A Review of RuralLink and the Mental Health Emergency Response Line

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<td>CERT</td>
<td>Community Emergency Response Team</td>
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<td>CMHS</td>
<td>Community Mental Health Service</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>ICT</td>
<td>Information and communications technology</td>
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<td>MHERL</td>
<td>Mental Health Emergency Response Line</td>
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<td>MH-ORC</td>
<td>Mental Health Operational Review Committee</td>
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<td>MH-REP</td>
<td>Mental Health Regional Enhancement Program</td>
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<td>NGO</td>
<td>Non-government organisation</td>
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<td>PACER</td>
<td>Police, Ambulance and Crisis Assessment Team Early Response</td>
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<td>PET</td>
<td>Psychiatric Emergency Team</td>
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<td>PLN</td>
<td>Psychiatric Liaison Nurse</td>
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<td>PSOLIS</td>
<td>Mental Health Clinical Information System</td>
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<td>RL</td>
<td>RuralLink</td>
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<td>SARC</td>
<td>Sexual Assault Referral Centre</td>
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<td>SCSEP</td>
<td>Statewide Clinical Services Enhancement Program</td>
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<td>SW24</td>
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<td>Western Australian Country Health Service</td>
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Executive Summary

The aim of the Review

In February 2011, the WA Centre for Mental Health Policy Research was commissioned by the Mental Health Operations Review Committee to review the Mental Health Emergency Response Line (MHERL) and RuralLink (RL). While MHERL provides a 24/7 mental health emergency telephone service for the metropolitan area, RL provides an after-hours mental health telephone support service to the regional areas of WA. Both services are currently managed as a single service and are provided by the same group of staff. The aim of the Review was to examine the effectiveness of these two services and make recommendations regarding their future development.

The Review process

A wide range of people from key stakeholder groups were consulted, primarily through face-to-face interviews, but some by videoconference. A literature review was carried out and telephone interviews were held with mental health service providers in other States, focussing on innovative models of service delivery, particularly the use of information and communications technology (ICT). The major focus of the consultation during this Review was on RL, as MHERL had been part of a previous extensive review of emergency services undertaken for the North Metropolitan Area Mental Health Service in 20101. Data was also collected and analysed to establish the current profile of service provision. The findings of the Review were presented to key stakeholders in a workshop for their consideration and feedback.

Historical development of MHERL/RL

MHERL and RL did not ‘start life’ together. MHERL, a centralised emergency telephone service, and seven Community Emergency Response Teams (CERTs), were established in 2006 to replace the Psychiatric Emergency Team (PET), which had been both a centralised emergency mental health telephone line and community-response service established some 15 years earlier to cover the metropolitan area.

RL, on the other hand, had started life in 2003 as two separate pilot telephone support services provided through a private provider; RuralLink, covering the Midwest/Gascoyne region, and SouthWest 24 (SW24), covering the South West region. While SW24 continued to provide services to the South West until 2010, RuralLink was handed over to PET to run following the trial and its remit expanded to take in the remaining country areas. In 2010, the contract for SW24 was not renewed and MHERL was given responsibility for after-hours services for the South West region.

Findings of the Review

While ‘embedding’ RL and SW24 in MHERL, an existing 24/7 centralised emergency telephone response line, seemed to have had a certain logical fit, there were clearly a number of potential downsides that were not apparent at the time. RL and SW24 were originally established as separate services, ‘owned’ by their regions and working closely with them to respond to local needs. This nexus has been broken in the process of integration of

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the three services. Despite there being virtually no specialist mental health services operating after-hours other than through RL, it has not been viewed by staff as an after-hours extension of local mental health services although RL was established with this specific remit as a part of its role. As a result, it has not been widely used as an adjunct to management by mental health staff but primarily seen as a service providing for the needs of consumers and their families.

Another downside had been that RL has remained simply an after-hours telephone service. In both South Australia and New South Wales, where the responsibility for providing support within rural and remote areas resides with country mental health services, there has been significantly greater ownership and uptake of services and much more innovative solutions to tackling the ‘tyranny of distance’. In the Greater Western and Greater Southern regions of NSW, for example, 24/7 videoconferencing services have been established into Emergency Departments (EDs) to assist them in the assessment and management of patients who present with mental health emergencies. This has reduced the transporting of patient for assessment by two thirds in Greater Western NSW.

The Western Australian Country Health Service (WACHS) has a specialist mental health videoconferencing service, the Statewide Clinical Services Enhancement Program (SCSEP), which provides a wide range of clinical, educational and staff development services for rural and remote clinicians and clients, mainly for Child and Adolescent Mental Health Services. There has been no formal or informal relationship between RL, which is managed by the North Metropolitan Area Mental Health Service, and SCSEP which is managed by WACHS, despite the major opportunities that such links could have presented.

There are generally between 1,800 and 2,000 calls to MHERL and RL each month, with the latter making up approximately 16% of these calls. Self referrals and referrals from family and friends make up the largest proportion of calls to both services. Despite the difference in the stated roles between the services, their triage category profiles were almost identical, with 14 to 15% of calls assessed as requiring an immediate or rapid (within two hours) response and 45 to 46% as not requiring a response from mental health services.

In 2010 calls to RL increased by 40%, due largely to the increase in calls following the closure of SW24. Call rates from the regions varied widely with the Great Southern having the highest rate, some 2 to 3 times that of the Kimberley which has the lowest rate.

In the country, the main avenue for obtaining an 'urgent' response after-hours is through the ED. Data shows that the peak period for calls to RL is between 3:00pm and 10:00pm, which is the same as the pattern of use seen in EDs. The role of RL was not well understood by staff in the EDs and very few had made use of its services. Similarly, the Police reported that that they rarely make use of RL, but generally take people requiring mental health assessment directly to the ED. Staff in the EDs in the Regional Hospitals were very clear that what was needed was specialist mental health input into the EDs, both during and after-hours. They believed that this would help to reduce the pressure on ED and reduce the number of people being admitted to hospital.

Most consumers and carers knew about RL, which was actively promoted by mental health services and other community agencies and feedback from those that had used the service was generally positive. There was also strong support amongst clients and their families, from the Police and amongst staff from non-government organisations for the establishment of after-hours specialist mental health services in the Regional Hospital EDs.
As stated above, MHERL was extensively reviewed in 2010. The major findings from that review were as follows:

- MHERL is not widely promoted within the community and for many people, particularly those seeking help for the first time, it is not easy to find out how or where to get help.
- Although MHERL has been designated as an ‘emergency’ response line, only 15% of the callers were assessed as requiring a response within two hours while almost 50% of calls were for information and advice.
- Although it was originally envisaged that MHERL would triage calls and have the authority to mobilise a community response, this has not occurred and the Community Mental Health Services/CERTs have continued to undertake their own assessment before responding. This duplication of effort is not only wasteful of resources, but has a significant effect on response time.
- The ambiguity in MHERL’s relationship with the Area Mental Health Services has meant that it has not been ‘owned’ by the services and, therefore, not been appropriately used as an adjunct to their services.

With the replacement of the PET by MHERL and the CERTs, the capacity of the system to respond to ‘high-end’ emergencies has diminished.

**The way forward**

Firstly, it needs to be stressed that the changes proposed are not meant to denigrate the work of MHERL and RL, which have continued to provide a valuable and high quality service to the community within the limits of their remit and resources.

There are, however, significant structural problems with the current system, primarily resulting from the separation of the specialist telephone triage line from the community response services. The current model for MHERL can best be conceptualised as a step in the transition of the emergency response from a fully centralised to a fully devolved service.

The embedding of RL within MHERL should also be seen in a similar light. The needs of country mental health go far beyond the requirement of an after-hours telephone response line. Services are thinly spread outside the regional centres and there will always be a reliance on other key health providers, especially General Practitioners and EDs. More extensive use of ICT can be used to support these providers and to provide direct clinical care.

The time has come to look at new and innovative approaches to the provision of emergency support in the metropolitan area and enhanced support for country areas. The proposals for the redesign of services can essentially be functionally differentiated into three major groups:

1. **Improving access to help for people with mental health problems.**
   - Provision of a 24/7 Statewide telephone information, advice and counselling line for consumers, their families and the general public. This would be a highly publicised service that would assist people navigate the system to get timely access to the ‘right’ service.
ii. Redesign of emergency mental response services for the metropolitan area.

- Area Mental Health Services to provide a 24/7 telephone triage service for people of all age groups from within their area. This service must be able to deploy the emergency response service without further re-triaging/re-assessment.
- Establish the capacity for an emergency co-response by police and mental health.

iii. Strengthening the capacity of country mental health services.

- Establish an extended hours specialist mental health consultation/liaison service in the Regional Hospital EDs.
- Create a Mental Health Regional Enhancement Program (MH-REP) within WACHS which would complement regional mental health services and also provide a range of support services for other country service providers such as GPs and EDs. This program would operate 24/7 delivering services to country areas using ICT. The program would not be accessible as a separate service but ‘through’ the regional mental health services.

The objectives of MH-REP are very much in line with those of the Southern Inland Health Initiative and funding could be sought from this source to commence the roll-out of the program across the southern half of the State.
Recommendations

There are seven recommendations arising from this Review. Further detail on each of these recommendations is provided in Chapters Five and Six.

Recommendation 1
North and South Metropolitan Area Mental Health Services each to provide 24/7 specialist telephone triage with priority access for police and other emergency services. These triage services would cover all age groups.

Recommendation 2
Establish a 24/7 Statewide Mental Health Advice Line to provide information, advice, counselling and on-referral for consumers, their families and the wider community. This service would operate using a single Statewide telephone number and be broadly advertised and promoted.

Recommendation 3
The Women’s and Newborn Health Service to be responsible for providing the after-hours telephone service for the Sexual Assault Referral Centre (SARC).

Recommendation 4
Establish a mental health/police co-response service in Perth based on the Victorian Police, Ambulance and Crisis Assessment Team Early Response (PACER) model.

Recommendation 5
Establish Psychiatric Liaison Nurse (PLN) positions in each Regional Hospital Emergency Department (Albany, Bunbury, Geraldton, Kalgoorlie, Port Hedland and Broome). This service would operate from 8.00am to 10.00pm, 7 days a week.

Recommendation 6
Establish a new 24/7 service, the Mental Health Regional Enhancement Program (MH-REP), within the WA Country Health Service (WACHS). This service would incorporate the functions currently provided by RuralLink and the Statewide Clinical Services Enhancement Program (SCSEP), expand the use of a range of services and use information and communications technology (ICT) to complement local mental health services and support other providers, primarily Emergency Departments (EDs), General Practitioners (GPs), non-government organisations (NGOs) and police.

Recommendation 7
Provide a 24/7 triage service for each region using MH-REP to support and complement local mental health services. Each region would operate with its own regional 24/7 mental health contact number, and not a Statewide number, so as to promote local ownership of the triage service.
1. Introduction

1.1 Background

In February 2011 the Western Australian Centre for Mental Health Policy Research commenced a Review of RuralLink (RL) and the Mental Health Emergency Response Line (MHERL). The Review was commissioned by the Mental Health Operations Review Committee (MH-ORC). This Committee has a co-ordinating function across the three Area Health Services (North Metropolitan, South Metropolitan and Country) which have operational responsibility for the WA Department of Health specialist mental health services.

1.2 Service description

MHERL and RL are a mental health telephone service located in central Perth and are part of the specialist mental health services provided by the WA Department of Health. While RL provides an after-hours service to all regional areas of Western Australia and MHERL provides a 24/7 emergency service across the metropolitan area, the two programs are operationally managed as one service provided by the same group of staff. Operational responsibility for the service lies with the North Metropolitan Area Mental Health Service.

RL is an after-hours mental health telephone service for rural and remote communities, accessible from 4.30pm to 8.30am Monday to Friday and 24 hours on Saturday, Sunday and public holidays. It is an after-hours extension of local mental health services. As such, it is an after-hours contact point providing information, advice, assessment and assistance to access appropriate services for new and existing clients and carers, community members, health professionals and community and welfare services.

MHERL provides a 24 hour, 7 days a week assessment and support service to:

- individuals who feel that they require urgent assistance
- families or carers of those with a mental illness
- members of the general public who witness a mental health crisis and require assistance
- health professionals
- community welfare service providers.

MHERL also provides an after-hours advice service for the Sexual Assault Referral Centre (SARC).
2. Review scope and process

2.1 Objective and scope of the Review

Broadly, the objective of the Review was to examine the effectiveness of MHERL and RL and make recommendations regarding the future development of the two services. The scope of the Review is detailed in Figure 1.

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**RURALLINK:**
An after hours component of the rural mental health service system.

1. Review its role, function and relevance to target population
2. Examine relationship with other services:
   • Internal – Rural MHS, ED, ICAYMHS, Older Adult, Metro MHS
   • External – Police, GPs and other health/welfare, NGO
3. Review gaps, effectiveness and make recommendations for service development

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**MHERL:**
Part of mental health emergency response for the metro area.

1. Review its role, function and relevance to target population
2. Examine relationship with other services:
   • Internal – CERT, CMHT, ED, ICAYMHS, Older Adult
   • External – Police, other telephone lines, Health Direct
3. Review gaps, effectiveness and make recommendations for service development
4. Review other functions [SARC]

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**Figure 1: Scope of the Review of MHERL and RL**

As MHERL/RL provides a service across the age continuum the scope included an examination of the relationship with Infant, Child, Adolescent and Youth Mental Health Services (ICAYMHS) and Older Adult Mental Health Services, in addition to the Adult Mental Health Services in both metropolitan and country areas. The Emergency Departments (EDs) were identified as a key part of the mental health service system, particularly after-hours as were other external providers such as the WA Police, GPs and NGOs. As a consequence the scope included an examination of the interface between MHERL/RL and these provider groups.

In 2009/10 the WA Centre for Mental Health Policy Research completed a *Review of Emergency Mental Health Services in North Metropolitan Perth*² which included an examination of MHERL as an important component of the metropolitan emergency service system. The current Review builds on this previous work and as a consequence it was considered not necessary to repeat the extensive consultations and service activity analysis for MHERL. The consultations and data analysis in this Review have focussed primarily on RL.

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This Review, however, provided a unique opportunity which was not possible in the previous *Review of Emergency Mental Health Services in North Metropolitan Perth*, in that it allowed the two services to be examined both as separate entities with their distinctive roles and as one operational unit which is managed and functions as a single entity.

### 2.2 The Review process and deliverables

The Review process comprised four key components:

1. **Consultations** with internal and external stakeholders through:
   - Interviews with mental health service and other service providers.
   - Visits to mental health service and other service providers in the regional areas of Albany, Kalgoorlie, Broome and Bunbury.
   - Face-to-face and telephone interviews with mental health service providers in other state jurisdictions to investigate initiatives and models being implemented in rural and remote mental health services.

2. A **workshop** with key stakeholders where preliminary findings and future service development options were presented and feedback obtained.

3. A **literature scan** which included the utilisation of emerging communication technology in health and a review of models servicing rural and remote areas.

4. **Data collection and analysis** of service use to establish the current profile of service provision for MHERL/RL.

The Review deliverables are detailed in Figure 2.

The Review will provide:

1. The current role and function of MHERL and RuralLink within the mental health system and their relationship with other service providers

2. A profile of service provision, including variations in the patterns of service use

3. Views of stakeholders, including consumers and carers, about the appropriateness of these services and the way in which they are delivered

4. An understanding of the strengths and weaknesses of the current service arrangements

5. Identify options and provide recommendations to MH-ORC for future development of service, including resource implications

**Figure 2: Review deliverables**
3. **Consultations**

3.1 **Process**

Over 70 people were consulted to obtain a wide range of views on how MHERL and RL were currently functioning and how they could be further developed. A list of those consulted is detailed in Appendix 1. These consultations predominantly focused on RuralLink, because as previously discussed, views on MHERL had been widely canvassed for the Review of Emergency Mental Health Services in North Metropolitan Perth.

Consultations were primarily conducted through interviews, with the majority being face-to-face and some via videoconferencing. A wide range of people were consulted including:

- Specialist mental health staff
- Emergency Department staff
- Office of the Chief Psychiatrist
- Non-government organisations
- Consumers and carers
- Mental Health Commission
- General Practice
- Police
- Ambulance

Site visits were conducted at country regional centres and Denmark with videoconferencing to selected district hospitals as detailed in Figure 3.

**Figure 3:** Site visits and videoconferencing to regional WA

The interviews were broadly guided by the following questions:

- How does RL currently operate and how do you use the service?
- What is working well?
- What is not working and why?
- What changes should be made to RL to enable it to function better?
- What future direction should mental health services take to enable a better service to be provided?
3.2 Key issues from the consultations: RuralLink

3.2.1 Consumers and carers

Most consumers knew about RL because it is actively promoted by mental health services and publicity material is widely displayed in Community Mental Health Services (CMHS), EDs and other community agencies. Feedback was generally positive from consumers and families that had used the service. However, consumers and carers generally wanted after-hours services to be available locally, particularly access to specialist mental health staff in EDs.

There were two issues that were raised in the Kimberley that were of local significance:

- **The ‘name’ and ‘badging’ of RL:** people in the Kimberley refer to their area as ‘regional’ or ‘remote’ and not ‘rural.’ The kangaroo paw, which is the symbol used by RL, does not grow in the North West.

- **Aboriginal consumers:** in addition to difficulties accessing a telephone, they experienced the lack of a ‘personal’ connection to the service provider as a significant barrier to using the service.

3.2.2 Local mental health services

Where staff used RL for after-hours support of their clients, they found it reliable and effective. However, it was not widely used as an adjunct to treatment by staff that saw it primarily as a service for consumers and their families. Overall, RL was not seen as an extension of local services but an ‘external’ service over which they had little control.

Each of the regions visited had particular after-hours issues, specific to their region:

- **South West:** There was some expectation that RL would continue to provide the same function as the sole entry point to services 24 hours per day as had SouthWest 24 (SW24). The South West Mental Health Service was in the process of transitioning to build its own triage service.

- **Goldfields:** ED staff at the Kalgoorlie Regional Hospital expressed some concern at the loss of the after-hours mental health call-out service some months earlier. It was reported that this had placed increased pressure on inpatient admissions, both on the psychiatric and general medical beds. In talking to the Mental Health Service, it was explained that they had found it difficult to maintain the roster because of staffing issues.

- **Great Southern:** Albany Regional Hospital was committed to introducing a psychiatric consultation and liaison position into the ED. The Mental Health Service was planning with RL to pilot an after-hours videoconferencing service into the Albany and Katanning hospital EDs.

- **Kimberley:** The Kimberley Mental Health and Drug Service provides a 24 hour on-call psychiatrist service staffed by their two regional psychiatrists. Medical staff in district hospitals used either this service or the Graylands Hospital medical staff as back-up.

3.2.3 Emergency Departments

The Regional Hospital EDs reported that they rarely use RL. Their preference was for specialist mental health staff available in the ED.

Many of the District Hospitals consulted knew little about RL, but were receptive to the idea that RL could help them in assessing and treating clients with mental health issues. The lack
of specialist mental health support in the district hospital EDs leads to staff feeling unsupported and not confident in managing people with mental illnesses. It was reported that this results in an over-reliance on the transfer of clients ‘on forms’ to regional or metropolitan hospitals. This not only places pressure on clients and their families and mental health services, but also on police and ambulance services.

One of the major challenges to greater use of RL by country health services is the high turnover of staff. This makes it difficult to maintain staff awareness about RL and to build staff knowledge and skills to enable them to better manage mental health clients.

Furthermore, ED staff do not have access to the Mental Health Clinical Information System (PSOLIS) which would provide them with essential clinical information.

### 3.2.4 Police

The Police rarely make use of RL and generally take people directly to the local ED. There appears to be a very supportive relationship in country areas between the Police and mental health services. However, the transport of patients after-hours can be problematic as many police stations are not staffed in the evenings and officers have to be called back to assist. Transporting people to the metropolitan area is particularly burdensome as it can remove police officers from their normal duties for a significant period of time.

### 3.2.5 Non-government organisations

The NGOs which were consulted reported that they rarely used RL and did not seem aware that they could directly refer people for after-hours support. However, while they were receptive to the concept of accessing the after-hours support which RL could provide, many also expressed their preference for a local response and to access specialist mental health support through EDs.

### 3.3 Key Issues from the consultations: Mental Health Emergency Response Line

As outlined earlier, MHERL was part of an extensive review of emergency services conducted on behalf of the North Metropolitan Area Mental Health Service in 2010. At that time, the reviewers consulted widely with a large number of key stakeholders across the metropolitan area. The key issues below were raised in earlier consultations and in additional interviews with a selected number of key people for the current Review. As MHERL and RL services are provided by the same staff some of the issues are relevant to both services.

- **Promotion/understanding of service among consumers:** Consumers and their families, particularly those who have not used mental health services before, report finding it difficult to know where to go for help and in accessing and navigating the system. Part of the problem is that MHERL is not widely advertised and the service’s name, which incorporates the term ‘emergency’, does not encourage people to make contact for matters that may be urgent but not an emergency.

- **Clarity of role:** The role of MHERL is, in fact, unclear. While it is badged as an emergency service, it undertakes a whole range of activity, including the provision of information, advice and non-urgent counselling. Although MHERL is tasked to provide support for specialist mental health services and other agencies, it is primarily used by consumers and carers. Reports from consumers and carers who have used MHERL
have been generally positive. The Police also reported that they found MHERL useful for obtaining information about people suspected of being mentally ill, but do not use the Community Emergency Response Teams (CERTs) because of their response time.

- **Assessment issues**: Currently, MHERL does not have the authority to mobilise a community service response from the CERTs or the Community Mental Health Teams, which reserve the right to make that decision following their own re-assessment. The Community Mental Health Teams, for their part, claim that MHERL often refers people to them without a comprehensive assessment. Whatever the reason, there is considerable duplication of effort, which is not only unhelpful for consumers and their families but wasteful of resources.

- **Limited engagement with broader MH system**: MHERL, which reports through the Deputy Director, North Metropolitan Area Mental Health Service, is clinically isolated and poorly linked into the mental health system. As a result of not being ‘owned’ by the system, there is limited engagement in any form of joint policy development or planning. Examples of this have been the limited involvement of key stakeholders in decisions about the future of the CERTs, MHERL taking on the after-hours service for SARC and the devolution of the functions of SW24.

- **Technology/system issues**: Data collection has presented a real problem for MHERL staff. The outdated telephone system does not automatically collate routine data such as the number of drop out calls, time to answer the call or postcode of the caller. Furthermore, the PSOLIS triage module is not well designed for a telephone triage service and attempts to remedy this have, to date, been unsuccessful in bringing about any change.

### 3.4 Key issues from the Future Options Workshop

The preliminary findings from the Review were presented to heads of service and senior staff from regional and metropolitan mental health services and the Mental Health Commission at a workshop on 7 July 2011.

Overall there was support for:

1. **A 24/7 Statewide Mental Health Line** which is well publicised and readily accessible to provide information, advice and counselling from a mental health professional.

2. **An enhanced rural service with local 'ownership'** which provides:

   - Psychiatric Liaison Nurse (PLN)/Consultation-Liaison service in the Regional Hospital ED which in turn supports the district hospital EDs and nursing posts.
   - Increased use of videoconferencing to enhance assessment and treatment.

3. **Strengthening the metropolitan local integrated service model** to enable 24/7 triage, assessment and intervention at the district/area level.

While there was broad support for the directions outlined above, there was no agreed approach as to the organisational arrangements required to achieve these goals.
4. Data

4.1 Calls to RuralLink by region

Overall MHERL/RL receives an average of approximately 1,800 to 2,000 calls per month. Figure 4 shows that in 2009, there were 1,953 calls to RL. This increased to 2,729 calls in 2010 was largely explained by an additional 825 calls from the South West following the closure of its dedicated telephone service, South West 24 (SW24).

![Calls to RuralLink by region 2009 and 2010]

Source: Mental Health Clinical Information System, WA Department of Health

Figure 4: Calls to RuralLink by region 2009 and 2010

4.2 Regional call rates to RuralLink based on population size

Figure 5 shows that in 2010, when the number of calls is adjusted for regional population size, the Great Southern had the highest rate of use per 1,000 population, followed closely by the South West. The Kimberley consistently had the lowest call rate.

![Regional call rate/1000 population to RL 2009 and 2010]

Source: Mental Health Clinical Information System, WA Department of Health

Figure 5: Regional call rate/1000 population to RL 2009 and 2010
4.3 Country calls to RuralLink during business hours

Figure 6 shows that although RL was set up to provide an after-hours telephone service to people living in country areas, approximately 20% of calls during 2010 were received during business hours, Monday to Friday between 8:00am and 4:00pm.

![Country Calls to RuralLink During Business Hours 2010](image)

Source: Mental Health Clinical Information System, WA Department of Health

**Figure 6:** Calls from regional areas to RL during business hours in 2010

4.4 Referral source for MHERL/RL

Figure 7 shows that in the 18 months to February 2011, just over 50% of referrals to MHERL and RL were recorded as self referrals or referrals from family and friends. This is probably an underestimate, as there were a significant proportion of referrals from these groups that were recorded under ‘other organisation’ and ‘unknown’.

![Referral Source for MHERL/RL July 2009 to Feb 2011](image)

Source: Mental Health Clinical Information System, WA Department of Health

**Figure 7:** Referral source of calls for MHERL/RL July 2009 to February 2011
4.5 Triage category of calls from country and metropolitan areas

Figures 8 and 9 show that although RL was set up as an after-hours service providing a range of functions and MHERL was set up as a 24/7 emergency service, the triage categories of calls received from each of the services during 2010 were almost identical. 5% and 4% of calls to MHERL and RL respectively were triaged as requiring an immediate response, while a further 19% and 21% were assessed as requiring a response within 8 hours. Almost half the calls to MHERL and RL were assessed as not requiring a response by mental health services.

Source: Mental Health Clinical Information System, WA Department of Health

Figure 8: Triage category of country calls to RL in 2010

Figure 9: Triage category of metropolitan calls to MHERL in 2010
4.6 **Number of calls to MHERL/RL by time of day**

Figure 10 shows that the number of calls to MHERL/RL increases sharply from 2:00pm reaching a peak between 4:00pm and 10:00pm. The number of calls drops off sharply after 10:00pm, reaching the lowest level between 4:00am and 6:00am. This pattern has been consistent over two years 2007/08 and 2008/09.

![Number of Calls to MHERL/RL by Time of Call for 2007/08 and 2008/09 Financial Years](image)

Source: Mental Health Information System, WA Department of Health

**Figure 10:** Number of calls to MHERL/RL by time of day 2007/08 and 2008/09
5. **Key findings and future directions: MHERL**

5.1 **Overview: MHERL**

In 2006, MHERL and seven CERTs were established to replace the Psychiatric Emergency Team (PET), a centralised emergency mental health service established some 15 years earlier to cover the metropolitan area. Unlike PET, which had provided both a telephone triage and community response, these functions were separated. While MHERL provided telephone triage, the CERTs, co-located with the clinics, took on after-hours community emergency response. During normal office hours, the Community Mental Health Teams continued to provide the emergency response. This change from a centralised to a devolved system is illustrated in Figure 11.

![Figure 11: Devolution of PET to MHERL and CERTs](image)

5.1.1 **CERT – CMHS relationship**

Although the CERTs were physically co-located with CMHS, they were never functionally integrated and they continued to operate independently, with different management lines. South Metropolitan Area Mental Health Service, unlike its counterpart in the North, went even further. Following a review of its emergency services, it re-asserted that the CERTs were part of a single area-wide emergency response service with a Coordinator who had line management responsibility for their operation.

There has been considerable debate about whether the CERTs should provide an emergency response or a broader range of after-hours services for patients of CMHS; and whether they should be an ‘area’ or ‘district’ resource. The opposing argument has been that this would negatively impact on the capacity of the system to provide a ‘true’ emergency response. The North Metropolitan Area Mental Health Service has signalled that it will be moving to integrate the CERTs into their community mental health services to expand local after-hours triage and response capacity.

5.1.2 **MHERL – CERT relationship**

Underlying this has been a fundamental problem of the functional relationship between the CERTs and MHERL. Although it was originally envisaged that MHERL would triage calls and
have authority to mobilise a community response, this has not occurred and the CERTs have continued to undertake their own assessment before responding. This duplication of effort is not only wasteful of resources, but has a significant effect on response time.

5.1.3 The role of MHERL

As can be seen from the data, although MHERL has been designated as an ‘emergency’ response line, it receives a range of calls, from emergencies requiring an immediate response to non-urgent requests for information and advice. Only 15% of the callers were assessed as requiring a response within 2 hours and almost half did not require referral to a specialist mental health service.

The ambiguity in MHERL’s relationship with the Area Mental Health Services has meant that it has not been ‘owned’ by the services and, therefore, not been appropriately used as an adjunct to their services. Nor has it been fully accepted as a ‘legitimate gateway’ into the specialist mental health system. MHERL has been primarily seen as a service for consumers and carers.

For many consumers and carers, particularly those seeking help for the first time, it is not easy to find out how or where to get help. MHERL is not widely promoted within the community and many people are unaware of the service or its role.

5.1.4 High-end emergencies

One of the main complaints by mental health services with regard to PET was that it had a high threshold for call-outs and handled most calls by phone. As can be seen from the MHERL data, there are relatively few ‘high-end emergencies’ and many calls can be managed without a community response. In combining the triage and community response functions PET had the capacity to respond rapidly to this small volume of high urgency calls. PET had a special relationship with the Police and was able to provide a rapid response to emergencies identified by them.

With the establishment of MHERL and the CERTs, the capacity of the system to respond to high-end emergencies has diminished. The Police reported that they use MHERL for obtaining information on clients, but the ‘two-step’ process has slowed the response time and resulted in them taking people directly to EDs. Essentially, the restructuring of services has led to a shift in the threshold for an emergency response towards the higher volume but lower urgency end of the continuum as illustrated in Figure 12.

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Figure 12: ‘Urgency’ continuum
5.2 Future directions and recommendations: MHERL

5.2.1 Entry to specialist mental health services

Recommendation 1
North and South Metropolitan Area Mental Health Services each to provide 24/7 specialist telephone triage with priority access for police and other emergency services. These triage services would cover all age groups.

Although MHERL was set up as a pathway for entry to specialist mental health services for emergency assessment, in reality CERTs/CMHS have maintained control of the entry points. The North Metropolitan Area Mental Health Service is in the process of integrating the CERTs into the CMHS and extending their hours of operation for emergency triage and assessment. For the services in the Areas to take on this function, the Areas will need to provide a 24 hour telephone triage service. This service is currently provided through the CMHS during business hours and Areas could consider a variety of options for providing the service after-hours. This service should be promoted to providers as the contact point for advice and referral to specialist mental health services. It should cover all age groups and ensure a seamless response without re-triage. Priority access should also be given to police and other emergency services. The proposed shift to this development is shown in Figure 13.

Figure 13: Development of local integrated services and Statewide Mental Health Advice Line

5.2.2 Mental Health Advice Line

Recommendation 2
Establish a 24/7 Statewide Mental Health Advice Line to provide information, advice, counselling and on-referral for consumers, their families and the wider community. This service would operate using a single Statewide telephone number and be broadly advertised and promoted.

As outlined above, around 50% of MHERL’s role has involved providing information, advice, counselling and on-referral. This probably represents an underestimate of the need for such a service because MHERL has not only been badged as an ‘emergency’ service, it has also not been widely promoted within the community. For consumers and carers, particularly those seeking help for the first time, these services perform a vital function and should be
retained as part of a Statewide Mental Health Advice Line, similar to that currently operating in Victoria. The service should have the following characteristics:

- a single Statewide telephone number
- operate 24 hours per day
- staffed by specialist mental health staff
- provide counselling rather than exclusively algorithm-based triage
- have access to PSOLIS, the specialist mental health information system
- widely promoted within the community.

Such a service provides a way of screening calls and, on the basis of the Victorian experience, it is anticipated that it would significantly reduce the load on the specialist mental health triage services. Figure 1 above illustrates the transition from the current MHERL/CERT service arrangement to establishing a Statewide Mental Health Advice Line and as well as developing integrated area based specialist mental health triage and community emergency response services.

5.2.3 Transfer of after-hours telephone service for SARC

Recommendation 3

The Women’s and Newborn Health Service to be responsible for providing the after-hours telephone service for the Sexual Assault Referral Centre (SARC).

While MHERL currently provides an after-hours telephone service for SARC, this would not be an appropriate function for a Statewide Mental Health Advice Line. The Women’s and Newborn Health Service would need to resume responsibility for managing any after-hours service for SARC.

5.2.4 Co-response with the Police

Recommendation 4

Establish a mental health/police co-response service in Perth based on the Victorian Police, Ambulance and Crisis Assessment Team Early Response (PACER) model.

The Police will always have an important role in emergency mental health system response. Consumers and carers consider that the Police should only be used as a ‘last resort’ but they are often the first service contacted by the public in a mental health crisis. As the system has moved from the centralised PET service to the ‘two-stage’ MHERL/CERT approach, the capacity for rapid response to police requests has reduced.

The WA Minister for Mental Health recently announced that “...when the Police attend a family with a person with known history of mental illness that they take with them a member of the medical services emergency response team”.

The Police, Ambulance and Crisis Assessment Team Early Response (PACER) program, a joint initiative between the Victorian Police, Ambulance Victoria and Southern Health, represents one of the most significant and innovative attempts to establish a coordinated response between police and mental health services in managing mental health emergencies in the community. The program involves a mental health clinician and police officer, in a police vehicle, responding to urgent requests for mental health evaluation from police patrols. Early evaluation shows that it has improved resource use, interagency communication and provides a more person-centred response.

6. Key findings and future directions: RuralLink

6.1 Overview: RL
In 2003, after-hours access to mental health services was identified as a priority. The Department of Health established trial projects in two rural areas utilising a private company, McKesson, to provide professional mental health support through a telephone call centre. RuralLink, which operated in the Midwest/Gascoyne, focused on providing after-hours coverage, while South West 24, operating in the South West Health Area was accessible 24 hours per day. The services were set up to provide assessment of new clients, crisis management, telephone counselling and support, after-hours management of standing orders, outbound calls to existing clients and support and advice to non-mental health professionals.

While SW24 continued to provide services to the South West until 2010, RuralLink was handed over to the PET to run following the trial and its remit expanded to take in the remaining country areas. In 2010, the contract for SW24 was not renewed and MHERL was given responsibility for after-hours services for the South West region.

6.1.1. Relationship between RuralLink and country mental health services
Developmentally, RL and SW24 were established as separate services, ‘owned’ by their regions and working closely with them to respond to local needs. Embedding RL and SW24 in MHERL, an existing 24/7 centralised emergency telephone response line, had a certain logic and there were clearly some efficiencies in optimising the use of an existing service.

One of the downsides, however, has been that although RL is actively promoted by country mental health staff and those who had used it have found it reliable and effective, it is not seen as part of, or an extension of, local services, but as an ‘external’ service over which they had little control. As a result, it has not been widely used as an adjunct to management by mental health staff but primarily seen as a service for consumers and their families.

Another downside had been that it has remained simply an after-hours telephone service. In both South Australia and New South Wales, where the responsibility for providing support within rural and remote areas resides with country mental health services, there has been significantly greater ownership and uptake of services and much more innovative solutions to the ‘tyranny of distance’. In the Greater Western and Greater Southern Regions of NSW, the regional mental health services have established a 24/7 videoconferencing service into EDs to assist them in the assessment and management of patients who present with mental health emergencies. These services are operated from a hub in the regional centres and have reduced the transporting of patient for assessment by approximately two thirds.

The WA Country Health Service (WACHS) has a specialist mental health videoconferencing service, the Statewide Clinical Services Enhancement Program (SCSEP), which provides a wide range of clinical and educational services for rural and remote clinicians and clients, mainly for Child and Adolescent Mental Health Services (CAMHS). There has been no formal or informal relationship between RL, which is managed by the North Metropolitan Area Mental Health Service, and SCSEP, which is managed by WACHS, despite the opportunities that such links could present.
6.1.2. **Support for other providers**

After-hours specialist mental health services are virtually non-existent in country areas and many people requiring assistance rely on EDs, GPs and police. Although RL was set up to support these local providers, they only rarely make use of the service.

One in five calls to MHERL/RL from people living in rural and remote areas are received during normal business hours. There are many towns outside the regional centres in WA that have no resident mental health services and rely on visiting services and/or telephone advice in a crisis. This points to the need to strengthen both in-hour and after-hour services.

South Australian Rural and Remote Mental Health Services, through its distance consultation service, has provided GPs with ‘next day’ access to specialist psychiatrist assessment via videoconferencing. This service is being provided by private psychiatrists funded by the Medicare Benefits Schedule (MBS). The Commonwealth Government has recently extended MBS benefits to support telepsychiatry.

Staff in the EDs of the regional hospitals were very clear that they wanted a mental health professional available to them in the ED. The smaller hospitals, however, were very supportive of the concept of videoconferencing into EDs as a means of accessing specialist mental health assessment and advice. Greater Southern Mental Health is currently in the process of establishing a PLN position in Albany Hospital ED until 8:00pm and also working in partnership with RL to pilot a videoconferencing assessment and support service into the EDs at Albany and Katanning Hospitals.

6.2. **Future directions and recommendations: RuralLink**

Simply ‘absorbing’ RL into a telephone service designed to manage emergencies in metropolitan Perth, has constrained its development and prevented it from growing into a service that is designed to meet the needs not simply of the country area as a whole, but those of each specific region. People living in the different regional areas, including service providers and consumers and their families, have a very strong sense of ‘local’ identity and have varied needs.

Specialist mental health services in the country are not only virtually non-existent after-hours, but also relatively ‘thin on the ground’ during business hours. There is clearly scope for increasing specialised services in rural and remote areas, but logistical and financial constraints will mean that there will always be a reliance on other key health providers, especially GPs and EDs. This raises the question of where resources can be most strategically targeted to get the best outcomes for consumers and their families and the best return on investment. It is our contention that this can best be achieved by a combination of expanding services in the Regional Centres and establishing a central resource that makes use of technology to enhance local service responses.

6.2.1 **Expanding the local response**

**Recommendation 5**

Establish Psychiatric Liaison Nurse (PLN) positions in each Regional Hospital Emergency Department (Albany, Bunbury, Geraldton, Kalgoorlie, Port Hedland and Broome). This service would operate from 8.00am to 10.00pm, 7 days a week.

As part of the Country Health Services Review, a role delineation exercise was undertaken that proposed country health services be developed as an integrated network of services in each region with the regional centres designated as ‘Regional Resource Centres’ (RRCs).
The idea was that each RRC would be resourced, not only to meet its local needs, but to support services across its region.

EDs are a major point of contact for people seeking help for mental health problems and also the first place that the Police take people when they come in contact with people they believe may be mentally ill. Staff working in the EDs at the Regional Hospitals made it very clear that what they required was specialist mental health staff available in the department, including after-hours. Consumers, their families and the NGOs were also very keen to have access to specialist mental health staff in the EDs.

As outlined above, Greater Southern Mental Health is establishing a PLN in the ED of the Albany Regional Hospital, initially to 8:00pm, but later extending this until 10:00pm. Furthermore, the Minister for Mental Health has announced that specialist mental health staff will be made available in the ED of Kalgoorlie Regional Hospital.

Following the cessation of the mental health on-call service to the ED of the Kalgoorlie Regional Hospital in September 2010, the numbers of admissions to both mental health and medical beds has increased significantly. The establishment of PLNs in the EDs, operating from 8:00am until 10:00pm daily, in each of the regional hospitals is the most cost-effective strategy for improving the quality of mental health care provided to people presenting to ED. Data show that the peak period for presentation to emergency service, including EDs and MHERL, is between 3:00pm and 10:00pm.

The PLNs in the regional hospital EDs would also be used to support the other EDs and nursing posts throughout their regions. The placement of the PLNs in the regional EDs would overcome the problem of ED staff not having access to the mental health information system, PSOLIS, which contains details of admissions and management plans for current and past clients.

Another cost-effective way of improving mental health services in country areas would be to extend the hours of operation of community mental health services in the regional centres and this should be considered in a future round of local service expansion. As outlined above, the evening is the peak period for emergencies, but community clinics close at 5:00pm. Providing intensive community support for people in crisis has been shown to be the most effective way of decreasing the rate of admission to inpatient beds. The availability of crisis accommodation with support, staffed by NGOs would be a valuable adjunct for people who need more support than they can get at home.

### 6.2.2. Establishing a regional enhancement program

**Recommendation 6**

Establish a new 24/7 service, the Mental Health Regional Enhancement Program (MH-REP), within the WA Country Health Service (WACHS). This service would incorporate the functions currently provided by RuralLink and the Statewide Clinical Services Enhancement Program (SCSEP), expand the use of a range of services and use information and communications technology (ICT) to complement local mental health services and support other providers, primarily Emergency Departments (EDs), General Practitioners (GPs), non-government organisations (NGOs) and police.

**Recommendation 7**

Provide a 24/7 triage service for each region using MH-REP to support and complement local mental health services. Each region would operate with its own regional 24/7 mental health contact number, and not a Statewide number, so as to promote local ownership of the triage service.
MHERL/RuralLink has served a very useful function as a service for consumers and carers, particularly those known to mental health services. It is proposed that the Mental Health Advice Line, as discussed in 5.2.2 above, be promoted to take over this function for consumers and carers across the country and metropolitan areas. The real challenge now is to establish a cost-effective strategy for complementing local mental health services and supporting provider groups such as EDs, GPs, police and NGOs which also play a major role in providing mental health support and care in country WA.

It is proposed that the Mental Health Regional Enhancement Program (MH-REP), be established for this purpose. This program would operate ‘Statewide’ using a range of information and communications technology (ICT) to engage and support country providers. Although consumers and carers would be able to access the program, it would be primarily marketed and promoted as a service to support providers in the assessment and management of people with mental health problems.

It is proposed that MH-REP would be managed within WACHS and operate 24 hours per day. There needs to be a sense of ‘ownership’ of the program by the regions, with each promoting it as a ‘seamless’ part of its own regional service. This could be achieved by each regional mental health service having its own telephone number that would be contactable by providers 24 hours per day, with a response from either local or MH-REP staff according to agreed protocols. For example, a provider in the Goldfields region could call the Goldfields Mental Health Service’s telephone number any time of the day or night. Unlike RuralLink, MH-REP would not be badged and marketed as a separate Statewide service. The advantages of this arrangement are:

- Simplicity of access for providers, which is particularly relevant in areas where there is high staff turnover.
- Opportunities for tailoring services to local needs.
- Enhances reputation for greater responsiveness of country mental health services.

If the MH-REP proposal were to be accepted there would be significant synergies in bringing it and the Statewide Clinical Service Enhancement Program (SCSEP) into a single program. Both services would be under the management of WACHS and deliver services to country areas using ICT.

The establishment of MH-REP would significantly enhance the capacity of mental health services in country WA using a range of ICTs. When fully developed, it would provide the following services across the age continuum:

- telephone advice service, primarily targeted at providers
- videoconferencing into EDs and nursing posts
- facilitating access to metropolitan inpatient services
- ‘next day’ access to specialist psychiatrist assessment for GPs
- after-hours access to specialist psychiatrists
- after-hours triage
- assessment and treatment of clients by videoconference
- development of e-mental health options for information, assessment and treatment (e.g. web-based, email, messaging)
- staff development and training
- clinical supervision
- discharge planning.

This model, based on the use of ICT, provides an opportunity to explore a range of flexible staffing options. Services do not simply need to be provided from a central ‘hub’. For
example, a psychiatrist using videoconferencing to assess a client referred by a GP can be located at home or in their office or in private rooms.

6.2.3. Funding options: Southern Inland Health Initiative

From July 2011, the State Government is investing $565 million towards the reform and improvement of access to health care for the southern inland area of Western Australia, as part of the Government’s Royalties for Regions Program. The aim of the program is to improve medical resources and 24 hour emergency coverage across the area. Amongst other things, the initiatives will target:

- increased access for GPs to specialist clinical services through enhanced e-technology
- improved access to safe and appropriate emergency care in regional settings
- increased support to nurses in delivering quality health care to country patients.

One of the key objectives of the proposed MH-REP initiative is the provision of specialist mental health support for providers, particularly GPs, EDs and nursing posts. The objectives of this program are very much in line with those of the Southern Inland Health Initiative and funding could be sought from this source to commence the roll-out of the program across the southern half of the State.
Appendix 1: MHERL/RL Consultations

**New South Wales**
David West
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Michael Bailie
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Dr Saibal Guha
Senior Consultant Psychiatrist, Deputy Clinical Director Country Health SA Mental Health Services & Clinical Director Rural & Remote Mental Health Network
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Acting Medical Program Director, Mental Health Program, Southern Health and Lead for PACER project

**Western Australia**
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Wynne James
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Johann Combrinck
Consultant Psychiatrist, Mental Health Emergency Response Line (MHERL) and RuralLink
Phil Andrus
Service Coordinator, Mental Health Emergency Response Line (MHERL) and RuralLink
A Review of RuralLink and the Mental Health Emergency Response Line

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**Albany**

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- **Debbie Easther** Clinical Coordinator, USW Community Mental Health, SW Mental Health Service, WACHS South West
- **Jocelyn Jones** Bunbury Pathways
- **Juliette Wrobel** Workforce Development Centre Coordinator, Jobs South West Community Services
- **Representatives** Carers
- **Representatives** Consumers

### Kalgoorlie
- **Dr Garth Herrington** Head of Emergency Department, Kalgoorlie Hospital
- **Jane Cuddihy** Clinical Nurse Manager, Emergency Department, Kalgoorlie Hospital
- **Dave Beard** WA Police, Kalgoorlie
- **Raelene Craft** Director of Nursing, Esperance Hospital
- **Sue Shales** Clinical Nurse Manager, Emergency Department, Esperance Hospital
- **Fiad Paraigh** Team Leader, Esperance Community Mental Health Team
- **Barbara Foggin** Registered Nurse, Edward Collick Nursing Home, Amana Living
- **Dawn Henderson** Edward Collick Nursing Home, Amana Living
- **Jo Owen** Goldfields Mental Health Service
- **Charles Webb** Goldfields Mental Health Service
- **Cate Dean** Goldfields Mental Health Service
- **Chris Brown** Goldfields Mental Health Service
- **Richard Hogan** Facility Lead, Four Hour Rule, Kalgoorlie Hospital
- **Annette Fagan** Goldfields Women’s Refuge
- **Andrea Connor** Acting Director of Nursing/HSM, Laverton Hospital
- **Kate Russell** Director of Nursing/HSM, Norseman Hospital
- **Jacinta Dalton** Aboriginal Mental Health Program Officer, Goldfields Esperance GP Network

### St John's Ambulance (WA)
- **Joe Cuthbertson** Manager, Clinical Governance
- **Julian Smith** Manager, Metro/State Ambulance Operations

### WA Police
- **Nigel White** Commander, Metropolitan Region
- **Scott Warner** Inspector, Metropolitan Region
- **David Mulhall** Sergeant, Acting Officer in Charge, Kensington Police Station, Metropolitan Region
- **Kim Lawson** Sergeant, Police Operations Centre
- **Brendan Barwick** Senior Sergeant, Regional Western Australia
Appendix 2: Innovative service examples

Victoria

*Victoria Mental Health Advice Line*

The Mental Health Advice line is a 24/7 mental health information, referral and advice service accessible to consumers across Victoria. The telephone service provides access to information and standardised screening-level assessment, and referral to appropriate services including general practice, specialist mental health triage and Emergency Departments (EDs).

The Mental Health Advice Line began operation in December 2009. It is a key initiative of the Victorian Government’s *Mental Health Reform Strategy 2009 –2019*, which recognises the need for better pathways to mental health care and a ‘no wrong door’ approach.

The Mental Health Advice Line is staffed by mental health professionals through Medibank Health Solutions, the contracted service provider. It is promoted as a gateway to the mental health system, offering expert advice and referrals to appropriate services. It is not a counselling or emergency line.

*Police, Ambulance and Crisis Assessment and Treatment Team Early Response*

The PACER (Police, Ambulance and Crisis Assessment Team Early Response) service is a partnership between Victoria Police, Ambulance Victoria and Southern Health. It is based on the “Ride Along” models originating in the United States and involves a joint mental health professional and police member unit responding to calls from police or ambulance officers for mental health assessment or assistance.[1]

PACER began as a three month trial program in 2007. Evaluation findings from the pilot were positive, with police and clinical staff involved reporting that it created a more person-centred response to crises and it improved interagency communication and resource use.[2] The Victorian Department of Health committed to extending funding for a further 12 months, with additional resources also provided by the Police.[2]

The Victorian Auditor-General, in its 2009 audit report on the effectiveness of Victorian service responses to mental health crises, described the PACER model as an example of collaborative innovation focused on consumer needs and recommended that the PACER trial be continued.[2]

New South Wales

*Mental Health Emergency Care Rural Access Project (MHEC-RAP)*

The Mental Health Emergency Care Rural Access Project (MHEC-RAP) connects hospital EDs in rural New South Wales with 24/7 mental health nurses and psychiatrists via video conferencing equipment. The MHEC-RAP aims to provide timely mental health assessments and assistance to staff in rural hospitals with the management of clients in a mental health emergency. The service covers the Western NSW and Far West Local Health Networks which is comprised of a population of 305,000 people over 444,586 square kilometres, with acute beds available at Orange, Dubbo and Broken Hill.
The model involves:

- a central team of nurses and psychiatrists at the Orange Mental Health Inpatient Unit (MHIPU) who provide 24 hour consultation to hospital EDs in the Western NSW and Far West Local Health Networks
- a network of video conferencing facilities based in the EDs
- ongoing training of general ED staff in mental health via these facilities, linked with the pre-existing telephone triage system.[3]

An evaluation of the MHEC-RAP found that the service resulted in reduced inappropriate transportation of patients. The number of patients referred to a Mental Health Inpatient Unit decreased from 73% to 52% of all admissions between 2008 and 2009.[4]

South Australia

South Australian Rural and Remote Mental Health Service

The Rural and Remote Mental Health Service (RRMHS) was established in 1996 to provide specialist mental health services to rural and remote communities in South Australia. The RRMHS integrates triage/liaison, telepsychiatry and inpatient care and is based at the Glenside Campus of the Royal Adelaide Hospital.

The RRMHS uses a ‘Consultation-Liaison’ model, with the delegation of routine psychiatric care to GPs or community mental health team members, supported by psychiatrists in Adelaide through telephone and videoconferencing facilities. The approach encourages the care of patients in regional centres and their own communities.[5] Access to expert psychiatric advice is available 24/7.

Western Australia

Statewide Clinical Services Enhancement Program

The Statewide Clinical Services Enhancement Program (SCSEP) was Western Australia’s first program to provide videoconferencing to rural and remote mental health services. SCSEP was established in 1998 and has grown significantly since its inception, now occupying a suite of studios at Graylands Hospital.

SCSEP was developed to address the issue of poor access to mental health services in rural and remote communities as well as difficulties in attracting, retaining and up-skilling staff in service delivery to these areas. The program aims to enhance existing services and takes a collaborative approach to working with rural and remote providers.

SCSEP uses videoconferencing technology to link in with all WA mental health services. The program is delivered through the WA Country Health Service (WACHS) and includes:

- specialist clinical services in infant, child, adolescent and youth mental health
- training programs in mental health competencies
- clinical supervision for health professionals
- regular network meetings and professional development opportunities
- a website for information on clinical, educational and training programs.
Southern Inland Health Initiative

The Southern Inland Health Initiative aims to reform and improve access to health care in the southern inland area of Western Australia. The State Government has allocated $565 million for the Initiative as part of the Royalties for Regions program. It is being progressively implemented from July 2011, with $240 million to be invested in the health workforce over four years and $325 million in capital works over a five year period. The WA Country Health Service is leading the roll out of the program, working with local stakeholders.

The target region for the Southern Inland Health Initiative extends from Kalbarri and Meekatharra in the north, to Laverton in the east, down to Esperance in the south east of the State. It does not include the regional locations of Albany, Bunbury, Busselton, Geraldton, Kalgoorlie and parts of the South West coast.

The Southern Inland Health Initiative consists of six funding streams:[6]

- District Medical Workforce Investment Program: $182.9 million for improved medical resources and 24 hour emergency response.
- District Hospital and Health Services Investment Program: $147.4 million to upgrade Collie, Katanning, Manjimup (Warren Hospital), Merredin, Narrogin and Northam district hospitals.
- These hospitals will be supported to have 24/7 doctor coverage. Recurrent funding of $26 million will also be provided to improve primary health care services in each district.
- Primary Health Care Demonstration Program: $43.4 million will be available for communities to review the delivery of health services in their districts. Participating communities will be able to access further funding to boost their primary health care services.
- Telehealth Investment: $36.5 million for innovative "e-technology" and increased use of telehealth technology, including equipment upgrades.
- Residential Aged Care and Dementia Investment Program: $20 million for private providers to expand options for residential aged care and dementia care.
- Small Hospital and Nursing Post Refurbishment Program: $108.8 million in capital works for the refurbishment or, if required, rebuilding of small hospitals and nursing posts.
References


