Clinical Excellence Division

Evaluation of the *Mental Health Act 2016* Implementation

Assessment and Risk Management Committee Evaluation Report

December 2017

Queensland Government

Evaluation of the *Mental Health Act 2016* Implementation: Assessment and Risk Management Committee Evaluation Report

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1. Summary

This report details the evaluation of the Assessment and Risk Management Committee (ARMC) framework across statewide public mental health services in Queensland, as part of a broader evaluation of the *Mental Health Act 2016* implementation.

This report provides a summary of key findings associated with the operationalization of the *Chief Psychiatrist Policy for the Treatment and care of forensic order, treatment support order and high risk patients* (the Policy) and makes recommendations for consideration of the Chief Psychiatrist.

2. Project Description

In early 2015, events involving high risk forensic patients caused the Chief Psychiatrist to order a number of investigations into the management of forensic patients whilst accessing limited community treatment. The investigations identified a number of systemic issues relating to the treatment and care of forensic mental health patients in Queensland.

As a result, in November 2015 a Forensic Patient Risk Management Project was commenced, working collaboratively with the Office of the Chief Psychiatrist, Queensland Forensic Mental Health Service and Authorised Mental Health Services (AMHS). The project undertook a review of the policy and practices relating to the treatment and care of forensic patients in Queensland and developed system reforms in line with the incoming *Mental Health Act 2016*.

In March 2017, the Policy was implemented to coincide with commencement of the new Act. Operating as a clinical governance framework, the Policy strengthens the assessment and risk management of forensic and identified high risk patients. One mechanism introduced under this Policy was the Assessment and Risk Management Committee (ARMC) framework within each AMHS.

The role of the ARMC is of a clinical nature and functions as a peer review of the treatment and care of patients subject to a forensic order (FO), treatment support order (TSO) and other patients (whether subject to a treatment authority or voluntary) whose risk profile is assessed as high by their treating team.

On conclusion of the Forensic Patient Risk Management Project the then Chief Psychiatrist, Assoc Prof John Allan, committed to a 6-month post implementation evaluation of the ARMC framework.

The evaluation outlined in this report uses information and data collected for the period 5 March 2017 to 5 September 2017. This period allowed sufficient time for AMHS to complete initial ARMC reviews for forensic patients[1] required under the framework.

3. Evaluation Focus

The focus of this evaluation aligns with the expected outcomes of the Forensic Patient Risk Management Project, including:

- Multi-disciplinary team frameworks minimise patient risks and support authentic clinical governance and strengthened decision making at the service level.
- Clear pathways for escalation and resolution of issues, both within the service and externally to the Chief Psychiatrist where required.
- Clear communication pathways between the treating team and the Community Forensic Outreach Service (CFOS).
- Clear processes and procedures for clinical documentation to be centralised and easily accessible by all relevant staff to enable decision making and reporting on all available information.

[1] Forensic patients must be reviewed at a minimum of twice per year, e.g. at six monthly intervals.

Key evaluation questions regarding the ARMC framework were determined through consultation with relevant stakeholder reference groups comprised of service providers, statutory authorities and consumer/carer representatives, as outlined in the Evaluation of the *Mental Health Act 2016* implementation project plan, including:

- Are the ARMC processes operating effectively: occurrence, attendance, record keeping, etc.?
- Are patients appropriately referred to the ARMC for review?
- Is the operation of escalation processes effective?
- Is the ARMC applied appropriately for people in custody?
- Does the ARMC enable local oversight and visibility of high risk patients?

The evaluation report also includes observations specific to young persons[2].

Summary of key findings

- The ARMC is considered by AMHS to be a valuable forum for improved local oversight, visibility and management of high risk patients.
- Expected outcomes of the Policy are being achieved including:
    - ARMC processes are operating effectively: occurrence, attendance, record keeping, etc.
    - Patients are appropriately referred to the ARMC for review
    - Operation of escalation processes are effective
- Deficits exist in current data collection capabilities, therefore the evaluation has only limited reporting on the appropriate application of the ARMC framework for:
    - people in custody
    - voluntary patients
- The introduction of the ARMC framework has resulted in an increase to existing workloads for clinicians, related to preparing, attending and documenting ARMCs.
- Minimum requirements of the ARMC Terms of Reference (documentation of minutes) are not being met within some services.
- Inconsistencies exist across AMHS in relation to operationalizing the ARMC framework. Although AMHS processes reflect local requirements, this creates challenges for services working across multiple AMHSs, such as the Mental Health Review Tribunal (MHRT) and CFOS.
- The use of ARMC minutes within MHRT review hearings has been identified as an issue by services due to matters being adjourned/delayed.
- The ongoing operation of ARMCs must have synergies with the Three-tier Risk Assessment Framework discussed in section 6.1 of this report (and other local protocols for assessment of risk).

4. Data Sources and Methods

Performance measures for this evaluation have been formulated from the requirements of the ARMC framework under the Policy.

The evaluation covers the six month period post implementation of the ARMC framework from 5 March 2017 to 5 September 2017. This period allowed sufficient time for AMHS to complete initial ARMC reviews for forensic patients required under the Policy.

Qualitative and quantitative data sources were used to evaluate the ARMC framework. A systematic audit of the Consumer Integrated Mental Health Application (CIMHA) was also conducted.

Data outcomes in this report are displayed by Authorised Mental Health Service (AMHS).

[2] Young person refers to a person aged 17 or below.

Quantitative data was extracted from the Mental Health Act (MHA) module in CIMHA by the MHAODB Clinical Systems, Collections and Performance unit (CSCPU). To add rigour, this data was cross checked against an available report in CIMHA of *Forensic and Treatment Support Order Consumers in a Specified Period*. Consideration was also given to data provided by the Queensland Forensic Mental Health Service.

Descriptive statistical analysis of the de-identified patient data was conducted using spreadsheet formulas and pivot functions. The focus of the analysis was to extract outcomes of the requirements of the Policy.

Interpretation of quantitative data is outlined in section 5.1.

A systematic audit was conducted of ARMC minutes documented in CIMHA for consumers reviewed by an ARMC during the evaluation period.

10% of all ARMC minutes were randomly selected for audit.

Numbers were randomly assigned against each ARMC clinical note event, then a random selection made.

The audit included patients under the following orders:

- FOs made by the Mental Health Court (MHC)
- FOs made by the MHRT (combining multiple existing FOs)
- New TSO made by the MHRT.

Outcomes of the audit are discussed in section 5.2.

Qualitative data was collected through a targeted stakeholder survey for mental health service staff involved in ARMCs. The survey was run over the period 28 August 2017 – 29 September 2017 to allow sufficient time for maximum staff participation. Questions were built around the evaluation indicators identified in the Project Plan for the broader Evaluation of the *Mental Health Act 2016* implementation.

Services were directed to multiple choice or Likert scale answers and were also invited to provide free text comments on benefits and challenges relating to the ARMC framework.

Themes identified through the collection of qualitative data are discussed in section 5.3.

5. Results, Conclusions and Interpretation

5.1. Quantitative data

The Policy includes a reporting requirement (section 5.4.2 of the Policy) that Administrators report to the Chief Psychiatrist on a quarterly basis regarding the treatment and care of patients subject to the Policy. The evaluation described here represented the first reporting and monitoring process for the ARMC framework. Prior to this, routine reporting of data by AMHS has not occurred in accordance with the Policy.

The following data was extracted from CIMHA by CSCPU of all clinical notes for *ARMC Minutes Attachment* dated during the evaluation period:

- Date of ARMC review
- Date ARMC minutes saved in CIMHA
- AMHS
- Patient demographic data including date of birth
- MHA order start/end date
- MHA status by order type

5.1.1. Patients reviewed by the ARMC

During the evaluation period, a total of 861 ARMC reviews were conducted for 774 patients. A count of total ARMC reviews by AMHS is shown in Figure 1.

Figure 1 ARMC reviews conducted 5/03/2017 - 5/09/2017 (by AMHS)

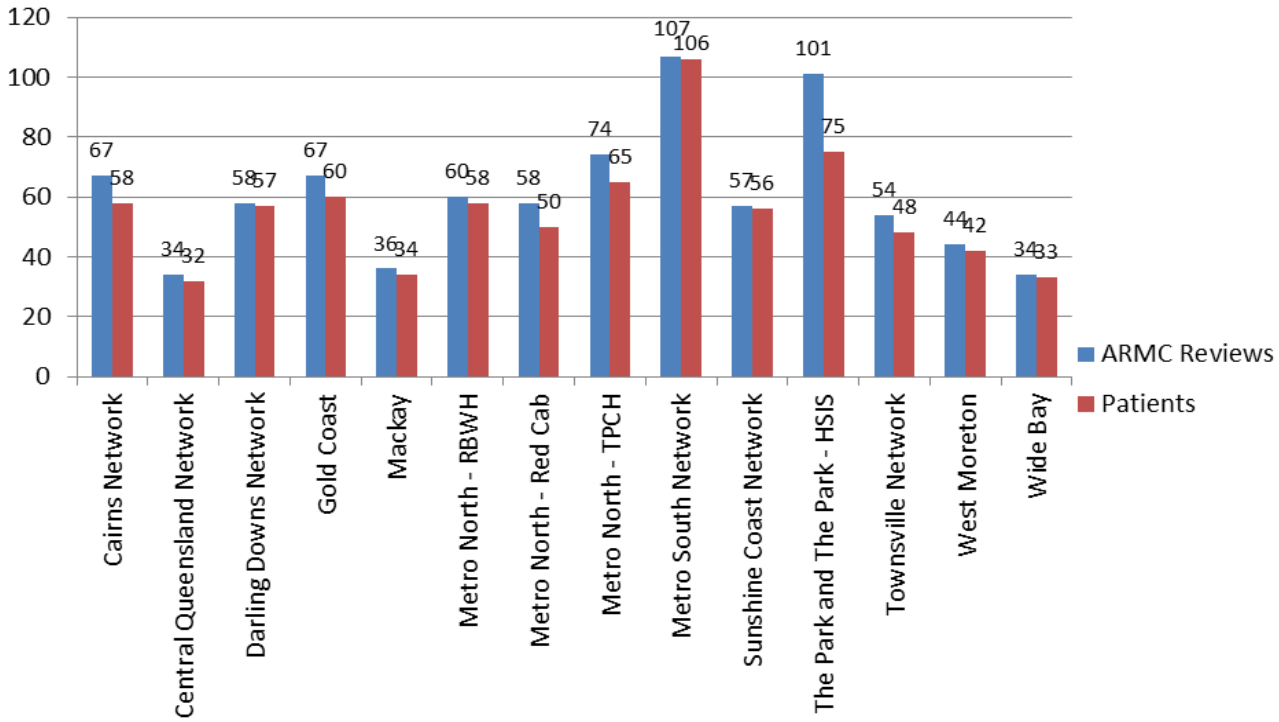


Table 1 shows total number of ARMC reviews conducted during the evaluation period for total patients including representation of young persons.

Table 1 ARMC reviews conducted 5/03/2017 - 5/09/2017

	FO	TSO	TA	CLASSIFIED	VOLUNTARY	TOTAL
ARMC Reviews	731	18	78	6	28	861
Patients (incl young persons)	672	18	73	5	26	774
Young persons	2	0	1	0	3	6

*Patients may be on multiple orders at time of ARMC review

The total 861 ARMC reviews includes a large portion of ARMCs conducted for patients on an order made prior to commencement of the *Mental Health Act 2016*, as shown in Table 2.

Table 2 ARMC reviews conducted 5/03/2017 – 5/09/2017 (under MHA2016)

	FO	TSO	TA	CLASSIFIED	VOLUNTARY	TOTAL
Order made under MHA2016	56	18	17	1	0	92
Order made prior to MHA2016	675	0	61	5	28	769
TOTAL	**731**	**18**	**78**	**6**	**28**	**861**

*Patients may be on multiple orders at time of ARMC review

5.1.2. ARMCs are conducted within required timeframes

The Policy requires that the ARMC must review a patient, within a specified timeframe, of the patient being made subject to a forensic order or treatment support order by the MHC.

Treatment Support Order (TSO)

A patient subject to a TSO must be reviewed by the ARMC within 90 days of the TSO being made including:

- patients stepped-down from FO by the MHRT or MHC (on appeal)
- change to risk profile or
- as determined by administrator/Chief Psychiatrist.

During the evaluation period, 18 ARMCs were held for TSO patients of which 89% (16) were held within the required 90 day review period.

The two non-compliant reviews were at Cairns AMHS held at 92 and 120 days after commencement of the TSO.

Forensic Order (FO)

The ARMC must review the treatment and care of a patient within 30 days of a patient being made subject to a forensic order by the MHC.

During the evaluation period, 56 ARMCs were conducted for patients subject to a FO. Of these orders, 48 were made by the MHC since commencement of the Act. The remaining 8 FOs were made by the MHRT (i.e. Combine existing FOs).

The following data includes only FOs made by the MHC as only these orders are subject to the 30 day review timeframe within the Policy.

Table 3 represents a summary of the ARMCs the number of days from FO made to the date ARMCs were conducted.

65% (31) of the required 48 ARMCs occurred beyond the 30 day requirement as shown in Table 3.

Table 3 ARMC reviews – Date FO made to Date of ARMC (in days)

Total ARMCs	0-30 Days	31-60 Days	61-90 Days	>90 Days
48	17	17	5	9
100%	35%	35%	10%	19%
		65%		
			29%	

A representation of timeframes for ARMC review by AMHS is shown in Table 4.

Table 4 Time from date FO made by MHC to date of ARMC (by AMHS)

AMHS	0-30 Days	31-60 Days	61-90 Days	> 90 Days	Total ARMCs	% ARMCs >30 Days
Metro South Network		7	2	1	10	100%
The Park - HSIS		1	1	2	4	100%
Metro North - Red Cab		1			1	100%
Darling Downs Network	1	2			3	67%
Gold Coast	1		1	1	3	67%
Metro North - RBWH	1	2			3	67%
Sunshine Coast Network	1	2			3	67%
Townsville Network	4	1	1	2	8	50%
West Moreton	1			1	2	50%
Metro North - TPCH	2			1	3	33%
Cairns Network	6	1		1	8	25%
TOTAL	**17**	**17**	**5**	**9**	**48**	**65%**

AMHS with ARMC events held more than 90 days from the patient becoming subject to the FO are shown in Table 5.

Table 5 ARMC reviews held more than 90 days from commencement of FO

AMHS	Days
Metro North - TPCH	164
Townsville Network	146
Townsville Network	144
West Moreton	129
The Park - HSIS	124
The Park - HSIS	104
Metro South Network	97
Gold Coast	97
Cairns Network	92

ARMCs Outstanding

Analysis of the evaluation data revealed three patients with an open MHA status for whom an ARMC review had not been recorded in CIMHA, as shown in Table 6.

Table 6 ARMCs outstanding as at 1/11/2017

AMHS	FO Made by MHC	Days since FO made
West Moreton	3/04/2017	212
Darling Downs	3/05/2017	182
Children's Health QLD	20/06/2017	134

Each of the outstanding matters were escalated under the Chief Psychiatrist compliance framework for action by the relevant AMHS. At the time of writing this report, the following updates were provided from each AMHS:

- **West Moreton** – ARMC for the patient took place on 1/05/2017 (within 30 days).
  The service has updated the clinical note in CIMHA.
- **Darling Downs** – ARMC for the patient took place on 12/10/2017 (> 30 days).
  The service has updated the clinical note in CIMHA.
- **Children's Health QLD** – ARMC for this client took place on 7/07/2017 (within 30 days).
  The service investigated why the clinical note didn't load up on CIMHA and has advised this was due to an incorrect selection of the clinical note type. The service has updated the clinical note in CIMHA and amended their local work instructions for ARMC documentation.

Persons charged with prescribed offence/s

Persons charged with a prescribed offence must be reviewed and assessed by CFOS within 60 days of the forensic order being made by the Court, except for patients detained as an inpatient to The Park – High Security Inpatient Service.

Currently there are limited data sets available for routine monitoring of CFOS assessments relating to persons charged with prescribed offences.

To determine whether this requirement is being met, data was extracted from CIMHA, of total clinical notes recorded by clinicians linked to the CFOS service including the following information:

- Clinical notes registered by CFOS
- Clinical note date

- Consumer ID
- Offence Description
- FO made date

Each record in the excel report was then individually cross checked against consumers reported in the MHA monitoring report in CIMHA *Forensic and Treatment Support Order Consumers in a Specified Period*, which identifies new FOs made for prescribed offences.

The data shows that during the reporting period:

- The MHC made 3 new forensic orders for persons charged with prescribed offences.
- 2 of the total 3 patients were detained as inpatients at The Park - HSIS.
- CFOS conducted an assessment and review of the remaining 1 patient within the required 60 day timeframe.

5.2. Systematic audit

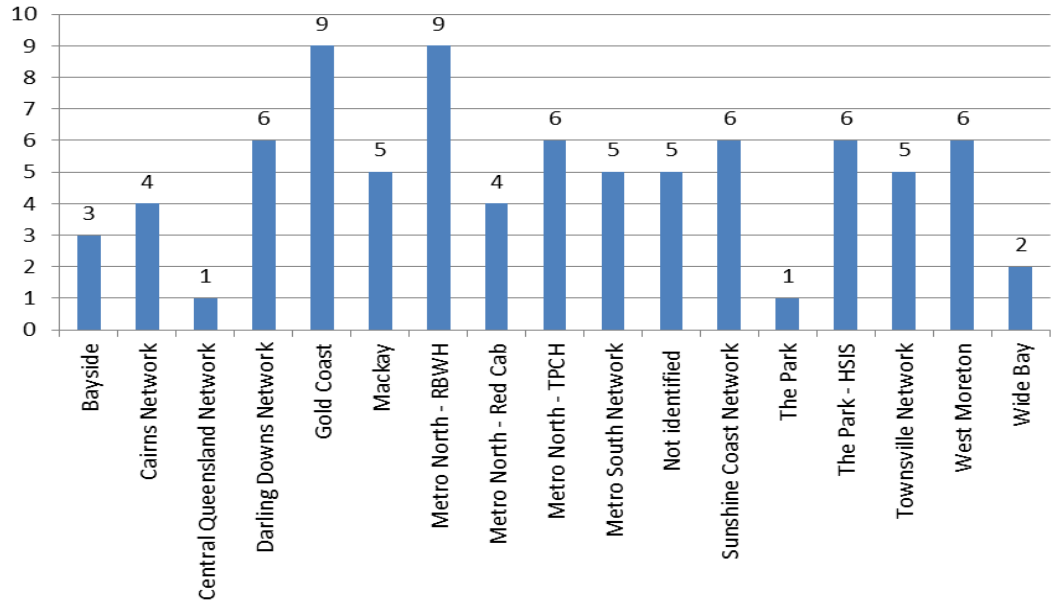
A systematic audit of randomly selected CIMHA clinical notes (ARMC Minutes) was undertaken to evaluate ARMC activity required for this evaluation that have no other reporting mechanisms currently available.

An audit tool was developed to monitor AMHS compliance with the Policy. The criteria for the audit tool were determined by the requirements of the ARMC Terms of Reference. It is intended that the audit tool be made available for AMHS to adopt or adapt, in addition to local monitoring and compliance procedures, (refer to Attachment 1).

The audit was performed on 83 records representing 10% of total ARMC reviews conducted during the reporting period.

The number of records audited per AMHS is shown in Figure 2.

Figure 2 Number of CIMHA records audited per AMHS



Outcomes of the audit are discussed below. Topic headings have been formulated from the requirements of the Policy and ARMC Terms of Reference.

5.2.1. Membership

The ARMC must include at least the clinical director, treating psychiatrist, forensic liaison officer, and a representative from CFOS. Additional (non-medical) members of the treating team may also attend.

- Quorum requirements were met at 94% (78) of ARMCs.

- Of the 83 records audited, ARMCs were attended by:
    - clinical director – 99% (82)
    - treating psychiatrist – 100% (83)
    - forensic liaison officer – 98% (81)
    - CFOS – 96% (80)
    - additional (non-medical) members of the treating team – 81% (67)

5.2.2. Governance

ARMCs must be chaired by a clinical director (or nominated proxy).

- ARMCs were chaired by a clinical director at 95% (79) of reviews.
- 1 review at Logan was chaired by the treating psychiatrist.
- A chair was not stated for 3 reviews at Bayside (2) and Logan (1).

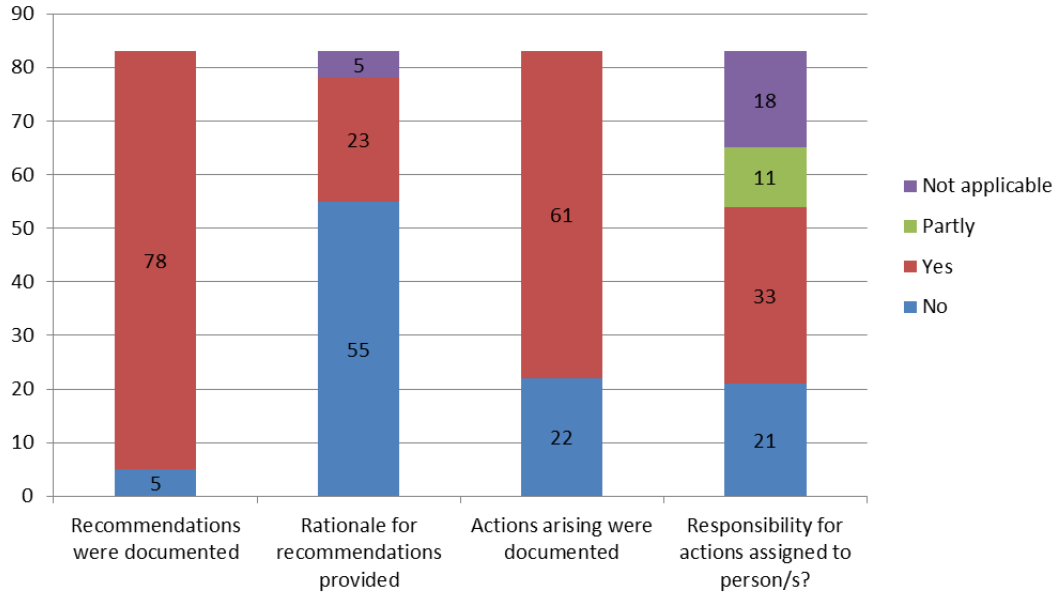
5.2.3. Documentation of ARMC minutes

Minutes of each ARMC must be documented in CIMHA and must include, at a minimum, the information presented in Table 7.

Table 7 Audit outcomes for TOR Minimum requirements

TOR Requirement	Audit outcome (83 Records)
Who attended the committee?	• 98% (81) of ARMC minutes documented attendance/membership
What information and evidence was before the committee?	• 90% (75) records included what information and evidence was before the committee including: ○ care plans ○ risk screens ○ risk assessments ○ CFOS reports ○ MHRT reports ○ other relevant documentation
Document concerns raised by ARMC members	• 99% (82) records documented committee concerns • 1 record did not document concerns however actions arising were recorded
Recommendations for the person's treatment/care and the rationale for the recommendation or change	• 94% (78) records documented recommendations of the ARMC • 28% (23) records also included a rationale for recommendations Documentation of ARMC recommendations/actions is shown in Figure 3.
Actions to be taken, and by whom, to ensure recommendations or changes are actioned	• 74% (61) records documented actions arising • 40% (33) records assigned actions to specific person/s • 13% (11) records assigned some actions but not all Documentation of ARMC recommendations/actions is shown in Figure 3.

Figure 3 AMHS documentation of ARMC recommendations/actions



In addition, the audit identified two key areas, not currently required by the ARMC Terms of Reference that are relevant and informative to an ARMC review.

- **MHA status** of the patient at the time of the ARMC was identified on 83% (71) records.
- **Reason for ARMC** was identified on 16% (13) records e.g. first review, 6 month review, change in risk, material change.

5.2.4. Frequency of meetings and reviews

The Policy requires review of specific patients within specified timeframes.

- 78% (65) records stated when the next ARMC should occur.
- In addition, the frequency of reviews were specified for the following nominated positions in some records:
    - case manager (or equivalent) – 36% (30)
    - forensic liaison officer – 27% (22)
    - treating psychiatrist – 45% (37)

5.2.5. ARMC recommendations/outcomes – Patient care

The Policy requires that patients meeting the criteria for ARMC must have a current Care Plan. The Policy also requires that the AMHS Administrator must ensure patients have an Involuntary Patient and Voluntary High Risk Patient Summary (IPVHRPS) with current information and circumstances kept on CIMHA at all times.

The audit performed an analysis of Care Plans and IPVHRPS completed within 60 days of an ARMC, as shown in Table 8. The evaluation did not have capacity to include a review of the specific content of these care plans and IPVHRPS.

Table 8 Patient Care Plan/IPVHRPS reviewed after ARMC

	Within 30 Days	Within 60 Days	Total plans reviewed
Care plans	20% (17)	20% (17)	40% (34)
IPVHRPS	18% (15)	21% (18)	39% (33)

The audit also considered the rate of patient referrals to CFOS for assessment and review. Referral to CFOS was included as an action on 10% (9) of ARMC minutes reviewed in the audit. This rate is consistent with overall referral data provided by QFMHS of 8.4%.

5.3. Qualitative data

An evaluation survey was formulated to address specific questions in relation to the ARMC framework, as outlined in the Evaluation of the *Mental Health Act 2016* implementation project plan.

The survey received 86 completed responses from across the state including participation from all AMHS as shown in Figure 4. Figure 5 shows surveys completed by role.

Figure 4 Survey participation by AMHS

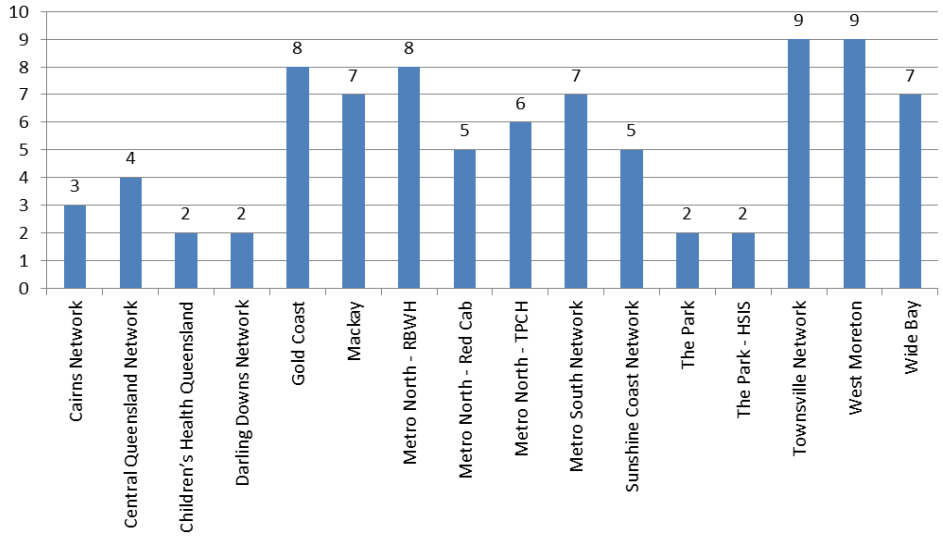
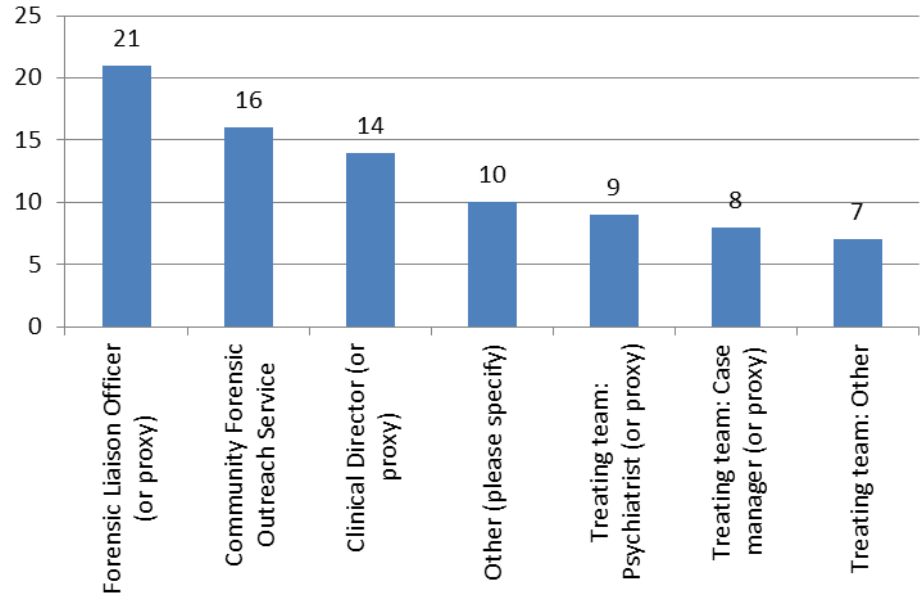


Figure 5 Survey participation by role[3]



Survey outcomes include the following consistent themes. These are discussed in detail at section 5.3.1:

- Patients are being appropriately referred to the ARMC.
- ARMCs are operating effectively including occurrence/scheduling, attendance, timely access to documentation, quality of documentation.

[3] Survey participants were asked to specify their role title if selecting 'Other' as their role description. Responses include: Administrator Delegate, Child and Youth Forensic Outreach Service, Mental Health Intervention Coordinator, Operations Manager (Community), Senior Governance Position, Program Manager, Administrative Support Officer.

- The ARMC framework has seen increased awareness and local oversight of high risk patients.
- ARMCs have been a beneficial strategy in improving the assessment and management of consumers who are at risk of violence.
- The ARMC enables an effective pathway for escalation of high risk patients.

5.3.1. Survey outcomes

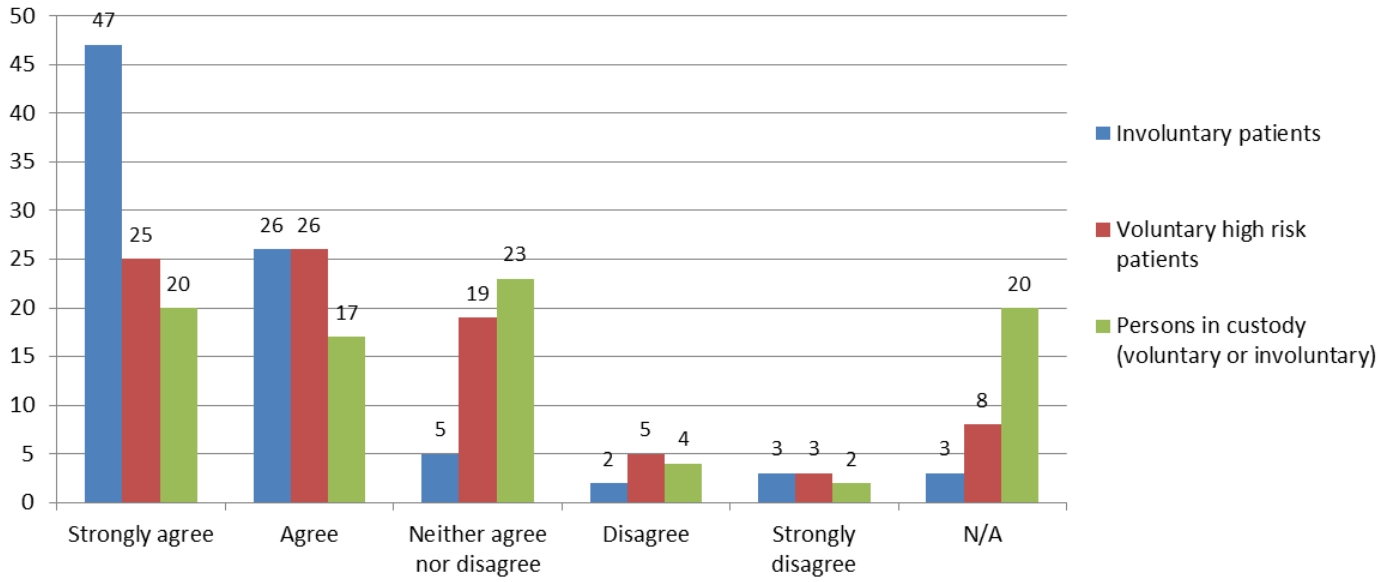
AMHS are aware of the Chief Psychiatrist Policy

- 99% (85) survey respondents are aware of the requirements of the Policy.

Patients are appropriately referred to the ARMC

- Involuntary patients: 85% (73) agree or strongly agree
- Voluntary high risk patients: 59% (51) agree or strongly agree
- Persons in custody (voluntary or involuntary): 43% (37) agree or strongly agree. 23% (20) respondents answered N/A - it is assumed the respondent has not participated in an ARMC for this type of patient.

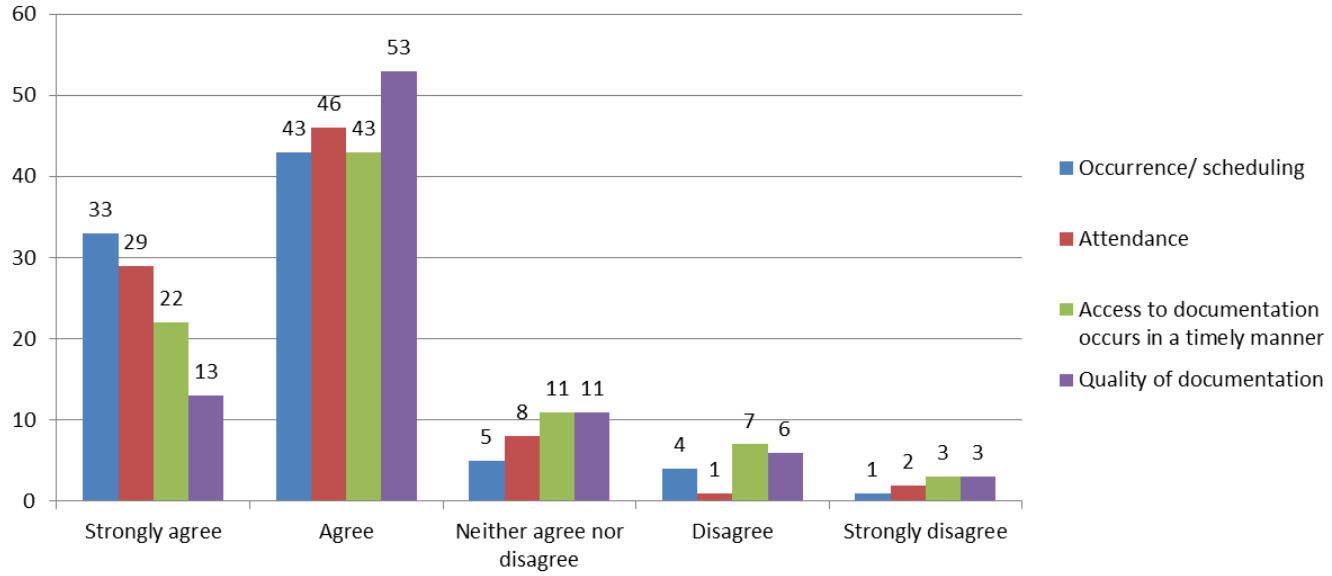
Figure 6 Patients are appropriately referred to the ARMC



ARMC meetings are operating effectively

- Occurrence/scheduling: 88% (76) agree or strongly agree
- Attendance: 87% (75) agree or strongly agree
- Access to documentation occurs in a timely manner: 76% (65) agree or strongly agree
- Quality of documentation: 77% (66) agree or strongly agree

Figure 7 ARMC meetings are operating effectively



Average duration of ARMCs

- The average length of time for discussion of an ARMC case is approximately 40 minutes.
- AMHS reported ARMC discussions as brief as 10 minutes ranging up to 2 hours and 30 minutes for more complex cases.
- The ARMC survey did not take into account preparation time required for an ARMC however data supplied by QFMHS indicates an average preparation time for CFOS representatives attending an ARMC is 54 minutes.

Table 9 Average duration of ARMC (hours:minutes)

AMHS	Responses	Average duration of ARMC (HH:MM)
Cairns Network	3	0:37
Central Queensland Network	4	0:48
Children's Health Queensland	2	1:00
Darling Downs Network	2	0:37
Gold Coast	8	0:29
Mackay	7	0:38
Metro North - RBWH	8	0:41
Metro North - Red Cab	5	0:42
Metro North - TPCH	6	0:22
Metro South Network	7	0:34
Sunshine Coast Network	5	0:36
The Park	2	1:45
The Park - HSIS	2	0:20
Townsville Network	9	0:38
West Moreton	9	0:31
Wide Bay	6	0:28
Total	**85**	**0:36**

ARMCs maintain good record keeping practices (including minutes)

- 85% (72) agree or strongly agree
- 9% (8) neither agree nor disagree
- 6% (5) disagree or strongly disagree

The ARMC framework provides opportunities for all participants to contribute opinions and recommendations

- 96% (82) agree or strongly agree
- 2% (2) neither agree nor disagree
- 1 respondent strongly disagrees

The ARMC process has increased awareness and local oversight of high-risk patients

- 75% (64) agree or strongly agree
- 19% (16) neither agree nor disagree
- 6% (5) disagree or strongly disagree

Discussion of cases at ARMCs has resulted in improved management of risk issues

- 71% (60) agree or strongly agree
- 18% (15) neither agree nor disagree
- 11% (10) disagree or strongly disagree

Decisions are appropriately disseminated (e.g. included in patient's treatment plan, communicated to relevant staff, included in MHRT reports)

- 69% (59) agree or strongly agree
- 26% (22) neither agree nor disagree
- 5% (4) disagree or strongly disagree

Escalation processes are effective in managing concerns/disputes between services

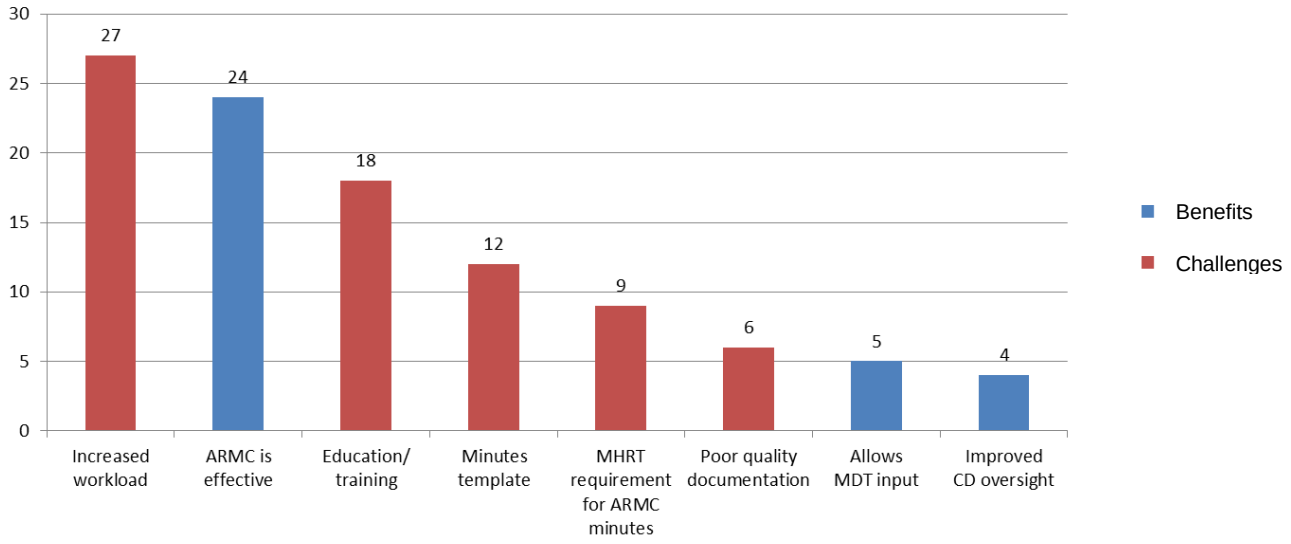
- 42% (35) agree or strongly agree
- 55% (46) answered neither agree nor disagree or N/A - it is assumed the respondent has not participated in any escalation processes.
- 4% (3) disagree or strongly disagree

Since the introduction of the ARMC framework, no matters have required escalation to the Chief Psychiatrist. However, a representative for the Chief Psychiatrist attended one review on request from the Darling Downs Network AMHS due to the complex nature of the patient's treatment and care needs.

Feedback/Comments

55 survey participants provided free text feedback about what they believe to be the benefits and challenges of the ARMC. A number of consistent themes were identified as shown in Figure 8.

Figure 8 Benefits and challenges associated with ARMCs



5.3.2. Benefits and Challenges

Benefits:

44% (24) of respondents believe the ARMC has been a beneficial strategy for improving the assessment and management of high risk patients.

9% (5) respondents commented that the ARMC provides a forum that allows multidisciplinary input.

7% (4) respondents believe the ARMC has improved Clinical Director oversight of high risk patients.

Challenges:

Increased workload

Survey responses indicate the statewide average length of an ARMC case is 30 minutes however each service reported average durations of between 15 minutes and 2 hours 30 minutes.

49% (27) of respondents have experienced a significant increase to workloads since the introduction of ARMCs. Issues raised include:

- Lack of administrative support for scheduling, distribution of documents, monitoring of patients due for ARMCs
- High volume of ARMCs requiring attendance, review of documents
- Requirements of MHRT/Attorney-General (AG) for ARMC documentation
- A report from CFOS submitted a lack of resources for CFOS clinicians to prepare sufficiently/meaningfully for participation in ARMCs.

Education/training

33% (18) of respondents requested further education and training for stakeholders involved in ARMCs including:

- Purpose of the ARMC and where ARMCs sit as part of overall risk management framework, including history/reason for introduction of ARMC framework.
- Statutory nature of ARMC including requirements for TA/voluntary patients
- Criteria for step down from FO to TSO[4]
- Framework for implementation of ARMC recommendations

[4] The Chief Psychiatrist issued a memo and factsheet on this issue on 3 November 2017. This occurred after the survey results had closed and therefore the concerns raised in the survey may have been subsequently addressed by this memo.

- Documentation – requirements and how to use CIMHA forms
- Clarification of definition of risk
    - A three-tier risk assessment framework is currently in development. Refer to section 6.1.

Suggestions were put forward by respondents of the evaluation survey to share 'lessons learned' to assist ARMCs to further develop/improve local processes and protocols and create consistency operationalizing the ARMC framework.

During the drafting of this report, a survey relating to change management for the implementation of the *Mental Health Act 2016* was concluded. That survey showed 28% (82) of respondents believe the ARMC should be a focus of future training/education for stakeholders involved in the provision of care and treatment to patients under the Act.

Minutes template

An example word template for ARMC minutes, developed by the Office of the Chief Psychiatrist (OCP), was made available to AMHS on introduction of the ARMC framework.

22% (12) of respondents commented on the need for a revised automated template for ARMC minutes including:

- Ensure minimum requirements for ARMC minutes are captured
- Need for CFOS endorsement on minutes to satisfy requirements of MHRT/AG
- Template is required in CIMHA – reduce time documenting ARMCs (pre-populated template)
- Consistent documentation creates efficiencies documenting ARMCs

MHRT Requirement for ARMC documentation

16% (9) of respondents requested clarification of AMHS obligations to provide information to the MHRT. In particular, MHRT requests for ARMC minutes prior to patient review hearings (e.g. determining step down to TSO and/or amendments to limited community treatment).

The OCP has communicated to AMHS that although provision of ARMC minutes for the purpose of a patient review hearing is not legislated, compliance with MHRT requests for documentation including ARMC minutes is required.

The OCP continues to liaise with the MHRT to clarify documentation and process requirements for patient reviews.

Poor quality documentation

As previously discussed, when questioned directly, 77% (62) total survey respondents responded positively to the quality of ARMC documentation, however 11% (6) respondents commented strongly that documentation relating to ARMCs is poor, including:

- ARMC minutes
    - Inconsistent/inaccurate account of ARMC discussion
    - Verbal summaries not documented
- Clinical documentation presented for consideration at ARMC
- Translation of ARMC recommendations onto care plans

6. Discussion/recommendations

6.1. Three-tier risk assessment framework

Further to the ARMC framework, a three-tier risk assessment framework is currently in development as a recommendation of the *Queensland Health response to the Final Report – When mental health care meets risk: a Queensland sentinel events review into homicide and public sector mental health services*.

The three-tier framework for determining a patient's level of risk is intended to precede the requirements of the ARMC. The ARMC framework is a clinical governance process that operates as a peer review

process for patients assessed as high risk.

Trial implementation of the three-tier framework is expected in 2018.

6.2. Recommendations

- Improve routine data collection mechanisms for ongoing monitoring and compliance, particularly in terms of monitoring the extent to which ARMCs are undertaken for the following patient groups:
    - persons charged with a prescribed offence
    - people in custody
    - voluntary patients.
- Develop automated CIMHA template for consistent and compliant documentation of ARMC minutes.
- Regular reporting of the ARMC framework (e.g. meeting frequencies, patient groups) is recommended for ongoing monitoring of AMHS compliance with obligations under the Policy.
- Revisions/amendments to the Policy including:
    - Quarterly reporting from AMHS Administrators is no longer required and is instead to be included in OCP ongoing monitoring and compliance reports.
    - ARMC review should be determined by a patient's risk profile and may be scheduled earlier than mandated timeframes.
    - Clarify CFOS requirement for assessment within 60 days of persons charged with prescribed offences – only applies to new FOs made by the MHC (i.e. where the patient is not already known to the service).
    - ARMC does not replace processes for risk assessment and review completed as part of the patient's ongoing treatment and care planning by the treating team.
    - ARMC framework must be consistent with the three-tier risk assessment framework (and other local protocols for assessment of risk).
- Clarify AMHS obligations for provision of ARMC information (minutes) to the MHRT.
- Provide opportunities for information sharing across AMHS in relation to ARMC 'lessons learned'.
- Multi-disciplinary representation at ARMCs could be strengthened.
- Consider an amendment to the ARMC name to more clearly reflect the intention of the framework as a process for peer review.

7. Use and Sharing

Findings of this evaluation will be provided to:

- Chief Psychiatrist
- Inter-departmental Executive Committee as part of the Interim Report for the Evaluation of the *Mental Health Act 2016* Implementation project
- Further distribution as determined by the Chief Psychiatrist

Implementation of any practical improvement activities will be included in the Final Report of the Evaluation of the *Mental Health Act 2016* Implementation.

8. Approval and Endorsement

☒ Approved

Project Manager

Name	Bobbie Clugston		
Position	Director – Legislative Projects, Office of the Chief Psychiatrist		
Signature	SIGNATURE PROVIDED	**Date**	03/01/2018

Chief Psychiatrist

Name	Dr John Reilly		
Position	Chief Psychiatrist		
Signature	SIGNATURE PROVIDED	**Date**	09/01/2018

Project Sponsor

Name	Assoc Prof John Allan		
Position	Executive Director, Mental Health Alcohol and Other Drugs Branch		
Signature	SIGNATURE PROVIDED	**Date**	09/01/2018

9. Contact Officer

If you have any questions regarding this document or if you have a suggestion for improvements, please contact:

Contact officer: Emily Mahoney

Title: Principal Policy and Project Officer, Legislative Projects, Office of the Chief Psychiatrist

Phone: 07 3328 9074

Attachment

1. ARMC Audit Tool

ARMC audit tool – MHA 2016 Evaluation

Meeting details		
1	Is the date of ARMC recorded?	☐ Yes ☐ No
2	Is the AMHS identified in the Minutes? If yes, identify:	☐ Yes ☐ No
3	Is the reason for the ARMC identified? If yes, identify: ☐ first review ☐ 6 month ☐ escalated to CP ☐ change in risk ☐ material change ☐ LCT	☐ Yes ☐ No
Patient details		
4	Are the patient's details (name, dob) included?	☐ Yes ☐ No
5	Is the patient's MHA status identified? If yes, identify: ☐ FO ☐ TSO ☐ TA ☐ Voluntary ☐ Classified	☐ Yes ☐ No
6	If the patient is a forensic patient whose order was made after 5 March 2017, did the ARMC review take place within 30 days of the order being made?	☐ Yes ☐ No ☐ Not applicable
7	If the patient is a forensic patient, is it identified whether they are charged with a prescribed offence?	☐ Yes – prescribed ☐ Yes – NOT prescribed ☐ No – prescribed ☐ No – NOT prescribed
Attendance		
8	Are attendees documented in the minutes?	☐ Yes ☐ No
9	Did a clinical director chair the meeting ? If no, who was chair:……	☐ Yes ☐ No ☐ Not stated
10	Did the treating psychiatrist attend? If no, who attended:……	☐ Yes ☐ No ☐ Not stated
11	Did other (non-medical) members of the treating team attend?	☐ No ☐ Yes ☐ Not stated
12	Did the Forensic Liaison Officer attend?	☐ Yes ☐ No ☐ Not stated
13	Did a CFOS representative attend the meeting?	☐ Yes ☐ No ☐ Not stated
Information		
14	Is information presented at the ARMC outlined in the minutes? If yes, identify: ☐ care plan ☐ risk screen ☐ risk assessment ☐ CFOS report ☐ MHRT report ☐ other……	☐ Yes ☐ No
Discussion		
15	Are concerns of the committee documented?	☐ Yes ☐ No
16	Are recommendations of the committee documented? If yes, are recommendations listed per individual member (e.g. CFOS recommendation, treating psychiatrist recommendation etc?)	☐ Yes ☐ No
17		☐ Yes ☐ No ☐ Not applicable
18	Where recommendations are provided, is there also a rationale?	☐ Yes ☐ No ☐ Not applicable
Actions		
19	Are actions arising from the ARMC documented?	☐ Yes ☐ No
20	Is the responsibility for an action assigned to a person/s?	☐ Yes – all

		☐ Yes – some ☐ No ☐ Not applicable
21	Is a referral to CFOS included as an action?	☐ Yes ☐ No
Review		
22	Do the minutes detail when the next ARMC should occur?	☐ Yes ☐ No
23	Is the frequency of reviews specified for the case manager (or equivalent)?	☐ Yes ☐ No
24	Is the frequency of reviews specified for the forensic liaison officer?	☐ Yes ☐ No
25	Is the frequency of reviews specified for the treating psychiatrist?	☐ Yes ☐ No
MHRT		
26	Has patient had an MHRT hearing subsequent to the ARMC?	☐ Yes ☐ No
27	If the patient has had a subsequent MHRT hearing, is the ARMC outcome noted in the report?	☐ Yes ☐ No ☐ Not applicable
28	If the ARMC is noted in the MHRT report, are the minutes attached to the report?	☐ Yes ☐ No ☐ Not applicable
Care plans		
29	Has the patient had a Care Plan completed subsequent to the ARMC?	☐ Yes – within 30 days ☐ Yes – within 60 days ☐ No (not completed or >61 days)
30	Has the patient had an Involuntary Patient and Voluntary High Risk Patient Summary subsequent to the ARMC?	☐ Yes – within 30 days ☐ Yes – within 60 days ☐ No (not completed or >61 days)