A Review of Emergency Mental Health Services in North Metropolitan Perth

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1. EXECUTIVE SUMMARY

“Instead of relatively short and sharp encounters with the health service, more people are embarking upon journeys of years or decades, requiring assistance and support ….. [The question is] what kind of services and care best fit the needs of people who are on a patient journey? It is better to spend time working out what provisions the patient needs for their journey than rushing to complete and document the plan and plug every hole ….. nothing beats actually hearing what the patient has to say and finding out what they think they want and need.”

Professor Stephen Leeder

This Review was commissioned by the Mental Health Executive Group, North Metropolitan Area Health Service with the objective of determining whether the mental health emergency service system is responding effectively to people living in the north metropolitan area of Perth who are experiencing a psychiatric crisis. The scope of the Review covered all age groups.

A large number of staff, including physicians and nurses working the hospital EDs, were consulted to obtain a wide range of views on current issues and the future directions for emergency mental health services.

Some of the key issues that emerged during the consultation included:

- There is a culture of ‘gate-keeping’ which makes it difficult for clients to access mental health services;
- The lack of common or complementary policies and protocols across services makes it difficult for clients and referring agencies;
- Questions were raised about the suitability of EDs as major entry points into the mental health system and about the practice of holding people in ED awaiting access to hospital beds;
- Community services need to be resourced to extend their hours of operation and provide intensive community treatment and support if they are going to provide real alternatives to ED and hospital care;
- Although there has been no question about the quality and effectiveness of the CERTs’ clinical work, the relatively low volume of emergency work has led a push for them to be functionally integrated into the clinics;
- Getting hospital beds for clients is a major problem and is both stressful and wasteful of resources;
- Many mental health services are operating as ‘silos’, with much re-triaging/re-assessing which is problematic for both patients and service providers in negotiating the boundaries;
- CAMHS does not have a system, which accepts the assessment of, and prioritises referrals from, the emergency mental health system [PMH and General Hospital EDs/MHERL/CERT].
There is a lack of any formal agreement between Older Adult Mental Health Services and the emergency mental health system about the assessment process and the pathways to care for older adults.

Mental health consumers reported that it was important, but frequently difficult, to be able to get help early, before a ‘problem’ escalated into an ‘emergency’. They endorsed the principle of ‘treatment in the least restricted environment’, with assessment and treatment at home being the most preferred option and hospital admission the least. Emergency Department experiences were generally not viewed favourably and involvement of the police was seen as an option of last resort. Carers expressed the strong view that they should be seen as a ‘resource’ by service providers and given information and support.

The data confirm that there were just over 20,000 mental health attendances across all the metropolitan EDs in 2007/08 and, although this represented just over 5% of all presentations, 22% were admitted to observation beds where they stayed for twice as long as non-mental health patients. Since July 2007, there has been a reduction in the ALOS in the ED at SCGH for patients on Forms from 39 to 23 hours. This still represents a significant challenge for the introduction of the 4-Hour Rule.

During 2008/09, the combined North Metropolitan CERTs averaged 4.6 service events per evening shift, with generally 2 to 3 after-hour call-outs per month. Triage category 1 [immediate] and 2 [within 2 hours] calls averaged 1.8 calls per evening shift. Most of the service demand came from the clinics at which the CERTs are located. The pattern of demand indicated that much of the non-emergency extended hours work was coming from the ‘host’ clinic. Although CERTs are providing services across the age continuum, the vast majority are for adults aged 18 to 65.

MHERL received over 7,000 calls in 2008/09 from clients in the North Metropolitan Area, the vast majority of which were from adults aged 18 to 65. MHERL was the referral source for just under one third of the North Metropolitan CERTs 1,686 referrals. Two thirds of its referrals to the CERTs were triaged as category 1 or 2. Clearly MHERL fields a lot of non-urgent requests for information and advice.

In setting up the new community emergency system, there were a number of objectives including increasing the number of people seen, decreasing the threshold for a response and reducing hospital admissions. There have been no significant changes in admissions or re-admissions to North Metropolitan Hospitals over the last 5 years.

The issues facing the Western Australian emergency mental health system are not unique and the Reviewers set out a schedule of visits to services in New South Wales and Victoria, which they believed would assist in informing the debate about future directions. Services in both States are faced with policies restricting the time that patients can be held in ED and, therefore, it is hardly surprising to find that the focus has been on finding alternative short-term mental health beds; the Psychiatric Emergency Care Centres [PECCs] in NSW and the Psychiatric Assessment and Planning Unit [PAPU] at Royal Melbourne Hospital. Like WA, there has also been a strong focus on bed flow management, although much of the effort is focussed on local management strategies.

Peninsula Mental Health Services in Victoria represents a rather unique approach to tackling the pressures on the emergency system. It undertook a lengthy review of its inpatient services before turning to a review of its community services. It moved from the typical set of Victorian services [CATT, CCT, Primary Mental Health, EEP, etc] to a ‘blended’ model based on 4 geographic teams, each delivering a range of ‘functions’, but with no separate teams. Almost over night, average bed occupancy within the inpatient unit fell from 100% to 85%, a result that the former Area Director ascribes to, “getting rid of the CATT led to a doubling of
acute assertive outreach that people were receiving early in their episode”. There is potentially much to be learned from Peninsula Health’s review of its services.

The Emergency Mental Health System is under pressure. The signs of that pressure are most evident in the EDs of the General Hospitals. The primary causes of the pressures on EDs are not to be found in the EDs themselves, but in the difficulty experienced across the mental health system in accessing psychiatric beds, in the lack of alternative community-based mental health services, particularly after hours, and in the difficulty that people experience in accessing community services in a timely manner, even when they are available. The introduction of the new community emergency mental health system - MHERL/CERT/CMHS has not brought about any real change in the use of inpatient services or of EDs.

The Reviewers believe that one of the fundamental problems with the current emergency mental health system in Western Australia is that it does not have the capacity to systematically provide intensive treatment and support for people undergoing crises other than through the hospital system. A disproportionate amount of effort and resources have been directed into ‘gate-keeping’ the entry points of our system through triage and assessment, and not enough into treatment. The solution lies in the development and re-design of our community services to give them the capacity to provide intensive community treatment and support, like the Crisis Resolution Home Treatment Teams in the UK, which have proved more successful than any other single initiative in reducing the use of hospital beds.

Currently, Child and Adolescent Services, Adult Services and Older Adult Services are each configured around very different catchment populations. This Review of Emergency Services has clearly highlighted the need for a greater degree of coordination and collaboration between the programs. North Metropolitan Area Mental Health Services have embraced a ‘district’ model based on four catchment area populations, each of sufficient size to support a comprehensive range of inpatient and community services. The Reviewers believe that the re-design of the emergency mental health system could most effectively be developed and implemented within this District framework.

The key proposals for the future directions of emergency mental health services in the North Metropolitan Area are outlined below:

- Adopt the principles of ‘no wrong door’ and ‘easy in, easy out’ in the community mental health sector with a shift in role from ‘gate-keeping’ to ‘facilitation’.
- Re-badge MHERL and, in addition to its emergency function, give it a broad role in assisting people access and navigate the mental health system.
- Give MHERL the capacity to mobilise community service responses following triage.
- Establish Intensive Community Assessment and Treatment Teams [ICATT].
- Restructure community mental health services, moving to a ‘blended’ model of geographic teams that combine acute assessment and treatment and continuing care functions.
- Move towards a system of allocating and managing beds at a District rather than Metropolitan-wide level.
- Develop separate mental health ‘suites’ in the EDs, serviced by specialist mental health staff.
- Establish properly resourced, multidisciplinary Consultation-Liaison Services in EDs.
- Cease the practice of holding people in ED while they are awaiting a bed in a psychiatric inpatient unit.
Establish 6 short-stay, ‘virtual beds’ at Graylands Hospital modelled on the Psychiatric Assessment and Planning Unit [PAPU] at the Royal Melbourne Hospital.

Establish Intermediate Care facilities as alternatives to inpatient care.

Improve the working relationship with the Police.

The key proposals for the future directions of emergency mental health services for children and adolescents in the North Metropolitan Area are outlined below:

- Provide the emergency response for children and adolescents through the EDs and specialist services within the Adult MHS.
- Improve access to CAMHS.
- Establish an Assertive Community Intervention Team.
- Multiply CAMHS capacity by changing the service model.
- Establish a mechanism to co-ordinate Mental Health Service for children and youth.
- Strengthen partnerships with adult Mental Health Services.

The key proposals for the future directions of emergency mental health services for Older Adult Mental Health Services in the North Metropolitan Area are outlined below:

- Provide the emergency response for older adults through the EDs and specialist services within the Adult MHS.
- Re-align Older Adult MHS and Adult MHS within a four-geographic District system.
- Establish a training program for Emergency Mental Health staff working with older adults.
- Plan for the establishment of a 6 to 8 bed Acute Assessment Unit for the North Metropolitan Area at SCGH.
2. THE REVIEW PROCESS

2.1 Objective and Scope of the Review

The Review was initiated by the Mental Health Executive Group, North Metropolitan Area Health Service which is chaired by Dr Ann Hodge, Executive Director Mental Health. The objective of the Review was to determine whether the mental health emergency service system is responding effectively to people living in the north metropolitan area of Perth who are experiencing a psychiatric crisis. It specifically examined the following service components:

- Mental Health Emergency Response Line (MHERL);
- Community Emergency Response Teams (CERTs);
- Community Mental Health Teams Triage and Emergency Response; and
- Hospital Emergency Departments.

The scope of the Review incorporated Infant, Child, Adolescent and Youth (ICAYMHS), Adult and Older Adult Mental Health Services. By including all mental health services in the Review it facilitated an examination of the interface between services; an issue which is important because the adult program has a key role in providing emergency services across the age continuum.

2.1 The Review Process

The Review comprised the broad stages:

![Diagram of Review Process]

Figure 1: Review Process
The Review was initiated in April 2009, with the aim of completing it by the end of the year. One consequence of these challenging deadlines was that it was not possible to undertake a full literature review. In addition, the original scope of the data collection and analysis was scaled back and restricted to data which could be obtained more readily from the Mental Health Information System. As a result data was not obtained direct from the Emergency Department Information System but was sourced from previously published reports.

2.2 Review Reference Group

The Emergency Services Review Reference Group was established to guide the process. It provided broad representation from key service provider stakeholders and comprised the following members:

- Ms Leanne Sultan, A/Director Operations, NMAMHS (Chairperson);
- Ms Deborah Bridgeford, Director Governance and Performance, NMAMHS;
- Ms Denise Bromwell, A/Service Coordinator Morley MHS;
- Dr Simon Byrne, Consultant Psychiatrist, SCGH;
- Dr Johann Combrinck, Consultant Psychiatrist, MHERL;
- Mr John Ellis, A/Director Clinical Redesign, NMAMHS;
- Ms Jennifer Hoffman, A/Service Manager, State Forensic MHS;
- Ms Raighne Jordan, Nurse Director, NMAMHS;
- Mr Patrick Marwick, Clinical Director, North Metropolitan ICAMHYS;
- Ms Kate McGivern, Nurse Director, Swan MHS;
- Dr Helen McGowan, Clinical Director, NMAHS Older Adult MHS;
- Dr Willem van Wyk, A/Clinical Director, North Metropolitan Adult MHS;
- Dr Geoff Smith, Medical Director, WA Centre for Mental Health Policy Research; and
- Ms Theresa Williams, Director, WA Centre for Mental Health Policy Research.

The Reference Group was chaired by Ms Leanne Sultan in her capacity as a member of the MHEG, NMAMHS. The final report of the Review will be presented to Dr Ann Hodge, Executive Director, NMAMHS and Chair of MHEG. The terms of reference are outlined in Appendix 1.

2.3 A Systems Approach

The Review was based on a systems approach, rather than evaluating each individual service in isolation. An important task of the Review was to consider the interaction between the component mental health services and to examine how the emergency service system as a whole was functioning.

The following figure illustrates how the reviewers conceptualized the key components in the emergency mental health service system and the complexity of the pathways between the services.
2.4 What is an Emergency?

Terms like ‘emergency’ and ‘urgent’ are often used interchangeably and it was important to clarify the concepts. The following definitions developed by the American Psychiatric Association Taskforce on Psychiatric Emergency Services in 2002 were adopted for this Review.

An emergency can be defined as:

“… an acute disturbance of thought, mood, behavior or social relationship that requires an immediate intervention as defined by the patient, family or the community. … Central to the concept of an emergency are the subjective qualities, the unscheduled nature, lack of prior assessment or adequate planning and resultant uncertainty, severity, urgency and conflict or failure of natural or professional supports all of which contribute to the need for immediate access to a higher level of care.”

Urgent problems:

“… as opposed to emergencies can be thought of as situations that have some or all of these features but where the situation is evolving more slowly, the feared outcome is not imminent and attention can be delayed for a short time.”

This Review conceptualizes emergencies and urgent problems as existing on a continuum, where, at certain points in time, there may exist some ambiguity and lack of a black and white demarcation between an emergency and an urgent problem.
3. SERVICE PROVIDER VIEWS

3.1 The Process
Over 80 staff were consulted as part of a comprehensive process to obtain a wide range of views on current issues and the future directions for emergency mental health services.

Semi-structured face-to-face individual interviews were conducted with senior staff from the NMAMHS Executive, ICAYMHS, Adult and Older Adult Mental Health Services and Emergency Departments across the NMAHS. Although Royal Perth Hospital is administered through the SMAHS and is therefore not part of the Review, key mental health service providers and ED staff from that service were included in the consultation. Their input was important because of the number of clients who live in the north metropolitan area who attend the RPH ED or are admitted to their psychiatric inpatient unit.

In addition to the individual interviews with key stakeholders, a series of open invitation forums were held with staff from ICAYMHS, each Adult MHS, and the Older Adult Services. The list of those who were interviewed and the participants in each of the staff forums is included in Appendix 3. Services included in the consultation are outlined in Figure 1 below.

![Figure 3: Outline of Consultations with Key Service Providers](image)

The individual interviews and staff forums were broadly guided by the following questions:

- How does your service currently operate?
- What is working well?
- What isn’t working and why?
- What changes should be made to this service to enable it to function better?
- What future direction should services take to enable a better emergency service to be provided?
3.2 The Consultation Themes

By their nature, reviews tend to focus on those aspects of services which are not working well. This can lead to comments which have a negative bias. It is important to state in this regard that those consulted were not saying that individual clinicians were not doing their job well or that their clinical practices were unsatisfactory. Rather, they were commenting on the service elements of the emergency mental health system that they considered were not functioning well or were working sub-optimally. The comments from the consultations should be considered in this context.

In analysing the extensive information collected during discussions with service providers, the following six key themes emerged:

- The Emergency Gateway;
- Developing Community Mental Health Services;
- Access to Inpatient Beds;
- System Fragmentation;
- Services for Youth and Older Adults; and
- Operational Issues.

3.3 The Emergency Gateway

![Gatekeeping](image)

- The whole system acts to try to prevent people getting in.
- It’s not easy for consumers to access the right care, in the right service, at the right time.
- CERTs are doing their own assessments because they can’t trust MHERL.

![Navigating the system](image)

- A lot of time is spent navigating the system.
- There is no clear systematic approach, common policies or protocols across the various services. This extends to EDs which also vary in their response.
- There is lots of duplication and fragmentation in the new system for referrers, clients, police, EDs and hospitals.

![ED as a major entry point](image)

- The system has become incredibly dependent on the ED ... as other systems reach capacity, patients drain down to us.
- The waiting time for beds has improved, but it is still not unusual for people to have to wait here in ED for 24 to 48 hours and sometimes up to 3 days.
- At worst, ED is unacceptable clinical care ... we are often juggling sedation, physical restraint and surveillance.

![The role of the Police](image)

- The Police won’t come to assist with a scheduled patient unless there is a bed.
- The biggest problem is ED to hospital transfer. You can get a bed but then have to wait for 4 to 6 hours to get transportation by the Police.
- Police see it as their role only to get involved if there is a risk ... they want to make sure Health is not using them as a taxi service.

Figure 4: The Emergency Gateway

It was clear from the consultations that service providers recognized that it is difficult for clients to access services, navigate the system and consequently get a response to emergencies. There is a culture of gate-keeping, rather than one which ensures easy access to services.
There is re-triaging and re-assessing as a person moves through component parts of the services, partly because there is no systematic approach to triage, nor common protocols and care pathways. The consequence of this lack of standardization is that there is inequity for consumers in their access to services. The services are fragmented and much time is wasted for consumers, their families, referrers and mental health staff connecting people to appropriate services.

The Emergency Departments have become a major entry point to mental health services and to psychiatric beds and the default place where people go when other parts of the mental health system are under pressure. While extra mental health staff now work in Emergency Departments and this has resulted in improved treatment, many staff questioned the heavy reliance on this service and its appropriateness as a place for treating people with mental illness.

Mental health staff, both in the community and in the Emergency Departments, have identified the relationship with the Police as an area of difficulty, despite attempts to improve communication and liaison between the two sectors.

3.4 Developing Community Mental Health Services

- We need to be serious about making community services viable 24 hours a day.
- ED is the only place that after hours has its lights on and presentations there are all about the lack of other community alternatives.
- Bentley had an after-hours service for a number of years and this reduced admissions.

- The future is in intensive home treatment ... we know that it works.
- If community teams had their own intensive home treatment service, they would hang on longer, knowing that there was extra support.
- Hospital@Home gave us a taste of what could be done to decrease the burden on ED and beds ... the single best initiative in the past 10 years.

- CERT see themselves as part of the Pod, but should be part of our team.
- CERTs are currently ‘in’ clinics, but not ‘part’ of them.
- The centralised system of people coming out to offer their services is not working.

- We have lots of ‘just in case’ services – CERTs, weekend clinic staff, PLNs, MHERL – that are fragmented and have huge resources tied up.
- With the weekend services all 6 clinics have 2 staff on duty each day – that is 24 staff involved. How about rostering staff over larger groupings?

Figure 5: Community Mental Health Services

There was a strong view that community services were inadequately resourced to provide the services which consumers and their families required. In particular, there was a lack of extended hours of operation of community mental health services and limited intensive community treatment options which could provide an alternative to hospitalisation.

A range of options were proposed to increase resource in the community services and included:
- Shifting the resources of the CERTs into the community services to enable them to expand their services, either into the Assessment and Short Term Treatment teams or into the generic community teams.

- Rationalizing the weekend roster by providing a service from fewer clinics.

- Abolishing Area-wide services or even State-wide services such as MHERL and embedding staff into the district community teams.

### 3.5 Access to Inpatient Beds

#### Improve access to beds

- To get people into a bed it is often best to advise them to go to the ED. The hospital gives priority for beds to people in its ED rather than those coming direct from recommendations from the CMHT.

- Getting a locked bed is difficult. If there are no beds we often take the person direct to Graylands and have to stay to manage the person until a bed becomes available, sometimes up to 12 hours.

#### Strategies to improve access

- Flow Coordinators have a map of what's available, but staff still have to do a lot of ringing around. I haven't seen any improvement on the ground in access to beds. Staff still get very stressed trying to get a bed and you can have 2 or 3 staff on the phone ringing around trying to find a bed.

- Direct admission to D20 is a good system.

- There has been an increase in bed availability because of the Flow Coordinators ... with the Metro Bed Manager, they have provided greater clarity and transparency across the system about bed availability.

#### Alternative bed types

- Community assessment and management is the ‘ideal’, with step-up and step-down services needed as an alternative to admission.

- I would support the PECC type system where we can hold people we are uncertain about for a couple of days ... probably only need 1 six bed unit for North Metro and 1 for South.

- I don't support the concept of PECC ... making mini-wards that are not economic or a proper environment. It is better if they go to proper psychiatric units where there is a full range of services, facilities and staff.

Figure 6: Access to Inpatient Beds

There was consensus that it was difficult for mental health staff to access a bed, particularly a secure bed, for their clients.

Staff recognized that there has been significant effort and resources allocated over the past few years to try to improve the situation regarding access to beds, but there were mixed views regarding the success of these initiatives. Overall the direct admission process to D20 at SCGH was welcomed; however there is still a diversity of opinion about the impact of the patient flow co-ordinators.

There was overall support for increasing the range of alternative bed types to reduce the need for an acute admission.
3.6 System Fragmentation

- Mental Health Services have a ‘pass-the-parcel’ mentality.
- Community mental health services disengage when people go to hospital, despite it often being a blip on their long-term care pathway.
- The Clinical Re-design Program has been looking at the role of community teams in the inpatient setting with the aim of reducing fragmentation of patient care.

- We have to make a decision about where we see the system centred – it should be a community-centred system.
- There are all the component parts, but the hotspots are the intersections between the PLNs, the Assessment Team and CERT.
- Too many agencies operating as silos. Freo is a good model with everything on the one site.

- PLNs do not have much of a relationship with the Clinics. We get no feedback on people referred to them.
- The use of PSOLIS is patchy, but double entry onto PSOLIS and into the case-notes is a problem.
- The CERTs are often having to set up their own files as risk assessments and care plans are not often entered in PSOLIS. If you don’t have sufficient information, you have to ring around to get copies of discharge summaries.

Figure 7: System Fragmentation

There is difficulty providing continuity of care for the consumers as the component parts of the mental health service system operate largely as independent units. Communication, particularly accessing clinical information, was identified as an ongoing challenge. While computerised information systems such as PSOLIS are available, there are a range of issues as to why it is not being adequately used.

3.7 Services for Youth and Older Adults

- CAMHS and Youthlink have a limited ability to respond to emergencies and try to negotiate with the adult system. But there is no clear systematic approach across the adult program. This extends to EDs.
- An area that has worked well has been the Youth Self Harm Social Worker, particularly at RPH … explaining and negotiating ED processes … providing follow up information … and ongoing support for the client.
- It was intended that the CERTs would have a child and adolescent liaison officer, but this didn’t happen.
- CAMHS don’t seem to understand the nature of the work in ED. Sometimes we get a standardised response from them 2 to 3 weeks later saying that the person has not been accepted.

- Most emergencies in this age group have medical co-morbidities and we want them to have a medical assessment before they come to the older adult program.
- The PLNs are resourced to do all assessments and should be able to assess older aged clients.
- Setting up a parallel system with the adults is not feasible.
- It has been more difficult for older age psychiatry since the PLNs were established in EDs. They have mainly trained in adult psychiatry and are not good at excluding organic states. We have offered educational programs but the uptake is low.
- With the older adult services there is a constant battle. They want a full-blown psychogeriatric assessment with each client. We generally manage to get them to come to ED but with lots of complaints.

Figure 8: Services for Youth and Older Adults
Both youth and older adults are heavily reliant on the adult mental health emergency services to provide an emergency response, as there is very limited capacity within CAMHS and Older Adult MHS to manage emergencies within their current resources. However, there is no systematic approach, agreed policy and protocols as to the role of CERT, MHERL and the PLNs to providing services across the age continuum. The lack of training and the adequacy of skill levels of staff in the adult program to provide services to youth and older people was also raised as a key issue.

3.8 Operational Issues

- **CERTs**
  - Scope of role
  - ANF/HSU positions
  - Award level
  - Reporting lines
  - On call roster
  - Supervision and training
  - Medical backup

- **MHERL**
  - ANF/HSU positions
  - Clarity of role
  - Isolation

- **PLNs**
  - Clarity of role
  - Reporting lines
  - ‘Medical clearance’

- **H@H**
  - After hours staffing
  - Scope of service

- **CMHTs**
  - Role of w/end services
  - Medical backup w/end

Figure 9: Operational Issues

### 3.8.1 CERTs

- There is ambiguity about the role of CERTs – should they be providing an emergency response in the community or should they also be providing intensive community treatment or even extended hours ‘routine’ care?

- The mix of ANF and HSU positions is causing confusion, as it is not clear which allied health skills are required in managing emergencies. To compound this confusion, staff with nursing qualifications has been appointed to HSU positions. There is concern among CERT staff about the different ANF levels on the one team where staff are carrying out the same work. Within the one team, staff have different lines of reporting depending on whether they are HSU or ANF positions. The disparity with the ANF levels in north metro compared with the SMAHS CERTs is a further source of grievance.

- There have been continued difficulties staffing the on call roster and on several occasions there has been no service available after 11pm. Staff in the CERT commented that being called out the previous night has an adverse effect on their capacity to work the next day.

- As a result of their hours of work, CERT staff have had difficulty accessing training and are often not able to attend staff meetings at the Clinic where they are located. They sometimes feel isolated from the other staff at the Clinic.
3.8.2 MHERL
- The mix of HSU and ANF positions at MHERL has resulted in similar difficulties to the CERTs.
- There has been a lack of clarity for many MHS staff about the role of MHERL, in particular, their role in the triage and assessment of clients.
- There is a view that MHERL is isolated from other mental health services. There is some concern that since the devolution from PET, the clinical governance and management accountabilities require strengthening.

3.8.3 PLNs
- There is no clear service model or standardised role for PLNs across the various Emergency Departments. The PLNs can feel isolated and operate almost as sole practitioners. The most satisfactory arrangements from the perspective of Emergency Department staff and the PLNs is where they are both a part of the ED team but stay closely integrated with mental health services.
- Practices vary regarding medical clearance. They range from sequential assessments where mental health staff have become involved after medical clearance from the ED, to assessments where both ED and mental health are working in parallel.

3.8.4 HITH
- While there is significant support for this service from community MHS, it is recognized that it has limited resources and is not a multidisciplinary team.
- The staffing arrangements in the evening are inadequate as with only one person on the roster they are unable to visit in the community.

3.8.5 CMHTs
- The staff resources provided for each clinic running a weekend service was questioned, with the most critical operational issue being the impact this has on the weekday service when staff are clearing leave from having worked the weekend.
- Weekend staff and after hours services such as CERT rely on the MHERL medical staff to provide medical support rather than this being provided by the community services.
4. CONSUMERS AND CARER VIEWS

4.1 The Process
An open invitation to attend a consumer consultation forum was advertised through WAAMH and also via a network of consumers who are actively involved in NMAMHS. Three consumers attended.

A forum for carers was organized and advertised through MIFWA and also advertised through WAAMH. The Development Officer of the MIFWA Carer Program provided invaluable assistance in contacting carers and families of people with a mental illness who have had contact with mental health emergency services over the past 12 months. Five carers attended, however an additional 3 carers who were unable to attend provided comments in writing.

While it was disappointing to have so few people come to the forums, it did enable the reviewers to gain in-depth input and hear, in detail, the stories of those who attended. It also highlighted how difficult it is to obtain the views of consumers and carers without any formalized structures and processes to facilitate this. The planned formation of ComhWA should provide a valuable vehicle for the voice of the consumer for future reviews.

4.2 Consumers
What the consumers said:

They say that you have to take responsibility and then when you do and ask for help, they tell you that you’re not sick enough.

When it gets to be an emergency, it’s too late.

To get in you need to be assertive and in the know.

The major issues identified were:

- Difficulty of access, knowing where to go and getting a response.
- Lack of alternatives to hospital such as crisis houses which are small and local.
- Access to Peer Support Workers.
- Shared care in private/public.
- ED and Police were unpopular options.

4.3 Family Carers
What the carers said:

We didn't know where to go for help. No-one told us about the community emergency team.

The community emergency team works well. It falls down when you get to ED and hospital.

As ‘carers,’ or more accurately the people that have to pick up the pieces when things go wrong, we are not provided with any information.
The major issues identified were:
- Navigating the system is difficult.
- Need more skilled Ambulance/Police.
- ED is a negative experience.
- Carers are ‘ignored’.
- Shared care in private/public is needed.

4.4 Summary
Overall, both consumers and carers found it difficult to access services and navigate the system, although once they accessed MHERL/CERT they were generally satisfied with the service they received.

Consumers and carers found the Emergency Department experience to be a negative one and contact with the police was, on the whole, considered to be a last resort option.

The lack of co-ordination between public and private mental health system also caused difficulties for consumers and their family caregivers, with the perception being that the public system is resistant to shared care arrangements with private psychiatrists. When an emergency occurs the public system is most often providing this service and a more co-ordinated approach is required between the two sectors.

Carers expressed a strong view that they should be included, by service providers, as key partners in supporting a family member when they become unwell.

Finally, the consumers placed a high priority on introducing Peer Support Workers to assist them in preventing emergencies where possible and support them if urgent or emergency care is required.
5. DATA ANALYSIS

5.1 Overview of Data
The following service utilisation data was analyzed as part of the Review:

- **Adult Psychiatric Inpatient Units**
  Hospital inpatient admissions and average length of stay from 2004/05 to 2008/09 (Designated psychiatric hospital beds/NMAHS hospitals only/excluding CAMHS and Older Adult facilities). This data was sourced from the Mental Health Information System.

- **MHERL**
  MHERL activity 2007/08 and 2008/09 was sourced from the Mental Health Information System. Although MHERL is a Statewide service, the activity data only relates to clients with an address within the NMAHS.

- **CERTs**
  The NMAMHS CERT database of activity from May 2008 to April 2009 for the Joondalup, Osborne Park and Swan CERTs was provided by the services.

- **Emergency Departments**
  Mental Health Emergency Department data was obtained from previously published reports compiled by the Mental Health Division, Department of Health and the NMAMHS/SCGH Mental Health Clinical Service Redesign Project.

5.2 Emergency Department Use
Obtaining data from the Emergency Department Information System was not feasible within the tight deadlines to complete the Review. Although using data from secondary sources has its limitations, nonetheless, it provides an overview of recent mental health activity in major Perth metropolitan hospital EDs.

The most comprehensive ED data has been sourced from the mental health clinical redesign work undertaken by SCGH hospital. It provides a detailed, in depth analysis of mental health activity in the ED of a major tertiary hospital.

5.2.1 ED Attendances at Selected Metropolitan Public Hospitals
Figure 10 shows that RPH had the highest number of mental health ED attendances in 2006/07, closely followed by SCGH. However of their total ED attendances, SCGH had a slightly higher percentage of mental health presentations (8.3%) than RPH (7.4%).
Figure 10: ED attendances at selected Perth metropolitan hospitals 2006/07 financial year

5.2.2 Trends in ED attendances

Figure 11 shows that the number of mental health attendances across all Perth metropolitan publicly funded hospital EDs grew significantly between 2003/04 and 2007/08 [39%] as did the number of non-mental health attendances. However, mental health attendances as a proportion of all attendances remained fairly constant between 5.1% and 5.6% annually.
5.2.3 Bed Utilisation in EDs

Patients with mental health conditions are much more likely to get admitted to an observation bed when presenting to an ED compared with non-mental health patients. In 2007/08, 22% (4,431) of mental health patients were admitted to observation beds in the metropolitan hospital EDs compared with 0.5% (18,634) non-mental health patients. Since 2004/05 more than 1 in 5 beds in metropolitan EDs have been occupied by a mental health patient on a daily basis. Furthermore, when they do occupy a bed, they do so for twice as long as medical patients. [reference MHD report].

Figure 12 shows mental health presentations to SCGH ED compared with bed usage.

Figure 12: Mental health presentations compared with mental health bed utilisation as a percentage of all ED presentations at SCGH 2002/03 to 2007/08 financial years

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

5.2.4 Daily Attendances at SCGH ED

Figure 13 shows that there was an average of 10 attendances of patients with mental health conditions in SCGH ED per day during July and August 2008, with an average of 1 person per day on forms. Assuming the cost of a nurse to ‘special’ a patient on forms is $25 per hour, it has been estimated that the cost would have been approximately $42,000 for the 2 months or $252,000 for the full year.
5.2.5 Attendances at SCGH ED by Shift

Figure 14 shows that almost half the patients presenting with mental health problems do so between 3:00 pm and 11:00 pm, with a further third presenting between 7:00 am and 3:00 pm. Only 1 in 5 patients present after 11.00 pm.

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

Figure 14: Number and percentage of mental health presentations per day at SCGH ED by shift 2007/08 financial year
5.2.6 Multiple Attendances at ED

Figure 15 shows that just over one third of patients who attended SCGH ED in 2007/08 visited an ED more than once a year. Very high users comprised 4%, while a further 14% were moderately high users.

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

Figure 15: Percentage of patients attending SCGH ED who had multiple ED visits at any publicly funded metropolitan hospital during the 2007/08 financial year

5.2.7 Diagnoses of Patients Using SCGH ED

The current codes used to designate patients as having mental health problems on presentation to ED incorporate a whole range of codes including ICD Chapter 5 F Codes (mental health diagnostic codes), T Codes (toxicology) and Z Codes (factors influencing health status). They also include EDIS T Codes (presenting problem). This represents a ‘broad church’ including such conditions as social problems, situational crisis and alcohol intoxication.

In addition, a number of different codes can be employed to describe similar presentations (e.g. attempted suicide by overdose can be coded as depression, poisoning or suicidal). These data issues need to be borne in mind when interpreting Figure 16 which outlines the top diagnoses for mental health patients attending the SCGH ED during the 2007/08 financial year.
Top Diagnoses for Mental Health Patients Attending SCGH ED 2007-08

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

Figure 16: Top diagnoses for mental health patients attending SCGH ED during the 2007/08 financial year

5.2.8 Presentation to SCGH ED after a MHERL or CERT Event

Figure 17 shows that some 9% of patients presenting to SCGH ED in 2007 had contact with MHERL or CERT within 24 hours of presentation and a further 6% within the preceding 28 days.

Presentation to SCGH ED After MHERL or CERT Event with Mental Health Issue 2007

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

Figure 17: Percentage of mental health patients presenting to SCGH ED after a MHERL or CERT event in 2007
5.2.9 *Length of Stay in ED*

Figure 18 shows the actual length of stay in SCGH ED for patients presenting on forms under the Mental Health Act has improved markedly since July 2007 with a reduction in the average length of stay (ALOS) from 39 to 23 hours.

![Control Chart of Actual LOS in SCGH ED for Admitted Patients on Forms](image)

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

**Figure 18:** Length of stay in SCGH ED for mental health patients admitted on forms from July 2007 to April 2009

Figure 19 shows that there has been a steady reduction in ALOS in the SCGH ED for admitted patients not on forms from November 2007 to April 2009.

![Average (Median) LOS in ED for Admitted General Mental Health Patients](image)

Source: Mental Health Clinical Services Redesign Project, NMAHS, Department of Health Western Australia, 2008.

**Figure 19:** Average (median) length of stay for admitted general mental health patients
5.2.10 Departure from ED

Figure 20 shows that during 2007/08, 31% of people attending the metropolitan hospital EDs were admitted to a psychiatric inpatient bed, with just over half (56%) being discharged to their own care. Analysis has shown that this pattern has been stable for the previous 5 years.

Source: The Mental Health of Emergency Departments in Western Australia, Mental Health Division Department of Health Western Australia, 2009.

Figure 20: Discharge destination for mental health patient attendances at Perth metropolitan public hospital (including Joondalup Health Campus) Emergency Departments for the 2007/08 financial year
5.3 Community Emergency Response Teams (CERTs)

A dataset was provided by NMAMHS for each of the CERTs (Joondalup, Swan and Osborne Park).

Activity for the 3pm to 11pm services provided by the CERTs were analysed for each of the three teams and also for the combined North Metropolitan CERT service for the 12 month period from 1 May 2008 to 30 April 2009.

Activity data covering the after-hours on call area wide service was analysed for the two year period 1 May 2007 to 30 April 2009.

5.3.1 Service Use: Individuals and Service Events

Figure 21 shows that during 2008/09, the CERTs averaged between 1.3 to 1.9 service events per day. The total number of individuals who received a service ranged from 331 per annum for the Joondalup CERT, to 407 at Osborne Park and 409 at Swan. Osborne Park had the highest number of annual service events at 698, followed by Swan at 511, with the lowest at Joondalup at 477.

![North Metro CERTs: Individuals and Service Events 1 May 2008 to 31 April 2009](image)

Source: NMAMHS, Department of Health Western Australia, 2008/09.

**Figure 21:** Number of individuals, service events and average service events per day for the Joondalup, Osborne Park and Swan CERTs 2008/09

5.3.2 Age Distribution and Service Use

Figure 22 shows that CERTs are providing services to individuals across the age continuum with the youngest being 11 years and the oldest client aged in their mid eighties. However, as would be expected, the greatest number of individuals who received services were aged from 18 to 65 years with those aged from 18 to 39 years the highest service users.

A number of clients were multiple users of the CERT service. This is consistent with their dual role of managing crises and undertaking non-urgent Clinic work.
5.3.3 Referral Source

Figures 23 and 24 show that the largest referral source for Swan and Joondalup CERTs is the Clinic in which their service is located, with MHERL being the next largest referrer. Figure 25 shows that MHERL is the main referral source for the Osborne Park CERT.

Figure 22: Age distribution and service use for the combined Joondalup, Osborne Park and Swan CERTs from 1 May 2008 to 30 April 2009

Figure 23: Referral source and service use for the Joondalup CERT 2008/09
Figure 24: Referral source and service use for the Swan CERT 2008/09

Figure 25: Referral source and service use for the Osborne Park CERT 2008/09

Figure 26 shows that between one in four referrals (Joondalup CERT) to one in three referrals (Swan and Osborne Park CERTs) originate from MHERL.
### Figure 26: MHERL referrals as a percentage of all referrals to the Joondalup, Osborne Park and Swan CERTs 2008/09

#### 5.3.4 Triage Category

Figure 27 shows that 60% of the service events for the combined CERTs were for non-urgent activity, with only 40% for emergencies (respond immediately or within 2 hours).
5.3.5 Triage Category by Referral Source

Figures 28 to 30 show that most category 1 and category 2 referrals originate from MHERL. The largest number of category 3 (within 8 hours) referrals come from the clinic where the CERT is located except for the Osborne Park CERT where Subiaco Clinic also has a significant number of category 3 referrals. The data for Subiaco may be skewed by activity associated with one client with over 100 service events.

Source: NMAMHS, Department of Health Western Australia, 2008/09.

Figure 28: Triage category for service events by referral source for the Joondalup CERT 2008/09

Figure 29: Triage category for service events by referral source for the Osborne Park CERT 2008/09
5.3.6 CERT Services to Children and Youth under 18 years

Figures 31 shows that in 2008/09 CERTs provided a service to a small number (27) individuals aged less than 18 years, with 40% of the individuals being aged 17 years.

Source: NMAMHS, Department of Health Western Australia, 2008/09.
Figure 32 shows that of the 34 service events for clients under 18 years, 65% were urgent (triage category 1 and 2).

Figure 32: Triage category of service events for clients aged less than 18 years for the combined Joondalup, Osborne Park and Swan CERTs 2008/09

Figure 33 shows that most referrals to the CERTs for clients under 18 years came from MHERL (61%), followed by the Adult Clinics (15%) and the Police (12%), with CAMHS referring only 6%.

Figure 33: Percentage of service events by referral source for clients aged less than 18 years for the combined Joondalup, Osborne Park and Swan CERTs 2008/09

Source: NMAMHS, Department of Health Western Australia, 2008/09.
5.3.7 CERT After Hours Call Outs

Figure 34 shows that during the 2 year period from May 2007 to April 2009 there were 3 or less after hours call outs per month in over 85% of the total 24 months. In 54% of the months (13 of 24 months) there were 2 call outs. In 25% of the months (6 of 24 months) there were 3 call outs.

![North Metro CERTs: Monthly After-Hours Call-outs 1 May 2007 to 31 April 2009](image)

Source: NMAMHS, Department of Health Western Australia, 2008/09.

**Figure 34:** Monthly after hours call outs and attendances for NMAMHS CERTs 2007/09

5.3.7 Time of After Hours Call Outs

Figure 35 shows the highest percentage of after hours calls were received between 11.00 pm and midnight, dropping sharply from 2.00 am, with the lowest percentage of calls between 4.00 am to 8.00 am.

![North Metro CERT: Time After-hours Calls Received May 2007 to April 2009](image)

Source: NMAMHS, Department of Health Western Australia, 2008/09.

**Figure 35:** Time of after hours calls received by the NMAMHS CERTs 2007/09
5.3.8 Time of After Hours Call Outs

Figure 36 shows that MHERL referred 82% of the after hours call outs to CERT, followed by 11% from the Police.

Source: NMAMHS, Department of Health Western Australia, 2008/09.

Figure 36: After hours call out referral source for NMAMHS CERTS 2007/09

5.4 Mental Health Emergency Response Line (MHERL)

Figure 37 shows that calls to MHERL for clients who live in the NMAHS span all ages from the under 14’s to the over 65’s, however, the largest number of calls are from those in the 20 to 49 year age group. MHERL received a total of 6,641 in 2007/08 and 7,232 calls in 2008/09 for NMAHS clients.

Source: Mental Health Information System, Department of Health.

Figure 37: Number of calls to MHERL by age of client from 2007/08 to 2008/09 (NMAHS only)
Figure 38 shows the number of calls to MHERL by time of call. The number of calls sharply increases from 2.00 pm reaching a peak between 4.00 pm and 10.00 pm. The smallest number of calls occurs between 4.00 am and 6.00 am. This pattern has been consistent over the two years 2007/08 to 2008/09.

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

Source: Mental Health Information System, Department of Health.

**Figure 38:** Number of calls to MHERL by time of call from 2007/08 to 2008/09 (NMAHS only)

### 5.5 Hospital Psychiatric Inpatient Separations

Figure 39 shows the trend in psychiatric inpatient multiday separations in designated psychiatric adult beds in NMAMHS. The data excludes older adult services, same-day re-admissions, transfers to other facilities, statistical discharges, deaths and leaving against medical advice. While the total number of separations has remained relatively stable over the past five years, there has been an increase in the proportion of separations which are voluntary admissions.

![Inpatient Separations from NMAMHS Facilities by Financial Year](image)

Source: Mental Health Information System, Department of Health.

**Figure 39:** Number of voluntary and involuntary multiday inpatient separations in NMAMHS adult psychiatric beds 2004/05 to 2008/09 financial years
Figure 40 shows the trend in readmission rates for psychiatric inpatient multiday separations in designated psychiatric adult beds in NMAMHS. The overall readmission rates within a year, as well as the readmissions within 28 days have remained steady over the past five years.

Source: Mental Health Information System, Department of Health.

**Figure 40:** Readmission rates for multiday inpatient separations in NMAMHS adult psychiatric beds 2004/05 to 2008/09 financial years

Figure 41 shows the trend in the average length of stay has remained within the range of 31 to 33 days over the past five years.

Source: Mental Health Information System, Department of Health.

**Figure 41:** Average length of stay for multiday inpatient separations in NMAMHS adult psychiatric beds 2004/05 to 2008/09 financial years
5.6 Summary

Emergency Departments: All Metropolitan

- Mental health attendances at metropolitan EDs over a five year period have remained constant as a percentage of all presentations, ranging from 5.1% to 5.6% per annum.
- Patients with mental health conditions are more likely to get admitted to an observation bed in ED (22%) compared with non-mental health patients (0.5%), and occupy an ED bed for twice as long as medical patients.
- Of the patients presenting to ED with a mental health condition 31% were admitted, 56% were discharged to their own care and 7% did not wait.

SCGH Emergency Department

- An average of 10 mental health patients per day attended SCGH ED, with 48% presenting between 3.00 pm and 11.00 pm and 31% presenting between 7.00 am and 3.00 pm.
- 34% of mental health patients attending the SCGH ED had multiple attendances at any ED, with 4% being very high users with more than 6 visits in the year.
- 9% of mental health patients had contact with MHERL or CERT within 24 hours of presenting to the ED.
- Since July 2007 there has been a reduction in the ED ALOS for patients on forms from 39 to 23 hours, and for those not on forms the reduction from November 2007 to April 2009 was from an average of 11.5 hours to 8.6 hours.

CERTs

- Each CERT averaged between 1.3 to 1.9 service events per day, with the total number of individuals receiving a service per annum ranging between from 331 at Joondalup to 409 per annum at Swan.
- While CERT services are being provided across the age continuum, most are provided to those aged from 18 to 39 years.
- Most individuals are referred by the Clinic where the CERT is located, except for Osborne Park where the main referral source was MHERL.
- Multiple service users largely come from the Clinic where the CERT is located, whereas one off services are mostly provided to clients referred by MHERL/other Clinics. This pattern fits with the dual emergency and extended hours clinic role of the CERTs.
- The majority (60%) of CERT service events were for non-urgent activity with MHERL being the largest referral source for the emergency activity (category 1 or 2).

CERTs: Services to Children and Youth (under 18 years)

- CERTs provided 34 service events to 27 individuals under the age of 18, with 65% being emergencies (category 1 or 2).
- Most referrals came from MHERL (61%), followed by the police (12%) with CAMHS referring only 6%.
CERTs: After Hours Call Outs

- There were 3 or less call outs per month in over 85% of the months in a two year period (19 out of 24 months).
- Over 75% of the calls were received between 11pm and 3pm, with the highest percentage between 11pm and midnight, with MHERL referring 82% of the calls, followed by 11% from the police.

MHERL

- MHERL received 7,232 calls (NMAHS only), from across the age continuum with the largest number of callers aged from 20 to 49 years.
- Calls to MHERL increase sharply from 2pm onwards, reaching a peak between 4pm and 10pm.

Psychiatric Inpatient Separations (Multiday)

- The trend in psychiatric inpatient separations in NMAMHS adult facilities has remained relatively stable over the past five years ranging from a total of 2,589 in 2004/05 to 2,557 in 2008/09.
- The rate of readmissions within a year has remained steady ranging from 25.3% in 2004/05 to 27% in 2008/09 with the readmission within 28 days showing the same consistency ranging from 10.3% in 2004/05 to 11.6% in 2008/09.
- The average length of stay has remained with in the range of approximately 32 to 33 days over the past five years.
6. LEARNING FROM OTHER JURISDICTIONS

6.1 Overview
As a result of the extensive consultation process, the reviewers identified three key themes:
- Access to Services;
- Emergency Departments and Access to Beds; and
- Enhanced Community Response.

These issues are not unique to Western Australia and the reviewers set out a schedule of visits to services in New South Wales and Victoria, which we believed would assist in informing a debate about future directions for emergency mental health services in this State.

The reviewers also looked within the Western Australian service system for potential models. We visited Fremantle and Bentley MHS because during the consultation a number of NMAHS staff considered that these models had merit. We had discussions with the South Metropolitan Area MHS, which had already undertaken a review of its emergency system. Looking internationally at innovative service models, we then corresponded with the Winnipeg Regional MHS in Canada and King’s College Hospital in the UK.

A summary of the approach taken is outlined in Figure 10 below.

![Figure 10: Learning from Other Jurisdictions](image)

6.2 Access to Services
Both Victoria and NSW are investing in reforms to provide enhanced telephone access to information and direction to the right service in a timely way and shifting their triage to an area based model as well as improving the quality of the triaging.
6.2.1 Victoria

As part of its recent strategic plan “Mental Health Matters”, Victoria has adopted a policy of ‘no wrong door’. The following figure outlines the proposed functions of two key initiatives:

- The Mental Health Advice Line (MHAL); and
- An enhanced triage function within an AMHS.

![Diagram of Mental Health Triage Functions in AMHS, Victoria](image)


**Figure 43: Proposed Mental Health Triage Functions in AMHS, Victoria**

- **Mental Health Advice Line**
  This Statewide 24/7 mental health information, referral and advice service will provide the general public with telephone access to information and standardised screening-level assessment and referral to appropriate services including general practice, specialist mental health triage and EDs. An important aim in setting up MHAL is that it will free up area mental health triage services to assess people with a serious mental illness. The roll out of the service began in December 2009.

- **Enhanced Mental Health Triage Initiative**
  The reform strategy recommended a centralised psychiatric triage service at the area level to provide a wider, more responsive ‘front door’ to services. This initiative will invest $17 million in the coming five years to ensure 24/7 telephone access to a specialist mental health triage response. It is intended the extra funding for triage will allow the CAT teams to focus on treating people and preventing hospital admissions.

  - Improvements in the triage capacity would be supported by systematic reforms:
  - Increased centralisation of triage functions within AMHS;
  - Standardized assessment/triage scales and data collection;
  - Dedicated training; and
  - Increased visibility of the services through advertising.
Southern Health Psychiatric Triage Service

In 2004 Southern Health set up an area-based Psychiatric Triage Service (PTS). It provides access to mental health services for CAMHS and Adult MHS through a 24/7 single telephone number for a population of approximately 800,000. An independent evaluation of the service concluded that the “evaluators believe that centralised triage services at an AMHS or AMHS cluster level (for smaller areas) may be an appropriate approach for other metropolitan areas wishing to achieve an effective and efficient model for access to specialist mental health services.”

The critical transferable elements of the model include:

- Triage protocols which support clinical decision-making;
- Unconditional acceptance of triage service mobilisations;
- Reciprocal sharing of client information among program elements;
- Information and communication technology, including telephone technologies; and
- Staff training and appropriate clinical governance arrangements.

6.2.2 NSW

State Mental Health Telephone Access Line

In the 2006 strategic plan, NSW: A New Direction for Mental Health, there was a commitment to provide 24/7 mental health telephone access line to provide advice, triage and referral across all age groups. It would be staffed by mental health clinicians and linked to the National Health Call Centre Network (healthdirect). The original model has been modified and it will now be implemented by linking the statewide number directly to AHS triage services. It will be implemented in two stages:

- **Stage 1** (currently underway) will establish the 1800 number with a message providing 3 options:
  - If it is an emergency hang up and dial triple-0.
  - Press 1 for general health advice and information about MHS and these calls will be routed to healthdirect Australia.
  - Stay on line to speak to a mental health professional if you require a mental health service and these calls are routed to the nearest AMHS.

- **Stage 2** will improve the quality of triage services to meet Statewide performance standards which specify that calls are answered promptly by a mental health professional who has access to current resources and a local database. The Department of Health will monitor adherence to these standards.

At the same time, NSW are starting to pull together their area-based triage services into larger sub-regional or network services. For example St George MHS and Sutherland MHS are in the process of amalgamating their triage service so they will cover all age groups across a larger population.

6.3 Emergency Departments and Beds

Access block and people waiting inappropriately long periods of time in ED an inpatient beds have also been challenges faced by all jurisdictions in Australia. Like WA, the ED has basically become a central point for assessment and a major doorway through which people get admitted to mental health inpatient services in both NSW and Victoria. Victoria and NSW have both introduced specialist mental health staff into the EDs and developed models for the
provision of emergency beds, essentially as a response to the introduction of the 4/8/24-hour rule which limits the time patients can be retained in ED. Under this rule, the maximum time that patients who are not going to be admitted can be kept in ED is 4 hours; 8 hours for those who are going to be admitted; escalating to 24 hours when sanctions are incurred.

6.3.1 Victoria

Emergency Departments

Since 2005/06 Victoria has increased the availability of specialist mental health staff in selected EDs. In 2007 this initiative has been supported by Statewide overarching guidelines outlined in the “Mental Health Care: Framework for emergency department services”. The development of an Emergency Department Mental Health Triage Tool assists ED triage nurses to appropriately respond to people with mental health needs.

The introduction of mental workers together with patient flow initiatives (including ED access to dedicated psychiatric inpatient beds) has significantly contributed to reducing or eliminating 24 hour stays and hence meeting the relevant KPI. There are a range of models for ED mental health workers, but they can primarily be categorized as:

- Extension of CATT (ECATT)
  Clinicians are part of the CAT team, sometimes working in the ED on rotation, and others having a permanent appointment to the ED. Services vary in whether the clinician is co-located in the ED or not. Under the extension to CAT model clinicians are typically rostered across extended hours including evenings, weekends and sometimes nights.

- Liaison
  Clinicians are part of the Consultation/Liaison service and provide education and support for ED clinicians, co-ordinate access to inpatient units and other services and are usually permanently appointed to the ED. Rostering under this model is mainly Monday – Friday.

Although the CAT teams are supposed to be 24-hour per day services, they actually finish at 10:00 pm and anybody who needs an emergency service has to either go to ED or be taken there by the Police. A recent report on ED Mental Health Services noted that while there is variability of approaches and implementation of mental health services in EDs and there is a need to improve coverage and consistency, they also concluded that:

“….it needs to be recognised that the presence of more ED mental health workers will not necessarily continue to provide benefits. One of the key roles of the ED mental health workers should be to promote improvement in the capacity of all clinicians within the ED to respond to the need of mental health patients.”

ED Beds

There are two types of short stay units linked to EDs in Victoria:

- Psychiatric Assessment and Planning Unit (PAPU)
- Mental Health Short Stay Observation Unit (MHSOU)
Psychiatric Assessment and Planning Unit (PAPU)

These beds are within the inpatient unit, staffed by mental health staff but funded through the acute not mental health program with access controlled by the ED. They are designed to provide intensive psychiatric assessment, care and treatment over a short period (< 48 hours) for disturbed patients where management within the ED is difficult and where it is expected that about 80% of patients would be transferred to a mental health inpatient unit.

Royal Melbourne Hospital (RMH) has operated a PAPU since January 2007. It consists of 4 ‘virtual’ beds located in the Psychiatric Inpatient Unit at RMH. It is not funded through mental health and is not counted within the ward’s bed-stock. The aim was to reduce the length of time for patients in ED waiting for a bed. RMH has a busy ED and attracts people from across the wider area. People can stay for up to 3 days in one of the virtual beds where they are very rapidly assessed and processed and either ‘moved into the ward’ (change of bed status), discharged or transferred to another unit. A PAPU Co-ordinator works to transfer people back to the inpatient unit within their local area where possible. About 1 in five gets discharged, 1 in 5 transferred out to another psychiatric inpatient unit and 3 in 5 admitted to the Royal Melbourne. Since becoming operational there has been only one patient waiting longer than 24 hours in the ED whereas previously it was 125 per year. The PAPU has resulted in reduced use specialling, mechanical restraint and code greys in the ED.

An evaluation of the PAPU conducted in 2007 and in recent discussions with RMH they confirmed the following finding:

“….the reduction in mechanical restraint and code greys in ED is a marker of a more humane and potentially less traumatic experience for psychiatric patients during their stay in ED. As well as this, mental health patients are now transferred out of the chaotic environment of the ED more quickly, as a result of PAPU, which is also likely to contribute to their perception of a more therapeutic experience of psychiatric care in the Royal Melbourne Hospital.”

However, the evaluation also noted the increased workload that resulted from faster throughput:

“…there has been a greater demand on medical and nursing staff, including greater admission and discharge paperwork, transfers back to out-of-area beds and more admissions overnight. While we have not directly measured this in this evaluation, there have been a greater number of Riskman incident reports regarding overdue discharge summaries, medical errors and lost patient property. While processes have been established to address these issues, there is potentially greater scope for resources to match the increased workload in any funding revision.”

Mental Health Short Stay Observation Unit (MHSOU)

These beds are located within or close to the ED providing short term shared medical and psychiatric care. There are a variety of models ranging from a unit which is an extension of the current ED services staffed by ED staff and supported by ED mental health workers (Dandenong), to shared units between Psychiatry, ED and Medicine (suggested by Peninsular Health), to the Psychiatric Emergency Care Centre (PECC) model established in Queensland and NSW. Currently there are no PECCs in Victoria. The recent Victorian Reform Strategy committed to evaluating short stay unit service models to determine future directions, but noted the model would include capacity for follow-up care post discharge.

RMH has both a MHSOU in their ED, a PAPU in the psychiatric inpatient unit and a PARC located in their catchment area.
6.3.2 NSW

Emergency Departments – Nurse Practitioner and Outpatient Service

Royal Prince Alfred Hospital has established a Nurse Practitioner position in the ED and has identified 3 aspects of the role: therapeutic techniques, nurse prescribing and care co-ordination and referral.  A Nurse Practitioner lead outpatient clinic has also been established in the ED. It is an expansion of the existing Nurse Practitioner role and provides an in-house referral source for ED staff, particularly for after hours presentations, and an alternative route for access to mental health services for the public. The target population is “...patients with risk factors or early symptoms of a mental health condition, such as anxiety and panic symptoms, emotional disturbances or situational distress.”

Psychiatric Emergency Care Centres (PECCs)

In the USA Psychiatric Emergency Centres attached to EDs have been established for a number of years. While there is considerable variation, the majority are freestanding and provide services in parallel to the ED. In Australia, the first PECC was established in Brisbane, however in recent years NSW has established PECCs in a number of Sydney metropolitan hospitals and regional centres. The NSW PECCs have a dual function of providing:

- 24 hour consultation to the EDs; and
- short term care up to 48 hours in 4 – 6 bed specialist inpatient unit located within or close to the ED.

The unit is generally adjacent to or close to the ED and staff are rostered across the PECC and the ED. The mental health nurse in ED can admit to the PECC beds, but not to the psychiatric inpatient unit. PECCs are generally restricted to people who are likely to need up to 72 hours care. They do not treat people who are psychotic or those requiring behavioural control. While the PECCs do not have isolation rooms, they are gazetted units under the Mental Health Act. A 12 month evaluation of the PECCs from 2006 – 2007 reported that persons admitted to PECC beds had a similar clinical profile to other admitted mental health patients with about half of those admitted to the PECC beds being subsequently admitted to an acute psychiatric unit in the same hospital.

There has been some controversy surrounding the introduction of the PECCs. The Mental Health Council of Australia (MHCA) in its June 2006 Newsletter expressed their opposition to the concept and argued that they stigmatize people by creating separate entry points to the general hospital and are a “simplistic band-aid measure to ease access block to Emergency Departments…..PECCs represent a very old system of care, at a very high cost…….”

A review of PECs in the USA concluded that separate facilities attached to the ED are only suitable for larger hospitals with more than 3,000 mental health presentations a year. If this were translated into the current WA context, it would restrict the applicability of the model to RPH and SCGH.

6.3.3 International Models: Emergency Centres

Kings College Hospital ED Redevelopment London UK

The Maudsley Hospital used to provide an emergency clinic where people could walk in off the street to get help. This clinic was closed in 2007 against a backdrop of significant consumer and carer protest, and the service moved to the ED at Kings College Hospital. The consumers managed to get agreement from Government that a separate mental health access point would be establish at the hospital. A compromise has now been reached that will provide for a single door into ED, but once through the door mental health clients will be
directed to a separate quiet area that will be serviced by specialist mental health staff. The consumers view since the closure of the Maudsley Emergency Clinic (EC) was that:

“……it offered the most fundamental characteristics that users require from a crisis service, ie open access, twenty four hour, seven days a week specialist service provided by mental health staff in a quiet and discrete environment. Since the closure of the EC, local users have been left without these crucial facilities ie Community Mental Health Teams still close their doors at 5pm and over the weekend, mental health Home Treatment Teams can only be accessed via a professional referral…….The only self referral option for mental health users experiencing a crisis “out of office hours” is to go to King’s College Hospital emergency department….We have been told that providing a separate mental health area would be “stigmatizing”. As people with direct experience of mental health crisis and facing considerable prejudice due to our mental health needs, we strongly object to being told that the safest and most appropriate way for us to access help when we most urgently need it, is stigmatizing…..We would argue that being stared at by members of the general public because we “look funny” or are talking to our voices or crying out with the pain of our distress is far more stigmatizing and very unsafe.” Theresa Priest, Coordinator Southwark Mind

Winnipeg, Canada

Following a review of Emergency Department Services in Winnipeg, a decision was made to establish a separate Mental Health Crisis-Response Centre on the site of the Health Sciences Centre. This unit will be open 24 hours per day and will take people requiring urgent assessment and treatment who walk in off the street. It will also have the capacity to provide a 24 hour community response.

6.4 Beds

In both Victoria and NSW, where they have implemented policies limiting the length of time that people can be held in ED, bed flow management has been introduced as a means of reducing the variation in clinical practice and accelerating the movement of patients through inpatient beds.

Bed Flow Management and Clinical Redesign

Southern Health and Western Health in Victoria have both implemented active programs of bed flow management, which, recognising that this is essentially about changing clinical practice, was centred around local clinicians. The programs essentially revolved around feeding back information to clinical services about their performance. The bed stock was being managed as an Area Mental Health Service resource, with ward staff teleconferencing twice a day about the bed state including waiting lists, admissions and discharges. The downside of bed flow management was being felt at Royal Melbourne, where some of the staff felt under a great deal of pressure from the increased workload.

NSW has put considerable effort into clinical redesign, with nine mental health redesign projects undertaken since 2005. They aim to improve access to emergency care and achieve access block benchmarks for mental health clients presenting to EDs as well as improved access to and better quality of care in community services. Streamlined processes have been introduced in ED, inpatient units and community services. Of the more than 100 solutions identified, 20 have been implemented.
Alternatives to Acute Beds

Victoria has made a significant investment in PARC ‘sub-acute’ community beds to offer consumers at risk of or recovering from a mental health crisis an alternative to inpatient care (‘step-up’) and/or support early discharge (‘step down’). These units are 8 to 10 bed community-based units run by NGOs, which provide the psychosocial support, with clinical care being provided generally by the CAT Team. Currently there are 10 operational PARC services across Victoria with a further 5 projects in development. There final number of PARC beds will be 150.

In the UK, subacute care is being provided in community-based ‘Crisis Houses’, which as in Victoria, operate as a partnership between NGO and public mental health services. These are domestic-style houses where people can go in a crisis to get support and treatment as an alternative to hospital admission.

6.5 Enhanced Community Response

Both Victoria and NSW have established teams to deal with urgent assessments and intensive community treatment - the Crisis Assessment and Treatment teams in Victoria and the Acute Community Treatment teams in NSW. These teams are multidisciplinary and significantly better resourced than the CERTs in WA. In both Victoria and NSW the CAT and ACT teams operate until approximately 10pm, after which time the ED is used for emergency assessments.

Neither the CAT Teams nor the ACC Teams consider themselves ‘front line’. It was stated on a number of occasions in both jurisdictions that they are an ‘urgent’ but not ‘emergency’ service and that it was the role of the Police to respond to ‘emergencies’ such as sieges and mentally ill people who were armed or dangerous.

The establishment of Crisis Resolution Home Treatment Teams (CRHTs) in the UK has been a major national initiative. They vary from large multidisciplinary teams operating 24/7 to much smaller teams operating more restricted hours. They were not set up to do emergency community assessments, but rather to assess clients prior to admission to determine whether they are suitable for intensive treatment and support outside hospital. They are also tasked with trying to effect early discharge. Evaluation of these services has found that they have been able to reduce admissions by 10%, and where they provide a 24/7 service, a further 23% reduction in admissions has been achieved. The same study reported that the introduction of assertive outreach teams was not associated with reductions in admissions.

The extended-hours service run by Bentley MHS, which ceased with the establishment of MHERL/CERT, was raised repeatedly during the staff consultations as the preferred model for the future organisation of emergency services in NMAMHS. Two community nurses were rostered on daily from 1:00 pm until 9:30 pm. From 1:00 pm until 4:30 pm they managed their own clients and thereafter provided an emergency mental health service for the Bentley catchment area. The service was set up to stop after-hours admissions and is reported to have been very successful. It is worth noting, however, that PET was available to respond to the ‘real’ emergencies and some of the new clients.

South Metro Area MHS reviewed its emergency mental health services last year. Early consideration was given to the establishment of a separate ‘emergency division’ across the Area incorporating the PLNs, Triage and CERTs, but this was not accepted. The outcome has been that the CERTs have been grouped together under the management of an Area Coordinator. Although the CERTs are still located in the Clinics, this is more to ensure a timely response to emergencies. The on-duty, after hours CERT service has been re-located
from Bentley to the Armadale Hospital ED which provides a base from which the team responds to community emergencies as and when required.

Fremantle has also tried to coordinate the triage, PLN, Liaison and CERT teams. With the recent re-alignment of the management of CERT services in SMAMHS, the Fremantle-based CERT is now sitting ‘uncomfortably’ on the boundary, although it would prefer to be part of the Fremantle system. Coordination of the various elements of the system would bring together entry though ED (PLNs), the General Wards (Consultation/Liaison), walk-ins/other referrals (Triage), with CERT providing the capacity to manage the emergency response in the community.

Ambulance and Police Response

The transport of patients detained under the Mental Health Act is primarily carried out by the Ambulance Service in both Victoria and NSW and the Police only become involved at the request of the Ambulance officers when they are concerned about the risk of violence. This is enabled under their respective Mental Health Acts and is a legislative change that could usefully be pursued in WA.

NSW currently has a program where they are training up a percentage of their Police Force to manage people with mental illness.

The 2009 report by the Victorian Auditor-General Report, Responding to Mental Health Crises in the Community, noted that the lack of responsiveness of CAT services to mental health crises was an issue frequently raised by police, paramedics and consumers who observed that they often don’t call the CAT services because of response delays. The other difficulty for the Police was the hours spent waiting in EDs for a mental health assessment to begin.

Victoria has recently funded a 12 month extension to a pilot collaborative service model for responding to mental health crises. The PACER (Police, Ambulance and Crisis Assessment and Treatment Team Early Response) service is a partnership between Victoria Police, Ambulance Victoria and Southern Health. The focus of PACER is on people who are, or suspected of being, in a mental health crisis and who come to the attention of Police or Ambulance. 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. There is significant support for the model by those involved and early evaluation shows it has improved resource use, interagency communication and provides a more person-centred response. The Auditor-General report recommends continuing the PACER trial and acting on the evaluation.

6.6 Restructuring a CMHS: Peninsula MHS

During the visit to Victoria, Peninsula MHS given as an example of a MHS which provided an interesting example of restructuring to establish integrated rather than specialized teams such as the CATT and Mobile Support and Treatment which are typically found in most Victorian services.

Peninsular covers a population of 260,000 in the south east of Melbourne; partly metropolitan and partly rural. It undertook a long, in-depth review of its inpatient services before commencing a review of its community services using the Six Sigma methodology. It had the Victorian set of services [e.g. CATT, Continuing Care Team, Primary Mental Health, Early Episode Psychosis, etc] all run as discrete teams.
CATT was identified as presenting a considerable barrier to entry to the service. It was seen by consumers and carers, who wanted this early access to services, as a problem. They wanted access before early in illness or early in episode to try to prevent emergencies.

The consultants working with Peninsular identified that only about 38% of the all the clinical processes ‘added value’. For example, repeated assessments with people telling their stories several times; but much information was lost or not used. Peninsula moved to a ‘blended’ model, creating 4 geographic teams, with each delivering a range of ‘functions’, but with no separate CATT, CCT, PMHT, EPS teams. A ‘care bundle’ approach was adopted, as illustrated below [for schizophrenia].

![Diagram of 'Care Bundle' approach adopted by Peninsular MHS](Source: Dr Richard Newton, Margaret Tobin Oration. RANZCP Congress May 2009)

**Figure 44: Example of the ‘Care Bundle’ approach adopted by Peninsular MHS**

This approach outlines what assessment and services a person with schizophrenia can expect. A care bundle has been developed for all major mental health conditions. It is expected that every patient will get access to a ‘bundle of Evidence-based Interventions. Case audits have shown that compliance is generally high.

Each of the 3 teams triages its own patients between 8:00 am and 5:00 pm, following which there is a roster including staff from across all teams until 9:00 pm. Every person who accesses triage must leave with “a service arrangement in place”. Frequent users are referred back to the same clinicians who can ask questions like, “how was your service arrangement last time” and “what went wrong?”

Peninsula has systematically developed partnerships, particularly with its local GPs, its local Carer Council and the Psychiatric Disability Rehabilitation and Support Services [PDRSS]. It sees these groups as an important resource for the long-term management and support of people with mental illness.

Following the restructuring of community services, bed occupancy within the inpatient unit almost immediately fell from around 100% to 85%. The former Area Director attributes this to “getting rid of CATT led to a doubling of acute assertive outreach that people were receiving early in their episode.”
Important principles that underpin the model of service delivery in Peninsula MHS are:

- Easy in, easy out, no refusal. If a patient is discharged to a GP, be prepared to readmit them and don't insist that they have to go back through the assessment process.
- Focus on intervening early in the episode. Place the emphasis on intervening before the ‘emergency’ occurs.
- The more steps in the process the more opportunities for error. Try to reduce the number of steps in a process and avoid passing patients from team to team.
- Cumulative assessment rather than repeated assessments. Cumulatively gather information rather than trying to get it all before or at the point of access.
- Separation of functions leads to discontinuity and loss of momentum. Don’t separate functions.
- Small integrated teams lead to teams ‘owning’ their clients.
- Case management is a ‘system of care’ and not an ‘intervention’. Ensure that all staff have the competencies to be able to deliver Evidence-based Interventions.

Importantly, Peninsula MHS placed a high value on staff training and right up front established a Committee composed of their senior staff to focus on research, training and education. They initially put about 20 hours of training into each of their staff to give them the basics of Cognitive Behaviour Therapy. As Dr Newton commented “there are only a handful of interventions which have proved their usefulness and effectiveness”. These are outlined below:

- Pharmacological Management
- Cognitive Behaviour Therapy
- Cognitive Remediation
- Family Interventions
- Assertive community Treatment
- Training in Illness Management Skills
- Integrated Treatment for Co-morbid Substance Abuse
- Skills Training ['real life’]
- Supported Education
- Supported Employment
- Supported Accommodation
6.7 Summarising

Outlined below are the various initiatives described above, overlaid on a schema of the WA emergency mental health system.

Figure 45: Schematic representation of innovations in other jurisdictions to improve mental health emergency services
7. KEY FINDINGS

7.1 Current Emergency Services
The current service model for managing psychiatric emergencies in the community within the North Metropolitan Area involves:

- Mental Health Emergency Response Line providing a 24 hour telephone triage and counselling service;
- Community Mental Health Services providing a response as part of their core function during business hours, with 2 staff rostered on each day at the weekend; and
- Three clinic-based Community Emergency Response Teams, with a combined staffing complement of 12 FTE, providing a mobile emergency response from 3:00 pm to 11:45 pm daily. After-hours services are provided by an on-call roster of staff from the 3 North Metropolitan Area CERTs.

7.2 Access
Consumers and their families, particularly those new to the system, report difficulty in knowing where to go for help and in accessing and navigating the mental health system.

There is a lack of consistency in the roles, policies, procedures and protocols of CERTs, PLNs and EDs across the North Metropolitan Area, so that the response that referral agencies and consumers and carers get depends very much on 'which door they knock on', an experience sometimes referred to as 'Postcode Lottery'.

MHERL is not widely promoted within the community and many people are unaware of the service or its role. Despite its designation as an 'emergency' response line, MHERL (including Rurallink) receives over 60,000 calls per year ranging from emergencies requiring an immediate response to non-urgent requests for information and advice. In 2008/09, MHERL was the referral source for 534 of the North Metropolitan CERTs' 1,686 referrals (32%), of which 342 (64%) were triaged as requiring an immediate response or a response within 2 hours. The vast majority of calls to MHERL are clearly not emergencies requiring an urgent response from community-based emergency services.

MHERL has no authority to initiate a mobile emergency response from the CERTs or CMHS, which frequently insist on re-assessing the referral to determine the appropriate response. As a consequence, there is considerable waste of resources by this duplication of effort.

MHERL, which reports through the NMAHS Deputy Area Executive Director for Mental Health, is clinically isolated and poorly linked into the mental health service system. In addition to Rurallink, MHERL has recently taken on the provision of additional telephone services, including South West 24. This raises questions about where it would best fit functionally and what should be its future direction.

7.3 Emergency Care in the Community: CERTS
It was expected that the establishment of the clinic-based CERT services would, amongst other things:

- Increase the number of clients seen;
- Reduce the threshold for an emergency response;
- Reduce the emergency response time;
- Reduce ED presentations;
- Reduce the incidence of hospitalisation; and
- Increase support for people discharged from hospital.

The average daily number of service events for the combined North Metropolitan CERTs is 4.6 of which 1.8 is category 1 or 2. While the number of emergencies requiring an urgent response remains small, it is apparent that the CERTs are, in fact, seeing more clients than the Psychiatric Emergency Team and the threshold for the emergency response has decreased. However, this needs to be understood against the background of a significant increase in staffing.

Overall, the number of after hours call-outs remains small. In the 2 years to April 2009, there were three or less after-hours call-outs per month in over 85% of the months. Of these calls, about half were received before 1:00 am and the rate dropped away sharply after 3:00 am. MHERL was the major after-hours source of referral (82%), followed by the Police (11%). There have been difficulties with the on-call service. The process of staff travelling to the MHERL offices in the CBD to pick up notes before proceeding to the crisis response adds to the response time. More importantly, there have been a significant number of occasions when it was not possible to mount an after-hours CERT service because of staffing shortages.

Since the establishment of the CERTs in 2006, there has been no significant reduction in the number of separations from North Metropolitan psychiatric inpatient services, in the average length of stay or in the re-admissions rates. Nor has there been any significant reduction in the rate of mental health presentations to the Emergency Departments.

The CERTs were established each with four positions, 3 nursing and 1 allied health. However, in the North Metropolitan Area, they have not managed to attract and retain allied health staff and the HSU positions have all been filled by nursing staff. Nurses employed under the HSU award have not been able to perform nursing duties, which has implications for their ongoing registration, and have been reporting through a different line manager. The employment situation in the North Metropolitan Area CERTs is further complicated by variation in classification between the ANF positions within the teams. In the South Metropolitan CERTs, all the nursing positions are classified as SRN 3.

Despite the CERTs being physically located in three of the community mental health clinics, the services operate essentially independently, with different management lines, very little interchange or sharing of staff, limited contact between them and little opportunity for CERT staff to participate in professional or other development activities. SMAMHS have maintained an area-wide CERT Co-ordinator with line management responsibility, however their four CERTs are physically located within each district.

Although there has been no question about the quality and effectiveness of the CERTs’ clinical work, there has been considerable debate about whether they should be just providing an emergency response or a broader range of after-hours services for CMHS patients. There has also been an issue as to whether they are an ‘area’ or a ‘CMHS’ resource. The CERTs have been caught between these positions, with the current model leading to an uneven distribution of their workload across the Pods. The work that the CERTs do for the CMHTs varies considerably in both volume and type depending on where they are physically located. The data shows that the CERTs do a lot less work, particularly non-
emergency work, for Inner City and Mirrabooka than they do for Osborne Park and Swan respectively.

Many staff interviewed believed that the CERT staff should simply be ‘absorbed’ into the CMHTs to enable them to provide an extended-hour emergency response, similar to the service provided prior to the devolution of PET by the Bentley Mental Health Service. This raises a number of questions, including just how the CERTs could be simply ‘integrated’ into the current North Metropolitan Area Community Mental Health Service system and how this would impact on the capacity of the system to provide an emergency response – both assessment and treatment - service.

While the three North Metropolitan CERTs have had intensive contact with some clients at risk (in one case in excess of 100 contacts in a single financial year), this falls far short of the systematic provision of the gate-keeping and intensive treatment and support services afforded by the Crisis Assessment and Treatment (CAT) Teams in Victoria, the Acute Community Care Teams (ACCT) in NSW and the Crisis Resolution Home Treatment (CRHT) Teams in the UK.

These latter services have all been established as well-resourced, multidisciplinary teams, operating extended hours services with a clear mandate for gate-keeping all potential admissions and providing intensive treatment and support where possible in an effort to maintain clients in the community.

This is very different from the way in which the CERTs have been set up and resourced; with 3 teams of 2 nurses operating an evening shift, essentially independently from the CMHTs, and with their only medical support coming from the on-call MHERL psychiatrist. Where medical assessment/treatment has been required, their only option has been to take the client to an Emergency Department.

7.3 Emergency Care in the Community: CMHTs

There is no readily available data on how effectively the CMHTs are managing emergency referrals during business hours or during the day on weekends. One CMHT reported that it did not have the resources to manage ‘emergencies’ - essentially those people needing to be seen immediately or within 2 hours - but referred them to the Emergency Department. CERTs reported that they were not infrequently asked to deal with emergencies that had presented earlier in the day. On the other hand, staff in one ED commented that they had no difficulty in getting people seen urgently following an initial assessment in the ED.

In an attempt to provide a more timely service response, three of the six CMHTs in the North Metropolitan Area have established dedicated Assessment and Short-term Treatment Teams; Swan (SAST) and Mirrabooka (MAST) through the allocation of additional resources and Inner City (ICAT) through a redistribution of existing resources. These teams have been used not only for the assessment and short-term treatment of emergencies but also of all new referrals, including non-urgent referrals, to the community mental health service. In effect, these teams have taken on a ‘gate-keeping’ function for all admissions, but primarily admissions to the Continuing Care Teams. This raises the question of whether the resources could more effectively be used in targeting emergencies and providing an intensive community treatment and support service for those requiring or at risk of requiring hospital admission.

The value of rostering 2 staff on each day at the weekend for each of the six clinics (total 24 staff) is questionable, especially in view of the lack of any standardisation of their role or operation. Could this service be provided by groups of clinics rather than each clinic and, if
so, could the resources saved be used in providing intensive community treatment and support for people at risk of hospital admission?

While consumers and carers want access to care early, before a ‘problem’ becomes an ‘emergency’, their experience is that the system is geared to trying to prevent their access to services - a view that was also expressed by a number of staff during the consultation process. There is a strong sense of ‘gate-keeping’ across the mental health system is aimed at limiting patient access. This is re-enforced by the disproportionate effort and investment of resources that seem to go into the front end of the system in ‘triage’ and ‘assessment’ – including re-triage and re-assessment. This is a long way from the ‘no wrong door’ principle adopted in Victoria or the ‘easy in, easy out, no refusal’ approach implemented in Peninsula Health. Almost counter-intuitively, the latter approach has led to a reduction in the number of people under CMHS care and a fall in average bed occupancy from 100 to 85%.

7.4 Emergency Departments and Beds

In the absence of adequate community mental health programs, especially after hours, EDs have become major entry points into mental health services for urgent mental health assessment. Royal Perth, Sir Charles Gairdner, Joondalup and Swan Hospital EDs between them have around 12,500 attendances per annum, about one third of which are admitted to an inpatient bed.

Mental health staffing in the EDs does not properly reflect their importance as an entry point into the mental health system, the range of service need (youth, older adult, drug and alcohol, multidisciplinary care), nor the variation in demand for services at different times of the day. For example, having one PLN on duty during the very busy time of 3:00 pm to 9:00 pm is not adequate. The Royal Colleges of Psychiatry and Emergency Medicine in the UK have recently published guidance on working with mental health clients in ED and this outlines the need for a properly resourced, multi-disciplinary consultation/liaison service.

The EDs do not have the physical infrastructure or therapeutic environment necessary for the proper assessment and treatment of people who are acutely unwell, which often escalates the psychological distress in mentally ill individuals. As a result, the level of seclusion and restraint in EDs has become worrying for the ED physicians and their staff. More fundamentally, clients and carers do not like having to access mental health services through ED and would much rather an “open access, 24 hour, seven days a week specialist service provided by mental health staff in a quiet and discrete environment.”

While there has been some improvement in access to psychiatric inpatient beds, there are still major problems with EDs acting as ‘overflow beds’ when mental health beds are full. The difficulty in accessing mental health beds is a major source of distress for patients and their families and also comes at a high ‘cost’ both financially and psychologically to EDs and CMHTs. Community staff, faced with the daunting task of accessing beds, often see ED as the ‘most reliable portal of entry’. The 4-hour rule is clearly going to have a significant impact on this practice and this raises the question of what are the most acceptable and cost-effective strategies that can be put in place to reduce the pressure on EDs.

Staff working in the CMHTs, CERTs and EDs currently have little alternative to hospital admission for people who require more urgent or intensive treatment and support. The CMHTs contend that they do not have the staff to provide intensive contact and treatment, even over a short period of time, and the EDs are clearly not set up or resourced to deal with such clients. As outlined above, the CERTs sometimes try to provide ongoing treatment and support, but their staff size and mix and their disposition militates against them being able to provide the level of service generally needed to manage crises in the community. Furthermore, there are currently no intermediate step-up/step-down facilities in WA like the
PARC units in Victoria or the Crisis Houses in the UK, which could offer an alternative to a hospital inpatient stay.

Hospital @ Home was originally set up at Joondalup CMHS to provide a home treatment option for people who otherwise might need a voluntary hospital admission. The management of the service has subsequently been transferred to SCGH to satisfy the requirements of the funding program. It currently provides a service for patients referred from Subiaco, Osborne Park and Mirrabooka Community Mental Health Services and for patients discharged early from D20. It does not provide a service to SCGH ED. Most of its referrals have been coming from Osborne Park.

All the service providers that have used H@H spoke highly of the service although recognising its significant limitations due to its size and staffing. Although the service operates from 8:30 am to 9:00 pm seven days per week, it cannot effectively provide a service to clients after 5:00 pm when there is only 1 staff member on duty. Significant difficulties have been experienced in getting psychiatrists from the clinics to provide the required regular review.

While the Bed Flow Coordinators have clearly had some positive impact on the availability of beds across the area, with positive comments from SCGH ED and Graylands. However, their role has not been well understood by many staff who commented that the Coordinators had not assisted them because they were still left to actually find the bed themselves.

Improving the flow of patients through the beds is clearly a very important element in improving access to beds. The question is, how is this best achieved; by ‘pooling’ beds across the metropolitan area and providing ‘central’ coordination or by ‘designated’ district beds and ‘local ownership’ of the problem? The impact on consumers of moving them between units and on their care should be central to this debate.

7.5 Working with the Police

There have been many attempts to try to resolve the issue of the role of Police in mental health emergencies. The Police currently have 2 broad functions; the first involving taking people who they believe to be mentally ill for psychiatric assessment and the second being the transport of involuntary patients to, or between, hospitals/EDs. The Police have always had, and will continue to have, a role in the former. They are often the first service contacted by the public. In other Australian jurisdictions, however, the Ambulance Service has the central role in transport and Police are only involved when the Ambulance Service requests their assistance.

A critical question for the mental health system is what exactly it sees as its role in responding to emergencies in the community: ‘front-line’ emergency service or following up after the police emergency response. Consumers and carers consider that the Police should only be used as a ‘last resort’.
8. FUTURE DIRECTIONS: ADULT MENTAL HEALTH

8.1 Making Sense of the Emergency Mental Health System

The Emergency Mental Health System in the North Metropolitan Area is under pressure. The signs of that pressure are most evident in the Emergency Departments of the General Hospitals like SCGH where:

- Patients with mental health conditions, which represent around 8% of all presentations, occupy 20% of the beds daily; and
- Although in the 21 months to April 2009, there has been a reduction in the average length of stay of patients on forms awaiting a bed from 39 to 23 hours, there are still patients with stays of more than 48 hours.

The EDs are not set up for the assessment and management of people with mental illnesses and can precipitate disturbed behaviour leading to the need for physical and chemical restraint. Prolonged periods of sedation of patients in ED waiting for a bed are clinically unacceptable and have the potential to cause serious complications [e.g. aspiration pneumonia, urinary tract infection and delirium].

People with mental health conditions have in the past, and will continue to use the EDs. The issue is not about preventing those people who wish to or need to use the ED from doing so, but about improving the infrastructure and service response in ED, making available real community-based alternatives and putting a stop to the practice of using EDs for people awaiting a bed in a psychiatric inpatient unit. The imminent introduction of the 4-Hour Rule into Emergency Departments adds a level of urgency to finding solutions for these problems.

As alluded to above, the primary causes of the pressures on EDs are not to be found in the ED itself, but in the difficulty experienced across the mental health system in accessing psychiatric beds, in the lack of alternative community-based mental health services, particularly after hours, and in the difficulty that people experience in accessing community services in a timely manner, even when they are available.

The introduction of the new community emergency mental health system - MHERL/CERT/CMHS – appears to have increased the number of clients seen face-to-face and reduced the threshold for emergency response, but it has not brought about any real change in the use of inpatient services or of EDs.

The experience of Peninsula Health in Victoria provides a plausible explanation. In moving from a ‘specialist’ to a ‘geographic’ team structure, it was able to very significantly increase the amount of “acute assertive outreach” that people were receiving and, importantly, delivered early in their illness/episode.

The Reviewers believe that one of the fundamental problems with the current emergency mental health system in Western Australia is that it does not have the capacity to systematically provide intensive treatment and support for people undergoing crises other than through the hospital system [see figure 14 below]
With the way that we have structured and operate our system, a disproportionate amount of effort and resources have been directed into ‘gate-keeping’ the entry points of our system, namely triage and assessment, and not enough into treatment. The solution lies in the development and re-design of our community services to give them the capacity to provide intensive community treatment and support.

For example, what community-based intensive treatment and support services are available for people who present to ED? If the problem is assessed as being urgent, the answer is none; leaving the most likely outcome as hospital admission. This is despite the fact that the period following an ED visit needs to be considered as a ‘part of the episode of emergency care’ and is marked by sustained urgency and intensity. Research has shown that the patients with the highest rates of suicide following an ED visit are those that have the lowest rates of compliance \(28\). This highlights the importance of ensuring that patients following an ED visit have ready and rapid access to services.

### 8.1.1 Threshold for Admission

There is no fixed ‘threshold’ for when a patient requires admission to hospital. It depends on factors like the clinician; his/her training and experience; how comfortable he/she feels about managing risk; on what ‘natural resources’, including families and friends are available and how willing and able they are to provide the required level of support. It also depends on factors like whether there is a weekend or even the end of the day coming up: what is he/she going to do with them? And sometimes it is easier just to admit them to a bed.
Low
Inpatient Beds
High
Intensive Treatment & Support

"If community teams had their own intensive home treatment service, they would hang on longer, knowing that there was extra support."

Stakeholder Consultation

Figure 48: The admission threshold

Staff at Swan MHS reported that some of its beds had to be closed at one time because of staff shortages and they noted that the threshold for admission went up. What it illustrates is that the decision to admit will be strongly influenced by the relationship between the availability of beds and the availability of community resources. The greater the availability of intensive treatment and support services, including after-hours services, the greater the likelihood that clinicians will be prepared and able to manage their clients in the community.

8.1.2 The ‘Urgency Continuum’

It is clear from the definitions of ‘Emergency’ and ‘Urgent Problem’ that there is no sharp demarcation between the two; rather there is a continuum, with a low volume of high urgency case at one end and a relatively high volume of lower urgency cases at the other.

Figure 49: The urgency continuum

The Psychiatric Emergency Team, despite receiving a large volume of telephone calls [similar to MHERL], operated its call-out service more towards the high urgency or ‘emergency’ end, maintaining a close relationship with, and high level of reactivity to, the Police. This end of the continuum is important, but often it ends up in staff expediting a person’s admission to hospital.

The CERTs, on the other hand are being ‘pulled’ in both directions, trying to manage the emergencies and being increasingly drawn into taking on the more routine clinic work; work
that in most cases is at low risk for hospital admission. This raises the question about whether they will continue to be able to retain their capacity to respond to the emergency work in an appropriate and timely manner.

8.1.3 ‘Separation’ or ‘Integration’

There was a prevalent view amongst staff consulted that the CERTs should simply be integrated into the CMHS. In clinics with Assessment and Short-Term Treatment Teams, some attempt had already been made to bring them ‘operationally’ together.

Figure 50: Separation or integration of community teams

Above is a diagrammatic representation of a Community Mental Health Service divided into 2 components; Assessment and Short-Term Treatment Team [ASTT] and Continuing Care Team(s) [CCT]. The focus here is on the differential rates of flow through the system. There is a large volume [Rate 1] coming through the ASTT, which provides assessment for all new referral, including emergencies and provides short-term treatment for some. The ASTT then discharges some clients [Rate 2] that do not require ongoing specialist mental health care and refers others on [Rate 3] for admission to the Continuing Care Team.

However, if the sum of Rate 2 + Rate 3 is less than Rate 1, there is a problem. This occurs primarily when the CCT is ‘full’ and is unable to take any further admissions. So what happens to the clients that can’t be referred across? What tends to happen is that the ASTT take on a ‘holding function’ and manages them as best it can. The rate limiting factor in this system is the rate at which the CCT can discharge its patients [Rate 4]. A key question is how can discharges from the CCT be expedited?

If more staff [CERT] are put into the front end [ASTT], more assessments can be done and more short-term treatment undertaken, but the rate limiting step will remain the rate at which people can be discharged from the CCT. Should additional resources, therefore, be put into the ASTT or into the CCT. Have we got too many resources tied up in triage and assessment and not enough in treatment?

Another important issue is that the ASTT is doing assessment of all referrals and not just the urgent referrals, including the ‘cold’ referrals from GPs. Why do all referrals need to be assessed by the ASTT? Why not just urgent referrals, particularly those that are in danger of requiring admission? Could the resources not be more effectively used to provide an
intensive community treatment and support service similar to the Crisis Resolution Home Treatment Teams in the UK?

Simply absorbing the CERTs into the CMH Clinics and continuing with ‘business as usual’ is not going to resolve the pressures on the Emergency Mental Health System. What is needed is a fundamental review of the way that the Community Mental Health Services are doing business.

8.2 Reviewing the Options

Below is a schematic of the Emergency Mental Health System in WA with its entry points and pathways between services. As outlined above, the pressure on the system is most in evidence in the EDs, but where do the solutions lie?

![Schematic of the Emergency Mental Health System in WA](image)

**Figure 51: Entry points and pathways in the emergency mental health system**

In the above schematic, if there is not a psychiatric inpatient bed available for a person presenting to the community-based emergency services, the person gets sent or taken to the ED to await the availability of a bed.

The New South Wales and Victorian Health Departments have introduced policies limiting the time that people can be held in ED before being discharged or admitted to a bed and a number of strategies have been developed to meet the demands of these policies. The Psychiatric Emergency Care Centres [PECCs] in NSW have been developed as 4-6 bed short-stay units adjacent to or near the EDs and are staffed by mental health professionals, while the Psychiatric Assessment and Planning Units [PAPUs] in Victoria are short-stay ‘virtual beds’ within psychiatric inpatient units.

Setting up separate small specialised units like the PECCs is expensive and does not give clients access to the range of services or staff available to people in inpatient services. Furthermore, people with challenging behaviours cannot be managed in these units. The overall impression is that many of these clients could be managed in a general Short-Stay Units [SSU]. The PAPU model [e.g. Royal Melbourne Hospital] offers a more ‘therapeutic experience’ and provides a ‘buffer’ for managing the day-to-day fluctuations in demand for beds. In the end, however, all these short-term bed strategies rely on being able to access beds in a psychiatric setting in a timely manner.
A major rate limiting factor in the emergency mental health system is the availability of inpatient beds. In New South Wales and Victoria, there has been considerable investment in bed flow coordination aimed at increasing the rate at which people move through the inpatients system. North West Mental Health in Victoria introduced a system which covers the beds in 4 psychiatric units in its region [100 beds], but it ‘manages’ its system ‘locally’ through daily teleconferences. One of the reported disadvantages of this initiative has been the sense of ‘unremitting pressure’ experienced by inpatient staff.

In WA, the Assertive Bed Flow Coordinators were introduced to try to improve the flow through the psychiatric beds across all metropolitan hospitals. Although there has been a substantial reduction in the average length of stay for people on forms in SCGH ED and improved access to beds at Graylands Hospital, the program has not been experienced universally positively across the system and there are still people spending unacceptably long periods of time in ED waiting for beds. A far more challenging task facing the system over the next 12 to 18 months will be finding ways of getting ED stays down below 4 hours.

One of the perverse incentives in a metropolitan-wide system of bed flow coordination is that where services are able to reduce the use of their beds, they have no control over the use of these beds by other service providers. It needs to be recognised that bed management is not about ‘finding beds’ but about changing clinician ‘attitudes and behaviour’. Giving clinicians not just the responsibility but the power to manage resources across both the inpatient and community sectors for a defined population will provide the strongest incentive for the development of alternatives to inpatient care.

An important question is what strategies can be put in place to divert people from, or limit their use of, inpatient beds? Consumers and carers have expressed a strong preference for community-based solutions. Intensive community treatment and support services, like the Crisis Resolution Home Treatment Teams in the UK, have proved more successful than any other initiative in reducing the use of hospital inpatient beds. These services are used both to divert people from admission and to support early discharge; to ‘pull people’ out of the system rather than ‘push them through’ as happens with bed flow management strategies alone.

Likewise, Peninsula MHS in Victoria has been able to reduce bed occupancy from 100 to 85% by increasing the level of acute intensive community treatment and support available for people early in their illness/episode. The availability of ‘step-up’, ‘step-down’, subacute beds such as the PARCs [Vic] and Crisis Houses [UK] have proved an effective alternative to inpatient care.

8.3 Establishing the Principles

Consumers and carers leave us in no doubt that they want a system that can provide

“… a greater emphasis on prevention, promotion of positive mental health, early intervention – earlier in the life course as well as in the course of an illness – and for more sustained, flexible and comprehensive support delivered in the community.”

Because Mental Health Matters, Victorian Mental Health Reform Strategy 2009 – 2019

The sentiments expressed above are equally relevant to consumers and carers in WA. The principles that we believe should be central to the future development of Emergency Mental Health Services are as follows:

- Early intervention in the course of the illness or episode: provide help early to prevent emergencies where possible.
- No wrong door: provide easy access to assessment and direction to the right service in a timely way.
Continuity of care: taking responsibility for a person’s ‘journey’ and not simply an ‘episode’ of care.

Care ‘closer to home’ and in the least restrictive environment.

Meaningful engagement of family carers; recognising the importance of carers as a central part of the natural support system and potential partners in care.

The overarching objective, however, should be to ensure that the consumer and his/her needs is at the centre of the system. But what does this mean? Fiona Godlee, Editor of the BMJ put it most eloquently when she wrote:

“If we really want to transform the quality and safety of healthcare, we can’t just do more of what we do now. Even doing it more efficiently won’t be enough. We have to do different things and we have to do things differently. … the current system is designed around healthcare professionals. …. [What is needed is] a more desirable set of rules that puts patients at the centre of things ….. Now this means standing in their shoes and seeing things through their eyes.”

8.4 Finding Local Solutions

The key proposals for the future directions of emergency mental health services in the North Metropolitan Area are outlined below and then discussed in detail.

- Adopt the principles of ‘no wrong door’ and ‘easy in, easy out’ in the community mental health sector with a shift in role from ‘gate-keeping’ to ‘facilitation’.
- Re-badge MHERL and, in addition to its emergency function, give it a broad role in assisting people access and navigate the mental health system.
- Give MHERL the capacity to mobilise community service responses following triage.
- Establish Intensive Community Assessment and Treatment Teams [ICATT].
- Restructure community mental health services, moving to a ‘blended’ model of geographic teams that combine acute assessment and treatment and continuing care functions.
- Move towards a system of allocating and managing beds at a District rather than Metropolitan-wide level.
- Develop separate mental health ‘suites’ in the EDs, serviced by specialist mental health staff.
- Establish properly resourced, multidisciplinary Consultation-Liaison Services in EDs.
- Cease the practice of holding people in ED while they are awaiting a bed in a psychiatric inpatient unit.
- Establish 6 short-stay, ‘virtual beds’ at Graylands Hospital modelled on the Psychiatric Assessment and Planning Unit [PAPU] at the Royal Melbourne Hospital.
- Establish Intermediate Care facilities as alternatives to inpatient care.
- Improve the working relationship with the Police.

North Metropolitan Area Mental Health Services have embraced a ‘district’ model based on four catchment area populations, each of sufficient size to support a comprehensive range of inpatient and community services. The above proposals for the re-design of the emergency mental health system need to be developed and implemented within this district framework.

During the consultation with staff in the North Metropolitan Area, much was made about the ‘fragmentation’ of the emergency mental health system. Despite the fact that for many service users their contact with the mental health system is much more like a journey than an
episode of care and hospital admission simply “a blip on the screen” of their long-term care pathway, community mental health services almost invariably disengage when people go to hospital.

In framing the directions in this Review, we have been mindful of the need to have a properly resourced community-centred system; one that can take a lead role in co-ordinating patient care across the services in order to enhance continuity of care and stop people ‘falling through the gaps’.

1. **Adopt the principles of ‘no wrong door’ and ‘easy in, easy out’ in the community mental health sector with a shift in role from ‘gate-keeping’ to ‘facilitation’**.

Consumers and carers want access to services early in the course of their episode/illness, before what started out as a problem becomes an emergency. This requires a fundamental re-think in the role of community mental health services - from ‘gate-keeper’ to ‘facilitator’: making sure that clients get to the right service, in the right place, in a timely manner.

Peninsula Mental Health has adopted these principles and, far from being overwhelmed by demand, has been able to reduce its average bed occupancy and its community case load. Anyone who comes in contact with its triage service “leaves with a service arrangement in place”.

2. **Re-badge MHERL and, in addition to its emergency function, give it a broad role in assisting people access and navigate the mental health system.**

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. The data from MHERL clearly indicates that it is offering a far wider service to the public than simply an emergency referral line. Victoria is currently establishing a Mental Health Advice Line to help people navigate the system and find appropriate help.

Rather than developing a separate ‘advice line’, MHERL could be tasked with providing this service for the general public and referral agencies. It would maintain its current role in triaging emergency calls. These two functions could be promoted separately and provided through separately badged telephone call lines.

3. **Give MHERL the authority to mobilise community service responses following triage.**

Currently, MHERL does not have the authority to mobilise a community service response from the CERTs or CMHTs, which reserve the right to make that decision following their own re-assessment. This step is not value adding and wastes resources. What is needed is the development of agreed triage protocols that support risk assessment and clinical decision-making, reciprocal sharing of client information and unconditional acceptance of MHERL’s authority to mobilise a service response.

4. **Establish Intensive Community Assessment and Treatment Teams [ICATT]**

The single most important initiative proposed is the establishment of ICATTs with a similar role and function to the Crisis Resolution Home Treatment Teams in the UK. Research has demonstrated that this type of service has had a very significant impact on reducing hospitalisation, with the largest reductions being achieved with properly resourced, multidisciplinary teams operating daily over extended hours.
The ICATTs would:

- Do a crisis assessment, BUT ONLY where hospitalisation is being considered;
- Function as the sole pathway to acute inpatients beds;
- Support early discharge;
- Undertake bed management function;
- Respond rapidly and have the capacity to do frequent daily visits;
- Have a close working relationship with EDs, inpatients units and CMHTs

Direct referrals would come from MHERL, CMHTs, EDs and Hospital Inpatient Units and possibly GPs, Police and Private Psychiatrists. Consumers and carers would like direct self-referral, but it is likely that this would result in an increased demand for assessment, which would detract from ICATT’s role in crisis treatment.

The preferred model would be for four ICATTs, each embedded within the community services in a district – Swan/Morley, Joondalup/Clarkson, Subiaco/Inner City and Osborne Park/Mirrabooka – operating day and evening shifts, with an on-call area-wide system after hours. Under this model, the inpatient beds in the North Metropolitan Area would be divided between, and managed by, the districts. This would ensure optimal management of the flow of people in and out of hospital.

Consideration has been given to other models of implementation including:

- A single Area-wide ICATT
- Three ICATTs – Swan/Morley, Joondalup/Clarkson and a combined team for Subiaco/Inner City/Osborne Park/Mirrabooka.
- Discrete ICATTs within CMHS or the function integrated into the operation of the CMHTs.

Although the area-wide service would be the simplest to achieve, it poses the greatest problems with lack of integration with other services and the attendant difficulties of communication and continuity of care. The three team solution is clearly a compromise but could be used as a step on the way to a district model, particularly while resources are tight.

While there are good arguments for and against both ‘discrete teams’ and ‘functional integration’ of ICATTs, the evidence suggests that the former model may offer greater benefits, at least in the early stages, as a lever for change. Movement of staff between the ICATTs, CMHTs and ED Consultation-Liaison Teams should be standard practice to encourage greater understanding and improved coordination and communication.

Going on the staffing recommendations for the CRHT Teams in the UK, it is envisaged that each ICATT would consist of a multidisciplinary team, including medical staff, of about 14 FTE per 150-200,000 population. Resourcing for the ICATTs could come from a range of sources, including:

- CERTs
- Current Assessment and Short-term Treatment Teams [SAST, MAST and ICAT]
- Rationalisation of weekend clinic services
- Hospital @ Home
- Assertive Bed Flow Coordinators
- Transition Program
- Re-allocation of inpatient staff

The potential benefits stemming from the introduction of the ICATTs include:

- Improved capacity to manage emergencies in the community;
Greater levels of consumer and carer satisfaction with services;
- Reduction in hospital admission and re-admission rates;
- Improved throughput in acute wards;
- Reduction in the number of inpatient beds;
- Elimination of the need to hold people in ED while awaiting access to beds in a psychiatric facility;
- Clearer and closer system wide working, above all with EDs, inpatient units and CMHTs.

Progress against these objectives will need to be monitored continuously to ensure that the services are on track to achieving these anticipated outcomes.

5. Restructure community mental health services, moving to a ‘blended’ model of geographic teams that combine acute assessment and treatment and continuing care functions.

It has been argued earlier that having a separate team doing the assessment of all referrals, including non-urgent referrals, from a team doing continuing care, is not an efficient or effective way of organising services. Much of the effort of the assessment team is going into gate-keeping access to community services rather than into managing the community-hospital interface. There is also considerable duplication of effort, with the CCTs re-assessing clients following referral.

It is proposed that community mental health services be organised into four district services – Swan/Morley, Joondalup/Clarkson, Subiaco/Inner City and Osborne Park/Mirrabooka – and restructured, with the formation of geographically based teams that combine the acute assessment and continuing care functions. It has also been proposed that the resources from the current Assessment and Short-term Treatment Teams should be used to staff the ICATTs.

It is envisaged that each District CMHS would provide its own triage service that would make referrals to ICATT for assessment where it was considered that there was a real likelihood of hospital admission. Less urgent and routine referrals would be handled through the CMHTs.

The resources saved from rostering staff on weekend services for four districts rather than for six clinics could be used to help resource the ICATTs. Consideration could be given for establishing extended hours services [till 9:00 pm] for each district similar to the Bentley model. These services could be used primarily to provide non-emergency support for known clients.

There is a pressing need for community mental health services to look at the sustainability of some of their clinical processes. Consultants working with Peninsula Mental Health in Victoria found that only about 40% of all their clinical processes added value. This Review of North Metropolitan emergency mental health services brought up many examples of this, including most notably:

- Routine assessment of all new clients by 2 clinical staff – even non-urgent cases seen in the clinic;
- Routine assessment of all new clients by 2 non-medical staff, even where the indications are that medical assessment and/or treatment will be required;
- Repeated triage and assessment.

It is envisaged that there will be multiple entry points into community mental health services where people will be “triaged” as outlined in figure 20. Within this framework, people who have
been triaged and referred to a CMHT by specialist mental health services would automatically be accepted for assessment by the team. The ICATT will regulate entry to inpatient services and, where appropriate, facilitate early discharge.

Two critical transferable elements of Peninsula Mental Health’s review of its clinical processes include:

- Introduction of a ‘care bundle’ approach in which it is expected that every person will get access to a ‘bundle’ of evidence-based interventions – recognising that ‘generic case management’ is a ‘process of care’ and not an evidence-based intervention;

- The systematic development of partnerships with local GPs, NGOs and private sector mental health services – recognising that these groups have the potential to be an important resource for the long-term management and support of people with mental illness.

6. Move towards a system of allocating and managing beds at a District rather than Metropolitan-wide level.

Having a larger ‘pool’ of beds clearly gives greater flexibility in managing the fluctuations in demand. However, it does not change the fundamentals of bed management, which is essentially about clinicians taking responsibility for the resource implications of their decisions. One of the unanticipated outcomes of the area bed management system at the Royal Melbourne Hospital was that clinicians in the inpatient unit were feeling a sense of unremitting pressure: in essence, they were complying with the policy, but had not embraced it. There was growing recognition that ownership of bed management at the local level made the outcome more sustainable.

Allocating the beds to the District MHS and giving them responsibility for management of those beds, together with the establishment of the ICATTs, district-based Intermediate Care facilities and a 6-bed PAPU at Graylands Hospital, will reduce the dependence on inpatient services and provide a strong incentive for the development of a community-centred and community-led system of care.
7. Develop separate mental health ‘suites’ in the EDs, serviced by specialist mental health staff.

The current infrastructure provided in ED for the assessment and management of people with mental health problems is not conducive to their proper assessment and care. It is proposed that there be single door into ED, but once through that door, mental health clients are directed to a separate mental health ‘suite’, serviced by specialist mental health staff. This model is being introduced in the ED of King's Hospital in London as a result of strong advocacy by consumer and carer groups. It is not proposed that there be any beds in these suites and people requiring admission would be transferred to a psychiatric inpatient facility.

8. Establish properly resourced, multidisciplinary Consultation-Liaison Services in EDs

The mental health consultation-liaison teams working in the EDs need to be multi-disciplinary and staffed at a level that recognises the importance of ED as a major access point into the mental health system. These teams should incorporate the PLNs. The Royal Colleges of Emergency Medicine and Psychiatry in the UK have recently published guidance on working with mental health clients in ED. The data on the pattern of flow of patients through ED shows that it is highly predictable and the rostering of staff needs to be linked to demand.

9. Cease the practice of holding people in ED while they are awaiting a bed in a psychiatric inpatient unit.

People, other than those whose health is physically compromised [e.g. overdose] should not be held in ED awaiting access to a psychiatric bed, but transferred as soon as possible to a psychiatric inpatient facility for treatment. The practice of sedating people and holding them for extended periods in beds in ED as a ‘place of safety’ poses serious risks to the health and welfare of individuals.


This is envisaged as a ‘transitional’ strategy to act as a buffer for managing the day to day fluctuations in the demand for beds during the development of the ICATTs. Priority access to these short-stay ‘virtual’ beds, which are not included in the regular bed count, will be given to patients in the ED who require hospital admission. Ideally, such a unit would be located in the psychiatric unit at SCGH, which would reduce the problem of patient transport, but the beds in D20 are not authorized to take involuntary patients. If the ICATT teams achieve their objective in reducing pressure on hospital beds, the PAPU will be able to be discontinued.

11. Establish Intermediate Care facilities as alternatives to inpatient care.

The Crisis Houses in the UK and the PARCs [Prevention and Recovery Care] in Victoria have been playing an increasingly important part in the emergency system as alternatives to hospitalisation. The Department of Health in Victoria has been establishing the PARCs as 6 to 8 bed units, with the NGOs providing the management and day-to-day support and the AMHS Crisis Assessment and Treatment Teams [CATs] providing the clinical care. The PARCs function both as an alternative to hospitalisation [‘step-up’] and as a support for early discharge [‘step-down’].
In WA, there are plans for the development of two ‘intermediate care’ facilities in the metropolitan area; a 21 beds facility on the Joondalup Hospital campus in the North Metropolitan Area and a 27 bed facility on the Rockingham Hospital campus in the South Metropolitan Area. Serious consideration needs to be given to developing the units on the same scale [6 to 8 beds] in ordinary community settings like the PARCs in Victoria. In the North Metropolitan area, there are good arguments for developing four units, one serving each District MHS.

12. Improve the working relationship with the Police.

In other Australian jurisdictions, the Ambulance Service has the central role in transporting patients between hospitals and the Police are only involved when the Ambulance Service requests their assistance for managing risk. The Review supports this direction and recommends that the Mental Health Act be amended to enable this to be implemented.

The PACER program [Southern Health, Victoria], which is a joint initiative between Mental Health, Police and the Ambulance Service, represents one of the most significant and innovative attempts to get a coordinated response from Police and Mental Health in the management of mental health emergencies in the community. This program is currently being evaluated and, based on the results of the evaluation, consideration should be given to initiating discussions with the Police about implementing a similar program in Western Australia.
9. FUTURE DIRECTIONS: CHILD AND ADOLESCENT MENTAL HEALTH

9.1 Learning from Other Jurisdictions

The 2009 report by the Mental Health Development Unit in the UK provides a number of examples of innovative models of practice. Set out below is a selection of examples from this report, which the Reviewers believe exemplify some of the important elements that need to be considered in setting out the future directions for emergency services for young Western Australians.

**Reducing Self Harm In Children: UK**

In Hartlepool, the CAMHS team in partnership with the acute service at the local hospital has developed protocols and standards for practice around deliberate self harm. If a young person presents at the A&E with self harm they will be admitted to the paediatric ward if they are under 16. If they are over 16, overnight admission for medical and mental health assessment is encouraged. A member of the CAMHS team, operating on a rota basis, will ring A&E each morning at 9.30am to enquire whether any young person has presented with self harm during the previous 24 hours. If so, then within 24 hours a member of the team will visit the young person, whether in hospital or at home, in order to make an appropriate mental health or risk assessment. Most young people are responsive but if the young person refuses to engage with the team, their GP is alerted and made aware of the issues. The team is also trying to bring school nurses into the loop by sending them discharge summaries so that schools are aware of the situation and can be supportive.

*Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Aged Under 18, National Mental Health Development Unit, UK, 2009*

**Early Intervention Psychosis Service: UK**

The Worcestershire Early Intervention Psychosis Service offers early intervention to the full age range from 14-35 years. It has an Early Intervention CAMHS case manager position funded by CAMHS who offers dedicated case manager support to the under 18s. The team from adult services works in an integrated way with CAMHS colleagues in the support of under 16s and has a clear protocol as to how it works together across the age transition in the support of 14-16 year olds with first episode psychosis. The EI team sits on the CAMHS multi-agency steering group with colleagues from CAMHS, local authority, youth service and education.

*Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Aged Under 18, National Mental Health Development Unit, UK, 2009*

**Community Intensive Community Treatment Team in South Wales**

The team was developed to assist young people who require more care than was available in conventional CAMHS. Many of these young people were being lost to care or requiring admission to inpatient care. The team provides intensive treatment and support for up to 1 year. Less than 10% of their clients need admission to an adolescent unit and, for those that do, the service provides support for early discharge.

*Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Aged Under 18, National Mental Health Development Unit, UK, 2009*
Adolescent Assertive Outreach Model

This is an integrated highly specialised service consisting of an outreach team, an 8 bed acute unit and a day program, mainly for adolescents 15 to 17 years old presenting with serious mental illness and at risk of inpatient admission. Most of the work is undertaken in homes, clinics, schools and environments where young people feel comfortable and hospital admission is reduced to a minimum.

Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Aged Under 18, National Mental Health Development Unit, UK, 2009

9.2 Findings

CAMHS has no capacity for the emergency assessment and management of children and young people. Emergency mental health services for children are primarily provided through the ED at PMH which receives approximately 900 cases per year of young people with mental health problems. The Department of Psychological Medicine at PMH provides a Consultation-Liaison service to the ED. However, PMH has an age limit of 15 years and, furthermore, the ED cannot manage younger adolescents who are physically large and/or behaviourally disturbed. This leaves the 16 and 17 year-olds, in particular, in the difficult position of having to seek help from the adult emergency mental health services, which includes general hospital EDs and MHS consultation-liaison services, adult CMHS, MHERL and the CERTs.

Moreover, as CAMHS only takes referrals from providers, the only point of direct access for consumers is via the EDs. The entry points and pathways for the CAMHS service system is presented schematically below.

Figure 53: Entry points and pathways in the CAMHS service system

Despite their shared mandate for providing mental health services for young Western Australians, there is no mechanism for CAMHS, PMH, the Bentley Adolescent Unit and YouthLink to coordinate their planning, policies or admission criteria or to collaborate in the provision of services or shared care. This has led to policies and operational practices which make it difficult getting a smooth transition of clients between services. For example, the PMH
Emergency Department has difficulty in getting follow-up services from CAMHS and even has its referrals rejected by CAMHS, which in turn has resulted in PMH establishing its own Acute Community Intervention Team (ACIT).

Similarly, there is no formal relationship between the child and adolescent services and the adult emergency mental health services and this has led to such problems as:

- A variable and unpredictable response from the emergency services towards children and young people; and
- No recognition that the emergency services provide a vital role for CAMHS, with no acceptance of their assessments or priority given to their clients (e.g. referrals from ED being rejected by CAMHS).

North Metropolitan CAMHS established an area-wide triage team at Mirrabooka in an attempt to get a more rapid and consistent response to referrals. Although this service has been tasked to make contact with priority clients within 48 hours, it is rarely face-to-face and most contact is by telephone. Despite establishing this central triage service, the decision to accept or reject referrals is still retained by the CAMHS clinic teams and triage officers may be asked to collect additional information before this decision is made.

Consider this scenario. A client in crisis is assessed in ED by a psychiatrist and referred to CAMHS. The person is then triaged by the area triage team and presented to the clinic team, which requests additional information before a decision is made. At re-presentation, the client is rejected as being unsuitable for CAMHS and a letter is sent to the psychiatrist 2 or 3 weeks later informing him that the client was unsuitable. The only mental health professional who actually saw the client face-to-face during the whole process was the ED psychiatrist. His comment: “CAMHS don’t seem to understand the nature of the work in ED”.

The whole process of entry into CAMHS needs to be critically reviewed. This process of repeated assessment is not only frustrating for clients and clinicians, but extremely wasteful of resources. Essentially, a disproportionate amount of effort and resources are being directed into ‘gate-keeping’ the entry into the system and not enough into other critical service components such as treatment, shared care and consultancy.

The CAMHS entry criteria of severe, complex, persistent disorder and its model of ‘tiered’ approach represented in Figure 15, together with the policy of secondary referral does not support what is seen as critical in contemporary practice, early intervention - both early in illness and early in episode.

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**Figure 54: The ‘Tiered Approach’**
Despite research consistently showing a better outcome with a shorter duration of untreated psychosis, most people with psychosis are not presenting to services for 2 to 3 years post onset. This highlights the need for active engagement and partnership with the agencies that young people come in contact with such as schools. Similarly, emergencies don’t start as emergencies and can be prevented with appropriate and timely intervention.

In his review of CAMHS in July 2007, Professor Nurcombe wrote:

“Tier Three [Specialist Mental Health Services] ..... services should be involved in educating, consulting with and supporting providers in Tier One and Two”.

He then went on to say:

“At the present time, private practitioners and public services in Tier 3 operate in a separate, unintegrated manner. It would be highly desirable for private practitioners to be more involved, on a part-time basis, in public services ...”.

Because child and adolescent mental health services are organisationally small, it is critical that they look at ways of multiplying their capacity through sharing care and helping other services enhance their capacity. The review found little evidence that the situation has improved since the Nurcombe Review in 2007.

9.3 Finding Local Solutions

The key proposals for the future directions of emergency mental health services for children and adolescents in the North Metropolitan Area are outlined below and then discussed in detail.

- Provide the emergency response for children and adolescents through the EDs and specialist services within the Adult MHS;
- Improve access to CAMHS;
- Establish an Assertive Community Intervention Team;
- Multiply CAMHS Capacity by changing the service model;
- Establish a mechanism to co-ordinate Mental Health Service for children and youth; and
- Stronger Partnerships with adult Mental Health Services.

1. Provide the emergency response for children and adolescents through the EDs and specialist services within the Adult MHS.

The number of children and adolescents using MHERL and CERT for emergencies is relatively small. In 2008/09 MHERL received 146 calls about 14 to 17 year olds and 78 calls about young people under 14 years of age. In that same year, the North Metropolitan CERTs saw 29 individuals and provided 34 occasions of service. Almost two-thirds of the calls were for 16 or 17 year old. Although the numbers were small, the significance should not be underestimated. Two thirds of the visits by CERTs were triaged as level 1 [immediate] or 2 [within 2 hours].

The vast majority of young people requiring urgent assessment and intervention were seen in the Emergency Departments of PMH and the General Hospitals. Although it is recommended that the emergency response continue to be provided by the EDs and specialist community-based emergency services, it needs to be recognized that CAMHS needs to develop the capacity to provide a timely and appropriate response to young people identified by the emergency services as at risk and requiring specialist help.
2. **Improve access to CAMHS**

The current processes to gain entry to CAMHS should be based on the principles of ‘no wrong door’ and easier, more open access which assists people to navigate a complex service system. Another important principle is the provision of assessment and treatment early in the course of the illness or early in the episode and, where required, assertive intervention to avert a preventable crisis. It is proposed that:

- Triage and subsequent referral to CAMHS by emergency services mental health practitioners in MHERL, the EDs, or the Adult CMHTs be accepted and an assessment undertaken by CAMHS without re-triaging; and
- Triage decisions by the CAMHS specialist triage staff are accepted by the CAMHS team and an assessment undertaken without further requests for information.

CAMHS, into the foreseeable future, will continue to be reliant on the other mental health services to provide an emergency response. As such CAMHS needs to recognize these clinicians as, in effect, arms of its own service system. This means recognizing their triage/assessments and providing training and consultation/liaison support.

When MHERL broadens its role with the community as a 24/7 major portal to mental health services and takes on a growing triage function, consideration could be given as to whether the CAMHS Central Triage service is still required and whether Duty Officers, who are ‘embedded’ within the local district teams at each of the Clinics, could undertake the triage role, particularly for routine referrals.

3. **Establish an Assertive Community Intervention Team**

Initially this team could be established as a North Metropolitan area-wide resource, but with the eventual aim of expanding it to be district based. The primary function of the Team would be to assertively follow up clients identified as having an urgent need for acute treatment in the community. It would have extended hours of operation and provide a resource which supports the work of the CAMHS Teams. This team would work in close collaboration with ACIT at PMH but would have a broader remit to also provide services to the 16 and 17 year olds who cannot access PMH and who may be accessing emergency services through EDs, MHERL, Adult CMHS or YouthLink.

The CAMHS Central Triage could be reshaped to form the core of an Assertive Community Intervention Team.

4. **Multiply CAMHS Capacity by Changing the Service Model**

CAMHS has limited resources and it is important that innovative options are considered to expand their capacity through sharing care with other service providers and enhancing their capability through consultation/liaison and training. It is proposed that rather than a ‘tiered’ service model which relies on shifting clients between service providers, an alternative approach is the Collaborative Care Model outlined in Figure 55 below.

This approach provides a person/family centred model with professionals moving in and out of the Individual Care Plan as needs change, rather than shifting the person between levels or tiers of providers. It multiplies capacity through sharing care and skills enhancement, builds stronger working partnerships between service providers and provides greater opportunities to intervene early to reduce emergencies. This Review also supports the recommendation of the Nurcombe Review to increase opportunities for psychiatrists in private practice to work part time in CAMHS. We would extend this to finding innovative ways to increase shared care
not only with psychiatrists in the private sector but with a wider range of clinicians in private practice including clinical psychologists and social workers.

Figure 55: The Collaborative Care Model

Another key aspect of the collaborative approach is to develop shared care models with the adult MHS which are based primarily on the individual’s needs and their likely pathway rather than their age. These collaborative service arrangements are particularly appropriate for young people with a psychotic illness.

5. Establish a Mechanism to Co-ordinate Mental Health Service for Children and Youth

A Child and Adolescent Mental Health Co-ordinating Committee should be established as a priority. Initially it should comprise the Heads of Service of the PMH Department of Psychological Medicine, North Metropolitan CAMHS, YouthLink and the Bentley Adolescent Unit. SMAMHS and WACHS should also be invited to participate to extend the co-ordination across the metropolitan area and rural areas. The purpose of the committee is to coordinate planning, policies, admission criteria and protocols to create a more seamless and responsive service system for clients and their families. While there are administrative separations between these services, these differing lines of reporting and accountability should not stand in the way of co-ordinating service delivery. A priority task of the committee should be to consider ways of improving emergency services for children and youth.

6. Strengthen Partnerships with the Adult Mental Health Services

The Adult MHS will continue to be a major provider of emergency services to children and youth under 18 years. The age barriers between the programs are in many ways artificial and the needs of the clients should be the major determinants as to which service is most appropriate. Older adolescents, particularly those with a psychotic illness, may well be best managed through a partnership between the CAMHS and Adult programs. To strengthen the links it is proposed that the district boundaries for CAMHS and Adult services be aligned to strengthen opportunities for shared planning and partnerships. This could have particular benefits in enhancing shared care arrangements for youth.
10. FUTURE DIRECTIONS: OLDER ADULT MENTAL HEALTH

10.1 Findings

The number of older adults using MHERL and CERT for emergencies is relatively small. In 2008/09 MHERL received 262 calls from people over the age of 65. In that same year the North Metropolitan CERTs saw 46 individuals and provided 74 occasions of service, with one individual receiving 21 visits.

The vast majority of older adults requiring urgent assessment and intervention go through the Emergency Departments of the General Hospitals. Older Adult Mental Health Services provide Consultation-Liaison [C/L] Services at SCGH and Osborne Park, but do not have the resources to provide this service to the EDs. Although C/L and Older Adult Community Services prioritise urgent referrals, they do not have the capacity to respond in less than 1 working day. Services operate 0900 to 1700, Monday to Friday with an on-call psychiatrist after hour, which means that a Friday afternoon referral may not be seen until Tuesday morning.

One of the complaints by the PLNs was that, although they did not see large numbers of older adults, it was very difficult to get assistance from Older Adult Mental Health [OAMH] on the very few occasions when it was needed. They also complained that OAMH expected them to do a “full-blown” assessment. OAMH, on the other hand, felt that the introduction of the PLNs had made things more difficult as they were generally not good at excluding organic states. Offers of training had not resulted in a high uptake.

One of the key concerns of OAMH is that the current emergency mental health system [PLNs, MHERL-CERT, ED C/L service] was set up to service all age groups including older adults, but because of the overwhelming number of adults using the system, it is easy for this age group to just “slip off the radar”.

10.2 Understanding the Position of Older Age Mental Health in Dealing with Emergencies

OAMH was not set up as a comprehensive service to take on the mental health care of all people aged 65 or older. It simply does not have the staffing or resources to provide an acute mental health service to this age group. Historically, the Psychogeriatric Extended Care Units [PECUs/Lodges] were developed to replace Swanbourne Hospital, which essentially provided a sub-acute/extended care service for older adults, but not a comprehensive service for all people with mental health problems in this age group.

Sixty five years of age should not be considered a ‘hard and fast’ cut-off point. North Metropolitan OAMH has adopted the following admission policy:

- People who have a long-standing mental health problem that has been managed through adult services and who are not physically frail or cognitively impaired will continue to be managed by adult services [principle of ‘continuity of care’].
- Where people have a ‘new episode of illness’ [have not been engaged with adult services for 2 years or more], OAMH will take them on.
People aged 65 or more who are physically fit and aggressive cannot be managed in the Lodges alongside those who are physically frail and need to be managed, at least initially, in an adult inpatient facility.

There are particular factors to be considered when assessing and managing older adults with mental health problems including:

- Mental health problems may present differently in older people;
- Cognitive impairment may impede gathering of information;
- High levels of cognitive impairment;
- Impact of changing environment on cognition;
- Frequent presence of co-morbid physical and psychiatric illness;
- Frequent presence of multiple physical illnesses;
- Impacts of medication;
- Social supports and networks.

Most acute behavioural disorders have an organic basis and the biggest risk in this age group is ‘undiagnosed medical problems’. This has strongly influenced OAMH’s preference for ED as the pathway of choice for the assessment of emergencies and, where an extended period of assessment is required, admission to Geriatric or General Medical beds. It has proved difficult to get timely medical assessment on site in the Lodges for patients who are medically unstable.

Older people tend to take longer in ED. For older people with multiple pathologies and problems, including physical and psychiatric co-morbidity, the introduction of the 4-hour rule in ED will present particular challenges to their assessment.

Older Adult Mental Health Services in the Northern Metropolitan Area is organised around five separate clinical units, each providing services to a geographic catchment area:

- Inner City OAMHS
- Joondalup OAMHS
- Osborne Park OAMHS
- Selby OAMHS
- Swan Elderly MHS

The 3 major mental health programs in NMAMHS – Child and Adolescent, Adult and Older Adult – are all organised around different catchment areas with the only point of shared governance being at the Area level.

10.3 Finding Local Solutions

The key proposals for the future directions of emergency mental health services for Older Adult Mental Health Services in the North Metropolitan Area are outlined below and then discussed in detail.

- Provide the emergency response for older adults through the EDs and specialist services within the Adult MHS.
- Re-align Older Adult MHS and Adult MHS within a four geographic District system.
- Establish a training program for Emergency Mental Health staff working with older adults.
- Plan for the establishment of a 6 to 8 bed Acute Assessment Unit for the North Metropolitan Area at SCGH.

1. **Provide the emergency response for older adults through the EDs and specialist services within the Adult MHS.**

The number of older adults requiring an emergency response from community services is very small and does not warrant the establishment of a separate service. The proposed pathways to assessment and care for older adults are set out in Figure 24 below.

![Fig 56: Pathways to assessment and care for older adults](image)

For the small number of people requiring an assessment in the community, this would be provided by the Intensive Community Assessment and Treatment Teams [ICATTs] attached to the Adult MHS. Most emergency assessment would continue to be undertaken in the general hospital EDs. With the introduction of the 4-hour limit in EDs, extended assessments would need to be undertaken either in the Observation unit or in the geriatric/general medical units. The OAMH Consultation-Liaison Service or OA Consultant will assess and provide advice/arrange transfer as appropriate.

Where a person is assessed and medically cleared in ED, but is too behaviourally disturbed to be safely managed alongside patients who are physically frail, admission to a adult mental health inpatient facility will need to be negotiated by the Adult C/L Team in ED. Once again, the OAMH Consultation-Liaison Service or OA Consultant will assess and provide advice/arrange transfer as appropriate.
2. Re-align Older Adult and Adult MHS within a four geographic District system.

The age barriers between the Adult and Older Adult programs are in many ways artificial and the needs of the clients should be the major determinants as to which service is most appropriate. Adult MHS will continue to be a major provider of emergency services to older adults both in the community and in the EDs. To strengthen the links it is proposed that the district boundaries for the Older Adult and Adult services be aligned to strengthen opportunities for shared planning and partnerships. This would result in OAMHS being restructured into the four District model:

- Inner City – Subiaco [Combined Inner City and Selby OAMHS]
- Osborne Park – Mirrabooka [Osborne Park OAMHS]
- Joondalup – Clarkson [Joondalup OAMHS]
- Swan – Morley [Swan EMHS]

3. Establish a training program for Emergency Mental Health staff working with older adults.

It should be mandatory that all staff working in the area of emergency mental health have the competencies to be able to properly assess older adults that they will meet in the course of their work. It is the responsibility of OAMHS to provide the training to ensure that these competency standards are being met.

4. Plan for the establishment of a 6 to 8 bed Acute Assessment Unit for the North Metropolitan Area at SCGH.

The current inpatient beds provided by OAMHS are not suitable for the assessment of older adults with acute conditions often consisting of a complex mix of physical, psychological and social factors. It is proposed that planning be commenced for the establishment of a 6 to 8 bed facility, collocated with geriatric/general medicine, at SCGH to service the Northern Metropolitan Area.
REFERENCES


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31. **National Mental Health Development Unit (2009)** *Working Together to Provide Age-Appropriate Environments and Services for Mental Health Patients Aged Under 18*. Department of Health, United Kingdom.


# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACCT</td>
<td>Acute Community Care Team</td>
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<tr>
<td>ACIT</td>
<td>Acute Community Intervention Team</td>
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<td>ALOS</td>
<td>Average Length of Stay</td>
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<td>AMHS</td>
<td>Area Mental Health Service</td>
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<td>ANF</td>
<td>Australian Nursing Federation</td>
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<td>ASTT</td>
<td>Assessment and Short-term Treatment Team</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Service</td>
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<tr>
<td>CATT</td>
<td>Crisis Assessment and Treatment Team</td>
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<tr>
<td>CERT</td>
<td>Community Emergency Response Team</td>
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<tr>
<td>CCT</td>
<td>Continuing Care Team</td>
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<td>C/L</td>
<td>Consultation Liaison</td>
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<td>Community Mental Health Service</td>
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<td>CMHT</td>
<td>Community Mental Health Team</td>
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<td>CRHT</td>
<td>Crisis Resolution Home Treatment Team</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>ECATT</td>
<td>Extended Crisis Assessment and Treatment Team</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EDIS</td>
<td>Emergency Department Information Systems</td>
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<td>EPS</td>
<td>Early Psychosis Service</td>
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<tr>
<td>H @ H</td>
<td>Hospital-at-Home</td>
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<tr>
<td>HSU</td>
<td>Health Services Union</td>
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<tr>
<td>ICATT</td>
<td>Intensive Community Assessment and Treatment Team</td>
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<tr>
<td>ICAYMHS</td>
<td>Infant, Child, Adolescent and Youth Mental Health Service</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<td>NMAMHS</td>
<td>North Metropolitan Area Mental Health Service</td>
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<td>MHEG</td>
<td>Mental Health Executive Group</td>
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<tr>
<td>MHERL</td>
<td>Mental Health Emergency Response Line</td>
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<td>MHS</td>
<td>Mental Health Service</td>
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<td>NMAHS</td>
<td>North Metropolitan Area Health Service</td>
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<td>OAMHS</td>
<td>Older Adult Mental Health Services</td>
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<tr>
<td>PACER</td>
<td>Police, Ambulance and Crisis Assessment Team Early response</td>
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<tr>
<td>PAPU</td>
<td>Psychiatric Assessment and Planning Unit</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PECC</td>
<td>Psychiatric Emergency Care Centre</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>PMHT</td>
<td>Primary Mental Health Team</td>
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<td>PMH</td>
<td>Princess Margaret Hospital</td>
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<td>RMH</td>
<td>Royal Melbourne Hospital</td>
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<td>RPH</td>
<td>Royal Perth Hospital</td>
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<tr>
<td>SCGH</td>
<td>Sir Charles Gairdner Hospital</td>
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<td>SMAHS</td>
<td>South Metropolitan Area Health service</td>
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<td>SSU</td>
<td>Short Stay Unit</td>
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<tr>
<td>WACHS</td>
<td>Western Australian Country Health Service</td>
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BACKGROUND
The NMAHS Mental Health Executive Group (MHEG) initiated a review of the North Metropolitan mental health emergency service system. The WA Centre for Mental Health Policy Research will undertake the review.

PURPOSE OF THE REVIEW
To determine whether the NMAHS is providing a mental health emergency service system which is responding effectively to people experiencing a psychiatric crisis.

The review will encompass Child and Adolescent, Adult and Older Persons mental health services. It will specifically examine ED Mental Health Liaison Services, MHERL, CERTs and the CMHT Triage and emergency response services.

REFERENCE GROUP PURPOSE
To support and advise the WA Centre for Mental Health Policy Research personnel in their task of reviewing the NMAHS mental health emergency services.

Specifically, the Reference Group will:
1. Ensure the key stakeholders are involved in this process.
2. Guide adherence to the agreed methodology, process and timetable.
3. Support reviewers’ access to documentation, data and key stakeholders.
4. Provide feedback and guidance to the reviewers.
5. Participate in a workshop with members of the MHEG to shape service options and a future direction for mental health emergency services in NMAHS.
6. Develop recommendations based on review based options.

PROPOSED MEMBERSHIP

Chair
Ms Leanne Sultan, A/Director of Operations, North Metropolitan Area Adult MHS

Members
- Ms Deborah Bridgeford, Director Governance and Performance, NMAMHS;
- Ms Denise Bromwell, A/Service Coordinator Morley MHS;
- Dr Simon Byrne, Consultant Psychiatrist, SCGH;
- Dr Johann Combrinck, Consultant Psychiatrist, MHERL;
- Mr John Ellis, A/Director Clinical Redesign, NMAMHS;
- Ms Jennifer Hoffman, A/Service Manager, State Forensic MHS;
- Ms Raighne Jordan, Nurse Director, NMAMHS;
- Mr Patrick Marwick, Clinical Director, North Metropolitan ICAMHYS;
- Ms Kate McGivern, Nurse Director, Swan MHS;
- Dr Helen McGowan, Clinical Director, NMAHS Older Adult MHS;
Dr Willem van Wyk, A/Clinical Director, North Metropolitan Adult MHS;
Dr Geoff Smith, Medical Director, WA Centre for Mental Health Policy Research;
Ms Theresa Williams, Director, WA Centre for Mental Health Policy Research;
Consumer Representative; and
Ability to coopt any other members required.

ACCOUNTABILITY
The Reference Group will report to Dr Ann Hodge, Executive Director, North Metropolitan Area Mental Health Services.

FREQUENCY, TIME AND VENUE
Meetings will initially be monthly and then on an as needs basis as determined by the Reference Group. The meetings will be scheduled for a Thursday and will be conducted in the Board Room, Moore House, Graylands Hospital.

QUORUM
The Chair and 50% of members constitutes a quorum.

RECORDS
The Research Officer, WA Centre for Mental Health Policy Research will record the meeting and produce a brief summary of the meeting and its actions within 3 working days of the meeting to be distributed by e-mail to all committee members and delegates. The Minutes / Action Sheets will be confirmed at the next meeting. The record of the meeting will be around decisions and actions. The Reference Group will determine the distribution of information and minutes to those outside the committee.

The files are the property of the DOH and must be preserved in accordance with the State Records Act 2000 and the Freedom of Information Act 1992.

AGENDA
An agenda and associated papers are to be circulated to members no less than two working days before the meeting is to be held. Only items that fall within the terms of reference of the working party will be placed on the agenda.

CONDUCT OF MEETINGS
In formulating advice or if providing a view, the Reference Group should aim for a consensus view.

Adopted 30th June 2009.
APPENDIX 2: Service Descriptions

Hospital in the Home (Mental Health)
The aim of Hospital in the Home (HITH) service is to provide an alternative to hospital admission. Patients can be treated in their homes following either a brief admission to hospital for an assessment or diversion from hospital admissions. The referral pathways include (1) Early Discharge (2) Referral from SCGH Emergency Department (3) Community Clinic referrals. HITH currently covers the Subiaco, Osborne Park and Mirrabooka catchment areas. Patients admitted to D20 at SCGH from other areas can also be referred to HITH. Clinical responsibility is shared between the Responsible Psychiatrist and the HITH treatment staff. While clients are admitted to the HITH service for a nominal period of two weeks, the time can be extended in extenuating circumstances. Patients will be reviewed by the HITH Nursing Team as required and up to twice daily. Direct admission processes are in place in the event those managed by HITH require inpatient care and management.

CERTs
The Community Emergency Response Teams (CERTs) were established in October 2006. This followed the devolution of the functions of the Psychiatric Emergency Team (PET) into the following:

- CERTs to provide a community mental health crisis response between 7 days a week between 3pm to 11pm with an after hours on call roster from 11pm to 8.30am; and
- The Mental Health Emergency Response Line (MHERL) to provide a 24/7 emergency telephone response.

The CERTs were established in 3 different settings; a general hospital (SCGH), a psychiatric hospital (Swan Valley Centre) and a community mental health clinic (Joondalup Community Mental Health). The remit of the CERT teams was to ensure equity of access to all age related programs in their catchment areas, specifically:

- Child and Adolescent Mental Health Services;
- Adult Mental Health Services; and
- Older Adult Mental Health Services.

Since being established the following key developments have occurred:

- The SCGH CERT has been relocated to Osborne Clinic;
- The service model has expanded from solely responding to a mental health crisis in the community, to a service which could also provide an after hours service capability but with priority continuing to be given to a mental health crisis.
- Management has been transferred from an area based CERT Coordinator to the local structures at Joondalup, Swan and Osborne MHS with the objective of embedding the CERTs into local management and clinical structures to achieve NMAMHS line management and governance for each CERT team and to improve supervision at a local level; and
- An after hours on call service 365 days per year was developed on an area wide basis.
Although the three teams are now more ‘embedded’ into the local structures, the CERTs are not totally independent as they provide a back up service for each other and provide staff for the area rostered after hours on call service.

**Mental Health Emergency Response Line/Rurallink**

The Mental Health Emergency Response Line is a 24-hour a day, 7 days a week specialist psychiatric triage, advice and referral telephone service. The MHERL also provides an after hour mental health telephone service for the rural communities of Western Australia – Rurallink.

The service was evolved from the Psychiatric Emergency Team, the primary difference between the services being there was capacity for two responses under the PET, whereas there are now 7 Community Emergency Response Teams (CERTs) located across the metropolitan area.

The services are provided to all people across the life span and include:
- Initial advice and assessment;
- Counselling and support;
- Referral to community emergency response teams;
- Triage and call out for Kalgoorlie and Esperance;
- An after hours extension of local mental health services for rural Western Australia;
- Dedicated 1800 number for the Peel region;
- Dedicated 1800 number for rural and remote; and
- Liaison across the State and up to date awareness of resources and geography.

These services are available to all people across the life span.

A multidisciplinary team of specialist mental health professionals provides these services; this team includes senior social workers and nurses who are backed by on call consultant psychiatrists around the clock. MHERL/Rurallink staffing comprises:
- Service coordinator, which also includes a 0.5 FTE clinical load.
- Administration Officer x 1.2 FTE
- Senior Mental Health Practitioner x 5.0 FTE
- Senior Registered Nurse x 8.0 FTE
- Consultant Psychiatrist x 0.4 FTE
APPENDIX 3: Consultation List

Executive

Dr Ann Hodge  Area Executive Director NMAMHS  
Sylvia Meier,   Deputy Area Executive Director, NHAMHS  
Leanne Sultan   A/Director of Operations, Adult Program  
Patrick Marwick  Clinical Director, ICAMYS NMAHS  
Dr Willem van Wyk  A/Clinical Director NMAHS MH  
Dr Helen McGowan  Clinical Director, Older Adult MHS  

Heads of Service

Dr Meta Schenk  ICCMHS  
Dr Nathan Gibson  Graylands  
Dr Mark Hall   Joondalup/Clarkson  
Dr Neil Molin   Swan/Morley  
Dr Helen Ward  Osborne Park  

Program Managers

Mark Anderson  Graylands/Joondalup/Clarkson  
Theresa Wilson  Swan/Mirrabooka/Morley  
Angela Hopfmueller  Subiaco/SCGH/ICCMHS/OCMH  

Nurse Directors

Rosemary Hoffman  Graylands/Joondalup/Clarkson  
Kate McGivern  Swan/Mirrabooka/Morley  
Raighne Jordan  SCGH/Inner City/Subiaco/Osborne Park  

Service Coordinators

Maggie O’Dea  Osborne Park  
Mark Hills  Subiaco  
Chris Heslin   Joondalup/Clarkson  
Kirsty Snelgrove  SCGH  
Fiona McDonald  Swan  
Mark O’Sullivan  Mirrabooka  
Denise Bromwell  Morley  

Older Adult

Dr Ruby Po-Yee  Psychiatrist, Swan  

Clinics

Inner City

Karen Kyriakou  Program Coordinator  
Stephen Arthur  MH Nurse  
Howard Beadle  OT  

Subiaco

Karen Axon  CMHN  
Helen Molloy  RN  

Jenette Seagrott  CMHN

**Joondalup**
Lee Collison  Clinical Nurse Specialist
Deborah Hill  Duty Officer

**Osborne Park Clinic**
Noel McGahern  CNS
Jayne Pitchford  Duty Officer
Linda Neilands  CMHN

**Swan**
Shane Holmes  PLN
Chris Morley  Social Worker SAST
Andre Rogowski  Suicide Intervention Officer SAST
Dr Hitesh Maru  Psychiatrist SAST
Dr Salam Hussain  SMO SAST
Howard Beeton  Social Worker CCT
Rod Smith  CNS SAST
Sarah Goddard  CMHN, Hills CCT
Louise Coolbear  Welfare Officer, Hills and Midland CCT
Ann James  Clinical Psychologist, Coordinator Hills CCT
Tracey Young  Triage Officer SAST

**MHERL**
Sylvia Meier  Line Manager
Phil Andrus  Service Coordinator
Dr Johann Combrinck  Clinical Director
Mark Rogers  CMHN

**CERT**
Osborne Park
Liam Avery  CERT
Daniel Fitzgerald  CERT
Ian Read  CERT

**Swan**
Susan Park  CMHN
Joanne Rogers  CMHN

**Joondalup**
Bryan Jones  CMHN
Catherine Tate  CMHN

**Child, Adolescent and Youth**
Denise Follett  Director, YouthLink
Craig Nicholls  Specialist Clinical Psychologist, YouthLink
Kate Simpson  Triage Officer/SRN2, YouthLink
Forest Pearl  Triage Officer, NMCAMHS
Wendy Simpson  Triage Officer, NMCAMHS
Vishal Maharaja  Cross Cultural Psychologist, NMCAMHS
Dr Johana Stefan  Consultant Psychiatrist, PMH
Dr Jacques Esterhuizen  Consultant Psychiatrist, PMH
Emergency Departments

Royal Perth Hospital
Dr Nigel Armstrong  Psychiatrist
Dr Frank Daly  Emergency Physician, RPH Clinical Redesign
Dr David McCoubrie  Emergency Physician and Toxicologist
Dr Steve Fenner  Consultant Psychiatrist
Peter Tyson  PLN, Alcohol and Drug Coordinator
Bernadette Sheehan  Nurse Coordinator

Fremantle MH Service
Zenith Zeeman  Operations Manager
Carrie Parker  Triage Officer
Tim Smith  Senior Reg Nurse, CERT
Polly McCann  R.M.H.N. Community Nurse

Joondalup
Dr Simon Wood  Head of ED

SCGH
Dr Simon Byrne  Psychiatrist
Dr Debra O’Brien  ED Consultant Physician
Wesley Sweetman  PLN
Trevor Norton  PLN
Shanthi Kumarasamy  H@H

Swan
Dr Greg Sweetman  ED Consultant Physician
Dr Amanda Stafford  ED Consultant Physician
Lisa Hollick  PLN
David Hewitson  PLN

External
Donald Cook  Nursing Director MH, Bentley Health Service
John Titmus  SMAHS Project Officer
Ruth Lawrence  SMAHS Program Manager

Joondalup Inpatient
Mark McAndrew  PLN
James McLean  PLN

Graylands
Kieran Byrne  Clinical Nurse Specialist, Statewide Bed Manager
John Ellis  A/Director, NMAHS MH Clinic

Mental Health Division
Terry Preston  Senior Program Officer