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.

# Terms of Reference, Executive summary and Recommendations

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# Acknowledgements

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The Reviewer records grateful appreciation to the above members of the Review Team without whose work and dedication this Review would have been impossible.

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## Important Disclaimer:

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# 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.

# 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.

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. 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 the full version of the Review.

**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.

**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.

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.

## 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.

## 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.

## 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.

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.

[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).

4.7 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.

## 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.

## 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.

## 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).

## 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.

## 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.

The full version of the Review is available online at:

**www.health.wa.gov.au**
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