

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.

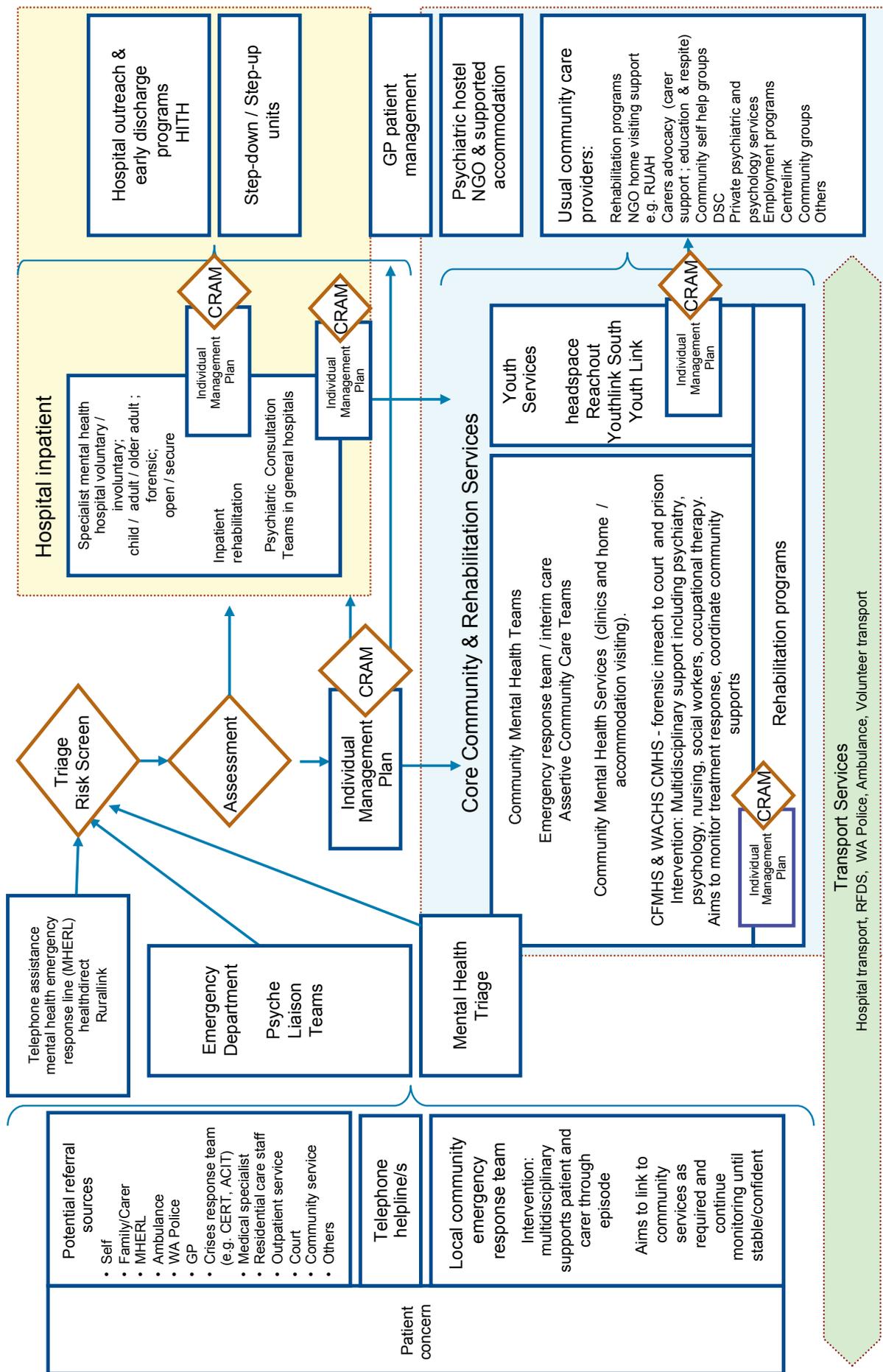
See Recommendation 1: Governance (1.1.1); and Recommendation 9: Judicial and criminal justice system.

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/carers 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

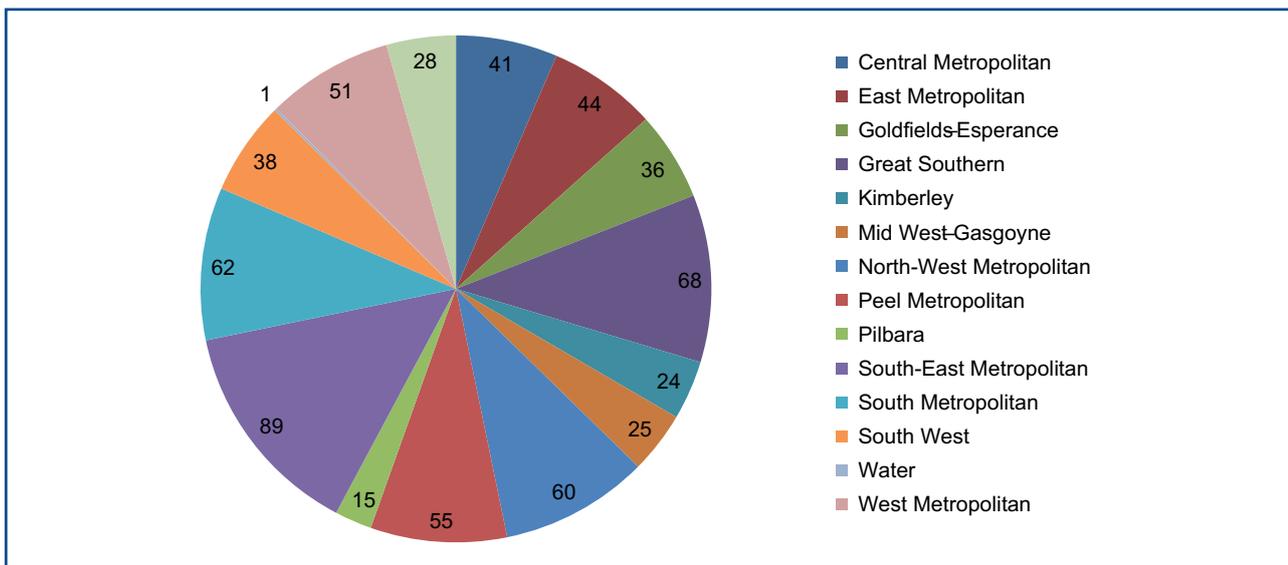
There are incidents when WA Police require the assistance of mental services. They include incidents in the community where a person:

- 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

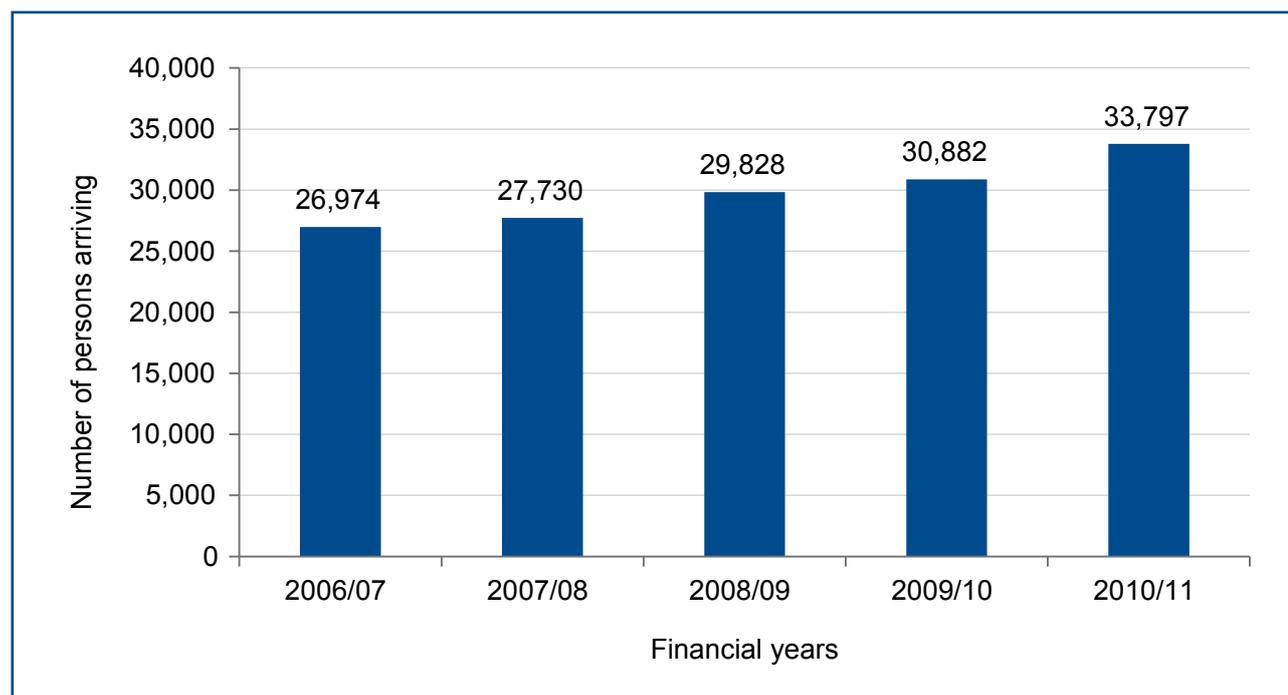
Over the past few years, improvements in psychiatric care in EDs characterises the desire of clinicians to continuously improve the system for patients. The Review notes the following examples:

- 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.

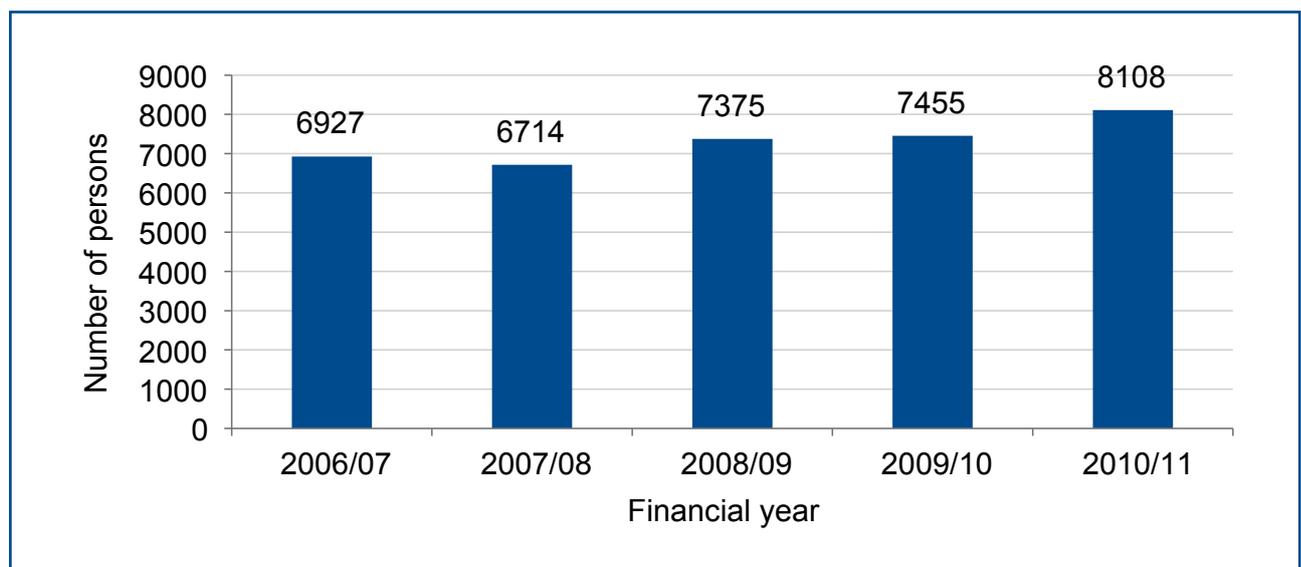
3.12.4 Admission to a general hospital

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.

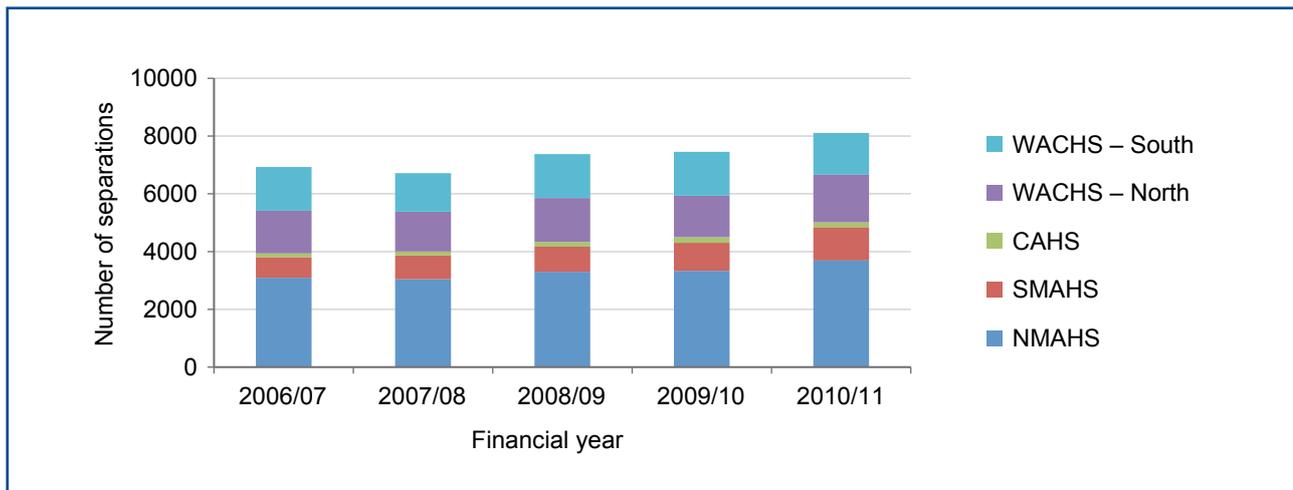
Figure 28 Number overnight separations of mental health patients 0–64 years in non-MH specialised units, 2006–11



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.

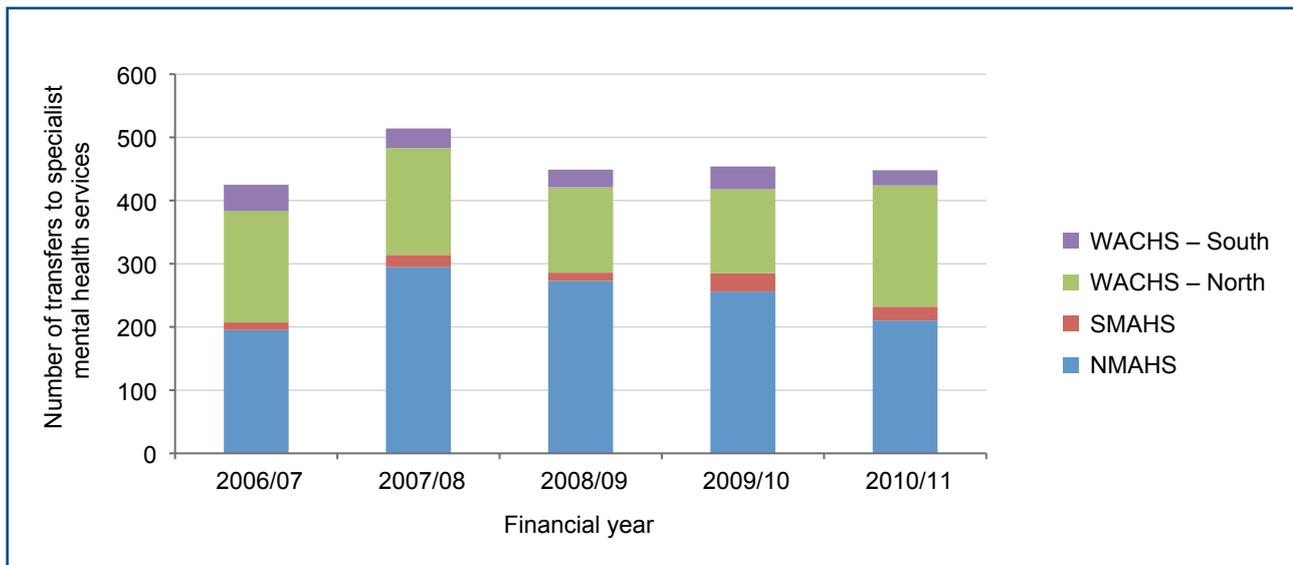
Figure 29 Number overnight separations mental health patients 0–64 years in non-MH specialised units by Area Health Service, 2006–11



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).

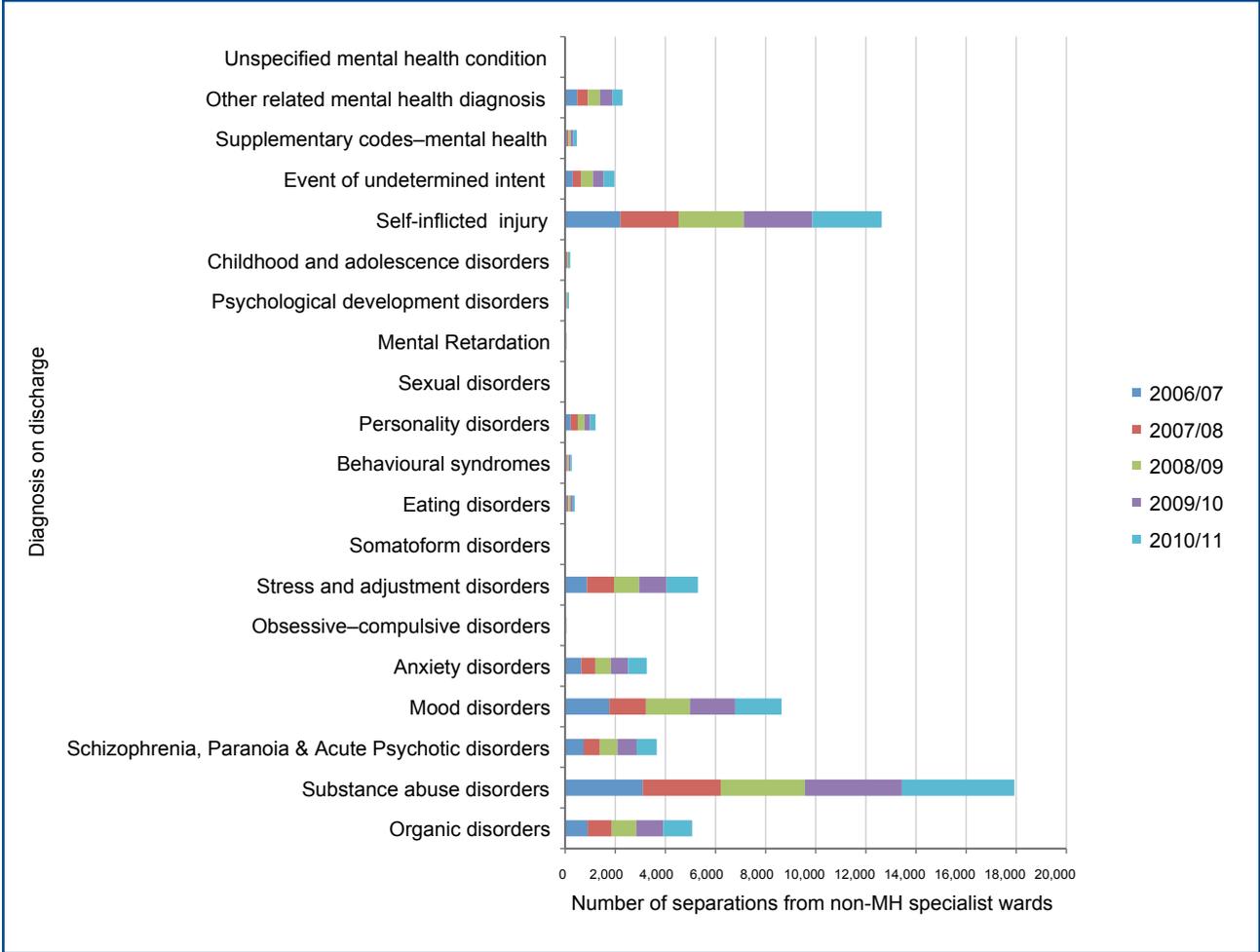
Figure 30 Number overnight mental health patients 0–64 years in non-MH specialised units transferred to specialist mental health services within 2 days, 2006–11



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 criterion⁵ 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:

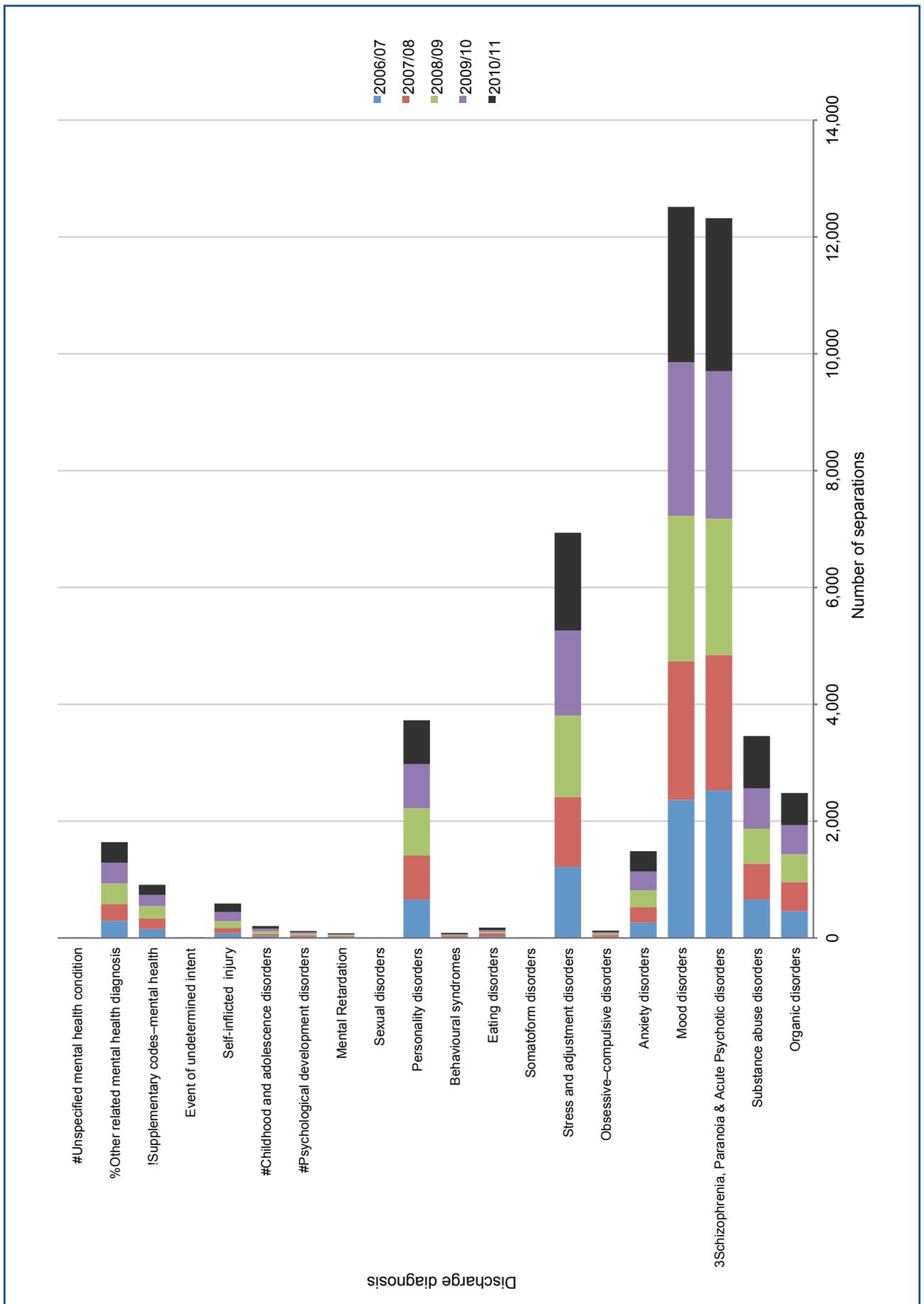
- mood disorders (2660 in 2010–11)
- schizophrenia, paranoia and acute psychotic disorders (2619 in 2010–11)
- stress adjustment disorders (1672 in 2010–11)
- personality disorders (751 in 2010–11).

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.

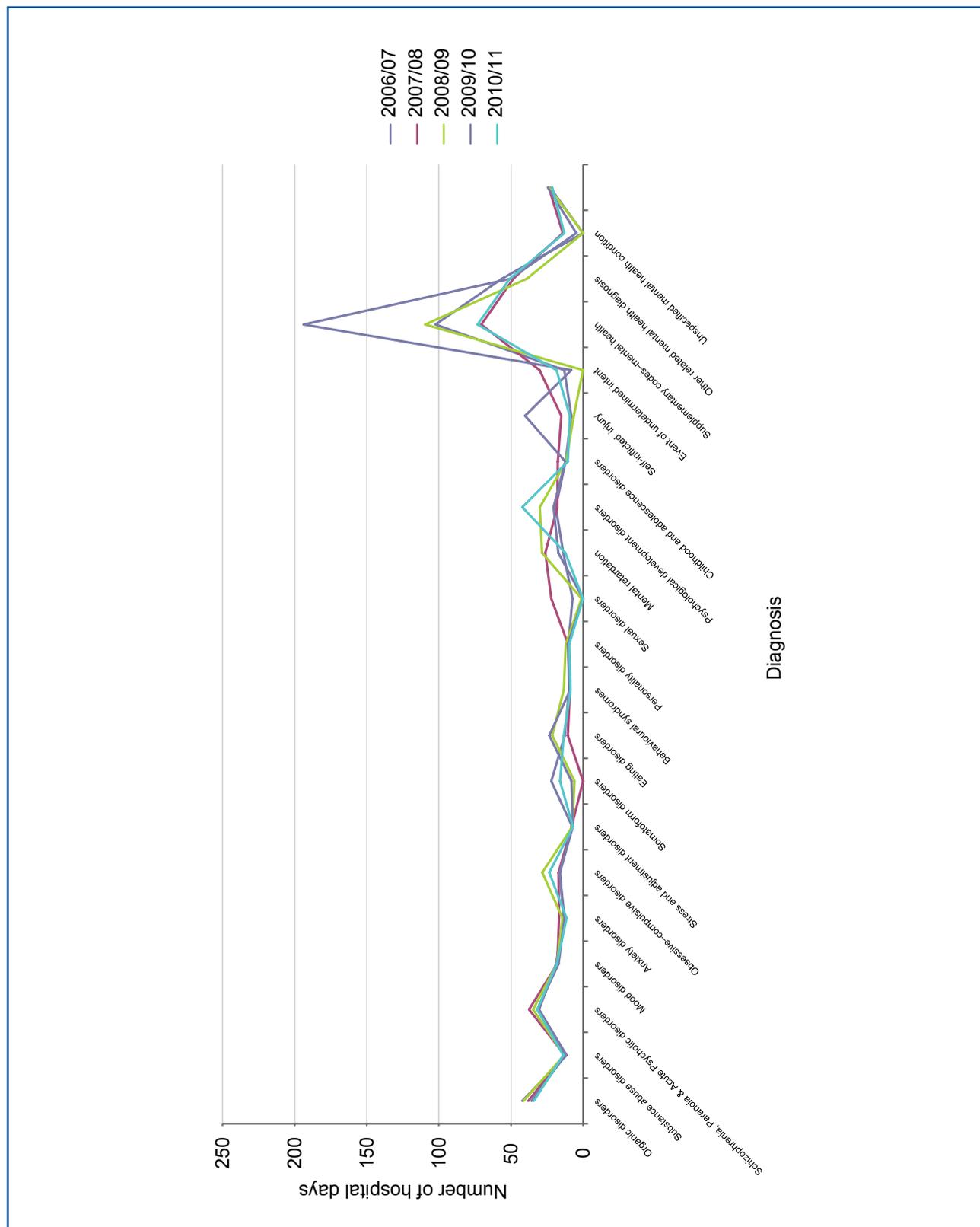
Figure 32 Mental illness diagnosis at separations from specialist MH units, 2006–11



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

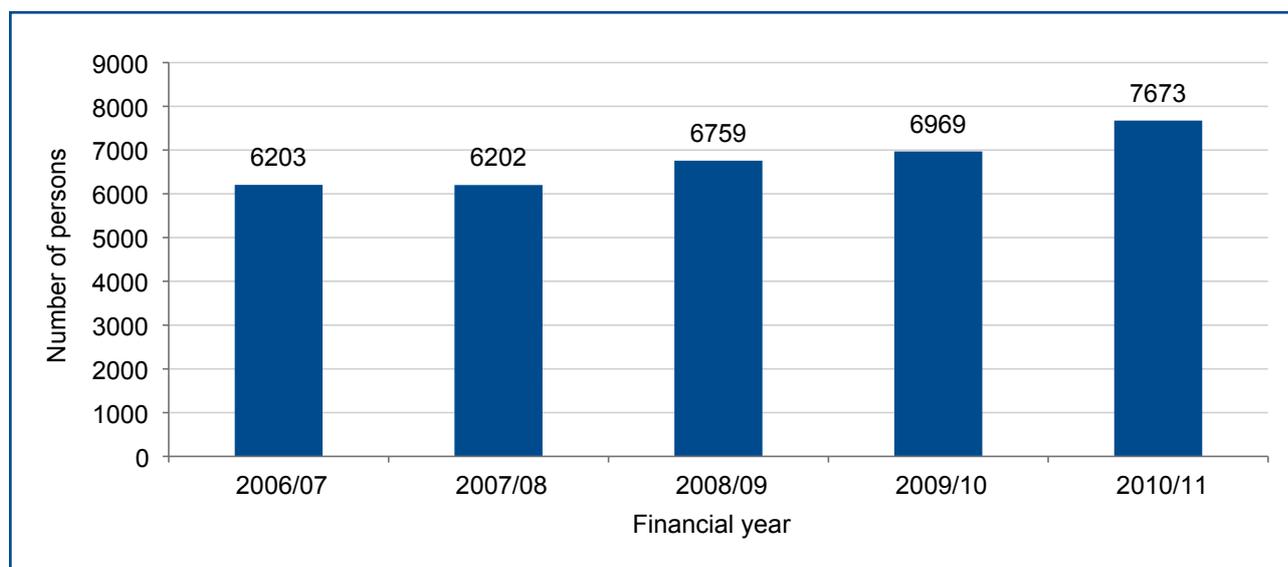
This Review acknowledges the importance of improving patient flow and maximising the use of acute care beds. However, every effort should be made to ensure that optimal care is not diminished by virtue of a focus on increasing patient flow.

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).

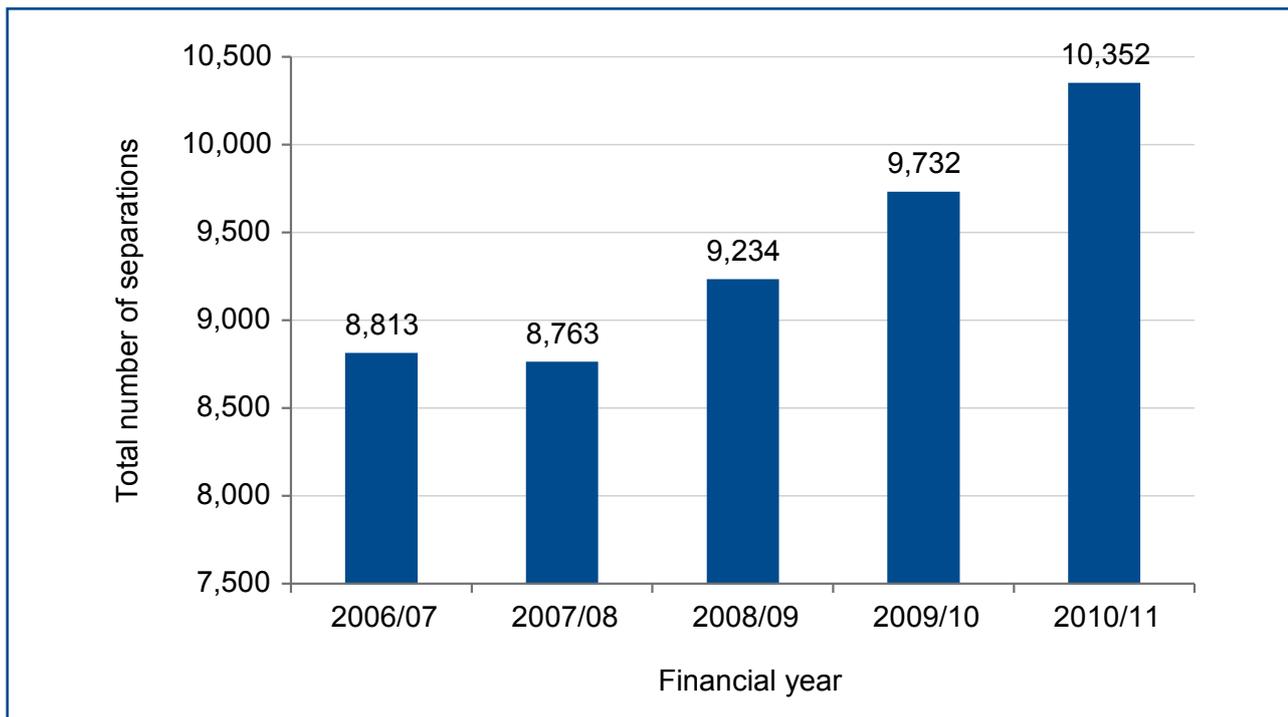
Figure 34 **Number of children and adults admitted to specialist MH services, 2006–11**



Note: A person is only counted once even if treated in more than one facility or frequently in the same facility.

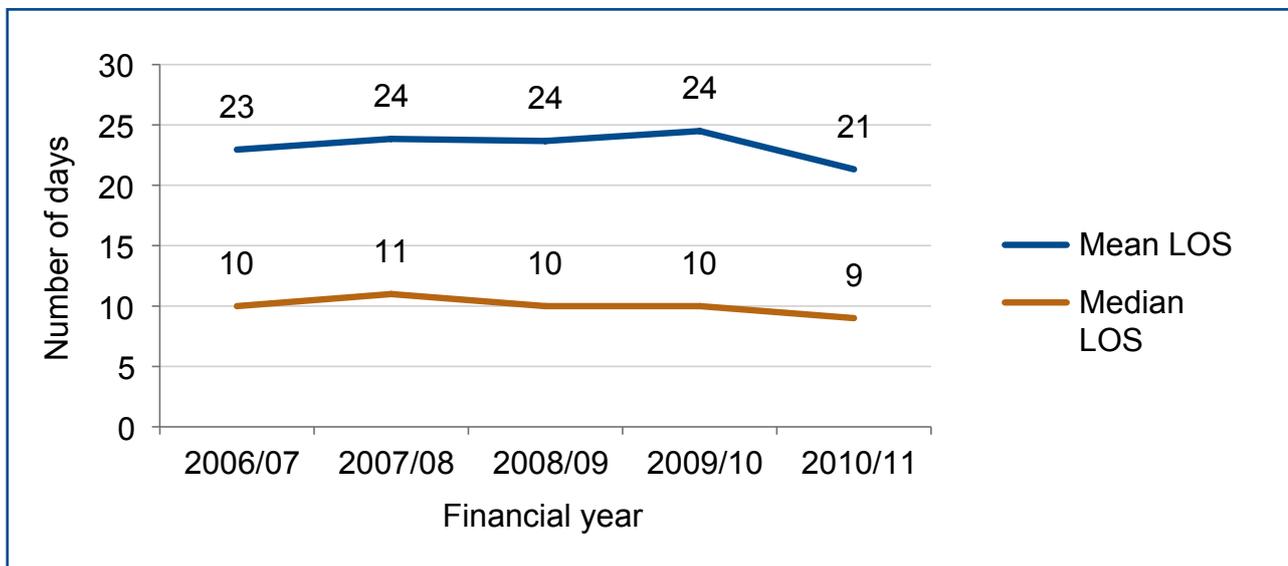
Source: MHIS DoH (2012).

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 & Laugharne 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.

Armada 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).