1. EXECUTIVE SUMMARY, FINDINGS AND RECOMMENDATIONS

1.1 The aim of the Evaluation

In June 2019, the Nexus Network was commissioned by the Mental Health Commission to review the Mental Health Emergency Response Line (MHERL) and Rurallink.[1] The objectives of the review were to document the current MHERL service model, objectives and key performance indicators, determine if the current service model is effective in achieving its objectives and key performance indicators, ascertain ways to improve the effectiveness and efficiency of the service, and recommend a model of care for a mental health emergency response service reflecting current evidence-based practice.

1.2 The Evaluation process

The methodology for the review consisted primarily of three components using a quantitative and qualitative approach. The three components were a literature review, a review of quantitative data, and consultations with relevant stakeholders – government including Health Service Providers (HSPs), non-government, and consumers, carers and families.

The process was overseen by an Evaluation Steering Committee with membership including a range of stakeholders. This included the Mental Health Commission (MHC), HSPs and representatives from consumer and carer peak bodies.

Quantitative data were primarily obtained from the Department of Health (DoH) PSOLIS, Hospital Morbidity Data Collection and Emergency Department Data Collection databases. Some call data were provided by MHERL.

Sampling of participants who were invited to provide qualitative input via the consultation process was guided by the MHC and the Steering Committee. Sampling was limited by the project's timeframe and the budget. With those limitations in mind, the Evaluation team considers that the qualitative data meets the necessary requirements of rigour, credibility, relevance and overall trustworthiness. Data collection consisted of semi-structured interviews with standardised questions. Interviews were either one-on-one or small focus groups, either in person, by telephone or written comments. Consultations were carried out in two non-metropolitan locations, Geraldton and Broome.

The findings and recommendations are based upon that research conducted between July and November 2019 prior to the emergence of COVID 19. The unprecedented events of the pandemic have transformed expectations of the health sector generally, and of emergency health responses, in particular. Consequently, the findings and recommendations arising from this report need to be read in this radically transformed context.

1.3 The current MHERL service model

MHERL is a 24-hour statewide emergency triage and intervention service which is, for geographical reasons, split operationally into MHERL and Rurallink. MHERL is the contact point for the Perth Metropolitan and Peel areas, and is available 24 hours a day, and Rurallink is the contact point for people living in rural areas of the State. Rurallink is available between 4.30pm and 8.30am Monday to Friday, and 24 hours on Saturday, Sunday, and public holidays. The Rurallink number called between 8.30am and 4.30pm diverts to the designated health clinic in the local town or region. Other services, including the Sexual Assault Resource Centre (SARC), divert their phones to MHERL or direct their callers after hours to contact MHERL.

[1] For the purpose of this Evaluation, unless otherwise noted, the term "MHERL" incorporates the embedded Rurallink component of the service. However, it should be noted that Rurallink operates as an after hours service, rather than a 24/7 line.

The MHERL service is staffed by a multidisciplinary team of mental health professionals and on-call consultant psychiatrists. The service has been in operation since 2006 and in its current form since 2010. MHERL provides advice for mental health consumers and their families, as well as practitioners (including practitioners from HSPs who participated in the Evaluation) when their clients are in crisis. Many of those practitioners reported that they use the Psychiatric Services On Line Information System (PSOLIS) database which MHERL staff use to store data from callers.

1.4 Summary points

The MHERL service is provided by a team of mental health professionals. Participants identified a number of areas of improvements which could make MHERL more effective and efficient. These included redefining the service model of care, developing protocols for following up consumer calls, developing MHERL operating protocols and updating the technology.

Since 2014-15 to 2018-19 MHERL received between 22,000 and a little over 27,000 calls (or contacts) per year with a steady increase since 2015-16. It is not possible to directly compare MHERL usage with that of Rurallink as there are many differences between the two services, however the available data indicate that per 1,000 head of population Rurallink is used less than MHERL.[2] In including this data, the Evaluation also notes that Rurallink is not a 24 hour service and this is another likely reason for Rurallink receiving less contacts that MHERL.

In 2018-19 78% of contacts were triaged by MHERL as requiring "no further action". Approximately 6% were triaged as requiring action immediately or within two hours, indicating that MHERL is not only used as an emergency line but also to provide information, advice and support for consumers and other services. Specifically, in 2018-19, 4% of MHERL contacts required immediate action and 2% required action within two hours. The percentage of MHERL contacts who were admitted to hospital with a mental health condition within 30 days of the contact date has declined gradually from 28% in 2014-15 to 24% in 2017-18.[3] Whether this is due to the MHERL intervention cannot be inferred from the available data.

While MHERL relies on referring consumers to external services to provide treatment and/or support, it has no ability to control what happens after the referral is made.

Representatives from metropolitan government departments demonstrated a greater awareness of MHERL than their regional counterparts. Most regional government representatives reported that providing access to PSOLIS information was the most valuable role that MHERL played for them. Although Rurallink was reportedly not widely used in the regional areas, and awareness of Rurallink was low, except by government officers in rural areas, regional clinicians indicated that it was reassuring to be able to give consumers the Rurallink number.

Many interviewees were unclear about MHERL's role, questioning whether it was really an emergency line. Some were unclear as to what MHERL could provide in terms of advice, support or other services.

There was a wide range of responses to questions about the quality and consistency of the MHERL service across all sectors. Some consumers praised the quality of MHERL staff, others described the service as inconsistent, unpredictable and sometimes lacking a customer services focus; for example, that staff were at times rude and dismissive. Rural government and consumer groups questioned MHERL's expertise in dealing with different consumer groups, including Aboriginal, Culturally and Linguistically Diverse (CaLD), older adult, adolescent and young adult.

There were inconsistent views about MHERL referral pathways. Some government participants gave positive feedback on MHERL's use of referral pathways during Assessment Treatment Team (ATT) and Community

[2] The differences include that Rurallink is an after hours service whereas MHERL is a 24 hour service, different referral pathways available to MHERL versus Rurallink, and the population size and geographical location of Rurallink consumers versus that of MHERL consumers.
[3] The MHC advises that 'Inpatient data for 2018-19 was incomplete due to lag of coding and data was up to May 2019 only'.

Treatment Teams (CTT) operating hours as did some non-government organisations (NGOs), meaning that consumers were referred on to these services as soon as practicable. However, a majority of government participants in both the metropolitan and regional areas mentioned problems with MHERL triage and the limited referral pathways offered to callers outside of normal business hours and/or when ATTs and CTTs were not operating. This is an issue particularly in regional areas. Most metropolitan NGOs were unhappy with what they considered to be limited referral pathways offered to their consumers by MHERL staff. For regional NGOs, Rurallink's recourse to the police is seen to be particularly problematic because calling the police was not always a positive or productive response for a consumer.

With the exception of its use of referral pathways during standard operating hours, MHERL is seen by most participants across the sectors to be inward-looking with insufficient knowledge or engagement with key stakeholder groups.

While MHERL is a recognised brand for most metropolitan participants, Rurallink has limited brand recognition.

Metropolitan government representatives spoke of the need for MHERL to be co-located with other mental health services and that MHERL staff needed greater staff supervision, training and support.

A number of government and NGO participants questioned the currency of the MHERL telephone-only communication. Regional government participants would value being able to use a range of media, including videoconferencing, texting and Skype.

SARC representatives, while generally supportive of the service, reported an ongoing technical problem with the MHERL phone system whereby calls which went to the answering system were not placed in a queue. Despite efforts by MHERL, the problem had not been resolved. SARC representatives felt this should be addressed.

Access to the data in PSOLIS was valued by many clinicians, although it was suggested that the way information was collected and stored within PSOLIS was from an adult focus using a medical model, which did not suit child and adolescent services.

Some gaps in governance were identified with some operational procedures being out of date or not finalised. An effective performance reporting framework was not evident, and a need was identified to implement MOUs with police, ambulance and other partners.

1.5 Key themes and Evaluation findings

The Evaluation identified four key themes under which a total of 22 findings were made. Based on those findings seven recommendations based on the key themes, and one overarching recommendation, were made and these are described in the following section of the report.

1.5.1 Theme 1: MHERL's services, usage and role

1a. MHERL remains relevant and there is an ongoing need for such a service.

Usage data show an increase of 26% of MHERL contacts per year across 2016-17 to 2018-19 and a large majority of participants across sectors indicated that there is an ongoing need for a 24/7 mental health emergency response line.[4] This feedback strongly indicates that MHERL/Rurallink has limitations but there is currently no suitable replacement service.

1b. Rurallink is used less than MHERL.

Noting that Rurallink is not a 24 hour service, usage data show that per 1,000 head of population Rurallink receives fewer contacts than MHERL. Contact data indicates a drop in Rurallink contacts from WACHS regions

[4] The 26% increase includes both MHERL and Rurallink contacts as the available data were not separated for the two services.

from 16% in 2014-15 to 14% in 2018-19. Noting the difference in population size, a sample two-months of available call data shows that 1,263 calls were received to Rurallink compared to 7,478 to MHERL for the period recorded. All regional participants report that while Rurallink is well known to government offices in regional areas involved in the Evaluation, reported usage in those areas is low. Participant feedback from almost all government and NGO participants indicated that MHERL has a stronger presence in the metropolitan area than does Rurallink in regions.

1c. There is some confusion about MHERL's role.

Qualitative data indicate that patients mainly use MHERL during a mental health crisis whereas non-patients most commonly use MHERL to access PSOLIS information. Notwithstanding this, a majority of participants across sectors indicated that there was some confusion amongst consumers about MHERL's role, including the type of 'response' that MHERL could provide in a mental health emergency. A small majority of participants across sectors said that there are sometimes gaps between consumer expectations and the 'response' that MHERL can provide.

1d. It is not clear whether MHERL is dealing mainly with emergencies or non-emergencies.

The majority of government and NGO participants reported that most calls to MHERL were not 'emergencies'. Quantitative data suggests 4% of MHERL contacts require immediate action and a further 2% require action within two hours.

1e. An ideal model of service includes some existing MHERL components plus others.

The most common views about an ideal model of service for an emergency response line as expressed by a majority of participants were: 24/7, 'no wrong door' policy, follow up contacts to patients, and a mobile and/or face-to-face component. Aboriginal consumers, and NGOs in the regional areas, provided feedback regarding the importance of a culturally appropriate service model.

1.5.2 Theme 2: MHERL referral pathways and interactions with other services

2a. There are notable criticisms about referrals made by MHERL.

While there were some positive comments about referral pathways, most participants across sectors provided negative feedback about their experiences with referral pathways, especially police and/or ambulance.

2b. There are strong dependencies between MHERL and other mental health services.

Most participants from other services which interact with MHERL reported that the effectiveness of MHERL is dependent upon other services which provide treatment and/or support to MHERL consumers. However, MHERL cannot directly influence how other services respond to MHERL referrals.

2c. Most mental health services are not satisfied with their interactions with MHERL.

Metropolitan and regional government participants gave strongly inconsistent reports about their interactions with MHERL but most were negative. The most positive comments came from CAMHS, SARC and EDs (all metropolitan) although some of CAMHS comments were mixed. The remaining sectors provided mainly negative comments.

2d. Integration is lacking.

Most participant comments across all sectors indicate a need for better integration of MHERL with other mental health services and clarification of MHERL roles.

1.5.3 Theme 3: MHERL's service standards, quality and cultural appropriateness

3a. MHERL's service quality and standards are inconsistent.

There were strong contradictory responses about the quality and consistency of the MHERL service from almost all participants across all sectors.

3b. Rurallink is not culturally appropriate.

All the Aboriginal and some of the non-Aboriginal participants from the regions questioned the cultural appropriateness of Rurallink. They perceive that Rurallink has inadequate local knowledge and other mental health emergency help services are preferred.

3c. MHERL's value add to other mental health services is limited.

Some participants, including most ATT and CTT participants and MHCR, described MHERL as providing little added value to other available services.

3d. MHERL is disconnected and isolated from the broader mental health sector.

Most MHERL staff expressed either a sense of disconnection from the wider mental health system or commented generally on issues with integration and connection to the broader mental health system.

3e. **Performance development, training and IT for MHERL staff needs improvement.**

Although MHERL staff reported having access to professional supervision and support, training appears to lack coordination and integration with performance development processes. Most participants across all sectors also raised the need for contemporary mental health training including cross-cultural training and training for specific consumer groups to better support consumer needs.

3f. Consumer engagement is lacking.

Almost all sectors identified the need for greater engagement of MHERL with the broader mental health sector and consumers to improve responses and support a more "demand-led" model. All sectors felt that MHERL needed to seek regular, meaningful feedback to improve services.

3g. **MHERL technology needs updating.**

Some regular users of the service, mainly SARC, experience problems with the MHERL phone system. Most government and NGO participants felt that different communication modes using smart technology need to be explored as part of the MHERL service model.

1.5.4 Theme 4: Management and governance

4a. Some key operational documents are not up to date.

Some documents assessed did not reflect current MHERL processes and were either in draft or did not appear to have been recently reviewed to reflect the MHERL model. Some operational documents lacked detail and were not cross referenced to reflect other procedures.

4b. Governance structures require review, updating and communication to stakeholders.

There did not appear to be an integrated governance framework, KPIs or performance reporting. The issue of accountability and the lack of auditing of clinical practice was raised by multiple participants across stakeholder samples.

4d. Operational arrangements between the WA Police Force and MHERL should be documented.

MHCR participants felt that obligations, expectations and processes for MHERL and the WA Police Force outside of MHCR should be clarified and documented in an MOU or similar agreement.

1.6 Recommendations

The Evaluation made a total of eight recommendations. Seven recommendations relate to the key themes. Most of the recommendations relate to more than one finding of the Evaluation. The primary section/s of the report containing findings and detailed information to support the recommendation is/are noted within each recommendation. Additional supporting information underpinning findings and recommendations is contained throughout the report particularly in Sections 2, 3 and 4.

The Evaluation made one additional overarching recommendation which is supported by all the key themes. This recommendation is listed at the end of the recommendations table. This recommendation reflected the views of the Evaluation team and the Evaluation Steering Committee (ESC) that there is a need for a broader follow up review of MHERL in the context of the overall mental health support system. The aim of such a review would be to identify a future integrated, system-wide mental health emergency support model.

Recommendation 1

1. **Retain and strengthen a mental health telephone support service by clarifying its role and promoting its use.** (Section 5.1 and 5.2)

Including:

- Clarify MHERL's role and where required define its aims and objectives.
- Update promotional material to clarify MHERL's role and services.
- Implement an ongoing communication strategy to promote the service to consumers which includes general awareness raising information, advocacy and training to targeted groups.

Recommendation 2

2. **Undertake tailored promotion of Rurallink in rural and remote locations where there is no suitable local alternative and where awareness and usage are low, through regular onsite visits and consumer engagement.** (Section 5.1)

Recommendation 3

3. **Implement strategies to increase the relevance and value of Rurallink for Aboriginal consumers and organisations.** (Section 5.3)

Including:

- Update MHERL protocols and pathways for contacting MHERL for cultural appropriateness.
- Regularly engage with local consumers and service providers to develop adequate local knowledge about consumer needs and local services.

Recommendation 4

4. **Implement strategies to better connect and integrate MHERL with the broader mental health sector and consumers.** (Section 5.2 and 5.3)

Including:

- Establish a stakeholder reference group, comprising government, NGO, consumer and regional representation, to provide regular guidance and feedback to MHERL/Rurallink.
- Explore options to integrate MHERL/Rurallink into the mental health system, such as co-location (for example, with MHCR or Telehealth or rotation of staff through mental health services.

Recommendation 5

5. Implement strategies for the use of improved technology to support quality services. (Section 5.3)

Including:

- Investigate and adopt new technologies suitable to meet the needs of existing and potential MHERL/Rurallink consumers.
- Improve the performance of IT infrastructure and hardware for MHERL staff to ensure that IT faults do not impact service delivery and that IT equipment is contemporary to the needs of the service (including the MHERL phone system).

Recommendation 6

6. Formalise, monitor and review the effectiveness of partnerships with response services. (Section 5.4)

Including:

- Review and update existing MOUs and other similar agreements.
- Ensure that detailed service protocols including handover are documented as part of agreements.
- Document formal agreements with partner organisations where an agreement does not exist such as ambulance, police and ATTs.
- Establish formal protocols between MHERL and WA Police incorporating MHCR, and direct contact with MHERL by police officers.

Recommendation 7

7. Undertake a review of MHERL governance with reference to the Public Sector Commission Good Governance Principles and Checklist as relevant to MHERL operations. (Section 5.2 and 5.4)

Including:

- Implement an integrated, clearly articulated, performance framework to measure whether MHERL is achieving its aims.
- Ensure that clear aims and objectives, Key Performance Indicators and success measures are integrated into performance reporting.
- Identify data required for effective performance reporting and develop systems to provide the required data.
- Incorporate a MHERL performance reporting framework as part of the MHERL/Rurallink funding agreement with the Mental Health Commission.
- Review and update MHERL operating procedures, protocols and processes to ensure that they are contemporary and reflect good practice.

- Ensure that operational documents including policies are finalised and that staff are trained in their implementation.
- Build in consumer feedback and engagement as part of the performance framework to monitor the quality of MHERL services and identify ways of improving the service.
- Implement an ongoing staff development program that links service performance, individual staff performance and staff training and development. Ensure that staff receive regular training and feedback on their use of service protocols.
- As part of the staff development program, ensure that staff complete ongoing contemporary training on contemporary mental health conditions and responses.

Recommendation 8

8. **Conduct a follow up review of the broader Western Australian mental health system (within which MHERL is a key service provider) to identify an appropriate, integrated, long term, future mental health emergency service model.**