountability. This group should as part of its task seek to develop a “new set of rules” to assist the sector to resolve the tension in attempting to be accountable for provision of empowering but safe services.*
- 2. That the profile of “optimal clinical accountability” outlined in section 7.3.8 of this report is circulated widely throughout the mental health sector and feedback sought as to the ways in which it can be further developed as a tool for helping to improve systems of (clinical) accountability within the mental health sector.*
- 3. That mechanisms are put in place to ensure consumer and family representation at all levels within the mental health sector particularly in relation to systems of clinical accountability.*
- 4. That mechanisms are developed to ensure that systems of clinical accountability are made explicit at all levels within the mental health sector, including:*
 - “ Ensuring issues relating to clinical accountability are addressed within THA service contracts*
 - “ Ensuring all mental health services have transparent and effective structures and processes to address issues of clinical accountability.*
- 5. That a separate review is undertaken to consider issues of clinical accountability from a Maori perspective.*
- 6. That consideration is given at a national level to clarification of accountability issues in relation to the specific issue of the roles and responsibilities within the multidisciplinary team, in particular the key worker in relation to the psychiatrist.. Gathering key individuals to debate the issues in this regard would be a useful starting point.*
- 7. That a programme of “case -based” training in the interpretation of legislation relevant to the mental health sector be initiated and continued - in particular regarding the Mental Health and Privacy Acts - as a follow-on to the guidelines based training which has occurred up to the present*

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APPENDICES:

- I List of Project members
- II Terms of Reference
- III Provider and Service User Questionnaires
- IV Project Methodology

APPENDIX I

PROJECT TEAM MEMBERS:

Valerie Bos	Consumer Consultant
Joanne Chiplin	Health Service Consultant - With a background in mental health nursing and purchasing
David Codyre	Psychiatrist
Chris Harris	Mental Health Consultant - With a Background in NGO management

Terms of Reference

Clinical Accountability Project

Background:

One of the important quality issues within the mental health sector is that of accountability with respect to the provision of treatment and support services to people who use mental health services.

The Mental Health Commission has therefore initiated a review of practices, viewpoints and expectations of different stakeholders within the mental health sector to gain a better understanding about issues in relation to clinical accountability.

There is a need to get a clear understanding about what is working well and why and to clarify those areas that require further development.

Areas for consideration

- Consumer Empowerment
- Safety issues (community and consumer)
- Integration of services

Outcomes

- The development of a written report which summarises the current practices and viewpoints regarding clinical accountability within the mental health sector.
- The development of a set of recommendations for improved outcomes to meet the needs of all stakeholders within the mental health sector.

Process

- For the purposes of this review “clinical accountability” shall apply to accountability in relation to the provision of treatment and support services to individuals.
- Development of a questionnaire and interview process which gives both qualitative and quantitative information regarding the areas for consideration.
- Survey of the range of practice, viewpoints and expectations of key stakeholders (CHE and NGO mental health service managers, clinicians, consumers and family members) within the mental health sector using the above questionnaire/process. Interviews will take place in one urban and one rural area within each of the four regions.
- Compilation of material from the interview process into a written report and recommendations.

APPENDIX III

PROVIDER AND SERVICE USER QUESTIONNAIRES

**NEW ZEALAND MENTAL HEALTH
COMMISSION**

**Clinical Accountability Project -
Provider Questionnaire**

Name _____

Group _____

Brief info re background_____

CHE/Area _____

Region _____

Urban - Rural (please circle)

INTRODUCTION

Within different service contexts in Mental Health Services, different meanings are ascribed to the term “clinical”. These meanings range from narrower definitions relating to diagnosis and treatment (biological aspects of care); through to broader definitions encompassing the range of activity from diagnosis/treatment through to support (bio-psycho-social aspects of care). For the purposes of this project, the broader definition is used; so that “clinical” is taken to mean the range from treatment (incl. diagnosis) to support. Thus, the terms “clinical”, and “treatment/support” are used together in places to reflect and confirm the broader definition used.

CONFIDENTIALITY

The intent of this questionnaire is to get a “snapshot” across the whole country of perceptions that the range of stakeholders in Mental Health have regarding issues of Clinical Accountability (accountability for treatment/support). As such, the information gained WILL NOT be used as an audit of the relative performance of individuals, services, or areas with respect to accountability.

The information will be compiled into a report which highlights issues, trends, and important differences NATIONALLY; and no identifying data (regarding individuals, services, or areas) will be used in the report. Once the report is complete, individual questionnaires will be destroyed. The report will make recommendations regarding how to address the issues nationally.

GENERAL QUESTIONS

QUESTION (1)

What is clinical accountability (accountability for treatment/support)?

Probes -

- What does it mean to you?
- Is this different to clinical responsibility? If so, how?
- Is this different to managerial accountability? If so, how?

QUESTION (2)

In your role within the Mental Health Service **what are the boundaries of your accountability?**

Probes -

- What particular aspects of service delivery are you clinically accountable (accountable for treatment/support) for? For example your actions in regard of particular clients Vs outcomes for particular clients Vs overall service quality/delivery of “best care”.
- Are you clinically accountable (accountable for treatment/support) for the actions of others within the service? If so, what is their role in relation to yours?
- What are the boundaries of your accountability in terms of transfer of information - to clinical services involved in an individual’s care, NGO services, family, client?
- What are the boundaries of your accountability in relation to -
 - (i) the Mental Health Act
 - (ii) the client
 - (iii) the family

QUESTION (3)

What are the lines of clinical accountability (accountability for treatment/support) within your organisation?

Probes -

- Specifically, what are the lines of clinical accountability (accountability for treatment/support) within your team/service, and the organisation?
- Who is accountable to you, who are you accountable to; and who holds ultimate accountability in the organisation?
- Do all members of the service share the same view of this?

QUESTION (4)

Is there an explicit system of clinical accountability (accountability for treatment/support) within your organisation?

Probes -

- Is your view of issues of accountability more based on implicit/unspoken understanding?
- Are there actual policies/protocols which address issues of clinical accountability? How/by whom were these developed?
- How helpful are these policies/protocols in addressing everyday issues of accountability? Are they used or referred to in actual practice? If not how do they need to be different to be useful?
- What is the focus of the system of monitoring accountability (e.g. everyday practice/activity, outcomes for clients overall, or adverse outcomes)?

QUESTION (5)

To what degree does your organisation support you in **maintaining optimal clinical accountability (accountability for treatment/support)?**

Probes -

- Are there clear understood processes for development, implementation and review of policy/procedure?
- Are you supported in developing attitudes, knowledge and skills necessary to do the job?
- Are you supported in getting regular supervision?
- Are there processes or forums for reviewing practice?
- How would you improve on what is provided by your organisation in this regard? What would an “ideal” system of accountability look like?

QUESTION (6)

Is there a system for discussing or reporting problems/concerns?

Probes -

- regarding (a) individual clients (b) quality of service?
- what is this system and how well does it work?
- how would you improve this system?

QUESTION (7)

Given that multiple CHE and NGO services can all be involved in delivery of services to an individual, **how are issues of clinical accountability (accountability for treatment/support) across service boundaries addressed?**

Probes -

- are there systems/mechanisms to address these issues?
- what are these systems?
- how well do they work?
- how would you do it differently?

QUESTION (8)

Many people in the Mental Health field talk of “**living in the gap**” between need for service and what is actually purchased by Government/purchasers; and the **suboptimal practice** which results from this.

To what degree is this an issue in your area?

Does this influence your practice and in particular your ability to ensure optimal practice and clinical accountability? If so, how.....?

QUESTION (9)

Give **three examples of what is working well in your area in supporting optimal clinical accountability?**

Why do you think these examples are working?

Give **three examples of what requires further development?**

RELATIVE INFLUENCE OF SAFETY, EMPOWERMENT, AND INTEGRATION ISSUES.

At times there may be tensions between some or all of these issues in delivering services to an individual in a clinically accountable (accountable for treatment/support) fashion. Please **rate each issue in terms of how much it influences (weights) your decision making in a clinical (treatment/support) context.**

ISSUE	Rate each in terms of how much it influences (weights) your decision making in a clinical context	Rank each in order of priority from 1 (highest) to 7 (lowest) - in terms of priority of each in clinical decision making
Individual Safety	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	
Community Safety	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	
Cultural Safety	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	
Individual Empowerment	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	
Family Empowerment	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	
Service Integration & Info Sharing - within CHE Services	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	
Service Integration & Info Sharing - Between CHE & NGO Services	<u>0</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> nil medium high	

COMMENTS -

CLINICAL SCENARIOS

For each scenario ask the following questions:

What are the key issues relation clinical accountability in this situation?

In your areas who is clinically accountable for delivery of services to this person and their family? Who should be?

What needs to be in place to ensue optimal accountability ins such a scenario?

Scenario (1)

A fifteen year old living with their family, is receiving services from a Community Mental Health Service for treatment of depression. They have problems with substance abuse and have been suspended form school for violence. The key-worker believes there is a problem with sexual abuse in the family which may be contributing to the individual's problems. The family deny this and say they can look after the young person, who is reluctant to move away from home. The person attempts suicide by taking an overdose.

Scenario (2)

A person has been in an Inpatient Mental Health Unit for some time and is being treated under the Mental Health Act. The person has been ready to leave hospital for some time, but needs supported accommodation and no suitable placement can be found. They are finally discharged to an accommodation provider who the community team have concerns about, and who rated poorly in recent monitoring, as there were no inpatient beds available for someone else requiring admission. The person is threatened by another resident in the house, becomes unwell and requires readmission.

Scenario (3)

A person is living in a level 3 residential rehabilitation home, and has had a change of medication resulting in disturbing side effects and symptoms. The next appoint with the psychiatrist is not for two weeks. The person tries t talk about their problems to the weekend staff at the home, but they do not respond. The person rigs the crisis team and is told that there is no-one available to see them, and to contact their key worker on Monday. The person later that day commits a serious criminal offence.

Scenario (4)

A person receives services from a CMHC, and also attends a consumer run drop in. the person confides to the drop in staff that they are no longer taking their medication, and do not want this discussed with their key-worker at the CMHC. The drop in staff observe a deterioration in the person's mental health which the consumer does not want to discuss - the staff are aware that the person has reported a bad experience with the CMHC so do not contact the key-worker. The person is admitted to hospital under the Mental Health Act.

Clinical Accountability Project
Service User Questionnaire

Introduction

Recent Reports have raised questions about the level of clinical accountability that exists within the mental health sector. The Mental Health Commission is interested to hear your views.

In the discussion today we will take the word responsibility to mean the same as accountability.

The aim of the discussion will be to explore various case scenarios in relation to:

- your rights
- your responsibilities
- staff responsibilities
- mental health system responsibilities

Confidentiality

The intent of this questionnaire is to get a "snapshot" from selected sites throughout the country of the perceptions of accountability issues in services. As such, the information gained WILL NOT be used to make judgements regarding the relative performance of individuals, services. And your access to health services will not be affected by your what you say.

The information will be compiled into a report which highlights issues, trends, and important differences NATIONALLY; and no identifying data (regarding individuals, services, or areas) will be used in the report. Once the report is complete, individual questionnaires will be destroyed

Outcome

The development of a written report which summarises the current practices and viewpoints regarding clinical accountability within the mental health sector.

The development of a set of recommendations for improving accountability

Questions

1. What do you think clinical accountability, in both treatment and support?
Brainstorm idea and then well come back to this at the end of the discussion

1 What does this mean to you?

2. Is this different to clinical responsibility?

3. Is this different to managerial responsibility/accountability?

4. What are your expectations in terms of staff responsibilities/accountability?

5. What are your own responsibilities when you are receiving treatment or support?

Check: Are these any different when you are acutely ill?

6. What are your rights when you are receiving treatment and support?

Check who is familiar with Code of Rights

7. Have you been ever been informed about what keeps staff responsible? What do you know about this?

8. What are your expectations about the accountability of the mental health system?

9. What options available for you to discuss concerns / complaints about your treatment or support?

ii)and do they work

10. When a person '*falls between the gaps*' e.g. the person doesn't fit the criteria for any service so there is nowhere for that person to get the help they need.

a. Where do you see the responsibility and/or accountability lie in this situation?

11. What about when a person is receiving care from a number of agencies, both CHE and NGO and something goes wrong.

a. Where does responsibility and/or accountability lie in this situation.

b. If you are receiving treatment and support from a number of different staff do you know who is responsible for what?

12. Have you been told or given any information about what the lines of responsibility and/or accountability are throughout mental health?

Do you have any expectations ?

13. Is there anything you know that is working well in terms of ensuring the responsibility of staff?

Explain

14. What is lacking in the mental health system that might ensure the responsibility and/or accountability of staff? **or**

What developments do you think need to be in place to ensure the right level of responsibility and/or accountability of staff?

15. Go back to original question on accountability and check if people have anymore to say.

16. Are there any other additional accountability issues particular for Maori and Pacific People?

1. DEVELOPMENT OF THE QUESTIONNAIRE -

As outlined in the body of the report, it was decided by the project team to use an interview approach to elicit views and opinions, and to base each interview on a series of open-ended questions with accompanying specific probes. Each set of questions was to be followed by a series of clinical scenarios each of which had associated questions, and a rating/ranking exercise regarding the importance of different aspects of clinical accountability. Following this process an opportunity was created for comment regarding any areas not covered during the interview.

First a format for Mental Health Service providers was developed by the clinician members of the project team with assistance from the NGO/Family and Consumer members. While it was seen as important to take a neutral stance in both the wording of questions and the approach of the interviewer, a number of assumptions were made based on the project groups' knowledge of both the Mental Health field, and issues relating to accountability within Mental Health practice. These included the assumption that there would be important differences both within and between different groups regarding –

- ◆ what clinical accountability means
- ◆ the sharing of accountability between clinicians and managers
- ◆ what individuals saw themselves as accountable for and who they saw themselves as accountable to
- ◆ and the lines of accountability within teams and organisations.

A number of questions were oriented towards drawing out these differences. The remaining questions addressed various issues which affect accountability of practice within organisations. The clinical scenarios were then developed to seek views regarding a number of situations which commonly compromise accountable practice - with questions seeking opinion regarding what the issues were and what needed to be in place to ensure optimal accountability.

These scenarios were evolved through a number of stages, from an initial draft which was given to the project team as part of its initial briefing by the commission as a suggested format for the questionnaire, through two amended versions developed by the clinician members of the project team to supplement the subsequently developed open-ended questions, to a final version developed by the consumer member of the team in consultation with her supervisor for the project.

Finally, interviewees were asked to rate (on a visual analogue 0 - 5 scale) and rank the degree to which each of the following issues weighted their decision-making in a clinical context –

- ◆ individual (client) safety
- ◆ community safety
- ◆ cultural safety
- ◆ individual empowerment
- ◆ family empowerment
- ◆ within CHE service integration and information sharing
- ◆ CHE – NGO service integration and information sharing

Following this development of the provider questionnaire, a complementary format for seeking the views of consumers and family members was developed by the Consumer and Family members of the team. This version asked questions relating to the same topics as the provider version, but from the perspective of people receiving services, and with additional emphasis on what both consumers and family saw as their personal responsibility. Both versions were trialed with representative individuals within the CHE area where one of the project team worked. On the basis of this trial and the feedback received several amendments and additions were made (see appendix III for final versions of both questionnaires). The final version of the consumer and family member questionnaire comprised questions only; the scenarios were removed as a result of feedback, and the rating/ranking exercise was adapted for provider response only.

1. WHO WAS INTERVIEWED –

Resource and time constraints limited the size of the sample group to be interviewed. After considering various approaches, it was decided to visit two CHE areas in each region - one urban, one rural (on the assumption that the issues regarding accountability may be different between urban and rural settings). The CHE's within each region were identified, and separated into urban or rural on the basis of their predominant demography. One CHE area was then randomly chosen from each group.

For each area visited, interviews with CHE staff were set up via the Mental Health Service Manager, who was sent a covering letter from the Mental Health Commission explaining the purpose of the project and enclosing a copy of the terms of reference. Personnel identified by the project team to be interviewed within each CHE service included the Mental Health Services Manager, the Clinical Director, two psychiatrists (one being the Director of Area Mental Health Services(DAMHS) if this was not a role undertaken by the Clinical Director), and two non-medical mental health professionals. The Manager was subsequently contacted to negotiate a day for the project team to conduct interviews, and was asked to arrange a series of two hour appointments with the selected staff over the course of this day. It was requested that a range of seniority and experience be reflected in the group selected. Interviews with the Manager and non-medical staff were conducted by the registered nurse member of the project team. The psychiatrist member of the team interviewed the medical staff .

For each area to be visited, the NGO providers of Mental Health Services, family member groups and consumer groups were also identified. If there were more than two NGO's in an area, two were chosen to be interviewed by a semi-random process. The assumption was made that there would be important differences between large and small NGO's. In addition we sought to interview a number of Kaupapa Maori providers. Thus, if there was a Kaupapa service this was chosen, and if the choice existed a large and small NGO was chosen. If there were more than one provider in any of these groups, the provider to be seen was chosen randomly. In some of the smaller rural areas, there was only one NGO to be interviewed. No areas offered more than two family member groups, so all these groups in the areas visited were interviewed. In each area, two to three consumer focus groups were held, each with approximately five people. In most instances these groups were convened by local consumer organisations. Two Maori and one Pacific Island consumer groups were interviewed. For each identified NGO or consumer/family group, contact was made and a day/time to be interviewed agreed. Interviews with these stakeholders were conducted using a "focus group" approach, with the manager or co-ordinator of the respective organisation arranging for relevant people to attend the group interview.

The decision to use a focus group format for these interviews was made because this format seemed to address a number of issues faced in canvassing the opinion of these stakeholder groups – there would likely be a range of familiarity with the issues so a richer discussion would be stimulated, each stakeholder group was potentially very large, and there was a need to attempt to get as representative a range of views as possible within the time budgeted for interviews. In addition, previous work undertaken by the Commission had indicated that small groups were the preferred option for consumers to give feedback on issues.

A questionnaire seeking feedback on the roles and responsibilities of the THA with respect to clinical accountability was also sent to each of the four THA mental health managers. Responses were received from three of the four managers. Finally, the Mental Health Directorate of the Ministry of Health (Director and Deputy-Director) were interviewed

2. DATA ANALYSIS –

Interviews in each area visited were conducted over the course of one day, and at the end of that day each interviewer compiled the completed questionnaires into a summary which highlighted the major themes and issues. Each interviewer also maintained a list of the recurrent themes and issues as the interview phase of the project proceeded. At the completion of the interview phase, each interviewer then compiled these summaries into an overall summary, and made reference back to the assembled questionnaires as a check to ensure no important information had been excluded.

Following this process, the project team met for a day to compile the findings of the project from these summaries, and through the course of the day again referred back to the completed questionnaires if an issue raised by another group seemed to be not represented in their summary, as a final cross-check. This process of compiling sought to highlight the major common themes and issues across the groups, and also to pick up any important areas of difference in view or perspective. The authors of the report then wrote up the findings using this compiled information.