1. Establishing the Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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