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

Government of **Western Australia**
Mental Health Commission

Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia

Professor Bryant Stokes, AM

July 2012

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Acknowledgements

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Important Disclaimer:

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Executive summary

In November 2011, the Minister for Mental Health requested three reviews about the suicides of people who had been discharged from mental health services in Western Australia (WA):

1. The Chief Psychiatrist's examination of four cases of patients who died unexpectedly following presentation at Fremantle Hospital.
2. The Chief Psychiatrist's review of the clinical decisions made around the admissions and discharges at Fremantle Hospital over the past 12 months in which people have died subsequent to their discharge.
3. This independent statewide review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in WA.

(See Terms of Reference, Appendix 1).

While this Review has revealed an array of challenges and imperatives for mental health care in WA, it is important to acknowledge that the all-pervasive and multifaceted nature of psychiatric illness and required support and care is not the responsibility of any one person, service or agency (Coid 1994). Mental health treatment is one component of a broader framework to support people with mental illness. Other components, such as social support, housing and employment, each play a crucial part.

This Review considered the efforts of staff, observing that staff are committed to the care and rehabilitation of people who are mentally unwell.

In the context of limited resources, the mental health system is under considerable stress, particularly in relation to staff already stretched, endeavouring to adhere to formal policies, procedures, legislative requirements and their own professional expectations and the expectations of patients and carers.

This Review notes that within the hospital and clinic situations there appears to be an absence of a single point of authority with a described responsibility for accountability for patient care and for consistency of process and practices. Best practice demands clinical and corporate governance remain separate entities, while a single point of authority must ensure linkages across a mental health system to deliver patient-focused care.

These tensions in the current system are exacerbated by demand outstripping provision of acute inpatient facilities, step-down units and rehabilitation services. The system must also address the imperatives of an adequate workforce and improved workforce training.

Information management across mental health is a key area for improvement. Ensuring that there is an accessible and effective system-wide information management system is an important challenge that must be addressed.

This Review of the admission or referral to and the discharge and transfer practices of public mental health facilities and services in WA offers recommendations to improve processes of care of the patient with mental illness and concurrently their family and carers. The recommendations are based on the opinions, views and evidence presented by the 891 persons interviewed, the data of 255 individuals who suicided in 2009, patients' medical record documentation and the 29 submissions received by this Review (see Appendixes 2 and 3). There are also reports and data presented by interview participants.

In Australia, one-third of the population experience mental illness at some time in their lives and mental illness 'accounts for 13 per cent of the total burden of disease … and it is the largest single cause of disability' (Australian Government 2011a, p. 1). The illness affects all ages across a lifetime and is the greatest risk factor for suicide (Australian Government 2011a, p. 10).

Mental illness has far-reaching effects on WA's community. Currently, mental disorders rank fourth highest burden of disease for men after cancer, cardiovascular disease and neurological disorders and is predicted to rank third by 2016. In 2006, mental disorders ranked second highest for women after cancer. By 2016 these rankings are projected to be reversed, with mental disorders accounting for the greatest burden[1] (Epidemiology Branch 2012).

In all states of Australia, people who access the mental health systems experience them as largely crisis driven. There appear to be significant barriers to accessing services, which contribute to poor health outcomes (Commonwealth Government of Australia, 2011a; PHAA 2009). Traditionally, Australian mental health services acknowledge social and psychological risk factors of mental illness and the need to focus on diagnosis, treatment and support for the individual in recovery.

Mental health services in WA consist of acute inpatient services, community mental health services, recovery/rehabilitation services, and non-government organisations (NGOs). NGOs provide supported accommodation, psychological support, disease education, prevention, rehabilitation services and in-home assistance. Other contributors to mental health care include general practitioners (GPs) and other private services.

The demand on emergency departments (EDs) of mental health-related care increased by 5.5 per cent per annum between 2004–05 and 2008–09 across Australia (Government 2011; AIHW 2011a). More people are admitted into WA specialist mental health inpatient units each year.

The number of persons admitted for treatment of their mental health condition has increased in WA by 23.69 per cent since 2006 and separations have increased by 17.46 per cent. In the last financial year (2010/11), 1021 children and 8364 adults (under 64) were discharged from specialist mental health hospitals. In addition, 44,491 persons received a total of 750,486 occasions of service from the community mental health service (CMHS) (Mental Health Information System 2012).

Increasing demand for services is a challenge to current mental health resources. This is most evident in the health system by the difficulty of admitting patients into a mental health bed from EDs and urgent cases from the community, especially for young people.

Patients with mental illness and other conditions such as drug and alcohol issues, and especially those under the influence of methylamphetamine, require intensive management.

The open layout of EDs is not conducive to managing mentally ill patients and, at times, places other patients at risk. A separate area within the ED for patients with mental illness, some of whom may also be under the influence of drugs and alcohol, would better meet the safety needs of all patients.

[1] NOCC are agreed data items for the National Minimum Data Set for Mental Health for mandatory collection and reporting by the service providers and HoNOS is a mandatory rating system that measures the severity mental illness symptoms (operationaal directive OD0206/09, DoH).

Patients: The Review heard patients concerns about the inconsistent response of mental health services to their presentation and that assistance was often not available until they were at their most vulnerable and in crisis.

Some were comforted by kind staff who listened to them and made them feel safe and secure. For many others, the difficulties of accessing services, the long wait for assessment, little information about their psychiatric treatment or physical health, and scant rehabilitative services raised concern that the WA mental health system was unable to assist them to recover or improve.

Carers: The Review heard clearly that there are areas of service where carers and families believe that considerable improvements need to be made. For some, an unhesitating opinion was that the system, by virtue of not providing adequate, timely and preventive care, was a major contributing factor to a patient's suicide.

While the Review received a considerable weight of negative carer and family experiences, a number of contributions to the Review did describe receiving positive and supportive care.

Of the many persons interviewed in this Review, a common theme from carers and patients was that they were not singularly or severally involved in planning of risk, care and treatment. Nor were they involved in discharge planning. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The sanctity of patient confidentiality should not be used as a reason for not informing the carer that the patient is going on leave or is to be discharged. It is to be noted, however, that many services do this well, although not uniformly across the system.

Carers were concerned they had no teaching about what may constitute triggers for a relapse in their patient and what to note as possible signs of impending deterioration.

Clinicians: Throughout this Review, clinicians consistently expressed a desire to provide the best possible care for patients and to improve the quality of care and service provision. However, they repeatedly expressed dismay at resource shortfalls, management and governance issues, workforce shortages, increasing demand, and prevalence of mental illness. The overriding message from clinicians is that these features all intertwine to effectively prevent mental health workers from achieving their aims.

This Review acknowledges mental health clinicians for their dedication and commitment to work in often-complex scenarios and volatile environments.

The Review also observed that while imperatives of professional skill and knowledge are a crucial factor, clinicians share a strong desire to work within the mental health system. Clinicians described their colleagues as committed and patient centred, and their teams as cohesive. Supporting the mental health workforce is an imperative that should be continually addressed, particularly if sustainable improvement in the delivery of mental health services is to be achieved.

The Review found the current mental health workforce is inadequate to meet the mental health needs of WA. There are fewer mental health nurse full-time equivalents (FTEs) and the second lowest psychiatrist FTE per 100,000 people compared with other states (Australian Institute of Health and Welfare (AIHW) 2012).

The Reviewer wishes to commend the Rockingham–Kwinana Mental Health Service on their overall excellent management and provision of inpatient and community services.

Mental health clinicians are severely overworked in almost all areas, which invariably has led to incomplete services being supplied to patients in some areas. This is most apparent in many rural areas where clinicians find it difficult to carry out any rehabilitation as they are already stretched to provide often only basic mental health care. One clinician said all their working time was spent dealing with acute mental health problems and 'putting out bushfires'.

Mental health beds: In order to provide meaningful comparative bed numbers, reference is made to Andrews and Tolkien II Team's (2011) contemporary Australian modelling and based on the WA population of 2,366,900 (Australian Bureau of Statistics (ABS) 2011). An ideal bed stock of 3197 places is required in a stepped configuration as follows:

	Existing places	Recommended places/100,000	Optimal places	Change required
Inpatient services				
Acute	469	15	355	–114
Non-acute	130	10	237	+107
Community rehabilitation				
Clinical staffed 24/7	111[1]	15	355	+244
Staffed <12 hours	79[2]	15	355	+276
Supported permanent housing				
Supported public housing	174[3]	20	474	+300
Supervised hostels	748[4]	20	474	–274
Permanent housing	n/a	40	947	n/a
Total places		**95/100,000**	**3197**	

Notes: Private hospitals are omitted from this equation because they 'do not admit people as involuntary patients and the level of acuity is less than in the public sector. There are no data as to the offset that private beds make to dealing with the burden of mental disorders' (Andrews and the Tolkien II Team 2011, p. 11).

This table excludes specific services for older persons and persons with dementia. (Andrews and the Tolkien II Team 2011).

1. Based on figures 14 and 15.
2. Based on figures 14 and 15.
3. Based on 34.5 per 100,000 AIHW 2008–09 and population 2.17 million in 2008 accessed at: http://mhsa.aihw.gov.au/resources/facilities/beds.
4. Based on AIHW 2009–10 Data Cube.

WA requires more non-acute beds, community rehabilitation beds and more supported housing based on the current population. Two important qualifications are that:

- supported accommodation beds would need to be operational before a reduction in acute beds would be feasible
- places must be configured to account for the population growth.

Deciding upon the best mix and distribution of bed stock is outside the terms of reference of this Review. However, it is essential that a consistent methodology and definition of ideal bed stock is determined within the mental health clinical services framework.

A range of accommodation is needed within each region of the State and there is a need to properly negotiate a formulated 10-year clinical services plan that:

- articulates the services purchasing intentions and reform agenda of the Mental Health Commission
- defines the required capital investments and infrastructure build over the next 10 years
- provides facilities and services that allow best-practice clinical mental health care
- defines how the configuration of services and investment in services best meet contemporary best-practice care models and future demand.

Transport: The transport of involuntary patients under the *Mental Health Act 1996* authorises the police to escort patients with a transport order. The Act only authorises police to undertake the order but does not compel them and so other escorts are able to transport patients when the risk is less. The Mental Health Bill 2011 proposes the use of other authorised persons to assist in transporting patients with mental illness in the future. It is clear that the police are best placed to intervene in the community where community safety is the primary concern, and WA Police undertake the task whenever community or personal safety is at risk.

Inter-hospital transfers could be undertaken by hospital security personnel who are appropriately authorised and trained in mental health first aid and soft restraint.

Trained hospital security personnel also could provide security for the patient within the hospital setting until the patient can be assessed by a psychiatric team. The transport issue is discussed further in Section 3.7.

Documentation: This Review supports the development and implementation of standardised documentation in all mental health services and facilities in WA. Standardised documentation increases quality and safety of patient care by greater adherence to standards of care, improved intra- and interdisciplinary communication and better-informed clinical decisions.

In addition to hand-written medical records, the main electronic information system used within the WA mental health service is PSOLIS. The system is designed to collect demographic information and treatment-related history from patients in order to support optimum care. It is essential that information is available and accessible to all clinicians involved in a patient's care. However, clinicians currently experience inconsistencies, limited access and delays in information entry. An absence of mobile equipment to facilitate on-the-spot data entry and information access, and insufficient staff training, inhibit the program's full utility and potential.

It is crucial that the mental health system has one universally accepted, mandated and well-utilised information system. LASSO, a program introduced in the South Metropolitan Area, is a quality information system but the Reviewer is of the view that two systems are unnecessary and all required functionality can be achieved in the one system, which currently is PSOLIS.

General practitioners: These are often the first health service to whom patients with mental illness present and are the mainstay health provider in most patients' lives. Communication has to improve between GPs and the mental health services.

GPs would benefit from direct communication with psychiatrists to ensure continuity of care and to receive expert advice. This Review gathered evidence that the current process is patchy and varies between mental health services. Some do report and communicate with GPs very well – many do not.

Clinical governance: The Review concludes that the governance of public mental health in WA is fragmented, variable in type and method of service delivery, and that there is no robust uniform clinical accountability across the system.

This results in the disparate application of protocols and policies. As the principal provider of public mental health care, it is essential that the Department of Health has responsibility for overall governance of policy setting in the provision of care for hospital and community clinic settings.

Currently, there are two types of mental health governance in the metropolitan area. One is program based; the other geographically based. This leads to confusion in governance, particularly as mental health patients tend to move frequently across the system.

Across the mental health system, overall leadership is lacking, as is the ability to make things happen. Many mental health facilities act as if they work in a silo. Their relationships with each other are fragmented so that patients moving from one facility to another are frequently subjected to repeated history taking and changing care.

There is disparate implementation of policies across sites even within the same area of mental health service. A stark example lies in the use of different risk assessment processes.

The Reviewer is concerned at the large number of managers in all mental health settings and is uncertain of the need for such numbers. A functional review of these positions and functions needs to be undertaken.

A significant number of management groups meet to discuss a variety of mental health management issues and yet little is seen to have altered as a result.

There is sufficient comment from carers and patients to indicate that their involvement with management planning is lacking in many instances. This is partly due to the enormous workload on clinicians. However, these aspects are often not acted upon, leaving the patients and carers vulnerable in their care processes.

The Review is concerned at the reported frequency of patients who are triaged at community mental health clinics without input from a psychiatrist or registrar-in-training.

Despite the training of non-psychiatrist mental health clinicians, in the opinion of the Reviewer, this increases the level of risk for the patient, especially when presenting with a risk of self-harm. This scenario is particularly common in rural settings.

There is no overall cohesive link between many of the acute inpatient facilities and the community mental health clinics. This results in clinics sometimes not accepting patients for ongoing care after discharge from the inpatient setting.

Rural Areas: The delivery of mental health clinical services is more difficult because of vast distances and scattered populations in WA. This is particularly the case in the Kimberley, the Pilbara and the Goldfields. The difficulty in attracting and retaining mental health staff makes the delivery of services insecure. In some areas, such as Kalgoorlie, fly-in fly-out psychiatrists support the service. With many chronic mental health conditions, this is not satisfactory for continued patient care. In one case, a patient saw five different psychiatrists over a three-week period.

The rural population makes up about 28 per cent of the State's population and many are Aboriginal persons requiring special attention. The difficulty of administering mental health care in the area north-east of Kalgoorlie is sometimes confounded by the fact that the area is managed for health and policing by three bordering states. Cohesive policies as well as the legislative provisions of three different mental health Acts seem difficult to implement.

Aboriginal mental health: Apart from the comments above, the care of Aboriginal patients from rural or remote areas is made much more difficult because hospitalisation may require transfer to acute facilities in Perth. Fear of incarceration and separation from family and networks adds heavily to a patient's stress as well as to that of the family.

Of concern to the Reviewer is the care of Aboriginal people with mental illness. The development of specific care models that integrate family and trusted members of the community to accompany the persons with mental illness throughout their psychiatric/ specialist treatment is needed. In order that cultural methods of care can be applied alongside conventional psychiatry, the system needs to be augmented by trained Aboriginal psychologists, psychiatrists and mental health nurses.

General physical and dental health of patients: Patients with mental illness have a very high incidence of general medical conditions and often poor dental hygiene and care (Mai, Holman, Sanfilippo & Emery 2011; Morgan et al. 2011; Boulter & Sultana 2012).

In some inpatient services, this issue is well attended to but in others there is a lack of general medical input on a regular basis. In the community clinics, mental health clinicians rely on the patient's GP to provide that general health service. However, many patients do not have a GP. The metabolic syndrome (combination of medical disorders) associated with some psychiatric drugs appears well understood by clinicians but carers and patients seem ill informed of this. Clinicians need to attend to this aspect of information delivery to both patients and carers.

Dental care is often neglected, and while this is also true in the rest of the community, it is greater in patients with mental illness, as research has shown (Boulter & Sultana 2012).

Conversely, patients with a mental illness who are admitted to a general hospital for treatment of some other condition often have their mental illness overlooked, which may lead to very serious side effects.

This Review outlines the case of one such elderly patient admitted to a general hospital for a simple procedure whose long-standing mental condition destabilised and was not recognised (see Section 3.4).

Prisoners of Corrective Services: It is estimated that between 20 and 25 per cent of prisoners have mental health conditions or acquire such. While they have psychiatric care in prison, treatment may cease on release, despite the best attempts of the Corrective Service's Clinical Service Division to ensure follow-up by a GP or mental health facility.

Of significance are those patients on remand who are suddenly released at a bail hearing and who do not get any medical or mental health follow-up as the critical services may not be informed of their release.

The Director, Medical Services, Department for Corrective Services, Dr Roslyn Carbon, is to be congratulated on how this care of prisoners is being improved.

Recommendations

In order to complete this Review it has been necessary to examine the administrative issues around the implementation of mental health services and the clinical care given to patients in other areas such as general hospitals, correctional services and psychiatric hostels.

Recommendations of this Review address the refinement and improvement of admission, referral, discharge and transfer practices for public mental health patients in hospital EDs, authorised public mental health facilities/services, and general hospitals. They build on the positive foundation of mental health clinicians who are dedicated to improving the quality of their services for people with mental illness and their carers.

In 1922 the Western Australian Government held a Royal Commission into the care of persons with mental illness (Jones et al, 1922). Many of the issues identified in the Report from that Review are the same issues which are being faced today although it is clear that there has been vast improvement in patient care in the intervening years. Still much needs to be done to have a patient focussed service.

There appears to be no articulated Clinical Service Plan for Mental Health which embraces the aims of the Mental Health Commission and encompasses the clinical care responsibilities of the Department of Health. Such a plan is crucial to providing a comprehensive and safe service for all West Australians irrespective of personal and geographical diversity.

The principal recommendation of this Review is the following:

That as a matter of urgency the Department of Health and the Mental Health Commission jointly develop a Clinical Service Plan which embraces the key elements of clinical care, rehabilitation, living accommodation, geographical location and infrastructure build and support.

Other Recommendations are below:

Recommendation 1: Governance

1.1 That the Department of Health establish an Executive Director of Mental Health Services reporting to the Director General of Health and that position be responsible for:

- 1.1.1 The development of the mental health Clinical Service Plan in collaboration with the Mental Health Commission.
- 1.1.2 Policy setting, including those of standards and those of best practice.
- 1.1.3 Developing standard documentation for service provision, including model of care, patient risk assessment and risk management.
- 1.1.4 Oversight of the compliance of policies by the various service providers and reporting on those services that do not comply.
- 1.1.5 Working closely with the Office of the Chief Psychiatrist to ensure compliance with regulations from that Office.

1.1.6 Actively pursuing workforce development, service growth and service provision.

1.1.7 Developing the mental health workforce and mandating systems of supervision, continuing professional development and credentialling of a service, as well as personnel, to provide the required mental health care of that service.

1.1.8 Being involved in budget-setting with the Mental Health Commission in conjunction with the Performance Activity and Quality Division of the Department of Health, to ensure that this budget is appropriate to deliver safe and quality mental health care.

1.1.9 Ensuring the development of a robust information system (including electronic) with flexibility for ease of use by all mental health practitioners including those who practice in areas of public mental health managed by a private provider (see Section 3.10.6).

1.2 Works closely with other service providers such as GPs, private hospitals, and NGOs to ensure the system has solid links between inpatient and community mental health clinics (so there is a seamless flow of patients between them) and establishes and monitor those links.

1.3 Develops a safe and quality mental health transport system in the metropolitan area with hospital staff trained in mental health and soft restraint, to transfer patients between hospitals.

1.4 Cultivates resources and builds knowledge that improves evidence-based care, strengthening practice and fostering innovations.

1.5 The new Executive Director of Mental Health Services of the Department of Health needs to ensure there are bridge programs that associate mental health with disability and culturally and linguistically diverse services.

1.6 The new Executive Director of Mental Health Services develops policy with the Drug and Alcohol Office to enable mutual cooperative working with complex cases.

1.7 The new Executive Director of Mental Health Services needs to urgently implement a review of the management structure of the services in each Area Health Service in conjunction with the area chief executives.

See sections:					
3.1	3.2.1	3.2.2	3.4	3.5	3.6
3.7	3.8.1	3.8.3	3.9.3	3.9.6	3.10
3.10.1	3.10.3	3.10.4	3.10.5	3.10.6	3.10.8
3.10.9	3.10.10	3.11	3.11.4	3.12.1	3.12.1.1
3.12.2.2	3.12.3	3.12.5	3.12.5.5	3.12.5.6	3.12.5.8
3.12.5.9	3.13.1	3.13.2	3.13.4	3.13.5	3.14.1.4
3.14.1.5	3.14.3	3.14.4	3.15	3.16	

Recommendation 2: Patients

2.1 That the new Executive Director of Mental Health Services mandates the policy development of a patient-focused service that insists every patient is involved in care planning and discharge planning.

2.2 Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan, the carer is also involved, as appropriate.

2.3 Every patient has access to individual advocacy services to assist with navigation through the system and development of a care plan.

2.4 That adolescents and young people are assessed comprehensively, particularly for factors which encroach upon self-image and self-worth and that their concerns are validated and taken seriously.

2.5 A detailed explanation of the advantages and side effects of psychiatric drugs is given to patients and the need to maintain medication regimes is comprehensively discussed.

2.6 When patients complain of medication side effects these are to be taken seriously and the issues explained fully. Medications should be reviewed regularly with the aim of identifying side effects and the lowest effective dosage of the drugs should be used.

2.7 All mental health clinicians must ensure that the physical wellbeing (including dental) of all patients under their care are regularly assessed and treated by appropriate specialists clinicians (e.g. podiatrist, diabetes educator). This is a key performance indicator that requires monitoring for compliance.

2.8 Patients who have a mental illness and are admitted to general hospital wards for other conditions are assessed and monitored by mental health clinicians during their inpatient stay.

2.9 Where a patient has indicated the possibility of performing self-harm, that patient must always be comprehensively assessed by a mental health practitioner and their care plan be approved by a psychiatrist or psychiatric registrar and not discharged until that approval occurs.

2.10 No patient is to be discharged from an ED or another facility without an adequate care plan. Where there is a carer clearly involved, the carer should be included in the discussion of the care plan and the discharge plan. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The sanctity of patient confidentiality should not be used as a reason for not communicating with carers in these situations.

2.11 Patients must clearly be made aware of their voluntary and involuntary status.

2.12 The names and contacts of carers should be recorded for each patient where appropriate.

See sections:					
3.3	3.8.1	3.9.6	3.10.10	3.11.3	3.12
3.12.1	3.12.2	3.12.3	3.12.4	3.12.5.1	3.12.5.2
3.12.5.3	3.12.5.4	3.12.5.5	3.12.5.7	3.12.5.8	3.13.2
3.14.1.4	3.14.2	3.14.3	3.14.5		

Recommendation 3: Carers and families

3.1 While the patient is the primary focus of care, the views of the carer must also be considered.

3.2 Carers must be involved in care planning and most significantly in a patient's discharge plan, including the place, day and time of discharge.

3.3 The carers of patients need education, training and information about the 'patient's condition' as well as what are the signs of relapse and triggers that may cause relapse.

3.4 The carer of a patient needs to be informed in a timely fashion when the patient is to be reviewed by the Mental Health Review Board and supported to attend.

3.5 The governance of the system should provide to carers, patients and GPs an appropriate way to navigate the mental health system in seeking advice and support, particularly in crises.

3.6 A carer should have equal status with the patient in reporting triggers that might indicate a deterioration in the patient's condition.

3.7 Carer communication by mental health clinicians is mandatory for the system to be robust and provide patient best practice.

3.8 Patients may demand confidentiality of care and treatment but mental health clinicians in this situation need to understand and take into account the requirements and vulnerability of carers. Mental health practitioners must be aware of the rights and safety of carers.

See sections:					
3.4	3.8.1	3.8.2	3.9.5	3.10.7	3.11.3
3.12.1	3.12.2	3.12.3	3.12.5.2	3.12.5.5	3.12.5.8
3.13.2	3.14.1.4	3.14.3	3.16		

Recommendation 4: Clinicians and professional development

The following are required of all mental health clinicians:

4.1 Clinicians need to work actively with the Executive Director of Mental Health Services of the Department of Health to assist in workforce planning and service development.

4.2 Clinicians must ensure the service in which they are working does not deviate from the standards and protocols set.

4.3 Clinicians must ensure within their area of work that the service is totally patient-centred and that patients and carer's rights and responsibilities are understood and respected.

4.4 Mental health clinicians must comply with reporting requirements for National Outcome and Casemix Collection (NOCC) and Health of the Nation Outcome Scales (HoNOS) data collection.[1]

4.5 Compliance with the electronic information system is mandatory.

[1] NOCC are agreed data items for the National Minimum Data Set for Mental Health for mandatory collection and reporting by the service providers and HoNOS is a mandatory rating system that measures the severity mental illness symptoms (operationaal directive OD0206/09, DoH).

4.6 Clinicians need to ensure that continued professional development occurs and is recorded yearly as required by the clinicians' respective colleges and professional organisations. This compliance must be audited.

4.7 Links between community mental health services and inpatient facilities must be maintained and maximised to ensure continuity of care and continuation of treatment plans.

4.8 Residents of psychiatric hostels and other mental health facilities should have equal access to mental health services as other members of the community.

4.9 Ensure adequate support is given to residents in psychiatric hostels and supported accommodation when advice is requested within the areas in which community mental health clinicians work.

4.10 Psychiatric hostels and supported accommodation should have appropriate levels of access to patients' care plans and receive clear communication of discharge plans.

4.11 Since mental health and substance-use disorders, including drug and alcohol issues, co-occur with high frequency in mental illness, it is imperative that clinicians are trained in the recognition and treatment of comorbid disorders of this type.

4.12 Education and training should be provided to all staff to ensure ongoing quality of patient care and management. This should also be specifically available to workers of NGOs to ensure a high quality of care.

See sections:					
3.5	3.8.1	3.9.6	3.10.4	3.10.6	3.12.1
3.12.2	3.12.2.1	3.12.2.2	3.12.3	3.12.5.8	3.12.5.9
3.13.1	3.13.2	3.13.3	3.13.4	3.14.1.4	3.14.3

Recommendation 5: Beds and clinical services plan

5.1 The current acute bed configuration can only be adjusted when there are appropriate step-down rehabilitation and supported accommodation beds established. Any attempt to close acute beds before these systems are in place will be further detrimental to the system.

5.2 Adolescent beds need to be increased to take into account the increasing population of youths. Beds must also be provided for child forensic and eating disorder patients. These are urgent requirements.

5.3 Rural child, adolescent and youth beds should be considered a priority in forward planning and attended to immediately.

5.4 Close working between the Department of Health as the provider and the Mental Health Commission as the funder, needs to occur so that a robust Clinical Services Plan is developed that provides step-down facilities as an early and pressing need.

5.5 The full range of beds needs to be provided in each geographical area. This is crucial to ensure continuity of care across the spectrum of accommodation.

See sections:				
3.6	3.8.1	3.8.2	3.9.3	3.12.5
3.13.3	3.13.4	3.14.1.5	3.14.3	

Recommendation 6: Office of the Chief Psychiatrist

The functions of the Office of the Chief Psychiatrist align most closely with service provision. Therefore, in the opinion of the Reviewer, the Office is appropriately placed operationally in conjunction with the Department of Health so that ready communication to clinicians and the proposed Executive Director of Mental Health Services can occur.

The Office should be entirely independent and report to both the Minister of Health and the Minister of Mental Health with access to the Office by both the Director General of Health and the Commissioner of Mental Health.

The Reviewer is firmly of the view that the Office should not be placed in either the Mental Health Commission or the Department of Health where it can be seen that conflicts of interest would arise in either situation.

See section:
3.9.2

Recommendation 7: Acute issues and suicide prevention

Recommendation 7 includes the recommendations of the Deputy State Coroner and those of the Office of the Chief Psychiatrist.

7.1 Patients presenting anywhere in the public health system with suicidal intent must undergo a best practice risk-screening process and, where required, a comprehensive assessment by a mental health professional. A care plan must be formulated and all decisions to discharge require medical oversight and approval.

7.1.1 It is important that no decisions are made in isolation or by isolated practitioners.

7.1.2 Any emergency response team will also require medical oversight for decisions made when attending urgent referrals.

7.2 If a patient is discharged they must receive an agreed and signed comprehensive discharge plan that includes a carer, if involved, stating:

- appointment time and date with the community mental health service
- contact details of emergency services
- medication and consumer medicine information
- an undertaking to return to the current service if needed
- name of mental health clinician or caseworker.

7.3 The care plan must accompany the patient between community and other treatment settings; and be communicated to new clinicians at the time of transition. This ensures the care passport maintains treatment continuity.

7.4 Every patient should have an identified case manager.

7.5 The assessment, care plan and decision to refer a patient from one public mental health service to another should be seamless. The patient should not experience further assessments as barriers to entry. There should be no requirement to repeat triage.

7.6 Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Service (SAMHS) to assist Aboriginal people to access culturally secure mental health services, particularly those in custody or on parole and those with comorbid conditions such as substance abuse disorders.

7.7 Encourage training and education of mental health workers in the management of comorbid conditions of drug and alcohol misuse.

7.8 Continue to resource the current COAG Closing the Gap funded SAMHS suicide intervention teams, including the support of Aboriginal Elders Specialist Mental Health Services and government and non-government agencies.

7.9 Develop respite services and increase rehabilitation services.

7.10 Deputy State Coroner's Recommendations:

The Deputy State Coroner's recommendations (2008) are fully supported by this Review and should be implemented with expediency. This Review examined the Deputy State Coroner's recommendations (2008) and found that only three of the 16 had been achieved. The first is Recommendation 7; the second Recommendation 13 that has occurred with the Broome facility; and the third is Recommendation 16. Recommendation 1 is recommended in the Clinical Risk Assessment and Management Policy (CRAM). However, risk assessments do not always follow these guidelines.

7.10.1 Recommendation

Risk assessments should always follow those guidelines published jointly in 2000 by the Australasian College for Emergency Medicine and the Royal Australian College of Psychiatry and as subsequently endorsed as policy by the WA Department of Health in 2001 as a minimum standard.

7.10.2 Recommendation

Where a person has been referred to an authorised facility for admission by a medical practitioner, final risk assessment should be undertaken by a psychiatrist after triage and preliminary assessment by a RMHN (registered mental health nurse) if 'wait' time is a problem.

7.10.3 Recommendation

Where a person who has undergone prior admissions is taken to an ED by a carer experienced with that person, final risk assessment should be undertaken by a psychiatrist after triage and preliminary assessment by a RMHN if 'wait time' is a problem.

7.10.4 Recommendation

Where a person has undergone risk assessment in an ED and is not to be admitted to any facility but referred to a CMHS (community mental health service), the person and their carer are to be provided with written advice as to their relevant CMHS and contact numbers and their proposed management plan and relevant time frames.

7.10.5 Recommendation

The contact numbers should include 24-hour service emergency numbers and people should be advised these can be accessed by anybody at any time and trained workers, who have the ability to call out emergency teams if necessary, will respond. These should be a reality.

7.10.6 Recommendation

Ultimately all community health services should be funded to respond holistically to crises. Families, as well as patients, need support, especially on discharge of a patient back into their care. Carers need to know the people involved with the care of their patient.

7.10.7 Recommendation

No person should leave an ED without being provided with written advice as to who to contact in case of a crisis.

7.10.8 Recommendation

CMHS should make every attempt to provide their clients with concrete continuity. By this, I mean written contact and appointment dates from appointment to appointment with emergency numbers to contact between dates and 24-hour numbers.

7.10.9 Recommendation

Every child or adolescent with mental health issues should know a person acting as a community liaison officer [case manager]. PMH should be included in all authorised facility guidelines and directives and should be funded for community liaison officers to maintain contact with any child who has presented to PMH with mental health issues. This is regardless of whether or not carers choose private or public sector treatment for their child.

7.10.10 Recommendation

The role of the liaison officer is to ensure a contact for the child in times of crisis. They should maintain contact with the Bentley Adolescent Unit if the child is admitted as a patient or the relevant CMHS where the child becomes a client of a CMHS. They should know by whom a child is being treated if the choice is for private treatment. I do not envisage the liaison officer as being involved with treatment per se, but as ensuring children and adolescents are being provided with or have access to ongoing treatment as a matter of community commitment to children and adolescents.

7.10.11 Recommendation

Bentley Adolescent Unit should also have community liaison officers with a similar role and function to ensure children not passing through PMH also are provided with ongoing input.

7.10.12 Recommendation

There is a very real need for day hospital facilities/transition units/wellbeing centres—whatever one chooses to call them as outlined by Professor Silburn in more locations throughout the metropolitan region and the rest of the State, as outlined by Professor Silburn. Such centres will accommodate the difficult transition from admission to the community following discharge and as a community support for those dealing with mental health issues.

7.10.13 Recommendation

There needs to be relevant facilities out of the metropolitan area for short-term care of patients in crisis to avoid dislocation as an added stress. I don't know if the secure facility at Bunbury Regional Hospital is now adequate but there is nothing in the north of the State. I note the reference to a plan for a facility for Broome. This needs to become a reality.

7.10.14 Recommendation

Practitioners prescribing medications should ensure they comprehensively discuss compliance issues and discontinuation issues as well as any other relevant information associated with the particular medication prescribed. I would prefer both providers and dispensers of medication ensured up to date CMIs [consumer medicine information] or other written information be provide to patients and/or carers as a written record, approved by TGA [the Therapeutic Goods Administration] of the advice given.

7.10.15 Recommendation

Those practitioners discussing discharge plans with patients and carers need to specifically consider the extent to which they discuss the potential for death as an outcome of self-harming behaviour.

7.10.16 Recommendation

The Office of the State Coroner review all suicides in 2009 to assess what, if any, contact the deceased persons had with State Mental Health Services in an attempt to determine progress in the provision of improved mental health services to the West Australian community.

7.11 Office of the Chief Psychiatrist Recommendations:

The four recommendations of the Chief Psychiatrist's review of clinical practice: Admission and Discharges of Mental Health Presentations at Fremantle Hospital (June 2012) and the Chief Psychiatrist's examination of the Clinical Care of Four Cases at Fremantle Hospital (June 2012) are supported by this Review. They are as follows:

7.11.1 Recommendation: Comprehensive psychiatric assessment on admission

a. All patients regardless of how well they are known to the MHS [Mental Health Service] should receive a comprehensive psychiatric assessment as is possible on entry to the MHS for each specific episode of care, including patients transferred from other facilities.

b. The MHS should use a standardised psychiatric assessment form to ensure consistency of data collection within and between mental health services.

c. The MHS, with the patient's informed consent, includes carers, other service providers and others nominated by the consumer in assessment (NSMHS 10.4.3).

7.11.2 Recommendation: Risk management

a. The MHS adopt the current or revised Clinical Risk Assessment and Management Policy as mandatory practice.

b. The MHS ensures that, where indicated, patients have a current risk management plan, separate from the Individual Management Plan (IMP).

c. Risk management plans are updated or revised with any new information relevant to that individual patient.

7.11.3 Recommendation: Individual Management Plan

a. There is a current individual multidisciplinary treatment, care and recovery plan, which is developed in consultation with, and regularly reviewed with, the patient and, with the patient's informed consent, their carer(s). The treatment, care and recovery plan is available to both of them (NSMHS 10.4.8).

b. The treatment and support provided by the MHS is developed and evaluated collaboratively with the patient and their carer(s). This is documented in the current individual treatment, care and recovery plan (NSMHS 10.5.11).

c. The MHS ensures that the IMP is kept on both the clinical record and on PSOLIS.

7.11.4 Recommendation: Discharge planning processes

a. The patient and their carer(s) and other service providers are involved in developing the exit (discharge) plan. Copies of the exit plan are made available to the patient and with the patient's informed consent, their carer(s) (NSMHS 10.6.4).

b. The MHS provides patients, their carers and other service providers involved in follow-up with information on the process for facilitating re-entry to the MHS if required and other resources such as crisis supports are provided (NSMHS 10.6.5).

c. The MHS ensures there is documented evidence in the file that the treating team is in agreement with the decision to discharge the patient. Alternatively, evidence is documented in the file as to why the decision was made that may have been different from the treatment plan for discharge.

d. The MHS ensures, as far as possible, that the next agency or clinician to support or provide care for the patient is made aware of the discharge date, the urgency of review and a specific contact within the services to manage issues of urgency or failure of follow-up contact.

e. The MHS has a procedure for appropriate decision making in regards to those who decline to participate in any planned follow-up (NMHS 10.4.7).

See sections:					
3.1	3.2.1	3.2.2	3.3	3.4	3.8.1
3.8.2	3.10.4	3.10.7	3.12.1	3.12.2	3.12.2.1
3.12.2.2	3.12.3	3.12.5.2	3.12.5.5	3.12.5.6	3.12.5.7
3.12.5.8	3.12.5.9	3.13.1	3.13.2	3.13.3	3.13.5
3.14.1.4	3.14.3				

Recommendation 8: Children and youth

8.1 A central referring position is established to receive referrals for children and youth services, which will then direct the referral to the correct services in the patient's locality.

8.2 After-hours services are established for children and adolescent and youth services in rural and remote communities, where possible.

8.3 Emergency response services, including the Acute Community Intervention Team and the King Edward Hospital Unit for Mother and Baby, are supported.

8.4 Clear entry processes are developed for the Bentley Adolescent Unit.

8.5 Recovery programs for children are established.

8.6 Special provisions are made for the clinical governance of the mental health needs of youth (16–25 years of age). The State would benefit from the advent of a comprehensive youth stream with a range of services that do not have barriers to access.

8.6.1 Children should be treated in separate areas from adults, and young children should be separated from youth. Establish a youth inpatient unit with the capacity to manage comorbidities and alcohol and drug withdrawal.

8.6.2 Respite and rehabilitation services are developed for youth.

8.6.3 A service is established for youths with gender and sexual identity problems. Such a service requires expertise in psychiatric morbidity, suicidal behaviour, endocrinology and hormone treatments and close links with surgical and legal services.

8.6.4 Appropriate credentialing for children and youth health workers must be assured (refer recommendation 1).

8.6.5 Workforce planning must be made to address the shortage of Child Psychiatrists.

8.7 To reduce disconnection between inpatient and community, treatment teams involve all the child's services and communicate with one another in a timely and respectful manner.

8.8 A more equitable distribution of community resources is provided.

8.9 Early childhood assessment and intervention programs are established for those children who show signs of the development of possible mental illness.

8.10 Commissioner for Children and Young People Recommendations:

This Review supports the recommendations submitted by the Commissioner for Children and Young People (submission 2012).

8.10.1 Recommendation

A strategic and comprehensive plan for the mental health and wellbeing of children and young people across WA be developed by the MHC [Mental Health Commission]. This plan should provide for the implementation and funding of promotion, prevention, early intervention, treatment and programs.

8.10.2 Recommendation

Funding to the State's Infant, Child Adolescent and Youth Mental Health Service be increased so it is able to provide comprehensive early intervention and treatment services for children and young people across WA, including meeting the needs of those with mild, moderate and severe mental illness.

8.10.3 Recommendation

Admission, referral discharge and transfer policies, practices and procedures of mental health services need to ensure the cultural needs of Aboriginal children and young people are met.

8.10.4 Recommendation

The statewide Specialist Aboriginal Mental Health Service (SAMHS) and Infant, Child Adolescent and Youth Mental Health Service establish a close working relationship and seamless referral process to ensure the best possible outcomes for Aboriginal children and young people.

8.10.5 Recommendation

Priority is given by the mental health service to the assessment, referral, admission and continuity of treatment of children and young people in out-of-home care or leaving care.

8.10.6 Recommendation

A dedicated forensic mental health unit for children and young people be established.

8.10.7 Recommendation

Children and young people appearing before the Children's Court of Western Australia have access to appropriate, comprehensive mental health assessment, referral and treatment services.

8.10.8 Recommendation

The new Acute Response Emergency Team and specialist mental health services establish a close working relationship and seamless referral processes to ensure rapid access to treatment.

8.10.9 Recommendation

Previous recommendations made by the WA Coroner, Deputy State Coroner, the Auditor General for WA and Telethon Institute for Child Health Research about assessment, referral, admission, discharge, follow-up care, communication and care coordination be taken into account.

8.10.10 Recommendation

Transition strategies for young people moving from child and adolescent services to youth mental health services and from youth services into adult services be developed and implemented to ensure the individual is supported and continuity of care is maintained at both transition points.

8.10.11 Recommendation

The Disability Services Commission work with the Mental Health Commission to identity the services required to address the unique needs and risk factors for children and young people with disabilities in a coordinated and seamless manner.

8.10.12 Recommendation

All children and young people admitted to the mental health system have a treatment, support and discharge plan and that policies, processes and procedures that ensure care and discharge planning occurs to the level that ensures continuity of services and includes planning for education, accommodation and other support services as needed.

See sections:				
3.5	3.8.1	3.10.4	3.10.7	3.11.2
3.14.1.3	3.14.1.4	3.14.1.5	3.14.3	3.14.3.1
3.14.4	3.14.5	3.15	3.16	

Recommendation 9: Judicial and criminal justice system

9.1 As a matter of urgency, the Department of Health, the Mental Health Commission and the Department of Corrective Services (and other relevant stakeholders) undertake a collaborative planning process to develop a 10-year plan for forensic mental health in WA. (This plan will form the forensic mental health component of the State Mental Health Clinical Services Plan). Important elements to that plan include:

As early as possible in the planning process, a business case for expansion of the currently inadequate number and location of secure forensic mental health inpatient beds needs to be developed for urgent government consideration.

9.1.1 To divert early and minor offenders from the formal justice system and further offending behaviour in appropriate model, business case and funding for a police diversion service in WA are established.

9.1.2 The rapid and timely establishment of the recently funded Court Diversion and Support Program for adult courts is supported. The approved program for the Children's Court is also supported and it is recognised it will need early expansion to a complete service as in the adult courts.

9.1.3 The planning, business cases and funding for provision of a full range of mental health services in WA prisons and detention centres. This will involve dedicated units and services in prison for mentally ill women, youth, Aboriginal and people with acquired brain injury/intellectual disability.

9.1.4 Community services are expanded to facilitate transition from prison, to assertively follow up people who are seriously mentally ill and present a serious risk of harm to themselves and others, and to closely follow up and monitor mentally impaired accused patients on custody orders in the community. Also, there is a need to assess and care for particular groups of individuals with particular care needs such as sex offenders, stalkers and arsonists.

See sections:				
3.9.6	3.11.1	3.11.2	3.11.3	3.11.4
3.11.5	3.14.3			

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1. Establishing the Review

This Review offers recommendations for the refinement and improvement to the admission or referral practices and discharge and transfer practices of Western Australian public mental health facilities.

The Review gathered views, information and evidence of 891 persons over a six month period.

In Australia, one-third of the population experiences mental illness at some time in their lives and mental illness 'accounts for 13 per cent of the total burden of disease … and it is the largest single cause of disability' (Australian Government 2011,b p. 1). The illness affects all ages across a lifetime and is the biggest risk factor for suicide (Australian Government 2011b, p. 10).

'Mental health care is delivered in high volume and often with high levels of acceptability to the Australian community' (Meadows & Burgess 2009). Increased community service has been a goal for mental health across Australia:

> *... The [mental health] system is still too crisis-driven, with many people only receiving help when they are at their most vulnerable, instead of help to stay well. There are a number of highly effective services, but they are often patchy and not connected and, for reasons of program design or funding, struggle to deliver a truly integrated service response based around the individual's needs. This fragmentation of services also creates gaps, which prevent people receiving the full range of services that provide an optimal path to recovery ... Some 600,000 Australians have severe and debilitating disease [mental illness] which challenges their ability to live independently and participate in life*
>
> (Australian Government 2011b, p. 1)

It is clear that WA is not immune to the challenges of the national mental health system as evidenced in the *WA Mental Health Plan 2020: making it personal and everybody's business* (Mental Health Commission 2011). The plan addresses the challenges of the:

- number of people who take their own life through suicide
- high level of vulnerability of young people to mental illness
- higher prevalence of mental illness among Aboriginal people
- the deficit in community support and accommodation to assist people to transition into the community from mental health services (Mental Health Commission 2011).

In response to concerns raised in Parliament in November 2011 about the suicides of people who had been discharged from mental health services in WA, the Minister for Mental Health requested three reviews:

1. The Chief Psychiatrist's examination of four cases of patients who died unexpectedly following presentation at Fremantle Hospital.
2. The Chief Psychiatrist's review of the clinical decision made around the admissions and discharges at Fremantle Hospital over the past 12 months in which people have died subsequent to their discharge.
3. This independent statewide review of admission or referral to and the discharge and transfer practices of public mental health facilities/service in WA. (See Terms of Reference, Appendix 1).

The scope of this Review was informed by the thematic review of discharge planning conducted by the Office of the Chief Psychiatrist (OCP) in December 2011. The thematic review included an audit of 1248 medical records from across the State and a patient survey with 207 responses. It focused on admission, risk assessment, management plans, outcome measures, application of the *Mental Health Act 1996* and discharge planning processes within public mental health services in WA.

The major finding of the OCP thematic review was an inconsistency of clinical processes across clinical areas. For example, not all records contained a documented risk assessment as required by the Clinical Risk Assessment Management Policy. In 47 per cent of records, there was no evidence of any standardised risk assessment (Office of the Chief Psychiatrist 2011 b, p. 21). In fact, only 45 per cent of the medical records had evidence of standardised risk assessment documentation and eight per cent of these were partly completed.

This current Review identified the factors contributing to variations in care processes across WA's mental health care services.

The methods used in this Review of clinical processes and governance of mental health services included:

- listening to, recording, transcribing and analysing the views of patients, carers, and mental health clinicians and managers
- examining the policies and protocols that guide admission, discharge, referral and transfer practices and processes
- auditing medical record documentation
- examining the corporate, financial and legal frameworks within which mental health services function in WA
- receiving Commissioner's and other organisational reports whose responsibilities include elements of mental health
- analysing the Deputy State Coroner's data of completed suicides in 2009
- receiving written submissions from individual and facilities/services.

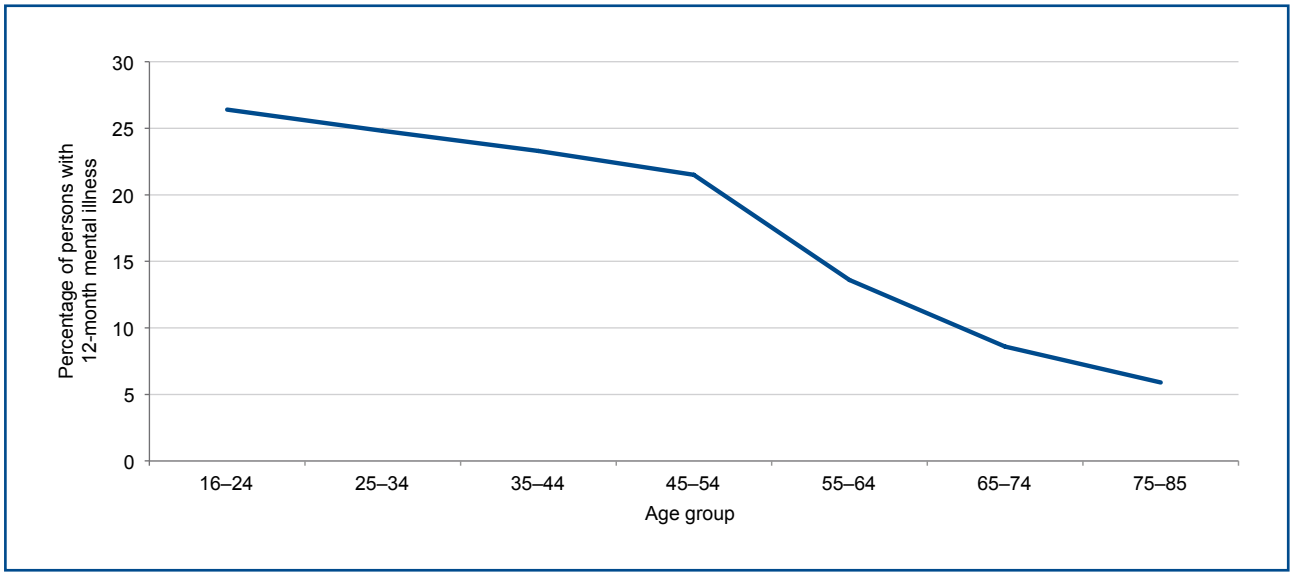
This methodology revealed an array of complex issues experienced by patients, carers, clinicians and managers within the WA mental health system and the challenges and imperatives that have led to variations in care processes. The recommendations that aim to improve mental health care in WA derived from this information.

2. Background

2.1 Mental illness and the current mental health system

Mental illness is defined as a clinical diagnosable disorder that significantly interferes with individuals' cognitive, emotional or social abilities (Council of Australian Governments' 2006). 'One in five Australians continue to experience a mental illness in any given year' (Australian Bureau of Statistics 2007; Australia Government 2009). This indicates that in any one year 450,000 Western Australians experience mental illness (ABS 2010). The prevalence of mental disorder is highest among young people aged 16 to 24 and many young people (17%) have severe levels of impairment (ABS media release, 19 July 2010, see Figure 1).

Figure 1 **Prevalence of mental health disorders in Australia, 2007**



Notes: People aged 16–85 years who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview.

A person may have had more than one disorder.

Source: Australian Bureau of Statistics (2010b).

Chronic mental illness is sometimes experienced by people who also have another disability (43%) that restricts their ability to self-care, mobilise and communicate. It affects schooling and employment (ABS 2007). These people have comorbidities such as chronic medical illness and substance use disorders. 'Of the 16 million Australians aged 16–85 years [….] 11.7 per cent (1.9 million) had both a mental disorder and a physical condition (ABS 2007 p. 22).

The mortality rate for patients with mental illness and associated comorbid chronic illness is 2.5 higher than the general population. The higher levels of morbidity and mortality among mentally ill Australians is compounded by the more frequent incidence of health-risk behaviours including smoking, alcohol and substance abuse, poor hygiene, inadequate diet and lack of exercise (Morgan et al. 2011). In addition, some patients with mental illness are also at risk of self-harm (Mental Health Division, CRAM Policy 2008).

Mental illnesses can occur as isolated or intermittent episodes, with or without partial recovery; and as a continuous, sometimes deteriorating, chronic disease illness (Morgan et al. 2011).

While well understood, the course of mental illness and associated social impacts are complex to manage. A recent WA study revealed the higher incidence of concomitant factors and debility that patients with psychosis experience when compared to patients without psychosis. A study of 1825 participants demonstrated higher rates of financial problems (42.7%), loneliness and social isolation (37.2%); unemployment (35.1%); poor physical health and disease (27.4%); uncontrollable symptoms of mental illness (25.7%), lack of housing (18.1%); stigma and discrimination (11.6%) and lack of family or carer (6.2 %) (Morgan et al. 2011).

Mental illness has far-reaching effects and places a growing burden of disease on WA's community. Currently, mental disorders rank fourth highest for men after cancer, cardiovascular disease and neurological disorders and is predicted to become the third highest burden of disease by 2016. In 2006 mental disorders for women ranked second after cancer. By 2016 these rankings are projected to be reversed with mental disorders accounting for the greatest burden[2] (Epidemiology Branch, DoH 2012).

These known potential impacts of mental illness on lifestyle should be catalysts for the mental health system to design quality services to:

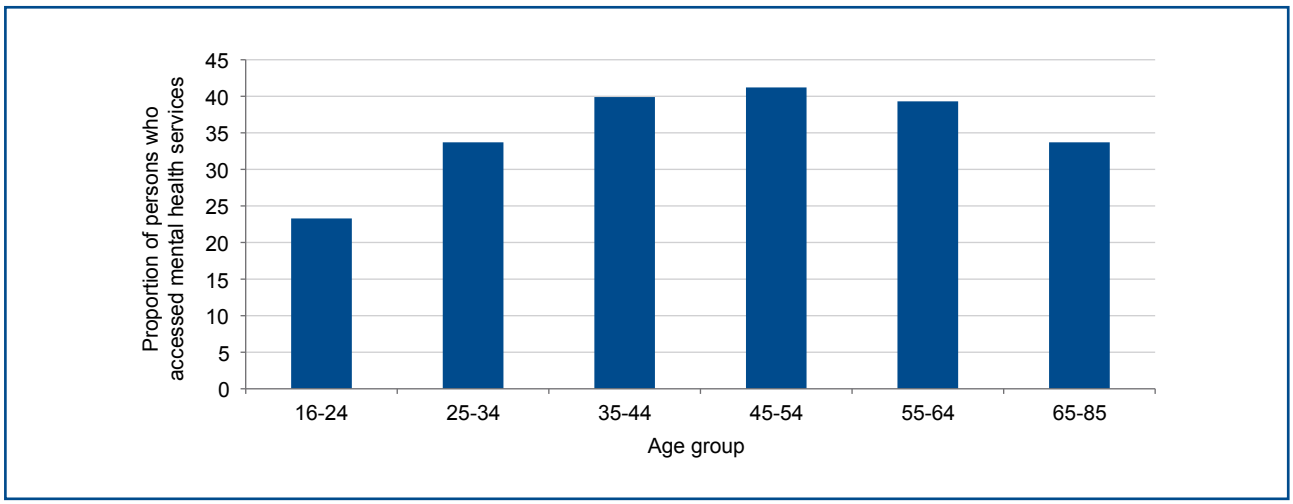
- strengthen and support patients' abilities
- promote and enhance protective factors (such as patients' social networks)
- provide recovery programs
- ensure service flexibility to respond to patients' changing needs
- smooth and expedite access to hospital care to treat severe disease.

A mix of public and private services delivers mental health care in WA. These include Commonwealth-funded primary care services; GPs and allied health professionals; state-funded hospitals and community services; private hospitals; and private psychiatrists. In addition, non-government organisations (NGOs) provide accommodation, support, rehabilitation and respite services that receive some funding from the State and Commonwealth governments.

There is variation in the use of mental health services by Australians who experience mental illness. More than half the persons in any age group do not access mental health services and young people seek them less often than adults (23% of young people compared with 41% of people aged 45–54 years) (ABS 2007, see Figure 2). Most people consult their GP for assistance with mental health issues.

[2] 'Burden of disease reflects the impact of an illness or disability on a population's life expectancy and quality of life. The Disability Adjusted Life Years (DALY) is a measure of burden of disease in the population, which integrates both mortality (Years of Life Lost) and disability (Years Lost due to Disability). One DALY equates to one year of healthy life lost. The sum of DALYs in the population is a gap measure used to quantify the difference between current health and ideal health situations' (Epidemiology Branch, 2012).

Figure 2 **Proportion of persons by age group, with mental health disorders who accessed mental health services in Australia, 2007**



Note: People aged 16–85 years who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview.

A person may have had more than one disorder.

Source: Australian Bureau of Statistics (2010b)

The public mental health system in WA provides a range of services to assess, diagnose and treat mental illness in inpatient and community settings. Quality and effective admission, referral, discharge and transfer processes are crucial to ensuring patients obtain the treatment and care they require when they need it.

2.2 Governance of Western Australian mental health services

Before June 1984, mental health services in WA were governed by a Director in a distinct government department directly responsible to a Minister. When the Department of Health was created in 1984, mental health amalgamated and mainstreamed with medical and public health operating in a regional structure. Some mental health services were colocated with general health locations such as Royal Perth Hospital, Sir Charles Gairdner and Fremantle hospitals. The administration of the services was integrated with acute medical services. At the same time, Lawrence et al. (2001) claimed the funding for mental health services was significantly reduced and, over the following years, services became outdated and inadequate, and there were breakdowns in care.

At that time a Ministerial Taskforce on Mental Health declared community mental health was severely underfunded and the increasingly heavy workloads made it difficult to retain sufficient psychiatrists (Lawrence et al. 2001).

In response to the taskforce report, the Mental Health Division was segregated from general health and became a distinct entity headed by the Chief Psychiatrist with a separate budget. The Chief Psychiatrist was responsible to the Commissioner for Health. Additional psychiatrists were attracted to the services by a new award. The *Mental Health Act 1996* became operational in 1997. The Act frames mental health care provision in WA.

The Act legislates the governing structure of mental health care. It also legislates admission, treatment and post-discharge support in relation to involuntary patient care and community treatment orders specifically.

It empowers the Minister for Health to promote and encourage, develop and coordinate to ensure delivery of mental health services in WA. Provisions of the Act do not specify the care and support of families. However, they stipulate the ministerial obligation to develop community services (s 1).

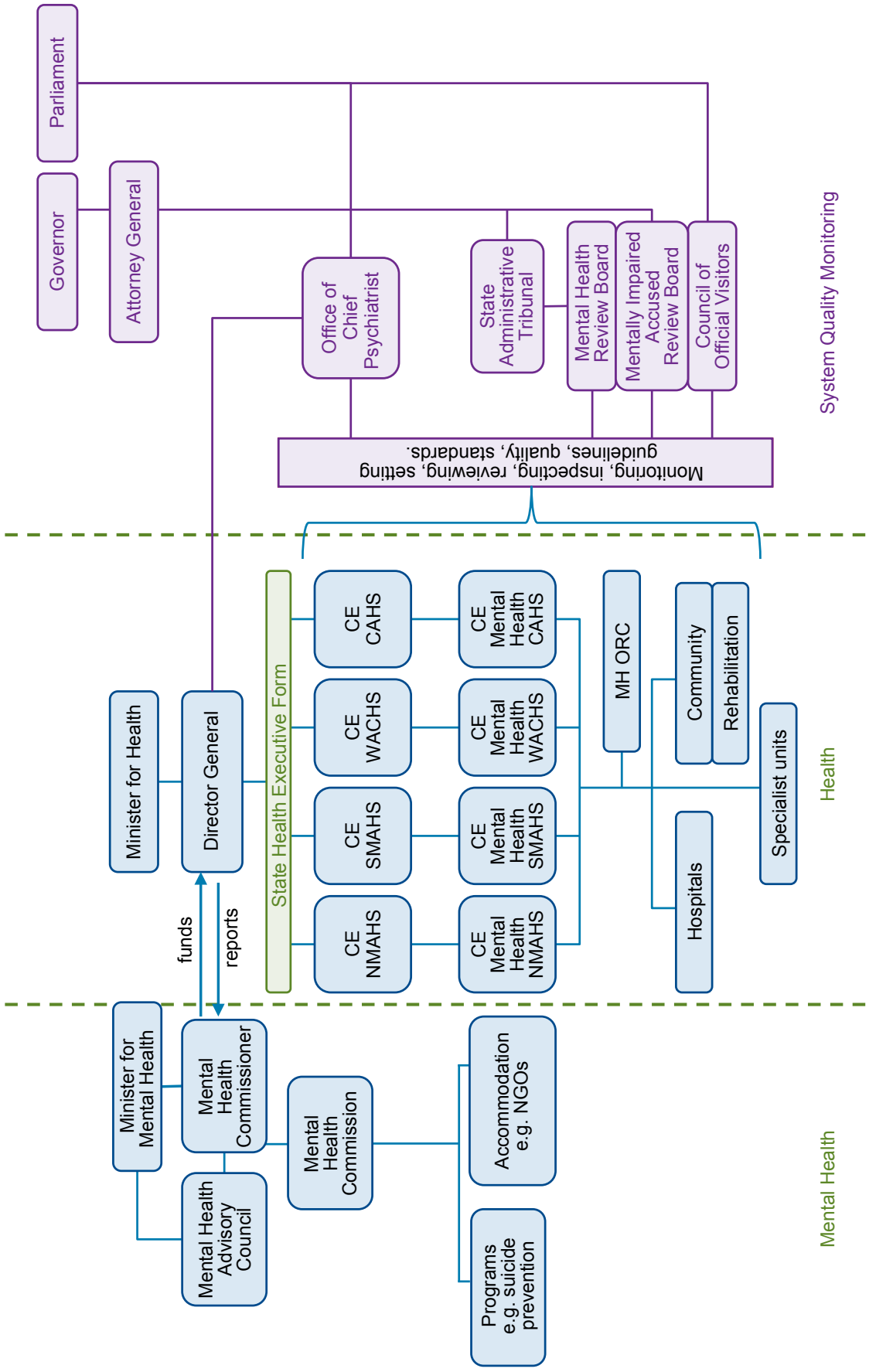
At the time of this Review, the draft Mental Health Bill 2011 was released for public comment.

The State Government budget for Mental Health in 2011/12 is $528 million, of which $457 million funds public health, and inpatient and community mental health services via service agreements; $80 million goes to Joondalup; and the remaining funds are distributed to:

- corporate costs
- policy initiatives, such as suicide prevention
- non-government organisations via service agreements.

Figure 3 illustrates the components of the mental health system in WA. A summary is offered to explain the interrelationships between the corporate governance, operational and clinical governance, and service providers.

Figure 3 **WA mental health governance structure, 2012**



Notes: NGOs = non-government organisations; CE = chief executive; NMAHS = North Metropolitan Area Health Service; SMAHS = South Metropolitan Area Health Service; WACHS = Western Australian Country Health Service; CAHS = Child and Adolescent Area Health Service; MH ORC= Mental Health Operations Review Committee.

In accordance with the *Mental Health Act 1996*, the **Governor of Western Australia** appoints a president and other members to the Mental Health Review Board on recommendation of the Minister for Health (Pt 6, Div 1, Sd 1, s 26).

The Minister for Mental Health appoints the Mental Health Commissioner (who purchases services from the Department of Health, private providers and non-government providers). The Minister also receives reports from the Council of Official Visitors.

The Minister for Health appoints the Director General of Health who in turn is responsible for the **Department of Health** providing public health services.

The Mentally Impaired Accused Review Board: Chairperson and members are appointed by the Attorney General and empowered by the *Criminal Law (Mentally Impaired Accused) Act 1996* to review the place and conditions of custody of patients subject to custody orders. The board advises the Governor about the release of mentally impaired accused persons.

The Council of Official Visitors (COOV) is empowered by the *Mental Health Act 1996* to provide advocacy for people with mental illness who are admitted as involuntary patients. In addition, they regularly inspect the inpatient environment of mental health facilities and provide recommendations for improvement. The COOV is funded by the Department of Health and reports to Parliament.

The Office of the Chief Psychiatrist (OCP) has legislated responsibilities for the clinical management and welfare of involuntary patients, and for monitoring the standards of psychiatric care throughout the State, including inspection of facilities (*Mental Health Act 1996* Pt 2, Div 2, s 9). Located in the Department of Health and reporting to the Director General of Health, the OCP also reports to the Mental Health Review Board about the care and welfare of involuntary patients. The OCP provides clinical guidelines and directives to mental health practitioners in WA.

Mental Health Strategic Business Unit: The interface between the Mental Health Commission and the specialised public mental health services has been limited and carried out by the Mental Health Strategic Business Unit (‘the unit’). It was planned that its main functions be quality control and risk mitigation and to provide liaison between Area mental health services and the Department of Health, Western Australia Police, Drug and Alcohol services and non-government services.

The unit was planned to negotiate the annual Memorandum of Agreement between the Mental Health Commission and the Department of Health and respond to the Commission’s service purchasing intentions on behalf of the Department of Health. This includes collation of business cases and developing service priorities for the Area mental health services. It was expected that the unit would undertake development of memorandums of understanding with the Performance Activity and Quality Division of the Department of Health.

Further, the intention was for the unit to collaborate with Area offices of the mental health service and the Mental Health Commission to develop frameworks for systematic monitoring, benchmarking and reporting on key performance indicators and outcomes.

The unit would also fulfil a central coordination role for the mental health information system (MHIS) and PSOLIS, and support inter-Area health and statewide projects with project management.

The Unit was also tasked with reporting on clinical reform initiatives such as the current recommendations of the Western Australian Auditor General for improving the performance of adult community mental health teams (Western Australian Auditor General (W.A.A.G.) 2009).

Western Australian Health Services are structured into four health areas:

1. North Metropolitan Area Health Service (NMAHS)
2. South Metropolitan Area Health Service (SMAHS)
3. Western Australian Country Area Health Service (WACHS)
4. Child and Adolescent Health Service (CAHS) merged child services from NMAHS and SMAHS into a discrete unit in February 2011. CAHS also supports WACHS. On 1 July 2012, NMAHS and SMAHS are expected to take responsibility for youth mental health services (16 years and over).

As of 1 July 2012, there will be two country health services: the Southern Country Health Service will include the WACHS regions of the Great Southern, South West and the Wheatbelt; the Northern and Remote Country Health Services will include the regions of the Goldfields, Kimberley, Midwest and Pilbara.

The Area Health Service (AHS) chief executives of each of these areas meet and report regularly at the State Health Executive Forum (SHEF) chaired by the Director General of Health.

The corporate governance of the AHS is mirrored in the operational offices for mental health. Each health area has a Mental Health Area Executive Director with offices of Deputy Executive Directors, Clinical Directors of Programs, Director of Nurse, Finance Director and Quality Assurance. These offices are responsible for the operation of the public inpatient and community mental health services within their regions.

Following the introduction of the Mental Health Commission, the mental health directors have continued the Mental Health Operations Review Committee (MH ORC) to discuss statewide issues. MH ORC has developed a statewide bed management policy for mental health. This committee no longer reports to SHEF and subsequently the line of communication to the Director General has been severed.

Since 1992 mental health services have reported quality data to the Australian Government under the National Health Care Agreement to the National Minimum Data Sets.[3] This includes the National Minimum Data Set for Mental Health Care and National Outcome and Casemix Collection (NOCC) data, such as the percentage of patients who are successfully followed up post-discharge within seven days (Department of Health 2009).

[3] National Minimum Data Set is a minimum set of data elements agreed for mandatory collection and reporting at a national level by the service providers.

Public mental health services and facilities in WA include:

Inpatient services

Graylands Hospital
The Frankland Centre
The Selby Older Adult
Joondalup Hospital
The Swan Valley Centre & The Boronia
The Ursula Frayne Unit, Mercy
20D Sir Charles Gairdner Hospital
Osborne Lodge
The Alma Street Centre
Ward 4.3 Fremantle Hospital
Leschen Unit, Armadale
Karri Mental Health Rehabilitation Unit (Armadale)
Banksia Ward (Armadale)
The Mills Street Centre, Bentley
Bentley Older Adult Mental Health Services
Mimidi Park, Rockingham
4 K Royal Perth Hospital
Albany Mental Health Unit
Princess Margaret Hospital
Kalgoorlie Hospital Mental Health
The South West Area Health Service – Acute Psychiatric Unit, Bunbury
Bentley Adolescent Unit/Families at work
Mother and Baby Unit King Edward Memorial Hospital

Adult community mental health services

Armadale
Bentley
Clarkson
Fremantle
Kalamunda
Hillarys
Inspire
Peel & Rockingham–Kwinana
Northbridge
Shenton
Stirling Street
Subiaco
Joondalup
ReachOut
Swan Valley
Warwick
Headspace
YouthLink
Youth Reach South

Child and adolescent community mental health services

Armadale
Fremantle
Kalamunda
Hillarys
Inspire
Peel & Rockingham–Kwinana
Northbridge
Subiaco
Joondalup
ReachOut
Swan Valley
Warwick
Headspace
YouthLink
Youth Reach South

Mental health rehabilitation services

Alma Street Centre Group Program
Bentley, Youth Transition
Centre for Clinical Interventions, Northbridge
East Victoria Park
Fremantle Living Skills Program
Hampton Road Service, Fremantle
Harrow House Living Skills, Subiaco
Horizons, Armadale
Kwinana Living Skills Centre
Mandurah Living Skills Centre
Scarborough Rehabilitation Service
South Guildford Centre
Viveash Rehabilitation Centre

(For all Western Australia mental health services see http://www.mentalhealth.wa.gov.au/getting_help/directory/SearchResults.aspx?ServiceType&Region=4)

2.3 Current admission, readmission, discharge and transfer policy for WA health services

The Admission, Readmission, Discharge and Transfer Policy (ARDT) for WA Health Services (Department of Health 2011a) provides an overarching framework for the rules and criteria that govern 'counting and labelling' of activity across the State.[4] The policy acknowledges the importance of the clinician's role in decision making and responsibility for clinical documentation, which enables accurate recording of service activity. This framework requires policy and decision rules to be developed within health services.

A summary of the framework's clinical requirements as they relate to this Review follows:

Mandatory recording at admission

The policy describes the broad categories for admission. It is expected that the clinician responsible for admission records the reason for admission and the expected length of time the patient will be in hospital at the time of admission (Department of Health 2011, p. 8).

Urgency of admission

Clinicians determine treatment and urgency and decide if the admission is elective (can be delayed for 24 hours or longer); emergency (should occur within 24 hours); or that the patient does not fit admission criteria—non-admitted patients.

Reasons for admission

Mental health patients may fit the criterion for physically unwell patients as well as ARDT s 2.5.3 reasons such as social factors, risk of self-harm and harm to others as factors that may influence the clinicians' decision to admit.

Care type

Clinicians must determine patient care types within several categories. Acute care is defined when treatment intent is to cure illness, reduce severity of illness or protect against exacerbation or complication of an illness that could threaten life or normal function; or to perform diagnostic and therapeutic procedures.

Rehabilitation is classified as sub-acute care (s 2.6.2). There are also provisions for maintenance care types, such as respite care, and care for patients with stable but severe levels of impairment and exceptional circumstances (s 2.7.9).

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[4] It is helpful to understand the many modes by which patients access the MHS. These access modes include:

- presenting to a GP and being referred to mental health services
- presenting to a hospital emergency department
- contacting help lines e.g. MERHL, RuralLink or healthdirect
- visits by community emergency response team (CERT)
- admission to hospital for physical care and obtaining a Hospital Psychiatric Liaison consult
- presenting to a community clinic or triage service in a mental health service
- being picked up by police and taken to a hospital emergency department
- being ordered to have a psychiatric assessment by a magistrate.

Triage in mental health services receives referrals for patients with mental illness.They contact the patient and undertake a risk assessment. This assessment determines the urgency of the referral and need for appointments with a specialist mental health clinician.

It is from the point that referral is accepted that the admission, readmission, discharge and transfer policy for WA health services applies.

Discharge destination

ARDT Pt 3 provides a definition of discharge ('separation'). When a patient is separated, the hospital ceases to be responsible for the patient's care and the patient is discharged from hospital accommodation. Formally, patients are discharged to private accommodation (their usual home) or another residence; transferred to another hospital, health service or other health care accommodation; dies; leaves against medical advice and does not return for continued treatment within seven days (leave without permission); or fails to return from leave within seven days (leaves with permission).

Discharge summaries

All admissions require that the Medical Officer complete a discharge summary at discharge (Department of Health 2011, pp. 47–48).

The summary must contain a statement:

a. that the intention is to not readmit the patient within 28 days or
b. the intention to readmit the patient within 28 days. Where patients with progressive/chronic conditions are expected to return to the hospital at some stage and an admission date is not planned, these patients are not routinely classified as planned readmissions.

Patient transfers

ARDT s 3.1 guides the recording of patient transfer between hospitals or health campuses. The definition of a transfer is when patients have been assessed or have received care and treatment in the first hospital and it is intended that the patient be admitted to the second hospital.

2.4 WA policy for clinical risk assessment and management

Risk assessment is guided by the WA Clinical Risk Assessment and Management Policy (CRAM) that prescribes a standardised approach for mental health services to assess and manage clinical risk. It takes the form of a framework that can be tailored to the specific requirements of each service. The framework is based on good risk management and treatment is based on the individual's history and circumstances. It acknowledges that mental health services are never risk free and that clinical risks such as suicide and violence cannot be predicted with 100 per cent accuracy (Mental Health Division 2008).

The CRAM Policy defines three major risk areas:

- risk of harm to self
- risk of harm to others
- risk of harm by others.

The policy also recognises system risks and risks 'that arise' in treatment that need to be considered. Risks are managed in a five-step process:

1. Establish the context.
2. Identify the risks.
3. Analyse the risks.
4. Evaluate and prioritise the risks.
5. Treat the risks.

The processes of admission and discharge of patients within MHS are recognised in the CRAM Policy as important steps in care delivery as defined by the policy. The policy and national standards for mental health services require that risk assessments and risk management plans are reviewed on the discharge or transfer of patients from mental health services.

The CRAM Policy requires clinicians to assess patients for risk on admission routinely, when their condition changes and before discharge. Informed by this assessment, clinicians develop an individual risk management plan in collaboration with the patient (and family, where legal and where patient wishes allow). The policy is underpinned by standard 10.4.5 of the National Standards for Mental Health Services, which also requires that treatment be reviewed in relation to assessment outcomes.

Thematic review

In 2011 the Office of the Chief Psychiatrist (OCP) conducted a thematic review of admission, risk assessment, management plans, outcome measures, application of the *Mental Health Act 1996* and discharge planning processes within public mental health services in WA. The OCP's thematic review made 18 recommendations to standardise documentation and align practices across WA. In summary:

- Mental health patients should receive a comprehensive psychiatric assessment at every episode of care.
- Each patient should receive risk assessment in line with the CRAM Policy.
- All patients should have a current risk management plan.
- All patients should have an individual management plan on their record and on PSOLIS, including those that are 'Medical Only'.
- On patient discharge, there should be documented evidence in the medical file that the treating team is in agreement with the decision to discharge the patient. Alternatively, patient records should reflect why a decision different from the team plan for discharge was made.

That mental health services should ensure that carers are involved in discharge planning, where appropriate and patient consent is provided.

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3. Review findings

3.1 Risk screening assessment and management

> *In a sense, mental health workers are perpetually working with people at risk and 'continuously walking a tightrope' with all patients (Mental Health Clinician).*

Mental health care has been increasingly required to respond to a need to appropriately assess and manage risk. The risks may be to the individual, to carers and families, to staff in mental health services and to the community. The primary reason an individual is admitted to hospital in western society is because they are at risk of self-harm or harm to others; and the Mental Health Act 1996 cites risk of harm to self or others as essential precursors to involuntary status. Risk assessments and individual management plans minimise risks to patients, other persons and mental health services (personal communication, Dr S Towler, Department of Health 2012).

The Review became aware of considerable debate among clinicians as to the usefulness of risk screening at entry points. However, risk assessment is a mandated requirement of the Chief Psychiatrist and an essential component of care in the national mental health standards.

In response to the need to properly identify and manage risk in mental health settings, the State Government developed the Clinical Risk Assessment and Management Policy (CRAM) in 2008.

The Review noted variable compliance with the CRAM Policy within and between mental health services. Some services had fully implemented the policy and used quality processes to ensure clinical compliance; a few services had developed non-standard tools; some services adhered to the policy in some components of the services and not others; while many services did not use a standardised risk screen at all.

The Reviewer observed a healthy discourse about the merit of risk assessment among clinicians. This included a questioning of the validity of the risk factors; efforts to improve the accuracy of risk determination; and an understanding that assessment of risk does not always indicate that a patient may or may not suicide.

Varying views on the value of risk assessment seems to have led to great variation in practice and a lack of adherence to the CRAM Policy. The variation affects the patients' access to services and leaves mental health services and patients exposed.

The fundamental problem is the expectation that a risk assessment can identify all factors with total validity.

There are simple yet significant differences between risk screening and comprehensive assessment. Risk assessment quickly captures a glimpse of the patient's risks via the use of a standardised screening instrument. Used throughout an episode of care, a standardised tool can provide snapshots of the level of risk and reflect the dynamic nature of an individual's illness. Risk assessments are used to make judgement(s) about the patient in order to determine if a referral for comprehensive assessment is necessary.

Brief risk assessments alone do not inform decisions about the care setting or intensity of care except in an emergency when risk is clearly unacceptably high. A positive risk assessment indicates a need for comprehensive assessment and therefore leads to referral for specialist assessment. The results of the specialist assessment then lead to the development of individual risk management and care plans.

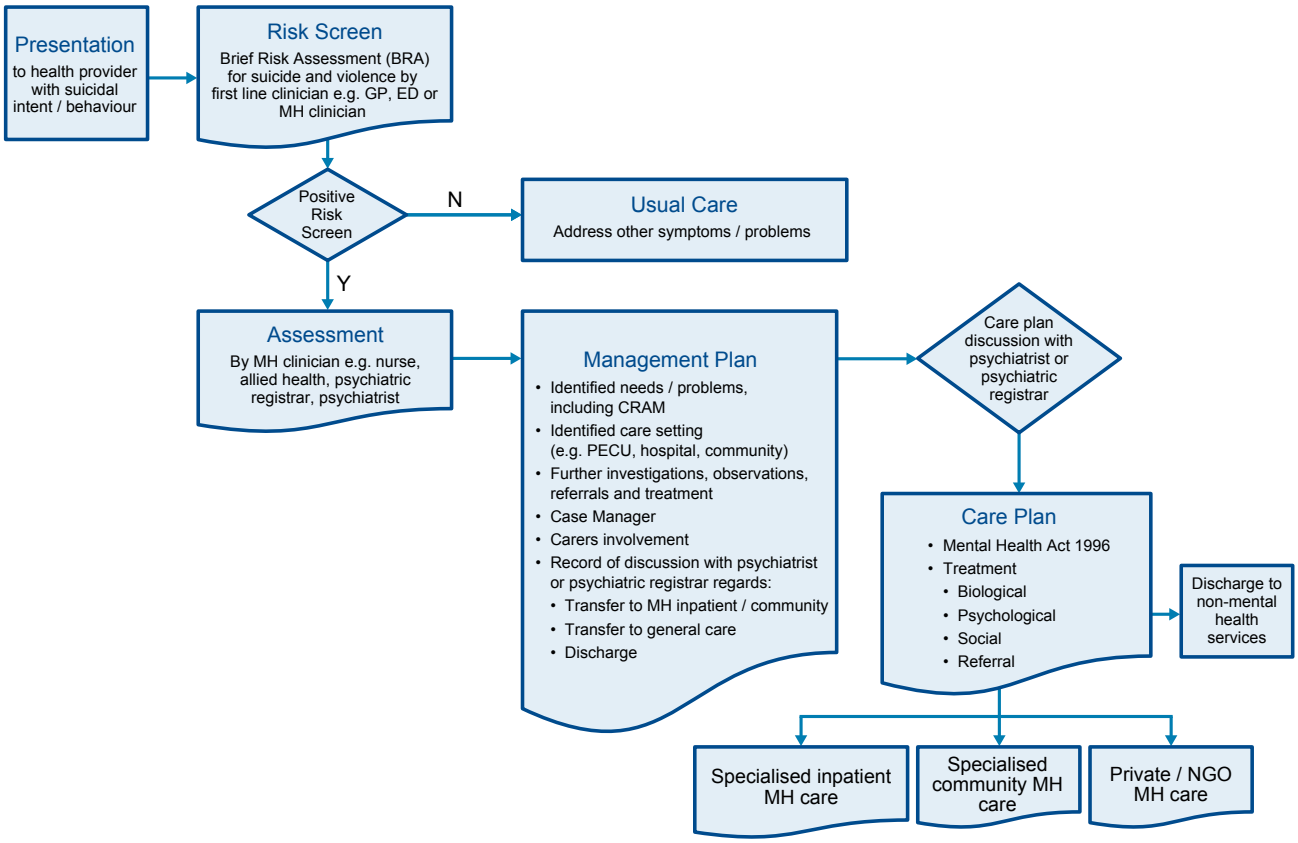
This Review supports the requirement of risk assessments for all patients who present for mental health care and, where indicated, a comprehensive assessment to quantify the level of risk and inform the individual risk management plan. Mental health practitioners in training should be supervised in their practice of risk and comprehensive assessment, to ensure practice wisdom is incorporated into assessment and treatment plans.

It is imperative to strengthen the clinical governance of mental health services to avoid disparate practice and to guide the clinical discourse to improve risk management across the State. This will enhance mandatory compliance with policy and provide the forums for discussions that can lead to clearly articulated frameworks for practice change.

This Review agrees with the Western Australian Association for Mental Health (WAAMH) that a 'revision of the mental health triage scale and risk screens to incorporate cultural and linguistic sensitivity and best practice principles should occur in annual cycles' (WAAMH Submission, 2012).

This following diagram demonstrates the required risk assessment process:

Figure 4 **Mental health risk process flow diagram, 2012**



Note: BRA = brief risk assessment; GP = general practitioner; ED = emergency department; MH = mental health; CRAM = clinical risk assessment and management policy; PECU = psychiatric emergency care unit; NGO = non–government organisation.

Source: Project team drawing, 2012

See Recommendation 1: Governance (1.1.2; 1.1.4; 1.1.5; 1.4); and Recommendation 7: Acute issues and suicide prevention; Deputy State Coroner's Recommendations.

3.2 Suicide

Mental health remains the biggest risk for suicide even though suicide accounts for less than two per cent of deaths overall (Australian Government 2011b p. 13). It is well accepted that the risk of suicide is higher in some groups of individuals: young men, Indigenous youth, displaced and separated men and those with mental disorders, particularly depression (Coroner's database in Mental Health Division 2009).

Suicide is the most common cause of death in Australians aged 15–44, more common than deaths from motor vehicle accidents or skin cancer, and the 10th most common cause of death overall for Australian males (Commonwealth Department of Health and Aged Care 2000).

Suicide is the main cause of premature death in mental health patients and this group has a 10-fold higher risk than the general population. Rates of suicide peaked in Australia in 1997 and dropped to around 9.8 per 100,000 from 2003 to 2007 (Mental Health Division 2009). WA rates have generally run at higher than the Australian average; it is currently about 11.8 per 100,000.

In WA '35 per cent of men and 60 per cent of women who completed suicide had suffered from a psychiatric disorder in the preceding 12 months' between 1986 and 2006 (Mental Health Division 2009 p. 24). Of those who died from suicide, more than one-third had been admitted to a private or public mental health hospital during their lives, 15 per cent of men and 20 per cent of women completed suicide on the day of discharge, and a third within a month of discharge (Mental Health Division 2009). This data informs us that patients are at high risk of suicide around the time of discharge.

The WA Suicide Prevention Strategy 2009–2013 advises that 'careful discharge planning and continuity of care of patients returning to the community is critical' (Mental Health Division 2009).

People who self-harm carry an increased risk of subsequent suicide. WA data indicates that for people discharged after an initial deliberate self-harm event, the rate of death from all causes, compared to the general population, was significantly higher (five times higher for males and three times higher for females) (Serafino, Somerford & Codde 2000). However, both sexes were more than 20 times more likely to die from suicide.

Patients who present to EDs with self-harm provide an opportunity to intervene. UK data, for example, shows that more than 40 per cent of people who died by suicide had attended an ED in the year before their death (Da Cruz et al. 2012).

A single and identifiable cause of suicide is not known. However, suicide and suicidal behaviour is believed to be an interaction of biological, psychological, social and cultural factors exacerbated by life stressors (Mental Health Division 2009). Life stressors include relationship breakdowns, psychiatric disorders, drug usage, issues with family and friends, financial issues, physical illness and associated issues, death of someone close, job loss and unemployment, loneliness, work issues, childhood abuse, child custody issues, old age and sexual orientation (Mental Health Division 2009).

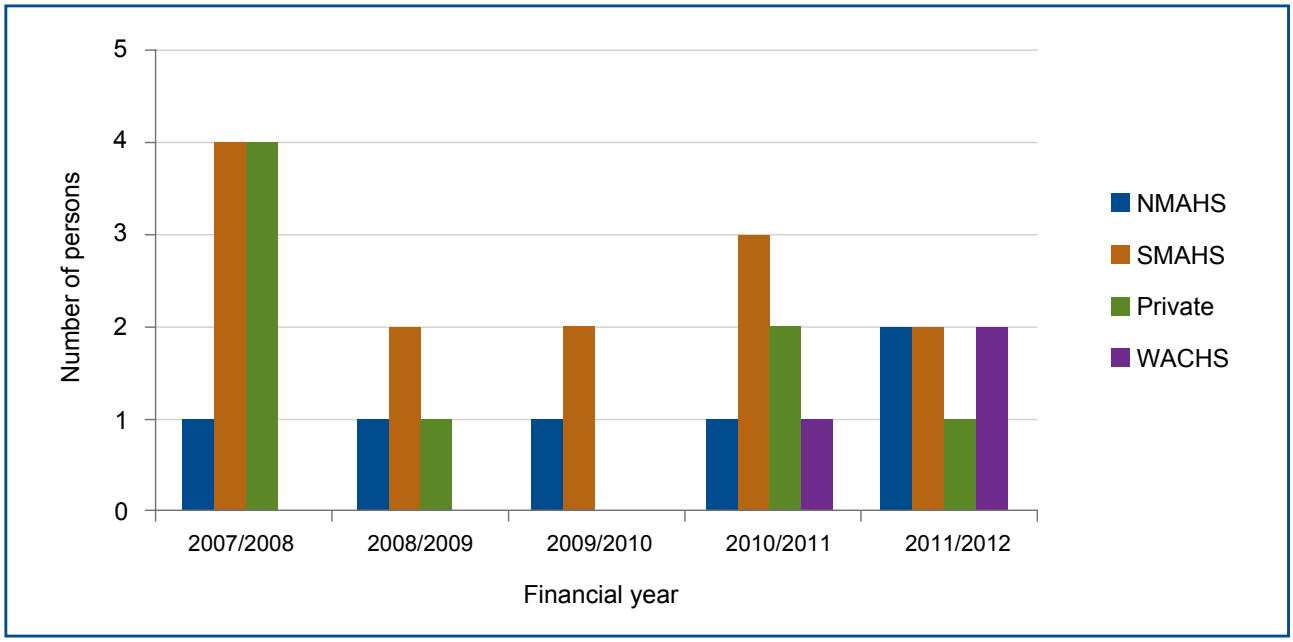
The evidence and processes around suicide risk assessment is a fiercely debated issue in mental health circles. There is a general perception among the public that risk assessment of those who are very likely to suicide is a precise science that only needs to be applied correctly to prevent the regrettable outcome. 'Such expectations have led patients, their relatives, their advocates and the coronial services to the belief that suicide is frequently the result of inadequate risk assessments within mental health services' (Mulder 2011).

Unfortunately, the reality is quite different. Large et al. conducted a meta-analysis of controlled studies of suicide within one year of discharge from psychiatric hospitals (long considered to be a high-risk group) and found:

> *No factor, or combination of factors, was strongly associated with suicide in the year after discharge. About 3 per cent of patients categorized as being at high risk can be expected to commit suicide […] however, about 60 per cent of the patients who commit suicide are likely to be categorized as low risk. Risk categorization is of no value in attempts to decrease the numbers of patients who commit suicide after discharge' (Large et al. 2011b).*

Suicide risk factors are not equivalent to suicide risk assessment. Checklist approaches based on risk factors to predict future suicidal behaviour have long been shown to be statistically significant in populations but of limited utility in individuals (Clark & Fawcett 1992). Suicide risk assessment has to be personalised to the individual and not a population of individuals (Draper 2012).

Figure 5 **Number of persons who suicided while admitted to hospital, WA 2007/12**



Note: NMAHS = North Metropolitan Area Health Service; SMAHS = South Metropolitan Area Health Service; WACHS = Western Australian Country Health Service.

Data source: Performance Activity and Quality Division, DoH (2012).

The majority of medium- to long-term suicides are not likely to come from identified 'high-risk' groups but that does not mean that 'low-risk' individuals do not become 'high-risk' under changed life circumstances. This is why individualised assessment is important and why reassessment needs to occur when the clinical context of a case changes.

Accurate risk assessment and management of the identified risk is crucial and the training of mental health professionals in how to perform risk assessments is a fundamental skill that all mental health professionals need to acquire. There is evidence supporting this call for better training from the findings of two large studies of suicide following contact with psychiatric services (Appleby et al. 2006). These studies conclude that around 20 per cent of studied suicides were considered preventable but for inadequate assessment and management of depression and other psychiatric disorders; poor staff-patient relationships; and inadequate continuity of care, particularly the transition between hospital and the community.

Suicide is rare among patients who are inpatients in adult public mental health services in WA. However, over the past five years, 30 suicides occurred in patients during hospital admission; 22 in public hospitals and eight in private mental health hospitals (see Figure 5).

In 2008 the Deputy State Coroner investigated nine deaths purported to be related to individuals not being able to access the public mental health services. That report identified that patients' difficulties in accessing services were related to extreme pressure on the mental health system and on the practitioners who were struggling to provide services under extremely difficult conditions.

That report also noted the risk of suicide within a short period of discharge from inpatient care. The Deputy State Coroner proposed that some suicides are preventable and extra care must be taken when people are discharged into the community.

The two main areas of difficulties were:

1. Risk assessment/admission to relevant facilities.
2. Discharge planning/communication—communication of the discharge plan to the patient and their carer.

Other issues included:

- not enough specialist mental health beds
- not enough mental health workers
- not enough qualified people to service the beds
- staff exhaustion.

These factors were recognised to have significant impact especially on mental health workers in rural and remote areas.

The Deputy State Coroner reported that many mental health practitioners believed completed suicides are rare and that if a person does not exhibit acute suicidal behaviours they are not always assessed to be at risk of completed suicides (p. 13).

Concerning risk assessment and access to facilities, six of the nine people who unequivocally asked for help did not receive the help they needed in time and there was an absence of assessments by a consultant psychiatrist.

The Deputy State Coroner reflected that previous inquests had also revealed that some patients do not receive a risk assessment and few patients are assessed by psychiatrists. She said:

> *More often, the mental health nurse determines that the patient in crisis has 'situational distress' or a 'substance abuse episode' rather than an episode of mental illness.*
>
> *There are also times when people in crisis are asked to wait in the community until a bed becomes available in a public mental health service*
>
> *(Deputy State Coroner 2008).*

3.2.1 Audit of 255 persons who suicided in WA 2009

Deputy State Coroner Evelyn Vicker offered the data of all WA suicides in 2009 to this Review to assess:

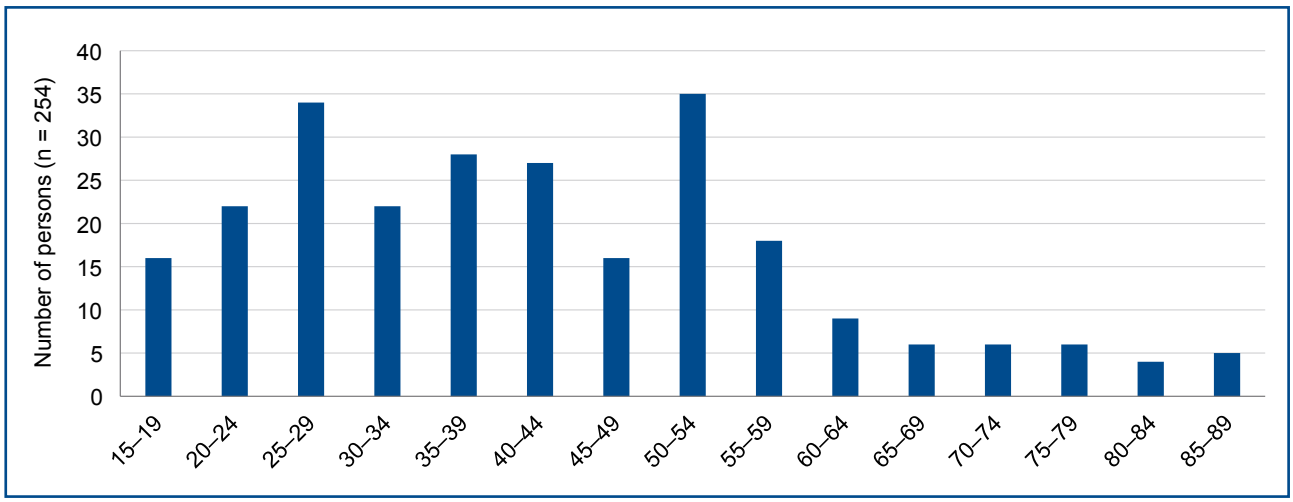
> *What, if any, contact the deceased persons had with the State mental health services in an attempt to determine progress in the provision of improved mental health services to the West Australian Community (Recommendation 16 of the 2008 Coroner's Report).*

For the sample, the Coroner used the Briginshaw 'Standard of Proof' as applied to WA inquests, that is, there is no doubt that suicide is the cause of death. These data therefore exclude deaths from single car accidents or 'natural causes' where chronic illnesses such as heart disease or diabetes are suddenly not managed and lead to death. Applying this criterion, a total of 255 persons died from suicide in WA in 2009.

The data of 255 persons were examined by this Review to determine if there were links between them and the mental health services, and the results of that analysis are presented here.

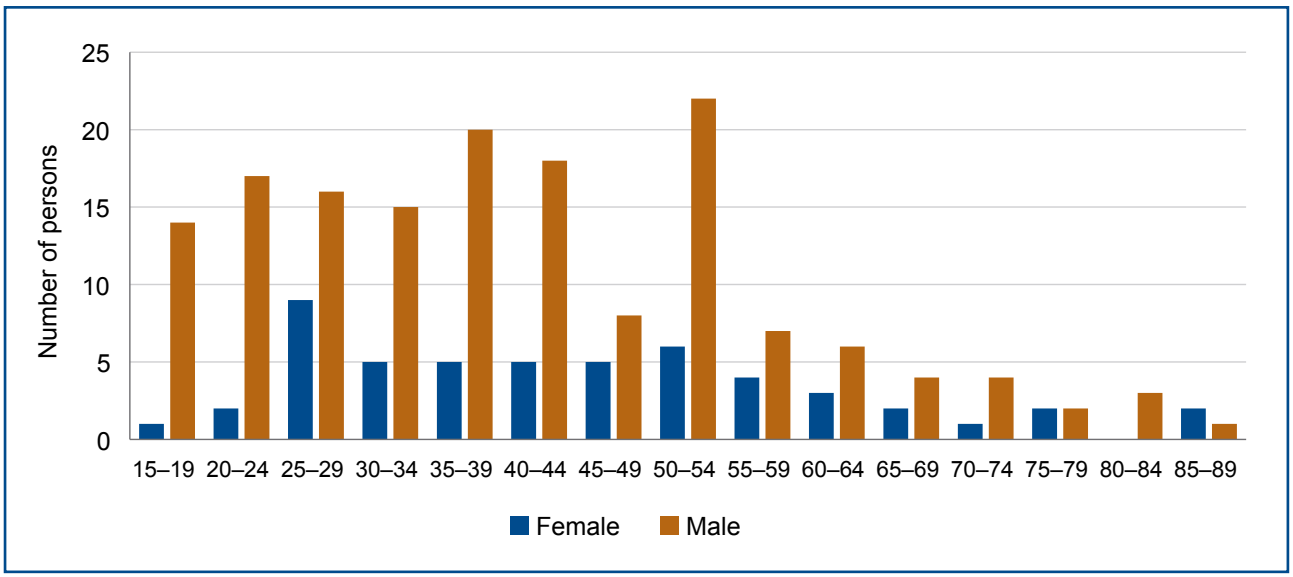
In 2009 suicide occurred within all age groups and a high number of completed suicides occurred among persons aged 50–54 (35 or 13.77% of people). Persons aged 15–39 represent 37 per cent of those who completed suicides (see Figure 6). More men than women completed suicide in each age group under 75 years of age (see Figure 7).

Figure 6 **Age distribution of suicide WA, 2009**



Source: Deputy State Coroner's data (2012).

Figure 7 **Age and gender distribution of suicide WA, 2009**

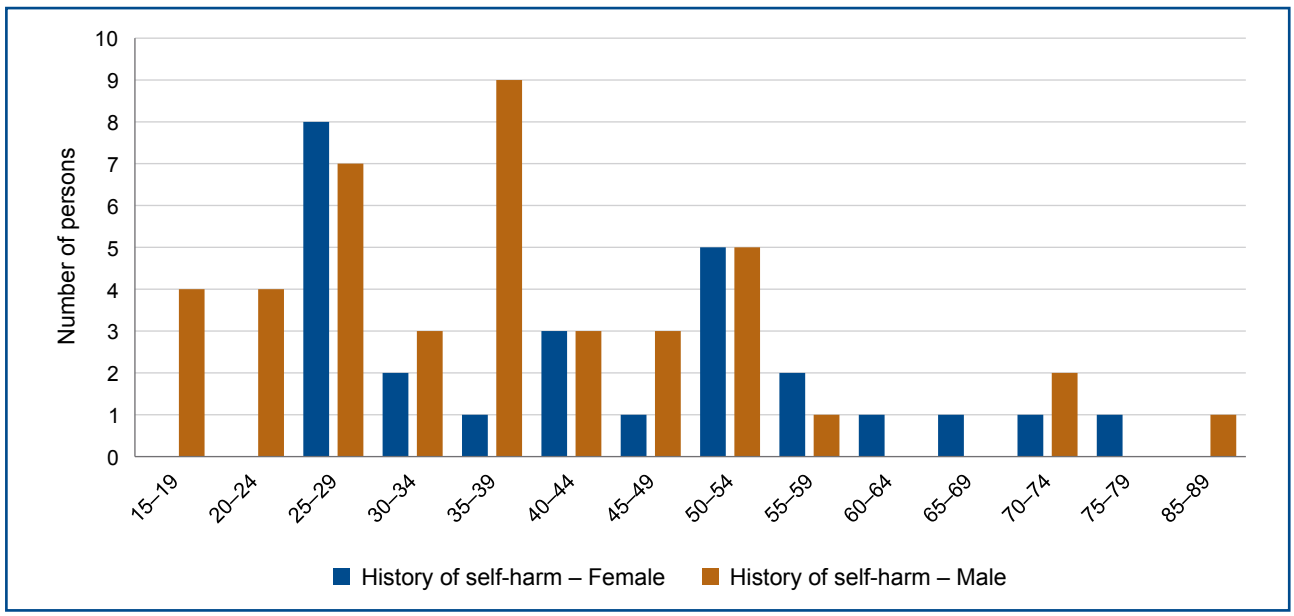


Source: Deputy State Coroner's data (2012).

International research revealed that in western societies half the people who suicide have had contact with mental health services during their lifetimes and 25 per cent have had contact with mental health services within the year of death (Bouch & Marshall 2005; Department of Health, London 2010; Tseng et al. 2010). Those figures align closely with the 2009 cohort where 104 (42.62%) of the persons who suicided had previously contacted mental health services. Of those with previous contact, 43 (41.34%) did not seek help before death; this included 14 women and 29 men. Some of these suicides were impulsive and occurred in association with alcohol consumption.

A history of self-harm was more prevalent among persons aged 25–39. There were 1.6 more men than women with a history of self-harm. Of the 255 people who completed suicide, 68 had a history of self-harm and 37 had known suicidal ideation (see Figure 8). A history of self-harm is strongly associated with suicide (Large et al. 2011a).

Figure 8 **History of self-harm by gender, 2009**



Source: Deputy Coroner's data (2012).

In 2009, 61 (24%) of the people who suicided actively sought help in the period immediately preceding their death. Twenty-one accessed public mental health services; 28 accessed private psychiatry and 12 sought help elsewhere, for example, from family members.

Twelve (4.7%) of those who sought help from public mental health services were unable to obtain services. Of these, nine persons received risk assessment by the mental health services. Five were assessed to be at no risk, four were assessed to be at low risk; and four did not obtain timely assessment (i.e. they were waitlisted). The false negative finding is similar to the findings of Large et al. (2011a) discussed above.

Of those who were accessed and were admitted to mental health services, two completed suicide while on unauthorised leave and a further two completed suicide while on 'official' leave.

Twenty-eight were admitted and then discharged from hospital. More than half were discharged from the mental health services with a discharge plan, including a plan for hospital follow-up. Of the 15 with discharge plans, one did not receive follow-up from community mental health services; five community mental health service referrals were not activated; five patients were discharged without a discharge plan; and three were discharged without discharge plans and did not receive any follow-up.

In addition, three individuals and one family had not complied with treatment plans and one had not disclosed their intent to suicide.

Twenty-seven of those who suicided were treated by private psychiatric services and most of those deaths occurred in association with a change in medication, where the patient's condition destabilised and there was no evidence of referral to community service or involvement of community mental health services to support or monitor the patient between psychiatry visits.

Twenty-one individuals completed suicide after discharge from a mental health facility, three died on the day of discharge and three the following day. The others died within 2, 5, 7, 14, 27 36, 40 and 52 days of discharge. The high risk of suicide following mental health inpatient care, particularly in the first day and week, is well documented (Hunt et al. 2009; Tseng et al. 2010). For example, in Thailand 28 per cent of deaths occurred within a week and in Britain, 43 per cent of suicides occurred within a month of discharge (Hunt et al. 2009; Tseng et al. 2010).

The importance of follow-up care in the days after discharge from inpatient cannot be overemphasised. Hunt et al.'s (2009) controlled study demonstrated that enhanced follow-up decreased the likelihood of suicide and suggests that risk assessments, mental state examinations and follow-up procedures are essential, including for those patients who self discharge. Follow-up may include telephone contact to encourage patients to seek social support and attendance at clinic within the week of discharge (Tseng et al. 2010).

In summary, this examination of the 255 completed suicides in 2009 revealed that almost half the people had contacted mental health services at some time during their lives. Many did not seek help immediately before suicide. Twenty-one accessed public mental health care and 12 were unable to obtain services. For nine persons who sought help from public mental health services, the risk assessment did not identify their need for immediate intervention.

Suicide occurred among those who accessed mental health services, and concern is raised as to whether the deaths that occurred where the patient was on leave could have been prevented. Had a risk assessment had been undertaken and were risk management plans in place prior to leave? Of the 21 persons who suicided after discharge, most had discharge plans. However, not all received the hospital aftercare that was planned.

Improving the processes of response to referrals, risk assessments, discharge planning and follow-up care in the mental health system is essential. Patients' needs for mental health care must be met with a cohesive mental health system, an experienced workforce and effective governance. Despite improving access to risk assessment and management of patients who are suicidal, it must be understood that prediction in this situation is a dynamic and often shifting scenario and, even with best management, not every suicide can be prevented.

See Recommendation 1: Governance (1.1.2, 1.1.3, 1.1.4, 1.1.5); and Recommendation 7: Acute issues and suicide prevention – Deputy State Coroner's Recommendations and Office of the Chief Psychiatrist's Recommendations.

3.2.2 Council for Suicide Prevention

The establishment of a Ministerial Council for Suicide Prevention ('the Council') arose from the WA Suicide Prevention Strategy 2009–2013 developed in response to an election commitment of the current State Government. The State Government committed $14.2 million to implement the strategy over four years. The plan highlighted the importance of a whole-of-government approach to suicide prevention and is a mandated priority for all State Government departments (Mental Health Division 2009).

The Council reports to the Minister for Mental Health. The strategy and budget is administered by Centrecare on behalf of the Council. It includes numerous approved programs to implement what are known as Community Action Plans (CAPs).

To date, 22 Community Action Plans in 163 geographical locations and eight target-group CAPs addressing 180 locations are in action (Centrecare WA Suicide Prevention Strategy, Business Plan 2011–2012 (2010)).

The Chair of the Council, Mr Peter Fitzpatrick, AM, informed this Review that the planned actions include community coordinated programs. For example, the Wheatbelt action plan involves 13 towns, each contributing to the action plan. Programs include suicide awareness training provided to community groups, police and teachers. A reference GP has also been identified for Indigenous persons where access to GPs is difficult.

The suicide prevention strategy operates by engaging communities to improve health through increased recreation facilities, life opportunities and social participation to ameliorate the adverse effects of social disadvantage on health (PHAA 2009), for example, to build community capacity by providing initial support through activities such as football. Coaches are trained to identify illness such as depression (personal communication P Fitzpatrick 2012). Programs also include taking children fishing or camping on the weekend, where trained community members provide informal leadership and young people talk during the course of activities (personal communication P Fitzpatrick 2012).

By attending meetings in a community hall, young people build up trust with leaders. The Chair of the Ministerial Council for Suicide Prevention told the Review that the basis of suicide lies in an individual's self-esteem; it is not all about mental illness. While engaging in social activities, many young people have explained they are reticent to attend professional services where they do not always feel listened to. Often the side effects of medication trouble them and symptoms of mental illness do not subside quickly. In addition, youth reflect that the environment of the ED is inappropriate to discuss self-harm (personal communication P Fitzpatrick 2012).

As yet 24-hour suicide preventions programs have not commenced due to difficulty in engaging willing individuals to provide this service. It has also been difficult to engage some communities, such as Derby, where meetings to date have contained more service providers than independent community members (personal communication P Fitzpatrick 2012).

A number of programs are in development including:

- Mensweb—a 'one-stop shop' to search and access a diverse range of men's services promoting mental health and wellbeing, awareness of mental illness, suicide prevention and self-help behaviours
- Carnarvon Family Support Service Inc—a Suicide Prevention Committee is undertaking service mapping and a gap analysis
- City of Vincent—Developing a Community Action Plan within the City of Vincent
- Abortion Grief Australia—engaging community groups and service providers to promote professional development and community awareness and improve accessibility for those experiencing abortion trauma/grief
- Gay and Lesbian Communities—developing suicide prevention initiatives for the gay, lesbian, bisexual, transgender and intersex community
- Injury Control Council of WA (incorporating 12 regions of the South West)—building capacity with a comprehensive suicide prevention education program
- Relationship Australia—Resilience program; Blokes and Chic's Gender Specific programs; Music program; and programs aimed to teach girls and boys to deal with power, strength and powerlessness (Spini 2012).

Suicide prevention programs identify themselves as the third arm of mental health, filling the gaps between hospital and mental health care (personal communication P Fitzpatrick 2012). However, the Review was informed that the suicide prevention programs do not always feel supported by mainstream mental health services and some have difficulties in obtaining advice from those services.

See Recommendation 1: Governance (1.1.2, 1.1.3, 1.1.4, 1.1.5); Recommendation 7: Acute issues and suicide prevention; and Deputy State Coroner's Recommendations.

3.3 Patients' experiences

Listening to the stories of people's experience of the mental health system was a critical and informing aspect of this Review. This Review has heard about the system from the patient's point of view through face-to-face interviews, group forums and by written submission. In some cases, aspects and insights of a patient's perspective have been supplied by carers, family and advocates as they describe their lived experiences with the patient.

While the Review heard predominately from patients expressing serious concerns, a number of patients and their carers reported positive experiences, some recalling feeling comforted and listened to and some felt safe and secure when in care.

Patients were forthright in their expression of concerns about the system, pointing out flaws and failings.

The Review heard patients' descriptions of experiencing inconsistent responses of mental health services to their presentation, with assistance not available until they were at their most vulnerable and in crisis. For others, the difficulties of accessing services, long waits for assessment, little information about their psychiatric treatment or physical health, and scant rehabilitative services raises important questions that must be addressed by the mental health system. `

Access and referral

Some parents with children suffering a mental illness explained to the Review that their children had presented numerous times to psychiatric triage and not been able to gain entry as expediently as they expected. Parents expressed anger and shock, and in the strongest terms said they felt that the system had failed to respond urgently to self-presentations at services and even with professional referrals.

A number of the stories presented to the Review were characterised by considerable trauma and, for some, sadly, suicide. In the following précis of patient stories, all were seeking validation of symptoms and to be provided with explanations of how the system could assist them.

- A GP's referral resulted in an appointment for a person at high risk in six weeks from the time of referral.
- A patient waited in the community for 48 hours to obtain a psychiatrist review.
- A patient was asked to wait on a bench at the Mental Health Triage for assessment; he waited there for hours that day, returned the following day and waited again.
- A patient was self-harming but not admitted to inpatient care.
- While waiting for assessment in the community, a patient's abnormal behaviour led to their assault while they waited for assistance in the community.

In each of these situations, parents expressed concern that the difficulty in accessing timely services was a major flaw in the system that contributed to the patients' suicides.

Delays receiving assistance culminated in some patients' behaviour escalating and WA Police intervening to de-escalate the situation and, in some cases, transport the patient to a mental health facility or ED for assessment. One mother described her son sitting on the bonnet of a police vehicle in the rain for an hour while he waited for a mental health service to assess him.

Parents explained that their child's physical health was attended to in EDs. However, in a number of cases their mental health was not assessed by a specialist mental health professional. A parent explained that her child had cut his wrists in the bath and was brought to the ED. In emergency, while the physical injuries were attended to, there was no psychiatric assessment. The Review suggests that the absence of psychiatric assessment in emergent situations such as this is a serious failing that must be addressed.

Conversely, this Review has formed a view that lack of attention to the patients' physical health when patients are under the care of a mental health service is an area that requires improvement in the system. Although many patients described receiving daily mental state examinations by nursing staff, they did not recall any type of physical examination at any time during their inpatient stay.

An insightful group of youth said that optimally there should be enough services to address everyone's needs and the system should be easy to navigate. They suggested that young people who were 'brave enough to go to their GP' with their mental illness concerns should be celebrated because health-seeking behaviour should be rewarded and early intervention in mental health is optimal.

A young person explained that she had presented to her GP at 17 years of age and explained her symptoms. The GP referred her to the triage team at a public mental health service. The triage staff asked 'a hundred million' questions and the patient was then seen by another worker (whose role was not identified to the patient) and who then made an appointment for her to return. The young woman returned to that appointment with her mother and after a brief assessment was informed that her illness was not severe enough to warrant mental health services. Instead, a letter was written to her GP and then she was to continue treatment with her GP.

This scenario continued with the same young woman presenting to her GP with depression and anxiety. Another referral was made to triage. On this presentation, she was taken to a consulting room and interviewed by a mental health worker (she was unsure of the discipline of the interviewer). She was informed that she was 'going through a phase', and needed to 'grow up' and she was again sent back to the care of her GP. She felt that her symptoms were not taken seriously. A more informed view by the mental health care worker may have validated her experience and provided insight into how she would be able control her symptoms over time.

Her mental illness finally led to hospitalisation at a designated mental health adult facility where her condition was diagnosed. Now, after nine hospitalisations she is able to manage her condition and continue her educative pursuits.

Patients described a wish to be involved in decisions about information sharing and with whom it could be shared. A young person was concerned about information sharing with her parents. She said that when she presented to the GP with an eating disorder and self-harm behaviours, the GP had called her mother into the consulting room and exposed the marks of self-harm on the youth's legs. The forced and unexpected confrontation exacerbated the patient's distress. The dilemma of sharing information with carers is discussed more fully in Section 3.4.

Admission to inpatient units

Patients' experience of admission to mental health hospitals varied. The circumstances of admission and voluntary or involuntary status appeared to the Review as important determinants in how mental health services were perceived.

One patient said explanations had been given about care and she felt involved in the development of her treatment plan. This patient's relationship with mental health staff in the inpatient setting continued after discharge and the patient confidently telephones these staff when she has troubled thoughts, especially at night. The patient told the Review that staff always respond to her and the interaction lessens her anxiety. Further, she explained that the psychiatrists have 'always listened' and 'worked hard' to modify medications and optimise her wellbeing.

By contrast, another patient described feeling very alone on admission. Some patients said they did not receive any orientation or explanations of care and treatment. One said she had wished there had been 'someone on her side' to explain the processes. She said that if someone was 'holding your hand' on admission it would ease the acceptance of help and encourage engagement with others. Instead, she was scared and perceived the service to lack a 'trusting therapeutic environment'.

Acknowledging that each patient's circumstance is unique, a common thread of feeling alone through an admission episode may be an important catalyst in considering patient advocacy and patient navigation from the point of admission. Every patient needs access to individual advocacy services to assist with navigation through the system and with the development of a care plan.

Lack of access to the treating psychiatrist concerned one patient, who described her referral to a public mental health unit from a private mental health hospital with a Form 1 (referral for assessment). This patient recalls that assessment by a psychiatrist was the only psychiatric interaction she received during her hospitalisation and she was never informed of her involuntary status.

Inconsistency in staff interaction with patients was described to the Review. For example, during one admission to hospital, nurses rarely interacted with one youth. However, during an admission to another hospital, the nurses were supportive of the same patient. Another patient found staff to be unsympathetic.

There was also inconsistency in involving the patient's family in care. A patient and carer wrote to the Review with concern that family and carers were not involved in her admission or plans for discharge.

Insufficient treatment information led to one patient feeling threatened. A patient explained that she had refused medications as an involuntary patient because the nurse would not describe what her medications were. The nurse told her she would be put in the 'quiet room' if she did not calm down. This patient absconded during a 30-minute period of unescorted leave by having her mother pick her up. Her mother later went to the hospital and negotiated voluntary status and the patient was discharged into her care.

Lack of clarity about voluntary and involuntary status and confusion about secure and insecure environments, along with patients neither receiving information nor understanding their status, should be afforded attention within mental health settings.

A patient cited her experience of being admitted to a designated bed in a public hospital describing how she had been refused leave and refused transfer to a private psychiatric hospital. Since the doors were locked, this patient assumed she was involuntary. However, when she retrieved her file through freedom of information, she found no forms that indicated she had been admitted with involuntary status.

Emphasised by a number of patients was that that admission to the mental health system can occur very abruptly, causing considerable disruption and distress that is exacerbated by not being able to sort out domestic issues.

In the crisis of admission, patients are often incapacitated or do not have the opportunity to prepare for a hospital admission. They often cannot carry out their responsibilities for childcare, pet care, payment for accommodation (rent or mortgage) and other bills and securing their employment and lifestyle (personal communication Dr S Patchett; and S. Boulter Mental Health Law Centre, 2012).

Where no family members are available or aware of admission, fulfilment of these day-to-day responsibilities of living does not occur, causing untold stress. There are occasions when the outcome includes recovered patients not having a home to return to when they are ready for discharge, or with home circumstances in considerable disarray.

This situation is made even more difficult when the patient is transferred long distances, such as from the Kimberley to Perth for treatment.

Often this occurs without notification to their family or the community mental health services. Many of these patients are Aboriginal people who arrive at inpatient facilities without winter clothing or money. Their families have difficulty finding out where they are because their official name is usually used by the hospitals whereas the families usually ask for the patient by their traditional name which is not recognised by the mental health facility.

When patients return, they can be taken to Perth Airport to wait all day for a flight, unaccompanied and without food. When patients arrive at their destination, they do not have money to telephone families to collect them, and many families are not notified of their impending discharge.

Rehabilitation

Designing and effecting age-specific rehabilitation programs is highlighted as a needed improvement. One young patient reflected that during admission to a designated hospital bed, she had attended a mindfulness group. The other participants were adults and this presented difficulties as the issues seemed more suitable to an adult than to a youth.

In a group held with adolescents and youths on cognitive behaviour that the patient experienced at another hospital, the youth found the participants were at a similar developmental stage and this was beneficial to her understanding of her illness and its impacts.

Important benefits of skilled rehabilitation and counselling were characterised in the experience of working with a psychologist. The patient described how she was assisted to develop self-awareness and recognition of mood changes and how to respond, including how to contact the assistance of mental health care for support. This skill has given her a sense of control and she is more aware of when to seek help, and appreciates how her medications help to control symptoms.

When asked about rehabilitation, a number of patients explained they had never experienced any rehabilitation program. Instead, their treatment was focused on medication and they were left to their own devices to overcome self-care deficits and to motivate themselves with the encouragement of their family to become involved in educative and employment pursuits.

Patients explained that under the Medicare Better Outcomes Program, they can receive 12 psychology services or rehabilitation for three months. However, some need more sessions or time to benefit from treatment.

The Review formed the view that recovery and rehabilitation programs are areas in which concerted and careful attention should be directed. It is apparent that there are some areas of good practice. However, in general, recovery and rehabilitation is not a major focus of mental health care, with resources focused at intensive inpatient management.

Discharge and information sharing

In direct contrast to many family and carers suggesting they were being given only minimal information, a number of patients described inappropriate information sharing and discussion with their families. For example, a young woman told the Review that she perceived hospital staff 'blamed her parents' for her overdosing. On discharge from an inpatient psychiatric unit, another youth explained that her father was informed that his child's self-harm behaviour was attention seeking. This minimised the youth's illness and the youth felt 'not believed'.

Youths claimed there should not be one golden standard for information sharing but rather each situation should be considered independently. Youths said they understood the importance of informing parents. However, in their maturing and seeking of independence, they did not always want their parents to know everything, and wanted a say in what and when information was disclosed. However, they recognised that information sharing is important when the illness is serious and ongoing.

Expanding on information sharing is an issue of patients' involvement in care and lack of explanation of treatment planning. For example, one youth said the medications were explained in a limited way and the pharmacist supplied written information. However, she was not informed that an electrocardiogram (ECG) was part of the process of care to monitor the effects of the antipsychotic medication on cardiac function. Being asked to have an ECG worried her.

Patients told the Review that the effect of ceasing medications was not always described to them. In the context of powerful medications, this is an area that can place patients at risk of harm. When one patient delayed filling her prescription until she had the money, she suffered severe symptoms associated with abrupt cessation of her medication. Other patients described how frightened they were when they experienced suicidal ideation and strange behaviour when they didn't take their medications and had not been warned about ceasing medication without advice.

One young woman explained how distressed she felt when she developed the side effects of metabolic syndrome. The unexpected alteration to her body exacerbated her sense of poor self-worth and led to increased social difficulties. She remarked that she was not told about this medication side effect and had not connected her treatment with changes to her physical appearance.

Exclusion from involvement in decisions about treatment and discharge plans was frequently described to the Review. Patients said they were told they were being discharged with little time to prepare their transport home and ensure they had food in the home or to understand medications and treatment plans and what to expect in follow-up. Late notice of discharge was especially difficult on weekends when community mental health services and GPs were not readily available.

Follow-up

A patient explained that patients are often left to self-direct their care, and it would better to have a care coordinator with whom to discuss feelings and get assistance to navigate the system. Patients and families' perception that the system is complex is supported by the Review's observation that the system is complex and difficult to navigate. The patients consistently refer to a need for someone who could assist them to find their way or to navigate the system. This further emphasises the need for effective case management that extends through patients' transition from inpatient care and beyond into the community.

GPs are often referred to as the primary medical support for patients in the community and patients seemed aware of this. The health system and the mental health system may also be placing high and sometimes unrealistic expectations on the shoulders of GPs. By way of example, one young person explained she received no follow-up or instruction other than to go to her GP following a self-harm emergency presentation. The GP did not feel able to help her further because of the GP's own poor understanding of mental health conditions.

Some patients characterised GPs as 'lovely' and 'helpful with prescriptions' but that many GPs admitted to the patient that they are neither knowledgeable about psychiatric conditions nor confident to modify medication regimes. This type of open admission, combined with GPs referring to specialists when needed, was praised by patients. GPs were viewed as advocates who would persist in making referrals until their patient got the service they needed.

The role of the GP in the care of people with mental illness is discussed more fully in the GP section.

See Recommendation 2: Patients; and Recommendation 7: Acute issues and suicide prevention.

3.4 Carers and family experiences

The Review heard clearly that there are areas of service where carers and families believe that considerable improvements need to be made. For some, an unhesitating opinion was that the system, by virtue of not providing adequate timely and preventive care, was a major contributing factor to the patient's suicide.

While the Review received a considerable weight of negative carer and family experiences, a number did describe receiving positive and supportive care.

The prominent theme for carers and families was a concern for the safety and wellbeing of the patient and a persistent sense of powerlessness within the system. They expressed a need for information about admissions, treatment, referrals and discharge/transfer plans.

Carers were concerned about the patient's illness and said they need education to understand the illness, treatments and the course of the disease. Training is needed to implement helpful interventions, to de-escalate symptoms and to support the patients' restorative pursuits. The carers also described their exhaustion and said that the burden of care sometimes affected their own mental wellbeing.

Access

Carers and family members describe a system that will often respond only when dramatic circumstances prevail, and that the response is often not consistent with what they would have expected.

The patient and others can be endangered while waiting for emergency intervention. There are times when a patient's deterioration places not only the patient at risk of harm but also carers, family and others. For one family, the difficulty of accessing inpatient care led them to hide until the patient committed a crime and the magistrate ordered him to be assessed at the Frankland Centre (a forensic psychiatric hospital).

One mother explained to the Review that the Mental Health Emergency Response Line (MHERL) does not always respond in the way that she expected. She said they seem to listen to her but did not offer to assess her son or advise her about what to do.

Carers reported it was difficult to access mental health community services after hours and on weekends and even when community emergency response teams (CERTs) are available they do not always come, or cannot come soon enough. In these circumstances, patients and carers rely on the EDs of hospitals to gain access to mental health services and this is a very serious deficiency.

A mother expressed dismay at the delay in CERT's arrival time after she had made an urgent request. The CERT visited the son's home 48 hours after she had them called and they contacted her to tell her the patient was not at home when they arrived. She expressed surprise that the team said they would not make any further attempts to locate her son despite her description of the urgency. In fact, her son had presented himself to a mental health hospital and had been admitted as an involuntary patient. The lack of assertive follow-up to an emergency call combined with the lack of communication from inpatient services to inform the CERT of the patient's whereabouts demonstrate system fragmentation.

In an illustrative case, the florid symptoms of a patient prevented him from being able to engage with reception staff at an ED. The result was that he could not provide details that would enable access to ED services. His father offered the required information but the administrative staff member insisted the patient must provide the information himself. The father's action, born out of his serious concern for his son's welfare, was to remain in the ED with his son. It was only when his son's behaviour attracted the attention of the security guard that he was brought into the treatment area in restraints.

A Council of Official Visitors' representative from Kalgoorlie described two recent occasions where patients who had sought assistance did not receive care until they had broken the law and were taken by police to the ED. The inability of mental health services to provide care when it was needed and sought led to untreated conditions with escalating symptoms.

A lack of after-hours mental health services in an ED seemed to contribute to a young mother's increasing distress at the lack of response to her presentation and request for help. It was not until she took particularly dramatic action placing her child at risk of harm on her third presentation that she received assessment.

A proprietor of a psychiatric hostel said difficulty in obtaining timely mental health care for a resident with deteriorating mental illness is a major concern. The patient required hospitalisation and was told to wait in the community until a bed became available. The resident's behaviour escalated out of control and led to harm to another person. The patient was arrested and ordered by the magistrate to be assessed at the Frankland Centre. An earlier response from the system could have avoided this, such as community visits and treatment commencement by a community mental health service.

Carers and patients provided the clear message that earlier intervention is essential to ameliorate the exacerbation of mental illness both in terms of responsiveness at early onset of symptoms and in the promotion of mental health. In children and young people, intervention programs to assess early in a child's life the possibility of the development of significant mental illness are to be encouraged and developed and it is a recommendation of this Review that this takes place in a timely fashion.

Communicating with carers at entry to the system

Carers expressed their confusion at the array of entry points and the difficulty in navigating the mental health system. A common theme is carers feeling disenfranchised from involvement in care, at times feeling that they would not have been involved at all unless they had insisted. Family members recalled receiving minimal to no information about ongoing treatment plans, discharge care plans and resources such as respite services that could assist after hospitalisation. Carers are usually key supports for patients and they want to be involved and informed about the patient's admissions, treatment plans and discharge plans.

One carer explained that the inpatient mental health service where her son had been admitted did not involve the family. A mother explained that even though staff knew her by name, they have never contacted her to say that her son had been admitted or discharged from hospital. However, if she rang to ask if her son was a patient there they would tell her. Some carers had been contacted about the expected length of stay of patients at some inpatient services but little or no information was provided about ongoing treatment and discharge plans.

A carer suggestion that clinicians take carers into a quiet space to discuss patient care and discharge plans was prompted by experiences of clinicians speaking to the carer in open spaces with no privacy and with many interruptions.

Carers were also concerned about the way in which clinicians communicated with the carer and patients. Although there are many staff who are kind, clinicians' attitude toward the patient and family was often experienced as judgemental and the staff as not empathetic. Another carer perceived that the staff in a mental health inpatient unit did not interact with the patients very often. The mother told the Review she visited her daughter for long hours over many days where clinicians were often behind 'the glass' at the nurses' station. She said they rarely came out except 'to tell them [the patients] off or give them medication'.

A young carer believed that he did not always receive information about his parent's condition, and that he did not receive any training from the mental health facility about how to manage his father's psychiatric condition. He felt that he was rarely briefed on any mental illness issues, recovery or appointments made for his father. At times, the lack of information led to the young carer feeling frightened about providing care and neglected by the system.

There is an impact on carers when patients go on leave (with or without permission) and are transferred or discharged. Carers need to be informed. This expressed concern of carers was emphasised for family members who said their rights should be respected, particularly when the patient has a history of violence or other disruptive behaviours. Carers stated that the responsible clinician should always contact the carer and check that the carer is feeling safe and help them to resolve any issues.

The Review notes that amid the array of expressed concerns by carers they have also pointed out attempts to improve communication and involvement. For example, after experiencing confused communications resulting from a patient not listing very involved and supportive carers as his contacts, the carer became involved in a Patient and Carer Committee.

The work of this Committee led to changes in the Carer Form and the hospital's process of collecting information about carers in the patients' record. The improved recording of the patient's relationships with family and carers provided clear information for clinicians with a record of with whom to share information. Importantly, family members and carers were confident that the staff would identify them as the patient's social network.

It is acknowledged that there are situations when informing the carer or parents is not in the best interest of the patient, and times when the patient explicitly requests the carer not be informed. These ethical conflicts need to be carefully considered by the clinicians in light of their duty of care to the patient and to the carer/s.

Noted at the National Mental Health Consumer and Carer Forum (2011) and apparent to this Review is that mental health services and clinicians struggle to reconcile seemingly conflicting requirements in relation to information-sharing and their role and obligations under the *Privacy Act 1988* (Cwlth) and the *Carer Recognition Act 2010* (Cwlth).

Clinicians expressed concern about maintaining patient's privacy and wishes when carers and family members approach them. They said they were torn between the conflicting guidance of professional duty of care, the Privacy Act, the Carer Recognition Act and mental health service policies. Clinicians explained that their duty to protect their patient's privacy and rights often overrode the decision to discuss care with family members and carers.

Schedule 1 of the Carer Recognition Act – the Statement for Australia's Carers – obliges health services to recognise and respect the relationship between carers and the persons for whom they care (s 1.6) and consider carers as partners with other care providers in the provision of care, acknowledging the unique experience and knowledge of carers (s 1.7).

The intent is to involve carers in patients' care and to support carers in their role (Carer Recognition Act s 1.10). The *Mental Health Act 1996* s 206 legislates 'even when consumer permission is not given, carers are to be given sufficient knowledge to enable them to provide effective care'. The proposed Mental Health Bill 2011 does address this issue to some extent.

Many family members and carers acknowledged that the patient might not want their family involved or informed. However, patient's privacy can be enforced at the same time as providing carers with necessary information and skills and this should be a principle of all mental health services (Mental Health Law Centre). At times, the nature of conflict between the rights of patients and the rights of family members will result in a best course of action being to use a patient advocate or legal representative to work with the patient to determine what information could be shared and with whom (Mental Health Law Centre).

In the event that carers are at risk, clinicians have a duty to provide necessary information. For example, they should notify a person whose physical wellbeing is in immediate danger. This duty overrides the duty of confidentiality (see also Office of the Chief Psychiatrist brochure: *Communicating with carers and families*) (OCP 2011a). Several carers described traumatic consequences where this information was not provided.

Carer concerns about the quality of mental health care

Carers articulated concern about the amount of medication patients were prescribed as well as their side effects. A carer reflected that when her son's medications were reviewed in Graylands hospital, his 77 tablets were reduced to 28 and his homicidal and suicidal thoughts subsided. Her son had experienced multiple admissions and, according to the carer, this was the only time he had received a pharmaceutical review. In another case described by a carer, the patient was on so much medication they could hardly walk and this level of drowsiness made it unsafe to drive or work let alone be left alone.

The admission of involuntary patients under the current Mental Health Act does not mean that the patient will be kept in a locked ward, and they can be admitted into a non-secure environment. There has been confusion about voluntary/involuntary and secure/insecure environments. The intent of good practice is to provide care in the least restrictive environment possible and, as treatment progresses, move from a secure ward to less restrictive areas, all the time remaining as an involuntary patient. Carers expressed concern that patients assessed to be at risk of self-harm could leave the services without supervision.

Carers views of non-government organisation (NGO) care is exemplified by one mother who expressed concern that a mental health carer who was assisting her son in NGO accommodation seemed unaware of his treatment plan, resulting in an assumption that medication had ceased. The carer had not checked the patient treatment plan, nor had the plan been discussed with the treatment team, which would have revealed the importance of a continuing medication regime. Without appropriate medication, the patient's condition deteriorated and a lengthy period of hospitalisation followed.

Within some public hospitals there are psychiatric consultation/liaison teams of mental health nurses and psychiatrists who provide consultation for patients in the general wards. Despite the presence of psychiatric liaison clinicians when individuals with mental illness are admitted for medical or surgical procedures in the general hospital, psychiatric assessment and care is not always provided.

One carer's mother was admitted for an elective surgical procedure at a general hospital. The carer explained his mother's escalating mental condition and treatment to the surgeon, to the anaesthetist pre-operatively and to staff on the ward at admission. The carer also alerted the CMHS who reviewed the patient before hospitalisation and planned to review the patient when she returned home.

The carer recalled that there was no specialist mental health interventions during the inpatient stay, even though symptoms of a deteriorating mental condition seemed very clear. In the carer's opinion, discharging to home was not safe or realistic because she lived alone, her thoughts were becoming more disordered, she had difficulty ambulating, and was unable to instil the required eye drops post-operatively. His mother died within two days of discharge, the cause unknown.

This example highlights the need for general hospital staff to acquire knowledge about a patient's mental illness and gain access to specialist mental health services. A psychiatric assessment and treatment plan were needed to stabilise the woman's symptoms and could have informed the discharge plan.

The inability of the health system to respond adequately in the above situation is in part due to the segregation of mental and physical health within the WA hospital system. With a mental illness prevalence at 20 per cent of the WA population, along with the fact that mental illness commonly presents as comorbid to physical illness, an ideal would be that all health care staff require a minimum level of knowledge about mental health. Clinicians in general hospitals should possess the skill to identify when symptoms of mental illness require specialist psychiatric assessment and consultation.

Discharge and information sharing

A number of carers described positive experiences with discharge processes at mental health units. For example, one mother described being involved in her son's discharge plan by a collaborative approach when her son planned to move into her home after hospitalisation. The service undertook a gradual approach giving her son the opportunity to adjust to living in the community on a community treatment order (CTO) by coming home for longer and longer periods until he eventually stayed home. Even after the successful transfer into the community, that mother continued to communicate with the treatment team on a daily basis by email to let them know how her son was progressing.

However, many carers explained to the Review that they were not always notified about discharge plans, nor informed when patients were on leave (officially or unauthorised). For one carer, the unexpected return of her violent partner endangered her life. This carer had specifically asked the doctor at the inpatient service to notify her should her partner leave the facility because of his violence. When the carer had recovered from her injuries in hospital, the carer explained she had contacted the psychiatrist at the mental health hospital and asked why she had not been notified, and the doctor replied 'because I don't have to'.

A carer described a paternalistic process when given a predetermined discharge plan at a family meeting. The carer was told, 'This is what we decided' and despite reading the plan and pointing out a deficiency, the carer was told that there was no time to go through it all and that this document summary was their plan (ARAFMI). The carer expected to be consulted about the discharge plan and to assist in a discussion to develop an optimal plan for care at home rather than to receive a predefined plan. In another case, a carer said that her son had had more than 20 admissions to psychiatric hospitals, and she did not know there was such a thing as discharge planning meetings.

Carers reported to the Review a number of very complex and traumatic scenarios in which the system seemed to flounder, and from the carers' perspective, the system has seriously failed the patient and their carers.

One distressed carer was very upset to be informed by the police that his son had committed suicide while an inpatient in a psychiatric hospital and could not understand why the hospital had not contacted him. The *Coroners Act 1996* requires police to notify the next of kin in situations such as this and this Review is recommending that discussion be undertaken with the Coroner to allow dual notification in such events.

Several families expressed concern that the patients were discharged too soon with outcomes of potential and actual harm. One father explained that his daughter had called him from a bus on her way home from hospital stating she felt unsafe. He had advised her return to the emergency department. However, the patient chose not to do this. She later took her own life.

One carer expressed her frustration with the mental health system in relation to a patient with a dual diagnosis of sporadic illicit substance abuse and psychosis. The mental illness has debilitated the patient's self-care capacity and there had been numerous ED presentations and hospital admissions during the course of the illness. Over the years, numerous experiences included premature discharge from hospital with unsuccessful accommodation and follow-up care plans. The mental health system was considered as unable to meet the patient's needs.

A father has sought assistance from every level of the mental health system for his son with a dual diagnosis of intellectual disability and mental illness. The father explained the interplay of symptoms of each condition. Given the high level of mental illness within the population (40% of 40,000) of intellectually disabled persons, he would like staff within Intellectual Disability Services to receive education about mental health and for intellectual disability to be part of the curriculum for clinicians. For example, mental health clinicians need to ensure transport is arranged to transfer the patient to their place of accommodation on discharge from hospital when they cannot manage this themselves. On more than one occasion, this father found his son sleeping rough, having been discharged without necessary assistance and being unable to manage to get himself home.

This population group of intellectual disability, cognitive impairment and associated mental illness results in a most distressing clinical picture and these patients require protection. There is a People with Exceptionally Complex Needs Program that targets dual and multiple diagnosis of mental illness such as acquired brain injury, intellectual disability and significant substance abuse who pose significant risk of harm to themselves and others. This program currently has nine places and is planning an expansion to 18.

Older parents of adult persons with mental illness expressed concern about continuing care provision as the carers themselves aged and became in need of support. One family explained they were keen to develop an advanced care plan so that their wishes could be known about the ongoing care of their child.

Rehabilitation

Carers recognised the benefit of involving family and patients in planning and implementing recovery plans. They said that patients often need individually tailored care packages that allow time for them to regain the skills they have lost. However, some carers were concerned that the focus of care was more often treatment with medication than a socio-biological framework that included rehabilitation. During the 20 hospital admissions for one patient at various mental health hospitals, one carer explained that only one had offered rehabilitation.

Some carers explained they had been left to their own devices to find out about rehabilitation services in the community because mental health services did not routinely provide such information. For example, one mother explained she researched community services herself and organised in-home services, including a mental health worker who then assisted her child to enrol in TAFE.

One carer described the positive effects of her son's stay in the step-down facility at Hawthorne House for 4–5 months. In this facility, her son participated in rehabilitative programs that have enabled him to be more self-sufficient in his permanent accommodation in a psychiatric hostel.

In the community, it takes time for patients to engage and establish a trusting and therapeutic relationship with the case managers, yet patients' case managers are continually changing, mostly due to staff turnover. The high level of staff turnover was perceived to reduce the effectiveness of care in the community.

Post-hospital follow-up

Follow-up is not always considered adequate. One carer explained that the 20-minute visit every two months provides little more than medication for her son. Although his medication appears to be controlling paranoid thought and homicidal ideation, the patient's behaviours are increasingly inappropriate. The carer has been informed to ring the police to intervene and no other supports have been offered to manage the patient's behaviour. Further, a carer explained that the community mental health service had told her they did not involve the family in care.

One young carer told the Review that he was well supported by the NGO community support services. However, other carers perceived that discharge occurred without follow-up support. One mother continues to support her adult child (who has a mental illness) financially since the child's entire income is required to meet the cost of her psychiatric hostel accommodation.

Family members said patients benefit from assessment and treatment at home when their condition deteriorates. With care from visiting mental health services, increased community services and family support many situations can sometimes be alleviated in a less disruptive manner to the patient's lifestyle than admission to a mental health hospital.

Carers are acutely aware of the complex and difficult interplay of a patient's mental illness within environments of family, social, financial, welfare, employment and general coping with day-to-day living. Often the hospital is in effect quarantining patients for a time from the stresses inherent when trying to live in the community. Transitioning from hospital care back to the community is multifaceted and should not simply be a medical process.

Homeless patients do not have any place to store their medication or an address to be visited for follow-up care. There are no community nurses or social workers on the street providing crises accommodation. To stay in a shelter, people require photographic identification or a passport; however, patients do not always have these when they are discharged from psychiatric hospitals.

One mother explained that she had been told by the triage worker at a community mental health service to call the police when her son's behaviour was out of control. The mother feared her son would be arrested. It was difficult for her to discern the role of police in her son's mental illness. Psychiatric community support services were not offered.

Carer education and skills training

Carers' perspectives in respect of carer education and training included a clear assertion that successful management of psychiatric illness and associated issues is dependent upon the family and patient's understanding of the condition, its manifestations and impact.

Carers told the Review they want to know how to provide care for someone with mental illness, acknowledging that mental health education occurred for some carers but not all. However, carers' perceptions indicate that a predominant feature is that most carers only receive informal training and information from clinicians in the course of their care of the patient.

The importance of providing formal and informal education and informing carers about the support and training available to them should be routinely emphasised during the health professional's training and ongoing professional development.

On the principle that carers are considered partners in care with the mental health system, there should be continuous information available to be delivered to family and carers. Carers and patients need formal and informal training to obtain the knowledge and skills they need to manage mental illness and there are some very good carer training programs available. Carers need to be informed and enabled to attend the training programs they need.

In an examination of five deaths, the Deputy State Coroner concluded that mental health services should be responsible for the carer's wellbeing and acknowledged services are not necessarily resourced to extend care to carers, which undermined the ability of the mental health system to provide holistic care (Deputy State Coroner's Report 2008, p. 5).

The Deputy State Coroner proposed that mental health resources should target carer and patient education about mental illness and associated issues. Contact information for services that can be helpful to the patient and carer should form a part of the information routinely provided.

The Review notes that some education and training for carers is arranged in partnership between the social workers and carer advocacy services, such as ARAFMI or MIFWA, at some hospitals including Northam, the Alma Street Centre and Joondalup hospital. This training, however, is not uniform in the system.

The training sessions provide a forum for the carers to learn about mental illness and to manage its effects as well as an opportunity to meet the social worker and carer advocate staff. The social worker and staff can provide ongoing support to them and a forum where the carers' views are listened to and valued (Manager Counselling and Support, ARAFMI). The areas presented include:

- *Mental Health Act 1996* and guardianship and administration
- mental health and drugs and alcohol
- bipolar disorder: how families and friends might respond
- schizophrenia: how families and friends might respond
- the young and mental health issues.

In the Wheatbelt, MIFWA works with the community mental health service to provide carer education. Mental health is promoted through population health forums and community networks. ARAFMI also organise education works shops in Perth, Broome and Carnarvon on topics such as:

- partners in depression
- coping with difficult behaviours
- assertiveness skills and smiles (a young carers' program) (ARAFMI).

Community mental health services also work with NGOs and Home and Community Care (HACC) to provide education to services and carers about mental health.

Knowledge of the Carers Recognition Act is a requirement of employment in mental health services and forms part of employment agreements. At Rockingham's mental health service, a carer consultant on the staff encourages family and carer interaction with the mental health staff.

At Rockingham General hospital, a number of family meetings are held. At the first meeting, families are invited to provide collateral information, discuss the effects of the illness on them and to develop a family support plan; the second meeting focuses on discharge planning; and the third meeting is a carer support group. Carers' education is a regular feature of mental health services at Rockingham and Peel. Programs including Hearing Voices, Grow and sessions by ARAFMI are also encouraged. As stated previously, the Rockingham–Kwinana mental health service appears to be an example of an excellent model of care.

At Northam, carers are also encouraged to contact ARAFMI and MIFWA, especially if patients refuse to have their involvement in care. The carer advocacy services provide the carers with the training they need to support the patient. Carers are encouraged to voice their concerns to the mental health staff, and support and training are provided to identify and decrease the stressors that can trigger patients' conditions. The premise is that carers require enough education and information to be able to assist the patient when they are discharged.

See Recommendation 1: Governance 1.5; Recommendation 3: Carers and families; and Recommendation 7: Acute issues and suicide prevention 7.9.

3.5 Clinicians

Throughout this Review, clinicians consistently expressed a desire to provide the best possible care for patients, and to work to continuously improve quality of care and service provision. Clinicians expressed a repeated theme of dismay at resource shortfalls, management and governance issues, workforce shortages, increasing demand and prevalence of mental conditions. All intertwined to effectively prevent mental health workers from achieving their aims.

This Review acknowledges the mental health clinicians for their dedication and commitment for work performed in sometimes thankless scenarios of complex issues and volatile environments, observing that, while imperatives of professional skill and knowledge are important, a crucial ingredient is a strong desire to work within the public mental health system.

Clinicians described their colleagues as committed and patient centred and their teams as cohesive. Supporting the mental health workforce is an imperative that should be continually addressed, particularly if sustainable improvement in the delivery of mental health services is to be achieved.

A community visitor described the staff as having a ‘heart for psychiatric care’ although she said that staff are under pressure with staff shortages and there are not enough clinical psychologists and allied health staff to deliver recovery programs. These ‘shortfalls are about lack of resources, not lack of will’ (personal communication Community Visitor 2012).

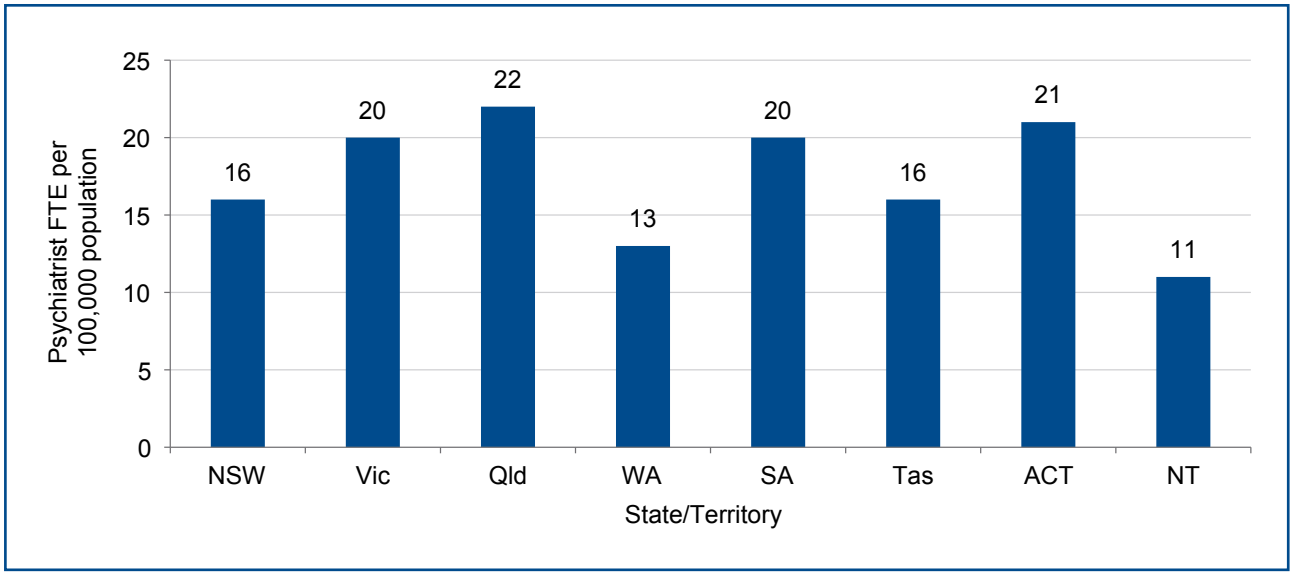
Adequate staffing and health professionals with sound knowledge and experience about mental illness are critical success factors to providing care in a safe environment within public mental health services. Clinicians describe their team members as competent and emphasised their ability to work well within a supportive model of practice. To keep up to date, clinicians attend regular peer review meetings and journal clubs and some participate in general hospital grand rounds.

A significant proportion of psychiatrists, particularly in the rural and remote setting, are overseas trained doctors working under the registration category of ‘in the Public Interest’ or in ‘Area of Need’. Under the national law of registration (AHPRA or Australian Health Practitioner Regulation Agency), only a limited number of medical practitioners can be registered in these categories, which in the next two years may pose very serious workforce issues.

Clinicians are acutely aware of the shortage of psychiatrists and nurses in the system. Compared to other Australian states, WA has the least number of mental health nurses and the second lowest number of psychiatrists per 100,000 population (AIHW 2012).

After Northern Territory, WA has the second lowest FTE per 100,000 population of employed psychiatrists and psychiatrists in training with 13.

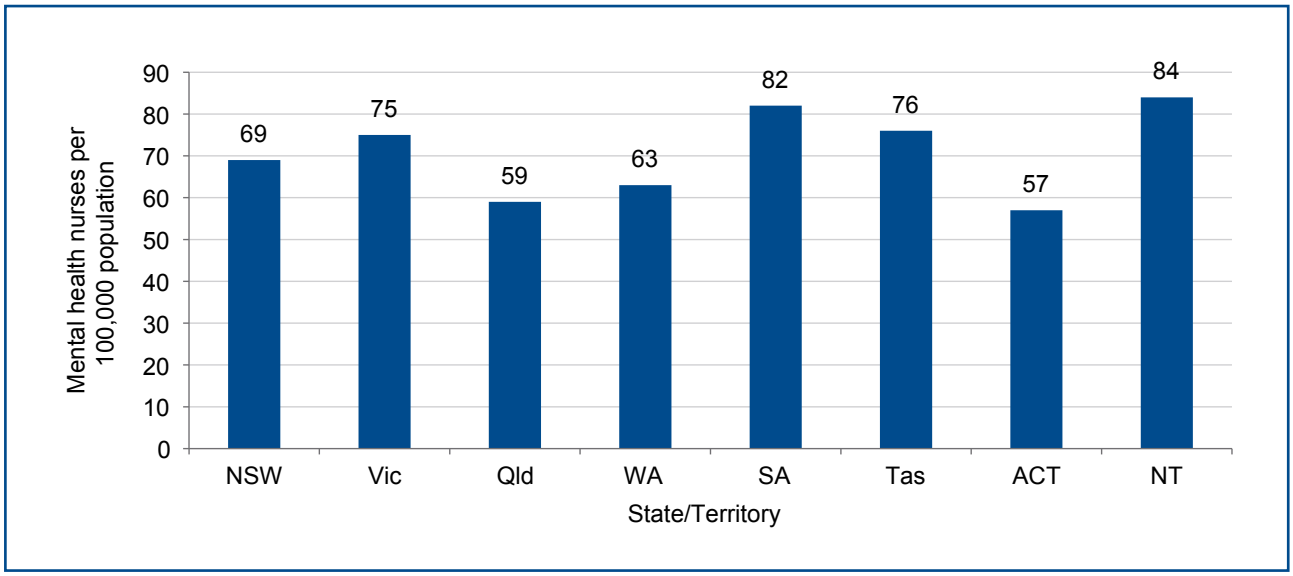
Figure 9 **FTE employed psychiatrists and psychiatrists in training in WA compared to other states and territories, 2009**



Source: AIHW Table 13.3 Medical Labour Force Survey (2009).

The nursing hours worked in mental health in WA was FTE 63 hours per 100,000. This is less than the national average of 69 FTE per 100,000 population.

Figure 10 **FTE employed nurses in WA compared to other states and territories, 2009**



Source: AIHW Table 13.12 Nursing and Midwifery Labour Force Survey (2009).

There is also an inadequate number of pharmacists. A pharmacist informed the Review that the standard national ratio of pharmacists to beds is 1:20. In mental health services, the allocation of pharmacists varies. For example, one 35-bed unit has three hours of clinical pharmacy per day, that is a 1:80 ratio. This limits opportunities for pharmacy medication reviews and education to patients about their medication regimes.

3.5.1 Workload and attrition

Clinicians informed the Review that inpatient beds are limited to patients requiring intensive care, such as those that are at risk of harm to self or others and those with symptoms that cannot be managed in the community.

Caring for patients with very high risk is stressful for psychiatrists and nurses; and patient throughput has increased. Additionally, adequate staffing requires the capacity to provide appropriate leave cover to enable staff to take leave when required. Currently, in many community mental health services psychiatrists do not have leave cover and there are also difficulties providing weekend cover because of low staff numbers.

These factors are likely to act to deter those who may otherwise seek employment within the public mental health services.

Maintaining a workforce capable of meeting the intense needs of acute mental health care requires concerted effort. High attrition rates and an ageing workforce require careful management along with effective succession planning. Twenty-five per cent of the nursing workforce and one-third of psychiatrists are aged 55 and over (AIHW 2012).

Sustaining safe mental health care with an appropriately trained and experienced staff in the remote areas of WA is currently addressed by a fly-in, fly-out or drive-in, drive-out model. In some regions, a community emergency response and after-hours face-to-face consultation cannot be offered. At times, staffing needs are met by clinicians in temporary positions and there is great concern in these areas that services are unable to meet the needs of all patients.

A fly-in, fly-out model provides experienced staff. However, the number of clinicians required for this model to succeed results in the patients meeting different psychiatrists at their appointments. Patients may be retelling their histories and it can be difficult for the clinicians to build trust. The mental health workers in most rural and remote areas engage the patient in therapeutic relationships, provide the after-hours care and use on-call consultant psychiatrists to provide advice and support.

Recruitment difficulties are also a significant problem affecting capacity of restorative services within the public mental health services in WA.

3.5.2 Staff training and professional development

The National Standards for Mental Health Services (2010) describe the requirement to recruit staff with the skills and capabilities to perform their duties. However, there are also requirements for the staff and the mental health service to ensure ongoing professional supervision, training and education (see Standard 8). This Review was referred to Queensland Health's work developing guidelines for clinical supervision (Queensland Health 2009).

Nursing workforce

There are 15,000 nurses working in Australian mental health services. However, specialties are not recorded by the Australian Health Practitioner Regulation Agency and no records are kept by AHPRA about post-graduate qualifications (CEO, Australian College of Mental Health Nurses; Assistant for Registration, AHPRA). The result is that the number of specialised practitioners in mental health services is unknown.

Enrolled nurses undertake TAFE certificate courses and graduate as comprehensively trained Division 2 nurses.

Division 1 Registered Nurses are university graduates with comprehensive qualifications enabling employment in the mental or general health services (personal communication CEO Australian College of Mental Health Nurses 2012). These nurses undertake a minimum three-year university course, including mental health theory and clinical placements. Nurses who choose to work in mental health are supported with a graduate program hosted at Graylands. Rather than obtaining experience in a range of mental health environments, the post-graduate course provides a six-month rotation within three specialties, for example, mental, surgical and medical health.

The Mental Health Nurse Education Taskforce aim to ensure that all nurses attain the knowledge and skills to recognise, understand and respond to the needs of patients with mental illness (Mental Health Nurse Education Taskforce 2008). Their report (2008) identified the need to strengthen the mental health content and clinical placements within pre-registration courses of Australian universities. The content has increased by 33 hours since 1999 and universities now provide an average of 254 hours of compulsory clinical placement and 149 hours of compulsory theory in mental health. Students can also select to major in mental health during their bachelor course. Post-graduate training for nurses varies in length, intensity and the type of qualification attained. These include the acute mental health courses and psychosocial intervention and recovery courses.

While Australian mental health nurses are comprehensively trained with a post-graduate qualification in mental health, nurses trained in the US, Canada or the UK have usually undertaken an undergraduate course focusing specifically on mental health care. In Australia, the practice of overseas-trained mental health nurses is restricted to mental health settings and they cannot practice in general medical or surgical care (CEO, Australian College of Mental Health Nurses; AHPRA, WA).

Clinicians expressed concern that student nurses on clinical placement often see the patient at their worst, rather than recovering, and few are attracted to a career in mental health nursing.

Clinicians commented that mental health nurses have little exposure to further education and there were few courses available. Further, attendance at professional education is hampered by lack of staff backfill, support and resources. Staff are concerned that when they attend educational sessions additional workload and stress is placed on their colleagues.

Mental health employees identified that it was difficult to find a supervisor who understands the complexities of their specialist roles and who is not a line manager to provide professional supervision and professional development.

Psychiatrists

Psychiatry training takes five years to complete with The Royal Australian and New Zealand College of Psychiatrists. Clinicians commented that services have difficulty retaining psychiatrists once they graduate and there is an influx of interns. Reasons provided include the high level of responsibility without clinical line management and supervision and the requirement to be on-call frequently.

As indicated, there is an increasing number of overseas-trained personnel who may not be recognised as psychiatrists until they obtain Australian qualifications. These doctors may also benefit from cultural training to better enable them to respond to questioning of their practice by carers and other health staff.

Training about legal matters, such as obtaining consents, assessing capacity, enduring power of guardianship, and advance-care planning with advance-care directives, are valuable skills in addition to knowledge of the Mental Health Act (personal communication S. Boulter, Mental Health Law Centre 2012).

Psychiatrists in rural and remote areas have clinical responsibility and are clinically isolated because there is no clinical leadership position or clinical line management. There is no clear single line of communication and it is difficult for the clinicians to find someone to provide supervision. They often need to use clinicians in the metropolitan area who are not familiar with the limitations of working in rural and remote areas.

A supervisory system should be encouraged that supports staff to manage and monitor the delivery of high-quality services and effective outcomes for patients. Clinical supervision as a formal process of support and reflection separate from individual performance appraisals is required for all mental health professionals. Such supervision needs to focus on the issues relating to and affecting clinical practice.

Regular protected time and confidential supervision can ensure clinicians are trained and supported in their practice within mental health. Novices may require one hour a fortnight while more experienced (more than five years) clinicians may need one hour a month (Queensland Health 2009).

3.5.3 Staff management

Unlike general hospital clinicians, mental health staff are not managed on the health campus in which they practice. Instead, they are governed by the Mental Health Area operational offices off-campus. The Review heard this disempowers the mental health clinicians and creates complex layers to obtain permission for any change and improvements. Clinicians are accountable to their discipline clinical lead concerning clinical matters and to the external operational division for line management.

Clinical mental health staff said they rely on their personality and personal relations with management staff in order to ‘get things done’. Lacking a clear model of management, the onsite mental health facility managers said they ‘were unable to communicate local resource needs and the scarcity of resources has depleted provision of restorative and preventative mental health care’.

The multilayered management presents onerous processes for clinicians who want to create improvements or to resolve a concern, the result of which is clinicians expressing a sense of administrative powerlessness—‘a throwing of the hands into the air’.

For example, to obtain access to PSOLIS, authorisations are required, and then the application is progressed up the bureaucracy to the data custodian of the Area Health Service for approval and this process can take over a month.

See Recommendation 1: Governance (1.1.5; 1.1.6; 1.1.7); Recommendation 4: Clinicians and professional development; and Recommendation 8: Children and youth (8.6.4; 8.6.5).

3.6 Mental health beds

A number of managers and clinicians informed the Review that there are more acute mental health beds per head of population in WA than in other states. It was suggested to the Review that the mental health system in WA is skewed towards an inpatient focus.

The total number of private and public specialist mental health beds is 936.

This comprises 726 public beds as tabled; with the addition of the beds proposed for Broome (14) and Albany (7) will bring the total public beds to 747.

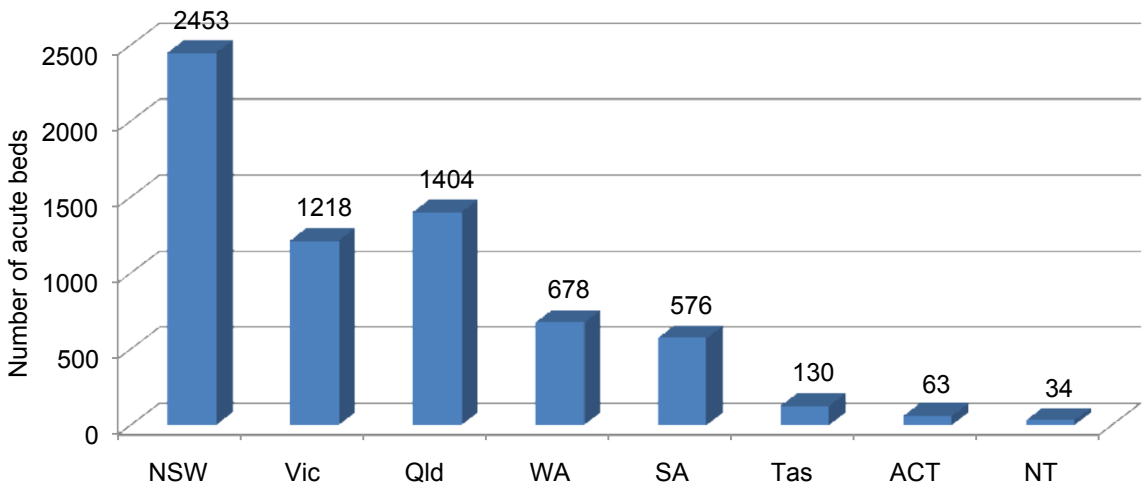
	Hospital/Facility	Adult	Child/ Youth	Older adult	Rehabilitation	Total
NMAHS	Graylands Hospital	62			114	
	Frankland Centre	30			8	
	Selby			39		
	Joondalup	42				
	Swan Valley Centre	27		16		
	The Ursula Frayne Unit			12		
	Sir Charles Gairdner	36				
	Osborne Lodge			24		
	Mother and Baby Unit	8				
	Sub-total	205		91	122	418
SMAHS	The Alma Street Centre	48		16		
	Armadale	25		8	8	
	Bentley	74		26		
	Rockingham	20				
	Royal Perth Hospital	20				
	Sub-total	187		50	8	245
WACHS	Albany	9				
	Kalgoorlie	7				
	Bunbury	27				
	Sub-total	43				43
CAHS	Bentley Adolescent Unit		12			
	Princess Margaret		8			
	Sub-total		20			20
	Total					**726**

There are 189 private beds.

Hospital/Facility	Adult Beds
Abbotsford Private Hospital	18
Hollywood Private Hospital	40
Perth Clinic	100
The Marian Centre	31
Total Private Mental Health Beds	189

Referencing AIHW analysis, the Review concludes that WA has fewer acute mental health beds and less acute mental health patient separations than many other states (3.1 per 100,000 populations) and territories in Australia (AIHW 2011a; see figures 11 and 12).

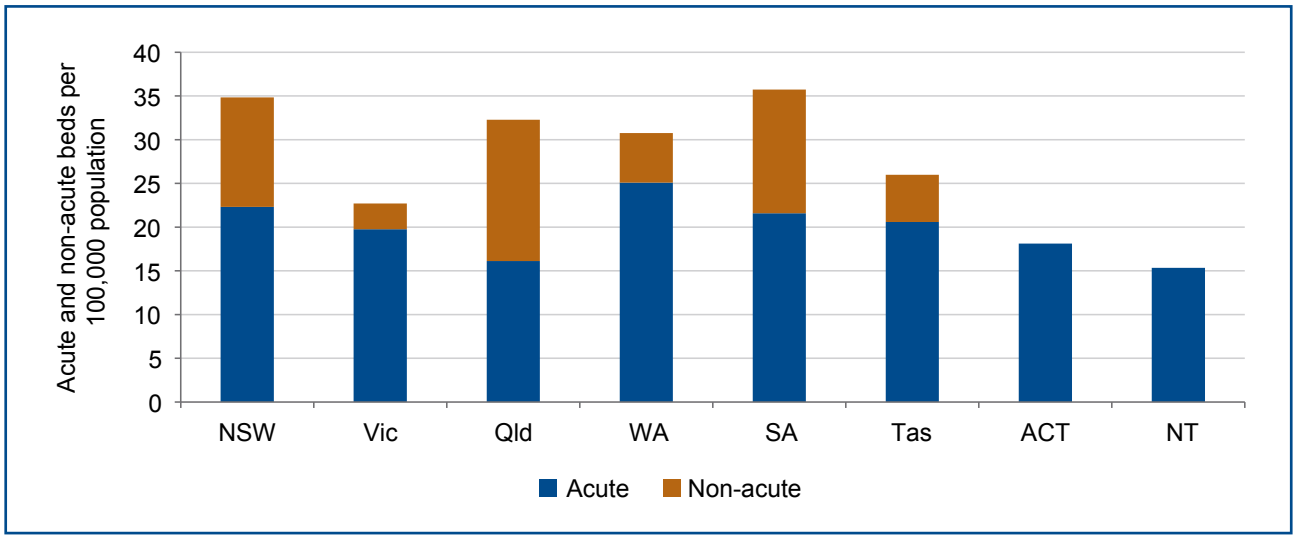
Figure 11 **Total acute MH beds per state and territories, 2008–09**



Note: Since these data were collected there have been some changes in bed numbers in WA. At the Alma Street Centre, two beds closed; eight beds were removed from Royal Perth Hospital, 16 rehabilitation beds were decommissioned in Hawthorne House and 20 beds were opened at Rockingham. The 14 beds in Broome will open soon, totalling eight additional beds.

Source: Table 12.13: Public Sector specialised mental health hospital beds per 100,000 population by target population and program type, states and territories, 2008-09. National Mental Health Establishments Database. Population as at 31 December 2008. http://mhsa.aihw.gov.au/resources/facilities/beds/ AIHW (2011).

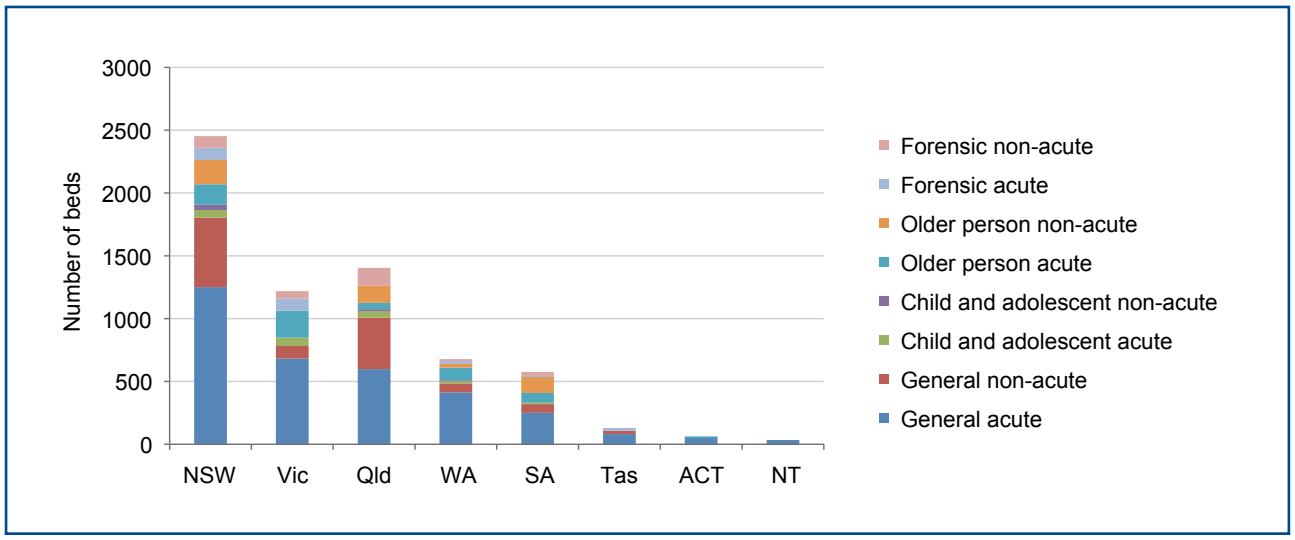
Figure 12 **Acute beds per 100,000 population, states and territories, 2008–09**



Source: AIHW (2011).

WA has proportionally fewer child and adolescent beds, forensic beds and non-acute beds than other Australian states (see the mix of mental health beds per 100,000 population and program type in Figure 13).

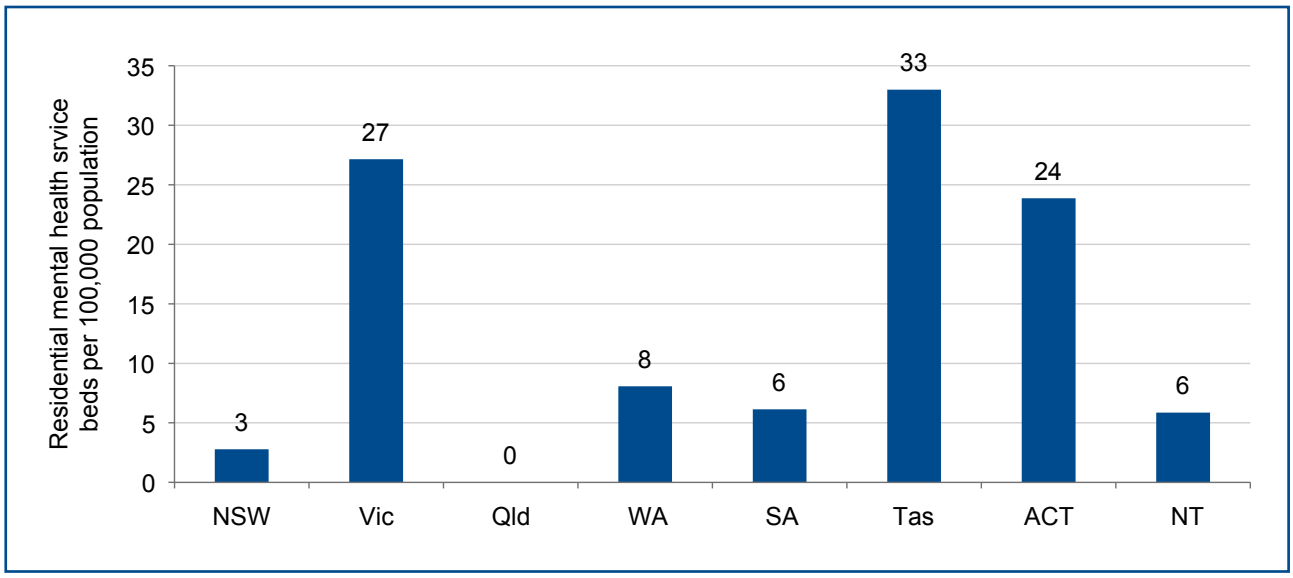
Figure 13 **Public specialised mental health beds by target population and program type, states and territories 2008–09**



Source: National Mental Health Establishments Database, based on population at 2008. Table 12.13: Public sector specialised mental health hospital beds and beds per 100,000 population, by target population and program type, states and territories, 2008–09, AIHW (2011).

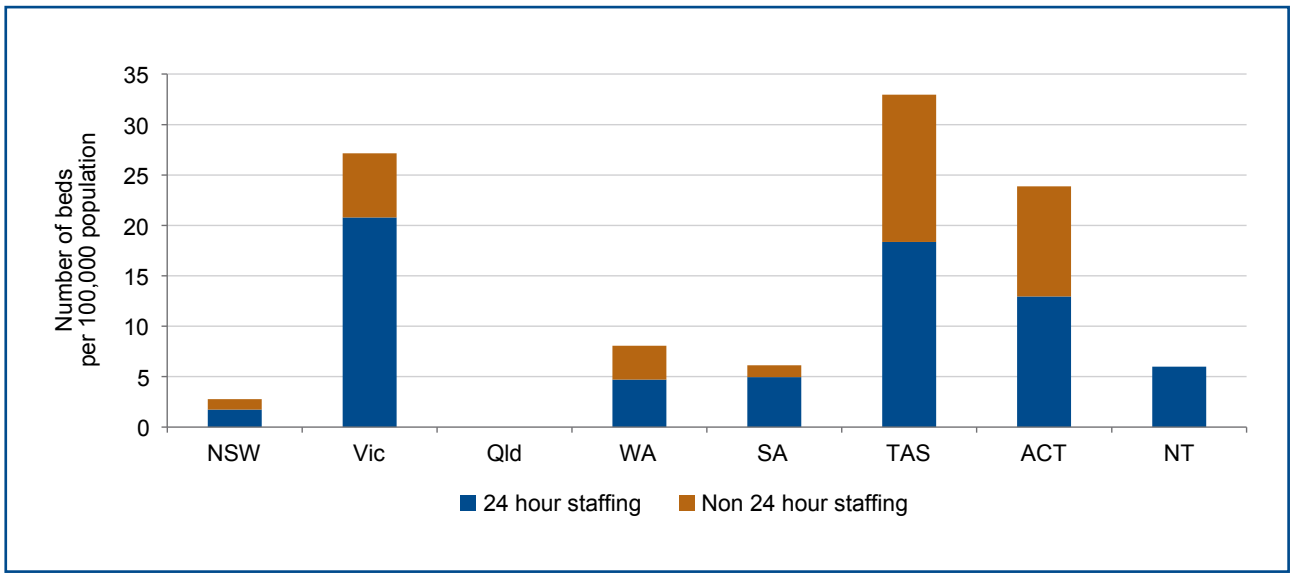
There is insufficient step-down and supported residential accommodation. The effect is that patients remain in acute mental health beds rather than receiving rehabilitation and care in the community (see Figures 14 and 15).

Figure 14 **Residential mental health service beds per 100,000 population, states and territories 2008-09**



Source: AIHW (2010).

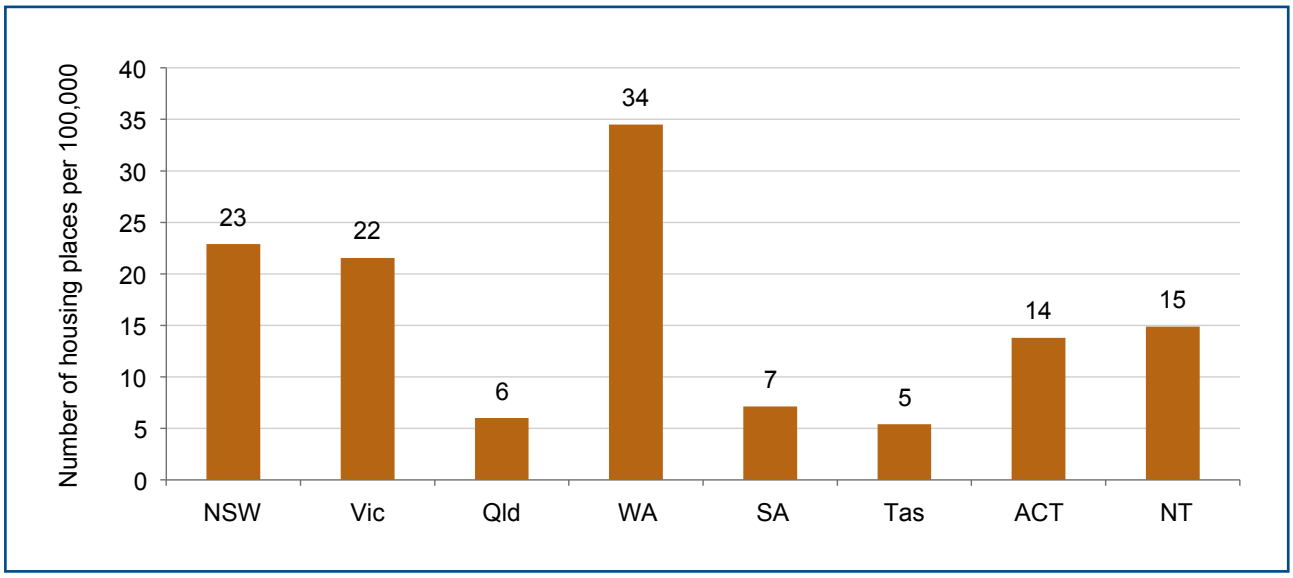
Figure 15 **Staffing 24 hours and non 24 hours residential mental health service beds per 100,000 population, states and territories, 2008–09**



Source: National Mental Health Establishments Database: Table 12.15 Residential mental health service beds and beds per 100,000 population, by target population, states and territories, 2008-09 and Table 12.14: Number of residential mental health service beds and beds per 100,000 population by service operator and staffing provided, states and territories, 2008–09, AIHW (2010).

There appears to be more supported housing places in WA than other states (see Figure 16). This figure includes the psychiatric hostels discussed in Section 3.13.4. These numbers do not appear to fit with a contemporary model of mental health care.

Figure 16 **Number of supported housing places per 100,000, states and territories 2008/09**



Note: The number of supported housing places in WA is 760.

Source: Table 12.16 Number of supported housing places per 100,000 population, states and territories, 2008-09 National Mental Health Establishment Database, AIHW (2010).

A contemporary Australian model

In order to provide meaningful comparative bed numbers, reference is made to Andrews and Tolkien II Team's (2011) contemporary Australian modelling.

Applying this modelling, and based on the WA population of 2,366,900 (ABS 2011), an ideal bed stock of 3197 places is required in a stepped configuration as follows:

Figure 17 **Ideal mental health bed stock for WA, 2012**

	Existing places	Recommended places/100,000	Optimal places	Change required
Inpatient services				
Acute	469	15	355	–114
Non-acute	130	10	237	+107
Community rehabilitation				
Clinical staffed 24/7	111[1]	15	355	+244
Staffed <12 hours	79[2]	15	355	+276
Supported permanent housing				
Supported public housing	174[3]	20	474	+300
Supervised hostels	748[4]	20	474	–274
Permanent housing	n/a	40	947	n/a
Total places		**95/100,000**	**3197**	

Notes: Private hospitals are omitted from this equation because they 'do not admit people as involuntary patients and the level of acuity is less than in the public sector. There are no data as to the offset that private beds make to dealing with the burden of mental disorders.' (Andrews and the Tolkien II Team 2011, p. 11).

This table excludes specific services for older persons and persons with dementia. (Andrews and the Tolkien II Team 2011).

1. Based on figures 14 and 15.
2. Based on figures 14 and 15.
3. Based on 34.5 per 100,000 AIHW 2008–09 and population 2.17 million in 2008 accessed at: http://mhsa.aihw.gov.au/resources/facilities/beds.
4. Based on AIHW 2009–10 Data Cube.

Using this model, it would appear that WA requires more non-acute, community rehabilitation places and supported housing. Two important qualifications are:

- that supported accommodation beds need to be operational before it would be feasible to reduce acute beds
- places must be configured to account for population growth.

A range of accommodation is needed within each region of the State and there is a need to properly negotiate a formulated 10-year clinical services plan that:

- articulates the Mental Health Commission purchasing intention and reform agenda
- defines the required capital investments and infrastructure build over 10 years
- provides facilities and services that allow best practice clinical mental health care
- defines how services configuration and investment best meets contemporary best practice care models and future demand.

The Review has not resolved a conclusion as to a best mix and distribution of bed stock. It is, however, essential that a consistent methodology and defining of ideal bed stock is a feature of a mental health clinical services framework.

See Recommendation 1: Governance (1.1.1); and Recommendation 5: Beds and Clinical Services Plan.

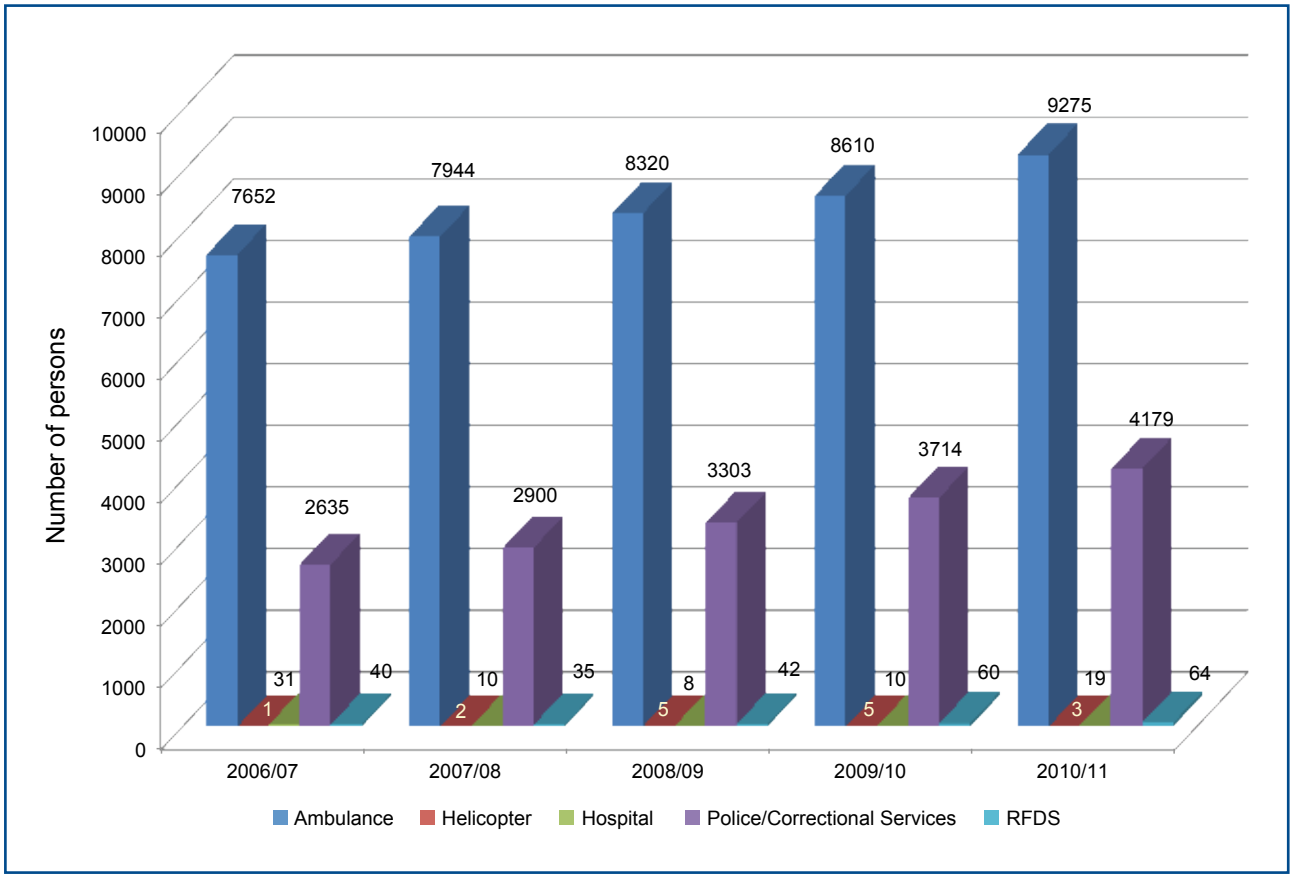
3.7 Transport

Patients with mental illness are transported to hospital by a number of modes including:

- private car
- taxi
- public transport
- hospital vehicle
- hospital transport services
- police
- ambulance
- Royal Flying Doctor Service (RFDS)
- rescue helicopter.

Over the past five years, there have been 25.13 per cent more ambulance arrivals and 77.41 per cent more Royal Flying Doctor Service arrivals (see Figure 18). Most people arrive by private transport. In 2010–11, 18,485 arrived by private car, an increase of 2500 since 2006.

Figure 18 Patient's mode of arrival by transport services (excluding private and community transport) to WA emergency departments, 2006–11



Source: The ED Data Collection, data from all HCARe sites and data for all EDIS (ED information system) sites, (i.e. metropolitan, including Joondalup Health Campus, excluding Peel Health Campus and Bunbury Hospital) as received up to 9 March 2012. Private vehicle, walking and bus/taxi modes of arrival are excluded from this table.

Sometimes patients suspected of having or diagnosed with a mental illness require transport to hospital by police or ambulance, the RFDS or hospital transport services. Such occasions include incidents in the community where the person with mental illness is in danger of hurting themselves or others and requires a psychiatric assessment. In addition, emergency services are deployed to move a patient from one hospital to another. In such instances, the Commonwealth and State guidelines, the National Safe Transport Principles and the National Standards for Mental Health Services (Standard 10.3.7) guide transport to occur in the safest and most respectful manner possible.

In the context of WA's vast geographical expanse, the most efficient and expedient mode of transport depends on the patient's location in relation to the destination ED or mental health service. As a rule, all patients transferred from above the 26th parallel latitude are transported by the RFDS and those below are transported by ambulance or car.

3.7.1 WA Police

The *Mental Health Act 1996* authorises Western Australia Police to apprehend a person and arrange their health and/or mental health examination when a person is suspected of having a mental illness and to protect the health and safety of that individual and any other person or to prevent serious damage to property (*Mental Health Act 1996* Pt 10 Div 2 s 196).

The police service is frequently required to intervene in situations that involve persons with mental illness who may be placing themselves, others, and the police themselves at risk of harm. It is an important acknowledgement of the work of the police that families, carers and hostel licensees informed this Review that police demonstrate a great deal of respect when dealing with and transporting patients. In addition, clinicians reflected that police respond quickly when asked to assist patients who display behaviours related to methylamphetamine use or are otherwise considered in need of restraint.

There are numerous occasions when mental health services rely on police to assist them in their work, including:

- mental health staff in imminent danger
- planned back-up to manage clinician or client risk
- police assistance with transporting a patient into protective custody or to a mental health facility
- high-risk situation involving trained police negotiators
- request for urgent police attendance at an inpatient facility—in relation to violence or threat of violence
- locating a missing person
- apprehension and transport of an involuntary person absent without leave from an authorised mental health service or in breach of a community treatment order (OCP undated b).

WA Police confirmed their role in the transport of patients with mental illness with this Review, noting that the initial interception of a person with mental illness in the community often involves the police where there are issues of community safety. Police understand that their uniform and manner enables transfers with little need for restraint and that dealing with mental illness is not an incident of criminality. The emphasis of their intervention is always on the health issue, emphasising that if the incident involved criminality, police do not charge the individuals until they are medically and psychiatrically 'cleared'.

In the case that a person requires emergency health or psychiatric assessment, the police will escort the patient to an ED. Police will stay with the patient to ensure their safety and the safety of others until the patient receives assessment and required medical or psychiatric attention.

Police are not compelled to wait with the patient if cooperative arrangements can be made with the health services 'whereby given the condition of the patient, immediate attendance by the police is not required' (OCP undated b). Such arrangements are rarely possible in hospitals that do not have hospital security staff.

Police are also requested to transport patients by GPs, ED staff, courts and mental health facilities and services. Guidelines based on the OCP (undated b) framework for dealing with psychiatric crises and high-risk situations involving a person who has a mental illness inform the referrer about assessing urgency (triage) and the roles of community services who can assist instead of, or as well as, the police.

These include the community emergency response teams (CERTs), forensic nursing staff and local Aboriginal medical services. The referrer must make a clinical judgement about the need for police escort; involving the police in transfer should not be common practice (OCP undated a & b). When police assistance is required, a transport order (Form 3) can authorise the police to apprehend the person and take them to a place for examination.

Police use the most suitable vehicle available, including Department of Health vehicles, ambulance services, police cars, police division vans or private vehicles. Families informed the Review that police seemed very thoughtful and often choose a private or unmarked car, which reduces the stigma in their neighbourhood.

The CERT clinicians at Osborne Park reported that police most often accompany the mental health nurse in the hospital vehicle unless safety requires the services of an ambulance. In addition, police call on the CERT team directly to obtain assistance with mental health issues in the community.

WA Police data demonstrates that the number of police interventions in community incidents has doubled and escorts have increased by 169 per cent in the past six years and the time taken to complete escorts is 261 per cent longer than five years ago (excludes forensic incidences) (See Figure 19).

Figure 19 **Table of incidents and escort WA Police**

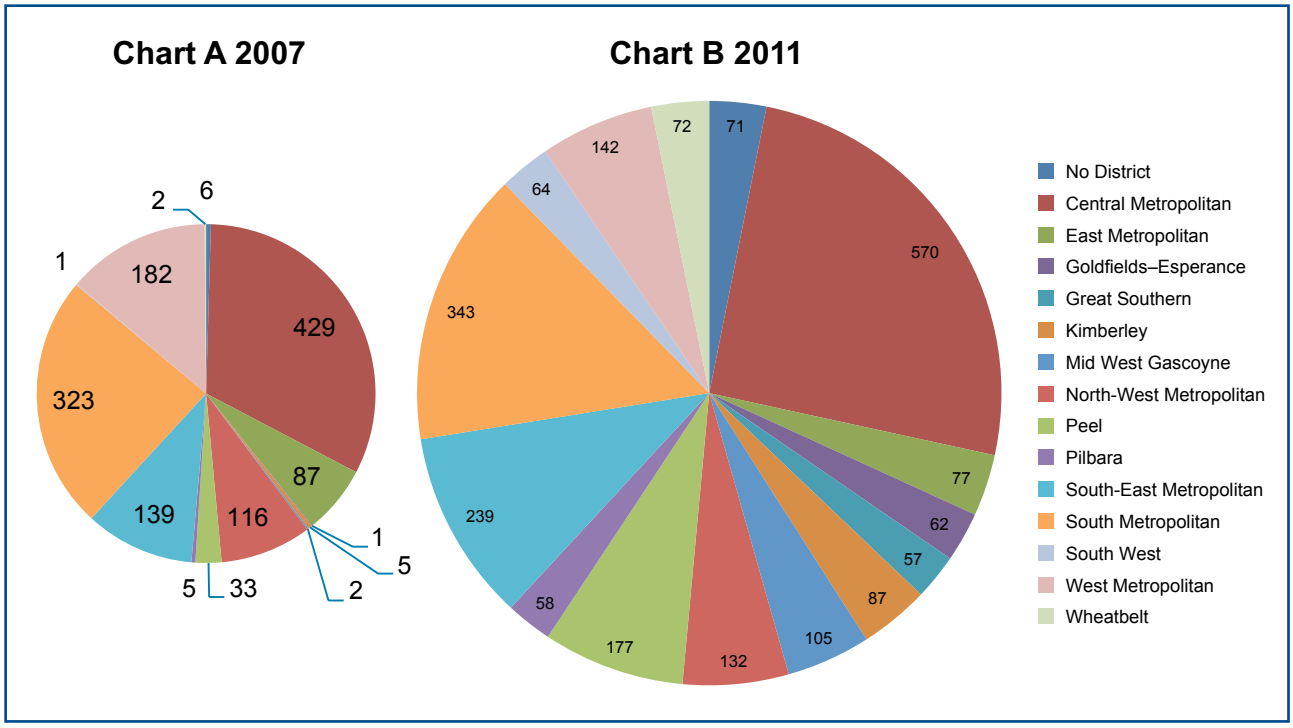
Year	Mental health escorts	Escort hours	Police attended incident
1/12/2006–1/12/2007	1331	2248	339
1/12/2010–1/12/2011	2256	5860	677

Note: Mental Health in these figures does not necessarily infer a psychiatric diagnosis of mental illness.

Source: WA Police (2012).

The state distribution of incidences and transports across the police regions are illustrated in Figure 20.

Figure 20 **WA Police mental health escorts by districts: Chart A, 2007 and Chart B, 2011**



Source: WA Police Reports (2012).

As with other services, the police do not have limitless capacity or resources and must prioritise service. Police prioritise community safety and promptly attend; the escorting of patients from one hospital to another is a lower priority. At times, patients may wait days until police are available to assist with their transfer.

Planning and backfilling of WA Police roles is necessary in order for police to transport patients, particularly from rural and remote areas, to metropolitan hospitals.

Tyranny of distance means that some transports to treatment centres are measured in days. This is the case for transports such as from Karratha to Perth. The low level of staffing in rural areas at times requires police to be flown from Perth to country towns to escort a patient. On some occasions, the police auxiliary officers provide escorts. Delays are lengthened when RFDS are deviated to medical emergencies. As these preparations and arrangements are made, the patient continues to wait in hospital.

WA Police representatives drew the attention of this Review to the Mental Health Intervention Team in NSW that has trained a number of frontline police and ambulance staff in mental health (NSW Health, Ambulance Services of NSW & NSW Police Force 2007).

These multiformed teams with training in mental health are able to de-escalate situations and, when necessary, use soft restraints and will transport patients between hospital facilities and from community situations. The ambulance officers have been trained to use Velcro model restraints and, while police maintain presence until paramedics arrive, they do not need to be present during patient transfers. The program aims for police assistance at initial contact and for paramedics to provide transport without police escorts. A model along similar lines is likely to be of benefit to patients and may contribute to an improved patient transport system in WA.

The introduction of a metropolitan-wide mental health transport service staffed by mental health trained escorts in an appropriate vehicle would do much to reduce waiting times (usually in EDs) for patients being transported between mental health facilities. This is a major recommendation.

Note: Police were concerned that on the occasions when they must use the police division van to take a patient to ED, they have to 'ramp' with the ambulances. Police officers cautioned and were concerned that they are not able to provide the patient with adequate assistance in this situation, suggesting that these patients 'jump the queue' and be triaged into the ED as soon as possible.

3.7.2 Royal Flying Doctor Service

Clinicians commented that the RFDS transfers severely ill patients promptly.

The WA Royal Flying Doctor Service has been involved in the air transport of patients with psychiatric conditions since 1982. Combinations of physical restraint, sedation and health professional escorts enabled safe air transport for restless and agitated patients, ensuring the safety of pilots, passengers and aircraft. Standardised sedation requirements for transporting patients with mental illness were established in 1982 (Western Australian Therapeutics Advisory Group 2006). The standardised requirements meets the obligations of aircraft operators and pilots to comply with CASA (Civil Aviation Safety Authority) safety regulations in regard to carriage of violent or disturbed individuals and with health providers' obligations in accordance with the *Mental Health Act 1996*.

In the financial year 2010/11, 342 acutely disturbed patients were transported on 418 flights in WA. The RFDS is generally only involved in transfer of acutely disturbed 'referred' patients who are not willing to travel voluntarily and where there are no other reasonable means of transfer. Both Form 1 (referral) and Form 3 (transport orders) are completed. Form 3 requires that police ensure the conveyance of the patient to the authorised hospital.

These patients are escorted by a nurse, police officer, and often a doctor.

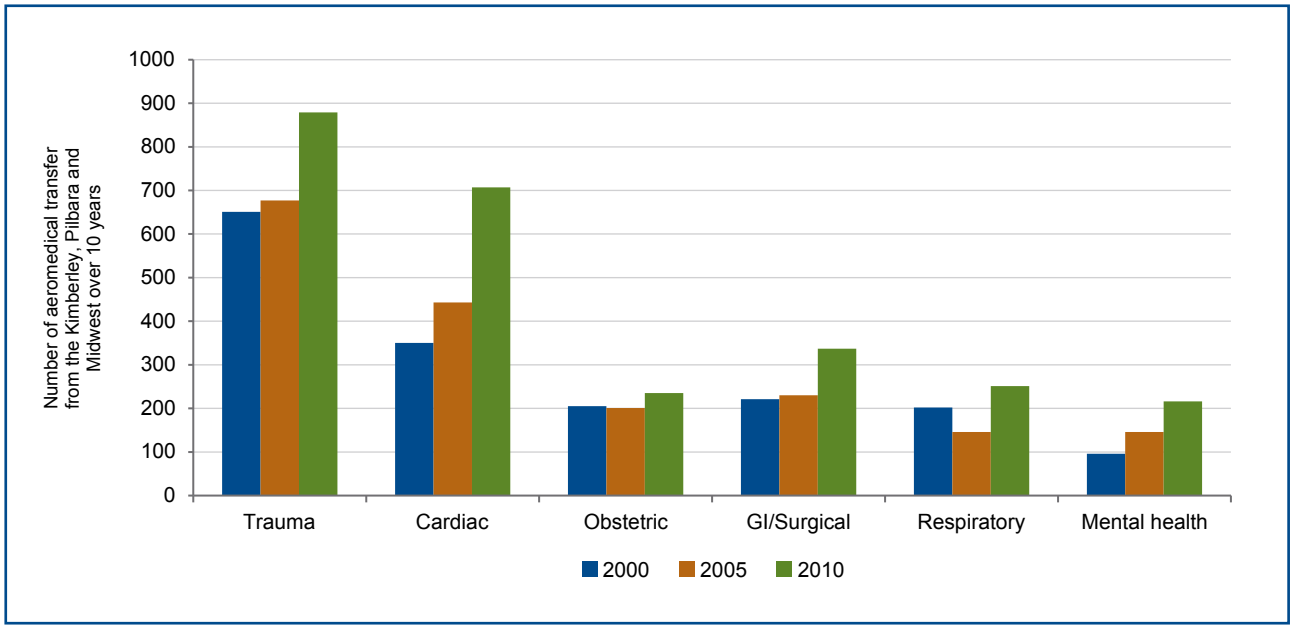
All patients are evacuated as quickly as possible and the RFDS applies a three-tier national system for allocating priorities to patients. Priority 1 is life threatening; 2 is urgent medical transfers (heart attacks, major trauma); and 3 is routine elective transfer.

It can take up to 24 hours to transport the patient from the referral point to their destination. Response times to a request for transfer averages 24 hours. However, it can take as long as 78 hours in the north-west.

Flight times can take 10–12 hours at times. In some cases, multiple flights with multiple aircraft and crew are required to cover the distances involved. A cited example is a transport of a patient from Kununurra to Derby, Derby hospital overnight, Derby to Port Hedland, handover to another crew, Port Hedland to Meekatharra, handover to another crew, then Meekatharra to Perth. A flight from Kununurra is costly at some $30,000 per flight. The outcome for patients is not ideal as they experience lengthy transport episodes and onerous periods of restraint.

There has been a marked rise in aeromedical transfers, with 70 per cent more transfers in 2010/11 compared to 2009/10 (see Figure 18).

Figure 21 **Aeromedical transfers from the Kimberley, Pilbara and Midwest, 2000–10**



Note: GI = gastrointestinal

Source: RFDS data (2012).

The new mental health facility in Broome is expected to alleviate the pressure on RFDS transfers of patients with mental illness in the north-west.

The RFDS expressed a number of concerns to the Review, including that:

- Mental health issues appear to be increasing in our community. It is an observation of RFDS personnel that substance abuse is exacerbating the behaviour of many patients and resulting in increased levels of violence.
- It can be difficult to obtain police escorts from country centres.
- Patients are transported a long way from their social networks.
- There is a 'revolving' door scenario in many cases, with patients receiving a brief period of treatment in the metropolitan hospital and are then discharged home to rural areas, only to present again a short time later.
- Physical restraint protocols and equipment need reviewing in country hospitals.
- There should be opportunities for commencing antipsychotic medication earlier with supportive expert psychiatric advice. Tele-psychiatry may have a role.
- The requirement of sedation and often intubation raises issues of increased risk to the patient.
- Increasing the capacity of rural hospitals could avoid some of the air travel.

The Chief Medical Officer of the RFDS said that over the past five years there seems to be an increasing number of patients transferred by air whose behaviour is violent, and the violence is more extreme. Often, the patient's symptoms are precipitated by illicit drugs and sometimes mental health services are required for very short intervals. The population are more often teenagers and young persons and most referrals derive from medical consultants rather than psychiatrists.

The RFDS do not require all patients to be sedated and intubated. Clinicians from country regions told the Review that sedation is given orally if possible and the patient is monitored. It is rare that patients require intubation and this is only undertaken where the oral sedation is ineffective and intravenous sedation needs to be used. Patients are secured with Velcro to a trolley and the sedation is titrated [adjusted according to effect] according to the patients' level of aggression. If they are not aggressive, they are only lightly sedated. Nevertheless, all patients require constant supervision, resuscitation equipment and a capacity to attend to respiratory depression or obstruction during transportation and for a minimum of 48 hours post-dose (Western Australian Therapeutic Advisory Group 2006).

One in four patients is intubated before transport by the RFDS. Hospital psychiatric liaison clinicians explained to the Review that when the sedated and intubated patients arrive they are taken to metropolitan intensive care units (ICU) for extubation. The patient then waits in ICU until an authorised mental health bed becomes available.

Some patients may require continuous sedation until a bed is available and no psychiatric treatment is commenced until the effects of sedation have dissipated. Once the mental health bed becomes available, often within 36 hours, the patient requires police-escorted transport. Patients may also wait for long periods in the ICU while police and ambulance transport is coordinated.

During the period of waiting for transfer to an authorised bed, the ICU could be exposed to considerable disruption. The Department of Health's Chief Medical Officer suggested that it would make sense to transport such patients to an ICU in hospitals that have secure mental health beds, thereby avoiding the additional transfer to a mental health facility.

When patients have completed an inpatient episode of treatment, the RFDS is not able to provide the transport back to their area. That is, the patient or their family may be left in many cases to make their own arrangements for transport home.

This risk to patients is illustrated by information provided to the Review that highly agitated children are transferred from the Pilbara only to be assessed and discharged the following day and issues arise concerning the way they return home.

Broome clinicians informed this Review that the opening of the mental health beds in Broome may not be of advantage to patients in the Pilbara because while they may be transported by RFDS from say, Roebourne to Broome, their return home may mean a long wait for air travel as there are few services between north-west towns. Road transport is an alternative but may not always be wise for a patient discharged from mental health care. There is also a lack of supported hostel accommodation in Broome where patients could wait for transport.

This Review is concerned about the sedation and the transport of patients from rural and remote communities to Perth. Capacity building in local EDs is required to enable a local response to acute presentation of patients with symptoms of psychosis and aggression. This may require increased security and a State Protocol for Patient Management.

The transport of patients away from their network of family and friends, and the often-complex arrangements for their return, are added stress to already fragile situations. This is exacerbated when patients re-present in a similar state within a short time of discharge. Dislocation from the local environment and meeting different treatment teams may also be damaging the patient's continuity of care. Young people who present with first episode psychosis are only flown to Perth if there are overriding factors that cannot be managed locally such as high risk and containment issues.

3.7.3 St John Ambulance (Western Australia)

St John Ambulance (SJA) provides a first line of emergency care and transport for patients with mental illness. In 2010–11 SJA provided 9572 transports for mentally ill patients in WA, most of which were for emergencies (ED Data Collection). In the metropolitan area during 2011–12, SJA transported 702 persons on forms, with 421 of these as inter-hospital transfers (pers. comm. Principle Business Analyst, SJA 2012). In the context of the mental health system, the ambulance service is confronted by a number of issues on a day-to-day basis, while working in collaboration with WA Police and mental health services.

Specific procedural requirements when transporting disturbed patients means paramedics, who are not authorised to restrain patients physically, can use only chemical restraint.

When physical restraint becomes necessary, usually because of violence, the ambulance paramedics call on police to assist with transferring the patient. In these cases, SJA operational staff report that police do assist and do physically restrain patients when necessary.

The Review was informed that police assistance with ambulance transfers is more difficult to obtain for inter-hospital transfers and that ambulance delays can result in difficulties of coordination of ambulance and police services. The key factor is that the ambulance service necessarily prioritises responses in accordance with urgency; transfers between hospitals are often delayed by one to four hours; in rural areas, transport can be delayed for days. If the ambulance has not arrived within 30 minutes of the police officer's arrival, the police must leave the ED to undertake other duties. This results in longer waits for the patient. When the ambulance arrives and the police are not present, they too must attend urgent calls if they occur while they wait for the police to arrive.

The Review was informed that in the ED environment, with pressure to discharge patients, the response may be to circumvent the formal procedural requirements related to the requirement of police assistance, resulting in SJA transporting patients without police assistance.

In rural areas, ambulances are crewed by trained volunteers. Volunteer ambulance transfers account for 10 per cent of all ambulance transports and include approximately 2000 mentally ill patients a year in rural areas. In the context of transporting mentally ill patients over long distances, operational managers expressed concern for patients who were sedated and restrained for long periods. This is an issue similar to the RFDS sedation of patients, including the risk to the patient and the transport personnel.

The Review revealed varying models and approaches to hospital transfers of mentally ill patients. For example, Swan District and Sir Charles Gairdner hospitals use police regularly while at Royal Perth Hospital transfers are undertaken with a nurse and companion security officer.

At Rockingham hospital, ED staff meet regularly with police to discuss issues. There is agreement that neither the ambulance nor police are always the appropriate mode of transfer for patients.

The ED and mental health staff who participated in this Review supported the concept of an inter-hospital transport team as outlined in section 3.7.1. They postulated that hospital-trained staff in a hospital vehicle would ease many problems involving patient transfer between hospitals and mental health services. Although patients may still wait, an assurance of a pick-up time would ease tension. In addition, it would reduce demands on police and ambulance services, enabling them to attend to other priorities. With a more certain time of departure, ED clinicians could provide more appropriate sedation and have a clearer understanding of the resources needed, such as the level of security.

Among comments by carers was a concern that authorised persons described in the Mental Health Bill 2011 should be well trained and not private security guards. In addition, clinicians suggested that using hospital security personnel to ensure safety might have an effect of reducing the 'criminalising' of mental health behaviours.

This Review considers that mental health services should develop a safe and quality transport system in the metropolitan area with hospital staff trained in mental health and soft restraint.

A need to ensure adequate mental health-focused training of security personnel is mandatory for such a system to be efficient and safe.

See Recommendation 1: Governance (1.3).

3.8 Specific issues

3.8.1 Mental health services in remote areas

Irrespective of geographic location, provision of regular patient assessment and care intervention, emergency response, and carer training and support are core aspirations of mental health services.

The capacity of the mental health system is directly affected by the effectiveness of a workforce strategy that results in securing and retaining a skilled and qualified workforce across WA. This Review was made acutely aware of workforce and MHS capacity issues in remote areas.

The tyranny of distance is a feature of WA that acts to reduce capacity to provide optimal psychiatric care to communities in remote regions such as the Kimberley, the Pilbara and the Goldfields.

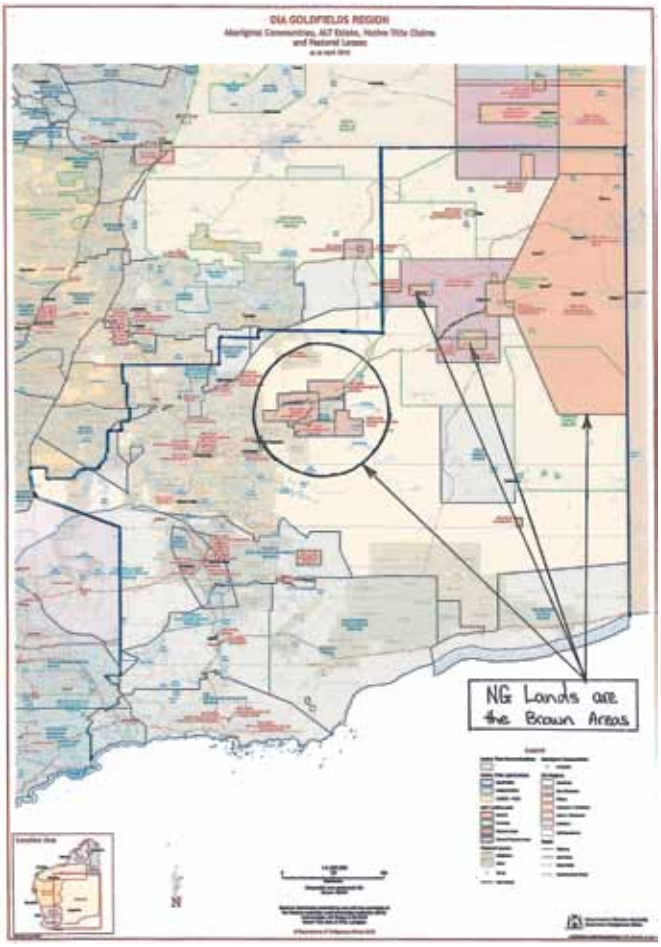
The rural and remote population makes up 28 per cent of WA's population and includes many Aboriginal persons who require special attention.

Mental health services in remote areas are intermittently provided by fly-in or drive-in practitioners and emergency responses include RuralLink telephone support, the RFDS and some volunteer-operated ambulance services.

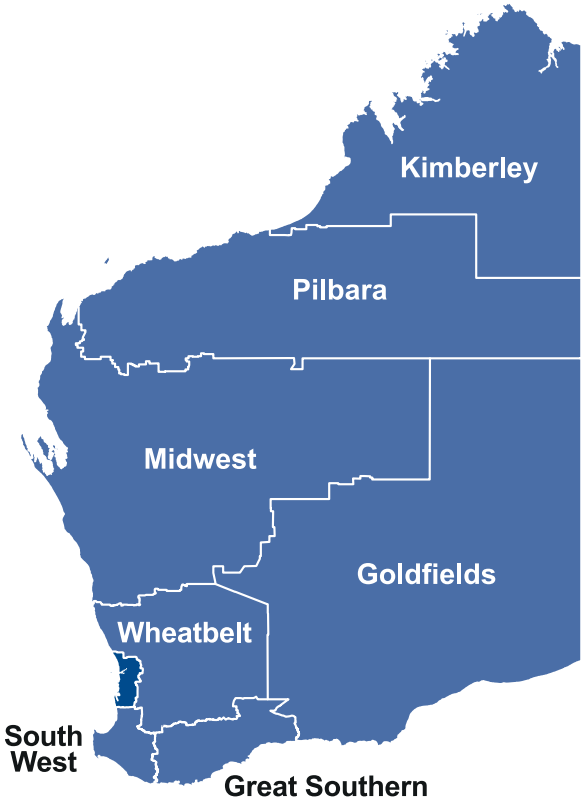
Remote area mental health care is provided in a hub-and-spoke model. Clinics are based in larger towns and staff travel to smaller towns and communities for a number of days at a time at regular intervals. The scarcity of GPs and lengthy travel by clinicians create obstacles to timely mental health care and there are virtually no after-hour services. Mental health care tends to focus on acute illness management and relies on frequent and regular communication with the GPs.

Figure 22 **Map 1 Tripartite lands & Map 2 WA country health region, 2012**

Map 1 *



Map 2



* Source: Map 1 supplied by Sidney J Carruth, Aboriginal Mental Health Coordinator, Kalgoorlie Hospital (2012).

Mental health care provision in the area to the north-east of Kalgoorlie is complicated by the influence of health and policing legislation of the three bordering states (tripartite lands). Australian states have disparate Mental Health Acts and, although cooperation between states exists, mental health workers in tripartite lands must manage three acts in addition to Commonwealth, State and local government legislation.

Each state provides services and it is not uncommon for several programs to be targeting different members of the same family, while many families receive no services. This complexity leads to staff tension in regards to who has the mandate, funding and capacity to provide services.

The Review was informed that there are occasions when services debate about who should be providing care, resulting in patients left to wait for services and increasing stress for the patient and for the family. These tensions are exacerbated by numerous service providers, each with a narrow focus, which sometimes results in each family member within a household receiving sporadic service from different agencies.

Mental health clinicians expressed concern to the Review about the difficulty of attracting and retaining mental health staff, rendering delivery of services uncertain. For example, they said services in Derby are insufficient to meet the current high level of self-harm. At present, there are two FTE mental health staff and one youth counsellor in Derby. These services are supplemented by fly-in consultant psychiatry and drug and alcohol services. Funding has been granted to rebuild the mental health clinic. However, expensive housing and the high cost of living in remote towns is believed to deter applicants from applying for vacancies.

Clinicians informed the Review that in some areas of the Great Southern mental health services are not currently available because of workforce shortages.

Fly-in, fly-out psychiatrists support the Kalgoorlie mental health service. For many patients with chronic mental health conditions, this is not a satisfactory arrangement for continuity of care, with patients likely to see different psychiatrists at each visit. For example, one patient saw five different psychiatrists over a three-week period. There is also a high turnover of staff, a loss of corporate knowledge and little knowledge about individual patients over time.

This shortcoming is constantly being addressed by services through clearly articulated processes and careful patient health documentation. The weakness of the fly-in, fly-out model is the discontinuity of care delivery by the same psychiatrist, and therefore written documentation and close liaison with the mental health team is essential.

In the Kimberley, psychiatrists reside in Broome and fly to Kununurra, Wyndham, Oombulgurri, Halls Creek, Kununurra and Kalumburru on alternate weeks. They also visit Derby, Fitzroy Crossing and Balgo via fly-in, fly-out visits every six weeks. Adult and child mental health clinicians and drug and alcohol clinicians stay in Balgo for three days every six weeks. The further outback is visited three monthly.

In the Pilbara and Goldfields, psychiatric care is also provided in a fly-in, fly-out model. The Western Desert and Canning Stock Route communities and Marble Bar receive three monthly visits (to bigger communities).

Psychiatrists are available one to two monthly in remote areas of the Great Southern and most referrals for patient assessment are received from GPs who prescribe medications informed by the psychiatrists' assessment and recommendations.

Carers in rural and remote areas told the Review that they feel particularly isolated and sometimes experience high levels of stigma. The provision of carer support and training is not a viable proposition when carers need to drive 400 km or so to attend centrally provided sessions (personal communication MIFWA representative 2012). It is also difficult for them to obtain assistance with health and caring issues.

Inpatient care in rural and remote areas is often provided in general hospital where patients are admitted under a GP and the psychiatrist provides consultation.

Mental health services provide assessments in EDs in addition to providing consultation to hospital patients. Flow charts and shared care guidelines clarify roles and responsibilities. To enhance collaboration, there are opportunities for general staff to orientate to the mental health service. Orientation of mental health clinicians to hospital services has recently commenced at Port Hedland.

Advances in technology have enabled some inreach of expertise into remote areas. Video-links enable assessment by psychiatrists for remote patients, who are transported by community mental health services to the nearest hospital with video-link capability.

Remote communities are supported by the comprehensive physical and mental health services from the metropolitan area, for example, RuralLink support, video-link assessment and on-call psychiatry advice 24 hours a day, and these should be promoted and actively offered.

Alcohol and cognitive impairment contribute to the enormous levels of cognitive disability, especially in the Kimberley, and there is no specific service for these conditions; instead, general hospital, community and mental health services provide the care.

The ED staff in all areas, and in particular the rural areas, should be required to complete education and competency testing in the skills of mental health assessment and de-escalating techniques.

ED medical officers and GPs in rural and remote areas should be encouraged to participate in the development of a clinical protocol for patients who present with behaviours associated with methylamphetamine and other drug-induced psychosis.

See Recommendation 1: Governance (1.1.6); Recommendation 2: Patients (all, particularly 2.7); Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development (4.11); Recommendation 5: Beds and Clinical Services Plan; Recommendation 7: Acute issues and suicide prevention (7.5, 7.7, 8.2); and Recommendation 8: Children and youth (8.8).

3.8.2 Aboriginal people and mental illness

When Aboriginal people experience mental illness, their symptoms are expressed within their cultural milieu and many prefer treatment within a family and community. In this cultural context, Western medicine continues to dominate and Aboriginal people do not have a place to receive cultural healing. This Review gave attention to the stories and views of contributors in this often-complex area for mental health service provision.

Improving the care of Aboriginal people with mental illness will require development of specific care models that integrate family and trusted members of the community to accompany and vouch for the persons with mental illness throughout their psychiatric/specialist treatment. The effectiveness of care models should depend upon a workforce of Aboriginal persons trained as psychologists, psychiatrists and mental health nurses, so that cultural methods of care can be applied alongside conventional psychiatry.

Note that while much of the focus of this Review in relation to Aboriginal people and mental health issues is on those in rural and remote areas, the importance of Aboriginal persons residing in metropolitan and large regional centres should not be diminished.

A young carer explained that in his community in Broome and the Central Desert, mental illness is accepted as always present within communities, and community members are constantly exposed to the symptoms and associated issues.

Community members, he said, were comfortable to accommodate members with mental illness in whatever capacity they could. Professor Helen Milroy, Winthrop Professor and Director of the Centre for Aboriginal Medical and Dental Health at the University of WA, also explained to the Review that communities have a long history of high tolerance to behaviours and symptoms of mental illness.

Past hospital admissions are remembered as poor experiences and the community lives with the intergenerational anxiety of the stolen generation and high rates of incarceration (personal communication A/Professor Wilkes & M Mitchell 2012).

Based on his experience as an Aboriginal psychologist, teacher and researcher, Darrell Henry identified that mental illness may manifest as a generalised anxiety and Aboriginal people often have multiple layers of trauma, some of which are generationally experienced. Issues include racism and a sense of minority and alienation.

Professor Milroy, who is a consultant child and adolescent psychiatrist with the Specialist Aboriginal Mental Health Service (SAMHS), is also concerned about the multilayered issues of Indigenous mental health that often lead patients to present late in an acute state and often requiring involuntary care.

Similar to other populations, young Aboriginal people with mental illness may have comorbid recreational drug and alcohol issues (personal communication R Menasse 2012). This experience can also be compounded by issues of unemployment, cultural destruction and relationship difficulties (personal communication R Menasse 2012).

The SAMHS is funded under the Closing the Gap National Partnership agreement until 2013. The treatment philosophy is ‘whole of life, whole of family’. This statewide program is governed by the North Metropolitan Area Health Service (NMAHS) and the WA Country Health Service (WACHS). Clinical governance is provided by the SAMHS Deputy Area Executive Director.

The aim of the program is to provide cultural security and integrity in MHS delivery by increasing the number of university-qualified Aboriginal mental health practitioners. Service provision includes: triage and brief interventions; consultation; liaison and shared care; inreach to Aboriginal people within inpatient settings, particularly the Frankland Centre; and contributing to multidisciplinary community mental health services, including case management.

Professor Milroy described the SAMHS program to be building capacity in the mental health workforce with Aboriginal clinicians undertaking university-level three-year courses. The program increases the responsiveness of mainstream services and supplies cultural consultation to them. The program also provides cultural training, including family systems and phenomenology, in line with overseas psychiatry courses.

Inviting families from remote areas to accommodation at Graylands is an initiative that seeks to demystify and destigmatise mental health treatment while the patient is in hospital.

Families are informed about the importance of continuing medication, even though the patient feels well. The program also ensures that SAMHS workers are part of the reception when the patient is discharged home. Obtaining accommodation for those that are sleeping rough is critical to ensuring follow-up occurs, as is escorting patients to their accommodation on discharge.

Aboriginal culture includes a personalisation of everything they do. Mr Henry remarked that when Aboriginal persons require assistance they will seek a receptive person who will assist them beyond the mental illness symptoms with the wider stressors of accommodation and drug problems. He explained that some Aboriginal people fear the mental health services, and it is important that mental health workers develop therapeutic alliances with the community.

Mr Henry said one of the skills taught in the care of Aboriginal people is the importance of listening to inner stories. Inner stories can be difficult to identify unless the clinicians work very closely with the community. In this environment, it is possible to develop an openness and network to support the person with mental illness and the community. Mr Henry noted the importance of providing courses and training to Aboriginal health workers.

A young carer said explanations about mental illness from a Western cultural perspective are not always culturally appropriate. For Aboriginal people, it is more important that the disease be explained in the context of what are useful and not-so-useful activities for the individual and community to do. The young carer proposed that the community was the best place of care for most Aboriginal people and more could be done to support the community in their care of members with mental illness.

The care of Aboriginal patients with mental health issues is made much more difficult for those who live in rural and remote areas because hospitalisation may require transfer to acute facilities in Perth and the fear of incarceration and separation from family and lands adds heavily to a patient's stress as well as to that of their family.

Associate Professor Ted Wilkes, a proud Noongar man and a Prime Ministerial appointment to the Australian National Council on Drugs and the Derbarl Yerrigan Health Service in Perth. He explained that Aboriginal people often use services when they are in crisis and do not return for follow-up treatment. To support ongoing care, communities need to establish partnerships with mental health services that also foster development of appropriate service models to be able to respond effectively to the needs of Aboriginal people who have mental illness.

Moreover, the written communication style of mainstream services, such as referral letters and discharge plans, in addition to phone calls, do not suit the culture of communities who rarely answer telephones or letters and who are itinerant. An executive of MHS suggested that in addition to encouraging individuals to seek help and support, parenting programs and mental health first-aid courses are needed by communities to assist them to support their members with mental illness.

Aboriginal people's degree of disadvantage is such that that they require special pathways to assist them (personal communication Professor Wilkes 2012). Communities require a structure to enable Elders to form positive pathways (personal communication Professor Wilkes 2012).

Suicide is occurring in younger children and children as young as six play 'hanging games'. Professor Milroy commented that such acting out results from multiple exposures to the volatile state of adolescents. In addition, there is much concern about the high numbers of

Aboriginal persons in the juvenile justice system and on remand. For example, there is a high number of Noongar boys at Banksia Hill Detention Centre (40% of population).

One view expressed to the Review was that the lack of Elders within Aboriginal communities has depleted the presence of mentors and many children and young people are subject to antisocial behaviours, violence, aggression and illicit drugs. When mentors are available, children fare better and are able to achieve educational and vocational goals. However, with the shortened lifespan of Aboriginal persons, along with high levels of chronic illness and high numbers of young adults in jail, there are few Elders to guide young people.

It was proposed by a contributor to the Review that cultural healing centres be strategically placed on Noongar land in areas in the south-west, such as Esperance, Katanning, Swan River and Albany. A similar strategy has been successful in New Zealand where Mäori healing centres have been established. It would be sensible in WA for mia mias (shelters) to be constructed to provide a place for spiritual and cultural healing (personal communication Professor Wilkes 2012).

There is in-principle support for a culturally appropriate model of mental health care. However, best practice models are yet to be identified (personal communication Professor Wilkes 2012). Current services have an emphasis on acute care and it is important that Aboriginal people are engaged in the development of any plan to improve their mental health.

The Deputy State Coroner remarked that there are no specific training programs to assist Aboriginal people with mental health issues in their environment. The Review acknowledges this absence of training programs, noting that an important theme for the future is to ensure that patients and carers have sufficient and practical access to targeted training programs.

Capacity building is an important concept when considering improving the delivery of mental health services.

The Review notes other areas that should be afforded considered and serious attention:

- Cultural sensitivity and cultural competence must be core competencies of practice.
- Development of the SAMHS suicide intervention team, including the support of Aboriginal Elders, specialist mental health services and government and non-government services, is supported (Commissioner for Children and Young People 2011).
- Concerted attention directed at factors such as substance abuse, foetal alcohol disorders and head injuries should be part of improving the mental health for Aboriginal communities (Commissioner for Children and Young People 2011).
- Ensure that admission, referral, discharge and transfer policies, practices and procedures of mental health services are attentive to and meet the cultural needs of Aboriginal children and young people (Commissioner for Children and Young People 2011).
- Ensure that SAMHS and the Infant, Child, Adolescent and Youth Mental Health Service establish a close working relationship and seamless referral process to ensure the best possible outcomes for Aboriginal children and young people (Commissioner for Children and Young People 2011).

See Recommendation 3: Carers and families; Recommendation 7: Acute issues and suicide prevention (7.6, 7.7, 7.8); and Recommendation 5: Beds and Clinical Services Plan and Recommendation (8.10.3; 8.10.4).

3.8.3 People from culturally and linguistically diverse backgrounds (CALD) and mental illness

Patient and families' understanding of mental illness, associated issues of consent, understanding of available care, legal rights and myriad related aspects are potentially inhibited when the patient and family are from culturally and linguistically diverse backgrounds.

The Ethnic Disability Advocacy Centre advised the Review that navigating the mental health system and understanding what care is provided can be particularly difficult and traumatic for people of a CALD background. The language and terminology or jargon used by clinicians to explain mental illness and treatment are at times complex and unfamiliar. In the absence of language and cultural interpretation, a person of a CALD background is unlikely to understand or to be adequately informed, rendering them impotent in relation to understanding their illness and treatment.

The advocacy service advised the Review that CALD patients require assistance to navigate the complexities of the mental health system and to understand care and follow-up treatment. Ethnically sensitive interpreters with expertise in mental health issues are frequently used within mental health care services.

This Review did not explore the full extent of the CALD population and associated cultural features of various population groups. The Reviewer did attend the Mental Health Access Multicultural Centre in Fremantle where a group of patients shared their experiences of migration and refuge in Australia. When mental illness further complicated their lives, these patients were assisted by the multicultural centre to navigate the system. Overall, the patients were satisfied with mental health services and the support they received from the multicultural services.

The issues they experienced included difficulties communicating with inpatient staff about a patient's general health issues; discharge occurring before symptoms were controlled; comorbid pain exacerbating mental illness; income; and accommodation.

To increase staff knowledge and sensitivity to the needs of patients from CALD backgrounds, courses on multicultural issues have been provided to staff in mental health services. These training programs on managing cultural diversity are mandatory.

This Review also received a submission from the Mental Health Law Centre about CALD patients. That submission asserted that mental health practitioners should be trained in cultural and linguistic diversity and the use of interpreters. The National Cultural Competency Tool for mental health services (Multicultural Mental Health 2010) should be implemented.

The Review considers that cultural competency should be emphasised in ongoing mental health education and that appropriately qualified interpreters be used to ensure that CALD patients and families receive information in a form, written or verbal, to enable them every opportunity to be fully informed and engaged in care.

The Review also supports the West Australian Transcultural Mental Health Centre's recommendation that translated information about the mental health services role, the patient's condition and treatment should be made available to the patient and carer and that the use of interpreters to convey information is imperative.

See Recommendation 1: Governance (1.5).

3.9 Strategic governance and legislation

3.9.1 Mental Health Bill 2011

Time constraints prevented a full review of the Mental Health Bill 2011. However, the Reviewer makes the following interim comments.

The Bill reflects many of the recommendations put forward by the Holman et al. report (2003) and omits a number of recommendations that were accepted by the Government (Holman 2003).

The Reviewer is of the opinion that the Bill is intended to protect the human rights of persons with mental illness, and contains specific schedules that empower consumers and involves carers in decision making about admission, treatment and discharge planning.

Many of the issues in need of improvement in the mental health system that have come to the attention of this Review are addressed in the Bill, including:

- Consent to and involvement of the patient with treatment. It is commendable that the Bill requires that patients are involved in the development of treatment plans and have the right to a second opinion; as well as the right to withdraw consent (Pt 13 and Pt 14 Div 3 s 252). The power of the Chief Psychiatrist is appropriate in ensuring that patient's rights are appropriately explained.
- Physical health of patients.
- Aspects of the Carer Recognition Act 2010, especially involvement of the carer with treatment and discharge planning.
- Aspects of Aboriginal ethnic requirements such as being accompanied by a nominated person or medicine Elder throughout treatment. Sections 142 and 143 and more generally Pt 4 Div 1 enable Aboriginal culturally appropriate care.
- The need for a nominated person to 'walk' or be with the patient through mental health services.
- Acknowledgement and inclusion of advanced care statements.
- Reporting of sentinel /incidents events [rare events that lead to catastrophic patient outcomes]to the Chief Psychiatrist.
- Special consideration in the care of children.
- Authorised professionals other than police officers needed to transport mentally ill patients.

This Review is concerned with some aspects of the Mental Health Bill as follows:

- The Office of the Chief Psychiatrist (OCP) would benefit by being external to the Mental Health Commission and the Department of Health, acting independently and reporting directly to the Minister for Mental Health and the Minister for Health. This would empower the OCP to carry out the duties specified in the Bill without any conflicts of interest.
- Such independence would enable the OCP to develop guidelines, monitor continuous quality improvement (particularly investigations of deaths and other incidents), patient advocacy and support to mental health staff from purchaser and provider associations. It is the Reviewer's opinion that for the Chief Psychiatrist to report alone to the Mental Health Commission or to the Department of Health raises major issues of conflicts of interest.

- It is commendable that the Bill acknowledges the differing needs of children with mental illness (Pt 15). However, there is no specific acknowledgement of the needs of youth aged 16–25 and the requirement for secure care environments for children and youth. Youth should be cared for in a separate environment to young children and adults.

The definition of mental illness needs re-examination or further description to remove the dementia of the ageing population or of some specific diseases, which are best cared for in the geriatric or other special medical environments.

The time frames that have been put forward concerning the involuntary patients and their review is very short and this Reviewer does not believe those requirements can be achieved, especially with current workforce issues.

3.9.2 Office of the Chief Psychiatrist

Before the Health Administration Review Committee (HARC) Report released in 2001, the Office of the Chief Psychiatrist (OCP) was both the funder and provider of mental health services in WA. This included responsibilities for operations, planning, policy and legislation. HARC recommended that the OCP separate from the Mental Health Division (Recommendation 13: The role of the Chief Psychiatrist be developed as a discrete function within the health care division) and the *Mental Health Act 1996* defined the statutory responsibilities in legislation.

The OCP became responsible for the medical care and welfare of all involuntary patients, and the monitoring of standards of psychiatric care throughout the State (s 9 of the *Mental Health Act 1996*). Other functions include keeping a register of authorised hospitals and practitioners and the maintenance of satisfactory standards in relation to medication use in psychiatry. The OCP introduced clinical governance reviews to discharge the Office's responsibilities with regard to the care and welfare of involuntary patients and standards of care in services.

The separate and independent office was established on 1 July 2002.

The OCP is directly accountable to the Director General of Health and the Minister for Mental Health and ultimately to the community and particularly those people with a mental illness, their carers and family.

In the new (services) purchasing environment, the roles and responsibilities of the Mental Health Commission, Department of Health and the OCP are unclear. The OCP informed the Review that they have been requested to inform the Mental Health Commission of the quality and safety of the services the Commission are purchasing. A concern in supplying data is that it be high level and generic and not at individual patient level. At the same time, the Chief Psychiatrist needs to inform the Department of Health of similar issues in the provision of services.

The mental health reforms and maintenance of the current level of service highlights that a purchaser cannot operate without close collaborative work with the providers.

See Recommendation 6: Office of the Chief Psychiatrist.

3.9.3 Mental Health Commission

Reporting to the Minister for Mental Health, the Mental Health Commission of WA has responsibility for the strategic planning and purchasing of WA mental health services. The Commission obtains strategic advice from the Mental Health Advisory Council. The establishment of this commission in March 2010 occurred as the first stage of system reform; the second stage will occur under the anticipated new mental health legislation in 2012. This reform aims to embed a stronger focus on the rights and protection for patients and carers.

In October 2011 the Hon. Colin Barnett, Premier and Minister for State Development, and the Hon. Helen Morton, Minister for Mental Health and Disability Services, launched the 10-year strategic plan *Mental Health 2020: making it personal and everybody's business* (MHC 2011). This Plan has five key principles:

Respect and participation

People with mental health problems or mental illness, their families and carers are treated with dignity and respect, and their participation across all aspects of life is acknowledged and encouraged as fundamental to building good mental health and to enriching community life.

Engagement

People with mental health problems or mental illness, their families and carers are engaged as genuine partners in advising and leading mental health developments at individual, community and service system levels across WA.

Diversity

The unique needs and circumstances of people from diverse backgrounds are acknowledged, including people from Aboriginal or culturally and linguistically diverse (CALD) backgrounds, people with disability and people of diverse sexual and gender orientation, and responsive approaches developed to meet their needs.

Quality of life

By developing personal resilience and optimism, maintaining meaningful relationships, having access to housing and employment, opportunities to contribute and engage within the community and access to high-quality mental health services when needed, individuals can build a good and satisfying life despite experiencing mental health problems or mental illness.

Quality and best practice

Mental health programs and services are statewide, based on contemporary best practice, easily accessed and delivered in a timely and collaborative way.

This Plan drives the objectives of the Mental Health Commission. The Commission aims to promote public awareness of mental wellbeing and address stigma and discrimination affecting people with mental illness. The Commission:

- acts as steward of the public investment in mental health and has a duty to direct funding towards those services and supports that best meet the needs of patients, their families and carers
- engages with people in the public and private mental health services and the non-government sector to ensure people are at the centre of thinking and planning
- raises awareness of the capacity of self-directed support programs to give vulnerable people greater control over their lives
- appreciates and supports the many established service providers who are dedicated to improving the wellbeing of Western Australians who experience mental health problems or mental illness.

The Mental Health Commission must work closely with the Department of Health as the largest provider of clinical mental health care and ensure there is adequate funding for acute and ongoing clinical services.

The Mental Health Commission favours the disability model of funding, where funding is attached to a person and gained via funding rounds. The funding enables choice and control of care by the individual's purchase of services to meet their needs. Not all persons qualify for such funding. While this funding may be suitable for persons with chronic disability, it may not meet the needs of persons with mental illness because of the often-fluctuating pathway that occurs in many patients between stabilisation and acute relapse.

The complexity of mental health needs confounds such a disability funding model. Clinicians support the disability funding model for community patients who have a chronic but stable condition. However, they do not agree that this model fits well with patients with acute illness.

People with mental illness often present with acute episodes of illness, some requiring an intensive level of care (e.g. involuntary secure environments with 1:1 care). Many have intermittent illness requiring acute inpatient followed by long-term acute community care. However, a number of people require rehabilitation and long-term support and could benefit from the disability services funding model (personal communication Chief Medical Officer 2012).

Applying the disability funding model alone will severely affect the ability of acute and rehabilitative specialised mental health services to respond to patients in need.

Clinicians commented that the Mental Health Commission requires a communication strategy that includes engaging clinicians 'on the ground'. They perceived that the Commission has been focused on non-government organisations (NGOs) when a collaborative model is required to address the needs of patients with mental illness. They feared this funding model would deplete mainstream services to the point of collapse.

Effective integration between hospital, community and NGOs was described as vital by the community mental health services. The ability to maintain relationships and perform in an integrated manner as suggested requires funded support.

Staff in the Great Southern wished for better understanding of Mental Health Commission plans and requirements to assist local service planning and designs, particularly in terms of Better Access and Better Outcomes for remote communities.

Mental health directors informed the Review that they had requested resources to implement innovation in services by submitting business cases. However, during the past four years, no case had been successful. The reallocation of existing resources and obtaining external funding from service club donations and research grants had been necessary strategies to fund innovations in some situations.

The Mental Health Commission needs to develop a Clinical Services Plan with the Department of Health that clearly demonstrates the hospital and community services required in WA over the coming decade.

See Recommendation 1: Governance (1.1.1; 1.1.8); Recommendation 5: Beds and Clinical Services Plan (5.4); and Recommendation 8: Children and youth (8.10.1; 8.10.2).

3.9.4 Mental Health Advisory Council

The Mental Health Advisory Council advises the Mental Health Commissioner and Minister for Mental Health about major issues affecting Western Australians with mental health problems, their carers and services providers (Mental Health Advisory Council, terms of reference).

The Chair and Deputy Chair are appointed by the Minister for Mental Health and the committee consists of members from a range of backgrounds including teaching, psychiatry, refugee settlement, mental health nursing, non-government mental health agencies and general practice as well as consumers and carers (media release, Minister Morton 2011).

3.9.5 Mental Health Review Board

The Mental Health Review Board ('the Board') is currently funded by and colocated with the State Administrative Tribunal as part of the Department of the Attorney General. As of 1 July 2012, the Board will operate independently of the Tribunal and be funded by the Mental Health Commission.

The Board undertakes periodic reviews of involuntary patient status in addition to reviewing patients on request. The Board uses a computerised patient management system wherein records of all involuntary patients are maintained and appointments scheduled. The Board has the power to reverse the involuntary status of patients.

Reviews of patients occur in the hospital or clinic providing care for the patient within the metropolitan area or by video-conferencing in regional areas.

The Chair of the Mental Health Review Board informed this Review that patient medical records often reflect that the patient's discharge planning commenced on admission. However, a lack of supported accommodation has been an obstacle to discharge of patients for many years. There is difficulty in supporting patients of no fixed address in community mental health services.

The Board has also observed that medical records often reflect the plan to make contact with a family member. However, engaging family or successful contacts are rarely recorded. It is unclear to the Board why it is that they have difficulty contacting the family.

Family members rarely attend the patient's Mental Health Review Board meetings. The Board writes to the patient encouraging them to bring along supportive family and friends and to the psychiatrist encouraging the family to be informed of the review. The Board is not empowered to invite family members directly.

When family members attend the review meetings, they are welcomed, often provide crucial information on the circumstances of hospitalisation, and assist with discharge planning. At times, the discussions at the Board with the family appear to be the first occasion of family engagement with the psychiatric care for the patient.

The Chair informed the Review that the quality of clinical notes has vastly improved over the years. However, reports for hearings are difficult to obtain. In part, this is related to a stretched workforce, and a Board member suggested that psychiatrists should have secretarial services as well as training to use them effectively.

The Mental Health Bill 2011 provides for the Board to be re-established as the Mental Health Tribunal (Pt 18) and required to review the involuntary status of patients more frequently:

- after 35 days for involuntary patients 18 years and older and three monthly thereafter
- 10 days after the order is made for children and three monthly thereafter
- six monthly for patients on community treatment orders for more than 12 months
- voluntary patients who have been hospitalised for more than 12 months (Div 4).

The impact of increasing frequency from the current *Mental Health Act 1996*, which stipulated eight weeks from the initial order along with six monthly periodic reviews, will extend to the treating psychiatrist who will be required to prepare patient reports. In addition, the Mental Health Tribunal may be legislated to authorise electroconvulsive therapy (ECT) (Div 5) and psychosurgery (Div 6) and review the appropriateness of transfer orders.

See Recommendation 3: Carers and families (3.4).

3.9.6 Council of Official Visitors

The Council of Official Visitors (COOV) is empowered by the *Mental Health Act 1996* to provide advocacy for people with mental illness. Council members investigate complaints on behalf of involuntary patients and those who reside in licensed private psychiatric hostels. In addition, they regularly inspect the inpatient environment of mental health facilities and provide recommendations for improvement.

The Mental Health Bill 2011 proposes to change the title of COOV to Mental Health Advocacy Services and to extend the advocacy role to include: involuntary and voluntary patients; patients referred under the *Criminal Law (Mentally Impaired Accused) Act 1996* (the CLMIA Act); mentally impaired accused; persons released under conditions and under a release order made under the CLMIA Act; residents of psychiatric hostels; and any person who is being provided with treatment described by the regulations in Part 17 s 263. The Bill also removes the responsibility for inspecting mental health premises and this remains a right of the Chief Psychiatrist (Pt 20 Div 1 s 406).

There is an absence of council members in the north-west and north of WA.

The annual report 2010–2011 describes the issues of concern to the COOV. The issues that relate to admission, discharge, referral and transfer are:

- Patients have difficulty in accessing services (pp. 33, 35–36, 80).
- Patients held in EDs and acute public hospital wards while they wait for a place in a mental health facility and whether the Mental Health Act can or should be enacted when mental health patients are in the ED, for example, use of restraint (p. 21).

- Patients report they are told they would remain a voluntary patient if they complied with care but would otherwise become involuntary (p.19).
- Inappropriate placement of children in adult wards (p. 39).
- Risks associated when children on bail are admitted into the adolescent ward at Bentley (pp. 27–28).
- Lack of rehabilitation programs in acute wards (p. 23).
- Lack of information provided on patient's discharge (p. 80).
- Insufficient number of step-down units and the need for patients to remain in hospital when they could be discharged into supported accommodation (p. 22).

In an interview with representatives of the COOV, these matters were discussed.

There has not been an 'inspection' by the the council focusing on admission. However, the Council undertook a statewide review of discharge planning in 2010–11. This review involved questionnaires to staff and patients. The findings include:

- Patient, family and staff have difficulty navigating the mental health services.
- Variation in patient and family involvement exists between the North and South Metropolitan Health Services.
- There is variation in computer system usage within the mental health services.
- Inpatient services are not aware of NGO contracts and therefore unclear about what they can provide.
- Accommodation liaison officers are not available to assist with housing for patients who are being discharged.
- Patients do not have their history or treatment plan provided to them at discharge.
- Receiving hostels indicated that they had inadequate notification of patient transfer, for example, less than two hours' notice.
- The information hostels receive on transfer is inadequate to enable continuity of care.
- Some hostels have exceptional relationships with individual staff from inpatient services and this improves the quality and timeliness of information from those services.
- Medical records including care and treatment plans are not shared between services, clinics and NGOs.

The COOV also raised concern that psychiatrists sometimes discharged or made patients voluntary just before their hearing by the Mental Health Review Board. This statement has previously been investigated by the Board and found to be ill-founded. It is clear that some patients are ready for discharge before the hearing and others are well enough to be voluntary. Changes in involuntary status were not found to relate directly to the intent of avoiding a hearing.

See Recommendation 1: Governance (1.2); Recommendation 2: Patient; Recommendation 4: Clinicians and professional development; and Recommendation 9: Judicial and criminal justice system (9.1.4).

3.10 Governance – corporate and operational

In each health area, the operational offices of mental health care have adopted a different model for the provision of mental health services. The North Metropolitan model is based on a program structure of adult and older adult psychiatric care and incorporates some statewide services. The South Metropolitan model is a district model. The WA Country Area Health Service (WACHS) operates on a regional model and the Child and Adolescent Health Service (CAHS) operates on an integrated model.

During a recent review of Department of Health committees where members are paid to attend the meetings, it was noted a large number of managerial and community advisory committees. For example, it noted a project working group; a clinical governance committee; a community advisory group; and a steering committee for mental health services, all of which had significant numbers of mental health staff as members.

All of these groups had more than 18 members, the majority of whom were staff. One project working group has been meeting for almost four years—a very long project. There seems to be a significant number of groups meeting to discuss a variety of mental health management issues and yet little is seen to have altered as a result.

The Review concludes that the governance of public mental health provision is fragmented, variable in type and method of service delivery, and there is no robust uniform clinical accountability across the system.

The Department of Health and the OCP provide clinical guidelines and directives to WA mental health services. Each mental health area has developed policies and procedures for the services within their area—for example, North Metropolitan's assertive patient flow, admission procedures and discharge policy. In addition, specialist mental health services have developed local policies and procedures within each service.

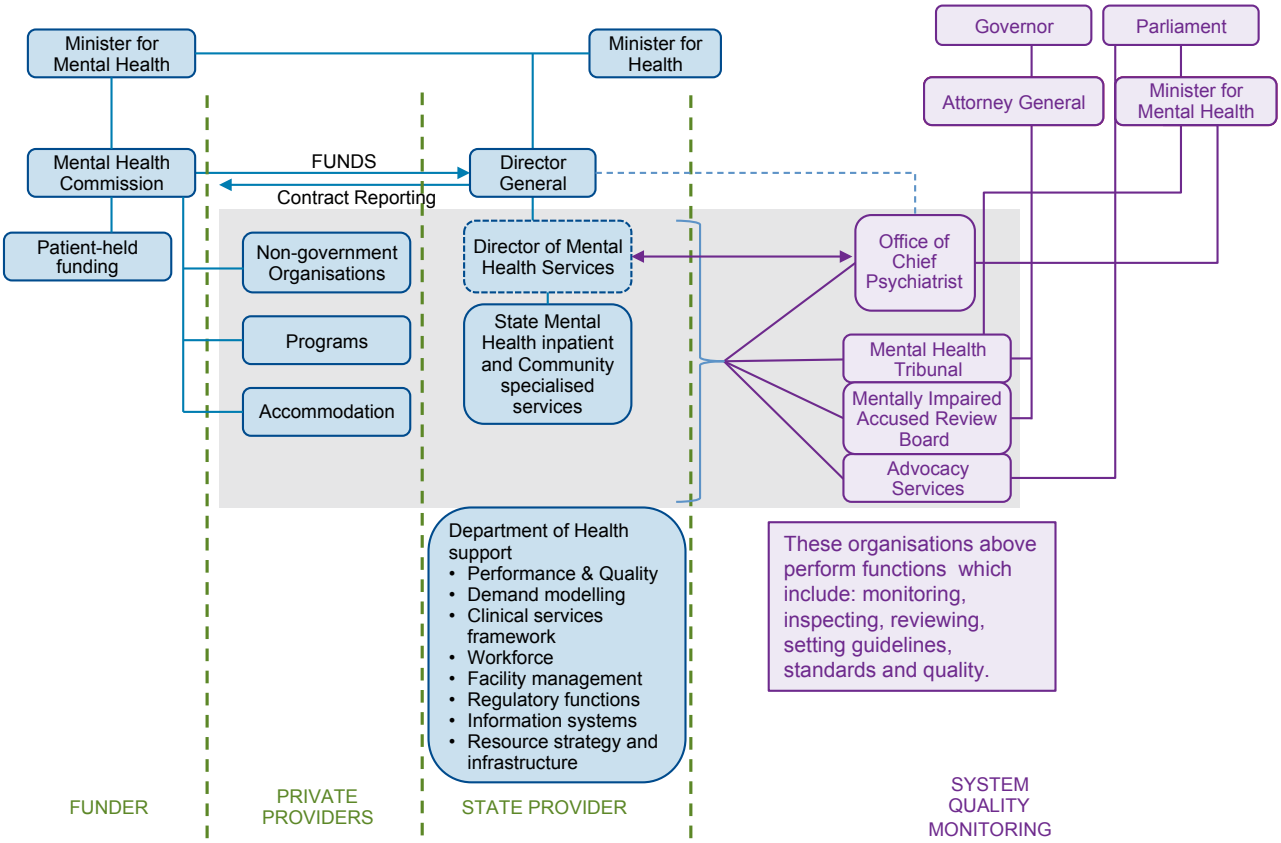
This results in the disparate application of protocols and policies. It appears essential that as the principal provider of public mental health care, the Department of Health has overall governance of policy-setting in the provision of care, both in the hospital setting and in the community clinic setting. There is no overall cohesive link between many of the acute inpatient facilities and the community mental health clinics, such that the clinics sometimes will not accept patients for ongoing care after discharge from the inpatient setting.

Across the system, governance is fragmented and overall leadership and the ability to make things happen is lacking. Many mental health facilities act like silos and the relationships with each other are fragmented so that patients moving from one facility to another are frequently subjected to repeated history-taking and triage.

A single line of accountability is required for WA mental clinical service provision and this should be present within the Department of Health. The Department should take responsibility for clinical outcomes, policies and procedures, workforce planning and support, strategic management, quality improvement, and service development. The proposed unit should have the authority to hold services accountable for mental health care outcomes. It is recommended that a new directorate be established in the Department of Health with a Director reporting directly to the Director General of Health and the member of the State Executive Health Forum (SHEF).

The following diagram illustrates the role and reporting relationship of the Mental Health Operations Directorate in the Department of Health. The Mental Health Commission would work closely with the Directorate of Mental Health Services in formulating service agreements.

Figure 23 **Proposed governance structure pending passage of Mental Health Bill 2011**



See Recommendation 1: Governance (1.1; 1.7).

3.10.1 Mental health State funding

The State Government budget for mental health in 2011/12 is $528 million. Of this, $457 million (including $80 million to Joondalup) funds public health, and inpatient and community mental health services via service agreements.

The remaining funds are distributed to:

- corporate costs
- policy initiatives, for example, suicide prevention
- non-government organisations via service agreements.

In WA emergency departments, mental and general health are integrated. The mental health system does not purchase the services provided within EDs as occurs within the Queensland health system, where designated psychiatric emergency care centres form part of the mental health services. For mental health, casemix funding will commence in WA EDs in 2012–13 and episodes of community care will be activity-based funded (ABF).

Funding of inpatient services by the Department of Health is activity-based and clinical diagnosis of patients' mental illness are grouped within ICD-10 Diagnostic Related Groups (International Classification of Diseases, see Appendix 4).

Community mental health services are funded on a formula of historical escalation. The historically-based community funding model differentiates between cost variations such as larger populations, number of sites and geographical size.

The Mental Health Commission purchases mental health services based on the historical model. Historically, mental health services for inpatients have been identified as units, that is, wards in a hospital, and funded in accordance with the number of patients treated rather than by diagnostic group.

Community mental health services are funded by identifying past expenditure that is then escalated forward, rather than calculated by activity-based funding. Progressing to ABF funding is part of the national agenda and the data to enable this to occur is due in 2013.

Capital costs and the subset of mental health services provided in EDs are not recognised by the Mental Health Commission, and are funded by the Department of Health.

The budget is therefore based on two components with inpatient funding by episode and International Classification of Diseases (ICD). The historically-based community mental health budget has increases in revenue escalated in line with demand (such as escalating operating costs, activity costs and costs of workforce), in addition to the indexation rate.

The Department of Health would require the proposed Executive Director of Mental Health in the Department to work in a triumvirate fashion with the Director of the Performance Activity and Quality Division and the Mental Health Commission to ensure that funding is appropriate to develop safe and quality mental health care delivery.

See Recommendation 1: Governance (1.1.8).

3.10.2 State bed management policy

In 2011 the Department of Health bed management policy (Mental Health, DoH 2011b) was made operational in WA. Named the Assertive Patient Flow Bed Demand Management for Adult Services, these guidelines were developed in response to bed occupancy consistently exceeding 95 per cent and a need to reduce the waiting time of patients in EDs. The policy was cooperatively developed by the chief executives of the Area Health Services and was endorsed by the State Health Executive Forum (SHEF) in the Department of Health.

Bed utilisation is centrally coordinated by the Nurse Director, Mental Health Patient Flow Monday to Friday 8.30 am to 5.30 pm. After hours, the beds are coordinated by the Mental Health Bed Management Medical Director, a senior psychiatrist who is available to discuss needs once all other options have been explored.

The State Bed Manager coordinates bed movements with local hospital-designated bed managers in a daily teleconference. At this meeting, expected discharges and vacant beds (such as those where the patient is on leave) are flagged. The local bed managers are responsible for negotiating the expected date of discharge with their local treatment teams.

BEDVIEW is the centralised electronic system that provides the status of beds throughout the State. Joondalup Mental Health Service is not included and verbal contact is necessary to obtain bed status figures from Joondalup.

According to one group of clinicians, the State bed system works better than the previous system, providing the ‘power to perceive the entire State’s bed stock’ and less time is spent by individual clinicians attempting to locate a bed.

ED clinicians informed the Review that the assertive bed management policy, with the mental health services taking ownership of the problem, reduced the amount of communication required of ED staff to locate a vacant bed for a patient. Clinicians also said that the system has sadly not reduced the amount of time patients spend in the ED while waiting for a bed.

Some clinicians characterised the bed management system as one more pressure that adds to them feeling pushed to assess patients frequently for readiness for discharge and scrutinise referrals more closely in an effort to reduce the number of admissions.

Bed pressure has an impact when patients go on planned leave. The demand for beds will very often mean an admission of a new patient to the bed made vacant by leave. The effect can be a disruption to continuity of care for the returning patient who will be transferred to a different bed, often in a different location. At one facility, eight patients can return from leave on the same day and the change in bed allocation for the returning individuals is disruptive.

Implementation of the bed management system was described as fracturing of previously established systems and communication between rural community mental health services, the communities and metropolitan hospitals. In the past, patients from the Pilbara were admitted at Graylands where their families could be accommodated onsite and clinicians had a good knowledge of the Pilbara.

With commencement of the bed management system, these patients are admitted to any available bed in the State. The outcome for patients and families may be significant given that the patient may be located away from their family and friends as well as their usual treating psychiatrist. Often confusion has occurred among family members who do not know where to look for their relative and they have difficulties finding conveniently located accommodation.

The response of some EDs to restricted bed access is to admit patients into the general wards rather than to await a specialist mental health bed (for one service, this is 50 per cent of inpatients with mental illness).

A pull system, with clinical pathways to guide length of stay and expected date of discharge identified on admission, would provide a more predictable patient flow within inpatient mental health and would ensure best practice principles underpin decisions about care.

Individual variation could then update information in the BEDVIEW system. Such a process would also decrease the labour-intensive bed management processes currently required by inpatient clinicians to meet the patient flow policy guidelines and could relieve psychiatrists from the regular meetings to discuss patients whose length of stay has exceeded 28 days.

3.10.3 Standardisation of admission, referral, discharge and transfer processes and documents

A project control group (‘Statewide Standardised Clinical Documentation Mental Health’) is developing standardised documentation for implementation across mental health services in WA. The group is a working group of the Mental Health Operation Review Committee (MH ORC).

In 2010 the group trialled 30 evidenced-based standardised documents at five sites in WA. The evaluation of this trial found that clinicians agreed that standardised documentation is a valued and necessary component of best practice. The current strategy is informed by that evaluation and plans a graduated implementation of paper-based and electronic forms (Mental Health DoH 2011a).

Clinicians also informed this Review that there should be standardised processes for admission and discharge rather than each service’s ‘home-grown’ products. Clinicians told the Review that they need everyone to be using the same documentation across the State.

The first seven mandatory documents to be implemented are:

- Triage
- Assessment
- Risk Assessment
- Care/Management Plan
- Transfer/Discharge Summary
- Physical Appearance (Community) / Physical Examination (Inpatient)
- Consent Form.

The review was informed by the Director of Mental Health for WACHS that these documents, based on mental health clinical documentation (from NSW Health) were being finalised to ensure they meet WA guidelines, reflect best practice, suit specific age cohorts, that is, children, adults and older patients, and can be adopted into the PSOLIS. A rollout is anticipated later this year.

Once the core documents have been successfully embedded into practice, the process for improving the quality and consistency of medical records will be pursued to implement the remaining forms.

The Minister for Mental Health and the Mental Health Commission support the concept of standardised documentation. However, funding for implementation is required (Statewide Standardised Clinical Documentation briefing note for MH ORC 2011). The project group has requested a full-time project coordinator to manage the implementation as well as funds to develop an electronic entry point for PSOLIS and for printing the finalised documents.

Clinicians informed this Review that the standardised documents have resulted in a common language within and between services and this has been helpful in communicating between the various disciplines that participate in care provision.

The Chief Psychiatrist supports the standardisation of documentation and informed the Review that these will ease orientation within the highly mobile WA workforce and promote high-quality patient information within medical records.

The Mental Health Operations Review Committee (MH ORC) does not possess the authority, capacity or resources to implement change.

This Review supports the development and implementation of standardised documentation in all mental health services and facilities in WA. The standardised documentation project can increase quality and safety of patient care by greater adherence to standards of care, improved intra- and interdisciplinary communication and therefore better informed clinical decisions (Keenan et al. 2008).

See Recommendation 1: Governance (1.1.3).

3.10.4 Co-occurring drug and alcohol abuse with mental illness and other dual diagnoses

Combined drug and alcohol and mental illness is complex and access to services is difficult for patients with both these condition (personal communication Mental Health Commissioner 2012).

In most WA hospitals, the psychiatry liaison team works closely with the dedicated positions of drug and alcohol (D & A) services to assess patients. D & A services are not just co-located but work closely with other health professionals to provide a seamless service. However, they are not available in all hospitals and there is variation in practice by some individuals and services, for example, there are no drug and alcohol services at Albany.

ED clinicians also informed the review that some hospitals do not have a drug and alcohol program and there are no other dedicated resources for patients with these conditions.

There are fewer problems in managing patients with dual diagnosis in Geraldton because the process of liaison between D & A and mental health services has improved. One staff mental health team member is also employed with Drug and Alcohol Office and the rehabilitation facility. With one mental health member specialising in D & A, knowledge-sharing within the team has improved knowledge and response capacity.

In the Midwest and in Port Hedland in the Pilbara, the drug and alcohol and mental health services also demonstrate collaboration. In addition, D & A clinicians attend patient review meetings with the mental health service. In the Midwest, mental health teams obtain immediate response to referral to a D & A team. The ongoing cross-referrals facilitate the cooperative relationship. The D & A services focus on counselling, and recovery models are yet to be developed in these areas.

To determine who ought to case-manage a patient with both mental health and D & A problems, the patient is assessed by the mental health and D & A clinicians together. The current or prominent illness is identified and a case manager assigned from either service based on the expression of the patient's symptoms. Training occurs to upskill mental health and D & A staff in each others' specialties.

D & A office build capacity within other services such as WA Police, Corrective Services, Child Protection and mental health services by providing formal and informal education in the course of their day-to-day work. Memorandums of Understanding (MOUs) between services clarify roles and processes.

Similar strategies are needed for patients with comorbid conditions such as head injury or intellectual disability where collaboration and boundary negotiations currently challenge services. For example, some behaviour associated with intellectual disability is outside of the remit of the mental health services.

The framework for managing dual diagnosis is embedded in the Mental Health Strategic Plan 2020 (Action 3 p. 36) and the State Dual Diagnosis Planning Group has developed a framework to identify entry points, needs and gaps, commencing June 2012.

Improved liaison between mental health and D & A services and worker willingness to cooperatively provide care and intervention for patients with dual conditions must be enabled and encouraged.

There are regions without drug and alcohol services, for example, in Kalgoorlie and the Wheatbelt where the service has been unable to recruit sufficient staff.

See Recommendation 1: Governance (1.5; 1.6); Recommendation 4: Clinicians and professional development (4.11); Recommendation 7: Acute issues and suicide prevention (7.7); and Recommendation 8: Children and youth; Recommendation (8.10.9).

3.10.5 Clinical models of care

There are few standardised protocols for the treatment of mental illness in WA, for example, Complex Attention and Hyperactivity Disorders Service (DoH 2009). Where clinical models are not adopted, treatment is guided by the expertise of the psychiatrist rather than agreed evidenced-based best-practice care models. In effect, there is variation in treatment types, lengths of hospital stay, place of care and support services offered for patients with similar conditions. For example, a youth moving from the north to the south of Perth or vice versa would be offered a different model of care at each site.

Clinicians informed the Review that opinions vary about the merit of hospitalisation for specific mental illness conditions.

The development of standardised treatment protocols guided by best practice would assist mental health services to plan patient care and service demand, and explain variances in relation to individual patient responses. The development of the protocols would also provide opportunities for clinicians to discuss and align their clinical practice. The clinical leadership of a Director of Mental Health Services could ensure WA participates in consultations such as the Clinical Practice Guidelines being developed by the National Health and Medical Research Council for the Management of Borderline Personality Disorders and to ensure finalised guidelines are implemented across the State's mental health services (see http://www.nhmrc.gov.au/nics/nics-programs/clinical-practice-guideline-management-borderline-personality-disorder).

See Recommendation 1: Governance (1.4).

3.10.6 Electronic information system: PSOLIS

Mental health services record vital patient information in an electronic information system named PSOLIS (Psychiatric Services Online Information System). PSOLIS was developed as a component of WA's response to the Second National Mental Health Plan (2004) agreed to by the Australian Health Ministers Conference. That plan introduced a nationwide requirement for collecting, recording and reporting of National Outcomes and Casemix Collection (NOCC) data. The WA Department of Health formulated a development plan known as the Mental Health Information Development Plan which had three key components: (1) PSOLIS, which evolved out of an already existing information system (LAMHIS); (2) training of all mental health clinicians in NOCC; and (3) business process re-engineering to meet the requirements of the new system and new data collection.

A PSOLIS support team based at Health Information Network undertakes ongoing business support, program development and functional upgrades with a recurrent budget of about $1.5 million. It is a Class 1 enterprise application with 24/7 support. PSOLIS is supported by five FTE Java developers and a four-FTE business support team (pers. comm. 2012). The Mental Health Operations Review Committee (MH ORC) provides program leadership and the Executive Director of Performance Activity and Quality Division is the executive custodian of PSOLIS data.

The South Metropolitan Area Health Service (SMAHS) developed a parallel quality and safety management information system to PSOLIS called LASSO. LASSO assists with the recording and reporting of activity related to quality, safety and clinical governance. This latter system appears to have been developed without the imprimatur of the MH ORC. The Reviewer is of the view that two systems are unnecessary and all required functionality can be achieved in the one system, which currently is PSOLIS.

Clinicians and administrators have tiered access to PSOLIS. The first tier gives all clinicians throughout mental health services access to global information on a 'read only' basis via their HE (health employee) number. This includes basic demographics, history of contact and alerts. Clinicians on the next tier access detailed information within their stream and 'write' information at levels that vary widely throughout mental health. Some administrators at executive level and clinicians across metro-wide services, for example, the Mental Health Emergency Response Line (MHERL), are authorised to access all information.

PSOLIS has the engineered capacity to meet mental health services requirement for a fully functional information system that would include:

- an electronic information records system with standardised documentation for history, mental state examination, physical examination, and risk assessment/management and risk alerts.
- care planning, referrals to other providers, discharge planning and electronic discharge summary.
- incident reporting and AIMS software reporting to meet critical incident reporting requirements to groups such as , for example, the Office of the Chief Psychiatrist and the National Minimum Data Set (NMDS).
- data collection/reporting to populate the mental health information system that informs the NMDS, NOCC and the Australian Mental Health Outcomes and Classification Network (AHOCN).
- functional capability to interface with planned information system developments such as an information system for non-government organisations.
- an electronic prescribing system and access to laboratory results.
- tiered access to specific information by specific services, for example, full access for frontline workers in community emergency response teams or Court diversion; limited access to care and discharge plans by non-government organisations or hostel staff.

Clinicians value the PSOLIS system, and services rely on it to measure activity and access important risk and discharge information. Psychiatric liaison teams use PSOLIS to record service events, referrals and brief histories and to link discharge summaries (attached as PDF documents). This information is crucial to safe and effective continuity in health care. Electronic access to this information is especially useful with a patient cohort that sometimes moves frequently across the system and for information access across mental health inpatient and community settings.

As a minimum, the risk management plan and discharge summary were highly valued. However, clinicians said there was sometimes a delay of 28 days before patient information was available in PSOLIS.

Currently, more than 120 requests for program repairs and enhancements are outstanding. A number of other concerns were raised to the Review. The issues of concern include:

- the information system lacks governance and requests for improvement have no authorising person to provide approval
- limitations to clinicians' level of access complicates access to patient information
- inconsistent or inadequate patient information is available within the system
- variation in the amount of training clinicians receive and the knowledge they have about the program's functions. The program does not link with other information such as laboratory test results
- the system needs to include mental health forms to assist standardisation
- PSOLIS needs to be more user-friendly with easier and more flexible data entry to decrease duplication by clinicians and standardise documentation.

The review was informed that governance of PSOLIS has floundered since the Mental Health Division was restructured in 2011. PSOLIS has not been allocated a sponsor and MH ORC has placed an embargo on all new developments.

The user interface of PSOLIS is considered by clinicians to be laborious, time-consuming, and not user-friendly. For example, consultant psychiatrists in one service spend up to three hours a week scanning documents into PSOLIS. One service suggested they need administrative support to undertake the upload of information into PSOLIS to improve the timeliness and quality of information.

Clinicians said that when information in PSOLIS is incomplete, the system becomes less useful in informing clinical care. Inconsistent or inadequate information is partly related to the limited information clinicians can enter in PSOLIS. Inconsistency is in part related to the available program choices. For instance, there are seven different risk screens in PSOLIS; the brief risk assessment (BRA) and psychological examination are most frequently used.

Risk management plans are not always present and even though PSOLIS has the facility to link discharge summaries these are not always uploaded. PSOLIS links with hospital electronic discharge systems—for example, TEDS (treatment episode data sets) and CGMS (clinical governance management system)—need to be enabled so that completed discharge summaries can be uploaded.

In addition, data fields are character limited requiring clinicians to summarise patient information. Further, although referrals are visible, clinicians cannot access information about the referral outcome.

Triage teams informed the Review that patients' records are sometimes only activated in the PSOLIS system when the patient has had three occasions of service, and therefore there is an absence of information about patients' request for assistance. This can be problematic when patients approach more than one service in order to obtain services. While this has not been verified, it remains a concern.

Data entry is optional and varies between sites. The mode of data entry also varies. At most mental health services, the clinician performing clinical care enters data in the course of their work. Some services have clerks who enter patient information during multidisciplinary team meetings.

Access to PSOLIS is not provided to physicians in EDs nor to private psychiatric hospitals. In addition, GPs and general hospital clinicians cannot access PSOLIS information to enable continuity of care. Further, many allied health staff such as mental health occupational therapists and social workers do not access PSOLIS even though guidelines indicate they can and currently these clinicians record information into a different database. At a minimum, the inclusion of allied health information would improve the quality of discharge summaries and follow-up care.

The Child and Adolescent Mental Health Service (CAMHS) can only access the electronic information related to the patients in their local areas and not that of patients from other areas who are referred for service. Since the Bentley Adolescent Unit is unable to store documents in PSOLIS, little information is available for CAMHS.

All information in PSOLIS is not accessible between mental health services. For example, clinicians at one mental health service explained they were unable to view community mental health service data even though the CMHSs could see inpatient data. However, CMHS clinicians cannot view all data either. Broome staff can see that files exist for their patients in Kununurra; however, they are not able to access the files, including the crisis management plan.

A public mental health service in a private hospital recently obtained access to PSOLIS as 'read only'. However, they are unable to contribute data to the program. Since Joondalup cannot enter data into the PSOLIS program, Mirrabooka CMHS are unable to access the patient information they require to provide continuity of care after discharge of the patient.

In addition to the information in PSOLIS, mental health clinicians need emergency and general hospital admission data, such as test results and hospital care episodes. At the same time, staff in general hospitals require patients' mental health care information, particularly their risk management plan.

Training: Many clinicians said they require training in PSOLIS. While some staff use PSOLIS expertly, adding good management plans that are regularly updated, others have not received the same level of training. The Review was informed that country services are provided fewer training opportunities than metropolitan services and therefore not all staff can use the program.

The delivery of training for PSOLIS needs to be equitable and available throughout the State.

PSOLIS does not interface with prison information systems. This link would enable mainstream community mental health services and forensic mental health services to provide continuity of care for patients once they are released from prison (see Department of Corrective Services 3.11.3).

The Reviewer is of the opinion the mental health electronic information system requires governance. It is essential that the access levels to PSOLIS are reviewed to enable clinicians' access to required patient data and the opportunity to add information necessary to continuity of care.

Remote access to PSOLIS should be made possible so that clinicians in the community can access and enter information in a timely fashion.

Staff also need access to general hospital information systems to gain information about patient emergency presentations and hospital admissions.

The reporting capacity of PSOLIS should enable clinicians to obtain feedback, for example, NOCC reports.

Carers WA also recommend that PSOLIS be upgraded to provide a field to identify the carer and to enable staff to record carer-related clinical activity (Carers WA Submission 2012).

PSOLIS was originally governed by the Mental Health Division. The dissolution of the division led to a significant breakdown of governance of the strategic development of PSOLIS. Three options to improve the operational management and strategic development of PSOLIS were presented to the executive directors of MH ORC (Briefing Note MH ORC 2011). Of these, Option 2 is supported by this Review.

That is, to create a mental health information directorate within the Department of Health. This directorate should be responsible for developing a functional PSOLIS management and development framework.

See Recommendation 1: Governance (1.1.9); and Recommendation 4: Clinicians and professional development (4.4; 4.5).

3.10.7 Telephone assistance and emergency calls

The Mental Health Emergency Response Line (MHERL) and RuralLink (country MHERL) are telephone response lines staffed 24 hours a day, seven days a week in Perth.

The service has four numbers, including a 1800 number (where connection and duration of calls are charged to MHERL and free to the caller) and a 1300 number (where connection fees are charged to MHERL call charges are not free to caller). During office hours, the 1800 number diverts the caller to the local triage service, and MHERL provides support for the State after hours. Ideally, the service wants a completely free call service for the caller.

Patients and carers sometimes complain that they do not have enough credit on their mobile phones to enable them to contact the team. Although MHERL will accept reverse calls, the initial connection of the call requires the person to have credit on their phone. Currently, the legislated 000 emergency is the only number that can be called without phone credit. The service organisations contacted on 000 would transfer the caller to the MHERL line, based on their assessment of need or request. The 000 number is a legislated responsibility of Telstra (Telecommunications Emergency Call Service Determination 2009). Providing a free call that is accessible free of charge is a complex process that the team at MHERL are pursuing.

When first developed, this service was aligned with the psychiatric emergency team that provided face-to-face assessment and treatment for patients in urgent need. This emergency service has been decentralised to community emergency response teams (CERTs) operating in the north and south metropolitan areas. The Northern CERTs are at Osborne Park, Swan, Joondalup and Inner City; the Southern teams are at Rockingham and Fremantle. These teams are attached to the triage teams at the local community mental health services.

MHERL receives more than 4000 calls per month and makes 2500 outgoing calls for patient referrals. In total, there are 65,000 calls per year on 20 incoming lines.

Phone access provides triage and counselling for callers and refers urgent situations to CERTs.

Clinical nurses experienced in mental health operate the phones. Phone support includes information about health services (system navigation); advice on treatment, including medications; behavioural modification strategies; and referral to community mental health services. The service also provides clinical advice to doctors and psychiatrists

Clinical governance is provided by 0.3 FTE psychiatrists, including decision support, and education and advice to the triage staff as well as GPs and patients. Clinicians explained to this Review that they meet daily to discuss the outcome of calls and ensure follow-up is provided where necessary. Clinicians follow up referrals by contacting the services to ask if the client has attended and, if not, request the service to follow up with the client.

When MHERL refers an emergency to CERT, the referrals are triaged again and patients do not always receive the intervention planned by MHERL (see triage discussion 3.12.3).

The MHERL team do not have the mandate to ensure interventions occur as planned. MHERL clinicians would prefer that CERT respond to their assessment with minimum delay and to be able to reassure callers with certainty that assistance is on its way (see also Smith et al. 2011b).

The Review was informed that a separate phone line is currently being established for the Child and Adolescent Health Service (CAHS) supported by the acute community intervention team who can provide emergency assessment and intervention in the community.

In addition to MHERL and RuralLink, the public have access to *healthdirect Australia* telephone advice.

The *healthdirect Australia* service is staffed by generalist nurses who are trained to handle mental health calls using triage guidelines. They use a research-based computer triage protocol underpinned by Australian standards to assess the caller's need and then recommend a course of action (disposition). Disposition may include Activate 000; Attend ED immediately; See mental health provider immediately; See Doctor immediately, See Doctor within four, 24 or 72 hours; See Doctor within two weeks; or Self/home care advice (pers. comm. Dr G. Karabatsos, Medibank Health Solutions Telehealth 2012). The dispositions vary in accordance with the urgency of the need for face-to-face assessment.

Callers can be referred or transferred to the mental health services for triage and management, including the CERTs (personal communication Dr G. Karabatsos, Medibank Health Solutions Telehealth 2012).

When medical issues are concurrent, EDs are the preferred disposition, for example, when the patient has disorganised thoughts, possibly delirium and drug and alcohol intoxication.

The Reviewer is of the opinion that the State telephone lines of MHERL and RuralLink need to be governed by the Mental Health Governance Unit in the Department of Health.

Reconfigurations of reporting lines should ensure MHERL, RuralLink and community emergency services are clearly linked and that MHERL can mandate CERT to respond to calls.

MHERL may require an update in skills with respect to particular local conditions and safety concerns that the CERTs require being included in the assessment for community visits.

Promotional activities to increase the public awareness of MHERL, for example, print media on mental health should also be encouraged.

See Recommendation 1: Governance; Recommendation 2: Patients; Recommendation 3: Carers and families (3.5); Recommendation 7: Acute issues and suicide; and Recommendation 8: Children and youth (8.1).

3.10.8 Local management in mental health facilities

Many facilities act like silos and create barriers, resulting in fragmented service delivery across mental health.

Mental health services are optimal when practised and coordinated within a holistic service model comprising:

- emergency departments
- 24-hour telephone assistance
- community emergency response teams
- outpatient clinics
- inpatient mental health beds
- general hospitals accepting care of mentally ill patients
- community service practitioners linked to inpatient services
- rehabilitation and step-down beds and services
- supported living arrangements.

In facilities with the full suite of services, there appears to be greater continuity of care and a sense of responsibility for the patients along their entire treatment journey. It is in these settings that this Review observed innovative practice and more consistent admission, discharge, transfer and referral processes. An example is the Rockingham-Kwinana mental health service where there appeared to be a greater sense of cooperation between the staff and a natural involvement of patients and carers within acute care and rehabilitative programs.

Statewide, the division into health areas and then 'catchment' areas has effectively created a category of persons who are 'in' or 'out of' an area. Clinicians in one area are unable to assure 'out of area' persons that any planned care and treatment will be continued when they are referred to their local area mental health service. The notion of a 'catchment area' also affects the clinician's ability to take responsibility for the patient's continuity of care when they move or are transferred 'out of area'.

Clinicians at one inpatient facility described working as a team with the community mental health service operating nearby until the health area divisions occurred. However, since the division of health areas, each now has different line management. The inpatient and community mental health clinicians no longer communicate well and patients referred to either service cannot be assured they will receive services.

The current model of governance also affects the clinicians' ability to initiate improvement. For example, the district model (SMAHS) appears less responsive to program-specific issues such as the care of older adults.

The Review was informed that psychiatrists are often the clinical head within mental health inpatient services. However, there is no clinical governance for the psychiatrist and psychiatrists are not always represented on the medical advisory committees of hospitals.

When mental health services are colocated with general hospital services, the reporting model for clinicians is via their disciplines, that is, nurses report to the nursing department. There is no single point of accountability for teams; each discipline reports within their discipline lines. This creates difficulties when cross-disciplinary clinical supervision is necessary, and the inpatient unit manager has no authority over the staff. This model demands the team coordinator use their personal influence to obtain cooperation since

they have no authority over staff. This situation has been untenable for a number of coordinators and the Review was informed there is a high rate of staff turnover at the team leader level.

The dichotomy of clinical and line management affects clinicians employed in a mental health unit within general hospitals with respect to professional support and onsite quality management. For example, clinicians told the Review that the general hospital administration did not always support the training needs of mental health staff, such as suicide prevention training.

In some rural areas, mental health services were well integrated with the general hospital in relation to Quality and Safety Reviews and the general hospital assessed all the safety risks and adverse events in all inpatient areas, including mental health.

In some rural hospitals, psychiatrists do not have admitting rights into the specialty mental health unit unless the patient requires involuntary care; voluntary patients are admitted under the GP and the GP requests psychiatric consultation and community mental health services if required.

Continuity of patient care is currently achieved for the majority of patients across inpatient and community services at Rockingham, Fremantle and Bentley mental health services where the psychiatrists work across inpatient and outpatients. The mental health hospital clinicians provide outreach into the community services and the community mental health services reach in to provide input to care when patients are in hospital. The limitation to continuity is when inpatients are from other regions, as discussed above.

Clinicians in the Great Southern are hopeful that the development of the new hospital at Albany will provide an opportunity to redesign the management of general and mental health services. It is planned that the existing nine beds will expand to 16 (12 open and four secure).

Variations in models of service delivery are reflected in policy and procedures that influence practice and lead to differences in service responses. This is experienced by patients as very confusing.

See Recommendation 1: Governance (1.7).

3.10.9 Review of admission, discharge, transfer and referral within each service

The Office of the Chief Psychiatrist informed this Review that there has not been a statewide approach to the development of policies and procedures for admission, discharge, transfer and referrals beyond the general Department of Health's statewide admission and discharge policy. Clinicians informed the Review that there are some Area health guidelines and these are interpreted variously within services resulting in:

- historical variation between each health area according to their structure
- adjustments for the authorised/unauthorised streams of care
- adjustments for elder care
- adjustments for general health streams.

The historical approach reflects locally implemented policy variation aimed to 'best fit each program and mode of governance' and to reflect the history and culture of specific practice environments, that is, the local operation and specific service components of each service. For example, where Graylands has voluntary and involuntary patients, a 'walk-up' triage and no ED, their policies differ from those of a public hospital that is restricted to voluntary patients and ED entry (personal communication clinician 2012).

Clinicians informed the Review that the procedures that provide directives enabling policies to be translated into practice are developed within the silos of clinical disciplines.

This Review included an analysis of each mental health service's policies and procedures. The audit revealed that the documents varied considerably and did not include essential elements reflective of the State admission, discharge, transfer and referrals policy, and many did not reflect the national standards or the Clinical Risk Assessment and Management Policy (CRAM). It was also apparent that the documents had not undergone regular review and none had been updated since the introduction of the Admission, Readmission, Discharge and Transfer Policy for WA Health Services (ARDT) released in September 2011 (DoH 2011a).

This Review suggests local clinical policies and procedures should be updated and that the new Executive Director of Mental Health regularly monitors the policies and procedures of all mental health facilities and services to ensure they comply with state and national guidelines and best practice.

The ARDT policy should be consistent with the:

- *Carers Recognition Act 2004* [WA]
- National Standards for Mental Health Services 2010
- WA Department of Health Language Services Policy 2011
- WA Department of Health Clinical Handover Policy

(Carers WA 2012 submission).

In addition, a representative of Carers WA suggests that the term 'carer' be added to the glossary of the ARDT policy and be defined and used consistently with the Carers Recognition Act 2004.

See Recommendation 1: Governance (1.1.2; 1.1.3; 1.1.4).

3.10.10 Audit of admission, discharge, referral and transfer practices

A clinical record audit was undertaken as part of this Review into admission, discharge, referral and transfer practices of public mental health services in WA (see Appendix 5).

The purpose of the audit was to gain an understanding of what was documented in the clinical record in relation to specific aspects of patient care which were identified for review by the project team and which were determined to be important to the Review's overall objectives. It should be noted that:

- the audit does not measure compliance
- lack of evidence in documentation of aspects of care does not mean that the care did not take place.

A random sample of 500 (200 inpatient and 300 community mental health service) records was drawn from the total number of patient separations and occasions of service from selected inpatient units and mental health services across the Department of Health for the 2010/11 financial year. Sites were selected to represent tertiary, non-tertiary, adult, child and adolescent services but on a random basis.

This audit looked at the documentation in relation to specific patient admission, discharge, referral and transfer criteria. In relation to referrals, the majority of both inpatients and community mental health patients had evidence of written referrals into the service, with most inpatients being admitted within one day of referral. However, an area for improvement would appear to be in feedback to the referrer of an admission, which was evident in less than half of the records audited. Feedback to the referrer could form part of a robust electronic system.

In relation to assessments, admission psychiatric and clinical risk assessments, these were undertaken on the majority of patients with most completed within a day of admission. Inpatients had a higher rate of full assessment, as opposed to partial assessment, than did community mental health patients. In contrast, documented evidence for physical assessments occurred in half of the inpatients and none of the community mental health patients, with several records in the community group indicating that this was not applicable as the patient was under the care of a GP or specialist.

As for assessments, the large majority of records indicated that patients had evidence of a clinical risk plan and, while there was evidence that patients had contributed to the plan, evidence for carer input was less.

For both inpatient and community mental health patients, the majority received a full or partial risk assessment within a day of discharge. Again, physical assessments were not evident for the majority of patients.

See Recommendation 1: Governance; and Recommendation 2: Patients.

3.11 The judicial system and forensic mental health services

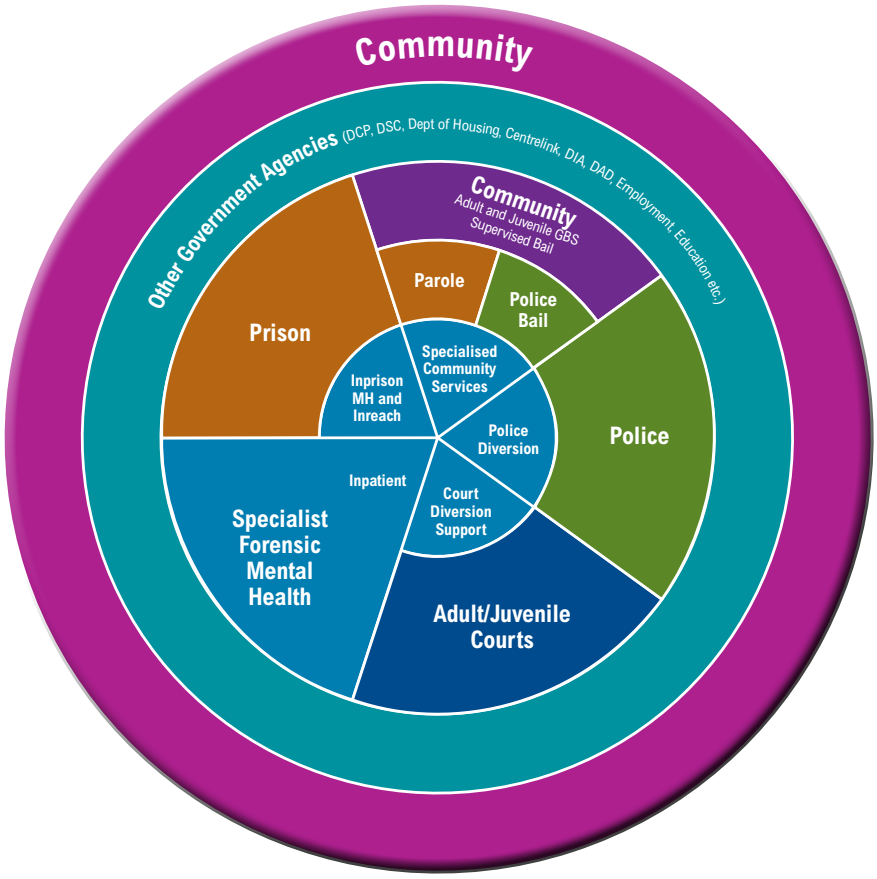
Forensic mental health care encompasses the humane and safe care of individuals who come in contact with the criminal justice system. It involves the assessment, care and rehabilitation of defendants who face charges in the courts; mentally ill offenders who are in prison or in the community; and individuals who have been found unfit to stand trial or who have been found not guilty by reason of unsoundness of mind in the District and Supreme Courts and placed on custody orders (*Criminal Law Mentally Impaired Accused Act 1996*).

Mentally ill individuals are over-represented in the criminal justice system at all levels. Of those who offend, court data cross-linked with the mental health database show that 85 per cent of court attendees have had contact at some previous stage with mental health services (Morgan et al. 2008). A UK survey of attendees at a Manchester Court showed about 5 per cent on any one day were psychotic and in urgent need of mental health care (Shaw et al. 1999).

Australian and New Zealand data clearly demonstrates the high incidence of serious mental illness in prison populations, running at around seven per cent for psychosis and 20 per cent for depressive disorders (NZ Prison Survey, Department of Corrections, Butler et al. 2005). Evidence also clearly shows that mentally ill people are consistently disadvantaged when they find themselves in the criminal justice system with higher arrest rates, higher conviction rates, higher incarceration rates and longer effective sentences because of reduced opportunities to access parole.

Furthermore, service provision to mentally ill defendants and offenders has lagged behind the provision of services to the general population and has led to the observation that mentally ill people who come in contact with the criminal justice system are among the most disadvantaged in our society.

Figure 24 **Elements and relationships of forensic mental health services, 2012**



Notes: DCP = Department of Child Protection; DSC= Disability Services Commission, WA; Dept of Housing = Department of Housing; DIA = Department of Indigenous Affairs; DAO = Drug and Alcohol Office; GBS = Adult and Juvenile Community Corrections.

Source: Dr S Patchett (2012).

The elements and relationships of forensic mental health need to be considered in the development of the mental health clinical services plan for Western Australia.

See Recommendation 1: Governance (1.1.1).

It is generally accepted that services need to be provided at the multiple levels of intersection between mentally ill people and the criminal justice system. This includes working with high-risk groups and individuals in the community prior to offending as well as providing:

- mental health presence and expertise to the police prior to arrest
- comprehensive services at the children's and adult courts to assess and intervene early and divert where possible into mental health care and away from incarceration
- comprehensive assessment and treatment services (also with specialised units in prisons)
- specialised secure inpatient care to defendants and offenders who are very unwell
- assertive community care to those released into the community from prison or on custody orders
- community care to special groups of offenders such as sex offenders, violent offenders, stalkers and arsonists
- consultation/liaison services to support general mental health services and justice-based services in the community.

3.11.1 Judicial system and adult mental health

In 2012 the State Budget provided funds for a Mental Health Court Diversion and Support Program. This Program will aim to develop a dedicated mental health and judicial support service that aims to identify mentally ill people attending court. Identifying mentally ill people will allow assessment and early intervention. Those who are able will be diverted into the community and in many instances back in contact with the mental health services that know them well.

The service will primarily aim to obtain mental health care for those who have slipped through the mental health net and fallen into the criminal justice system, often with relative minor offending combined with issues of homelessness, substance abuse, unemployment and social exclusion.

The program will also aim to reduce reoffending that may be the outcome for very disturbed/disorganised persons and subsequently reduce the burden on both adult and children's courts, on the prisons and detention centres, and on community-based programs. Funding also has been made available for specialist mental health expertise in the Children's Court.

The Court Diversion and Support Program will operate out of a separate court with a dedicated magistrate. It is envisaged the program will lead to the development of dedicated prosecution and defence functions operating in a restorative justice paradigm with some similarities with the functions of the current Drug Court in WA.

The mental health component will have a team based at the Central Law Courts equipped to respond with urgent assessment and care planning that will then inform a diversion plan mandated by the judicial officer.

In the current system, the accused are provided with assessment by court liaison clinicians from the forensic community mental health team. The forensic team explains that they identify accused persons who have a history of mental illness, by comparing arrest lists with patient records in the PSOLIS (mental health) and TOPAS (general health) information systems. When requested, a magistrate may also stand down an accused for assessment if identified in this way.

These assessments are very quick and limited by the lack of collateral information and appropriate private interview facilities. The clinicians must be able to determine if the individual is mentally ill, under the influence of substances such as drugs or alcohol, or has another cause for mental impairment.

The primary task is to assist the court in a decision about whether to impose a hospital order, which leads to admission to the Frankland Centre for seven-day assessment. In remote areas, people are sometimes held in police custody, and assessed by video link by the forensic community mental health service, before a decision to impose a hospital order is made.

The new funding and programs are promising; however, this Review considers that a revision of the *Criminal Law (Mentally Impaired Accused) Act 1996* should also be a priority. Consideration must be given to the inclusion of intellectual disability. Intellectual disability can coexist with mental illness; however, not all people with intellectual disability are in need of psychiatric care. In addition, children are currently included in the CLMIA Act, and consideration of their unique requirements needs to be taken into account.

The relationship between mental illness, criminal behaviour and passage through the criminal justice system is complex, as illustrated by the following example:

> *A young Aboriginal girl who was homeless and suffering from psychosis was arrested four times in one month for four breaches of four different 'move on notices' [Police Act 1982 amended under the Criminal Law Amendments (Simple Offences) Bill 2004 WA]. Three of the 'move on notices' were issued for erratic, unexplainable and aggressive behaviour consistent with her mental illness. After the fourth breach, the young girl appeared in front of a Magistrate who granted supervised bail. Because of the severe nature of her mental illness and disadvantaged social circumstances, she remained in custody for 20 days until her charges were finally dealt with. This incarceration for 20 days stemmed entirely from her mental condition rather than her engaging in any serious criminal misconduct that warranted her being in custody*
>
> (Eggington & Allington 2006).

The CLMIA Act enables judicial officers to make a hospital order if they suspect the accused has a mental illness. If the person is mentally ill, they will be treated under the *Mental Health Act 1996* until they become fit to stand trial. Once fit to stand trial, the courts determine culpability and if the accused is found not guilty by reason of unsoundness of mind, the courts may impose a custody order.

This affects the public mental health system with clinicians providing assessment and reports to the courts in addition to caring for patients admitted under hospital and custody orders.

The new funding announced by the Minister for Mental Health, the Hon. Helen Morton go a long way to assisting this situation.

See Recommendation 9: Judicial and criminal justice system.

3.11.2 Judicial system, the Children's Court and mental health

The President of the Perth Children's Court, Judge Denis Reynolds, informed the Review that 14,500 criminal offenses were committed in WA during 2011 and, of those, 750 (6%) had been committed by children under nine. He is concerned that the Children's Court has inadequate mental health services to meet the level of demand. Judge Reynolds explained that specialist reports addressing the child's psychiatric needs are required to assist judicial officers in determining the best outcome for children appearing in court.

In 2012 the State Budget provided funding over two years to place specialised mental health expertise within the Children's Court.

Currently, there are no specific services within the court and the forensic mental health services provide assessment and reports on an urgent 'as needs' basis. The current forensic services are insufficient. Staff do not have sick leave and annual leave cover, and the provision of reports is not timely. The court may also order psychometric testing via psychologists; however, there are long waits and the child will remain on bail, often with severe dysfunction and often without family support. Judge Reynolds explained that ideally the Children's Court would have a mental health team based in the court, with responsibility for screening all children and families.

Currently, the system does not have a 'least restrictive option' to house children safely while they wait passage through the court so they are placed in Rangeview Remand Centre ('Rangeview'), or return to their family where mental illness can regress to crises. Judge Reynolds told this Review that many children are at real risk, living in a chaotic environment and many are introduced to hard drugs and prescription medication by their parents.

The Bentley Adolescent Unit is not a secure unit (from a Corrective Services' standpoint). However, some children are placed there when they are released on supervised bail. The mix of children at the unit is a concern, as expressed by the Commissioner of Children and Young People (CCYP), and this needs immediate attention (CCYP 2011b).

The Reviewer agrees that it is not appropriate to place children and adults in the same accommodation. Nor is it appropriate to place young children (such as 11-year-olds) with well-developed adolescents and those who are serious offenders.

There are reported plans to close Rangeview and for the children to be transferred to adult prisons. This is of major concern. Western Australia requires a dedicated forensic mental health unit for children and young people.

The mental health needs of children in protective service is an ongoing concern of the CCYP. Judge Reynolds also explained that children with mental illness or criminal behaviours, who are often unfit to stand trial and become wards of the State, are often placed at Rangeview rather than with the Department of Child Protection.

Mental health services at Rangeview are limited to a psychologist assessment and children are rarely able to access psychiatric assessment. The environment is essentially one of incarceration and punishment. Without access to mental health care, the condition of these children can deteriorate rapidly.

The CCYP also raised concern that there are no suitable facilities for young mentally impaired accused made subject to a custody order. She explained that children on remand and bail at the Bentley Adolescent Centre as well as at Rangeview and the Banksia Hill Detention Centre are not protected by the Mental Health Review Board. Commissioner Michelle Scott suggests the CLMIA Act should be reviewed to ascribe special consideration for children, particularly regarding the potential in the *Act* for indefinite detention (CCYP 2011a).

In Scott's submission to this Review, the Commissioner of Children and Young People offered three recommendations in relation to children and judicial system:

1. Priority is given by the mental health service to the assessment, referral, admission and continuity of treatment of children and young people in the out-of-home care or leaving care.
2. A dedicated forensic mental health unit for children and young people be established.
3. Children and young people appearing before the Children's Court of WA have access to appropriate, comprehensive mental health assessment, referral and treatment services.

This Review fully supports the Commissioner's recommendations.

This Review also supports the recommendation of the Review of the *Criminal Law (Mentally Impaired Defendants) Act 1996* (Holman 2003). In addition, the concern expressed for consideration of children in that report and those by Commissioner of Children and Young People above are echoed here.

It is essential that WA has a mental health team including a psychiatrist to address the needs of children in protection. The Review notes that:

- Pre-teen children who appear in criminal justice system need particular care.
- Services to meet the needs of child and adolescent health need to be developed.
- Court liaison processes must be timely and proactive to the needs of the court and at the time of court appearances.

Children aged 10 and older charged with criminal behaviour appear in the Children's Court. Those nine years and under receive intervention by the Department of Child Protection.

Judge Reynolds informed the Review that the best possible mental health investment is in young people. However, the system appears to have invested most heavily in adult mental health where there are poorer opportunities for recovery. The Public Health Association of Australia also promotes investing in strategies and programs to support the early years that increase the life chances of children and ameliorate the adverse effects of social disadvantage on health (PHAA 2009).

See Recommendation 1: Governance (1.5); and Recommendation 8: Children and youth (especially 8.10.5).

3.11.3 Department of Corrective Services

Mentally ill people are over-represented in prison populations throughout the Western world. Many prisoners suffer with comorbid substance abuse disorders and the prison population in WA is no exception.

A survey of the health of Australia's prisoners indicates that one in three prisoners has a mental disorder and one in five is taking medication to treat their mental illness (AIHW 2011). One in 10 seeks assistance for psychological and mental health issues while in custody (AIHW 2011b).

There has been no specific survey of the WA prison population of 5000 prisoners. However, at any given time about 615 patients are receiving mental health care—an estimated 50 per cent of the total number of prisoners who need mental health services.

While these figures reflect disadvantage and poor resourcing of mental health services, custody also offers a unique opportunity to address the needs of mentally ill people who would otherwise go untreated.

The Deputy State Coroner expressed concern to this Review that prisons could be described as a catchment for patients with mental illness. Similarly, the Director of the State Forensic Mental Health Service claimed that prison services have been likened to an acute mental health intensive care unit, with an average length of stay of three to five years, and that they provide care to more persons with psychiatric illness than any other mental health service.

It is reported that 10 per cent of juveniles in prison have major psychiatric illness (not including mental impairment) and that 8–10 per cent of these are affected by head trauma, substance abuse or foetal alcohol syndrome. In addition, approximately 50 per cent of WA's mentally impaired accused persons detained under custody orders are in prison (14 people) and there are no specific services for them. These patients are vulnerable within the prisons and the community.

The Department of Corrective Services governs prison medical services that provide physical and psychiatric care for patients in prisons. In most prisons, psychiatrists are

appointed on a sessional basis and report to the Deputy Governor of the prison services. Recently a psychiatrist position was contracted from the Frankland Centre, with the intention that the position will provide specialist clinics and clinical governance for the private psychiatrists delivering prison services.

Mental health nurses are employed within the prison system. After hours, psychiatrists and medical officers are on call and nursing support is limited. There is a prison addiction service team (PAST) who assess and manage co-occurring drug and alcohol conditions.

Staffs receive ongoing training, including a weekly teleconference and 'Scopia,' an education program led by the College of GPs. Regular case discussions with the psychiatrist further educate and support the staff and enhance patient care.

When first imprisoned, prisoners are assessed by the mental health nurse or GP and referrals are made to psychiatrists when needed. Medical and nursing staff do not have access to PSOLIS and use an independent electronic system (ECHO) to record assessments, interventions and discharge information.

The process of care includes developing management and treatment plans. If the patient has a family and the patient consents to their involvement, the family is involved in the discharge plan.

When patients need acute hospital care, specialised physical and psychiatric care is provided under conditions of security in public hospitals and the Frankland Centre. Within prisons, secondary mental health care is provided in crisis care units, the prison infirmary and safe cells. Non-acute health care is provided within the prison living environment and clinics. Mental health nurses review and follow-up patients on a day-to-day basis.

When release is planned, prisoners receive a medical summary, appointments for follow-up care and an exit interview. The prison health services are not always informed that the prisoner is being released. Some prisoners are released directly from court following successful bail applications and others are transferred to another prison. Sudden 'leaving' is common for younger prisoners.

The judicial system does not have processes to notify the treating psychiatrists of the intent to release a prisoner and there is no mandate or formal process to follow up the care of prisoners once released. Ensuring continuity of mental health care once patients are released is very difficult, but it is especially important within the first three months of release when rates of relapse and suicide are increased (personal communication Dr E Petch, Forensic Unit 2012).

The Director of Medical Services for the Department of Corrective Services, Dr Roslyn Carbon, is currently addressing the difficulty of communicating patients' treatment plans. An objective is to ensure that a discharge plan is completed and that continuity of treatment is provided for prisoners likely to be released using the 'Fit to Travel' mandate. This mandate provides an opportunity for doctors to undertake a clinical assessment before transfer. This service can be augmented with a mental health discharge plan and a letter that prisoners can bring with them to their transfer destination. The medical officer can also request transfer to a prison close to hospital.

The high rate of homelessness and sudden discharge from bail and court proceedings complicate follow-up from the Forensic Community Mental Health Service. Unlike hospital services where the patient can remain in hospital while seeking accommodation, prisoners must leave immediately they are released. The Department of Corrective Services has no model (or step-down facility) to ensure patients have accommodation (personal communication Dr Carbon 2012).

For Aboriginal persons, a recent COAG-funded 'Bridging the Gap' program has enabled improved follow-up care. Arranging community care for others is problematic because some community mental health services are reluctant to accept referrals, especially for adolescents. The Director of Medical Services for Corrective Services informed the Review that rural CMHS accept prisoners more readily than those in the metropolitan and some CMHS have good relationships with prisons and remain involved in care while the patient is serving their prison sentence.

Dr Carbon stated that too often the services' 'attempts to find' the patient to provide outreach results in no follow-up. Clinicians informed the Review that many of these patients do not meet their eligibility criterion. In fact, many meet the services' 'exclusion criteria' because of a history of violence or because they are homeless. The Review observed that the services' triage process of writing letters in response to referrals rather than contacting them by other modes limits the ability of ex-prisoners to respond since many prisoners are homeless and some are illiterate. The referral process effectively disenfranchises prisoners from community care.

The Chief Executive of Acacia Prison provided an example of psychiatric care in prison to the Review. There are 1000 prisoners at Acacia, 40 per cent of whom have a mental illness. At any one time, 10 per cent are experiencing active psychosis. Two full-time GPs (Monday to Friday) and three FTE mental health nurses (seven days a week) provide health and psychiatric care within the prison. A memorandum of understanding with psychiatric services enables three sessions of psychiatrist consultation per week. No mental health staff are on duty overnight.

Prisoners are transferred to the Frankland Centre for stabilisation of acute disorder that cannot be managed within the prison. There is an effective relationship between the prison and the Frankland Centre. This relationship includes reciprocal visits of clinicians between the Frankland Centre and Acacia Prison to foster understanding of environments, service characteristics and an understanding of service limitations (personal communication P McMullen, CE Acacia Prison June 2012).

The three challenges of good practice in mental health care for prisons relate to transition points:

1. *The waiting time for an inpatient bed at the Frankland Centre when the patient is too ill to be cared for in the prison.*
2. *The precipitant discharge of the prisoner back to prison in response to the need to admit a new patient to the Frankland Centre when the prisoner may not have been fully treated.*
3. *The delay in responses from community services when the prisoner is released*

(personal communication P McMullen June 2012).

Prisoners have access to physical and mental health care; however, rehabilitation services in a therapeutic environment are also required for their recovery. An example of a successful model is Broadmoor, a high-security psychiatric hospital in Berkshire, England (personal communication P McMullen 2012).

Community mental health clinicians remarked that when patients receive regular medication in prison they are in relatively better mental health on discharge. Clinicians informed this Review that a secure step-down unit would provide an environment where patients could receive continued care as they safely transitioned into the mainstream community.

The Principal Solicitor and General Manager of the Mental Health Law Centre, Sandra Boulter, informed the Review that there are serious unmet mental health needs within the prison population and that, for many prisoners, mental health deteriorates during incarceration. She also observed that unwell patients in prison do not always receive medications (personal communication S Boulter, Mental Health Law Centre 2012).

A prison peer support volunteer also said that prisoners rarely receive prescribed anti-psychotic medication in prison because the medications are often traded or stolen. These concerns need to be addressed by the Department of Corrective Services.

The Deputy State Coroner advised the Review that to ensure patients receive treatment to alleviate their mental illness, the Department of Corrective Services requires a regular prison psychiatrist presence to enable compliance. She observed that community treatment orders (CTOs) are a mechanism used to enhance compliance with treatment by involuntary patients under the Mental Health Act 1996. She suggested that CTOs be applied to the prison setting. The orders require a treating psychiatrist to take responsibility that the patient receives treatment. Prison mental health care does not extend to rehabilitative care (personal communication Dr S Petch 2012).

See Recommendation 2: Patients; Recommendation 3: Carers and families; and Recommendation 9: Judicial and criminal justice system.

3.11.4 Forensic mental health – Frankland Centre

The Frankland Centre ('Frankland') is WA's only forensic secure inpatient mental health facility. It has 30 beds and is located on the Graylands Hospital campus. The centre was opened in 1993 with the current complement of secure beds. There has been no addition to the bed stock in 20 years despite a significant increase in demand brought about largely by the proclamation of the Criminal Law (Mentally Impaired Accused) Act 1996 in 1997. Clinicians informed the Review that the mix of patients at Frankland comprises approximately 50 per cent from prison, 30 per cent on hospital orders (ordered by a judicial officer of the court, see CLMIA Act Pt 2 s 5) and 20 per cent referred from community health services, predominantly the forensic mental health team.

Inpatient length of stay at Frankland has some unique features:

- Patients under hospital orders usually have a length of stay of seven days.
- Patients admitted under custody orders (those unfit to stand trial or those found 'not guilty for reason of unsound mind') can remain at Frankland for very lengthy periods, often years.
- Patients admitted with psychiatric illness from prison remain until their condition stabilises or unless treatment is disrupted when a bed must be found to accommodate a new admission. In these circumstances, one patient must be moved into prison to make space for the individual on a hospital order from the court. (personal communication S Boulter, Mental Health Law Centre 2012).

Patients from court are admitted within two hours; however, prisoners who require psychiatric care at Frankland sometimes wait up to three or four weeks in prison before a bed becomes available.

The Review heard unanimously from the Director of the State Forensic Mental Health Service, from clinicians within it, from the Deputy State Coroner, from the Mental Health Law Centre and from the Director of Health Services, Department of Corrective Services that the current number of secure beds in the Frankland Centre is highly inadequate to meet demand.

The Review heard that if new secure forensic hospital beds are built they should be close to a prison, such as on the Hakea Prison campus, next to—but outside—the prison walls and designated 'authorised beds' under the *Mental Health Act 1996*. As well as recommendations for a significant increase in total beds, there is a widespread call for designated units or wards specifically for women, adolescents, Aboriginal prisoners and rehabilitation.

Clinicians informed the Review that sudden discharges sometimes occur on Fridays when the prison mental health staffing is minimal. Frankland's contingency is to prepare the 'most well' patient for transfer. Clinicians explained to the Review that when patients are transferred back to custody, the prison's risk management system sometimes requires a prisoner to be kept in a safe cell in an anti-suicide gown until they have been assessed by a psychiatrist, which can take three days or longer. During this period, patients are cared for by nursing staff. Some patients are transferred to the crisis care unit at Casuarina prison.

The Review was informed that accused persons on hospital orders might travel long distances to be assessed at WA's only forensic inpatient service, even in situations of a minor offence. A system is needed to enable people to be assessed locally by video-link in rural courts.

At Frankland, patients develop and sign their care plan with nursing staff and keep a copy along with a copy of their safety plan. Their safety plan contains identified triggers of agitation and is reviewed each two weeks with the patient.

Carer involvement is encouraged by the social worker who contacts the family to obtain collateral information and to provide families with appropriate involvement. Families are invited to face-to-face interviews with the treatment team. However, families are often disengaged because of the joint stigma of mental illness and imprisonment and have often disengaged well before the patient's involvement with the criminal justice system.

The social worker at Frankland commented that by the time patients arrived at Frankland they have usually committed a serious offence. Criminal behaviour is often the result of the longstanding difficulty that these patients and carers have in accessing care in the community, and families often express gratitude that the patient is finally receiving treatment.

Another concern expressed by the clinicians was the vulnerability of female patients in a male-dominated environment populated by sometimes seriously dangerous fellow patients. It was strongly felt that a female-only unit is needed to provide a more protective and appropriate therapeutic environment. It was also drawn to the attention of the Review that the admission of juveniles to Frankland presents significant problems and risks and there was a very strong call for the establishment of a dedicated juvenile secure inpatient unit.

When patients are transferred back to prison, discharge plans are faxed and a copy is sent with the patient. However, Frankland staff are concerned that the care and treatment plans are not always continued. Clinicians expressed concern that persons who are transferred to prison are often not well enough for discharge from Frankland and yet treatment compliance cannot be assured. Opinion is divided on whether this situation could be improved by having community treatment orders available in prisons with the capacity to enforce treatment. This issue also has been raised by the Deputy State Coroner who explained to the Review that in the absence of involuntary mental health provisions, the mental health of patients often deteriorates on return to prison.

When discharge occurs as the result of a court directive (bail or community based order), the Psychiatric Report provides a discharge plan that includes arrangements for accommodation, a treatment plan and appointment with the community mental health service. These are required to satisfy the judicial officer that the patient will receive continuity of care in the community.

The entry and discharge of patients at Frankland is very often outside the control of clinicians but the scarce acute service resource is managed very tightly by the lead clinician in the inpatient team. However, once patients arrive, the admission and care process appear to be of high quality. There are opportunities to improve hospital follow-up when patients are transferred to prison and the community.

See Recommendation 1: Governance (1.2; 1.5; 1.6); and Recommendation 9: Judicial and criminal justice system.

3.11.5 Forensic community mental health

The Community Forensic Mental Health Service (CFMHS) is charged with four key functions:

1. Court liaison services.
2. Assertive care to seriously mentally ill high-risk offenders.
3. Consultation/liaison, advice and support to general mental health services.
4. Targeted clinics for people with problem behaviours such as sex offences, stalking and arson.

The CFMHS currently fulfils three of these functions— providing court liaison (face-to-face assessments in the metropolitan area and video-link assessments in rural and remote areas) and assertive care to a cohort of 'forensic patients' in the metropolitan area.

Referral sources include Frankland, community mental health services, courts and prisons. The services are limited to managing patients with a high risk of reoffending and there is a three-month waiting list for some services, for example, community service consults.

Usual care comprises weekly contact with the patient by the multidisciplinary team and six-weekly medical reviews. Eight clinicians have caseloads of eight patients each. Many visits are undertaken in pairs. However, if the patient resides in a supported hostel, clinicians visit alone.

The CFMHS does not have offices, and clients are more often visited in their homes or in public places. Some 'mainstream' community mental health services provide clinic space for the forensic team and patients can attend these clinics. Many other community mental health services are unable to accommodate the forensic team. Clinicians explained that even though non-forensic services deal with patients at much higher risk, the 'fear' and stigma of forensic clients deters community mental health services from accommodating the forensic clinics.

Forensic clinicians observed that persons who are not followed up are more likely to reoffend and return to jail.

Forensic clinicians are concerned that referrals and discharge plans are often not received from the prisons and that many patients arrive home without medications. Sometimes family members have returned to the prison to pick up medications. When the prison notifies the community mental health service that a prisoner has been released, there is often no fixed address for the forensic service to make contact and information is often incomplete.

Clinicians explained to the Review that when patients are released directly (unplanned) from court, there is no process to notify the community mental health services, which either delays follow-up or results in no follow-up. This is a serious problem. When psychiatric conditions are untreated, it is more likely that a crime and reimprisonment will reoccur.

Forensic clinicians said ex-prisoners often miss out on the mental health care to which they are entitled because the psychiatric services in prisons, the judicial system and the community are not connected.

This differs in some rural areas. Over the past 12 years, the Broome mental health services have embraced the regional prisons as part of the community that they service. The model is based on the British Columbian approach and recognises that imprisoned patients with mental illness are known to have the highest risk of suicide.

The service process is formalised with Department of Corrective Services by a Service Agreement and the community mental health services are paid an annual sum to provide services. The case manager and triage clinicians attend the prison each week, along with a registrar/consultant to provide care for prisoners.

The Kimberley mental health services said they need a court liaison position to identify the people who require services and to track the patients who are released to ensure community follow-up occurs.

In the Midwest, minimal inreach is provided into the prison; however, patients are referred to the community mental health services on release. The local prison would like a local psychiatrist to supply care rather than the fly-in private psychiatrist system currently in use.

In the Children's Court, forensic clinicians explained they provide a limited 'as needs' service and It is imperative to develop a robust court liaison service and system to support the judicial system and mental health services in the Children's Court, as occurs in the adult system.

The Review finds that WA also needs dedicated services for forensic adolescents. There is no forensic unit for adolescents and accommodating young people is difficult. The Bentley Adolescent Unit is not appropriate for accommodating physically violent adolescents on remand. The only services with outreach are YouthLink and Youth Reach South.

A passport system is a solution to assist continuity of patient care with better information across treatment settings. If carried by the patient, illness and treatment plans would thereby be available for prison and community mental health services.

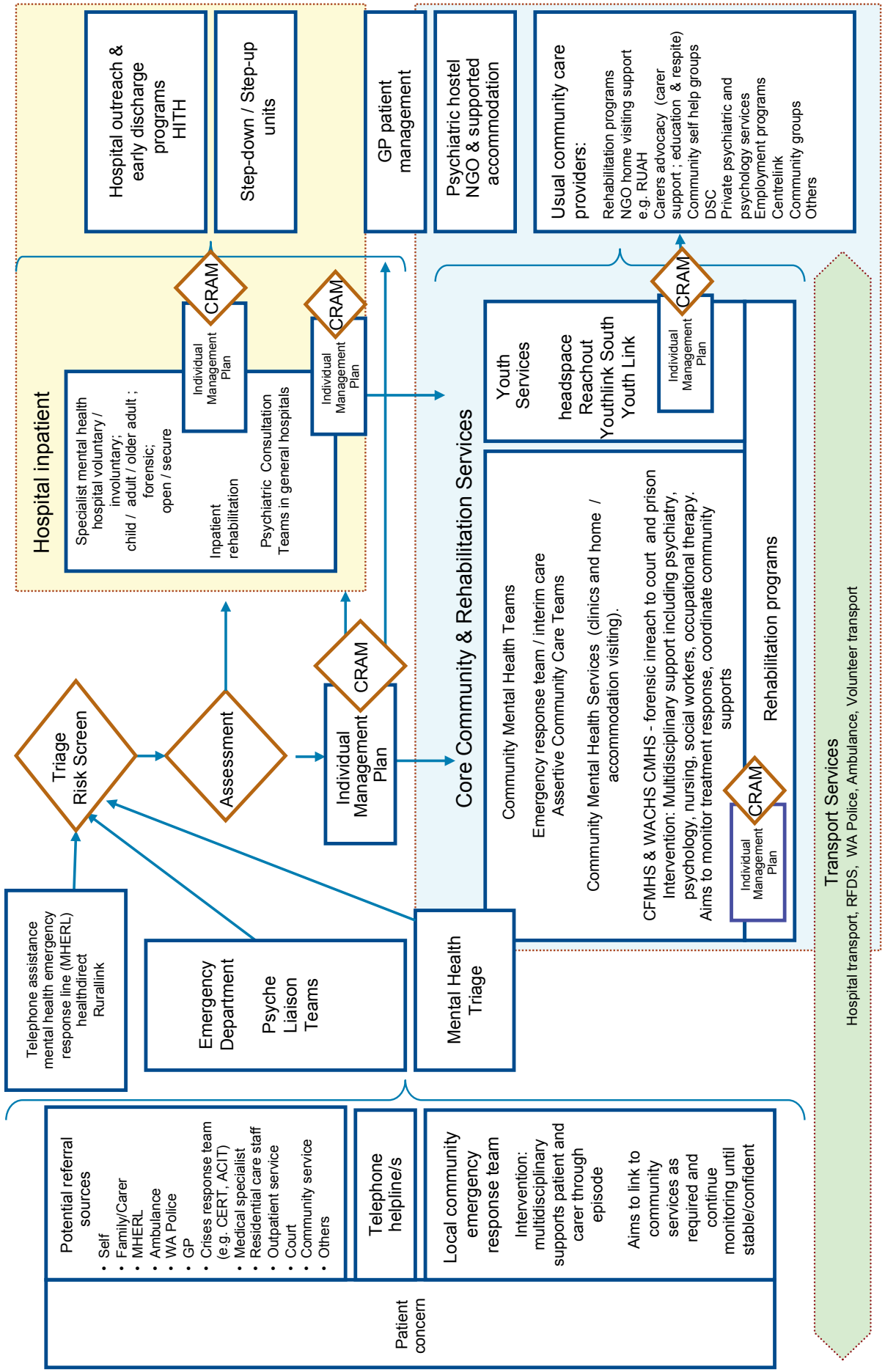
See Recommendation 1: Governance (1.1.1); and Recommendation 9: Judicial and criminal justice system.

3.12 Inpatient mental health facilities and services

The public mental health services provide mental health care for children, adolescents, adults and older people. This care is provided in hospital inpatient services, residential services, community mental health clinics, and in the community.

Figure 25 outlines the patient pathway through the mental health system. On considering the patient pathway and questioning the clinicians, this Review has observed that the flow is somewhat fractured by the required screening at entry to each component.

Figure 25 **WA mental health patient pathway, 2012**



The Reviewer acknowledges that it is an imperative that mental health services assess and minimise the risk of deliberate self-harm and suicide within all mental health settings (National Standard for Mental Health Services 2.3). Therefore, mental health services are required to conduct risk assessment of patients at each stage of the care continuum, including when the patient exits the service, such as when they exit 'temporarily and/or are transferred to another service' (National Standard for Mental Health Services 2.11, see also Standard 10.5.9).

However, the Review found that in transferring from one component of mental health services to another, the patient pathway is not seamless. Indeed, the necessity of repeating assessment is experienced as a barrier to entry. For example, before discharge from hospital, the patient undergoes a risk assessment. The Individual Management Plan is updated and a discharge letter, including a summary of care, is completed. However, when the patient arrives at the mental health facility, the process of triage is repeated and the outcome of triage is a further decision to provide services or not. The previous care plan may be reformatted or discarded.

See Recommendation 2: Patients (2.10).

3.12.1 Community emergency response team

In the metropolitan area, the first psychiatric emergency teams began to provide 24-hour crisis and emergency responses in 1986 (Lawrence et al. 2001). This tradition has continued and is currently provided throughout the metropolitan and most rural areas.

Increasing demand for urgent assessment and management of mental illness in the community has necessitated expansion of emergency response services. Hours of availability have increased in the North Metropolitan and South Metropolitan mental health areas (Western Australian Auditor General 2009; Smith, Williams & Lefay 2011a).

For example, North Metropolitan has increased from three to four community emergency response teams (CERTs) that now operate 24 hours a day rather than only overnight. These services support adults as well as youths, and particularly those aged 16–18 who cannot access Princess Margaret Hospital.

CERTs comprise multidisciplinary clinicians and their core activity is to provide urgent care to patients in the community. They aim to reduce severity of illness by responding early to deteriorating conditions and to decrease the duration or risk of recurrent relapse (SMAHS 2012). With the recent expansion of CERT services, the functions also include the provision of hospital follow-up care to bridge the gap until regular mental health services commence.

CERTs aim to:

- provide after-hours support and treatment for up to six weeks to manage the crisis and reduce the need for hospitalisation
- respond to requests for mental health intervention in a consistent, timely manner with a minimum of delay
- provide urgent and emergency interventions and avoid patients being unnecessarily redirected to hospital emergency departments
- reduce the demand for urgent response on community mental health services (WAAG 2009).

After hours, when calls to MHERL require urgent intervention, MHERL triage [prioritise] the call and request the local CERT to attend. During office hours, the call is diverted to the triage of the local community mental health service. Common situations include requests from police for mental health assessment and management of mental health symptoms in community incidents.

CERT clinicians explained to the Review that on receiving referrals from MHERL, their response is to re-triage the incident. This includes obtaining collateral information from PSOLIS (previous risk screen, risk management plans and the names of practitioners involved in care); contacting the original caller; and reassessing the urgency and need for attendance. CERT clinicians informed the Review they needed to ensure the situation was safe to attend; for example, to know of the presence of dogs on the property. However, this activity duplicates assessments, delays attendance and often confuses the patient and carer with conflicting dispositions (courses of action).

Currently, MHERL does not have the mandate to direct CERT activity and cannot provide the caller with any assurance that assistance will arrive.

WA Police provide security for CERT on an on-call basis. WA Police explained community safety is their core business and they will always attend promptly to assist CERT. However, they prefer a briefing from mental health staff about situations and the reason they are required to attend.

The Review heard from CERT clinicians and managers about the stresses involved in attending urgent and difficult situations in the community and a number of poor outcomes from interventions. Carers and patients also highlighted their anxiety with service delays.

Each of the metropolitan areas are responding to these difficult issues satisfactorily and implementing improvement within their areas. Ongoing monitoring of these processes is critical and these types of activities need to be monitored by a proper quality and performance management process.

The Reviewer is concerned that in crises, mental health services perform multiple triage/assessment processes and do not immediately assure the patient/carer that assistance will be provided promptly. It is also confusing to anyone navigating the mental health system, let alone those in crises, that each of these services have varying names, such as CATT (Crisis Assessment and Treatment Team), ACIT (Acute Community Intervention Team) and CERT. Uniformity should be established.

Recommendation: 1 Governance (1.2); Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.

3.12.1.1 Police and mental health services at community incidents

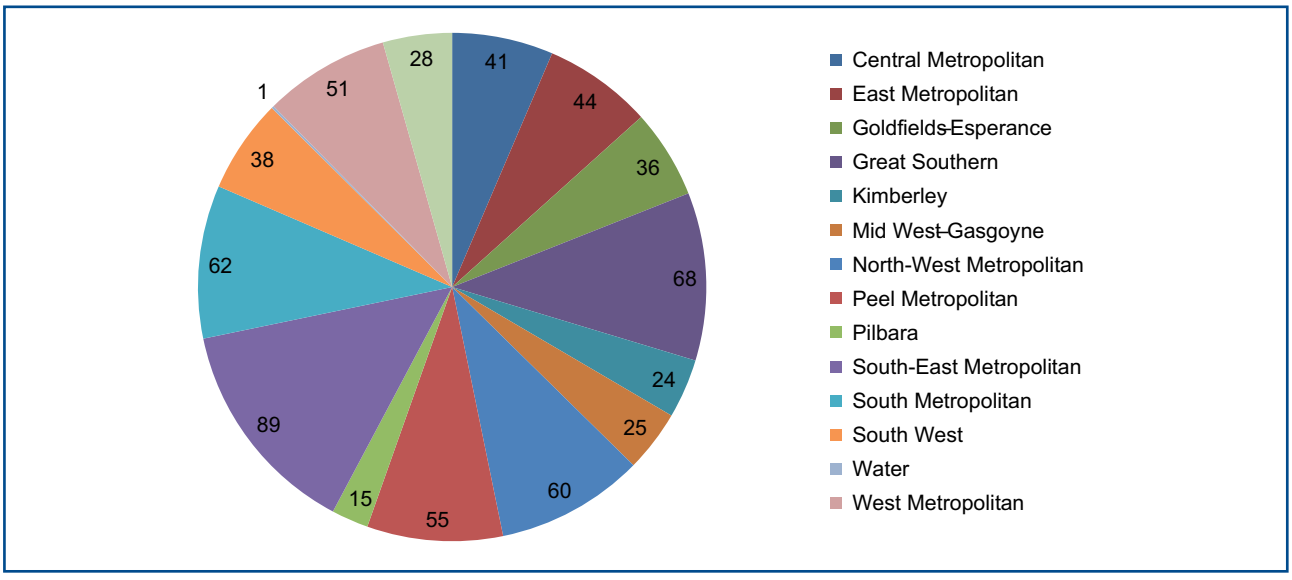
There are incidents when WA Police require the assistance of mental services. They include incidents in the community where a person:

- has a history of violence
- is a current threat to the safety of others
- is a serious threat to property
- shows significant self-neglect
- has a high level of distress
- has a history of deliberate self-harm
- presents a current threat of deliberate self-harm
- is behaving in a bizarre or unusual way
- is displaying gross mismanagement of personal affairs as a consequence of an acutely disturbed mental state

(Department of Health, undated b).

There were 677 such incidents in WA in 2010, with 280 in the metropolitan area (see Figure 26). In these situations, the police can contact MHERL or the local CERT to obtain a mental health worker from an emergency response team to assist. The police provide security and the mental health worker de-escalates the situation and determines if the patient needs a mental health assessment. If an assessment is required, the mental health worker can organise a specialist inpatient mental health bed and complete a Form 1: referral for assessment and a Form 3: transport order (if security is a concern) to ensure the person obtains assessment.

Figure 26 **WA Police-attended community incidents involving mental health patients, 2010**



Source: WA Police Reports (2012).

The Reviewer is of the opinion that expertise and cohesiveness of emergency service teams would be improved by a more cohesive approach between the police and the mental health clinician and by identified teams in the north and south to be the 'on-call' response to police.

A multiskilled team of ambulance, police and mental health clinicians is required for emergency community incidents, similar to the NSW mental health interventionalist model outlined in Section 3.7.1. This will provide the community with optimum expertise to manage situations. However, this model takes time to establish and it would be sensible to commence the process with skilled and dedicated mental health response teams north and south of the river to assist police when requested. These teams would also liaise regularly with the police and provide mental health education to both police and ambulance services.

See Recommendation 1: Governance.

3.12.2 Presentation with mental illness at emergency departments

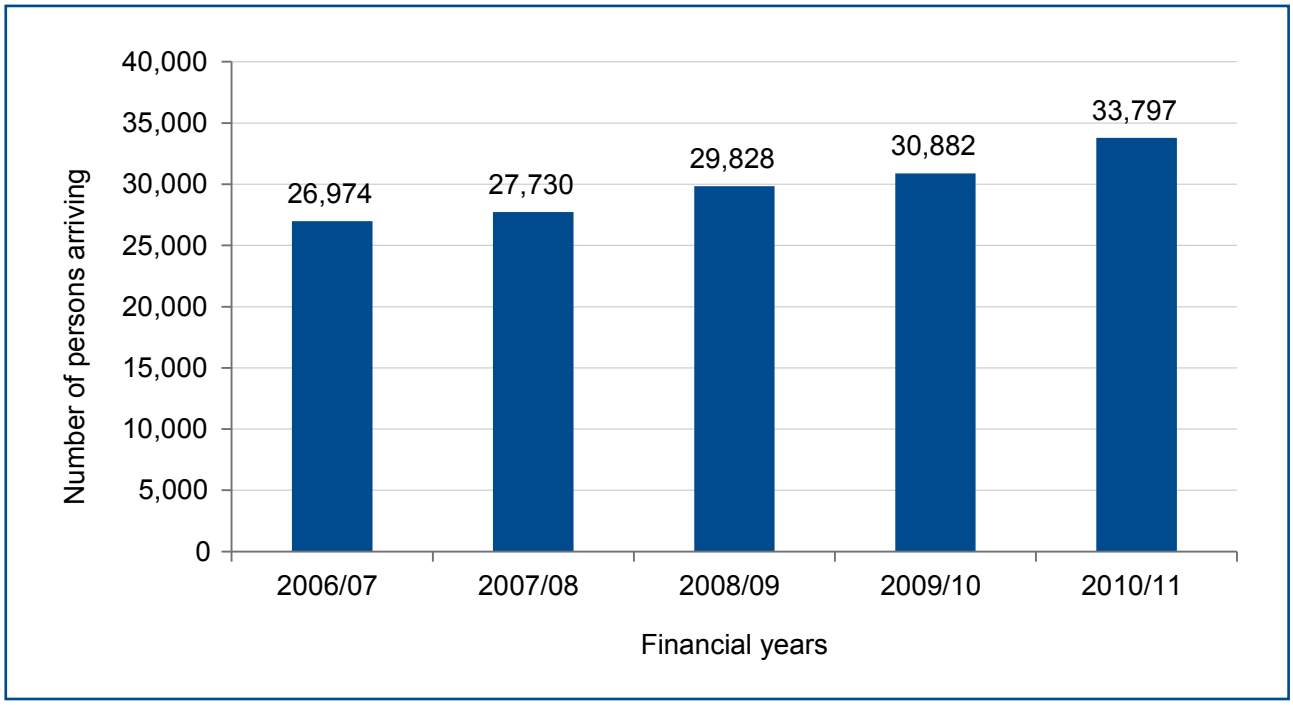
Over the past few years, improvements in psychiatric care in EDs characterises the desire of clinicians to continuously improve the system for patients. The Review notes the following examples:

- The heads of metropolitan EDs perceive that psychiatry liaison in the ED has 'improved spectacularly in the past five years'.
- ED clinicians perceive that the psychiatry liaison nurse position has improved patient care in the ED and smoothed relationships between inpatient units and community mental health services.

While every effort is being made to improve the system, it is apparent that more people with mental illness are directed to EDs to access mental health services and there is inconsistency in the response to mental illness in each ED across WA.

Clinicians in EDs said increasing numbers of patients are presenting with mental illness, especially with an initial onset of mental illness. The clinicians' claim is validated by ED data. In the past financial year, there were 33,797 presentations with mental illness in emergency departments in WA. Presentations have increased by 25.29 per cent over the past five years (see Figure 27).

Figure 27 **Total number of persons arriving at WA EDs with mental health conditions, 2006-07 to 2010/11**



Notes: For all WACHS sites (except Bunbury Hospital) mental health attendances are identified using the MDC codes 19 (Mental diseases and disorders) and 20 (Substance use and substance-induced organic mental disorders), as HCARE does not provide Diagnosis Codes (ICD) or Presenting Problem to the ED Data Collection (EDDC). The addition of MDC codes to mental health definitions were endorsed by the SHEF Performance, Reporting and Governance Sub-Committee on 12 October 2010.

It is not possible to identify mental health related ED attendances at Peel Health Campus because neither Diagnosis (ICD), Presenting Problem, nor MDC codes are provided to the EDDC.

Source: Emergency Department Data Collection (2012).

When patients arrive in ED, they are triaged into urgency categories depending on their condition. Patients with mental illness who appear to be at risk of self-harm or harm to others are triaged to Category 2 [need to be attended to by a health practitioner within 10 minutes] and the ED triage nurse immediately notifies the psychiatry liaison team (PLT) in some hospitals, and in others, the patient is brought into the ED. Here, they are examined by an ED nurse and doctor, and the assessment of these clinicians determines if a PLT or psychiatrist consult is required.

In most hospitals, the PLT consists of a mental health nurse, a psychiatry registrar and a consultant psychiatrist. Heads of ED described these team members as variously available. There are variations in the hours PLTs are available. In metropolitan hospitals, they are 24-hour services; rural hospital do not have a PLT overnight; and remote area hospitals have access to on-call psychiatrist advice only.

Roles of the PLT also vary. Some are located in the ED and other PLTs also provide mental health consultations in the general hospital wards. Some have a role within a colocated community mental health service. Most often, the patient is assessed by a mental health practitioner and is discharged without a psychiatric consult.

ED clinicians expressed concern that patients who were not at risk of self-harm were rarely assessed by the PLT who instead advised the patient be referred to their GP. Further, some patients at risk of self-harm are diverted to a self-harm prevention programs and the rather than the PLT.

The patient's experience in ED would ideally be: the psychiatry liaison nurse undertakes a risk screen and mental health assessment. The nurse then develops a risk management plan and a care plan with the patient and carer (where available). Determining the best place to deliver care—in the inpatient or community setting—depends on whether the patient can be safely managed in the community; the psychiatry liaison nurse consults the psychiatrist in making this decision.

It is usual for the psychiatry liaison nurse to discuss assessment and outcomes with the consultant psychiatrist and, where necessary, the consultant undertakes a comprehensive patient assessment. Where available and needed, the State Aboriginal Mental Health Service (SAMHS) worker assists patients in the ED with cultural and language translation and contact with family members.

Patients discharged from ED into the care of a community mental health service

Referrals to community mental health services are faxed from the ED to the health service and the psychiatry liaison nurse provides the patient with a pamphlet containing emergency mental health numbers and contact numbers for the health service to whom they are referred. The nurse cannot provide the patient with an appointment time or certainty that they will receive an appointment because all referrals are triaged by the health service to determine eligibility and the person may be placed on a waiting list.

An exception occurs at Rockingham Hospital where the PLT discharging a patient from emergency can provide the patient with an appointment time for community follow-up. At Rockingham, the community mental health service always leaves one or two openings in their appointments and urgent visits are booked by the PLT.

Due to the long wait for child and adolescent mental health services CAMHS (up to nine months), the Acute Community Intervention Team (ACIT) provides interim services in the metropolitan area. An ACIT member meets the patient and family in the emergency department or hospital ward. The ACIT service commenced in March 2012 and is similar to adult community emergency response team (CERT).

The head of an ED service explained that when patients require acute care there are insufficient alternative dispositions to hospital admission. Currently, services in the community, such as Hospital in the Home programs that are able to provide the intensity of supervision needed, are only available at Sir Charles Gairdner Hospital. The increasing availability of CERT in the metropolitan area is anticipated to provide an improved response, enabling more frequent discharge from EDs into the community with intense follow-up by these community teams.

Admitting patients to specialist mental health beds from ED

When the patient's condition is serious and treatment cannot be provided in the community, the patient is admitted to a specialist mental health bed.

The heads of ED informed this Review that EDs are well resourced and responsive to patients with general medical issues and ED clinicians are able to transfer patients to medical and surgical inpatient beds when needed. However, when mental health patients require hospital admissions, ED doctors do not have any control in the process of locating an available mental health bed.

To obtain an inpatient bed, the psychiatry liaison nurse or ED medical officer activates the State bed management system. The patient most often waits in the emergency room until a bed is found and transport is arranged; this can take up to 72 hours and patients are rarely transferred to a mental health inpatient facility during weekends. At one metropolitan hospital, there are often five patients waiting for a bed on a Monday morning, and it can take three to four hours to coordinate an ambulance and police escort for each.

At one hospital, the period of time patients wait for an inpatient bed has decreased markedly since 2008. Although some people continue to wait one to two days, the median time has been less than 24 hours (Royal Perth Hospital ED statistics).

In 2011 voluntary patients waited less than four hours and involuntary patients waited less than 19 hours for a bed (RPH total wait time data 2006–11).

A clinician informed the review that 'the number of psychiatric patients arriving in ED can make EDs a dangerous place'. EDs are not safe places for a disturbed patient, nor are they conducive to psychiatric assessments. ED clinicians explained they are not specialists in mental health.

The Review heard that while waiting for a mental health bed in the ED, patients who are disturbed are often sedated and therapeutic interventions are not usually commenced. EDs are not authorised to detain involuntary patients. Security guards are not authorised to bring a patient back if they abscond.

To provide a safe environment, some hospitals admit patients in a general hospital ward while waiting for a specialist mental health bed.

Relatives and carers

Involving relatives and carers in EDs is usual practice. ED staff notify the patient's next of kin when the patient arrives. When calls are received from relatives, the caller is referred to the psychiatry liaison nurse. The nurse encourages carers to provide collateral information and incorporates this information into their assessment to inform the care plan, depending on the patient's consent. Sadly, carer and family communication in many situations does not occur or is inadequate for carers to understand the situation. This inconsistency in the system produces many serious gaps, which affects patient total care.

Clinicians informed the Review that the majority of patients require community mental health services. For example, at PMH only 15 per cent of emergency presentations require admission to an inpatient unit.

It is of concern to the Reviewer that patients tend to arrive in ED as a pathway to mental health services. They are either sent in by community mental health services to obtain inpatient care or are sent by GPs to obtain community mental health services. This occurs because the waiting list and processes to community services are too onerous and there appear to be significant barriers within mental health services for specific types of mental illness.

The Reviewer is also concerned about the lack of after-hour services for youth aged 15–17 and older people in rural areas. At Bunbury Hospital, no after-hours psychiatric services are available for youths. The general psychiatrists refuse to consult on younger people and youth wait in ED until the CAMHS (Child and Adolescent Mental Health Service) becomes available in office hours.

This situation differs in Rockingham where there is no age limit for assessment by specialist mental health clinicians in the ED. If beds are unavailable at specialist mental health facilities, young patients are admitted into the general wards with a one-to-one nurse–patient ratio. Children and young people are also reviewed in the EPIC (Early Episode Psychosis Program) meeting and assigned a Child and Adolescent or Adult Case Worker. The general hospital clinicians have access to the CAMHS psychiatrist on the weekend and after hours. Children in intensive care and the children's ward are assessed by the psychiatry liaison nurse and CAMHS staff also provide advice where needed.

An example of good practice, for a physically well but mentally unwell patient, also occurs during office hours at the Swan Valley Centre. At this hospital, patients who have been assessed by the ED medical officer as requiring a psychiatric assessment are accompanied to the community mental health clinic where the assessment is undertaken. If the psychiatric assessment indicates the patient needs inpatient care, they are transferred from the clinic to the inpatient ward. On the occasions that a bed is not available, the patient is returned to the ED to wait for a mental health bed to become available. This clinic is in the grounds of the Swan Districts Hospital Campus.

Recommendation 2: Patients (2.8; 2.9); Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.

3.12.2.1 Comorbid conditions in the ED

The pressure to move people through ED is not conducive to good mental health assessments. Clinicians explained that it can take days to assess and admit a patient to a mental health bed. Some patients need to sober up or detoxify from illicit drugs; others require urgent treatment for overdose or other self-harm injuries. There is a need to alleviate patient stressors to enable a comprehensive assessment and provisional diagnosis to be made and for a treatment plan to be developed.

Patients with mental illness often have comorbid physical conditions and are at high risk of metabolic syndrome (see 3.12.5.3). Clinicians informed the Review that thorough physical examinations occur on a patient's first presentation. On subsequent ED visits, they do not always receive a full physical examination. For example, where the patient is directed from triage to the psychiatry liaison nurse, the resident medical officer (RMO) does not provide an initial physical assessment. However, the psychiatry liaison nurse can request an RMO's input when required.

When patients present to ED and they have a physical problem as well as mental illness, clinicians address the crisis first, for example, drug toxicity or a wound, and then assess and treat the patient's mental illness. Patients who require antibiotics or hydration require general hospital care until the physical illness is alleviated and then transfer to mental health specialist services.

See Recommendation 4: Clinicians and professional development (4.11); and Recommendation 7: Acute issues and suicide prevention (7.7).

3.12.2.2 Methylamphetamine and the ED

Patients with comorbid mental illness and drug and alcohol issues, and especially those under the influence of methylamphetamine, require intensive management. The National Minimum Data Set highlights amphetamine as one of the top three drugs of concern after alcohol and cannabis and WA has a substantially higher percentage of amphetamine-related presentations than other Australian states—seven per cent higher than the national average (AIHW 2011).

Heads of EDs and mental health clinicians told the Review that the presentation of patients influenced by methylamphetamine has changed emergency and psychiatric care. These patients often exhibit psychotic, violent and unpredictable behaviour. The demands on emergency staff and the disruption to other patients can be significant.

Methylamphetamine psychosis and the collapse of other psychiatric conditions with this drug magnify the issue.

Training and education of clinicians in the management of acute methylamphetamine intoxication and induced psychosis is an urgent need especially in rural and remote environments. Further, the standardised protocols for the management of the Acutely Aroused Adult Patients is in need of review (see http://www.watag.org.au/wapdc/docs/Acute_Arousal_Guide_ARCHIVE.pdf)

The heads of emergency staff said that up to 13 years ago restraining patients was unheard of. The use of amphetamine peaked three years ago. Currently, 20–50 patients a week require a Code Black (protection from harm) in one metropolitan hospital to keep the patient and those around them safe. Such a code may include four security personnel, a doctor and nurses to contain the situation.

There is now much higher security in hospital EDs where staff must manage very aggressive persons with sedation and intensive monitoring. Once the patient has detoxified, a mental health assessment can be undertaken and decisions made about mental health care if needed. The incidence of methylamphetamine-induced psychosis occurs in waves, although at some EDs such patients present every day.

The open layout of EDs are suboptimal to manage this type of patient. A separate area in the ED would better meet the safety needs of all patients (also a recommendation of the WAAMH submission 2012). In remote communities, where there is an absence of security guards, staff rely on police and orderlies or use private security services to keep patients safe.

Serious consideration must be given to develop separate areas in EDs to accommodate patients with mental issues away from the mainstream ED patients so that a quieter environment can be produced for these persons and at the same time patients with non-mental health conditions are protected from a potentially aggressive environment.

See Recommendation 1: Governance (1.1.1); Recommendation 4: Clinicians and professional development 4.11; and Recommendation 7: Acute issues and suicide prevention (7.7).

3.12.3 Presentation or referral to mental health triage

Mental health triage services are available at mental health inpatient and community services. The central function of triage is to assist the patient to navigate the system and enable access to inpatient or community services. The service also provides health care advice.

Triage services are available during office hours, except in the Alma Street Centre, which is open until 9 pm. After hours, MHERL and RuralLink provide this service.

Referrals occur in the form of face-to-face presentations, telephone calls or letters. Referrals include EDs, MHERL, mental health facilities, GPs, police, other mental health and community services, such as Centrelink, non-government organisations, and the Department of Housing.

The triage team usually comprises a duty officer (most often clinical nurses level 2 and 3) with a psychiatrist providing medical governance. All triage clinicians have global access to the mental health information system, PSOLIS. The patient's presentation or referral triggers the duty officer to review the patient's information in PSOLIS.

The duty officer is a dedicated role filled 80 per cent by registered nurses and 20 per cent by another health professional, such as a social worker or occupational therapist. The duty officer assesses the urgency of the referral. This is achieved by undertaking a risk assessment and gathering collateral information from PSOLIS, the patient's GP, family and referring agency. The level of urgency results in a disposition (course of action). For example, the patient is provided with mental health assessment within one to two hours or an appointment is arranged for psychiatric assessment either face to face, by video-link or by telephone.

If the patient is at risk, or there is risk to others such as children and family members, the duty officer consults with the psychiatrist and the patient is assessed urgently. Some services have access to CERT, who can undertake a community visit to assess the patient. When patients' presentations are severe, they may be directed to the ED.

Assessment usually occurs at the triage clinic. In remote areas, it can occur by video-link conference with the patient and a psychiatrist. The assessment includes a risk assessment, a comprehensive mental health assessment and a treatment plan to address immediate, medium- and long-term needs. In some services, the referring GP is invited to attend the patient's full assessment at the community mental health clinic.

The outcome of referral to mental health triage includes direct admission to a mental health hospital, intervention by CERT, admission to a community mental health service or referral to a GP or other community service.

The triage team reviews all referrals daily (metropolitan), weekly (rural) or monthly (remote areas). At this 'intake meeting', the referrals are discussed and urgency is confirmed with the supervising psychiatrist. The referral response is determined and, if the patient is accepted:

- An appointment is made for the patient with the most appropriate assessing clinician (psychiatrist, nurse or social worker).
- A letter or telephone call is made to the patient within one to five days (according to urgency).
- In some services, a case manager is assigned. The case manager is responsible for the patient assessment and provides monitoring of the patient's treatment and recovery care. The case manager involves the consultant psychiatrist for patient assessment and advice as needed.

If the team determines the referral is ineligible for services, the patient is informed by letter and advised to see their GP. A clinician explained there is a large administrative workload resulting from the high numbers of referrals that are redirected.

Northam mental health services pride themselves on their ‘no wrong door policy’, where all referrals are accepted and the triage is not a form of gatekeeping. Their success is in part due to their close working relationships with the drug and alcohol team.

Quality and Performance

At the Alma Street Centre, the triage consultant psychiatrist is full time rather than a rotational, rostered medical officer. This provides the team with increased consistency and has raised the skill base.

Commencing six months ago, the multidiscipline team at Alma Street Centre triage meets daily to ensure all assessment processes have been undertaken and referrals have been followed up. Where gaps in process or documentation occur, the responsible staff member is provided with guidance and assistance to improve performance. All work processes are signed off by the governing clinical psychiatrist.

This initiative hopefully will improve the service to patients and will assist in reducing the risk to patients who may self-harm.

The assessment and treatment plan elements to which the psychiatrist signs off includes:

- Legible
- Technically complete
- Clinically relevant
- Signature
- Plan
- Collateral discharge summary
- Presence and accuracy of risk screen
- GP letter sent, notification to GP; follow- up of individuals who did not attend assessment appointments
- Electronic discharge summary faxed to ED
- Medical entry
- Discharge concerns.

This quality assurance process aims to ensure that every patient experiences best-practice processes and clear documentation, and that a team member is assigned to undertake any follow-up required for each client. In addition to peer review, the forum provides an opportunity to discuss broader systemic issues and proposals to improve practice.

Recommendation 1: Governance (1.2); Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.

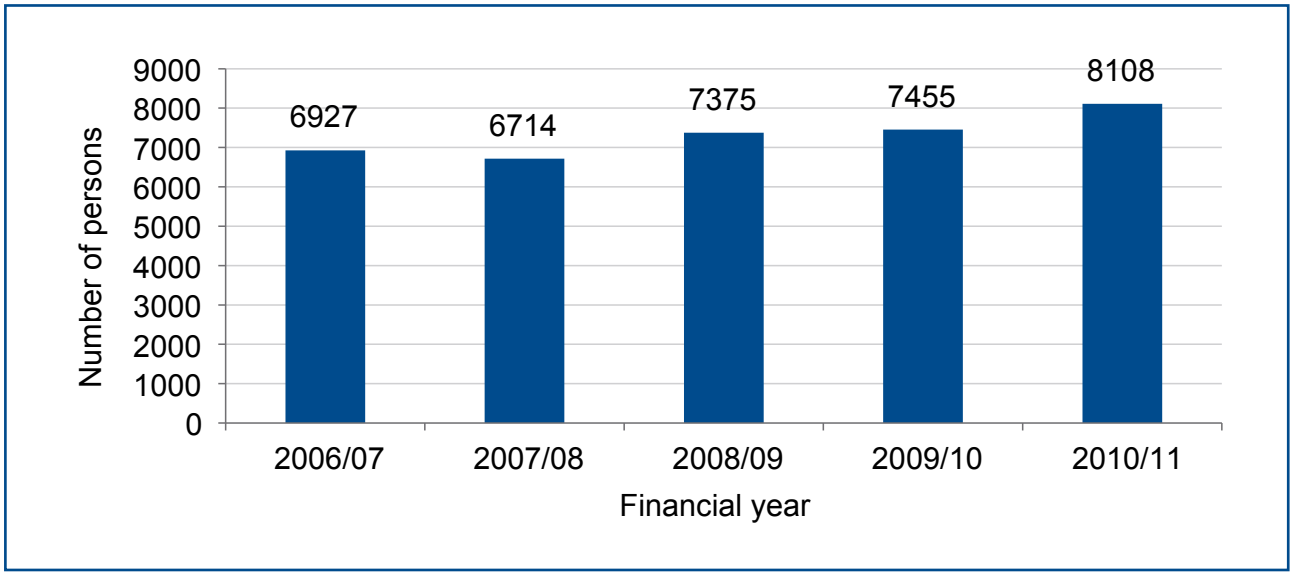
3.12.4 Admission to a general hospital

Many patients with mental illness are admitted into non-specialised mental health beds for treatment (see Figure 28). These patients can be admitted under the specialties, such as cardiology, endocrinology or general surgery, depending on comorbid conditions. About one-third of patients are transferred to specialist mental health facilities within a day or two; the remainder continue treatment in the general hospital.

In some metropolitan general hospitals, there are hospital psychiatric consultant teams who provide advice and assessment for patients with mental illness in the general hospital ward. These teams said they follow up 15–20 patients and admit three new patients each day. In other hospitals, the psychiatric liaison team provides hospital consultation and all hospitals have access to onsite or on-call consultant psychiatrists.

With these numbers of patients with mental illness in the general hospital, the Reviewer is concerned that general hospital clinicians require mental health knowledge, skills and support in addition to regular competency testing. Skills such as de-escalating situations and contacting specialist mental health advice are essential.

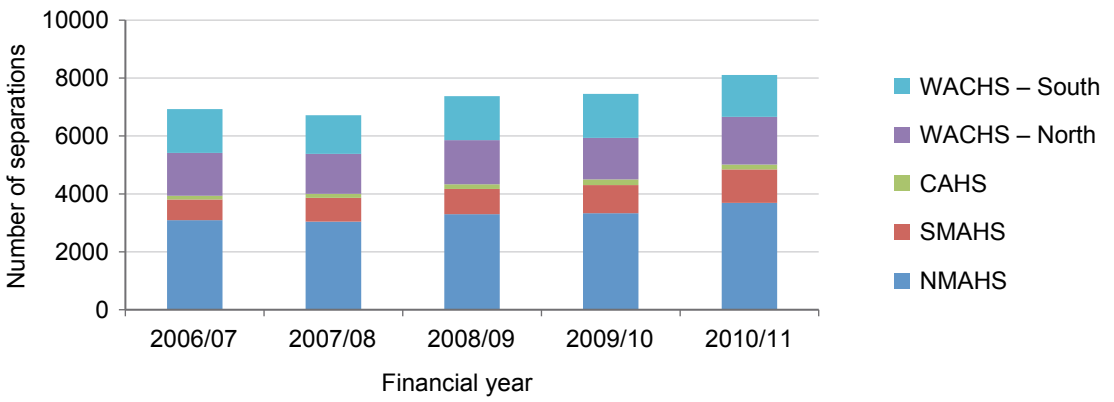
Figure 28 **Number overnight separations of mental health patients 0–64 years in non-MH specialised units, 2006–11**



Source: Non-designated units summary, MHIS Stokes 12 072 v2 (2012).

Admissions of patients to non-specialist hospital beds for the treatment of mental illness has consistently occurred across the State (see Figure 29).Separation is the term used by hospitals for persons who leave one hospital by discharge, referral to or transfer to another service.

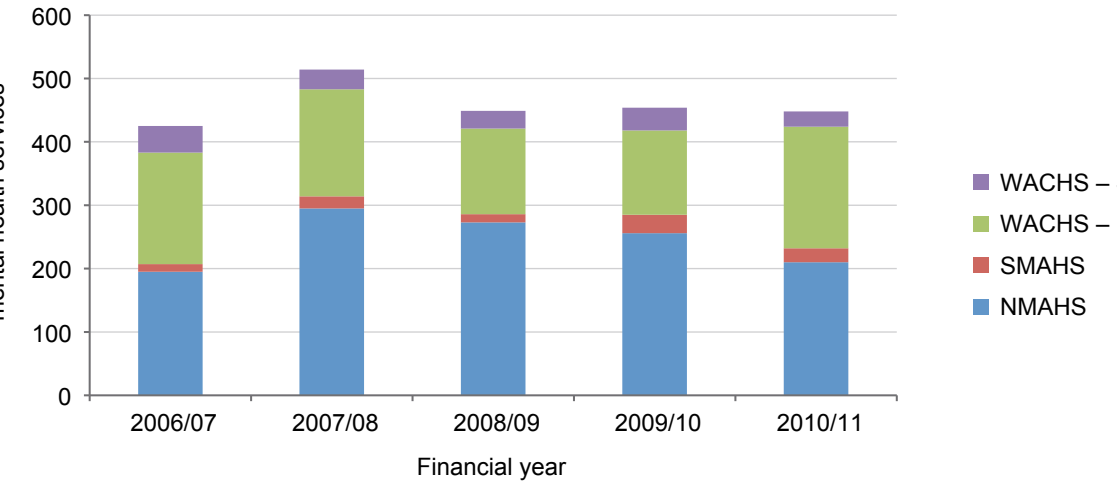
Figure 29 **Number overnight separations mental health patients 0–64 years in non-MH specialised units by Area Health Service, 2006–11**



Source: Non-designated units summary, MHIS, Stokes 12 072 v2 (2012).

Of these general hospital admissions, one-third of patients are transferred to mental health specialty beds within two days, as stated above (see Figure 30).

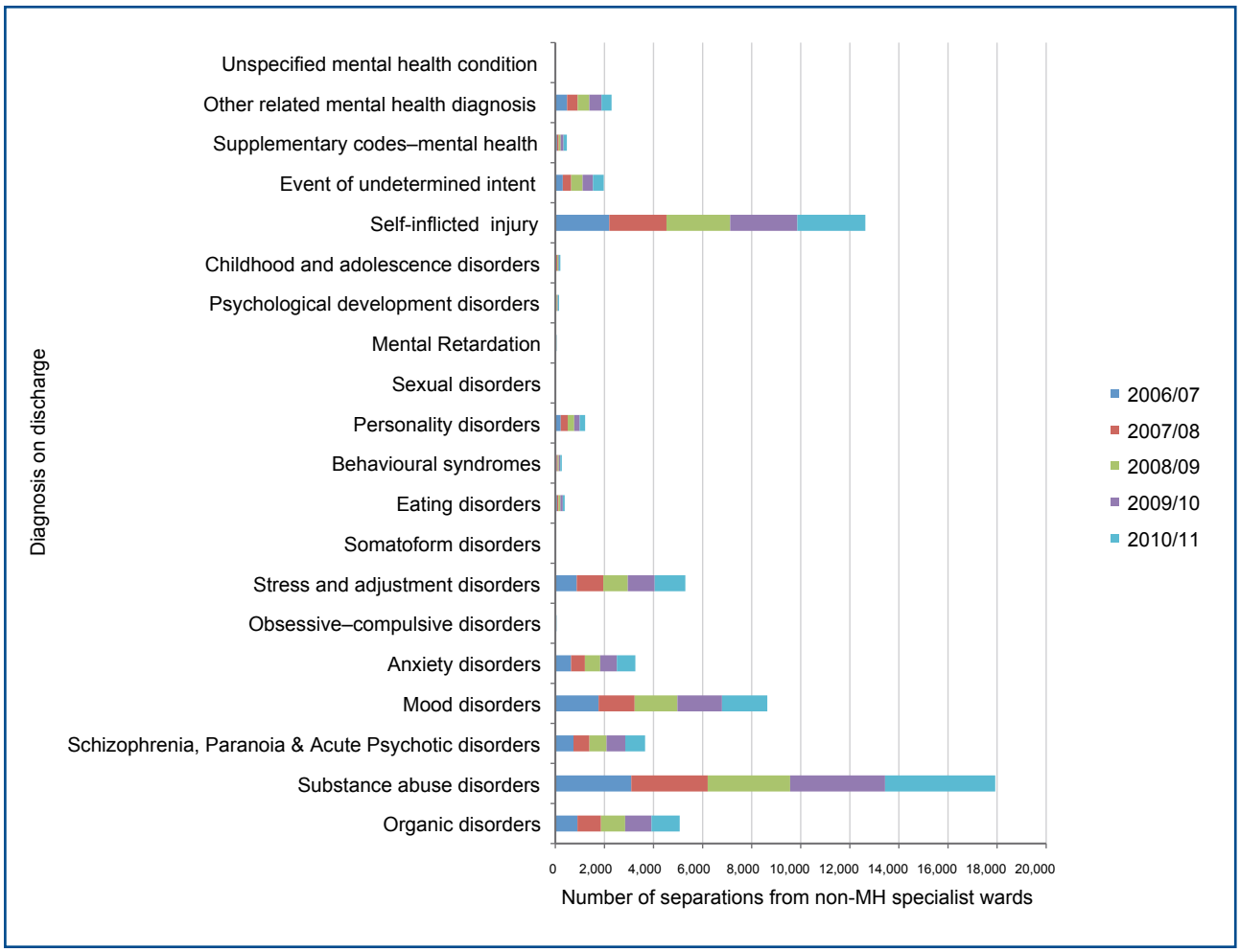
Figure 30 **Number overnight mental health patients 0–64 years in non-MH specialised units transferred to specialist mental health services within 2 days, 2006–11**



Source: Non-designated units summary, MHIS Stokes 12 072 v2 (2012).

Substance abuse, self-inflicted injury, mood disorders and stress and adjustment disorders are the most frequent mental health diagnostic groups of patients admitted to general hospitals (see Figure 31).

Figure 31 **Mental illness diagnosis at separation in non-specialist public hospitals, persons aged 0–64 years, 2006–11**



Source: MHIS, DoH (2012).

However, many patients remain in hospital for the duration of their inpatient treatment. Clinicians at Albany Hospital said 50 per cent of patients with mental illness are admitted into Albany's general hospital beds in preference to transferring the patients to specialist mental health beds in other cities. Clinicians informed the Review that where patients require mental health care in general hospital wards, the general hospital requests psychiatric consultation and, where necessary, patients are provided with a mental health nurse for one-to-one ('special') care.

Of concern, however, are the situations where patients admitted with a physical illness, either medical or surgical, also have a concomitant mental illness. These patients may quickly destabilise during their generalist treatment and this may fail to be recognised, with severe consequences.

The Review was informed by a relative of a patient who was admitted for an ophthalmic procedure that the patient's mental health deteriorated after the surgical procedure and this deterioration was not detected. The patient was discharged without psychiatric assessment and was found deceased at home a few days later from possible self-harm.

Many carers informed the Review that general hospital staff did not always respond as expected to deteriorating mental health conditions.

It was outside the terms of reference of this Review to explore the mental health care of patients in general hospitals. However, it is clear that the needs of patients with mental illness in EDs and wards of general hospitals must be met with best practice care.

All hospital practitioners need basic knowledge of mental illness and how to access psychiatric services within hospitals and the community. General hospital staff require annual updates on mental illness and service availability.

It is essential that the mental health services provide their expertise in training, support and psychiatric advice to the clinicians when requested to so.

The Reviewer anticipates the proposed Executive Director of Mental Health Services will enhance the relationships between general and mental health hospitals.

See Recommendation 2: Patients (2.8; 2.11).

3.12.5 Specialist mental health inpatient facilities

Patients are admitted or transferred to specialist mental health hospitals from the community or other hospitals through the mental health triage system. Patients are admitted to specialist mental health services when they are severely ill and at risk to themselves or others, and it is for this reason that specialist mental health services have been described as 'intensive care units'.

The *Mental Health Act 1996* legislates involuntary patient admissions using safety criterion[5] concerned with protection of the health and safety of the patient or any other person, against self-inflicted harm, causing damage to property, financial harm, lasting or irreparable harm to any important personal relationship and serious harm to the reputation of the person. This legislation does not exclude voluntary admissions for less severe conditions; however, the 'pressure' on mental beds has reduced availability to those patients at risk and they are admitted as voluntary or involuntary patients, depending on their capacity to participate in decision making.

The major disorders treated in specialist mental health inpatient services (see Figure 32) are:

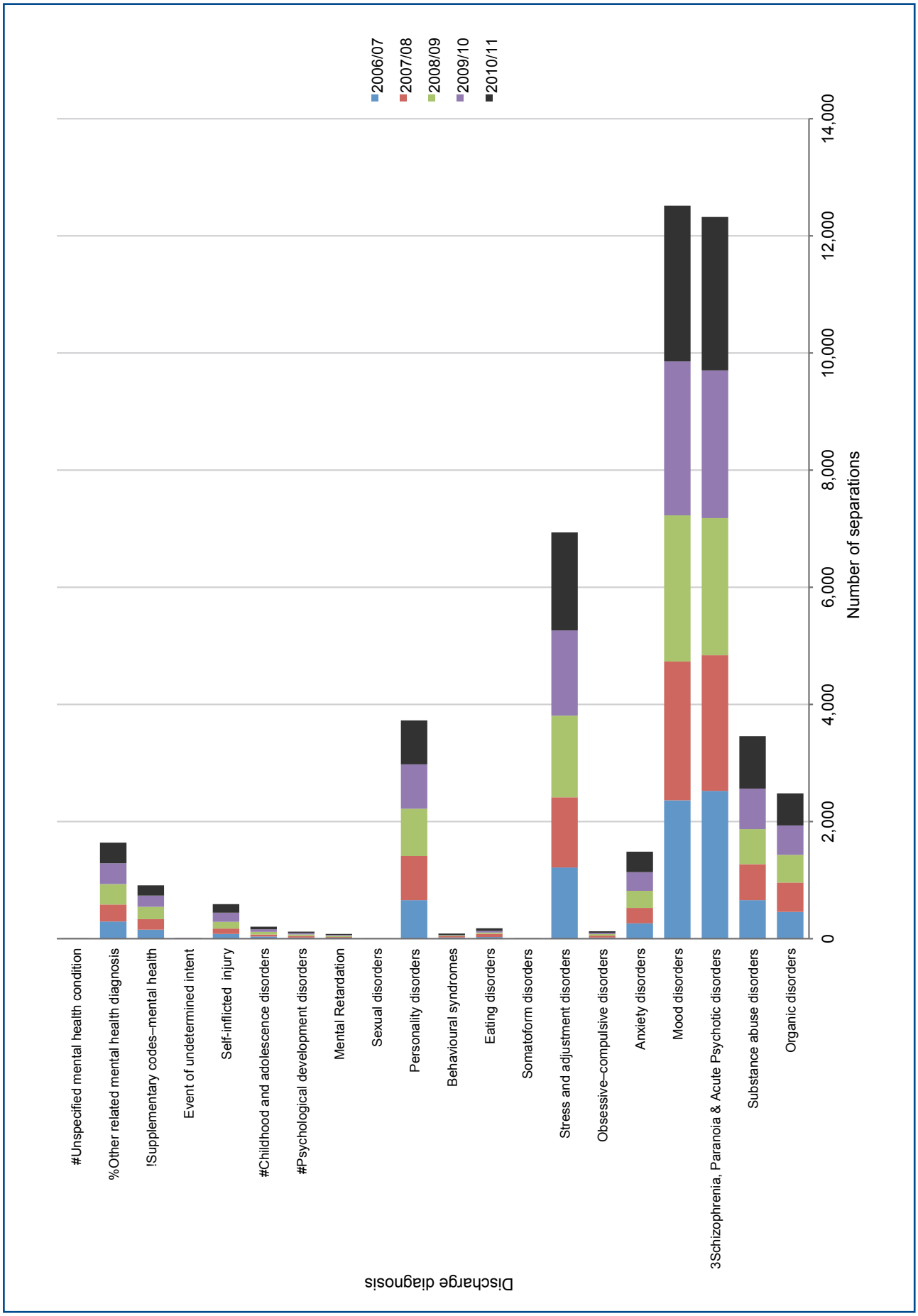
- mood disorders (2660 in 2010–11)
- schizophrenia, paranoia and acute psychotic disorders (2619 in 2010–11)
- stress adjustment disorders (1672 in 2010–11)
- personality disorders (751 in 2010–11).

The intensity of care in specialist mental health hospitals (see Figure 32) is indicated by the increasing number of admissions for treatment of:

- self-inflicted injury (81.25%)
- eating disorders (57.14%)
- substance abuse disorders (36.02%)
- stress and adjustment disorders (37.5%).

[5] The Mental Health Act 1996 Pt 3, Div 1 s 26 defines circumstances under which a patient may be made involuntary.

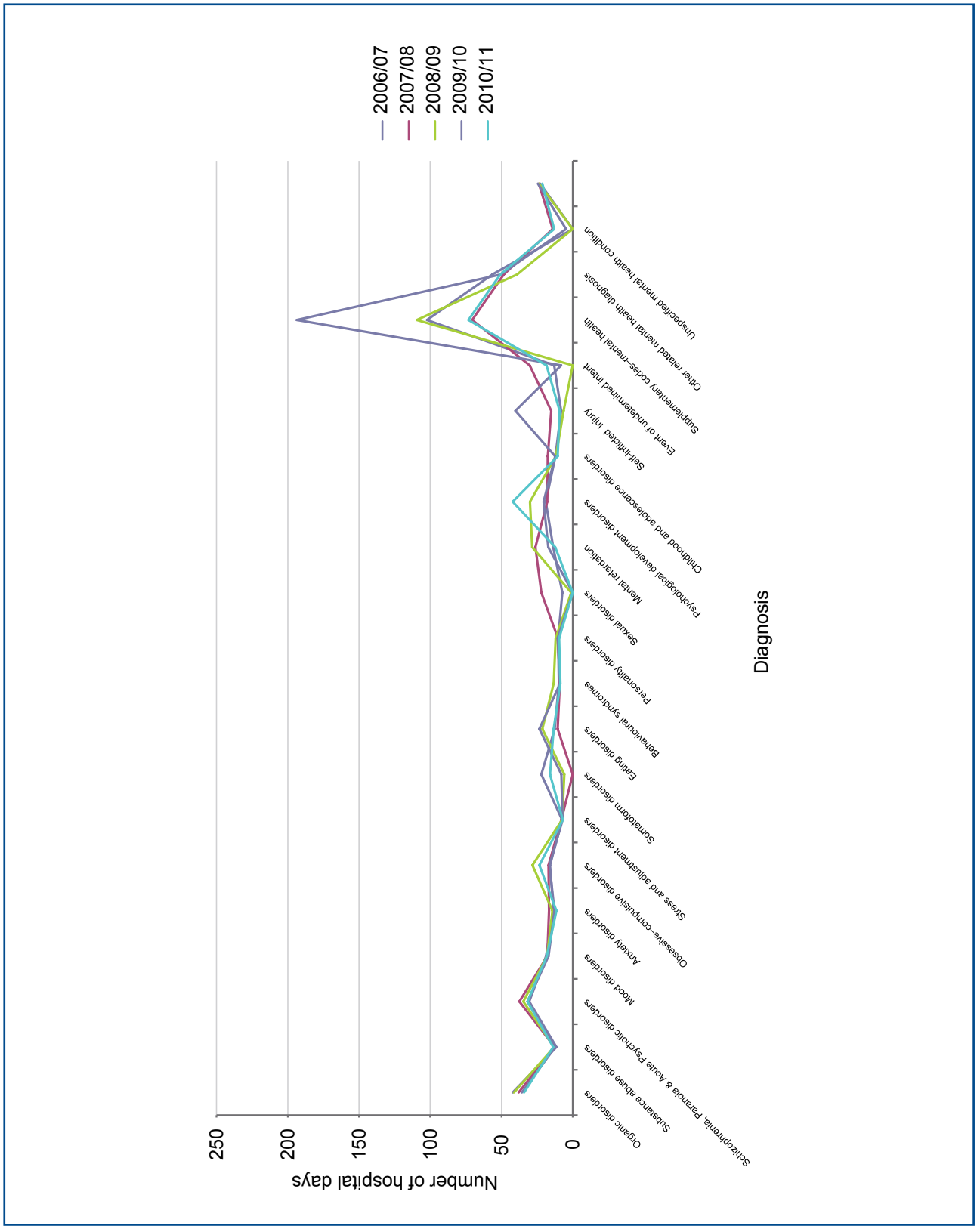
Figure 32 **Mental illness diagnosis at separations from specialist MH units, 2006–11**



Source: MHIS, DoH (2012).

Figure 33 demonstrates the mean length of stay of patients with mental illness in specialist mental health hospitals in WA over the past five financial years. It can be seen there has been a reductions in the length of stay in many disease groups such as organic disease and schizophrenia.

Figure 33 **Mean length of stay per diagnostic group, specialist mental health units 2006–11**



Source: MHIS DoH (2012).

Patients, separations and length of stay

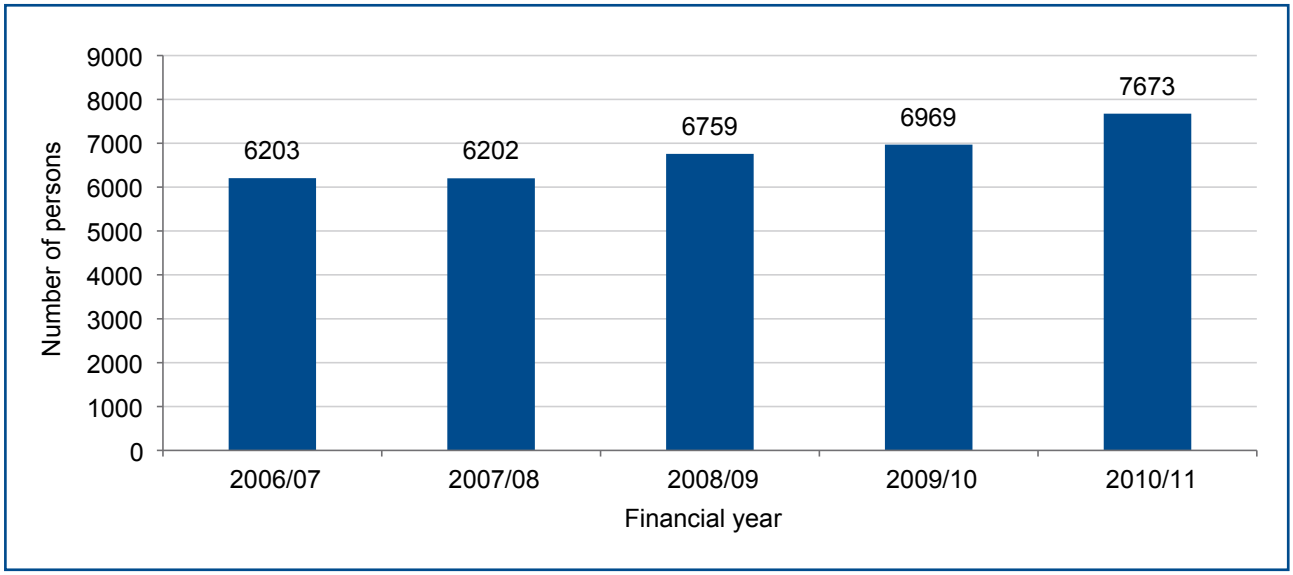
This Review acknowledges the importance of improving patient flow and maximising the use of acute care beds. However, every effort should be made to ensure that optimal care is not diminished by virtue of a focus on increasing patient flow.

Figures 34, 35 and 36 illustrate that the length of stay within mental health specialty services has decreased and that there has been an increase in the number of persons admitted to mental health inpatient hospital beds. This has resulted in bed occupancy at 104 per cent, characterised in the system as an intense pressure to discharge.

The Review was informed that the increasing demand for beds leads to a 'mad rush' to discharge, at times risking curtailment of treatment. A flow-on effect to an already stretched community mental health system was described. This flow-on effect includes community mental health services receiving increasing numbers of more acute patients.

Clinicians asserted that resources do not allow for the increased length of stay required for persons where social and housing supports are strained or non-existent, and that sub-optimal outcomes for patients is a risk. Unnecessary extended hospital stays for some patients relate to lack of downstream pathways rather than the need for acute treatment (personal communication Mental Health Commissioner 2012) and there has been no growth funding for inpatient services in the current year (personal communication Executive Director, Resource Strategy and Infrastructure, DoH 2012).

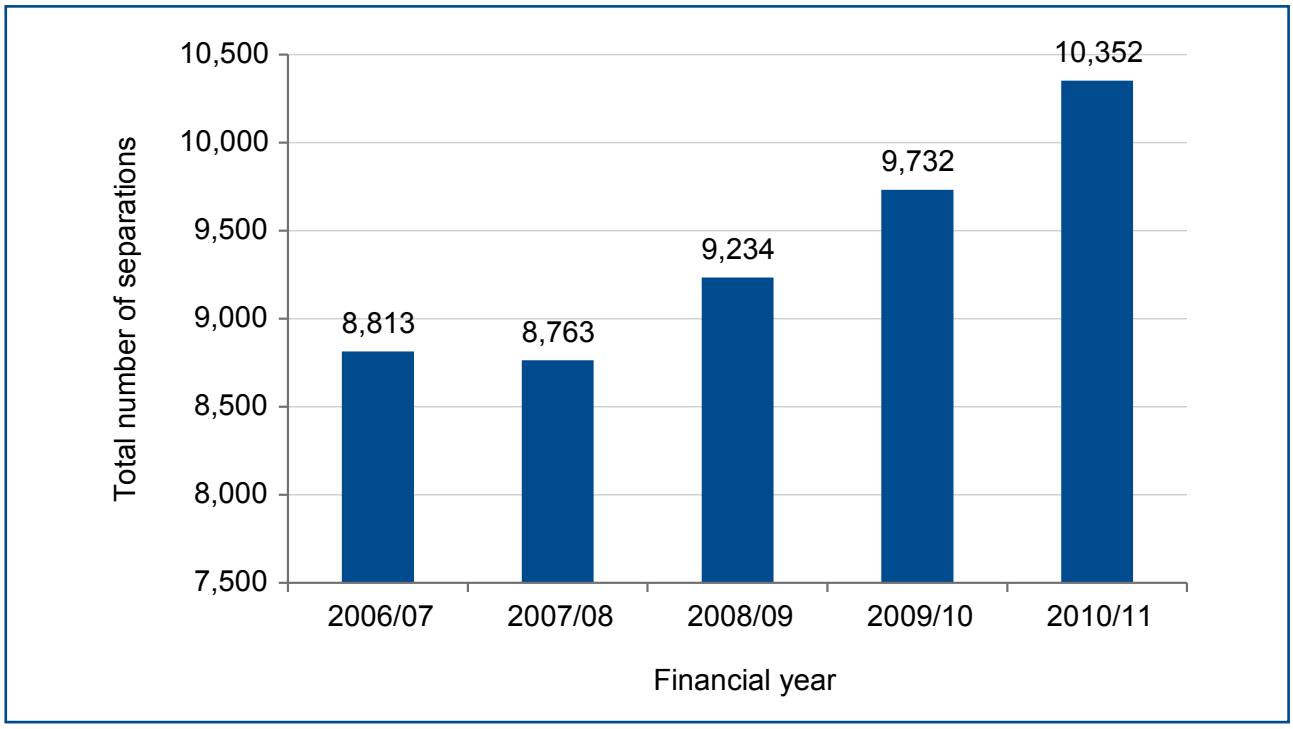
Figure 34 **Number of children and adults admitted to specialist MH services, 2006–11**



Note: A person is only counted once even if treated in more than one facility or frequently in the same facility.

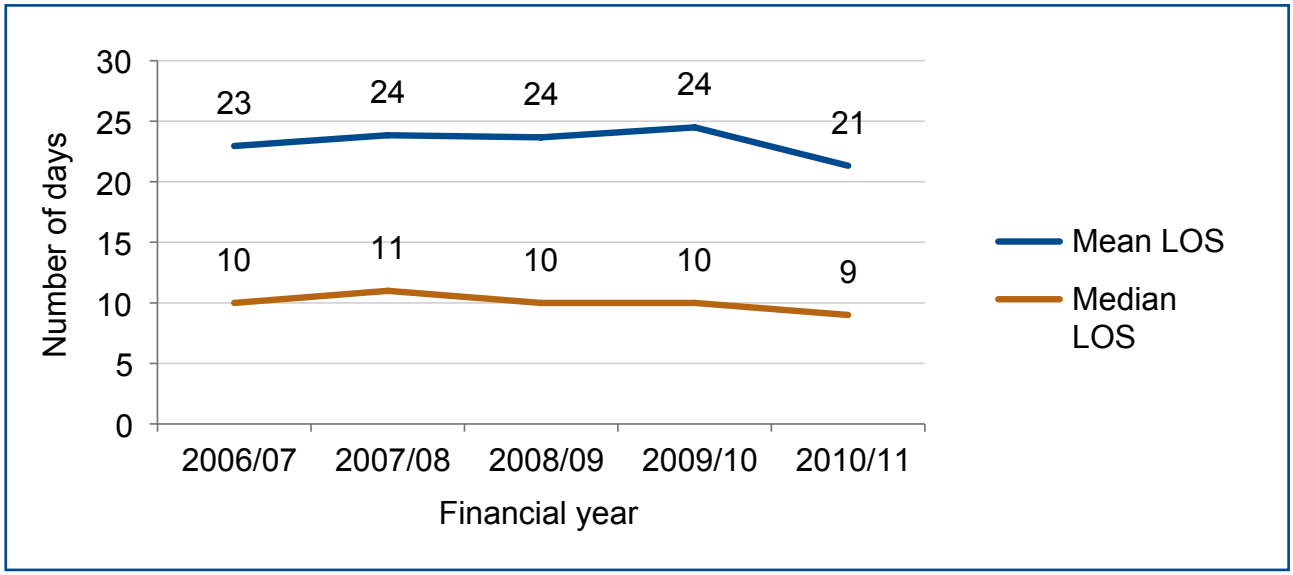
Source: MHIS DoH (2012).

Figure 35 **Total number of separations of patients diagnosed with mental illness from specialist MH units, 2006–11**



Source: MHIS DoH (2012).

Figure 36 **Mean length of stay (LOS) adult specialist mental health units, 2006–11**



Source: MHIS DoH (2012).

This Review underscores the need for mental health services to carefully consider the ramifications of an increasing patient flow in the context of providing best possible patient care. One part of a solution may be (1) addressing the 1.4 per cent readmission rate by boosting community mental health service capacity and (2) focusing on innovative models that target provision of responsive services that aim to prevent exacerbation of illness and inevitable readmission.

Clinicians described the pressure to discharge patients. The patient's treatment and discharge plan are developed in relation to clinical needs. However, when a patient has remained in hospital for two weeks, the treating psychiatrists receive an email reminder from the facility managers indicating the possibility of a prolonged unnecessary stay. This places clinicians under undue pressure to balance the situation between optimal care and bed capacity. Clinicians described many patients being discharged early, and few can be assured they will receive hospital follow-up by the community mental health services in a timely fashion.

Clinicians at every inpatient service described insufficient community accommodation, including step-down units and supportive accommodation, as an impediment to discharging a patient.

In the past five years, bed utilisation has been maximised within specialist mental health facilities. Data recorded in this Review demonstrates that the workload within the State's mental health facilities has increased by 17.46 per cent without increases in staffing or the number of specialist beds. In addition, there are increasing numbers of patients with mental illness admitted within non-specialist public hospitals in WA.

Staff at Graylands acknowledge that good staff, tranquil grounds and open wards benefit the patients' return to wellbeing. Staff said they managed some custodial and complex drug and alcohol patients exceptionally well. However, the wards are inappropriately appointed and are outdated. Patient should have their own rooms and bathrooms. Ward design should enable 'swing beds' and there should be open/closed environment to better meet patients' need for security (for example, the Alice Ward).

See Recommendation 1: Governance (1.1.1); and Recommendation 5: Beds and clinical services plan (5.1; 5.4; 5.5).

3.12.5.1 Involving patients in admission processes

Working towards restoration of self-governance is core to contemporary mental health treatment and rehabilitation. This intention demands the recognition that patients, including those declared legally incompetent, can make autonomous choices and benefit from respectful recognition of their role in self care (Grant & Briscoe 2002).

Nurturing self-governance is an important therapeutic factor in the restoration of a sense of self, including self-preservation and a sense of wellbeing (Holstein 1998). As medication and treatment take effect, the ability for self-governance re-emerges. It is expected then that patients will be politely and respectfully engaged in their care and treatment plan (to the extent of their ability) as an essential aspect of care.

Clinicians explained to this Review that it is not always possible to involve the patient in their care and treatment, particularly early in admissions when their capacity to make decisions is often compromised.

Where patients are able to participate, clinicians discuss care with patients. Clinicians said documenting decisions made with patients was not always completed. However, at one mental health service, clinicians encourage patients to sign their care plan to signify their acknowledgement and agreement.

Clinicians at a number of facilities explained that meetings are held with the patient, family, carers and an assigned case manager early in the admission to discuss care, treatment and an estimated discharge date. This does not happen regularly in all facilities.

During hospital care, some hospitals provide a patient booklet that guides care discussion and education about treatment, discharge and accommodation. An example is in the Wheatbelt where the booklet guides patient education, and specific illness and medication information is added. Discussions about illness management prompted by the booklet occur throughout the inpatient stay.

At Graylands hospital, clinicians involved willing patients in the ward round during a three month trial of this process, that is, the patient joined the treatment multidisciplinary team to discuss their care. This trial was well received and the service has been given executive approval to continue this process.

An innovation at Rockingham hospital is to involve patients in ward rounds where the patients are supported by peer support workers and assist in developing their own discharge plan.

In some facilities when staff perform mental state assessments, they involve the patient and carers when available. They discuss the outcomes with the patient and write a summary in the progress notes.

See Recommendation 2: Patients (2.1; 2.2).

3.12.5.2 Providing care and information to carers

> *It should be that every carer is identified and assessed in their own right and offered education* (personal communication, clinician, South Metropolitan Area Health Service 2012).

The Review notes that national standards for mental health promote that discharge plans are commenced as early as possible in the admission and plans should include information about how to re-enter services and arrangements for continuity of care (National Standards for Mental Health Services 2010, 6.11; 6.12; 10.6.2). Plans also should engage the carer specifically in regards to crises management (National Standards for Mental Health Services 2010, 7.12; 10.6.4). The standards specify links with the patients' primary health care providers and processes to review referrals (9.4). All patients are to be followed up seven days post-discharge (10.6.8).

At most mental health inpatient units, patient's admissions involve both patient and the carer. Clinicians described carers as the first 'port of call' for collateral information about the patient's history. Clinicians said most patients are willing to share information with their family. However, when patients are not, clinicians abide by the patient's wishes, and without divulging information, obtain background information from the carers about the patient.

Some mental health inpatient clinicians recognised that they do not always notify carers of patients' admission and some said they were not good at involving the carers in patient care. At one hospital, the clinicians were also informed by a patient and carer satisfaction survey and they are working toward improving this aspect of care.

The clinicians explained the difficulty of arranging meetings with carers with varying schedule and family circumstances, such as patient estrangement. In addition, communicating with carers is time-consuming and challenging. Clinicians said carers sometimes have expectations of cure and other times insist the patient stays in hospital longer.

Clinicians said carers provide both criticism and praise of the care by staff. Sometimes staff feel harassed by family members who want to 'drive care'' and others threaten to go to the media when their demands cannot be met.

At one rural hospital, clinicians explained patients are often impatient to be discharged and do not want to wait until the scheduled discharge meeting. Staff found it difficult to arrange family attendance during the seven- to eight-day length of stay. Other clinicians claimed that opportunities for family meetings were provided where possible and that both patient and carer's expectations were discussed.

Some inpatient hospitals have social workers who organise family meetings. At a rural inpatient setting, the social worker explained that their focus was on sustaining the patient's housing during hospital care. This sometimes involved feeding the livestock, ensuring rents were paid and encouraging neighbours and family members to assist.

Psychiatrists said they were not always available to speak to carers, especially when they arrive unexpectedly. However, they said they always endeavour to return phone calls when messages are left. This was not borne out in many situations by interviews with carers.

Clinicians explained that all staff use the glassed areas in wards for documentations and handovers, and were aware that the Council of Official Visitors were concerned about staff locating themselves in these areas rather among the patients. Clinicians explained this behaviour is in part habitual as well as a requirement of retaining medical record documentation in a secure environment. The increasing throughput of patients has also increased the amount of administrative requirements for staffing.

The State Aboriginal Mental Health Service (SAMHS) assists patients by involving their traditional Elders to reintegrate the patient back into the community. The SAMHS clinician involves significant others by inviting them to the discharge meetings. The clinician advised the Review that it is less common to see fractured family life in the rural areas; however, there are problems within some families in the towns. Also, where the patient has caused violence within the family, they are sometimes reluctant to be involved, so the patient is assisted to alternative accommodation and care through non-government organisations. Most families have a high level of tolerance and assist in discharge planning and provide the support needed when the patient returns home.

A wellness plan has been trialled in Broome community mental health services early in 2012 The plan identifies a number of family members/carers and is very useful to clinicians because it is patient-driven.

The Reviewer is of the opinion that best practice models of patient and carer involvement in care and discharge plans are not embedded in the clinical practice in all specialist mental health services, and this view was also submitted by a representative of Carers WA. Carers WA advise that:

- clinical assessment tools be developed that are holistic and which routinely identify whether there is a family carer and assess the needs and skills of the carer
- discharge planning should routinely involve the carer and other family members at the earliest possible stage to ensure that they are well prepared to support their family member on discharge from hospital
- as part of the discharge planning, and after an assessment, both the person with mental illness and their family be provided with supported referrals to primary care and other community service providers, including carer-specific services
- that the Prepare to Care program already in place in public hospitals be expanded to mental health services to provide staff with the resources to support family carers.

In addition, clinicians need to be resourced to coordinate meetings with family members, for example, with the assistance of a social worker, social welfare or clerical team member.

See Recommendation 2: Patients (2.12); Recommendation 3: Carers and families; and Recommendation 7: Acute issues and suicide prevention (7.9).

3.12.5.3 Physical and oral health

Patients informed this Review that their physical complaints are sometimes interpreted as mental health problems and they do not always receive treatment for chronic physical conditions.

Physical health is essential to mental wellbeing and regular monitoring and management of physical health is paramount to the wellbeing of patients with mental illness. A psychiatrist informed the Review that the need to address physical care presents an opportunity for mental care services to develop partnerships with physicians and GPs from general health services (see also Lawrence et al. 2001; Morgan et al. 2011). The Review was informed by non-government organisations that the need for physical and oral care is often evident when patients are transferred to community accommodation after long hospital stays.

Physical health requires regular attention because 60 per cent of mental health problems are reduced when physical health is fully investigated and problems treated (Castle et al. 2006). Western Australian studies identified the high level of physical and dental health problems experienced by patients who are also mentally ill (Lawrence et al. 2001; Morgan et al. 2011). Patients with mental illness frequently suffer with comorbid chronic physical conditions such as diabetes and its complications, adverse drug events, chronic obstructive pulmonary disease, convulsions, epilepsy and congestive heart failure (Mai, Holman, Sanfilippo & Emery 2011).

The high risk of developing metabolic syndrome in patients on atypical antipsychotic drugs is a cause for concern about physical wellbeing. Metabolic syndrome is the combined symptoms of abdominal obesity, dyslipidaemia, hyperglycaemia, hypertension, co-occurring type 2 diabetes and cardiovascular disease (Zimmet et al. 2005). To ameliorate risk, patients need to be well informed and existing chronic illness needs to be well managed (Department of Health 2010; Stanley & Laughaurne 2010).

In WA mental health services, assessment and care that minimises the risk of metabolic syndrome is guided by the Department of Health operational directive OD 0288/10 (OCP 20101): Risk of the Metabolic Syndrome Associated with the use of Antipsychotic Medications 2010. Where this protocol is implemented, the syndrome is identified, and preventive processes and care—including lifestyle alteration—are planned for the long term.

This Review was informed that physical examination skills can diminish with lack of practice. Focus on mental health can also overshadow the need for diagnosis and treatment of physical illness. It is also possible that physical complaints are sometimes interpreted as psychosomatic symptoms (Leucht et al. 2007).

In all hospitals, physical assessments are mandatory components of patient admission and ongoing care. Psychiatrists told this Review that they were aware of the need for physical care, including metabolic syndrome screening and prevention. However, this Review found there was extraordinary variability in the arrangements that mental health services make to achieve this. The Reviewer is concerned that physical care is not provided to all patients in mental health services.

Psychiatrists described a number of models by which they can achieve general health care:

Metropolitan area

- In mental health services closely aligned to hospitals, the junior medical officer or resident on the team is delegated responsibility for physical assessment and they have access to the expertise of general hospital physicians and surgeons.
- Some general hospitals provide a physician or registrar dedicated to the mental health unit.
- Other general hospitals provide a medical officer (resident or registrar) to the mental health services each two to three weeks and patients receive physical care by appointment.
- Some mental health services have a resident medical officer assigned to the mental health team who provide physical care.
- Patients are transferred to general hospitals when mental health clinicians do not feel confident to meet patient clinical needs.
- Specialist nursing and allied health programs also can inreach to mental health services, for example, podiatry and diabetes education.

Rural and remote

- In some rural hospitals, GPs and psychiatrists have memorandums of understanding to guide shared-care arrangements.
- In other rural areas, patients are admitted into the care of a GP and the psychiatrist functions in a consulting capacity akin to a shared-care model.
- In rural hospitals where the patient is admitted under the GP, there is not always an awareness of the metabolic syndrome and the Office of the Chief Psychiatrist's guidelines are not necessarily known to the admitting doctor.

To standardise care in metropolitan hospitals, Boulter & Sultana (2012) proposed that an independent medical practitioner could provide objective assessments and promote a habit of regular GP attendance. Advice on this model was provided to the Review by the Intergovernmental Relations and Resource Strategy Department at the Department of Health and included:

- GP would need to be engaged on a salaried sessional arrangement or to be working under a Medical Services Agreement and be credentialled as a Visiting Medical Practitioner. The patient would need to be admitted under the GP.
- Medicare will not pay for medical services provided to public patients.
- The Commonwealth *Health Insurance Act 1973* Insurance Acys 19(2) has prevented states from pursuing a range of initiatives that involve private practitioners delivering services, rather than hospital-appointed doctors. However, there is a possibility that the Commonwealth Minister would grant an exemption to s 19(2) and this would require further enquiry.
- In this proposed model, doctors may need compensation for travel and for the State to top up payments for the GP since GPs may only be able to bulk-bill the patients they examine. Unfortunately, the Commonwealth will not accept service volume related payments and this would prohibit the most practical way for the State to contribute to the services that a GP would deliver to a mental health patient in the inpatient setting.

The physiotherapist services at Graylands focus on physical wellbeing. The sense of physical wellbeing is believed to positively influence mental health. A healthy lifestyle program involves dealing with weight gain, a frequent side effect of psychotropic medication, spinal pain and improving fitness. The program includes metabolic screening.

Oral health

Good dental health contributes to a healthy appetite and general wellbeing. Therapeutic drug reactions can include periodontal disease or disability, and this affects oral health and increases cavities and other oral infections (Boulter & Sultana 2012). Clinicians should watch for therapeutic drug reactions and ensure patients receive regular dental care.

In some mental health facilities, public dental clinics are colocated, and others have dental clinics nearby. In these situations, some mental health services have arranged for patients to be treated as a priority during their hospitalisation. Patients receiving mental health services in the community are encouraged to seek private dental treatment since waiting lists for public services are long.

Public dental services are limited to treating urgent problems. A gap was identified in essential routine dental checks and preventive dentistry for public patients.

Hospital protocols in line with metabolic syndrome guidelines would assist attention being drawn to the metabolic syndrome in general hospitals.

Patients would benefit by regular general physician consults. Formal arrangements are needed between mental health services and a general hospital or the patient's GP to enable regular medical care and specialist nursing and allied health services (e.g. diabetes education, continence advice, podiatry).

Regular dental care should be included in treatment plans to address the needs of patients with self-care deficits in dental hygiene.

See Recommendation 2: Patients (2.7).

3.12.5.4 Medication management

Clinicians informed the Review that a patient's return to mental health and wellbeing was influenced by three major factors: (1) a safe environment, (2) medication, and (3) recovery programs. Pertinent consideration in medication compliance requires patients to be provided with information and education, in particular about the effects of medication changes, rapid cessation of regimes, and titrating (adjusting the dose of) medication to control side effects. With understanding of the expected mood and thought responses, patients can prepare themselves and make informed decisions about compliance. Ensuring patients receive adequate supplies of medication on discharge to continue treatment until their next doctor's appointment is also essential.

Patient compliance is complicated by their sense of wellbeing. Clinicians said when patients make a recovery they are 'grateful' and have better capacity to manage medication side effects. However, when they are 'really well', their hospitalisation becomes a distant memory and some think they no longer require medications.

Medication side effects can affect a patient's ability to work and drive safely. Many drugs can be altered to slow-release forms and dosage can be titrated to maximise effectiveness without compromising patient safety. When patients are medication naive, clinicians carefully observe effects and side effects and psychiatrists adjust doses to minimise ill-effects. However, rapid discharge from hospital often leaves titration incomplete.

A survey undertaken at one mental health service alerted clinicians that patients need more information about medication and are sometimes confused by generic medications. The different names for the same medication are often mistaken for an additional drug. These situations must be addressed by education via pharmacists and mental health clinicians.

Psychiatrists explained they do not always communicate information about medications well; however, they do present treatment options to patients.

In some inpatient units, the ward pharmacist assists by reconciling the patient's medication regimes. At some mental health services, each pharmacist is responsible for 35 acute beds or 40 rehabilitation beds for whom they review patients' medication regimes and provide consultation to psychiatrists. In such services, pharmacists are involved in discharge planning with the multidisciplinary team and provide patients with medication information and education in preparation for discharge.

In addition to the pharmacy input and at hospitals without an onsite pharmacist, mental health clinicians, such as the discharge coordinator or nurses, discuss and inform the patients about their medication management.

Discharge

The amount of medications dispensed at discharge is determined by the psychiatrist and most patients receive a five to seven day supply. If the patient can manage medications safely, PBS quantities (one-month supply) of discharge medication is dispensed, that is, in all hospitals except Fremantle and Rockingham.

Clinicians were concerned that patients with one week's supply might not be reviewed by the community mental health services in time to renew scripts. In the Midwest, the health services pay for and pick up medication to assist patients in the community with treatment compliance.

A caller who wished to remain anonymous expressed concern about medications used in mental illness to this Review. The caller was concerned about side effects, such as increasing suicidal thoughts, increased drowsiness and the interactions of medications such as analgesics. She said the high reliance on medication within the current system directs expenditure to pharmaceuticals rather than to therapeutic recovery programs.

A number of clinicians explained there should be pharmacy policies and procedures aligned across the inpatient setting.

See Recommendation 2: Patients (2.5; 2.6).

3.12.5.5 Patients on leave

During hospitalisation, patients may attain authorised leave by members of the mental health team, if their care plan reflects 'leave' as a component of care. Otherwise, a request for leave is referred to the psychiatry consultant who assesses the patient before determining if leave should be granted.

The *Mental Health Act 1996* s 59 stipulates the conditions of leave for involuntary patients and, although unlegislated, similar considerations are given to maintaining the safety of voluntary patients. The requirement for medically determined leave includes situations where patients will be escorted by an experienced mental health nurse or nurses within hospital grounds (escorted leave).

When a patient is on a secure ward, risk assessments are completed before patients leave the grounds. However, the regular mental state examination is considered sufficient to enable leave for patients on open wards (*Graylands Hospital Policy and Procedure Manual* CLIN51, R/V 2010).

Where service providers or family members are escorting the patient, they are advised of any identified risks. Authorisation is documented in the medical record notes, along with the permitted duration of leave, action plan for the event of the patient failing to return, and time of leave and return.

If clinicians are concerned about the patient's risk, leave is denied and staff contact the psychiatrist for a medical review.

If unplanned leave occurs (if a patient leaves the ward without permission), some hospital protocols indicate that the next of kin and police are notified.

This review found that policies and procedures for the granting of leave were inconsistent across the mental health system. Given the legislative requirements to protect the patient or any other person (*Mental Health Act 1996* Pt 3 Div 1 s 26), risk assessments should be undertaken when patients request leave and at the time of leave. Notification to family members is essential when patients take leave without permission.

See Recommendation 1: Governance (1.1.2; 1.1.3; 1.1.4; 1.1.5); Recommendation 2: Patients (2.9); Recommendation 3: Carers, all, in particular (3.8); and Recommendation 7: Acute issues and suicide prevention.

3.12.5.6 Rehabilitation

> *The vision and intent of mental health service in Australia is "... – a mental health system that enables recovery that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to fully participate in the community" (Australian Government 2009 p. ii).*

A clinical director informed the Review that the acuity of patients in inpatient services requires an intensive-care approach and the focus of care is less on rehabilitative or restorative care. A number of rehabilitative programs are delivered within inpatient and community mental health services, and others are delivered by non-government organisations in the community. Rehabilitation programs include increasing patients' functional skills and education, together with discussion focused on helping the patients to understand and manage their mental illness.

Clinicians informed the Review that increasing demand on acute care drains existing resources and they are forced to focus on severe and persistent mental illness.

In Rockingham, the rehabilitation support program provides maximum support at various stages of illness in the intensive day therapy unit (IDTU). This program is led by a consultant psychiatrist and extends to the psychosis and rehabilitation team who provide comprehensive community follow-up. The IDTU program enables earlier discharge because it can deliver sub-acute management, and patients who are destabilising in the community can be referred directly. Patients can also be referred directly to the program by their GP.

The IDTU programs include psychiatric education, medication follow-up and patients' progress reviews. Therapy includes learning new living skills, such as cooking and woodwork, relaxation, anxiety management, mindfulness, art therapy and behavioural education.

As of June 2012 this program had not been formally evaluated, other than by patient satisfaction surveys. The case-management culture of the program enables intensive management to be continued during community mental health service care. More often, when the sub-acute care is complete, the patient is referred back to the treating community mental health service.

Integral to the IDTU program is the consultant psychiatrist's attendance with the patient at their GP appointment. During this appointment, the psychiatrist undertakes a patient assessment with the GP, and discusses the discharge outcomes and treatment plan. The program thus enhances the GP's confidence in managing mental illness and the patient's transition to community services.

Inpatient rehabilitation is provided at Graylands hospital. The recovery program involves the Clinical Rehabilitation Services, community services and GPs. The Clinical Rehabilitation Services Clinical Model (2011) was launched in 2009 and targets the high use – high resource patient with chronic psychosis, conditions that are least responsive to treatment.

The clinical rehabilitation framework targets patients in the community with complex needs and major functional disability, including those suffering from a severe and persistent mental illness such as schizophrenia, psychotic disorders, bipolar disorder or comorbid substance abuse. Patients who do not respond to the program within 18 months are transferred back to the clinical treatment team. The expected caseload for individual clinicians is 12–15 patients based on acuity, clinical intensity and needs.

The clinical rehabilitation services model works with patients to develop their sense of self-efficacy, personal support systems and independent living within their chosen community (Bromwell 2011). The model involves patients and carers and includes the development of strategies to ameliorate the development of crises and to manage crises when they occur.

Needs are identified by the patient and clinician using the Manchester Care Assessment Schedule (MANCAS). 'Need' is defined as a circumstance with a potentially remedial cause which requires external intervention to stabilise or improve functioning and which, if not provided, will lead to functional deterioration.

The model involves assigning each patient a case manager, patient-involved goal setting, a pathway with clear delineation of responsibilities, and patient-involved evaluation and adjustment of goals (Graylands hospital 2011). Success is defined by the patient's ability to manage in the community. For example, a forensic patient currently on the program is living in their own unit for five days a week with support from Graylands outreach and community mental health services.

The rehabilitation model requires a specific focus that differs from acute care. One of the difficulties with the rehabilitation program in Graylands is that acute and rehabilitation patients are colocated on wards. Acutely ill patients in the same ward can be disruptive to other patients and require time-intensive care by staff, leaving less time to focus on patients' rehabilitative needs.

A number of community rehabilitation models are offered at Alma Street Centre. They include:

- assertive community mental health service teams who provide intensive rehabilitation in the community with occupational therapy and social work. The teams include a clinical psychologist and mental health nurses
- patient-centred group programs, which are available post-discharge, that teach patients about managing their conditions and life skills to provide a toolkit to manage illness. These programs are not inclusive of family or carer training
- active case management of patients, including teaching patients and carers how to manage the illness
- occupational therapy in the community to teach patients new living skills in an individualistic, patient-focused and symptom-focused model.

Living Skills programs are integral to mental health services in WA. Staffed by occupational therapists and social workers, rehabilitation assistance programs focus on leisure; social skills and self care; cooking and physical health; computer-based clinical information and education programs; art therapy; self-esteem groups; and getting back into work. Some training programs are provided in partnership with non-government organisations, such as the Salvation Army and private employers, who create voluntary employment opportunities.

The team at Armadale is particular proud of the HORIZONS program for which they won a WA 2011 Mental Health Good Outcomes Awards from the Mental Health Commission and presented at a conference in London.

Clinicians concerns

- Clinicians informed the Review that more rehabilitative services are needed within the mental health system. For example, there are no rehabilitative services or step-down units at Kalgoorlie. In addition, non-government organisations are relied upon to provide rehabilitation in the Wheatbelt.
- Clinicians identified that more allied health staff are needed to provide rehabilitation in the inpatient setting.
- Peer support and mentoring provide some assistance in home care programs but are not sufficient to promote recovery. There are no occupational therapists in some hospitals and community health services.
- Further, clinicians are concerned that many of the workers in non-specialist services are not trained in mental health. Rehabilitation in a clinic or central place might seem optimal. However, many patients in the rural environment would need to travel 250 km or more to enable attendance.

Clinical psychologist group programs should also be available in the community for carers and family members to learn how to care for their mentally ill relative.

In 2012 the WA Association of Mental Health (WAAMH) also recommended step-down (sub-acute/slow-stream rehabilitation) beds within the hospital to enable patients to develop relationships with community services and transfer into appropriate accommodation on discharge.

See Recommendation 1: Governance; and Recommendation 7: Acute issues and suicide prevention (7.9).

3.12.5.7 Discharge from hospital and community mental health care

Discharge is an important phase of hospital care, and the transition to community requires careful planning to ensure the patient feels safe and supported to continue their treatment. Patient vulnerability at the time of discharge must be acknowledged and services, including emergency telephone numbers, put in place to support their transition. Care is a continuum across inpatient and community-based care and the shortened length of hospital stays require teams to be well integrated across all care settings, including GPs, private sector psychiatrists and hospitals.

Ideally, a single case manager for each patient ensures care is coordinated across the continuum. Clinicians informed the Review that this is not always possible and patient management is triaged and redeveloped at each service interface. In addition, a number of patients' care needs cannot be met in the community.

The Mental Health Commissioner told the Review he is concerned about the insufficient support and accommodation available on discharge. The preparation for successful discharge includes social considerations, such as housing, nutrition needs and social support. Clinicians said some families appear unwilling to take the patient home when they are themselves not fully recovered from the pre-admission events.

Armadale clinicians reflected that the more experienced a clinician is, the more successful the discharge was likely to be. Clinicians at two hospitals described a discharge-coordinating role that efficiently coordinates discharge plans.

Clinicians explained to the Review that it is standard practice to discuss discharge plans with the patient as soon as they are well enough to engage. Mental health services notify GPs of the patient discharge by letter and invite the GP to refer the patient back for further psychiatric involvement if required. This communication sadly does not always occur.

The Review found that all services provide patients with emergency telephone numbers and the name of the service to which they are referred. The standard information includes how to return to the hospital if they need to.

In preparation for discharge, clinicians at a mental health service said patients are encouraged to have a period of leave with their carer and provide feedback to the inpatient team before a final discharge date.

A particular challenge for metropolitan hospitals is linkage with services for patients from 'out of area'. Hospital staff said they need to create therapeutic alliances with the patients' local services to enable follow-up and ongoing treatments. This sometimes proves difficult.

Some specialist mental health hospitals are linked to multidisciplinary teams in community mental health services and discuss patient progress weekly. For example, at Graylands hospital each community mental health service links by video/teleconferences at the patient progress meetings. These discussions with peers include management plans, patients who require community treatment orders, and patients in the community who may be impending inpatient admission. Case managers from the community mental health services follow up patients at Graylands and are involved in weekly discussions about discharge plans.

Clinicians informed the Review that even with this level of communication there continues to be poor relationships between inpatient and outpatient services and delays in discharge and medication information.

To determine discharge readiness from a community clinic, community mental health services consider the patient's dimension of change (e.g. if their clinical assessment HoNOS score is less than 20) when considering discharge. They discuss within the multidisciplinary team whether the patient can manage without specialist services and consider if the patient can maintain their employment and attend their doctor regularly. There is usually a three-month lead-up to discharge.

Discharge summaries are completed for all patients. Currently, at one hospital 70 per cent are completed within seven days of the patient leaving hospital. The summaries contain the essential information necessary to continue treatment in the community, including medication regimes that are usually posted/faxed to the GP and the community mental health service. The Review was informed that two years ago discharge summaries arrived at the health service on the day of discharge but since the introduction of electronic discharge summaries they are often delayed beyond their usefulness.

Even when discharge summaries are completed by the resident before the patient goes home, they must be checked by a registrar and signed by a consultant. This process can create a time lag of a week and interim summaries are not sent.

This is not timely and interim discharge information should be given to the patient and sent to the GP on the day of discharge.

Many patients are discharged without a follow-up appointment with a community mental health service and, despite the requirement of being seen within five to seven days of discharge, this often does not occur. Some health services wish to re-triage the patient before agreeing to review them and their treatment plans. The Reviewer believes this is unacceptable but understands it occurs because of high caseload. One health service reserves daily two places for assessment of acute or discharged patients. This is to be encouraged.

See Recommendation 2: Patients; and Recommendation 7: Acute issues and suicide prevention (7.2; 7.3; 7.4; 7.5).

3.12.5.8 Hospital follow-up

A number of innovative programs, such as early discharge programs, Mental Health in the Home, the Primary Care Liaison role, and SHACC (Self Harm and Crises Counselling), assist patients in the transition from inpatient to community care. Hospital programs such as these meet patient needs until community mental health service care commences.

Joondalup

Joondalup hospital is also keen to develop a Hospital in the Home program for patients with mental illness. Such a service could decrease the demand on inpatient beds and provide timely community support for patients.

Joondalup Hospital clinicians follow up patients post-discharge to ensure the GP is aware of their discharge and to prompt medication compliance.

Royal Perth

The discharge follow-up from RPH is a six-week transition service, where the patient attends clinic as an outpatient and receives monitoring by a case manager. This service attempts to bridge the gap between discharge and commencement of community mental health services. However, it is restricted to a limited geographical area.

Rockingham

The community mental health service team at Rockingham includes a brief intervention officer, who follows up patients who have presented to the ED and ensures they have attended their appointment with their GP. However, community mental health services are not always notified when patients are admitted or discharged from hospital; when they are aware, they see the patient within five to seven days. Lack of notification occurs most often when a patient's discharge date has been changed.

Sir Charles Gairdner

The Mental Health in the Home program at Sir Charles Gairdner Hospital has four virtual beds, with 3.5 FTE providing care seven days a week. Patients in these programs receive care in their home to stabilise acute phases of their illness, include clinical psychology, and link patients to other services such as Centrelink. Clinicians explained the current demand indicates a need for eight beds. The service is limited to Osborne Park, Subiaco and Mirrabooka and operates between 8.30 am and 9 pm. After-hours care is therefore dependent upon emergency services.

Community mental health services must bypass their triage process when patients are transferred between mental health services and provide appointment times to the referring services and patient on request, especially for patients discharged.

Interim discharge summaries with treatment plans and medication regimes should be made available on PSOLIS and at the treatment clinics to which the patient is referred at the time of discharge.

The patient should be given a copy of the discharge summary when they are leaving the hospital (ARAFMI).

The Review heard from parents, forensic community mental health services, prisons, members of the Western Australian Mental Health Association and mental health clinicians that patients are sometimes discharged from facilities when they have no place of residence.

See Recommendation: 1 Governance (1.2); Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.

3.13 Community mental health services – adult

> *Gaps in service availability and access mean that there are still too many people for whom the experience of care is not a good one, and who slip into crises before getting help* (Auditor General's Report on Adult Community Mental Health Teams 2009).

Since the 1970s, there has been a shift away from institutionalised care and mental health care is increasingly provided in the community (Doessel et al. 2005; Lawrence et al. 2001; Smith et al. 2011a). The first outpatient clinic in WA was opened in 1956. The vision for community mental health services is to extend the traditional stand-alone outpatient clinics to become integrated services delivering case-managed mental health treatment and tailored rehabilitation (Lawrence et al. 2001).

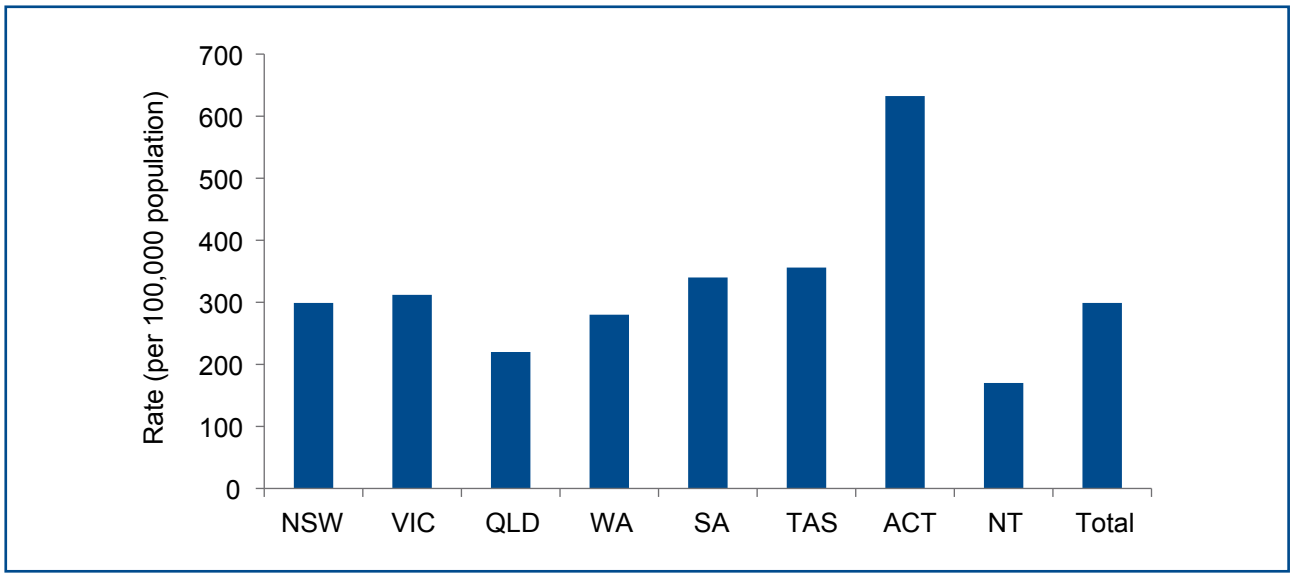
People with mental illness need assistance in the community to:

- continue treatment
- monitor side effects of treatment
- interact with family and friends
- look after themselves
- obtain and keep employment
- obtain and keep accommodation
- obtain specialist hospital care when their illness gets severe
- secure protection from homelessness and crime.

The challenge for community mental health services is to provide a coordinated approach with non-government organisations to enable optimal community service of treatment, rehabilitation and independent management.

In Australia, 336,000 persons received 6 million contacts in 2008–09, an average of 17.86 occasions of service per person (Australian Government 2011a). The mean number of service occasions in WA is 16.87 per community mental health patient (Australian Government 2011a; AIHW 2010 see Figure 37).

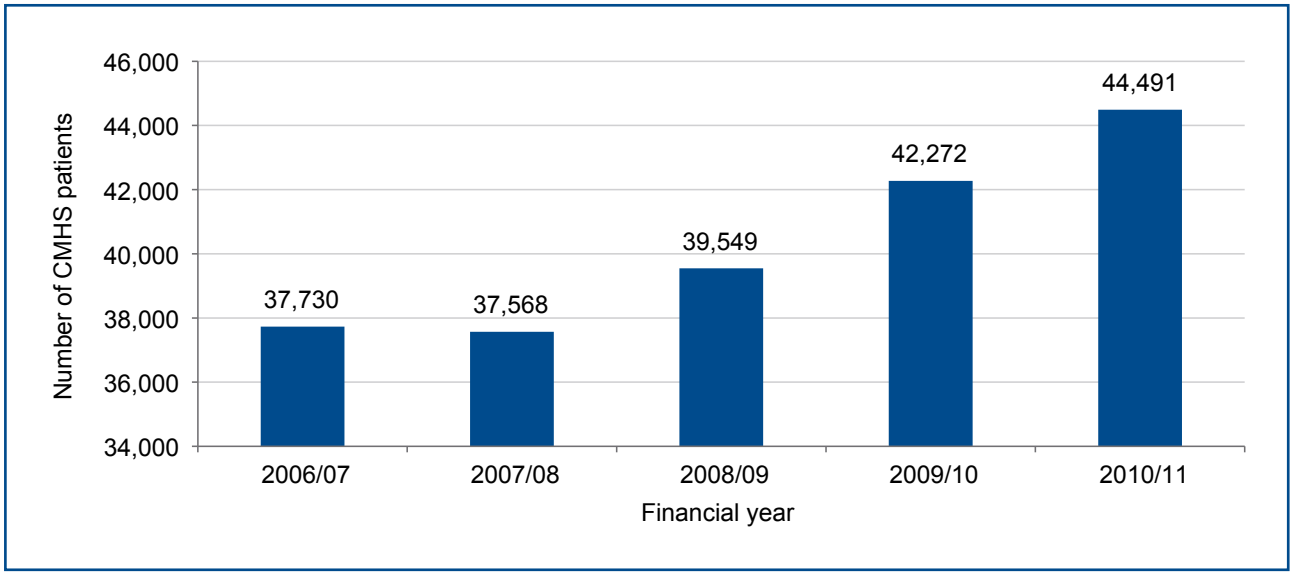
Figure 37 **Occasions of service per 100,000 in community mental health services, Australia, 2008/09**



Source: AIHW (2011).

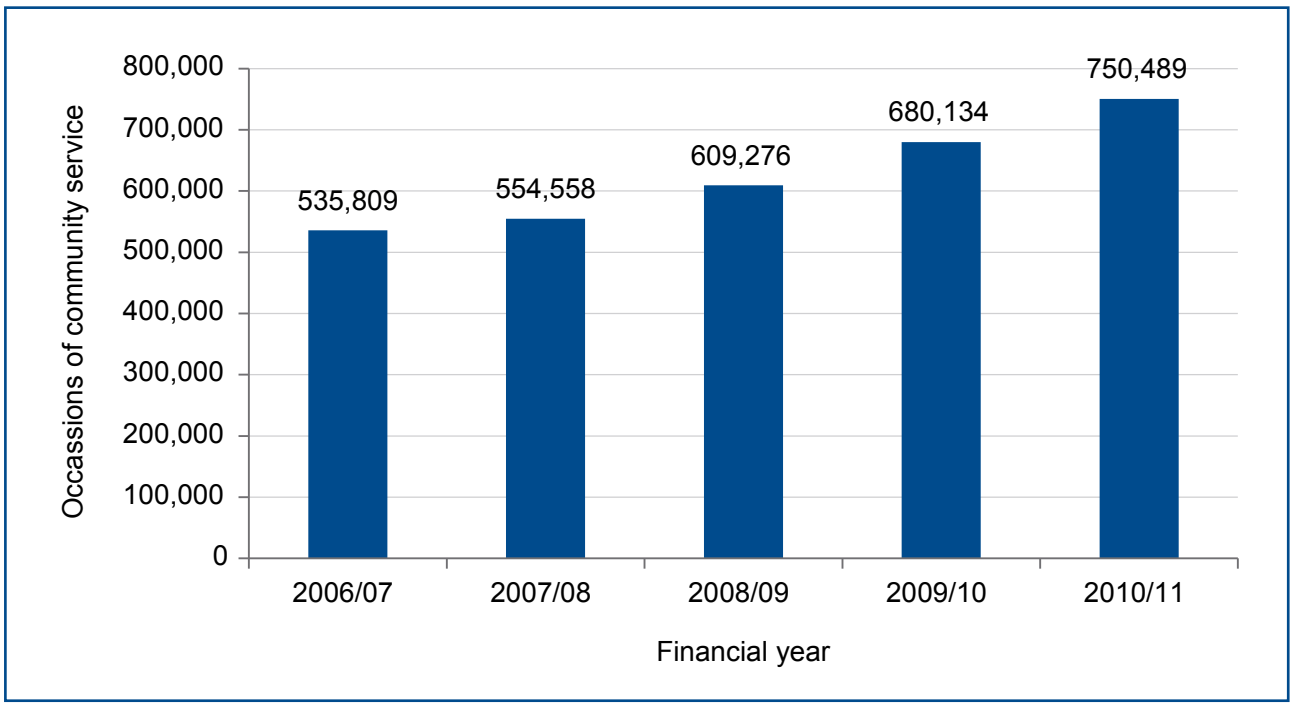
In WA, 44,491 patients received 750,489 contacts during 2012–11 (MHIS 2012; Figures 38 and 39). As one clinician told the Review, there are increasing rates of presentations to both inpatient and community health services. Community mental health service activity has increased substantially during the past five financial periods. There are now 17.91 per cent more patients receiving 40.06 per cent more occasions of services (see Figure 38).

Figure 38 **Number of community mental health service patients WA, 2006–11**



Source: MHIS DoH (2012).

Figure 39 **Number of occasions of service in community mental health services WA, 2006–11**

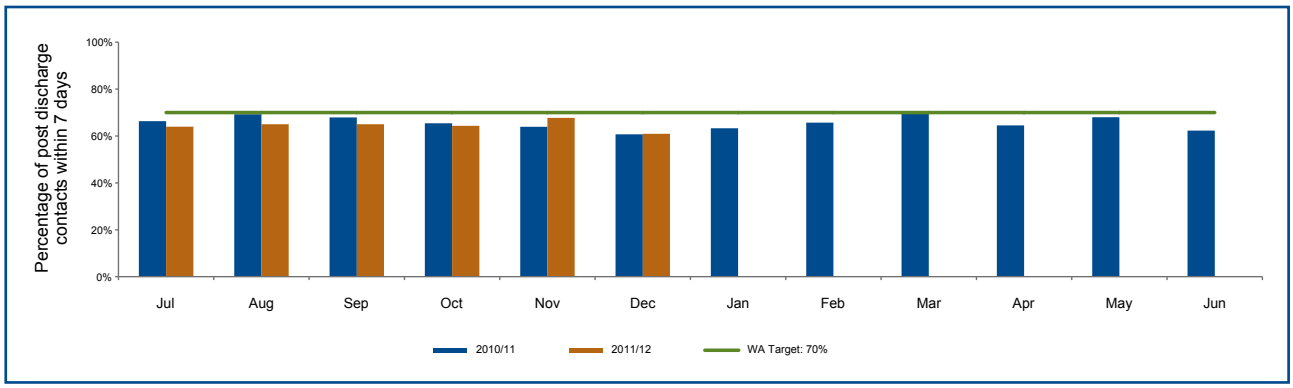


Source: MHIS DoH (2012).

3.13.1 Post-discharge follow-up

Patients can access community mental health services directly from the community and by referral after an episode of inpatient care. Post-hospital follow-up is an important national efficiency indicator measuring the continuity of care between hospital and community mental health services. The current target is for 70 per cent of patients to be followed up within seven days (Government Budget Statement 2011–12). Figure 40 illustrates Western Australia's performance against this target has not improved significantly.

Figure 40 **Post-discharge follow-up within 7 days by community mental health services, 2010–12**



Notes: Please note that data is preliminary and not fully complete due to coding delays. Historic data has been updated in the current report.

Data does not include patients referred to the private sector.

Source: MHIS DoH (2012).

In an effort to improve this aspect of the system, specialist mental health hospitals have employed discharge liaison officers and developed other outreach programs to achieve more timely and specialist follow-up.

Clinicians at one community mental health service explained that the duty officer at triage gives priority to post-hospital follow-up and assigns referrals directly to the psychiatric consultant. That health service achieves follow-up within five days for all post-hospital patients.

These efforts are set to improve the mental health system's ability to meet nationally agreed targets, improve the system of care and improve the experiences and outcomes for patients.

See Recommendation 1: Governance (1.2); Recommendation 4: Clinicians and professional developement (4.7); and Recommendation 7: Acute issues and suicide prevention (7.5; 7.10.4; 7.11.4).

3.13.2 CMHS clinics and home visits

Community mental health services are provided by outpatient clinics and home-visiting services. Patients are deemed eligible for service by the mental health triage process described in Section 3.12.4. To receive community mental health service, the patient must have a residential address and therefore accommodation is a primary concern at the time of hospital discharge. The CMHS teams comprise a multidisciplinary team of social workers, welfare officers, nurses, occupational therapists, psychologists, consultant psychiatrist and psychiatrist in training.

Clinicians informed the Review that care is often short term and targeted to patients with severe illness. When a patient's conditions stabilises they are referred to their GP for ongoing management.

Lack of certainty that the patient would receive timely services was an expressed concern of clinicians and GPs who referred to community mental health services. Referring clinicians also said they did not always receive feedback on referrals and this exacerbated their uncertainty. The Medical Records Audit undertaken by this Review also indicated that feedback is not always provided to the referrer.

To achieve improved patient transitions, integration between mental health hospitals and community mental health services needs to occur, along with the development of protocols and policies that align across transition points.

The Review was informed that intense caseloads and limited staffing within community mental health services has limited patient access and the intensity and longevity of service provision. One psychiatrist informed the Review that staff work in a reactive rather than proactive mode 'putting out fires' and often referred deteriorating patients to hospital.

All community mental health services have waiting lists and these vary from three weeks to 12 months. At one CMHS, 73 per cent of the referred patients are assessed within two weeks and this is a comparably good outcome.

The caseloads of community mental health services vary between 160 and 700 patients at a time, and each psychiatrist can expect a case load between 34 and 60 patients.

Clinicians said that ideally all hospital referrals for community services should be accepted before discharge and a case manager assigned. The case manager could then inreach into the hospital to meet the patient and participate in discharge planning. In most teams, the patient is allocated a case manager after the triage process. The case manager engages with the patient, monitors their care, and fulfils administrative tasks, such as patient registration, scheduling review meetings, and patient documentation.

Most patients attend CMHS clinics to receive care. When patients are too unwell or have difficulty with clinic visits, clinicians visit them in the community. Most home visits are undertaken by a single staff member and, where safety is a concern, by two staff members.

Most psychiatrists see 20 per cent of patients in the patient's home and 80 per cent in the clinic. This proportion is reversed for community mental health nurses. Nurses visit 80–90 per cent of patients in the patient's home and see 20 per cent in the clinic.

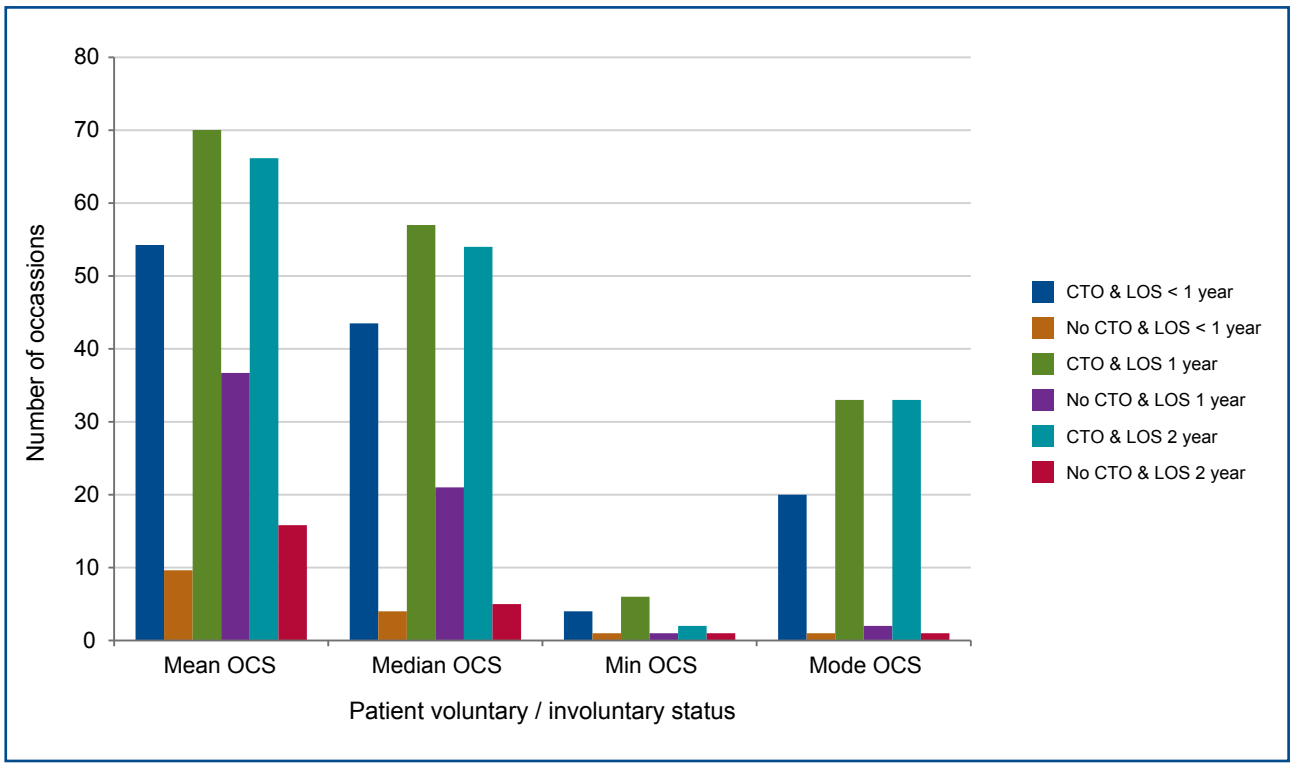
During the community visits, the clinicians involve family, when available, in care planning and interventions in accordance with the patient wishes. Contact with family continues through telephone calls and CMHS staff informed the Review that they most often have good relationships with the patients' families.

When a patient is referred on a community treatment order (CTO), the referring psychiatrist speaks directly with the receiving psychiatrist and discusses patient treatment. Community appointments are scheduled before the patient is discharged from hospital, and there is confidence that the patient will receive community treatment.

For these CTO patients, community mental health services ensure appointments are attended. When patients are on CTOs and do not arrive for appointments, the health service conducts a home visit and attempts to contact family to locate patients. In these situations, the CERT team are also alerted and continue the attempts of follow-up after hours. It is rare that patients on CTOs are not able to be followed up.

Figure 41 illustrates that patients on CTOs receive more occasions of service than voluntary patients. Voluntary patients are likely to receive an average of five to 10 occasions of service in a year.

Figure 41 **Length of stay (LOS) in community mental health service CTOs and non-CTOs 2011**



Note: CTO = community treatment order (involuntary status); OCS = occasions of service; LOS = length of stay

Source: MHIS DoH (2012).

Missed patient appointments

Clinicians remarked that in addition to scheduled appointments, community mental health services respond to urgent calls and new admissions as assigned by triage. To achieve this, current appointments need to be rescheduled. However, systems to inform patients of changed appointments are insufficient and sometimes do not occur, thus disrupting treatment. Therefore, metropolitan community mental health services have extended their ability to provide an emergency response without interrupting regular appointments.

This improvement occurred in response to an audit by the Auditor General (2009). That review observed that 'Mental illness can diminish a patient's capacity to access the services they need' and successful models will reach patients innovatively and locally (Auditor General 2009). Metropolitan community mental health services have increased the number and availability of services by augmenting assertive and emergency response teams.

For example, Rockingham CMHS includes an 'on-call team' who are available to provide same-day services for urgent referrals. In addition, the community mental health services at Rockingham and Peel leave emergency slots in their schedules so that the psychiatric liaison nurses in the emergency departments can make appointments directly into their diaries (this enables the patient to receive a clear plan of care before they leave the ED). This emergency response is similar to the added capacity recently commenced in the North and South Metropolitan Health Areas and the ACIT team at Princess Margaret Hospital to manage urgent visits. With these systems, scheduled patient appointments are not interrupted.

Variation in service provision

Community mental health services vary in size and governance:

- Some provide psychiatric liaison in local EDs.
- Some provide mental health support to GPs for patients in crises, that is, the emergency team attend the GP rooms in addition to providing phone advice.
- Some provide programs of carer education and training.
- Some are colocated on hospital sites and this eases communication, improves patient flow and provides access to services and information, such as laboratories and pharmaceutical support.
- After hours, most adult community mental health services extend services to children and adolescents.
- In rural areas, where specialist occupational therapy, physiotherapist and social workers are not part of the CMHS, these specialties can be accessed from the general hospital, when needed.

Similar to the Auditor General's Report, this Review was informed that community mental health services were crises-driven and provided variable services. The Auditor General's review (2009) identified the need for strategically planned community services, standardisation of service types, innovation, service coordination and improved quality and risk management processes.

This Review also found fragmentation between mental health services. The fragmentation frustrates ED and hospital staff who are not confident that patients will receive continuity of care and treatment after hospitalisation. More importantly, patients and families are uncertain if treatment will continue to be provided as they are moved across care settings.

In the opinion of Mirrabooka community mental health service clinicians, colocating with a hospital would improve the interface between inpatients and community mental health service, foster mutual understanding, and encourage innovative practice. Neither Osborne Park nor Mirrabooka community mental health services have integral relationship with any inpatient service and expressed difficulty in obtaining discharge information and in locating an inpatient bed when patients require admission. They perceived themselves as a nuisance to the inpatient services and the psychiatrist explained that they carry a lot of risk without the support of clinical governance.

By contrast, community mental health services located on hospital grounds are well integrated to the health systems. To enable continuity of care, clinicians from those community mental health services attend ward and the psychiatrists communicate directly with one another. Some psychiatrists provide continuity of care by sessions in both inpatient and outpatient settings.

Offsite community mental health services attend team meetings by video-link, and this method is also used to link rural and remote services to metropolitan specialist services.

The links are important to continuing care. For example, discharge summaries are needed by the community mental health services within 14 days in order that prescriptions can be completed and treatment regimes maintained.

Clinicians in hospital-based community mental health services have access to the inpatient electronic discharge summary. Where services are not colocated, clinicians said that ensuring good communications requires continuous efforts. One psychiatrist explained how he made efforts to visit the inpatient setting intermittently, and this has developed relationships and improved the timeliness of discharge summaries.

Currently, private mental health services do not have access to PSOLIS, and inpatient care information is therefore not available to other components of the mental health system. Without formal interconnectivity, information flows are impaired, as demonstrated by the difficulties experienced by community mental health services and private mental health services. With no community mental health service involvement in discharge planning at the hospital and minimum discharge summaries limited to nursing information, continuity of care is challenged. To bridge the gap, the community mental health service contacts the inpatient services to receive verbal patient discharge information. Communication could be improved if private hospitals used the same information systems as the public mental health system.

Some CMHS clinicians expressed concern that they could not always provide recovery support because they were continuously managing crises. Recovery programs are frequently provided in step-down units and non-government organisations provide rehabilitation programs.

Community mental health services function optimally when they are integrated with mental health inpatient services. In the opinion of the Reviewer, they need to be better integrated with inpatient services as well as preventive and recovery programs provided by non-government organisations.

Recommendation: 1 Governance (1.2); Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.

3.13.3 Public mental health services step- down units and short-term supported accommodation

> *Integration of patients with mental illness into the community is not something that can be bought. It requires a whole of society acceptance and industry support* (Health and Disability Services Complaints Office 2012).

Clinicians and community providers informed this Review that the roles and functions between mental health services and step-down units are clear and communication is smooth. The same is not true between these mental health services and long-term hostel accommodation.

There is a statewide rehabilitation facility at Hampton Road in Fremantle for patients with significant functional decline. The facility provides respite and rehabilitation. Patients have a community-based (CMHS) case manager and a discharge plan before entry. The unit is staffed 24 hours a day by nurses and therapy assistants. Staffs of the CMHS and the step-down unit communicate throughout the care episode in an effective and professional manner.

Local community mental health services also provide inreach and case management to step-down units managed by non-government organisations (NGOs).The health services and NGO providers operate in concert in a network of patient support. The health services provide mental health treatment and care planning and the NGO provides patient assistance with activities of daily living, rehabilitative programs and hostel services.

The health services case manager (or liaison workers) visits the patient in the accommodation regularly to monitor progress and attend weekly meetings with NGO staff and to discuss patient progress and guide practice. Some health services also meet regularly with the managers of the NGO accommodation to ensure inter-agency relations run smoothly.

For example, at the Armadale step-down unit Graylands clinicians provide clinical governance for the first three months of patient transition and then refer the patients to the Armadale community mental health services for ongoing management of their mental health. The CMHS nurse operates as the case manager and works closely with the psychiatric teams at Graylands during the transition period, and meets weekly with the NGO staff to resolve patient management issues such as behaviours and risk-management strategies.

It is the opinion of the Reviewer, step-down units are an essential element in the mental health system and future clinical services plans must ensure that sufficient step-down units and supported accommodation is available within each region to meet the needs of patients.

See Recommendation 4: Clinicians and professional development (4.7; 4.8; 4.9; 4.10; 4.12); Recommendation 5: Beds and Clinical Services Plan (5.4; 5.5); and Recommendation 7: Acute issues and suicide prevention (7.9).

3.13.4 Long-term supported accommodation – hostels

Specialist mental health services do not appear to acknowledge and engage hostel care providers as members of the patient's health care team. This results in poor communication and poor continuity of patient care, insufficient hospital discharge information and variation in community mental health service provision. This concerns hostel managers, and sometimes leads to deterioration in a patient's condition, which often results in their admission to hospital.

The Review was informed that a range of communication problems exists between hostels and community mental health services and there is a need for stronger collaboration between these system components. For example, a hostel manager described how one patient was discovered to have a comorbid alcohol problem that had not been disclosed by the referring mental health service. Without awareness of the problem, the hostel had not supervised the patient's behaviour, which led to criminal offenses. The fractured communication between services was emphasised when the hostel requested assistance for the patient from the community mental health services and was refused.

There are two types of hostel accommodation: Hospital Licensed Psychiatric Hostels and mental health service-funded NGOs.

NGOs operate as a slow-stream step-down aiming to transition the patient to independent living within 12 months. Psychiatric hostels are more often long-term or permanent supported accommodation.

All hostels use case management models. Hostels licensed by the Department of Health provide case management with staff within their services, and patients in NGOs receive case management from community mental health services where NGO staffing does not include case managers[6].

[6] Some NGO hostels employ experienced mental health nurses, and most of the direct care workforce has attained a TAFE Mental Health Certificate level 4. The Mental Health NGO workforce project is the first national study workforce for the mental health accommodation sector (National Health Workforce Planning and Research Collaboration 2011). That there is high variability of workforce and workforce structures within NGO psychiatric hostel accommodation is a finding of the workforce project.

Key findings of the Mental Health NGO workforce project include:

- 39% of organisations employ staff with some type of mental health qualifications, and professional employees include psychologists, registered nurses, social workers and occupational therapists
- 78% had staff training plans
- 77% of services are supported by volunteers.

Variation in support to hostel patients

Mental health care is provided to patients in hostels by the local community mental health services. However, the Licensing and Accreditation Regulatory Unit (LARU) informed this Review that the frequency of health service provision to hostels varies.

Residents in some hostels are visited weekly by the health service psychiatrist and several times a week by the mental health nurse. In addition, the CMHS responds to calls for urgent intervention and assists the patient's admission to hospital where needed.

In other hostels, community mental health services visit less frequently. For example, psychiatrists visit two to three monthly, and the CMHS nurse visits fortnightly. For new patients, hospital follow-up does not always occur and the hostels' request for urgent assessment is often met with the instruction by the CMHS to send the patient to an ED (Licensing and Accreditation Regulatory Unit, DoH April 2012).

The variations of CMHS services to psychiatric hostels require further exploration.

The Reviewer was informed that most hostels will refuse patients admission unless they can be guaranteed of community mental health service assistance. If patients are in a mental health hospital and are 'out of area', they often cannot move to a hostel of their choice unless accepted by the CMHS in the area of the hostel.

To address these communication issues, some hostels have developed memorandums of understandings with the local mental health services. Some also liaise with the mental health services regularly. For example, St Vincent de Paul meets with Swan mental health services weekly to discuss potential discharges. In addition to this collaborative strategy, St Vincent de Paul reserves two beds for sudden arrivals, noting that sudden hospital discharges are commonplace.

Complexity of patient care

The patients referred to hostels are often complex and the clinicians in the inpatient setting must have confidence that the hostel is the best place of care for each individual (personal communication Richmond Fellowship 2012).

NGO staff explained to the Review that clinicians in acute mental health services do not always understand the capacity and limitations of hostels, particularly in relation to providing a safe and responsive service for patients with higher complexity and levels of acuity (pers. comm. Richmond Fellowship 2012). NGOs are perceived by some clinicians to be reluctant to accept patients who are impulsive and at high risk of harm and some specialist mental health clinicians are concerned about the level of training or core competencies of NGO staff to care for complex patients.

The community accommodation workforce should also be beneficiaries of a relevant and effective education and training framework to ensure a sustainable and skilled workforce.

Where CMHS relationships with NGOs have been formalised, patients are well supported in their mental health needs. Facilitated information-sharing sessions that aim to enable better understanding between acute services and NGOs are needed to inform each service of the other's capacities and strengths.

NGOs and hostels also need to align their intake processes and eligibility criteria to improve understanding of their service accessibility (personal communication Clinical Cluster Lead SMAHS).

Communication between community service providers

Communication problems also exist between community providers. For example, a hostel manager described to this Review that a community provider had negotiated a patient's transition from the psychiatric hostel to a Department of Housing unit without discussion or involvement of the hostel services. A number of such transitions have failed and the residents have requested a return to the supported hostel.

In the opinion of the Reviewer, no single agency involved in patient care is central, and all services involved in patient care should be informed and involved when patient care plans are renegotiated.

Improved communication systems to better coordinate patient care within and across the mental health system need to be formalised (personal communication Richmond Fellowship & WAAMH).

See Recommendation 4: Clinicians and professional development (4.7; 4.8; 4.9; 4.10; 4.11; 4.12); and Recommendation 5: Beds and Clinical Services Plan (5.5).

3.13.4 Supportive housing and recovery programs

Resolving the need for supportive housing have been an ongoing difficulty for many patients with mental illness. A number of NGO services provide services to assist patients in finding accommodation and also provide community support. The Review felt that the services provided by RUAH were very satisfactory as were those of other NGOs.

For example, RUAH has six local teams across the metropolitan area and provides services to patients with mental illness. Eighty-five per cent of the team members have tertiary qualifications (e.g. social worker, psychology, occupational therapist and counsellor). Caseloads are 10 to 12 patients per clinician. Peer support workers are also employed and operate with four clients each.

Services include recovery programs, intense support, social and family programs, help with drug abuse, personal helpers, mentors, employment services, and homelessness programs. The programs aim to connect the individual into the community using a case management model.

In other mental health programs run by RUAH:

- Early Psychosis Initiative funding enables caseworkers to engage with patients and with the treatment team during hospitalisation and discharge planning. Referrals are also received from GPs. Many patients have comorbid conditions and have not received specialist mental health services in the past. There are 10 FTE case managers in the EPIC (Early Episode Psychosis Program) with caseloads of six to eight patients each. The staff engage with the patients to establish therapeutic relationships, provide medication assistance and help the patients to access local community mental health services.
- NGO intensive-housing programs have housed 100 patients since 2010 and RUAH is proud that all of these patients have remained housed.
- A Street to Home Program supports and houses people who are sleeping rough. RUAH also manages two female refuges.
- A contract with the Department of Corrective Services allows RUAH to assist women in prison. The patient involvement commences three to six months before their release.

- Recovery programs include WRAP, which is a wellness recovery action plan where the client is helped to understand the symptoms of deterioration and determines who needs to know when they act in a certain way and need help.

RUAH employees commented that it is sometimes difficult to get community mental health services for patients once they have been housed due to the long waiting lists for services.

Other NGOs also provide community services including:

- personal helpers and mentoring programs. These programs include carer education aimed at broadening carers' capacity to manage patient behaviour and in-home respite care (personal communication Richmond Fellowship 2012)
- community support groups such as Hearing Voices Network and Independent Living Skills Support
- prevention and health promotion activities
- prevocational training.

Personalised funding

The Review was informed that there are insufficient numbers of supported accommodations places (personal communication Clinical Cluster Lead SMAHS & Richmond Fellowship) and already the Minister for Mental Health is making endeavours to correct this with funding allocated to purchase 100 homes and $25 million to provide support services.

The Hon. Helen Morton informed the Review that a current trial of personalised funding in the community shows significant promise.

The program involves community coordinators who assist the patient and carer to navigate the system and broker community resources in accordance with individual's needs for as long as required. This structure enables patients buy the service/s they need. The coordinator also monitors patient progress in concert with the GP and assists in the patient's transition to acute services where required.

See Recommendation 1: Governance (1.1.1).

3.14 Children and young people

Children and youth with mental illness present particular challenges that the system must attend to. About 50 per cent of the disease burden among young people aged 12 to 25 are accounted for by mental illness (McGorry 2007). Prevalence rates of mental illness in children are at 14 per cent, adolescents (19%) and youth (26%), which begins to demonstrate the magnitude of the challenge (National Advisory Council on Mental Health, McGorry 2011).

Dealing with mental illness in these age groups is made ever more complex when considering the effects of developmental stages (children to adolescence to adulthood), family and social environments, multiple agency involvement (including schools and at times police and hospitals), age-driven transitions across mental health services, geography, and system resource limitations.

Simplifying access and entry processes, improving pathways of referrals, improving after-hours and emergency response services irrespective of location, and closing identified gaps should each be given strategic priority. The Review has identified a specific imperative in relation to youths over 16 where support needs are approaching those of an adult.

A conceptual framework for child and adolescent services in Western Australia describes four tiers of service as follows:	
tier 1	Non-specialists in mental health provide development opportunities that promote mental health and wellbeing, initiate prevention strategies, identify mental health problems early and refer children for assessment. Some case management, advice and treatment are also provided. For example, Inspire.
tier 2	Identify children with mental health problems and disorders and assess less complex, severe or persistent cases. For example, headspace.
tier 3	Provide emergency services, assessment, and some aspects of treatment for complex, persistent and more severe cases; case manage multi-modal service provision; screen and refer to tier 4, train and consult to tier 1 and 2 services; undertake research and development programs. For example Child and Adolescent Mental Health Service.
tier 4	Provide complex assessment, treatment of the most complex, persistent or severe cases; contribute to services, training and consultation at Tiers 1, 2, and 3; undertake research and development programs. For example, YouthLink and Youth Reach South.

The responsibility for delivery of child and adolescent mental health services is currently with the Child and Adolescent Health Service (CAHS) in metropolitan Perth and with the WA Country Health Service (WACHS) for all other areas. The CAHS commenced in 2011 with 10 per cent of the mental health budget.

The Executive Director of CAHS informed the Review that the recent separation of child and adult services from the Area Health Services has enabled devolvement of the mental health model to a child-centric service delivery model. The treatment involves the parents and siblings, and aims to build the child's capital by enabling education, work and avoidance of the justice system.

CAHS focuses on children under 16. Youth presenting with a newly diagnosed condition at age 16 and over are excluded from most metropolitan CAHS services, including acute inpatient care and specialist programs such as eating disorders.

Many of the other mental illness of children cease in adulthood. The CAHS Chief Executive informed the Review that the needs of young people aged 16 to 25 are best met by adult mental health programs and CAHS is relinquishing governance of adolescent services to adult services.

3.14.1 Services for youth

3.14.1.1 Inspire – ReachOut – tier 1

Inspire is one of a number of Australia-wide services that support youth with mental illness with early recognition of mental illness and encouraging health seeking behaviour. The program commenced 15 years ago and targets youth aged 14 to 25. It features an online system with fact sheets and moderated chat lines (ReachOut forum) as well as information such as the contact details of local mental health services. Off-line programs encourage young people to get involved in promotional and benevolent activities.

The program has a philosophy of benevolence, encouraging young people to seek help, to help others, to become involved, to undertake training to become ambassadors at public events, and to 'ReachOut' to Members of Parliament.

The average 'user' of Inspire (person who accesses the program more than three times) is aged 15 to 18 and to date 500,000 use the website in this way.

3.14.1.2 Headspace – tier 2

Early detection and treatment anticipates a reduced risk of developing severe mental illnesses and disabilities in adulthood (Scott et al. 2012).

Headspace provides care for mild to moderate mental health conditions in youth-friendly venues where young people are comfortable to attend. Medical and specialist services such as drug and alcohol services, psychology, social work and psychiatry are colocated and bulk-bill (Scott et al. 2012). This 'under one roof' youth-friendly environment is non-threatening and attractive to young people (CCYP 2011).

Some 56,000 young people have attended Headspace services at Fremantle and new services are planned in the Kimberley, Albany, Bunbury, Esperance, Northam, Geraldton and Perth.

Headspace has memorandums of understanding with hospital and community-based mental health services. At Fremantle, five to seven referrals are received each day and some 15 new patients are registered each week. The service promotes mental health issues and services within schools and at major events such as Big Day Out.

A mental health clinician informed the Review that further service fragmentation is occurring as more preventive programs have emerged and this complicates service delivery. For example, Headspace extends services into local school communities, managing critical incidents around suicide, a role traditionally undertaken by local community groups and the community mental health services. At times, all groups are providing interventions in schools in an uncoordinated manner.

3.14.1.3 Acute community intervention team (ACIT) – tier 3

The acute community intervention team (ACIT) service is a recent tier 3 innovation at Princess Margaret Hospital. The service provides assessment, treatment and follow-up for young people who have been discharged from the emergency department or hospital until an appointment with the Child and Adolescent Mental Health Service (CAMHS) can be arranged.

Clinicians explained the team's functions to the Review. The service is limited to children under 16, for periods of up to four months. The team bridges the link between the hospital and CAMHS, with daily contact with patients in inpatient services where they contribute to the patient's discharge plans. They also provide assessment for patients within EDs of adult hospitals and provide community support, including case management, discharge planning and interventions. When children are discharged from the ED or hospital, ACIT provides community intervention services until CAMHS can activate the individual's referral. The team liaises with the child's other community services and school and maintains contact with the patients to local Child and Adolescent Mental Health Service. Education for parents about strategies to enable medication compliance is a high priority.

ACIT also provides proactive follow-up when children and their families miss CAMHS clinic appointments.

See Recommendation 8: Children and youth (8.3; 8.10.3).

3.14.1.4 Child and adolescent community mental health services (CAMHS) – tier 3

An example of entry processes was explained to the Review by the Family Community Service team at Bentley Health Service. They receive two to three referrals per day by fax from GPs and school psychologists. Patients who self-present to triage receive an assessment for risk and are then asked to attend their GP to obtain a referral.

Referrals are received and assessed by the duty officer—a nurse or social worker. The duty officer undertakes a phone assessment of the child's circumstances by contacting the family. Many families are not at home during the hours the service operates (9 am to 5 pm Monday to Friday) and it can take weeks to contact family by phone. A letter is often sent to request that the family contact the CAMHS. In rare circumstances, staff undertake home visits to assess the family's circumstances.

A weekly team meeting is held and referrals are allocated to one of two waiting lists—the general waiting list and the priority waiting list. Referrals on the priority list will receive assessment within 30 days.

Patients on the priority list, who are also of particular concern, receive a preliminary assessment by the mental health nurse. Outcomes of these assessments are then discussed at weekly intake meetings. The referral might be accepted or the patient might be redirected to organisations such as In focus, YouthLink or Headspace.

Where referrals are accepted, a Systemic Treatment Assessment Review Team (START) is activated to conduct a multidisciplinary assessment of the family and a medical assessment of the child. The treatment team comprises specialists according to need and a case manager is allocated. A letter is sent to the GP explaining the referral outcome within three weeks. In some areas, there are extra services available for children with risk of self-harm.

For example, a youth counsellor has been employed at Mandurah to focus care on youth with histories of deliberate self-harm.

Referrals accepted by rural CAMHS include conditions of low mood (50%), anxiety (25%), and conduct problems (25%). About 20 per cent express suicide ideation and 14 per cent have a history of deliberate self-harm. The number of patients presenting with eating disorder or psychosis varies between services.

CAHMS clinicians explained to this Review that services focus on therapy and treatment and less on rehabilitation. There are rarely opportunities to provide preventive care.

Services are most often provided for frequent short-term care episodes.

Re-triage, re-assess

Similar to adult entry processes, referrals for care are received from the specialist mental health hospitals and are triaged by CAMHS. Assessment and treatment plans are re-developed. Clinicians in mental health hospitals and EDs said entry to CAMHS is difficult and care is often delayed by waiting lists of five to nine months. This is unacceptable.

A clinician from the inpatient services also informed the Review that this is not a therapeutic process but a gatekeeping exercise to manage service demand.

Circumventing entry

For GPs, the lack of a coordination centre to assist system navigation requires the GP to identify the service in the patient's local area to make a referral.

ED clinicians informed the Review that GPs circumvent these onerous processes by advising the family to present to emergency departments where they can obtain immediate access to CAMHS. ED clinicians at Princess Margaret Hospital estimated that 80 per cent of patients with mental illness who present to the ED are referred to community care.

There needs to be a simple one-point referral system for all child referrals. In the opinion of the Reviewer, a central referral point is also essential to facilitate referrals and reduce the complexity of navigating mental health services by individuals and primary and general services.

Medications

CAMHS clinicians informed the Review that medications are cheaper for the patient when provided by CAMHS. To ensure compliance, CAMHS continue to manage the child's medication rather than refer the patient back to the GP when they are otherwise stable. Clinicians explained that this creates a bottleneck in the patient flow, that is, children on the wait list cannot be provided services until children with stable conditions are discharged. This problem is particularly evident with Aboriginal children requiring medication by injection.

Limited specialist psychiatrists for children

Clinicians explained to the Review that some CAMHS teams do not have a psychiatrist, and without community support or available psychiatrists, it is difficult for the family to comply with treatment regimes. Patients in these areas often present to EDs to receive regular medication.

Psychiatrist Dr Prue Stone provides child psychiatry services to rural and remote areas by video-linked assessments as well as consulting advice to local medical officers and adult psychiatrists. For example, in rural and remote areas, psychiatrists provide care to patients of all ages with Dr Stone's support for advice with children and adolescents on a needs basis.

CAMHS services in the Kimberley provide assessment and advice but not therapeutic intervention. Currently, there are no child psychiatrists in Broome. However, adult psychiatrists are available on a single telephone number (through the Broome switchboard) and can provide assistance 24 hours a day for children and adults. Adult psychiatrists informed the Review that they are not endorsed to care for people under 16 and child psychiatry requires an extra two years of training.

In the Great Southern, children who require inpatient care are admitted to the children's ward, with a staff member providing one-on-one supervision. Since psychiatrists are not available, clinical decisions are made by the medical officers in the ED and the treating GP with the assistance of RuralLink and input from a psychiatrist consultant. Youths may be admitted to the Albany mental health inpatient unit if their development stage allows; otherwise, they are transferred to Princess Margaret Hospital or to the Bentley Adolescent Unit.

CAMHS in Geraldton and the Midwest liaise with PMH specialist programs to receive guidance and support. PMH mental health teams visit the area regularly and provide training, clinical supervision and consultation about individual patients.

It is challenging to manage patients on community treatment orders, particularly when they are itinerant and this is particularly pertinent in Carnarvon. Clinicians liaise with the family and case managers, who often need to visit the home several times to meet up with the young patient. Midwest clinicians informed the Review that issues of trust are ameliorated when clinicians have had a long-standing relationship with the patients and community.

CAMHS clinicians explained that they communicate complex management and crises plans to all services involved in the youth's care and this includes the local ED. However, when the youth attends an out-of-area ED or is admitted to mental health inpatient services out of area, these plans are not available, and the new mental health team often repeats assessment processes and re-forms a care plan.

See Recommendation 1: Governance; Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; Recommendation 7: Acute issues and suicide prevention; and Recommendation 8: Children and youth.

3.14.1.5 After-hour services for children in rural areas

The presentation of youth in emergency departments (EDs) is increasing due to the growing demand for mental health care and illicit drug use. Clinicians have noted that peaks occur in November when students are under pressure with exams and future concerns. Clinicians at Bunbury explained that the EMO subculture of emotional expression is also affecting youth and increasing the number of young people presenting with self-harm.

Outside the metropolitan area, CAMHS do not provide urgent or emergency case responses in after-hours care. When there is a call for urgent referral, the patients are advised to present to an ED. After-hours cover in rural and remote areas when there are no CAMHS services available children and adolescent care appears to be provided by adult psychiatrists except at Bunbury

Clinicians at Bunbury Hospital informed the Review there are no after-hour services for children and youths at Bunbury. The Child and Adolescent Health Service (CAHS) psychiatrists are not available and the adult psychiatrists will not provide consultation to children or youths. Therefore, a 15-year-old presenting with psychosis on Friday night must wait in the ED until Monday to be assessed.

Children with severe psychosis often require inpatient care, and the processes for obtaining a bed cannot be commenced without a completed psychiatrist's assessment. The reluctance of the adult psychiatrists in Bunbury to provide consultations to children after hours persists, even though training in child and adolescent mental health has been offered to the adult psychiatrists and child psychiatrists are available for telephone and video-link consultation from Princess Margaret Hospital.

At the Armadale ED clinicians commented on the difficulties in managing adult-sized youths with long-standing problem behaviours. The adult psychiatrists in Armadale are not comfortable with caring for children and there are no after-hours CAMHS services available. These children often wait 72 hours to be assessed and obtain an inpatient bed.

The lack of after-hours CAMHS services and psychiatric liaison clinicians in some rural and remote areas results in up to seven patients waiting for assessment by the mental health team on Monday mornings, either in the ED or in general hospital beds.

The Reviewer is concerned about the patchiness of mental health services for young children and youth.

Immediate action is needed to address the emergency response and after-hours service needs for children outside the metropolitan area.

See Recommendation 1: Governance (1.1.1); Recommendation 5: Beds and clinical service plan (5.5); and Recommendation 8: Children and youth (8.2).

3.14.1.6 Multi-systemic Therapy Program – tier 3

An award-winning program operating at Hillarys and Rockingham is the Multi-systemic Therapy Program. This program has won the National Institute of Criminology's Crime and Prevention Award; the Award for Excellence in Prevention and Community Education at the National Drug and Alcohol Awards; and the Department of Health's Healthy Communities Award 2008 (Gov. of WA2012; Healthy Awards, 2008[7]).

The program targets children aged 12 to 16 with 'diagnosed conduct disorders on the verge of school expulsion and/or being told to leave the family home' (Government of Western Australia 2012). Conduct disorder is strongly associated with substance abuse and the program aims to break the link by increasing the capacity of parents, families and the youth's school to modify the youth's behaviour.

3.14.1.7 YouthLink – tier 4

YouthLink services in north and south metropolitan areas and in Northam provide care to youths aged 13 to 24 with serious mental illness and those at risk of developing mental illness. This service focuses on youth experiencing barriers to other mental health services, for example, those without a fixed address, youth who are treatment-resistant (not attending clinic appointments), and youth who are unable or who are unwilling to respond to letters. These patients would not be eligible for CAMHS services. In addition, the service provides care for young people for whom the CAMHS family-based model of care is unsuitable, such as where families do not accept this formulation of the problem and view the 'problem' to be imbedded in the young person. These families include those that are damaged or damaging, with potential abuse of the young person.

Patients are referred to YouthLink by non-government organisation providers, accommodation providers, street-based youth programs (e.g. RUAH), EDs, drug and alcohol services, and the Departments of Child Protection and Corrective Services. The youth can also self-refer. More than 60 per cent of the patients receiving support are over 18. Many young people (14–15 years old) have brief encounters with YouthLink and then return for more consistent care at age 18.

Referrals are triaged and interim case management is provided. There is a waiting list of 10 to 12 places in YouthLink, and this clears within the month. Case managers have a 10 to 12 person caseload.

Services include psychotherapeutic interventions and case management (advocacy and support), and YouthLink works closely with community social and recreational support services.

The service staff include 0.2 FTE psychiatrist, clinical psychologists and social workers, and a nurse triage officer. The biggest gap is in consultant psychiatry and this impedes the provision of comprehensive care. To bridge the gap, YouthLink operates in shared arrangements with the local area's CAMHS services. The itinerant nature of the youth complicates shared arrangements and frequent changes of mental health services occur along with a multiplicity of arrangements.

[7] http://www.health.wa.gov.au/hrit/docs/publications/Healthy_WA_Awards_2008.pdf

Accommodation options are often limited by the behavioural difficulties of the youth such as drug and alcohol use and self-harm behaviour. YouthLink works closely with Life without Barriers (a recovery program to assist young people to resolve homelessness for individuals). However, there are some young people who are also too complex for this program.

The YouthLink Chief Executive informed the Review that the difficulty of locating suitable accommodation sometimes results in youth being discharged from inpatient settings to their family, even when the volatility of relationships is likely to result in this becoming a short-term solution.

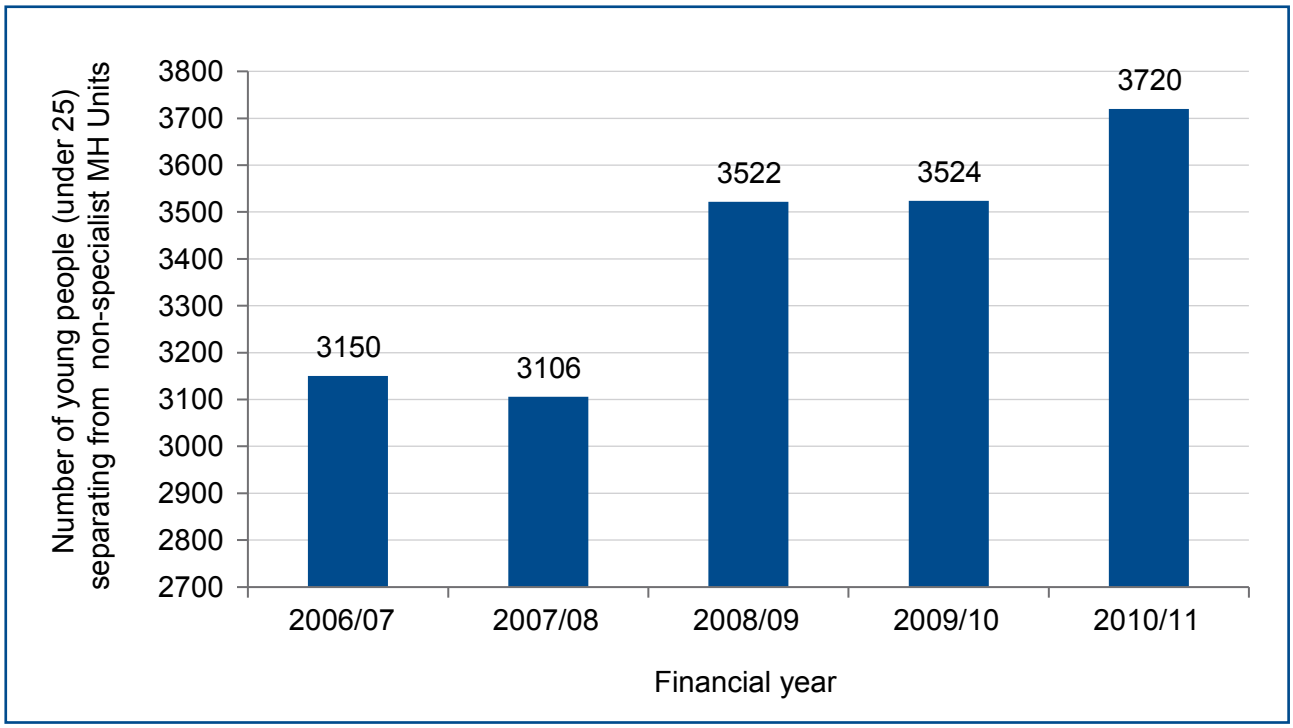
YouthLink also inreaches to the Bentley Adolescent Unit with weekly visits to maintain contact with youth and get to know young people before they are discharged. This process supports the program's assertive follow-up.

Youth aged 16 to 18 cannot access ED services at Princess Margaret Hospital (Area Mental Health Clinical Reform Group, 2011). In 2012 the acute community intervention team (ACIT) commenced as described below. However, this service is limited to the metropolitan area.

3.14.2 Children admitted to general hospitals

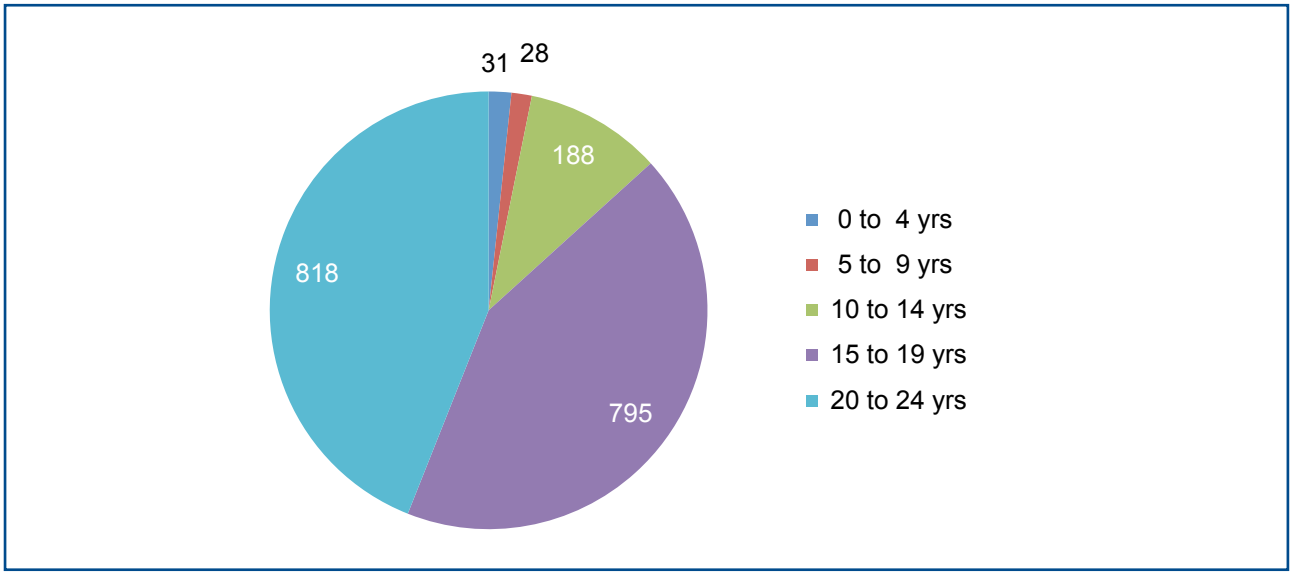
Some children and young people (under 25 years of age) are admitted into general hospitals with mental illness for short lengths of stay of one to four days (see Figure 42). The majority are 15 to 24 years of age (see Figure 43). These admissions occur across all health areas, with the majority in the north metropolitan and country health areas and the numbers are increasing (see Figure 44). The children in general hospitals are cared for by general hospital staff and CAMHS do not always provide inreach to guide care.

Figure 42 **Number of separations of patients 0–24 years, 2006–11**



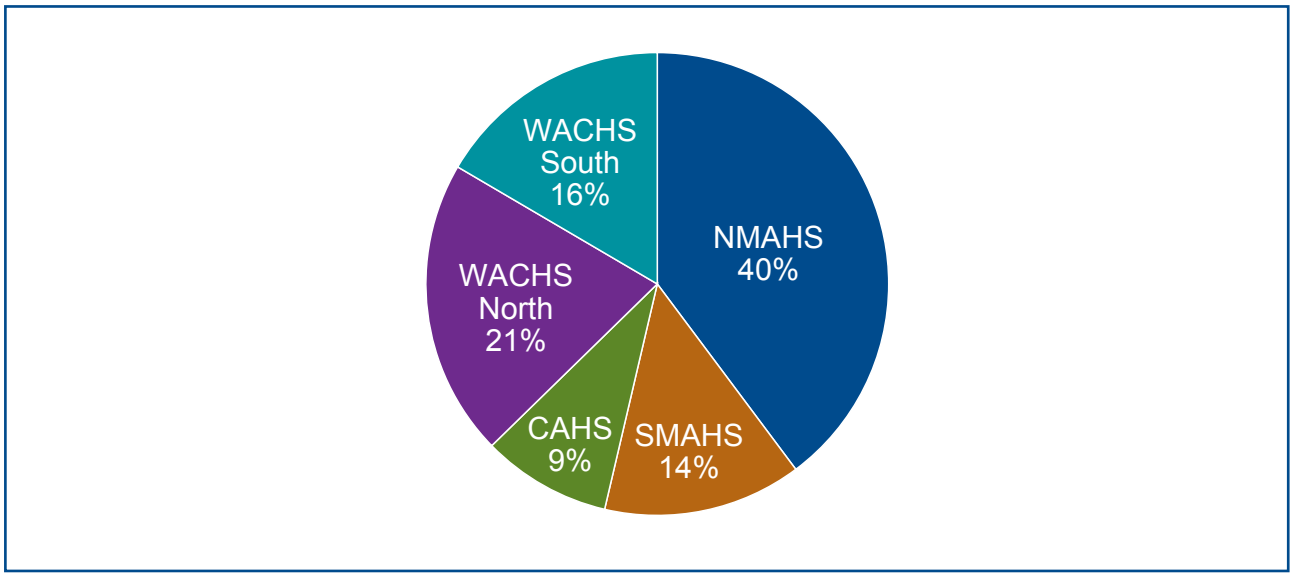
Source: MHIS DoH (2012).

Figure 43 **Age distribution of children admitted with mental illness to non-specialised hospitals, 2010–11**



Source: MHIS DoH (2012).

Figure 44 **Separations of persons under 25 years of age by Area Health Service, 2010–11**



Source: MHIS DoH (2012).

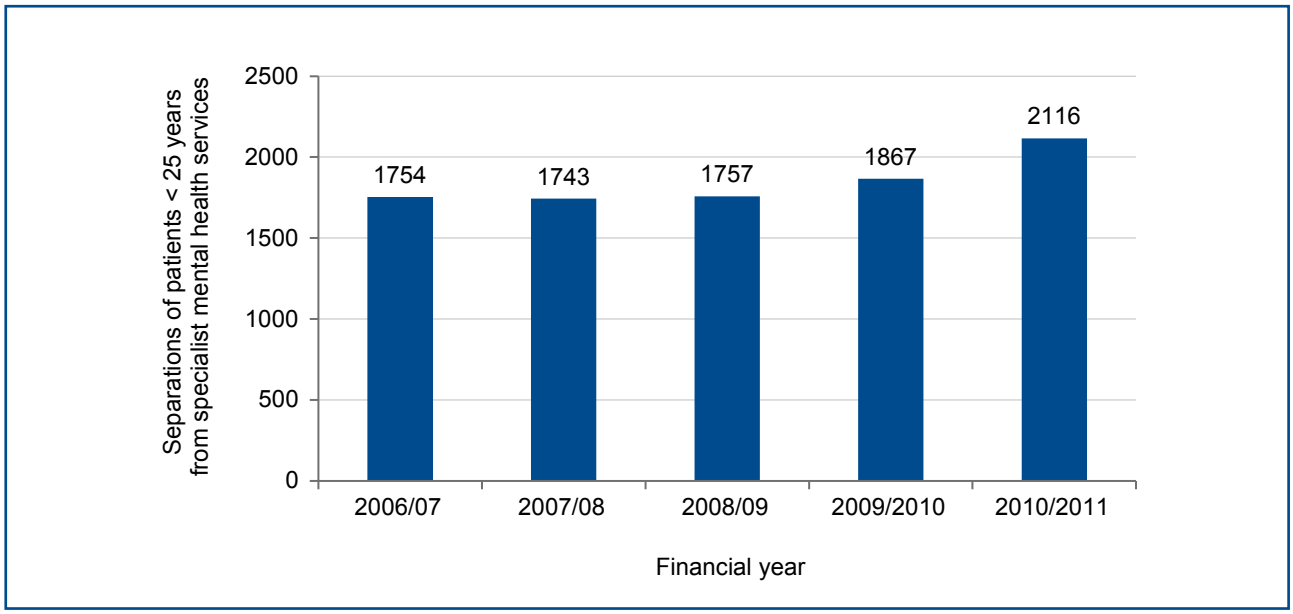
There are no specialised mental health inpatient beds for children and adolescents in rural areas. Young people are sometimes admitted to the general ward if this is safe and appropriate; otherwise, they are transferred to Princess Margaret Hospital or the Bentley Adolescent Unit.

See Recommendation 2: Patients (2.8).

3.14.3 Specialist mental health inpatients for children and youth

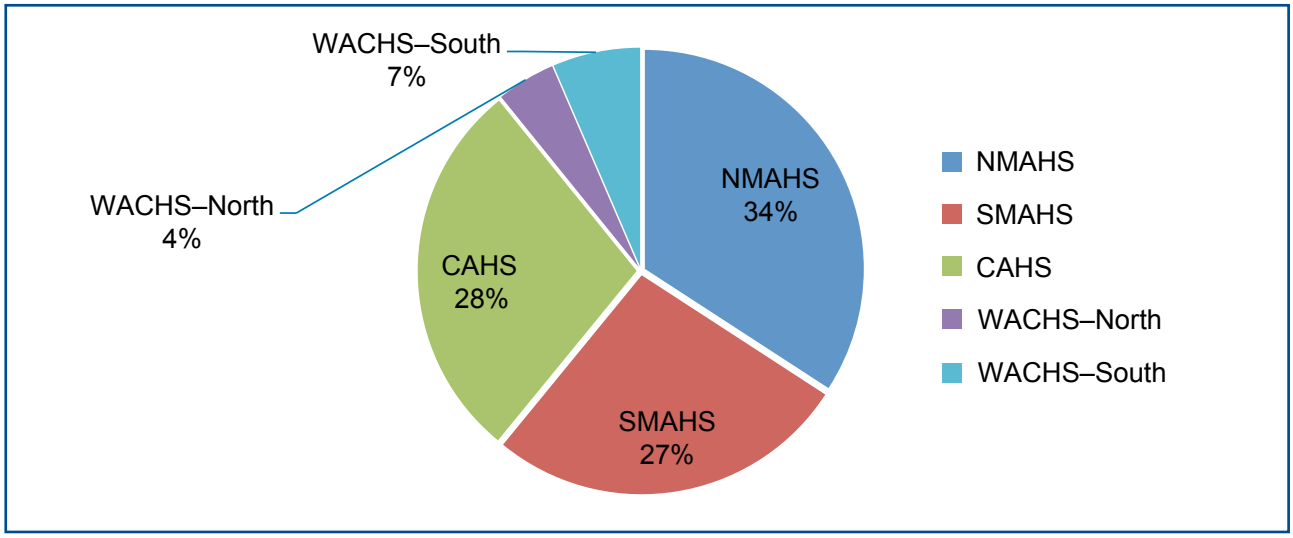
Increasing numbers of young people (under 25 years of age) are also being admitted to specialist mental health facilities (see Figures 45 and 46).

Figure 45 **Numbers of separations of patients 0–24 years, 2006–11**



Source: MHIS DoH (2012).

Figure 46 **Separation of patients under 25 years from specialist mental health services by Area Health Service, 2011**



Source: MHIS DoH (2012).

There are two State specialist mental health units for children and youth—an eight-bed unit for voluntary patients at Princess Margaret Hospital and a 12-bed unit for involuntary patients and youth at the Bentley Adolescent Unit (BAU). A 20-bed unit is planned in the new children's hospital currently under construction at the Queen Elizabeth II Campus in Nedlands.

In the Reviewer's opinion, more attention must be given to providing physical and dental care for children in specialist mental health services.

Communication problems similar to those described in the adult specialist mental health services exist between child inpatient and community CAMHS services and at transition points from child to adult services, especially in the metropolitan area. Community CAMHS clinicians in rural and remote areas informed this Review that discharge summaries from inpatient facilities were sometimes delayed and CAMHS was not always notified when a patient was discharged. The entry processes to BAU were unclear to rural CAMHS and patients are sometimes sent to metropolitan EDs rather than directly to the BAU to gain access to specialist inpatient care.

The current children's unit at Princess Margaret Hospital is restricted to children and adolescents aged 6 to 16 who present with a range of severe or complex mental health problems (Child and Adolescent Health Services, PMH 2007). Further exclusions include care for patients with the following primary presenting issues:

- containment, and/or accommodation
- drug and substance abuse
- forensic
- where admission may reinforce maladaptive aspects of behaviour, including severe aggression or it is deemed to be counter-therapeutic to the individual or the ward milieu.
- Ward 4H is not approved to diagnose pervasive developmental (disorders) (CAHS, PMH 2007).

The children excluded from PMH can be admitted to the Bentley Adolescent Unit.

The BAU provides care for youth aged 12 to 18, including involuntary patients.

Clinicians, Judge Reynolds, the Commissioner of Children and Young People and the Council of Official Visitors (COOV) informed this Review of their concerns about the mixture of patients at the BAU.

BAU is the only State hospital to admit children on hospital orders issued by the courts. Data from COOV indicated that seven to 14 children are ordered to the BAU by the courts each year, and they remain there for periods ranging from one to 78 days (COOV Annual Report 2010–11. In addition, there are young people with mental health conditions linked to substance abuse, such as drug-induced psychosis, and younger children admitted with involuntary status. It has been difficult for the BAU to provide a therapeutic environment to meet the needs of this combination of conditions.

This issue was also raised in the recent review of the BAU, the Orygen Youth Health Report (2011). This Review supports the recommendations of that report.

A progress report on the Orygen recommendations was provided to this Review by the Child and Adolescent Health Service (CAHS) and indicates that two of the Orygen (2011) recommendations are beyond the authority of CAHS to implement:

- Recommendation 11: Explore opportunities to provide developmentally appropriate inpatient facilities for 12–15 year olds and separate facilities for 16–18 year olds.
- Recommendation 12: Although beyond the remit of CAMHS, it is recommended there be the establishment of a dedicated forensic mental health unit for young people within the State.

The Chief Executive of CAHS proposed to this Review that a specific unit for young people aged 16 to 24 be established. The current number of inpatient beds is not adequate to meet the needs of children and adolescents and it is not appropriate to have very young children within the same units as well-developed adolescents.

A step-down facility is also required to provide care for children who are floridly acting out and not requiring acute intervention (personal communication Chief Executive CAHS). The development of step-down units should include the capacity to care for very complex groups and groups who are currently excluded.

In the opinion of this Reviewer, the services recommended by Orygen, along with step-down units for youth, are essential components to be considered in the State's Mental Health Clinical Services Plan.

See Recommendation 1 Governance; Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; Recommendation 5: Beds and Clinical Services Plan; Recommendation 7: Acute issues and suicide prevention; Recommendation 8: Children and youth (in particular 8.4; 8.6.1); and Recommendation 9: Judicial and criminal justice system.

3.14.3.1 Recovery programs

The Transition Unit at Bentley is a Monday to Friday day-program based on a recovery model that also provides inreach to the Bentley Adolescent Unit.

Youths from the BAU, in addition to community-dwelling youth, attend the program daily as part of their recovery.

The program engages youth in life skills such as cooking, woodwork and education. As a centre-based program, some children and families have difficulty in attendance, and the clinicians would like to have additional satellite programs.

See Recommendation 8: Children and youth (8.5; 8.6).

3.14.4 Youth transition to adult services

Youth informed this Review that their needs differ from those of younger children and adults. Age-appropriate environments and therapeutic approaches to youth rehabilitation programs are needed. The Mental Health Commissioner also informed the Review that specific programs that recognise and address the specific needs of youth aged 14 to 25 are required.

Child-focused services address developmental stages and the unit of care is the family. The family is expected to attend assessment and therapy sessions with the child. Adult services focus on the individual and illness management (DoH 2011b). Adults and adolescents usually attend their assessment and therapy alone, and family/carers are involved in care with the patient's consent. Patients therefore experience differing service delivery models with different clinicians providing care at each transition step.

The risk of the patient's condition(s) deteriorating at program transition points was the impetus for the development of the State's Paediatric Chronic Diseases Transition Framework (Child and Youth Health Network 2009). In order to assist the patient to adapt, this framework highlights the necessity of introducing the patient to the clinicians, the transition environment and to independent appointment attendance in a planned and gradual manner.

This Review was informed by CAMHS outside the metropolitan area, that child, adolescent and adult services are integrated and the transition between them is seamless. The close working relationship between clinicians in rural and remote areas assists the transition of adolescents to adult service. Staff said transitions are also smooth on an interpersonal level.

The shared spaces of colocated services also increases the patients' awareness of other services, and clinicians informed the Review there are few problems in transitioning between services.

In the metropolitan area, CAMHS are governed and located separately and therefore smooth transition from one age-specific program to another requires planning and patient preparation, and this is not standard practice (Child and Youth Health Network 2009).

Currently Youth Reach South facilitates the transition of adolescents from the BAU to adult services and this appears a satisfactory arrangement for patients involved with those services.

Clinicians informed this Review that children transitioning from PMH to the Bentley Adolescent Unit is administratively smooth. However, a carer informed the Review that his daughter's transfer was sudden and occurred from the ED at PMH when there were no available beds in the hospital's mental health unit. The father described the contrasting environments, of the child-friendly unit of PMH with its Snow White images on the wall to the bare and institutional environment of the BAU[8]. He was concerned that his child would not feel safe in this new environment.

A submission to this review by the Commissioner of Children and Young People, Michelle Scott, places emphasis on the careful processes required at transition points of children to adolescent services and adolescent services to adult services.

A submission to this Review from Carers WA suggested that the Paediatric Chronic Diseases Transition Framework be implemented in mental health services to support young patients and their family carers.

This Review supports the adaptation of a transition framework to assist young people and their family/carers to transition across programs.

See Recommendation 1: Governance (1.2); and Recommendation 8: Children and youth (8.10.10).

3.14.5 Comprehensive children and young people services

The Commissioner of Children and Young People, Michelle Scott, informed the Reviewer that four out of five children with acute mental health disorders do not receive services or assistance. The Commissioner said there was work to be done at every level of mental health care for young people.

The Commissioner expressed concern that mental health services focus on severe disorders and less attention is provided for children with mild and moderate illness. The continuum of care is inclusive of promotion, prevention and early intervention in addition to the treatment of mild, moderate and severe disorders (CCYP 2011). Prevention strategies for psychosis, pre-pregnancy counselling and early intervention in pre-school are not currently provided in WA (CCYP 2011).

[8] Reconstruction is currently improving the environment of BAU as recommended in the Orygen Review 2011.

Continuity of care within an integrated service system is essential for effective and comprehensive services (McGorry 2011). This necessitates collaboration between all sectors of child care, including juvenile justice and legal services. The Commissioner said 'service gaps at any stage of the continuum must be eliminated so as not to compromise the effectiveness of care'.

In addition, children and parents should have access to specialist psychiatric services through teachers as well as school psychologists. These specialists should provide schools with advice, consultation and training in the care of children with mental illness. In addition, WA needs a model to address the issue of children who lack the ability to self-regulate.

When children approach mental health services, they need to be taken seriously and consideration should be given to eligibility criterion such as the arbitrary amounts of weight loss required to meet a diagnosis of anorexia; these make little sense to the child or their carers (pers. comm. CCYP 2012).

In WA a number of programs have been established to meet youth needs as are described above. However, there is no clear governance structure; services for youth between 16 and 18 appear to be particularly tenuous and responsibility for them outside the remit of current governance structures.

All specialised mental health beds for children are located in the metropolitan area. Clinicians explained that children at risk outside the metropolitan area were accommodated in the local general hospitals where family supports could be maintained.

CAHS suggested to this Review that youth services should have a separate governance structure and that models of care specific to youth need to be developed and implemented.

The Youth Mental Health Working Party developed 26 recommendations to address youth's needs under a specific youth director (DoH 2011c). The recommendations are summarised here:

- Establish a youth specific lead.
- Establish a youth specialist mental health stream.
- Establish early psychosis intervention programs.
- Create and strengthen collaborative partnerships with the NGOs.
- Enhance WACHS (WA country health service) youth mental health.
- Develop a youth-specific inpatient unit, youth-friendly ED and specialised eating disorder unit.
- Enhance Aboriginal youth services.
- Develop an attention deficit hyperactivity disorder (ADHD) program for adults with youth transition options.

The Reviewer supports these recommendations.

See Recommendation 2: Patients; and Recommendation 8: Children and youth (8.6; 8.6.3; 8.7; 8.8; 8.9; 8.10.1 – 8.10.10).

3.15 Mother and Baby Unit

King Edward Memorial Hospital (KEMH) has two programs of psychiatric services: one provides psychiatric, psychological and mental health services to hospital patients and staff; and the other is an eight-bed Mother and Baby Unit.

Mothers are screened for mental health issues at the 32-week antenatal period and positive screens automate referrals to the Department of Psychological Medicine. Referrals are also received by self-presentation and GP referral.

Interventions commence during pregnancy with the mother's consent and many patients are co-managed by community mental health services.

Drug-related problems are managed by WANDAS (Women and Newborn Drug and Alcohol Service), and the psychiatric liaison team also provide consultation.

Mothers present to the ED where the mental health team provide psychiatric assessment and referral for specialist assessment. Risk assessments are conducted by the mental health nurse, doctor and psychiatrist.

There is no safe room to care for patients at risk in the ED or hospital and patients may wait up to 12 hours in ED for an inpatient bed. Staff promote safety by reducing harmful materials in the area and, when needed, a team comprising a mental health nurse, nurse managers, psychiatrist and triage assist to calm a mother and prevent harm.

KEMH staff advised that there have not been any studies on safe application of restraints. Currently mental health nurses undertake restraints and the security guards stand back. Security guards need training to a competency-tested standard to enable them to assist with patient restraint.

Mild to moderate illnesses are managed in the Mother and Baby Unit, and patients with severe illness are managed at the Alma Street Centre.

On admission, patient and carers needs are assessed and a plan of care is developed in consultation with the patient. Family meetings are held during the inpatient stay and there is provision for partners to stay over; this is encouraged. Discharge plans are developed in consultation with the mother and partner.

Partner groups are held during the mother's inpatient stay and parenting advice is provided.

At times it is a challenge for the clinician to engage partners as some do not want to become involved, some have 'deserted', and some have dominating and violent behaviours that are not in the best interest of the patient.

For women of diverse cultural and linguistic (CALD) backgrounds it has been difficult to obtain interpreters with the appropriate Muslim dialect. However, Ishar (Multicultural Women's Health Centre) provides cultural support for many women at the hospital.

There are occasions when a patient's symptoms become too severe to manage in the unit. In these instances, the mother is transferred to a secure inpatient unit and the baby is placed in the care of relatives. When symptoms are more controlled, the mother and baby return to the unit for ongoing care.

The services extend education to GPs and psychiatrists about medication affects on unborn and breastfed babies.

Midwives from KEMH also provide consultation to pregnant patients at Graylands hospital and at times Graylands refers patients for obstetric assessment.

The mental health nurses of the psychiatry and midwifery programs provide follow-up of patients in the community when they return home from hospital.

This Review found the services of the Mother and Baby Unit to be satisfactory.

See Recommendation 1: Governance (1.4); and Recommendation 8: Children and youth (8.3).

3.16 General practitioners

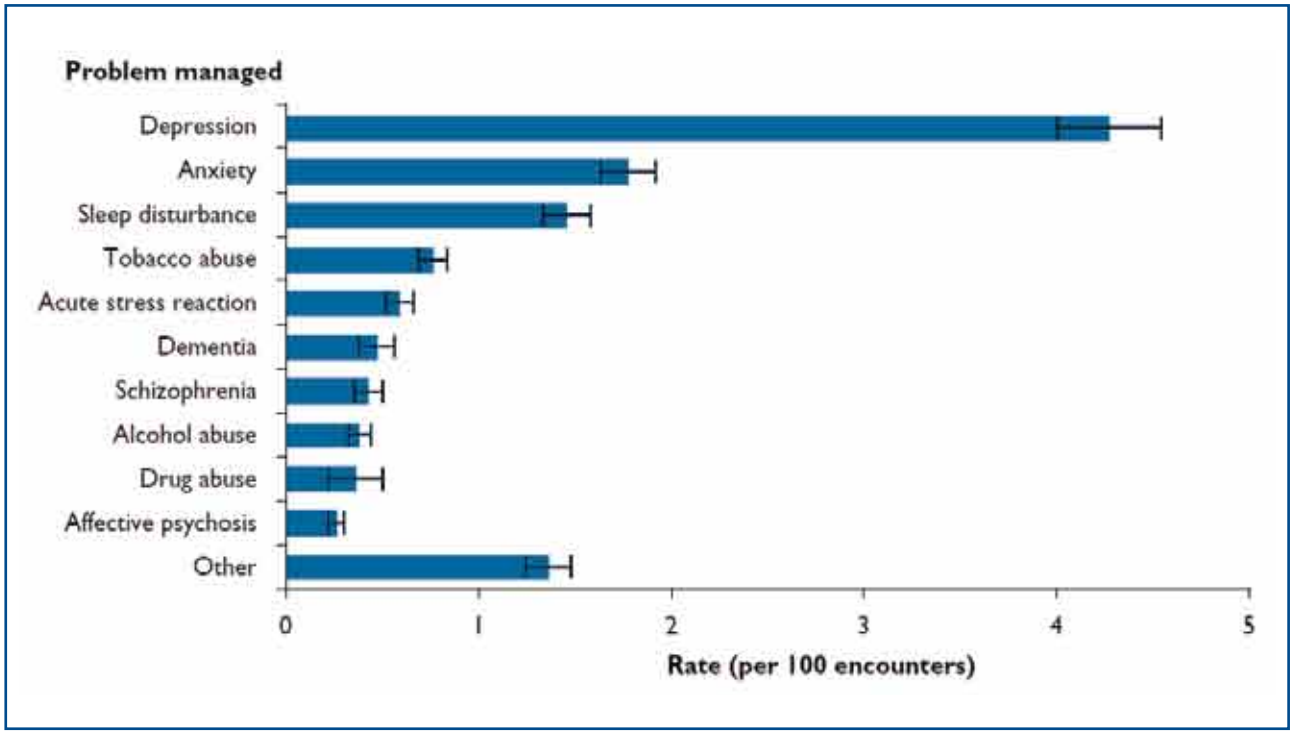
To improve patient continuity of care, close links between the mental health services and GPs are essential.

Seven factors were identified in this Review to improve current linkage. These are:

1. A central referral point.
2. Promotion of a GP/mental health service partnership model.
3. Provision of GP training in mental health assessment and treatment.
4. Strengthening GP knowledge and involvement in mental health care.
5. Provision of GP liaison models by community mental health services across all jurisdictions.
6. A navigation system, such as a website and booklet containing mental health descriptions.
7. Provision of direct access by GPs to the patient's consultant psychiatrist.

GPs promote mental wellbeing and manage mental illness with medications, treatment, counselling, advice and referral to specialist care (Australian Government 2011a). A majority group (one-third) of patients access mental health care through their GP (Australian Government 2011a). Figure 47 illustrates the mental illnesses most frequently managed by GPs, which represents 11.7 per cent per 100 GP encounters.

Figure 47 **Ten most frequent mental health problems managed by general practitioners, 2009–10.**



Source: Mental Health in Brief, Figure 2 Based on Bettering the Evaluation and Care of Health (BEACH) Survey (2011).

GPs are often involved in patient care both before and throughout the specialist care provided by the mental health system.

GPs informed the Review that they experience difficulties at interfaces with some mental health services. These difficulties include:

- lack of clarity about service availability and difficulties in locating the local services (Government of Western Australia 2011)
- not receiving feedback about their referrals to mental health services
- not always feeling confident that their patient will be accepted to the mental health services for care
- concern about the long waits patients have for mental health care
- lack of information about the patient's progress
- delayed discharge summaries.

GPs informed the Review that in order to refer patients to mental health services they require assistance to determine which health services are available in the patient's local geographical areas. The complexity of access to mental health services has led some GPs to send their patients directly to EDs to obtain services (Government of Western Australia 2011d). A central mental health referral centre would be beneficial.

A number of mental health clinicians commented that good relationships with GPs results in timely referrals and better continuity of care for patients. Some mental health inpatient services send patient progress reports to the GPs during hospital episodes. Some mental health services meet with local GPs regularly to improve communication and smooth referral processes.

An obstacle to patient's discharge from community mental health services and hospital care can occur when patients do not have a nominated GP. There is a high turnover of GPs in some localities (e.g. Rockingham has a 50% annual turnover).

Some patients are reluctant to attend their GP for economic reasons and others have difficulty attending appointments. GP connections are especially patchy for forensic patients; these patients often live chaotic lives in or out of mental health services and prison.

GP liaison officers

Care partnerships between mental health services and GPs are vital to continuity of care. The WA GP Network praised the mental health/GP liaison model (Government of Western Australia 2011d). This model promotes GP involvement in mental health care and ensures community mental health services correspond with the patient's GP during care episodes.

Currently GP liaison officers are a feature of some and not all community mental health services. This model consists of a CMHS clinician with the key responsibilities of assisting patients to link with their GPs and to improve communication between GPs and local mental health services.

The GP liaison's role includes:

- identifying GPs with enthusiasm for mental health care
- providing GPs with information about their patient's progress
- providing general mental health information and education
- encouraging patients to connect to their GP for ongoing care.

GPs would be more comfortable in providing mental health care if they:

- received timely treatment plans from the mental health team
- were able to consult directly with the patient's treating psychiatrists
- obtained information and training about the patient's mental health condition (Government of Western Australia 2011d).

GPs observed that the mental health system differs from that of general medicine to the extent that some GPs feel alienated from their patient's care. GPs at the Australian Medical Association (AMA) suggested to this Review that the mental health system needs to assimilate their processes to those of general health, so they could interact with the patients' treating practitioners directly rather than through duty officers.

Better collaboration is needed between GPs and consultant psychiatrists (AMA). A GP suggested to this Review that this could occur with a training program to upskill GPs in mental health assessment and treatment in exchange for rotating psychiatrists-in-training through GP practices. The doctor said GPs would benefit from 6 to 12 months of training in psychiatry as well as drug and alcohol conditions.

See Recommendation 1: Governance (1.2); Recommendation 3: Carers and families (3.1); and Recommendation 8: Children and youth (8.1).

Glossary

Carers

This report adopts the term ‘carer’ to denote a family member or other support person who contributed to this Review in concern of a person diagnosed with a mental illness. The term is also used in this report according to the definition (Western Australian Government 2007):

People, often family and friends, who provide care or assistance to another person who is frail, has a disability, a chronic or a mental illness. The care is provided without payment apart from a pension, benefit or allowance.

The Carers Advisory Council promotes the definition of carers as described in the Carers Recognition Act 2004: an individual who provides ongoing care or assistance to:

a. a person with a disability as defined in the Disability Services Act 1993 s 3
b. a person who has a chronic illness, including a mental illness as defined in the Mental Health Act 1996 s 3
c. a person who because of frailty requires assistance with carrying out everyday tasks or
d. a person of prescribed class.

Patients

This report adopts the term ‘patient’ to denote a person who has been diagnosed with a mental illness. In many documents, ‘mental health consumer’ is used to denote a person who has accessed mental health services. However, in the interviews of this Review the majority of individuals said they prefer to be called patients rather than consumers or clients when they are using mental health services.

Policy

The Clinical Risk Management Process

In line with both the Australian/New Zealand Standard AS/NZS 4360:2004 *Risk Management and the Clinical Risk Management Guidelines for the Western Australian Health System*, this policy follows a five-step process and contextualises this process for mental health settings.

Step 1: Establish the context. Identify and understand the service’s operating environment and strategic context.

Step 2: Identify the risks. Identify internal and external clinical risks that may pose a threat to the health system, organisation, business unit, and team and/or patient.

Step 3: Analyse the risks. Undertake a systematic analysis to understand the nature of risk and to identify tasks for further action.

Step 4: Evaluate and prioritise the risks. Evaluate the risks and compare against acceptability criteria to develop a prioritised list of risks for further action.

Step 5: Treat the risks. Identify the range of options to treat risks, assess the options, prepare risk treatment plans and implement them using available resources. Two factors underpin these five steps, namely:

- Communication and Consultation
- Monitoring and Review.

Both are vital to effective clinical risk management and need to be implemented simultaneously at each level of the clinical risk management process. Services seeking further information about this process should refer to both the Australian Standard and the Department of Health's *Guidelines*.

Risk

The following has been extracted from the CRAM Policy.

Risk in mental health has been defined as the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others (Morgan, 2000). Mental health services are particularly concerned about risks that are highly likely in terms of probability and that have severe consequences, such as imminent suicide attempts or violence. Examples of clinical risks in mental health include:

Risks to Self:

- Self-harm and suicide, including repetitive self-injury
- Self-neglect
- Absconding and wandering (which may also be a risk to others)
- Health including:
- Drug and alcohol abuse
  - Medical conditions, e.g. alcohol withdrawal, unstable diabetes mellitus, delirium, organic brain injury, epilepsy;
  - Quality of life, including dignity, reputation, social and financial status.

Risks to Others:

- Harassment
- Stalking or predatory intent
- Violence and aggression, including sexual assault or abuse
- Property damage, including arson
- Public nuisance
- Reckless behaviour that endangers others e.g. drink driving.

Risks by Others:

- Physical, sexual or emotional harm or abuse by others; and
- Social or financial abuse or neglect by others (Adapted from Ministry of Health, 1998; Top End Mental Health, 2004).
- Risks may also be posed to patients by systems and treatment, such as the side-effects of medication, ineffective care, institutionalisation and social stigma. Whilst these types of clinical risks are often not immediately obvious, they should be carefully considered in management planning (Ministry of Health, 1998).

The frequency and prevalence of certain clinical risks that clinicians encounter will also depend on the setting and age group seen. For instance, the risk of abuse or neglect by others may be higher in children and the risk of self-neglect higher in older adults. However, age alone does not preclude the presence of certain clinical risks. Adolescents may still be at risk of self-neglect, and adults living independently can still be at risk of exploitation.

Step-down unit (mental health)

A unit providing mental and physical healthcare, including rehabilitation immediate between that of an intensive specialist mental health hospital unit and independent community living.

Triage

The sorting of and allocation of appointments for assessment to clinical priority

Acronyms

ABF	activity-based funding
ABS	Australian Bureau of Statistics
ACIT	Acute Community Intervention Team
AHS	Area Health Service
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ARDT	Admission, Readmission, Discharge and Transfer Policy for WA Health Services
BAU	Bentley Adolescent Unit
CAHS	Child and Adolescent Health Service
CALD	culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service
CEO	Chief Executive Officer
CERT	Community Emergency Response Team
CLMIA	Criminal Law (Mentally Impaired Accused) Act 1996
CMHS	Community Mental Health Service
COAG	Council of Australian Governments
COOV	Council of Official Visitors
CRAM	Clinical Risk Assessment and Management Policy
CTO	community treatment order
D & A	drug and alcohol
DCS	Department of Corrective Services
DoH	Department of Health
ED	Emergency Department
EPIC	Early Episode Psychosis Program
FTE	full-time equivalent
GP	general practitioner
HoNOS	mandatory rating system that measures the severity of mental illness
ICD	International Classification of Diseases system

IDTU	Intensive Day Therapy Unit
IMP	Individual Management Plan
MH	mental health
MHC	Mental Health Commission
MHIS	Mental Health Information System, Department of Health
MHERL	Mental Health Emergency Response Line
MHN	mental health nurse
MHS	Mental Health Service
NMAHS	North Metropolitan Area Health Service
NOCC	National Outcome and Casemix Collection
NGO	non-government organisation
NSMHS	National Standards for Mental Health Services
OCP	Office of the Chief Psychiatrist
MH ORC	Mental Health Operations Review Committee
PLN	psychiatry liaison nurse
PLT	psychiatry liaison team
PMH	Princess Margaret Hospital
RFDS	Royal Flying Doctor Service
RPH	Royal Perth Hospital
SAMHS	Specialist Aboriginal Mental Health Service
SFMHS	State Forensic Mental Health Service
SHEF	State Health Executive Forum
SMAHS	South Metropolitan Area Health Service
WA	Western Australia
WAAG	Western Australian Auditor General
WAAMH	Western Australia Association of Mental Health
WACHS	Western Australian Country Health Service

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Coroners Act 1996 (WA)

*Criminal Law (Mentally Impaired Accused) Act 199*6 (WA)

Draft Mental Health Bill 2011 (WA)

Commonwealth Acts

Carer Recognition Act 2010 (Cwlth)

Commonwealth Health Insurance Act 1973 (Cwlth)

Disability Services Act 1993 (Cwlth)

Privacy Act 1988 (Cwlth)

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Appendixes

Appendix 1

Terms of Reference: Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia

Appendix 2

Individuals, organisations and service participants

Appendix 3

Written Submissions

Appendix 4

ICD-10 Diagnosis for mental health

Appendix 5

Clinical Record Audit

Appendix 1

Terms of Reference: Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ services in Western Australia.

The Review team, led by Professor Bryant Stokes AM, will prepare a report for the consideration of the Director General of Health and the Mental Health Commissioner, who will in turn advise the Minister for Mental Health.

The Review is to include recommendations for the refinement and improvement to the admission and referral practices for public mental health patients to public hospital EDs and/or authorised mental health facilities/services and the discharge or transfer of public mental health patients from the public hospital EDs, mental health facilities or services.

The scope of the Review is to examine services provided at the following:

- South Metropolitan Area Health Service (SMAHS) with the tertiary sites of Royal Perth Hospital (RPH) and Fremantle Hospital (FH) and the secondary sites of Armadale Kelmscott Memorial Hospital (AKMH), Rockingham General Hospital (RGH), Bentley Hospital.
- North Metropolitan Area Health Service (NMAHS) with the tertiary sites of Sir Charles Gairdner Hospital (SCGH), Graylands Hospital, including the Frankland Centre, King Edward Memorial Hospital's Mother and Baby Unit and the secondary sites of Osborne Park Hospital (OPH) and Swan Districts Hospital (SDH).
- WA Country Health Service (WACHS) with sites/services within all regions but specifically at the authorised mental health units of Bunbury, Albany, Kalgoorlie and Broome (March 2012), and review the application of the policy and processes in remote communities.
- Child and Adolescent Health Service in relation to the transition of child and adolescent mental health patients to adult services and the child and adolescent services provided at both Bentley Adolescent Unit (BAU) and Princess Margaret Hospital (PMH).

The Review team will first consider the findings of the Chief Psychiatrist's thematic review of discharge planning (December 2011) and provide a workplan/scope of work in context of its findings.

The Reviewers will consult with key stakeholders to gather views, information and evidence sufficient to:

1. Investigate whether the prescribed admission and discharge policies for public patients are being consistently adhered to. (Admission, Readmission, Discharge and Transfer Policy for WA Health Services (ARDT) OD 0343/11, superseding 1572/02).
2. Examine the current referral rates and patterns from the hospital EDs to both inpatient mental health services and community mental health services to ensure that all 'at risk' patients are treated.
3. Examine the practices and policies for the transition of mental health patients from child and adolescent mental health services to adult services.
4. Examine and contrast discharge planning policy and processes in place for child and adolescent and adult services.

5. Examine the use of community assessment and preadmission services such as the Community Emergency Response Teams (CERT), and the telephone clinical advice and referral services such as the Mental Health Emergency Response lines, (including Ruralink for country patients and clinicians).
6. Review the support systems currently in place to assist with admission and discharge referral practices with regard to the involvement of carers and families and that the use of primary care and community support services for the follow-up of patients is appropriate.
7. Make recommendations regarding improvements identified as part of the Review to ensure compliance with policy and appropriateness of its application in an operational setting.
8. Provide a final report including recommendations to the Director General of Health and the Mental Health Commissioner. It is expected the Review will take four months.

The key stakeholders will include:

- Key staff at all Area Health Services, that is NMAHS, SMAHS and WACHS, including, but not exclusively, the Chief Executives, the Executive Directors of the sites, the Executive Directors of Mental Health, the Heads of the EDs, the Heads of the community mental health services and other clinicians within each Area Health Service.
- The Chief Psychiatrist, the ED Performance Activity and Quality (PAQ), and the ED of the WA Health Mental Health Strategic Business Unit.
- The Mental Health Commissioner and senior staff at the Mental Health Commission.
- Mental health patients, carers and their families, the Council of Official Visitors (COOV), the Health Patients Council and peak mental health patient bodies such as the Association of Relatives and Friends of the Mentally Ill (ARAFMI), Carers WA, and the WA Association for Mental Health (WAAMH), the Mental Health Advisory Council (MHAC) and the WA Association of Mental Health Patients (WAMHC).
- Others as the Review team consider appropriate such as Corrective Services for the Frankland Centre.

The Reviewer may also examine the admission/referral and discharge and/or transfer practices provided at the ED and the authorised inpatient mental health facilities/services at Joondalup Health Campus and the interface and interaction between the SMAHS community mental health services and the ED at Peel Health Campus, but permission will be sought prior to these occurring.

Appendix 2

Individuals, organisations and service participants involved in the Review

- Patients, carers and family members
- Aboriginal Health Council of Western Australia
- Aboriginal Psychologist, Darrell Henry
- Acacia Prison, Director Peter McMullin
- AMA
- Association of Relatives and Friends of the Mentally Ill (ARAFMI)
- Australian College of Mental Health Nurses, Kim Ryan
- Carers WA
- Centre for Aboriginal Medical and Dental Health, Winthrop Professor Helen Milroy
- Children's Court, Judge Denis Reynolds
- Commissioner of Children and Young People, Michelle Scott
- Council of Official Visitors (COOV)
- Deberl Yerrigan Aboriginal Health Services
- Department of Corrective Services, Dr Roslyn Carbon and Dr Gosia
- Department of Health, Strategic System Support, Sally Skevington
- Deputy State Coroner, Evelyn Vicker
- Director of Aboriginal Services
- Director General of Health, Kim Snowball
- Drug and Alcohol Office
- Ethnic Disability Advocacy Services
- Headspace Fremantle
- Health and Disability Complaint Office, Anne Donaldson
- Inspire WA
- Mental Health Advisory Council
- Mental Health Commissioner, Eddie Bartnick
- Mental Health Commission
- Mental Health Law Centre
- Mental Health Matters 2
- Mental Health Multicultural Access Service
- Mental Health Strategic Business Unit
- Mental Health Review Board
- Mental Illness Fellowship of Western Australia (MIFWA)
- Minister for Mental Health, the Hon. Helen Morton
- Office of the Chief Psychiatrist
- President of Private Psychiatric Hostels, Judith Baalfe
- Richmond Fellowship

- Romily House
- Royal Flying Doctor Service
- RUAH Community Services
- St Batholomew's
- St John Ambulance operations staff
- St Jude's
- St Vincent de Paul
- Statewide Indigenous Services
- Suicide Prevention Council Chairman, Peter Fitzpatrick
- Western Australian Association for Mental Health (WAAMH)
- WA GP Network, Chief Executive, Debra Selway
- Western Australia Police

Chief Executives of:

- Child and Adolescent Health Service
- North Metropolitan Area Health Service
- South Metropolitan Area Heath Service
- Western Australian Country Health Service

Mental Health executives and operations staff:

- Managers and operations staff Western Australian Country Mental Health Service
- Managers and operations staff Mental North Metropolitan Area Mental Health Service
- Managers and operations staff South Metropolitan Area Mental Heath Service
- Managers and operations staff Child and Adolescent Mental Health Service
- Standardised Documentation Committee, Chair and members PSOLIS, Application Manager, System Adviser, system information and administrators and HIN (Health Information Network) Manager
- Senior Project Coordinator SMAHS, Joel Gurr
- Clinical Cluster Lead for Mental Health SMAHS, Dr Nigel Armstrong
- State Bed Manager, Kieran Byrne
- Performance Activity and Quality Division, Dr Dorothy Jones
- ABF/ABM System Lead, Performance Activity and Quality Division, Beress Brooks
- Resource Strategy and Infrastructure, Wayne Salvage, Mark Miller
- Consumer Representative to the development of Review Audit tool, Liza McStravick
- Mental Health Information Services, Tom Pinder
- Department of Epidemiology, Peter Somerford
- Chief Medical Officer, Dr Simon Towler.

In the following list, the clinicians of mental health services include those at community emergency response teams, triage, psychiatric liaison teams, hospital psychiatric liaison teams, inpatient services, community mental health services, child and adolescent community health services, outreach and in-reach programs, rehabilitation services, GP liaison.

- Albany, Katanning mental health clinicians and ED heads
- Alma Street Centre, clinicians and Fremantle ED heads
- Armadale Hospital mental health clinicians and ED heads
- Bentley mental health clinicians and ED heads
- Bentley Adolescent Unit mental health clinicians
- Bunbury mental health clinicians and ED heads
- Bunbury Council of Official Visitors representative
- Kalgoorlie, Goldfields mental health clinicians and ED heads
- Kimberley, Broome, Derby, Kununurra mental health clinicians and ED Heads
- Frankland Centre mental health clinicians
- Graylands Hospital mental health clinicians
- Hampton Road Service, Fremantle
- Inner City CMHS
- Joondalup Health Campus mental health clinicians and ED head
- King Edward Memorial Hospital Mother and Baby Unit
- Mental Health Emergency Response Line (MHERL) mental health clinicians
- Mirrabooka CMHS mental health clinicians
- Midwest, mental health clinicians
- Osborne Park CMHS mental health clinicians
- Peel Health Campus mental health clinicians and ED head
- Pilbara, Meekatharra, Port Hedland, Karratha, Newman, Tom Price mental health clinicians and ED heads
- Port Hedland Manager
- Princess Margaret Hospital mental health clinicians and ED head
- Rockingham mental health clinicians and ED heads
- Royal Perth Hospital mental health clinicians and ED heads
- Sir Charles Gairdner Hospital mental health clinicians and ED heads
- State Forensic Mental Health Service
- Swan Valley Centre mental health clinicians and ED heads
- Horizons, Armadale
- South Guildford Centre mental health clinicians
- Youthlink
- Viveash mental health clinicians
- Wheatbelt, Northam mental health clinicians and ED heads.

Appendix 3

Written Submissions to the Review

- Anonymous
- Alan Robinson
- Association of Relatives and Friends of the Mentally Ill
- Association of Relatives and Friends of the Mentally Ill. Kimberley Mental Health Carers
- Carers WA
- Commissioner for Children and Young People
- Council of Official Visitors
- Geoff Diver
- Geraldine Casey
- Goldfield's Mental Health Services
- Hugh Cook
- Kim Ryan
- Mental Health Strategic Business Unit
- Mental Health Commission
- Mental Health Law Centre
- Mental Health Matters 2 (2)
- North Area Health Service
- Osborne Clinic
- Paul Whitley
- Richmond Fellowship
- Royal Flying Doctor Service
- Russell Clemens
- State Forensic Mental Health Service
- Suicide Prevention
- Transcultural Mental Health Centre
- WA GP Network
- WA Police
- Western Australian Association of Mental Health Services

Appendix 4

ICD-10 Diagnosis for mental health

The principle diagnoses of the ICD-10 related groups classed into 10 mental diagnoses with subdivisions (see Commonwealth of Australia 2008, *Australian Refined Diagnosis Related Groups Version 6 Definitions Manual,* vol. 2 (DRGs J01A-Z65Z).

The 10 mental health DRG groups are:

1. Mental health treatment, same day with ECT – U4OZ
2. Mental health treatment same day without ECT – U6 OZ
3. Schizophrenia disorders – U61Z
4. Paranoia and acute psychotic disorders (Cat or severe CC or mental health legal status voluntary – U624, involuntary U62B
5. Major affective disorders – U63Z
6. Other affective and somatoform disorders – U64Z
7. Anxiety disorders – U65Z
8. Eating and obsessive/compulsive disorders – U66Z
9. Personality disorders and acute reactions – U67Z
10. Childhood mental disorders – U68Z.

The Mental Health Commission explained they are intent on gaining better mental health system traction (alignment) by diversifying the service base, improving control of hospital purchased services and increasing investment into community. For example, in 2011–12, the $9 million growth funding for hospital care was redirected, with 60 per cent given to health for community services, and the remainder to private community health services. To decrease reliance on public hospital beds, some are planned to close. At present, there is no growth in inpatient funding.

The costs of new beds at Rockingham and Broome are expected to be accommodated by transferring current funding to those areas; the idea being that patients currently cared for in the metropolitan areas will be repatriated. No funding has been allocated to meet the expected increase service demand when the mental health services become available in those areas.

Kathy Eager, Centre for Health Service Development, at the University of Wollongong (2011) published a paper on the implication of ABF/ABM funding for mental health and notes that the COAG agreement does not place specialist mental health services into any one distinct activity for ABF. Eager proposed that mental health should be considered as one service and receive Block Grants until mental health is 'nationally recognised as a distinct "activity" for ABF purposes and as a specific type'.

DRG Classification is a poor predictor of the cost of mental health care that is not used for this purpose in any Australian state or in other comparable countries such as the UK or the USA. ... With mental health being split across the five different activity types, the outcome will be to fragment integrated hospital and community services by applying different funding arrangements across service components. There will also be incentives to treat patients in settings that are the most profitable. For example, introduction of ABF in acute admitted psychiatric services without an equivalent ABF model in the community will create incentives to hospitalise, resulting in an increase in hospital admission and a decrease in care in the community. These incentives are not consistent with national or state mental health policies and are not compatible with either good clinical practice or current mental health legislation, which requires the least restrictive form of care consistent with safe and effective treatment ... A specific approach needs to be developed that aligns ABF with national policy directions which have explicitly aimed to bring hospital and community services together in a single system (Eager et al. 2011).

Appendix 5

Clinical Record Audit

A clinical record audit was undertaken as part of this Review into admission, discharge, referral and transfer practices of public mental health services in Western Australia.

The purpose of the audit was to gain an understanding of what was documented in the clinical record in relation to specific aspects of patient care that were identified for review by the project team and that were determined to be important to the Review's overall objectives. It should be noted that:

- this audit does not measure compliance
- lack of evidence in documentation of aspects of care does not mean that the care did not take place.

A random sample of 500 (200 inpatient and 300 community mental health patient) records was drawn from the total number of patient separations and occasions of service from selected inpatient units and community mental health services across The Department of Health, WAHealth for the 2010/11 financial year. Sites were selected to represent tertiary, non-tertiary, adult and child and adolescent services. Records were audited for admission criteria and the discharge, transfer and referral criteria that, where these occurred, were associated with that admission. Some records were audited for more than one criterion. Analyses for admission and referral criteria were conducted on 165 inpatient and 201 community mental health (CMH) records for patients admitted into a service during the 2009/10 and 2010/11 financial years, on 152 inpatient and 78 CMH records for the discharge criteria and on 11 inpatients for the transfer criteria. Records were excluded from analyses where they were found to be outside of the audit time period or, for inpatient records, had a length of stay of zero days and were therefore not considered to be inpatients.

Results

Referrals

Inpatients: More than 85 per cent of patients had written referrals into the service with the majority (86.7%) admitted within one day of referral. Records indicated that in only 20.1 per cent of cases did referrers receive feedback of the admission.

CMHS: Written referrals were evident in 73.2 per cent of the records with the time between referral and admission to the service ranging from zero to 541 days (median of 10 days). Records indicated that in only 39.3 per cent of cases did referrers receive feedback of the admission.

Admission Assessments

Inpatients: A full or partial psychiatric assessment was evident in 95.7 per cent of records with the assessment being completed within one day of admission for 98.7 per cent of patients. Physical assessments were undertaken on half of the patients (50.3%) with 3.6 per cent of these being partial assessments (circulatory and respiratory systems). For clinical risk assessment, 98.8 per cent of patients had an assessment undertaken with 6.1 per cent of these partial (level of suicide risk and current protective factors).

CMHS: A full or partial psychiatric assessment was evident in 94.1 per cent of records with the assessment being completed within one day of admission for 87.8 per cent of patients. None of the CMH patient records indicated that patients had received a physical assessment with 26 records indicating that this was not applicable because the patient was under the care of a GP or specialist. For clinical risk assessment, 96.5 per cent of patients had an assessment undertaken with 43.8 per cent of these partial assessments.

Clinical Risk Plan

Inpatients: The large majority of patients (97%) had evidence of a risk plan. While there was evidence that the patient had contributed in most cases to the risk plan (94.4%), this was not the case for carer input where, excluding no patient consent and no identified carer, about one-third of the records had evidence of carer participation.

CMHS: Again, the large majority of records (94.5%) had evidence of a risk plan with patient participation in most cases (98.4%). As for inpatient records, excluding carers not identified or present, carer input was less evident with just under a half of the records indicating involvement.

Discharge assessments

Inpatients: The majority of patients (94.1%) received a full or partial risk assessment on discharge with most of these being completed within a day of discharge (89.1%). Only seven patients had a full or partial physical assessment at the time of discharge. Records for 97.4 per cent of the cases had evidence of a discharge plan with patient and carer input into these in 93.2 per cent and 33.3 per cent of cases respectively.

CMHS: As for inpatients, most CMH records (85.9%) had evidence that patients received a full or partial risk assessment on discharge with most of these being completed within a day of discharge (89.1%). Only one patient had evidence of a partial physical assessment at the time of discharge. Records for 80.8 per cent of the cases had evidence of a discharge plan with patient and carer input into these in 69.8 per cent and 28 per cent of cases respectively.

Patient transfer

Ten of the 11 patients had evidence of a risk assessment being performed before transfer. Seven patients had evidence of a transfer plan in their records with all of these patients involved in the development of their plan. Carer involvement was evident in two instances only with one case recording no consent for carer involvement.

Conclusions

This audit looked at the documentation in patient clinical records in relation to specific patient admission, discharge, referral and transfer criteria. In relation to referrals, the majority of both inpatients and community mental health patients had evidence of written referrals into the service with most inpatients being admitted within one day of referral. However, an area for improvement would appear to be in feedback to the referrer of an admission, which was evident in less than half of the records audited.

In relation to assessments, admission psychiatric and clinical risk assessments were undertaken on the majority of patients with most of these completed within a day of admission. Inpatients had a higher rate of full assessments, as opposed to partial assessments, than did community mental health patients. In contrast, documented evidence for physical assessments occurred in half of the inpatients and none of the CMH patients, with several records in the latter group indicating that this was not applicable as the patient was under the care of a GP or specialist.

As for assessments, the large majority of records indicated that patients had evidence of a clinical risk plan and, while there was evidence that patients had contributed to the plan, evidence for carer input was less.

For both inpatient and community mental health patients, the majority received a full or partial risk assessment within a day of discharge. Again, physical assessments were not evident for the majority of patients.

Limitations

While this audit has identified information on aspects of admission, discharge, referral and transfer practices that are being documented in patient's clinical records, methodological limitations warrant caution in the interpretation and generalisation of the results. These limitations relate to:

- the small sample size and the number of records lost to analysis further reducing this size
- the sample being drawn from selected sites and not therefore inclusive of all mental health services in WA
- the fact that while criteria were audited for evidence of documentation in the clinical record, this review did not cover the level or depth of involvement patients or carers had in any of their assessments or plans.

Because of these limitations, definite conclusions about documentation and evidence of the practices audited cannot be made here. Instead, this audit should be read as providing a tendency for such practices.

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