The Crisis Awareness Plan (CAP) Pilot Project

Project report and recommendations

North Metropolitan Health Service: Adult Mental Health Program for the Mental Health Commission (Western Australia)

February 2013
Additional copies may be obtained from nmahsmh.AdultProgramExecutive@health.gov.au

The CAP Pilot Project report has been produced by Fiona McDonald, Senior Clinical Planning Officer and Dr Sandy Tait, Consultant Psychiatrist from the NMHS Adult Mental Health Program.

The Evaluation Report has been produced by Associate Professors Geoff Smith and Theresa Williams and Research Officer Anita Lumbus from the WA Centre for Mental Health Policy Research.
Contents

Preface ................................................................................................................................. 4
Executive Summary ............................................................................................................ 5
Key Recommendations ........................................................................................................ 8

I. Pilot project report ........................................................................................................ 9
   1. Background ................................................................................................................ 9
   2. Project description ..................................................................................................... 12
   3. Implementation ......................................................................................................... 14
   4. Lessons learned from project management ............................................................. 23

II. Evaluation Report: WA Centre for Mental Health Policy Research .......................... 29
   1. Evaluation objectives and process .......................................................................... 29
   2. Analysis of Crisis Awareness Plans ......................................................................... 31
   3. Consultation overview ............................................................................................. 34
   4. Views of Mental Health Service staff ....................................................................... 35
   5. Views of consumers and carers ................................................................................ 39
   6. Views of Community Managed Organisations and GPs ........................................ 42
   7. Survey of Mental Health Service clinicians ............................................................. 44
   8. Findings ..................................................................................................................... 48
   9. Discussion ................................................................................................................ 52

III. Conclusion and recommendations ............................................................................. 56

IV. Appendices .................................................................................................................. 59
References ......................................................................................................................... 59
Supporting literature ......................................................................................................... 60
The CAP project and links to the Stokes Report (2012) .................................................. 72
My Crisis Awareness Plan and consumer pamphlet ....................................................... 87
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAP</td>
<td>Crisis Awareness Plan</td>
</tr>
<tr>
<td>CMO</td>
<td>Community Managed Organisation</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GSMH</td>
<td>Great Southern Mental Health</td>
</tr>
<tr>
<td>KMHDS</td>
<td>Kimberley Mental Health and Drug Service</td>
</tr>
<tr>
<td>MHERL</td>
<td>Mental Health Emergency Response Line</td>
</tr>
<tr>
<td>MHNIP</td>
<td>Mental Health Nurse Incentive Program</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
</tr>
<tr>
<td>NMHS</td>
<td>North Metropolitan Health Service</td>
</tr>
<tr>
<td>PaRK</td>
<td>Peel and Rockingham Kwinana</td>
</tr>
<tr>
<td>PSOLIS</td>
<td>Psychiatric Services On-Line Information System/ Mental Health Clinical Information System</td>
</tr>
<tr>
<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
</tr>
</tbody>
</table>
Preface

This 2013 report on the Crisis Awareness Plan Pilot Project was auspiced by the North Metropolitan Health Service, Adult Mental Health Program following a contractual agreement with the Mental Health Commission of Western Australia.

The incorporated evaluation report is produced by the WA Centre for Mental Health Policy Research.

All people involved with any service providing mental health treatment or support should have a plan which guides them and others towards recovery. The Crisis Awareness Plan Pilot Project assessed a shared intersectoral approach to help highly vulnerable individuals develop their own crisis plan. The major finding was that Crisis Awareness Planning is overwhelmingly supported by consumers and carers. For them and mental health workers in the public mental health sector and community managed organisations it is a means to both potentially mitigate a crisis and, importantly, to emphasise a person centred, recovery approach. Adopting an agreed (standardised) approach to developing a Crisis Awareness Plan can reduce complexity, improve intersectoral communication and enhance the voice (choices) of consumers and carers.

This project also describes how service functionality and culture directly influences the effective production of a collaborative Crisis Awareness Plan. To ensure person centred plans are always produced in a sustainable culture of effective collaboration with consumers, carers and sister services, investment to embed this model and culture is required.

I encourage the Mental Health Commission to consider funding for a further two years to finesse and embed this practical working model in the four services before standardising this approach throughout the State.

Importantly I must thank Fiona McDonald, the Senior Clinical Planning Officer and lead author who has worked conscientiously and tirelessly to produce this impressively comprehensive report. Fiona has consulted widely with a major emphasis on ensuring the opinions and experiences of consumers are heard. The project was underpinned by a solid research strategy and expertise and we are indebted to Anita Lumbus, Research Officer, for her work. We were extremely fortunate to be supported by the research and policy development experience of A/Professor Theresa Williams and Dr Geoff Smith of the WA Centre for Mental Health Policy Research.

Finally I need to thank the following for their direct involvement and support from the four services who volunteered for a complex project in the hope it would improve services for consumers and carers. Particular mention goes to (in alphabetical order) Geoff Anderson, Phil Andrus, Clare Bestow, Jo Brown, Lesley Boyd, Marcella Cannon, Murray Chapman, Kay De Brett, Petra Elias, Hector Faulkner, Gail Lee, Kate McGivern, Melinda Misson, Liz Moore, Robyn Nazary, Adam Vincent, Paul Williamson and Sally Wilmott and the many others not mentioned who invested their time and support for this project.

Sandy Tait

Lead Clinician and Chair of the Crisis Awareness Plan Project Steering Committee.
Executive Summary

Background
The National Mental Health Plans enshrine the need to develop intersectoral linkages and effective partnership approaches between agencies to provide services to mental health consumers. The importance of consumers and carers being directly involved in planning individual treatment and recovery goals and of continuity of care is emphasised.

North Metropolitan Health Service (NMHS) Adult Mental Health Program initiated the Collaborative Care Working Party in 2010, which confirmed agreement for cross sector shared or standardised crisis planning guided by the experience and wishes of consumers and carers. As a result the NMHS Adult Mental Health Program submitted a business plan and received funding from the WA Mental Health Commission for a pilot project to establish the validity of cross sector crisis planning using the shared definitions, principles and crisis plan fields agreed to by the Collaborative Care Working party.

Aim
The Mental Health Commission funded the pilot project to trial and evaluate the effectiveness and acceptability of cross sector Crisis Awareness Plans in four sites in Western Australia over a 12 month period. The four communities willing to be involved were Broome, Denmark, Swan and Rockingham. The aim was to assist at least 40 consumers in each of those areas to develop Crisis Awareness Plans and to then evaluate the program and tool.

Method
A small project management team consisting of a Senior Clinical Planning Officer, Lead Clinician and a Research Officer was accountable to a Steering Group. The project management team also reported to the NMHS Adult Mental Health Program management structure and the Collaborative Service Integration Group associated with the Mental Health Commission. A timeline was established to introduce, educate, implement, evaluate and report on the pilot project over the 12 month timeframe.

Qualitative and quantitative methodologies were used to determine the acceptability and effectiveness of the CAP approach, the education tool and the implementation process as well as the perceived usefulness in mitigating or preventing the deleterious impact of a crisis.

Results
Crisis Awareness Planning was overwhelmingly supported by consumers and carers involved with the project in the Mental Health Services in the areas of Western Australia, targeted.

Practitioners confirmed that crisis planning was a useful therapeutic process and the consumers experienced it as empowering. Developing CAPs in collaboration with a range of stakeholders was identified as complex, due sometimes to conflicting views and expectations, and
sometimes to scheduling difficulties. It was perceived to be a time consuming process. Many CAPs were done purely by the case manager and consumer. CAPs were not always shared between stakeholders and on many occasions consumers did not have a copy.

Changes to the tool and process were seen as necessary to make it more consumer and carer friendly. The plans need to be used for a longer period so that their usefulness in crisis mitigation can be thoroughly assessed.

**Discussion**

Multiple impediments to effectively implementing the plans, at cross sector and operational levels, were identified. Some of the issues that came to light were how adequately resourced services were and whether involvement in the project was timely and a priority to them. The CAP pilot project highlighted other issues to do with the organisations that participated such as whether case management had been embedded and whether a ‘person centred’ approach was key to all interventions. Ability or lack of ability to complete cross sector CAPs highlighted the strengths and the limitations in the partnership relationships. Nevertheless, the CAP project showed, in WA, that cross-sectoral collaboration, including consumers and carers, with an agreed goal, can be highly effective.

The project also revealed a change management formula that is linked to best outcomes. This effective change management process included:

- local ownership and coordination
- realistic timeframes
- involvement of all levels of staff in the participating organisations
- ongoing staff development
- embedding the project as a quality activity and
- strengthening of cross sector relationships with consumers, carers, community managed organisations and GPs around a specific issue/ goal.

**Future Directions**

As the best outcomes for consumers can be linked to organisations that have had engrained values of person centredness and connectedness, embedding these values in each area and service culture is a priority. Adoption of the Crisis Awareness Planning model is one way that organisations can introduce and embed person centred and collaborative practices.

Progress must be made at the systems and organisational level to support this cultural change. Ongoing developments can also ensure that the CAP tools and processes are user friendly and that the majority of consumers and families have been afforded the opportunity to complete a CAP. Contemporary technology and standardised tools require development so that the CAP is easily retrieved when needed.
Developing person centred, connected organisations is an incremental process and there is an ongoing need for strategic change management to reinforce the positive changes that have been made. Practical, centralised and time limited clinical planning ensures best outcomes as each community develops capacity and sustainability.

With multiple agencies engaged in working with mental health consumers and their carers or families during the course of personal recovery journeys, a cross sector electronic data base that can be accessed by multiple agencies is invaluable. In terms of the day to day operation of Crisis Awareness Planning, the Psychiatric Services On Line Information System (PSOLIS) is a useful tool as it is a Statewide database but it lacks contemporary functionality and cannot be easily accessed by workers in community managed organisations or staff working in different health areas. With due attention to consumer rights and privacy and allocation of levels of access, this problem could be overcome.

To embed a person centred culture, consumers could complete initial Crisis Awareness Plans with consumer consultants. Case managers would then be involved to ensure that the plans cover all the fields so as to be useful in mitigating a crisis. Consumer prepared documents can be copied or transposed onto PSOLIS. Interactive cross sector websites that can be accessed by multiple stakeholders will soon be available in the Health Department of WA and may present a solution to communication issues. Regardless of the database used, the case manager will continue to have a role in ensuring quality information is documented. The best outcomes are associated with the owner of the Crisis Awareness Plan being the consumer and overwhelmingly consumers prefer plans that are not in a formal, clinical format. Embedding respect for consumer ownership of the CAP in local services is a priority.

Cross sector networks and governance structures are emerging across the mental health sector and there is enormous potential for ongoing person centred, partnership approaches. Shared instruments or approaches such as the CAP will reinforce partnerships. A second phase to the project would be beneficial to support the services to embed crisis awareness planning and the values of person centredness and connectedness. A further two year commissioning project to embed this approach, involving each of the existing four communities, is recommended. This would involve some time limited ongoing central coordination as well as local part time CAP coordinators and consumer consultants to further develop each site’s capacity for person centred and cross sector crisis awareness planning. A business plan for the second phase, outlining a budget over two years has been prepared and will be lodged with the Mental Health Commission along with this report.
Key Recommendations

1. Pilot sites to be invited to continue their commitment to the project for a further two years, to embed the cultural changes of person centred planning and partnerships in the existing services, prior to making this a Statewide initiative.

2. Shift local ownership to the pilot sites by allocating funding to each of the community mental health services for a part time CAP coordinator/project officer and a part-time consumer consultant.

3. Maintain a part time Statewide CAP coordinator for two years to continue to coordinate and develop resources and linkages.

4. Build problem solving and a learning network across and between the pilot areas in preparation for Statewide adoption.

5. Follow up with further evaluation involving the WA Centre for Mental Health Policy Research, in approximately 18 months, before making this a Statewide initiative.
I. Pilot project report

1. Background

The guiding framework for mental health reform in Australia supported by State and Territory Governments since 1993 have been the National Mental Health Plans. A key policy direction of the First National Mental Health Plan was the need for intersectoral linkages and partnership approaches between agencies providing services to mental health consumers and their carers or families.

The Second and Third National Mental Health Plans further reinforced the expectations of collaborative practice and the right of consumers to participate in mental health services. This required the development of policies at State and organisational levels that ensured consumer participation in implementation, planning and evaluation of mental health services as well as, at the personal level, in their own treatment.

Consistent with the direction of the Second and Third National Mental Health Plans, in 2008, the Commonwealth of Australian Governments developed a Care Coordination Initiative Pilot Project (CCPP), which sought to integrate community (non-government sector) and government agencies to work in effective partnerships to provide consistent and coordinated care for individuals with serious and enduring mental illness. It was expected that improved intersectoral linkages and use of universal tools would result in more effective service delivery and reduce duplication of care plans and other documents created by each service working with a consumer.

The Fourth National Mental Health Plan was released in 2009 and remains current until 2014. Priorities listed under it are to:

- Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.

- Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions.

The National Standards were established to clearly articulate the benchmarks to be achieved by mental health services in Australia. The current National Mental Health Standards were developed in 2010. Public and community managed mental health organisations are expected to meet standards that they work:

- collaboratively

- in a person centred fashion; and
• involve consumers and carers in planning for recovery, early intervention and as appropriate in the development of “advance directives.”

In response to the national policy guidelines, the Coordinated Care Planning Working Party was formed in 2010, under the auspices of and with representatives from the North Metropolitan Health Service, Mental Health Adult Program, many Community Managed Organisations (CMOs), consumers and carers. This group was formed to operationalise the COAG policy guidelines and hoped to develop cross sector treatment and wellness plans. As a cross sector group they agreed that the use of universal Crisis Plans, where the experience and wishes of consumers and carers were clearly listened to and recorded, could be standardised across all sectors.

A business plan to evaluate and field test a standardized Crisis Awareness Plan format was submitted to the Mental Health Commission of Western Australia in 2010. Consistent with the Mental Health 2020 directions paper, this pilot project was funded and commenced in February 2012.

This pilot project’s scope and objectives are consistent with the Mental Health Commission’s 2020 paper. This is the guiding document that highlights the key reform directions that underpin the future of supports and services for people living in Western Australia who are affected by mental health problems and/or mental illness. That is for:

• Person centred supports and services
  The unique strengths and needs of the person experiencing mental health problems and/or mental illness are the key focus of individualised planning, supports and services.

• Connected approaches
  Strong connections between public and private mental health services, primary health services, mainstream services, businesses, communities, individuals, families and carers help achieve the best outcomes for Western Australians living with mental health problems and/or mental illness.

Finally, the Stokes report: Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ service in Western Australia was released in November 2012. Contained were observations of how poorly integrated and inefficient service delivery was in WA public Mental Health Services. It contained multiple recommendations that are consistent with the findings of this research. Key recommendations from the Stokes report included the need for public mental health services to:

• …work closely with other services such as GPs, private hospital and CMOs to ensure the system has solid links between inpatient and community mental health clinics, so there is a seamless flow of patients between them…

• (ensure that) every patient … has a care plan and is given a copy of it

• (ensure) that the governance of the system… provides to carers, patients and GPs an
appropriate way to navigate the mental health system in seeking advice and support, particularly in crises

- (ensure) that the service (clinician’s provide) is totally patient centred and carer’s rights and responsibilities are understood and accepted

At a national, state and area level these guiding documents highlight the need for collaborative practices and cross sector partnerships between agencies and organisations working to support the recovery of mental health consumers. The guiding documents also highlight that care and crisis planning are a priority for the public mental health services and that consumers and carers must be involved in this and that their voices, as part of the person centred, recovery process, are key. Consumers and carers should be involved in documenting early warning signs and in planning to manage or mitigate crisis at the earliest juncture.

This project was funded to trial a tool and process to see if cross-sector planning and active involvement of consumers and carers is effective in early intervention and crisis mitigation.
2. Project description

Context
The Mental Health Commission funded this project. A Senior Clinical Planning Officer position was developed and eventually appointed to, to lead the project. It was also agreed to fund half a day a week of a consultant psychiatrist as the lead clinician to the project. The WA Centre for Mental Health Policy Research jointly committed to supporting this project and provided a Research Officer to be involved throughout the life of the project.

The project formally commenced in February 2012 with the appointment of the Senior Clinical Planning Officer. Under leadership and governance of the WA Centre for Mental Health Policy Research, the Research Officer soon joined the project and the Project Management Team was formed, meeting weekly and operating under a formal terms of reference.

Aim and objectives
The aim of the CAP Pilot Project was to trial the use of shared Crisis Awareness Planning in Western Australia, and make recommendations to the Mental Health Commission based on the project results and evaluation.

The specific objectives of the pilot were to:

- Develop 160 crisis plans between four areas across Western Australia (Broome, Denmark, Rockingham and Swan)
- Evaluate the usefulness and acceptability of the tool, process and education
- Evaluate the effectiveness of the change management process utilized
- Report on the findings including recommendations for future Statewide use

Key stakeholders
The key stakeholders were the four mental health communities which had volunteered for the pilot project. These were Broome, Denmark, Swan and Rockingham. Consumers, carers, public mental health services, non government workers and GPs in all these areas were considered stakeholders. Where possible representatives of the Primary Care Networks or Medicare local were engaged and a Specialist Aboriginal Mental Health representative was invited to be involved.

Scope
The initial scope of the project covered the four communities specified in the funding agreement, that is, Denmark, Broome, Swan and Rockingham. The scope was extended to include Albany. The pilot project primarily targeted mental health consumers of the public mental health services who were who were also receiving shared care services from community
agencies and/or general practitioners residing in these areas. Only consumers formally ‘admitted’ to the community mental health service were included in the pilot, thus excluding those singularly receiving consultation liaison and/or ‘triage’ assistance. In the Denmark community the model of care used most frequently is one where the consumer is managed by a General Practitioner and the community mental health nurse funded under the (Commonwealth) Mental Health Nurse Initiatives Program and receives consultation liaison from the specialist mental health service. As a result the project engaged directly with the General Practices and some consumers there.

The scope of the project encouraged networking and provided training to improve stakeholder buy in with formal evaluation of the process and tools. Completion of the evaluation report and recommendations for future Statewide use were included in the scope of the project.
3. Implementation

Governance

*Project Management Group (Senior Clinical Planning Officer, Lead Clinician and Research Officer)*

The purpose of the Crisis Awareness Plan Project Management Group was to provide supervision and ensure fidelity to the business plan as funded through supervision and provision of clinical, systems and research expertise to the CAP pilot project and to the Senior Clinical Planning Officer. The Project Management Group objectives were to:

- Review the project documentation (including but not exclusively the charter, scope, stakeholder communication plans, risk management plans, quality plans and the project report) and suggested Terms of Reference for the CAP Reference Group and the CAP Project Management Group.

- Finalise the project goals and timelines.

- Assist the Senior Clinical Planning Officer to develop linkages with key stakeholders in the four areas through supplying contact details and personal approaches.

- Monitor the integrity and fidelity of the project.

- Maintain and monitor the commitment to, and involvement of, all pilot project partners including consumers and carers and non government and government stakeholder from each of the areas.

- Advise on suitable qualitative and quantitative evaluation tools and review their implementation submitted by the Senior Clinical Planning Officer.

- Review the recommended communication and education strategy and advise on use of technology as appropriate.

- Monitor the time line, milestones and risk mitigation strategies to support the Senior Clinical Planning Officer to produce desired outcomes and outputs, as agreed.

- Monitor the time line, milestones, constraints and deliverables and liaise and renegotiate with the project sponsors and funding body, as appropriate.

- Assist the Senior Clinical Planning Officer to problem solve impediments to CAP implementation in any or all of the sites.

- Review draft versions and the final report on the project.

- Make recommendations on the strategy for dissemination of the report and promote and enhance opportunities for the recommendations to be actioned.
Project Steering Group
The purpose of the Project Steering Group for the Crisis Awareness Plans (CAP Steering Group) was to provide local representation and advise and guide the Senior Clinical Planning Officer and Project Management Team. The Senior Clinical Planning Officer reported to the Steering Group on progress in working with stakeholders in Broome, Rockingham, Denmark and Swan.

The Senior Clinical Planning Officer informed and received feedback from all members of the Project Steering Group through regular e-mails, telephone calls and intermittent personal contact.

The Project Steering Group met monthly through chaired Scopia video-conferencing meetings with an agenda and detailed minutes.

North Metropolitan Health Service: Adult Mental Health Program
Funding for the project was managed by North Metropolitan Health Service Adult Mental Health Program. Clinical and operational governance and line management occurred through this unit.

Collaborative Service Integration Group and the Mental Health Commission of Western Australia
The Collaborative Service Integration Group, initiated and developed by the Mental Health Commission, is the peak Statewide body to represent consumer, carer, non-government and public mental health voices across Western Australia. This group sponsored the CAP Pilot Project and monitored and advised the project through quarterly reports supplied to the group. Presentations made to the group ensured opportunity for direct feedback and guidance.

Activities
The Crisis Awareness Plan pilot project ran for twelve months and was conducted using clear phases and milestones.

Phase (1) Networking and building local support
The initial phase was to promote the project and establish buy-in from services in the four areas. The Senior Clinical Planning Officer had been supplied with the names and the contact details of key contact people, who had either been involved in the initial Collaborative Care Working Group or who had expressed support for the initial submission and enabled access to their community. Initial contacts included the Heads of Clinic of all of the areas and in most cases the senior operational and management staff for the area.

At a local level, these conduits facilitated access to key personnel within their organisations and to contacts in the non-government sector and community/carer sector. In the case of Denmark, Great Southern Mental Health also facilitated access to the two General Practices and to key
staff at Denmark Hospital.

Enormous diversity existed in the developmental history and level of established cross-sector and partnership networks in each of the four areas.

Swan MHS already had a well established partnership group facilitated by the Community Development Officers. Members included consumers, carers and representatives of local non-government organisations. The Senior Clinical Planning Officer addressed this consortium to seek cross-sector sector buy-in to the project.

The Great Southern Mental Health, manager supplied the Senior Clinical Planning Officer with a list of agency names and telephone numbers. Cold calling e-mails and phone calls were followed-up with networking/public relations and personal visits from the Senior Clinical Planning Officer. Attempts were made to support established or local interagency networks. Great Southern Mental Health had well established linkages with the local consumer and carer advisory group and involved two consumer representatives in the steering group from inception of the project, throughout its lifespan. These consumers assisted in establishing links with the Great Southern Carer and Consumer Advisory Group.

There was a limited non-government organisation presence in Denmark although alcohol and other drugs services (based in Albany) offered outreach to the community. Denmark had been approached to be involved in this project due to the strong Primary Care involvement with consumers with mental illness. A unique feature of this community was that the two General Practices jointly employed a Mental Health Nurse Incentive Program (a Commonwealth Government funded mental health nurse) who operated providing a case management service for mental health consumers treated by one or other of the practices.

A consultation and liaison service with the General Practices was provided by a visiting psychiatrist from Great Southern Mental Health Service, in addition to triage services. Great Southern Mental Health Service provided limited case management to consumers in Denmark, prioritising its resources for consumers with acute or complex mental health needs and or those who were receiving treatment under conditions of the mental health act. Limited resourcing was cited as a significant issue which impacted on the capacity of the public mental health service to provide an extensive case management/outreach service to consumers in the Denmark community.

Broome MHS had a well established interagency network supported by the Clinical Coordinator of the Broome Network Recovery Centre (BNRC). The BNRC Clinical Coordinator contacted non-government organisation colleagues in the community and facilitated introductions that were followed up by visits from the Senior Clinical Planning Officer. The BNRC Clinical Coordinator also worked the Health Consumers Council to create access to the Yagarrbulanjin Carers Group and the newly established Broome Consumer and Carers Advisory Group. Given that a high percentage of the Broome community is of Aboriginal heritage, the Kimberley Mental Health and Drug Service also facilitated culturally appropriate introductions to these groups with the Aboriginal and Torres Strait Islander, Mental Health Coordinator who attended the initial ‘meet and greet’ sessions.
Peel, Rockingham and Kwinana Mental Health Services have well established interagency relationships and the Acting Service Development Manager facilitated an information session that was delivered to public mental health staff, consumers, carers and non-government sector representatives.

The project steering group, that met monthly, with use of video-conferencing facilities, was established during this time and operated under a clear terms of reference.

**Phase (2) Education and re-focusing clinical practice**

Between May and early June the second phase of the project involved developing and delivering consistent cross-sector training. A training module was researched and created. Included were the standard definitions of a crisis, the seven consistent principles and guidelines for documenting along seven consistent fields. Adult experiential learning principles were followed in designing the tool with a major focus on the consumer centred approach and collaborative practice.

The training tool was designed to be flexible, able to be delivered to a group, to be used in a train the trainer situation and could also be done as self directed learning. The Senior Clinical Planning Officer delivered this training to public mental health staff in Swan and Rockingham and to several non-government agencies. Train the trainer occurred with key staff in the rural communities and multiple non-government agency staff and public mental health workers there undertook the module independently.

**Phase (3) Implementation**

It was planned that between June and September, 40 Crisis Awareness Plans were to have been completed in the areas of Broome, Swan and Rockingham. It was identified quickly that Denmark/Albany service would be unable to produce many CAPs. An alternative strategy of working closely with the Denmark General Practices and utilising the consumer network to complete ‘tick box’ pamphlets, that constituted a basic crisis plan, was adopted.

By the end of the implementation phase Broome had 28 plans on PSOLIS, Rockingham had 37 (with one other in a hard copy format only), Swan 17 and Great Southern had none (although one consumer was known to have completed a CAP interview and hard copy). Throughout the implementation phase there was consistent communication.

**Phase (4) Evaluation**

The first of sixteen focus groups, across five communities (including Albany and Denmark) commenced in late September and these continued until late November 2012. These focus groups involved carers, consumers, non-government workers, General Practitioners and the local implementation sub-group.

PSOLIS Clinical reports forwarded to the survey team allowed all the Crisis (Awareness) Plans to be counted and the content analysed.
In early October 2012 an electronic survey was distributed electronically to all public mental health workers who were trained in CAP or who had completed CAPs with consumers. In total 71 public mental health staff were invited to participate in the survey.

Throughout the period of the project, the Research Officer harvested and archived e-mails, weekly log sheets and minutes and conducted a thematic analysis of the project’s archives.

The various forms of data were analysed over November and December 2012.

**Phase (5) Report writing**

The format of the report was developed following sourcing of similar project reports from other jurisdictions and discussion with the WA Centre for Mental Health Policy Research. The report content was constructed in the final phase from December 2012 to early February 2013.

Other non-scheduled activities were included. Throughout the project there was constant dissemination of information to stakeholders via e-mail, video conferencing, newsletters, progress reports and mail out of resources. As resources were developed these were distributed to the steering group and representatives and advisory groups prior to release.

**Key Contacts**

Multiple contacts were made during the period of the project. The list of contacts has by necessity been pared back. Some senior staff were involved primarily at the point of inception. Other staff were actively involved in implementation and/or as clinical leaders to other ‘coal face’ staff. While not exclusive, this list includes those who were instrumental in creating linkages and opportunities and ensuring CAP was introduced and implementation supported across sectors, ensuring a wide distribution and involvement of staff, consumers and carers and importantly a fair trial.
**Kimberley Mental Health and Alcohol and Drug Service and the Broome Partnership**

<table>
<thead>
<tr>
<th>Dr Murray Chapman: Consultant Psychiatrist</th>
<th>Adam Vincent: Team Leader</th>
<th>Liz Moore: Project Officer and Acting Team Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron North: Clinical Coordinator, Broome Network Recovery Centre</td>
<td>James Gibson: ATSI Mental Health Coordinator</td>
<td>Yagarrbulanjin Mental Health Carers Group</td>
</tr>
<tr>
<td>Broome Consumer Advisory Group</td>
<td>Laura Elkin: Health Consumers Council</td>
<td>Simon Williams, Cecelia Dann and Miriam Feeler ARAFMI</td>
</tr>
<tr>
<td>Steve Cook: Manager, Kimberley Personnel</td>
<td>Loretta Bin Omar and Henry Councillor: Red Cross, Peer Helpers and Mentors Program</td>
<td>Michael King and Jodi Latham: Centacare</td>
</tr>
</tbody>
</table>

---

**Peel and Rockingham Kwinana Mental Health Service and the Rockingham Partnership**

<table>
<thead>
<tr>
<th>Clare Bestow: Service Development Manager, Rockingham MH</th>
<th>Simon Walters: Team Leader Assertive Community Treatment Team, Rockingham MH</th>
<th>Georgie Paulik- White: Team Leader Early Episode Psychosis Team, Rockingham MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warwick Smith: Operations Manager, Peel and Rockingham Kwinana Mental Health</td>
<td>Dr Gordon Shymko: Peel and Rockingham Kwinana Mental Health</td>
<td>Penny Thomas: Acting Operation Manager, Peel and Rockingham Kwinana Mental Health</td>
</tr>
<tr>
<td>Sally Whyte: Consumer Consultant, PaRK Guidance Group</td>
<td>Kay De Brett: Carer Consultant</td>
<td>Sharyn Pickett: Carer Consultant</td>
</tr>
<tr>
<td>Tracie Booth: Peer Support Worker, Mimidi Park (inpatient unit)</td>
<td>Maureen Robertson, Rockingham Division of General Practice</td>
<td>Annette Cotton: Team Leader Mandurah Ruah/EEP</td>
</tr>
<tr>
<td>Sean Gardyne: Team Leader Rockingham Ruah/EEP</td>
<td>Linda Borrison: St Bartholomews</td>
<td></td>
</tr>
</tbody>
</table>
### North Metropolitan Health Adult Mental Health Program, Swan Catchment and the Swan Partnership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Petra Elias</td>
<td>Service Coordinator, Swan Community Mental Health</td>
<td>Dr Amit Banerjee: Head of Clinical Services, Swan Adult Mental Health</td>
</tr>
<tr>
<td>Theresa Wilson</td>
<td>Acting Program Manager, Swan Adult Mental Health</td>
<td>Sally Willmott: Manager, Perth Central and East Metro Medicare Local Network</td>
</tr>
<tr>
<td>Gail Lee</td>
<td>Carer Consultant</td>
<td>Dusa Tokic: Richmond Fellowship</td>
</tr>
<tr>
<td>Rosemary Dravnieks</td>
<td>St Bartholomews</td>
<td>Cabaal Abon (see also Eric Norseman): North East Metro Community Drug Service</td>
</tr>
<tr>
<td>Mike Seward</td>
<td>ARAFMI</td>
<td>Francine McCarthy: Senior Occupational Therapist Swan Adult Mental Health</td>
</tr>
<tr>
<td>Cliff Holmes</td>
<td>Acting Social Work Coordinator Swan Community Mental Health</td>
<td></td>
</tr>
</tbody>
</table>

### Great South Mental Health and the Denmark and Albany Partnership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcelle Cannon</td>
<td>Manager, GSMH</td>
<td>Dr Neil Cock, Consultant Psychiatrist, GSMH</td>
</tr>
<tr>
<td>Janette Kostos</td>
<td>Team Leader, GSMH</td>
<td>Robyn Nazary: Consumer Consultant</td>
</tr>
<tr>
<td>Marcia Overmeyer</td>
<td>Carer Consultant, Great Southern Mental Health Carer and Consumer Advisory Group</td>
<td>Terri Harwood: Community Mental Health Nurse/ Case Manager GSMH</td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td>Dr Hector Faulkner: General Practitioner, Denmark</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melinda Misson</td>
<td>Senior Mental Health Clinician, Clinical Education, GSMH</td>
<td></td>
</tr>
<tr>
<td>Jo Brown</td>
<td>Consumer Consultant</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Robyn Millar</td>
<td>Nurse Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Pallier and Lauren Risby</td>
<td>Vincent Care</td>
<td></td>
</tr>
<tr>
<td>Adie Gibbons</td>
<td>Clinical Nurse Specialist Swan Community Mental Health</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Pallier and Lauren Risby</td>
<td>Vincent Care</td>
<td></td>
</tr>
<tr>
<td>Francine McCarthy</td>
<td>Senior Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Marcia Overmeyer</td>
<td>Carer Consultant, Great Southern Mental Health Carer and Consumer Advisory Group</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Pallier and Lauren Risby</td>
<td>Vincent Care</td>
<td></td>
</tr>
<tr>
<td>Francine McCarthy</td>
<td>Senior Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Marcia Overmeyer</td>
<td>Carer Consultant, Great Southern Mental Health Carer and Consumer Advisory Group</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Pallier and Lauren Risby</td>
<td>Vincent Care</td>
<td></td>
</tr>
<tr>
<td>Francine McCarthy</td>
<td>Senior Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Marcia Overmeyer</td>
<td>Carer Consultant, Great Southern Mental Health Carer and Consumer Advisory Group</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Pallier and Lauren Risby</td>
<td>Vincent Care</td>
<td></td>
</tr>
<tr>
<td>Francine McCarthy</td>
<td>Senior Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Marcia Overmeyer</td>
<td>Carer Consultant, Great Southern Mental Health Carer and Consumer Advisory Group</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
<th>Position and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne Pallier and Lauren Risby</td>
<td>Vincent Care</td>
<td></td>
</tr>
<tr>
<td>Francine McCarthy</td>
<td>Senior Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td>Marcia Overmeyer</td>
<td>Carer Consultant, Great Southern Mental Health Carer and Consumer Advisory Group</td>
<td></td>
</tr>
<tr>
<td>Julie Harper</td>
<td>Acting Mental Health Liaison Nurse, Albany Hospital</td>
<td></td>
</tr>
<tr>
<td>Sam Barron</td>
<td>Health Service Manager, Denmark Hospital</td>
<td></td>
</tr>
</tbody>
</table>
Dr Peter Austin: General Practitioner, Denmark

Dr Jane James: General Practitioner, Denmark

Paul Williamson: Mental Health Nursing Initiative Practitioner, Denmark

Catherine Patterson: Manager Fellowship House

Kerry Arundel: Coordinator Carer Respite

Vera Morgan and Peter Ashby: Halfway House CSRU

Tamala Ridge and Bryan Taylor: Palmerston Albany

**North Metropolitan Health Service: Adult Mental Health Program**

Dr Nathan Gibson: Program Director

Leanne Sultan: Deputy Director

**North Metropolitan Health Service: Area Mental Health**

Patrick Marwick: Acting Area Executive Director

**Department of Health Western Australia**

Sue Nye and Carly Dolinski: Mental Health Commission

Adjunct Prof Theresa Williams: Director, WA Centre for Mental Health Policy Research

Dr Geoff Smith: Medical Director, WA Centre for Mental Health Policy Research

Phil Andrus and Geoff Anderson: MHERL (Mental Health Emergency Response Line) and RuralLink

Mary Blake: Area Administrator PSOLIS NMHS

Sharon Mannion and Helen Parsons: Area Administrator PSOLIS SMAHS

Kay Pak and Robert Edey: PSOLIS Portfolio WACHS

Peter Newby and Stanley Bayer: Network Manager & Desk Sup Off, Statewide Telehealth Service

Allen Finley: NMHS Staff Development
General Practice Engagement

Extensive efforts were made to engage with the General Practices in the Swan area of the project with the assistance of the manager of the Perth Central and East Metro Medicare Local Network who was on the steering committee. Strategies used to inform this group included an article in the network newsletters and sessions being arranged for both local General Practitioners and Practice Nurses. The later were cancelled due to non-uptake by the practitioners in the region. Likewise a representative of the Rockingham and Kwinana Division of General Practice engaged with the project throughout. Attempts were made to connect with Boab Health in Broome, to no avail. Amity and Pioneer Health in Albany were identified as practices oriented to mental health consumers and a Mental Health Nurse Incentive Program practitioner from Pioneer Health was involved in the focus group. Further work needs to be done in establishing relationships with General Practitioners and where possible this should involve working with any GP Liaison position in the area.
4. Lessons learned from project management

Many lessons were learnt by the project management team. While some of the learning was about the effectiveness of the Crisis Awareness Model the major issues requiring the attention of the Senior Clinical Planning Officer were related to the culture, structures and processes within the services required to create ‘enthusiasm’ for adopting new approaches to old clinical dilemmas.

It is necessary to invest in creating a robust cross sector communication system. Despite the basic tool to be tested being finalized and enthusiastic support from the four services, developing the logistics of communication, introduction of the model and the process of ensuring effective quantitative and qualitative evaluation required the constant attention and most of the time of the Senior Clinical Planning Officer. Developing and maintaining better cross sector communication systems is key to mitigating crisis at a cross sector level.

An ongoing commitment to CAP education and training is required. The contemporary adult learning model demands that information and training is provided in a variety of ways in different contexts. A training package was designed in a PowerPoint format and attempts were made to change this to an e-learning tool so it could be used in an interactive format on-line. There was an absence of funding and expertise to convert the tool to an e-learning module so it was widely distributed on CDs as a short term option for those who opted for self directed learning. Training was also offered in a standardised group format and in a ‘Train the Trainer’ way. Ongoing CAP training needs to be part of each organisations regular mandatory training schedule.

Improved change management strategies need to be utilised across the sector. The variety of work cultures, governance structures and partnership models between services contributed to the significant differential in adoption and production of CAPs. The move towards standardisation and improved integration recommended in the Stokes Report should help in changing organisational and service culture. Adoption of the personalised and partnership approaches is key to effective cross sector Crisis Awareness Planning.

Challenges arising from program timeframe

Having one year to introduce, implement and evaluate a project in four sites across the State was challenging. Excellent groundwork was done in preparation for the project but while cross sector planning is superficially a simple process it required a level of commitment from multiple stakeholders that disappointingly many workers (in both the public mental health and non government sector) didn’t make.

While all of the communities had some pre-existing partnerships networks, the history and level of integration of these was unique. Several months, at the commencement of the project, were of necessity dedicated to public relations and networking. Following this, the education campaign took a further two to three months.
The Crisis Awareness Plans were not initiated by workers or consumers until four months into the project and the timeline for submission of the CAPs was extended on several occasions. The evaluation commenced four months later and the delay enabled more opportunity to complete the CAPs. Fortunately, many consumers had not experienced a crisis in this timeframe but were able to participate in the focus groups as they were able to clearly articulate their experiences in being involved in the process as well as their beliefs about initiatives and interventions required to make a CAP effective.

Ideally there should be a timeframe to longitudinally evaluate the usefulness in preventing crises and acceptability of CAPs to both consumers and clinicians in times of crisis.

There was insufficient time to do this during this one year project.

**Enablers to implementation**

The project management team were overwhelmed and buoyed with the support for the project across the state, across levels of various organisations and across carer and consumer groups in the mental health sector. The positive attitude of stakeholder groups and the expressed interest in the project were key enablers to implementation. Another key enabler was the thorough and collaborative work previously undertaken by the Collaborative Care Planning Group. NMHS Adult Mental Health Program, as the auspicing body, had already worked with prospective services and sectors to gain, in principle support, for the project before it began, creating a list of established contacts on commencement. This preparatory planning meant that the networking and public relations phase of the project was relatively uncomplicated in several communities.

**Barriers to implementation**

Great Southern Mental Health Service were unable to complete the forty plans in Denmark as they had significantly reduced public mental health case management outreach services there. GSMH continued to supply a consultant psychiatrist to the community who offered consultation liaison. Triage services were also supplied. The model for CAP was however reliant on case manager involvement in coordination of this.

The two General Practices in Denmark had jointly employed an experienced private practice mental health nurse (from the Mental Health Nurse Incentive Program MHNIP paid for under Federal funding) who operated as a case manager. Funding does not allow for state based services (that supply public mental health case managers) to be involved if a MHNIP is employed. The MHNIP was not in a position to complete the CAPs with consumers nor could the practitioner access the PSOLIS data base. Some Denmark consumers largely brainstormed their own plans and these hand written Crisis Awareness Plans were kept on electronic files at the General Practices. These plans were not put on PSOLIS as the consumers were not active with GSMH.

In an attempt to assist GSMH to complete the plans it was agreed to include Albany in the trial. No plans were completed in Albany, as only plans completed with case managers and loaded
on PSOLIS were counted in the evaluation. It was noted that as part of the trial, a comprehensive plan was completed with one of the consumer consultants but that this could not be entered on PSOLIS as she was not being treated by the service at the time of completion.

In Albany as in Denmark, case management had to be prioritised to those whose needs were too complex or whose mental health put them at too high a risk to be managed purely by General Practitioners. CAPs were also not completed because many consumers activated for case management were considered either too unwell to be ready to participate in crisis planning at that time or the staff involved in their care had not been trained to use the model having been recently recruited and as they were still being oriented to the service.

The timing for the project in GSMH was less than ideal and the public mental health service would not have engaged in the pilot had they been consulted immediately prior to commencement. The situation in Denmark did however allow for learning about how crisis planning can occur where GPs are key in supporting consumers and where there are very limited resources and fragmented systems of care.

Broome MHS had already engaged in a project to introduce Consumer Wellness Plans (CWP) coincident with the introduction of the CAP project. As the model of Crisis Awareness Planning was not reliant on the use of a standardised tool (but on use of consistent principles and fields) the Project Management Team supported the Broome initiative. This was particularly the case because the introduction of the use of Consumer Wellness Plans can be considered the ‘gold standard’ in terms of contemporary, recovery based, practice. As a point of compromise Broome included the seven fields of the Crisis Awareness Plan on the CWP which was completed in a hard copy format, with consumers.

Broome had originally hoped that the Consumer Wellness/ Crisis Awareness Plans could be uploaded as a PDF attachments onto PSOLIS to avoid clinician’s use of time on what was perceived to be data entry. In the short term the PDFs could not be attached to PSOLIS but a system upgrade request was lodged for this to occur. In the meantime, KMHDS, allocated a nurse to enter the Crisis Awareness Plans on PSOLIS. This was regarded as important because the Crisis Plan needed to be accessed by clinicians across the state.

Consumer Wellness and Wellness and Recovery Plans (WRAP) were also being trialled in Rockingham and various CMOs used similar WRAP or variations of Crisis Plans. This did lead to duplication and repetitive similar processes which was a barrier to engagement with consumers, carers and mental health staff.

A large percentage of the consumer group in Broome are of Aboriginal heritage - approximately 50 % of the local population and 70 % of the mental health population - and there were concerns that the tool may not have been culturally sensitive. The wording and layout of the tool is perceived to be more appropriate for a non- Aboriginal (and non Culturally and Linguistically Diverse) populations. A CAP that is more diagrammatic/ pictorial and allows for selection from a range of options as well as including language of “spirit” may be more appropriate. A similar tool sourced from Menzies Health of the Northern Territory is used by the Red Cross, Peer Helpers and Mentors, in Broome, as part of their Wellness and Recovery Program (WRAP).
Likewise the North Metropolitan Health, Hostels and Rehabilitation Liaison Team encountered difficulties in engaging with some of their consumers to complete the Crisis Awareness Plans. Many of this cohort had long term experiences of mental illness. Some had poor language and planning skills because of their long term mental health problems and others had pre-existing learning difficulties. The CAP principle that no consumers should be excluded from being offered the opportunity to complete a CAP, regardless of their point in the recovery journey was regularly reinforced in communications to encourage staff participation. The Project Management Team acknowledged the difficulty in engaging this cohort in the CAP process. To improve engagement a diagrammatic or pictorial tool and the checklist to help elicit a response may be helpful. The consumer brochure was a popular initiative to assist this client group as well as others.

Early in the project, the limitations associated with the Statewide database, PSOLIS, became very apparent, despite the comprehensive assistance supplied by the administrators of the three services (North Metropolitan Health Service, South Metropolitan Health Service and Western Australian Country Health Service). A functional enhancement was lodged by the PSOLIS administrators, in consultation with the Project Management Team, and a self populating template was created on the Crisis Plan section to assist staff entering the CAPs.

On numerous occasions Community Managed Organisations commented that, as well as having cross sector Crisis Plans, it would be highly beneficial to have cross sector PSOLIS access. The issue of shared access to clinical data, to promote effective working partnerships, will need to be addressed as the services provided by CMOs expand. Clear guidelines and strict governance processes underpinned by formal memorandums of understanding and read only PSOLIS access for registered Community Managed Organisations would resolve the issue. Ruah has had past access to PaRK PSOLIS and Ramsay Health has access at Joondalup Health Campus for both their inpatient mental health facility and the emergency department. Jurisdictional issues remain with WA Health being the owner of PSOLIS.

While PSOLIS is the best public mental health has in terms a Statewide data base it remains a relatively inflexible archaic program that is still ‘dos’ based. It is not easily translated into a ‘user friendly’ interface. Broome MHS has requested a system upgrade so that plans can be entered in a ‘word’ format. Ideally self populating fields should exist, linking Management and Consumer Wellness Plans and Crisis Awareness Plans. In the contemporary era of laps tops and tablets, ideally double handling, could be minimised so that mental health workers are able to focus on enhancing consumer recovery rather than on administrative tasks.

On-line training was an early priority for the project, prior to implementation, to ensure a standardised approach by practitioners regardless of agency. Expertise to develop interactive on-line training packages was limited and the project eventually relied on use of a CD Rom training package. Sustainability of the CAP approach requires a Statewide investment in cross sector information technology support on an ongoing basis.

In some of the public mental health services, in particular, there were major issues with staff turnover and vacant positions. Increased work demands with lack of allocation of resources was cited as a reason for lack of success in completing CAPs by at least one of the areas. Constant change and competing demands for practitioners time meant that each of the four public mental
health services were intermittently or permanently unable to consistently and reliably maintain a focus on implementing operational changes such as those that were required to introduce the CAP model. These operational changes had a noticeable impact, at one time or another, on morale and on enthusiasm at the ‘coal face’. At an organisational level, all gate keeping functions used by various agencies became more overt and it appeared to the project team that there was increasing protection of service boundaries. This process was referred by some steering group members as dealing with ‘organisational noise.’ In effect, the generosity of spirit and openness to work collaboratively, required in a project like this became more diluted as services concentrated on their own ‘organisational noise’. In one carer consultants view “in an attempt to protect, build and manage empires, consumers are often forgotten.”

Strategies used to successfully overcome barriers

Many barriers were successfully overcome. Lack of commitment to the project by workers was overcome in varying degrees in three of the areas by a clear implementation approach adopted by the managers on the sites. This involved identification of champions, often team leaders or senior clinicians. Realistic timeframes and milestones were established that were adjusted according to the day to day demands and business of the services involved. To create achievable goals clinical staff were asked to identify a specific number of consumers who would benefit from a CAP. In many cases Community Managed Organisation workers identified consumers who would benefit from the Crisis Awareness Planning process and worked collaboratively with their public mental health colleagues to complete the plans. Consumers were also encouraged to drive the CAP process. Posters and pamphlets were created to educate and empower them to request to be involved in the Crisis Awareness Planning process.

The short time frame between completion of the CAPs created a problem with evaluating whether the CAPs actually mitigated crisis. As such the clinical expertise of Mental Health Emergency Response Line (MHERL) was drawn upon. MHERL staff regularly deal with crises in the community. A representative was asked to review a sample of CAPs to judge if they were likely to have supplied the quality of information required to help in a crisis.

Strategies used that failed to overcome barriers

Timelines for completion of the 40 plans required serial re-negotiation. No successful strategy to maintain a consistent focus on this project was found. Each service faced major organisational issues at some time during the project (see above). They had competing priorities and high demand environments. Their workforces expressed that they felt “information saturated”. Carers and consumers likewise expressed concerns at being “smothered by information” leaving them feeling overwhelmed and immobilised.

Working as outside consultants or ‘external change agents’ the project team were available to provide substantial assistance to the four areas but during the periods of time when internal ‘organisational noise dominated' the project had limited priority within some services.
Strategies implemented to assist in the sustainability of the changes

Consideration of capacity building and sustainability of this project were foremost on the agenda of the project management team. Where intersectoral and network meetings existed the project management presented through formal agenda items. Where networks did not exist the Senior Clinical Planning Officer developed linkages connected through the local community mental health service rather than the project team. There were disparities between the local public mental health services engagement with, support of or commitment to progress the project.

The need for training and sustained follow up to change culture, values and embed clinical practices became apparent early on in the project. The training module was designed to be used in a staff development session, by a staff member who had completed the ‘train the trainer’ module or as a self learning module. While the material was consistent and standardised, the value of training in a group was clearly evident. In a shared session, staff could have conversations about logistical issues, impediments and solutions. The training CD was broadly distributed as were other resources such as templates and other pamphlets. Ideally a web link to the resources will need to be maintained by North Metropolitan Health Service, Area Mental Health or the Mental Health Commission.

Recent developments have highlighted that there is a strong possibility that the WA Health Department will have server capability within the next twelve months to support a web based ‘my plan’ which all stakeholders could access if granted the password. This password could be managed by the consumer and would meet the needs for smart phone access and portability raised by consumers.

Project limitations

This project was never targeted at consumers who have been discharged from public mental health services for ongoing management by General Practitioners although it is quite apparent that there is a need for cross sector crisis planning between primary care and public mental health services.

The CAP tool and CAP development process is currently not well designed for use with consumers who already have patchy and fragile connection to mental health services. This is a significant issue in working with mental health consumers who are itinerant.

The effective uptake by and with the Indigenous populations in Broome was quite good but this is more of a reflection on the cultural literacy of the workers there than an indication that the tool is culturally appropriate. So that the tool can be versatile, there needs to be opportunities for local modifications, as appropriate, built into any ongoing use of the tool.
II. Evaluation Report: WA Centre for Mental Health Policy Research

1. Evaluation objectives and process

The Centre for Mental Health Policy Research, which is a Statewide resource funded to research key policy and health service issues facing mental health in WA, was engaged to provide evaluation support to the Crisis Awareness Plan (CAP) pilot project.

1.1 Purpose and objectives

The purpose of the evaluation was to inform key stakeholders on the effectiveness of the roll out of the CAP Pilot Project, with the findings to be considered in developing recommendations and strategies for the future use of shared Crisis Awareness Planning by mental health services.

The objectives of the evaluation were to examine:

- Usefulness and acceptability of the Crisis Awareness Plan (CAP) template
- Perceived and objective usefulness and acceptability of the CAP in avoiding or minimizing the deleterious effects of a crisis, for all individuals involved
- Effectiveness of the processes used to develop the plan
- Effectiveness of the implementation of the project (including the education and change management processes used to inform and engage staff)

Considering the evaluation objectives, the evaluation aimed to explore the following questions:

- How many crisis plans have been developed as part of the pilot?
- Is the template useful and acceptable for all stakeholders involved in the development of care plans?
- How effective is the education and training package?
- How effective is the process for completing the standardised template?
- How useful are the standardised plans when people are in a crisis?
- What was learnt from the implementation process?
1.2 Process

The evaluation used a participatory approach. The Research Officer, with guidance from the Centre Director as the project consultant, developed an evaluation methodology with feedback from the project implementers and the Steering Committee.

The Research Officer attended monthly Steering Committee meetings and weekly project management team meetings to provide guidance as needed and observe issues and tasks involved in the implementation phase of the pilot.

The evaluation comprised the third phase of the project, and was conducted from October to December 2012. The evaluation process involved:

- Focus groups with consumers and carers that had participated in the CAP process, consumer and carer advisory group representatives, community managed organisations, local implementation committees and GPs.
- An online survey with public mental health clinicians.
- Quantitative analysis of completed plans.
- Feedback from emergency staff (Mental Health Emergency Response Line) on the usefulness of the completed plans.
- An analysis of project implementation records, including Steering Committee minutes and weekly logs written by the Senior Clinical Planning Officer and Research Officer.

Consumers and carers were invited to participate in a focus group by letter of invitation from their mental health service, while other stakeholders were contacted directly by the Senior Clinical Planning Officer responsible for implementing the project. Some consumer and carer focus groups were organised to include both those that had completed a CAP as well as local advisory group representatives as guided by local needs.

The Research Officer visited the four sites with the Senior Clinical Planning Officer to obtain feedback from focus group discussions. Guiding questions were developed for the evaluation although the sessions were kept unstructured.

For the online survey, public mental health staff who had participated in the training and/or completed a CAP were invited via email to participate.

PSOLIS administrators and local managers also collected the Unit Medical Record numbers of CAPs which were on the database for analysis.
2. Analysis of Crisis Awareness Plans

2.1 Completed Crisis Awareness Plans

The four pilot sites aimed to complete 40 CAPs and upload these on to the mental health clinical information system, PSOLIS. The total number done at each of the sites is shown in Figure 1.

![Graph showing number of CAPs on PSOLIS from each site]

**Figure one: Number of CAPs on PSOLIS from each site**

**Albany/Denmark**

Albany and Denmark is within the jurisdiction of Great Southern Mental Health Service (GSMHS). While the pilot originally focused specifically on Denmark services, the town has a small population and GSMHS does not provide outreach case management to Denmark consumers. The pilot was therefore extended to include Albany. One consumer from Albany completed a CAP which was not recorded on PSOLIS, as the consumer did not have a mental health service case manager.

**Broome**

Prior to the CAP Pilot, the Kimberley Mental Health and Drug Service (KMHDS) had begun work to introduce a consumer wellness plan, which is guided by a person centred approach and has some similar fields to the CAP. For the pilot project the CAP and wellness plan templates were combined. One of the additional fields on the wellness plan is information on consumer medication. The Broome KMHDS team completed 28 CAPs.
**Rockingham**

In Rockingham Ruah Mental Health has been contracted to work in partnership with Peel and Rockingham Kwinana (PaRK) mental health service to jointly deliver the Early Episode Psychosis (EEP) service. Ruah Mental Health was using the Wellness Recovery Action Plan (WRAP) framework with clients prior to the pilot. Ruah Mental Health provides case management for PaRK EEP consumers and had completed approximately half of the 38 CAPs at Rockingham.

**Swan**

Swan Mental Health Service completed 17 plans. Six additional plans were also put forward by Swan to be counted toward the target of 40 but were in the format and language of a traditional crisis management plan.

2.2 **Analysis of completed CAP fields**

The CAPs were analysed by the Senior Clinical Planning Officer and the Lead Clinician to see if all fields were completed and if they met measurable CAP principles of being written in the first person and included after-hours information, as shown in Figure two. It was evident that:

- The current template does not include a field for incorporating after hours plans.
- Lower levels of completion by the Broome site in relation to some fields can be attributed to using the combined consumer wellness and crisis plan format.

![Figure two: Completed fields of the CAP and adherence to measurable principles](image-url)
2.3 Analysis of the usefulness of the CAPs in a crisis situation

The short time-frame for the pilot project did not provide sufficient time for the CAPs to be used in a 'real' crisis situation. As a proxy for this, a senior MHERL clinician reviewed a sample of 17 completed plans and was asked to rate the plans from a scale of one (not at all useful) to five (extremely useful).

![MHERL analysis of the usefulness of CAPS in a crisis situation](image)

The main reasons that CAPs were rated lower included:

- No information on medication.
- No contact details for people listed on the plan.
- Some plans were incomplete.
3. Consultation overview

Consultation with key stakeholders took two main forms:

**Project Steering Group**

This Group was established to advise, guide and provide local representation on the implementation of the CAP pilot. There were regular meetings, teleconferences and email communications. Project logs, which were produced as part of the implementation process by the Senior Clinical Planning Officer and the Research Officer, were analyzed for the evaluation.

**Focus groups**

Consumers and carers who completed a CAP were invited to participate in a focus group by their mental health service, while other stakeholders were contacted directly by the Senior Clinical Planning Officer. In total 16 focus groups were held at the four pilot sites. These are shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Albany</th>
<th>Denmark</th>
<th>Broome</th>
<th>Rockingham</th>
<th>Swan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumers and carers</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Consumer and carer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>advisory group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>representatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>managed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>organisations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation sub</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPs</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As there was limited involvement from GPs in the pilot, it was only possible to arrange one focus group in Denmark, where the GPs and MHNIP mental health nurses were often the primary workers with consumers. One person representing the interests of GPs from the Perth Primary Care Network, which services 45% of the catchment of the North Metropolitan Area Health Service, participated at the Swan local implementation group feedback session.

The Albany and Swan consumer and carer meetings were attended by those who had completed a CAP as well as local consumer and carer advisory group members, as this arrangement worked best for stakeholders. Many of the advisory group representatives had been consulted over the course of the pilot project and were involved in raising awareness about the pilot among consumers and carers in their area.
4. Views of Mental Health Service staff

4.1 Competing demands

“We have been through so many decentralisations, centralisations, reconfigurations and realignments. But amongst all that there is really good quality care.”

Mental health services highlighted that significant issues within their organisations, such as service reconfigurations, understaffing and high workloads, competed with staff energy and attention when new service initiatives such as the CAP were introduced.

4.2 Consumer centred

“We want client centred care. We are definitely time restricted but personally I want to see something like this in mental health.”

“There are some staff that are doing the CAPs and some that aren’t. The people that are persuaded to do it are the converted”.

“The process for completing it is good. It gives people a sense of empowerment, a true say in their care.”

Some staff from mental health services that were involved in supporting implementation at a local level discussed their support for the consumer centred approach and the value of the process to consumers.

Staff also brought differing values and experiences to their roles which impacted on how much they prioritised and valued Crisis Awareness Planning. Services with both the capacity and framework that aligned with the CAP principles and ethos were more likely to use the tool.

4.3 Therapeutic process

“Talking with the other clinicians, they said using the CAP was a very good therapeutic process. There were things they hadn’t talked about before with consumers, it was challenging and had to be done over a few sessions. It was thought provoking for the consumers.”

“The process of completing the plan is very engaging, you find out things you didn’t know before.”

Staff feedback was that the CAP was a good clinical tool which could be used as part of therapy. Many staff felt that they learnt more about consumers in the process of engaging with them to do the CAP.
4.4 Access and ownership

“Anecdotal feedback was that clinicians selected who they were going to approach to do the CAPs. Who is the clinician to decide on who is to access the crisis plan and who isn’t?”

“We have to reinforce to consumers that it’s theirs, trying to support them in their self determination.”

“Permission to share has to come from the patient. If the case manager wants to share information from the person, it has to come from them.”

There was considerable uncertainty about who should control access to the CAP process; whether it should be freely available to all consumers on request or whether case managers should be the gatekeepers. Similarly, there was some confusion about the purpose of the CAPs: whether it is primarily for mental health services and Emergency Departments to access through PSOLIS in the event of a crisis or whether it should be a wider ranging document available to consumers, their families, GPs and other agencies.

4.5 Relationship between services

“This whole model is predicated on the success of collaborative relationships, and in working in a respectful way with consumers. You have to have those things in place first.”

“It’s a good idea to do things cross sector though. The community managed organisations have those good relationships, they may see the person three times a week. They are important for early intervention and they can get in much quicker than our service.”

Despite seeing the value in collaboration and connectedness between agencies in the development and sharing of the CAPs, there were many difficulties and the level of collaboration depended on the strength of existing relationships. Many CAPs were primarily completed by the case manager and the consumer alone.

Despite the importance assigned by consumers to their GP, mental health services and community managed organisations generally perceived that GPs had limited time and would be difficult to engage in the development of the CAP. In the country, Emergency Departments were often reluctant to use RuralLink which could provide them with access to PSOLIS. It was perceived that being a centralised service RuralLink was not aware of local issues and services.

A number of stakeholders identified limited connectedness between agencies working with mental health consumers and their carers/ families as an issue. Organisations working in isolation, were perceived as something that needs to be addressed more broadly within the mental health system.
4.6 CAP tool

Some feedback on the template was that it did not reflect the person centred philosophy of the CAP as it used clinical language and positioned the name of the case manager on the form in a way that made the CAP appear to be owned by the case manager and not the consumer.

For some sites, the brochure was completed instead of the CAP and a copy given to the consumer. Some stakeholders highlighted that the brochure should be a tool to help the consumer as part of the process, but must not replace the CAP.

Staff in the Kimberley identified the need for the template, brochure and CAP process to be culturally appropriate for Aboriginal consumers who make up more than 70% of the people using the service.

Stakeholders made a number of suggestions for improving the CAP template as outlined below:

- Consumer’s name should be on top of the form as it belongs to them and not the mental health service.
- Call it a wellness plan.
- Business rules for how to complete the CAP.
- Build in a review date.
- Form to include:
  - consumer’s signature
  - details of other people involved in developing the plan
  - details of MHERL and other after hours information
  - details on medication to be included
  - who the consumer would like to have access to the plan
- Time for consumers to take away and reflect on the CAP.
- Copy for the consumer to be in a format that they can carry with them.

Suggestions for improving the brochure included:

- The snapshot section was unclear to some consumers.
- Remove information on the brochure comparing the CAP to a will.
- Instructions needed for how to use the brochure as it is not to replace the CAP tool.
- Information on emergency contacts (e.g. MHERL).
4.7 PSOLIS

“If you want shared care then you have got to figure out the information sharing processes. It may be that PSOLIS is not the answer.”

“The best place to store the info is in the health record. If you make it PSOLIS specific you are really limiting it. If we can put most of the info on the health record it would be really helpful for the consumer.”

The problem with using PSOLIS for storing CAPs is that access is currently limited to public mental health service staff and not to staff in community managed organisations or GPs. Emergency Department staff can only access information on PSOLIS through the Psychiatric Liaison Nurses (where they exist) or other mental health service staff. There is no PSOLIS access for stand alone general hospitals such as Denmark.

There were also problems with setting up the CAP template so it was available to staff on PSOLIS and it had to be adapted to fit the existing ‘Consumer Management Plan’ field. Furthermore, it was not able to be directly uploaded onto PSOLIS in a PDF or Word format.

4.8 Length of pilot

“The timing is another issue. If you are going to implement this in a sustainable way it is all about doing it at a time and a pace that suits the services.”

“I think the pilot has worked. It shows that things can change. Change takes time. I think if the work has been done, you shouldn’t back pedal.”

The short timeframe of 12 months for rolling out the pilot project meant that it was not possible to determine whether the CAP had been useful in a crisis. It was suggested that work with services over a longer period of time would ensure Crisis Awareness Planning is more effectively implemented.
5. Views of consumers and carers

Overall, consumers and carers were very supportive of CAPs and were keen to see them continue. The main themes that arose during consultation are outlined below.

5.1 Person centred approach

“… to have a voice, and that people actually listen is wonderful.”

“It gives you an identity and that can be lost with a mental health issue.”

Many consumers and carers/families talked about previous experiences using mental health services where they felt they were not listened to or received a poor level of service. They saw the CAP as a ‘person-centred approach’ that enabled them to have a stronger voice in expressing their needs and wishes about themselves and their mental health care. These views were also supported by carers/families.

The process of completing the CAP helped consumers feel empowered, as it gave them the chance to take a more active role in managing their health and well being. Being involved in writing the plan themselves meant that they valued it more because it used their words.

5.2 Therapeutic tool

“When I see things written down it helps things to be clearer in my head.”

“Doing it was empowering at the same time as it was confronting.”

Some consumers who did the plan spoke about the value of the process in helping them reflect and articulate their needs in keeping well and managing a crisis situation. They found this to be both challenging and worthwhile.

One consumer spoke of the value in having input from their case manager in helping them develop the plan. The case manager provided an additional insight and perspective which was valued by the consumer.

5.3 Sharing the CAP

“You should let some family members know about the CAP. Family members who you are close to and are important to you.”

“With the CAP we are all talking the same language. If we go to the psychiatrist we can take the CAP with us.”
Consumers could see the value in their sharing the CAP with other services and family members, provided it was with their permission. It was viewed as a tool that could be taken to different services, such as the GP or psychiatrist. Some consumers and carers talked about the issue of high staff turn over at their mental health service and the value of the CAP as a tool to be referred to by new staff, instead of having to revisit their personal information again in detail with a new clinician. Not all consumers received a copy of the plan when it was completed.

There was concern expressed by some consumers about the lack of coordination and information sharing between agencies. As one consumer commented:

“From the consumer perspective, why would I want a CAP if I already have a management plan with the service, a recovery plan with a community organisation, my own recovery/wellness plan at home, and am bouncing from issue to issue with no-one seeming to talk to each other?”

5.4 Consumer access

“People don’t necessarily have a case manager… if you don’t have a case manager you won’t get a CAP.”

Consumers commented that there was limited awareness of CAPs as the program was not well publicised and that many consumers were not being offered access to the program. Consumers and carers pointed out was that if they did not have a case manager within the public mental health service this could limit their ability to access the initiative.

There was discussion about the best point in a consumer’s care for them to complete a CAP. Many consumers commented that they would not want to do a CAP when they were unwell and undergoing specific treatment or when they were not feeling comfortable in their relationship with their case worker. The point was made that the CAP may not be suitable for all consumers.

Some suggestions for improving consumer access included:

- Supporting increased consumer ownership of the initiative, with more targeted promotion and information to consumers and carers.
- Involve peer support workers in promoting and completing the CAPs with consumers.
- Workers to use a person centred approach when identifying how the consumer can best participate in the CAP process.
5.6 The CAP Template and Brochure

Some feedback on the template was that it did not reflect the person centred philosophy of the CAP as it used clinical language and positioned the name of the case manager on the form in a way that made the CAP appear to be owned by the case manager and not the consumer. The print of the CAP needed to be slightly bigger to allow the consumer to read it more easily.

Many stakeholders thought the CAP brochure, which includes suggestions to guide the consumer, was a useful tool. It was viewed as consumer friendly and generally appropriate for consumers from different backgrounds.
6. Views of Community Managed Organisations and GPs

6.1 Consumer centred approach

“We already had training in the person centred approach. We had made the shift across all of our programs. With the CAP it was easy to make that shift.”

“The consumers that would benefit the most from the CAP are the hardest to work with. In dealing with this the process needs to be 100 per cent person centred and we may spend one hour with them, discussing benefits.”

Many community managed organisations (CMOs) talked about their support for the consumer centred approach which underpins the CAP and highlighted their experience with this approach prior to participating in the pilot, through the use of tools like the Wellness Recovery Action Plan (WRAP). Some community managed organisations had also begun using the CAP template in their services with other consumers outside the pilot area. The development of CAPs was seen to be both useful and therapeutic.

While most stakeholders supported the definition of crisis adopted for the pilot, a couple of community managed organisations suggested a more succinct and person centred definition, pointing out that the current definition did not include the consumer’s voice.

6.2 Collaboration

As highlighted earlier, one of the problems identified with the CAP process was limited collaboration between services. When there were no established partnerships between mental health services, community managed organisations and GPs, collaboration was limited or non-existent. Even where partnerships/MOUs were in place, effective communication and collaboration was challenging.

6.3 PSOLIS

As highlighted earlier, PSOLIS access is limited to mental health services staff and is not accessible to CMOs that may have an important role in the early identification and response to crises.

6.4 Consultation with General Practitioners

“The CAP is a really good idea. It encourages patients to be self sufficient.”

Despite limited uptake of CAP by GPs in all sites apart from Denmark, there was overall support for it from GPs.
In Denmark, coordinated clinical care is offered through the Mental Health Nurse Incentive Program (MNHIP). A mental health nurse, based at the GP practices, provides additional support to consumers with severe mental disorders. The GP practices used the CAP brochure as an alternative to the formal CAP template and completed copies were being put on consumers’ files as practices do not have access to PSOLIS.
7. Survey of Mental Health Service clinicians

Public mental health clinicians that had participated in the CAP training and/or had completed a CAP at the pilot sites were invited to give their feedback through an online survey. Of 77 staff invited to participate, 18 or 23% completed the online survey.

The survey showed that:

- There was support for Crisis Awareness Planning among clinicians.
- Most staff had not yet used the CAP in a crisis situation. Two staff members who indicated they had used it reported that they found it somewhat useful.
- Clinicians found it challenging to involve different stakeholders in developing the CAP.
- The CAP tool can be further improved.
- Existing organisational issues also need to be addressed in order for initiatives such as Crisis Awareness Planning to be successful.

7.1 Respondents

Of the survey respondents, 29% (5) were from the Swan, 29% (5) from Broome and 41% (7) from Rockingham. One person did not identify their site, while there were no survey participants from Albany/Denmark.

7.2 Training and education

53% (9) of the respondents had participated in the CAP training. Overall, those that did the training agreed that it prepared them well for developing a CAP. Suggestions for improving the training were for refresher sessions and involvement of consumers in training to help them better understand the CAP process.

7.3 Completing the CAP

From the survey, it was evident that:

- Nearly three quarters of the staff that did the survey (72%) had done one or more CAPs over the course of the pilot. Three or 17% of staff had done more than five CAPs.
- For those that did do a CAP, most found that each part of the process took less than 30 minutes, or 30 to 60 minutes of their time.
7.4 Perceptions about the process

Of the respondents who completed a CAP:

- More than half of the clinicians (8 or 62%) agreed that doing a CAP with the consumer increased their understanding of the consumer’s needs and wishes.

- The majority of staff (11 or 84%) perceived that it was difficult to involve the different parties in developing a CAP.

- Over half of staff (7 or 54%) thought that it was easy to put the CAP on to the mental health database PSOLIS, while 4 (31%) were neutral and 2 (15%) found it difficult.

- Staff also gave mixed views when asked if the process challenged them to work differently. While 5 (39%) agreed, there were 5 (39%) who disagreed or strongly disagreed.

Clinicians put forward a number of suggestions for improving the process of developing the CAP with the consumer. These are summarised in Table one.

<table>
<thead>
<tr>
<th>Table one: Suggestions/comments for improving the CAP process</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Involve peer workers in the process.</td>
</tr>
<tr>
<td>● Factor in a review process, tailored to needs of individual consumers.</td>
</tr>
<tr>
<td>● Feedback to clinicians about when a CAP was used in a crisis and how it assisted in the situation.</td>
</tr>
<tr>
<td>● Explain to consumers that their wishes may not always be possible when a crisis occurs.</td>
</tr>
</tbody>
</table>
7.5 The CAP template

Respondents were asked to rate their level of agreement with statements about the CAP template.

- The majority of clinicians understood what information should be written in the seven fields.
- More than two thirds felt that the seven fields on the template were appropriate for capturing information which would be useful in a crisis situation.

Clinicians also provided suggestions for improvements to the template. Their comments have been compiled in Table two.

<table>
<thead>
<tr>
<th>Table two: Suggestions/comments for improving the CAP template/form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section in the template to record who is included in developing the plan and who has a copy.</td>
</tr>
<tr>
<td>Split the triggers and symptoms section of the plan into an item on ‘triggers’ and another on ‘early warning signs’.</td>
</tr>
<tr>
<td>Include details of MHERL in the contact list of all clients in case of crisis.</td>
</tr>
<tr>
<td>The last three sections of the CAP are very repetitive and could be combined into a ‘do’s’ and ‘don’ts’ section.</td>
</tr>
<tr>
<td>Include information for factoring in a review process.</td>
</tr>
<tr>
<td>A print out of the completed CAP for consumers and families which looks the same as the one they completed and not the PSOLIS version which is less user friendly.</td>
</tr>
<tr>
<td>A wallet sized card to be given to the consumer which has crisis contact details.</td>
</tr>
</tbody>
</table>

7.6 Using the CAP in a crisis situation

Most of the respondents (14 or 78%) had not yet used the CAP in a crisis situation.

Staff who had used the CAP to mitigate or manage a crisis were asked to rate the level of usefulness. All gave a mid point rating in response to the question, which suggests that the CAP may have been somewhat useful.

Staff were also asked about whether they were aware of other staff who had used the CAP, such as emergency clinicians. Four staff indicated that either inpatient or triage staff had used the CAP.
7.7 Improving the uptake of CAPs

Respondents had suggestions for improving the use of Crisis Awareness Planning within their services. The main suggestions are summarised in Table three.

Table three: Suggestions/comments for improving the CAP uptake

- **Increase awareness of CAPs and crisis planning with consumers and carers.** Ways to promote the CAPs could be information in the reception areas of health services; or as one respondent suggested a mail out to all consumers inviting them to participate, which would allow consumers to initiate the process with their case manager. Additional information for carers and families about how to anticipate and prepare for a crisis situation was also suggested as well as education for staff on ensuring the consumer’s voice is heard in the CAP process.

- **Existing issues within services may need to be addressed to ensure the successful uptake and use of CAPs by clinicians.** This includes issues of large case loads, limited capacity to integrate new approaches to working with consumers and general staff attitudes about change.

- **Increase involvement of the Community Managed Organisations in initiating the plans with consumers.**
8. Findings

In 2010, the Coordinated Care Planning Working Party, with representation from NMHS MHS, CMOs and consumer and carers, was formed to develop cross sector treatment and wellness plans. They developed a Universal Crisis Plan - the Crisis Awareness Plan (CAP) - with agreed definitions, principles and fields. It was intended that consumers and carers would be centrally involved in the planning process and that cross-sectoral planning would be undertaken to reduce duplication. This project was funded by the Mental Health Commission to determine the usefulness and acceptability of both the CAP template and process to manage or mitigate crises.

8.1 Active Involvement of consumers and carers

There was strong support for the CAP process amongst consumers and carers who saw the CAP as ‘person-centred’. The process of completing the CAP helped consumers feel empowered, as it enabled them to have a stronger voice in expressing their needs and preferences in relation to their mental health care. The process was seen as challenging but worthwhile, helping them reflect and articulate their needs in keeping well and managing a crisis situation.

8.2 Uptake

Although the four pilot sites had a target of 40 CAPs, the actual number of completed plans was 38 at Rockingham, 28 at Broome, 17 at Swan and 0 at Albany/Denmark. There were a number of challenges identified by the sites which affected their capacity to reach the target including understaffing, competing pressures on their service (e.g. hospital development, restructures) and the short time-frame for the pilot.

Albany/Denmark presented particular problems in their capacity to engage in the CAP process. The Great Southern MHS primarily focuses on treatment for people experiencing an acute episode of mental illness and consumers are discharged to GPs and nurses funded through the Mental Health Nurse Incentive Program (MHNIP). Furthermore, there is no outreach case management service provided to Denmark and care is provided through the MHNIP, with a mental health nurse based in the GP practices. The GP practices used the CAP brochure as an alternative to the formal CAP template and completed copies of the forms were then placed on consumer files as practices did not have access to PSOLIS.

At Rockingham, where they came close to reaching their target, almost half of the CAPs were completed by the Early Episode Psychosis Team. This team comprises of some public mental health workers including the team leader and case managers employed by Ruah. This team had already been using the WRAP prior to the commencement of the pilot.
Similarly, the Kimberley Mental Health and Drug Service (KMHDS), which completed 28 CAPs, had begun work to introduce a Consumer Wellness Plan, guided by a person centred approach, with some similar fields to the CAP. For the project, the CAP and Consumer Wellness Plan templates were combined. At Swan, which completed just under half their target, it was reported that there were differing views among mental health service staff about the relevance of the CAP.

It became apparent that, despite the reported challenges, services that had already embarked on the path of person centred planning - WRAP in Rockingham and Consumer Wellness Plan in Broome – had a significantly greater uptake with the CAP.

8.3 Coordination and collaboration

It was intended that ‘cross sector’ crisis planning would be undertaken to reduce duplication of effort by both services and consumers and carers. What was not clear was whether this meant the joint development of plans by agencies, the subsequent sharing of the developed plans between agencies, the incorporation of the crisis plans into each agencies broader treatment and wellness plans or some combination of these elements.

Despite seeing the potential value in the joint development and sharing of the CAPs, most CAPs were largely completed by the case manager and consumer. Case managers, with the exception of Rockingham, were employed within public mental health services and there was generally limited participation by community managed organisations or GPs in the development of the crisis plans.

Despite the importance assigned by consumers to their GP, mental health services and community managed organisations generally perceived that GPs had limited time and would be difficult to engage in the development of the CAP.

At Swan some CAPs were completed collaboratively between the CMOs and Swan Mental Health Services. Despite an established partnership agreement between them, it was reported that there was a lack of clarity about who was leading the process and who was responsible for selecting the clients.

Consumers could see the value in their sharing the CAP with other services and family members, provided it was with their permission. It was viewed as a tool that could to be taken to different services, such as the GP or psychiatrist.

There was concern expressed by stakeholders about the lack of coordination and information sharing between agencies. They identified limited connectedness, with organisations working in isolation, as something that needs to be addressed more broadly within the mental health system.

The placement of CAPs on PSOLIS, which restricts access to authorised staff within mental health services, presents a major barrier to sharing the CAP with other agencies such as GPs, EDs and CMOs that may play an important role in the early identification and response to
crises. There was a proposal that consideration should be given to other ways of storing the CAP that are more accessible.

8.4 **Technical issues**

**CAP Tool and process**

The key messages that came through from stakeholders were that the CAP process of engagement with consumers and carers was seen as person centred and empowering, but that the CAP tool needed to be further developed and refined to make it more consumer and carer friendly and suitable for consumers across different cultures. On the other hand, the CAP brochure, a guide for completion of the CAP, was viewed as very consumer friendly and useful.

There were a series of suggestions for improvement of the CAP process and tool that came up in consultation.

**Suggestions about the CAP process:**

- Allow time for consumers to take the CAP away to reflect on it before completion.
- Promote increased consumer ownership of the initiative.
- Ensure consumer gets a copy of the completed CAP.
- Involve peer support workers in promoting and completing the CAPs.

**Suggestions about the CAP tool:**

- Record details of other people involved in developing the plan.
- Include details of MHERL and other crisis services.
- Include information on medication.

**PSOLIS**

There were difficulties setting up the CAP template in PSOLIS for use by the pilot sites. An existing client management plan template on PSOLIS had to be adapted so the CAPs could be recorded. The format of this template was viewed as overly clinical and not supportive of consumer ownership. Furthermore, handwritten copies/hard copies of the plan could not be uploaded as PDFs and this led to double handling and staff spending considerable time on data entry.
Length of Pilot

There was general agreement amongst stakeholders that the length of the pilot project had been too short and that working with services over a longer period of time would have assisted with the implementation of the CAP project. Furthermore, the 12 month timeframe did not provide enough time to determine whether the CAPs were effective in a crisis situation.
9. Discussion

9.1 Purpose and ‘Ownership’

Consumers generally found the process of working with case managers to develop their crisis plans to be empowering and therapeutic, giving them the chance to take a more active role in managing their health and well being.

However, feedback on the CAP template was that it did not reflect the person centred philosophy of the CAP as it used clinical language and positioned the name of the case manager on the form in a way that made the CAP appear to be owned by the case manager and not the consumer. There was much discussion about the CAP tool needing to be more user-friendly and owned by the consumer.

The key purpose of the project was to “trial a tool and process to see if cross-sector planning and active involvement of consumers and carers is effective in early intervention and crisis mitigation.” The process clearly has two distinct objectives: firstly, to enhance the awareness and response of the consumers themselves and secondly, to shape the provider’s response in a crisis.

The CAP template, on the other hand, is simply a standardized tool for engaging consumers in the process so that their “experience and wishes” are “clearly listened to and recorded”. As one mental health service provider commented:

“Consumers and families should be given a print out of the completed CAP, which looks the same as the one they completed and not the PSOLIS version which is less user-friendly”.

What the service provider was intimating was that the CAPs completed with consumers and their families did not necessarily need to be identical in their format and wording to the version recorded on PSOLIS.

While the involvement of consumers needs to be acknowledged as being of paramount importance in the CAP process, service providers may need to adapt or translate this plan to enable them to better record and use the information. The crisis plan recorded on PSOLIS may indeed be different from the consumer version. However, it must accurately reflect the choices and preferences of the consumer, meet the information requirements of crisis care providers and be available in a readily usable format. The CAP tool itself should be regarded as owned by the consumer and, as such, consideration needs to be given to making the template more consumer-friendly.

If the consumer has already completed a crisis plan as part of another wellness plan (e.g. WRAP, Kimberley Consumer Wellness Plan) the crisis planning process should not be repeated. The information provided by this plan should be used to form the basis of discussion with the case manager, with relevant elements recorded on PSOLIS. The proposed approach is outlined in the diagram below.
There has been some concern expressed about the accessibility of crisis plans recorded in PSOLIS. While it is not directly available to GPs and CMOs, it is available to the service providers who are most likely to be accessed in a crisis such as EDs (through PLNs), MHERL, RuralLink, CERTs and after-hours mental health services. Family members, GPs and CMOs, however, could be given a copy of their CAP or the PSOLIS crisis plan by the consumer.

The original intention of the Collaborative Care Working Party was for the development of “cross-sector treatment and wellness plans”. What was actually agreed was the development and use of a universal Crisis Plan. However, it would appear that there has been proliferation of a range of different plans. Furthermore, the cross-sectoral element of the process has generally not been apparent. As one consumer commented:

“From the consumer perspective, why would I want a CAP if I already have a management plan with the service, a recovery plan with a community organisation, my own recovery/wellness plan at home, and am bouncing from issue to issue with no-one seeming to talk to each other?”

Whether multiple agencies need to be involved in crisis planning, individual management planning or recovery planning is a moot point. What is required, however, is some form of collaboration to eliminate duplication and ensure that all agencies involved do actually “talk to each other” and work together and coordinate their approach for the benefit of the consumer.

One of the suggestions for improving the CAP process was for “time for consumers to take away and reflect on the CAP”. Crisis plans, or indeed wellness or recovery plans, do not need to be developed with a single provider or indeed at a single appointment. There may well be considerable benefit in time being given for providers to seek wider input into their plans.

Regardless of the planning process, it is essential that all case-managers working in mental health services provide consumers with the opportunity to develop a crisis plan that can be recorded on PSOLIS. Priority, in the first instance, should be afforded to consumers who are at greatest risk of repeated crises.
9.2 Culture

As outlined earlier, there was a very significant disparity between the sites in terms of the number of CAPs they completed. Each of the sites reported a number of challenges that had affected their capacity to reach the target, with all commenting on the shortness of the timeframe for the pilot. Understaffing was reported as a major problem in Albany, as was their particular model of service provision.

Importantly, the two sites with the greatest uptake of the CAP were the ones that had already embarked on a pathway of wellness planning – WRAP in Rockingham and Consumer Wellness Plans in Broome. In the opinion of the evaluation team, the critical issue for the higher uptake at these sites was the cultural preparedness of the services: that is to say, they had already adopted person-centredness as the underpinning of the development of their wellness planning programs. It could be said, where the ground had been prepared, the CAP was more likely to take root.

As one mental health service worker commented:

“There are some staff that are doing the CAPs and some that aren’t. The people that are persuaded to do it are the converted”.

If crisis planning, or indeed wellness or recovery planning, is going to take root in a service, it will only do so where the culture of the service itself is ready rather than where only the converted, that is individual staff members, are persuaded.

It was intended that cross sector crisis planning would be undertaken to reduce duplication for consumers and service providers. As we pointed out earlier, it was unclear whether it was intended that crisis plans would be developed jointly by agencies or subsequently shared between agencies. As it was, the vast majority were developed by the case manager working alone with the consumer.

Even where there were established partnership agreements between the CMOs and mental health services, there appeared to be challenges for agencies in working together. In a person-centred system, the critical element is increased choice and control for consumers in deciding what help and support they want and need. What they have said is that they want the agencies involved with them to talk to each other, to work more closely together and to share information. In talking about the crisis planning process, one mental health service provider commented:

“This whole model is predicated on the success of collaborative relationships, and in working in a respectful way with consumers. You have to have those things in place first.”

Apart from the direct benefit the introduction of the CAP pilot may have on the mitigation and management of individual crises, this project has highlighted the importance of evaluating the cultural readiness of services before the introduction of new projects and the importance of preparing them for change. Keeping with the earlier analogy, the ground needs to be prepared before the seeds are sown; and some fields will require more preparation because of the condition of the soil.
A culture characterized by the principles and practice of person-centredness and intersectoral collaboration provides the ground on which the seeds of crisis planning, recovery planning, wellness planning and individual management planning are most likely to take root and flourish. Preparing the ground will take time; and all services commented that they found the length of the pilot too short.
III. Conclusion and recommendations

Three key conclusions arose out of the pilot and the evaluation. These are broadly summarised as: values, formula for change and ownership.

Values

The project highlighted how advanced each area was in regard to two key values associated with contemporary mental health reform in Western Australia. Specifically these values are: person centredness and connectedness. Without organisations holding values that support planning being centred around consumers and without views that partnership approaches are necessary, the process of Crisis Awareness Planning is likely to remain challenging and on the periphery of day to day business. The extent to which these values are embedded in the everyday practice of the organisation also impacts on the implementation process and on the usefulness of the plans. These values need to be embedded in the organisation and activities like Crisis Awareness Planning needs to be seen as core business.

Formula for Change

While each of the areas demonstrated many strengths, in regard to implementing the project, no one area had a monopoly on effective change management. By studying the success factors, a formula or algorithm linked to best outcomes emerged. To attain the best outcomes, realistic timeframes to implement the project (of two to three years) are necessary. Each of the areas should be able to target the community they see as most appropriate to engage and there should be flexibility in regard to commencement dates, so as to avoid clashes with other major activities/ change scheduled in the area.

From the public mental health service, the endorsement and support of executive officers and lead clinicians is imperative. The lead clinician and operational manager/s can create access to all levels of their organisation and their community. They need to be supported in a local clinical leadership capacity by either team leaders or senior clinical staff. Ongoing involvement, modelling and monitoring by these senior staff is necessary. Where there is delegation without ongoing ‘hands on’ leadership, outcomes will be compromised.

While external training can, initially, be supplied during the initiation period, this needs to be embedded in regular and mandatory staff development and quality processes. Team leaders and senior staff are responsible for negotiating timeframes and workloads, helping workers overcome impediments and performance management. Individual staff, be they senior personnel or ‘coal face’ workers, have the ability to disrupt or derail the change management process.
Throughout the organisation, all parties should be aware of the shared vision, for the organisations to evolve into a more person centred and connected organisation.

At a cross sector level memorandums of understanding and service level agreements formalise relationships but are only effective where the organisations have ensured their staff understand the spirit and the practical implications associated with these. ‘Coal face’ staff from different agencies need regular exposure to one another. Community development mental health workers and general practice liaison positions can continue to develop and support linkages within the sector and in reach into private practices. Links with the Medicare locals and organisations auspicing the ‘Partners in Recovery’ project need to continue to be developed.

Carer and consumer consultants need to be embedded in the areas and have regular contact with mental health workers, individual consumers and advisory groups. Use of consumer consultants in the implementation, planning and evaluation of services and eventually in selection, orientation and training will embed their roles in the organisations and will shape culture. Consumer consultants can work with consumers to assist them to start to develop their own Crisis Awareness Plans and will reduce demands on case managers.

Ownership
Ownership by the consumer means that the consumer is able to take their crisis awareness ‘passport’ to any service they engage with. There is still a need to collect information on consistent fields but where there is good engagement, documentation and person centred processes, duplication can be avoided. So long as the same information is collected across the sector the form does not need to be the same. Writing these in the first person reinforces consumer ownership and centrality. For those agencies that have no process or template for crisis planning, the tool used in this pilot will be reviewed, taking into account feedback from the evaluation, and it will remain available for use.

Public mental health services need to continue to use PSOLIS until it is superseded or cross-sector interactive web based technology becomes available. The public Statewide documentation committee has been consulted in regard to the existing template and it is hoped, in due course, that the modified tool will become a standard template.

Key Recommendations
1. Pilot sites to be invited to continue their commitment to the project for a further two years, to embed the cultural changes of person centred planning and partnerships in the existing services, prior to making this a Statewide initiative.

2. Shift local ownership to the pilot sites by allocating funding to each of the community mental health services for a part time CAP coordinator/project officer and a part-time consumer consultant.

3. Maintain a part time Statewide CAP coordinator for two years to continue to coordinate and develop resources and linkages.
4. Build problem solving and a learning network across and between the pilot areas in preparation for Statewide adoption.

5. Follow up with further evaluation involving the WA Centre for Mental Health Policy Research, in approximately 18 months, before making this a Statewide initiative.
IV. Appendices

References


Stokes, B., (2012), Review of the admission or referral to and discharge and transfer practices of public mental health facilities / services in Western Australia. Perth: Government of Western Australia.
Supporting literature

Joint Crisis Planning

<table>
<thead>
<tr>
<th>Article</th>
<th>Summary/key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cournos, F., and Stephen M., Goldfinger, S.,(Eds), (2009), Frontline Reports: From Psychiatric Advance Directives to the Joint Crisis Plan, <em>Psychiatric Services</em>, Vol 60, No 10,1390-1391.</td>
<td>Description of the pilot study into the feasibility and use of “advance directives and joint crisis planning” in New York City in two publicly operated clinics and one affiliated nearby hospital over 2005-2006. Included in the study were consumers admitted to a psychiatric inpatient service at least once in the past two years with a diagnosis of psychotic or bipolar illness. Inpatients and those in mandated community treatment were excluded. <em>In summary, the intervention was welcomed by consumers and providers, and the results provide evidence that it promoted shared decision making.</em> The authors suggested that further work needs to be done if such plans are to be used by emergency service providers in the US context.</td>
</tr>
<tr>
<td>Flood,C., Byford,S., Henderson,C., Leese,M., Thornicroft,G., Sutherby,K., Szmukler,G., (2006), Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial, <em>British Medical Journal Online</em>,1-5.</td>
<td>The research was aimed at investigating the cost effectiveness of joint crisis plans. A single blind randomised controlled trial was conducted across 8 community mental health teams in southern England. The research group included 160 people with a diagnosis of psychotic illness or non-psychotic bipolar disorder who had been admitted to hospital at least once within the previous two years. Half were invited to develop joint crisis plans with their care coordinator, psychiatrist, and project worker. The other half, the control group, was given standardised service information. The main outcome measure was admission to hospital in the15 months after the plan was completed. Use of a joint crisis plan was associated with less service use and lower costs on average than in the standardised service information group but the reduced costs were not statistically significant. <em>The researchers concluded that joint crisis plans produced a non-significant decrease in admissions and total costs but that there was a relatively high probability of the plans being more cost</em></td>
</tr>
</tbody>
</table>

The research was aimed at investigating whether a form of advance agreement for people with severe mental illness could reduce the use of inpatient services and compulsory admission or treatment. A single blind randomised controlled trial was conducted across 8 community mental health teams in southern England. The research group included 160 people with a diagnosis of psychotic illness or non-psychotic bipolar disorder who had been admitted to hospital at least once within the previous two years. Half were invited to develop joint crisis plans with their care coordinator, psychiatrist, and project worker. The other half, the control group, was given standardised service information. The researchers measured the outcomes — admission to hospital, bed days, and use of the Mental Health Act, over a 15 month follow up period with both groups. Use of the Mental Health Act was significantly reduced for the cohort with joint crisis plans. As a consequence, the mean number of days of involuntary admission was also reduced for the group with joint crisis plans. There was no evidence for differences in bed days (total number of days spent as an inpatient.) **The researchers concluded that use of joint crisis plans reduced compulsory admissions and treatment in patients with severe mental illness.** There was a slight reduction in overall admissions but it wasn’t statistically significant. The need for further research was indicated.


This research reports consumers’ and case managers’ use of and views on the value of Joint Crisis Plans (JCPs). In total 160 consumers with psychosis or bipolar disorder participated in a randomized controlled trial. 62 of the 65 consumers with whom JCPs had been done were interviewed at least once. Consumer interviews were conducted when the JCP was completed, if and when hospitalisation occurred and at 15 month followup. Case managers were interviewed at 15 months. Depending on the question, 46–96% of the 44 consumers interviewed who did JCPs responded positively to questions concerning the value of the JCP at immediate follow up. At 15 months the proportions of positive responses to the different questions was 14–82% from the 50 consumers who had done JCPs, interviewed. 39-85% of the 28 case managers interviewed responded positively at 15 months. Comparing the total scores of participants who had completed both the initial and follow up questionnaires there was a shift in responses, from positive to no change, from the immediate follow up to 15
month follow-up interview. The two items that received highest endorsement also showed least shift over time, i.e. whether the participant would recommend the JCP to others (90% initial vs. 82% at 15 months) and whether they felt more in control of their mental health problem as a result (71% at initial vs. 56% at 15 months). The researchers stated that the best supported hypothesis was that participants felt more in control of their mental health problem. Together with the previously reported outcomes, this suggests JCPs empowered their holders to obtain their preferred care and treatment in a crisis. They concluded stating further research is needed to more clearly identify the mechanisms of action of JCPs and how their initial positive impact can be sustained.

<table>
<thead>
<tr>
<th>Henderson, C., Flood, C., and Szmukler, G., (2007), Shared Decision Making, Psychiatric Services, Vol 58, No 1, 139-140.</th>
<th>Letter to the editor questioning the assertion that psychiatric advance directives allow shared decision making to occur. The authors argue that as the documents can be produced by the consumer alone in the absence of any practitioners that they represent a ‘consumer choice’ rather than a ‘collaborative’ model. The constraints on the ‘consumer choice’ approach are legal, that is, the advance directive has to be witnessed etc. While advance directives appear to offer consumer choice they are often divorced from the system that manages treatment. Joint crisis plans, however, are prepared conjointly by consumers, carers and mental health practitioners. Disagreements that cannot be resolved are made explicit on the plan. Although the final choice of content is the client’s, the involvement of the client’s usual care providers increases the chance that they will be aware of and able to act on the preferences, expressed. Fragmentary systems of care, they argue, increase the work needed to disseminate the joint care plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moran, P., (et al), (2010), The effectiveness of joint crisis plans for people with borderline personality disorder: protocol for an exploratory randomised controlled trial, Trial Journal, 11:18, 1-8.</td>
<td>This is the description of beginning research into the effectiveness of joint crisis plans between consumers who have Borderline Personality Disorder and their treating mental health team. A single blind exploratory randomized controlled trial with a total of 120 participants is being set up. All participants are to have a primary diagnosis of borderline personality disorder. After completing a baseline the cohort is to be invited to do a joint crisis plan, or to have treatment as usual. All those in the JCP group will be involved in a facilitated meeting and they and those they specified in the plan are to be supplied typed copies. A follow-up is scheduled for 6 months after. Outcome measures are whether any self-harm event has occurred, the time to first episode of self-harm and the number of self-harm events</td>
</tr>
</tbody>
</table>
over the follow-up period. Secondary outcome measures are length of time from contemplation to act of self-harm, help-seeking behaviour after self-harm, cost, working alliance, engagement with services and perceived coercion. Other outcome variables are quality of life, social impairment and satisfaction with treatment. **The project is not completed but the results of this trial will help to clarify the potential beneficial effects of JCPs for people experiencing a borderline personality disorder.**

| Sutherby, K., Szmukler, G., Halpern, A., Alexander M., Thornicroft, G., Johnson, C., Wright, S., (1999) A study of ‘crisis cards’ in a community psychiatric service, *Acta Psychiatry Scand*,100,56-61. | Research paper on a pilot study with consumers who completed crisis plans after being invited to do by their community psychiatric service. The project was designed to examine the feasibility of introducing crisis cards or joint crisis plans. A ‘crisis card’ was defined as records a set of statements made by a consumer independent of any agreement with the treatment provider about what should happen in a crisis. A ‘joint crisis plan’ was defined as a similar set of statements made in collaboration with, and agreed with, the treatment provider. The term ‘cards’ was used generically to refer to either of the above. All consumers of the community psychiatric service with a psychosis and deemed to be at “high risk of crisis” were invited to participate. 106 consumers were identified and invited to complete a crisis card, and 40% agreed to participate resulting in a sample group of 40. Consumers with an affective psychosis, past suicide attempts and less frequent admissions were over-represented among those who agreed to take part. Consumers chose to include a wide range of information. The follow-up examined consumers’ satisfaction and how the cards were used. For participants, admissions fell by 30% in the follow-up year.

**The researchers concluded that crisis cards serve both a practical function (to provide important information when the person is too ill to do so) and a psychological one (positive effects on the consumer’s attitude to self, their illness and treatment, and their relationship with the clinical team). They recommended that they be developed collaboratively.**

| Thornicroft, G., (et al),(2010), CRIMSON [CRisis plan IMpact: Subjective and Objective coercion and eNgagement] Protocol: A randomised controlled trial of joint crisis plans | The CRIMSON trial aims to determine if Joint Crisis Plans, compared with treatment as usual, are effective in reducing the use of the Mental Health Act (MHA) in a range of treatment settings across the UK. This is a 3 centre, individual-level, single-blind, randomised controlled trial of the JCP compared with treatment as usual for people with a |

| Study participants include individuals with a history of relapsing, psychotic illness, residing in Birmingham, London and Lancashire/Manchester. 540 service users are to be recruited across the three sites. Eligible service users will be adults with a diagnosis of a psychotic disorder (including bipolar disorder), treated in the community under the Care Programme Approach with at least one admission to a psychiatric inpatient ward in the previous two years. Current inpatients and those subject to a community treatment order are to be excluded. Research assessments will be conducted at baseline and 18 months. Following the baseline assessment, eligible service users will be randomly allocated to either develop a Joint Crisis Plan or continue with treatment as usual. Outcome will be assessed at 18 months. The primary outcome is the proportion of service users treated or otherwise detained under an order of the MHA during the follow-up period, compared across randomisation groups. Secondary outcomes include overall costs, service user engagement, perceived coercion and therapeutic relationships. Sub-analyses will explore the effectiveness of the JCP in reducing use of the MHA specifically for Black Caribbean and Black African service users. Qualitative investigations with staff and service users will explore the acceptability of the JCPs. |
## Advance directives

<table>
<thead>
<tr>
<th>Article</th>
<th>Summary/key findings</th>
</tr>
</thead>
</table>
| Cochrane Collaboration, (2010), Advance treatment directives for people with severe mental illness (review), *The Cochrane Library*, issue 3. | The authors reviewed advance directives and the complexities of these in the mental health setting and did a meta analysis, comparing contrasting two studies into their use. An advance treatment directive is a document that specifies a person’s future preferences for treatment, should he or she lose the mental ability to make treatment decisions.  

There are two general forms of mental health advance directives, the *instructional directive* and the *proxy directive*. A third form, the *hybrid directive*, combines the advantages of the instructional and proxy directives. Instructional mental health advance directives communicate instructions for treatment providers in the event of a mental health crisis, should the patient become incompetent and unable to do so themselves (including wishes in regard to methods for handling emergencies, medication management, treatment approaches, persons to be notified in the event of hospitalisation, persons responsible for childcare, personal, and financial matters and medical care issues.) *Proxy directives* are health care, ‘power of attorney’ documents, which allow the patient to designate someone else to make decisions on his or her behalf should he/she become ‘incompetent’ to do so. *Hybrid directives* name an individual who is authorised to make treatment decisions on behalf of the patient while also providing instructions to that person, combining the specificity of the *instructional directive* with the flexibility of the *proxy directive*.  

This review looks at whether having an advance statement leads to less hospitalisation (either voluntary or involuntary), less contact with mental health services and whether there is an improvement in general functioning, for the mental health consumer. Two studies were reviewed, involving 321 people. Both took place in England. One trial involved the consumer making a joint crisis plan in collaboration with the psychiatrist, care coordinator and project worker (high intensity group) while the other required filling in a booklet called ‘preferences for care’ (low intensity group). Both studies were compared to the usual care in the area.
concerned. Since the interventions were quite different, and not all outcomes were measured by both studies, it is difficult to compare the trials.

Those who filled in the booklet showed no decrease in admission to hospital (voluntary or involuntary) or contact with outpatient services, when compared to usual care. **The high intensity group showed no differences in voluntary admissions compared to those in usual care, but were less likely to be hospitalised involuntarily, or assessed under the Mental Health Act. They were also less likely to be violent.** There was no difference in use of psychiatric out-patient services by those in the intervention groups. These are small studies and more research is needed, **but they suggest that using an advance treatment directive could be an alternative to community treatment orders.**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government of WA, Department of Health, <em>Preparing an Advance Health Directive.</em></td>
<td>WA health information booklet and form. Has a general health focus with explanation of key terms and some explanation of circumstances when the form may be utilised.</td>
</tr>
<tr>
<td>Henderson, C., Jackson, C., Slade, M., Young, A., and Strauss, J., (2010), <em>How should we implement psychiatric advance directives? Views of consumers, care givers, mental health providers and researchers,</em> <em>Adm Policy Mental Health,</em> 37, 447- 458.</td>
<td>The study aimed to measure expert consensus on the implementation of Psychiatric Advance Directives (PADs) within the Veterans Health Administration. The authors stated that despite the documented benefits (therapeutic, reduced coercive treatment, consumer support and crisis mitigation) there has been a poor uptake in developing PADs by clinicians. They were interested in the process of how PADs should be conducted. The research used a Delphi (a standard then a follow-up targeted survey) study with 44 participants where consumers, carers, mental health professionals and researchers had an opportunity to rate items. Participants were based in the USA and Europe. The researchers compared and contrasted the findings from the different cohorts and found a lack of consensus with difference between the views of consumers and non consumers. The consumers indicated that they preferred these PADs to be completed in non-medical settings with completion independent of the treatment team. <strong>The researchers concluded that the principle of consumers choice should be applied in the process of developing mental health advance directives and policy and training for mental health professionals should</strong></td>
</tr>
<tr>
<td>Source</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Mental Health Legal Centre, Advance care</strong></td>
<td>Guideline and form from the Victorian Mental Health Legal Centre for the development of an advance care directive.</td>
</tr>
<tr>
<td>directive guidelines and form.</td>
<td></td>
</tr>
<tr>
<td><strong>The Mental Health Legal Centre Inc, Advance</strong></td>
<td>Overview of advance directives and of a project which involves consultation with consumers and carers about a suitable format, education approach, trial of the advance directive forms, analysis and dissemination of the information learnt.</td>
</tr>
<tr>
<td>directives project- Information for clinicians,</td>
<td></td>
</tr>
<tr>
<td>(no date).</td>
<td></td>
</tr>
<tr>
<td><strong>Vuckovich, P.,(2003), Psychiatric advance</strong></td>
<td>In the USA, psychiatric advance directives (PADs) have been legally defined in 12 states but only implemented in 9. PADs are a specific form of advance directives linked to the (US) Patient Self Determination Act (1990). The authors argue that PADs may prevent unwanted treatment and identify preferred treatment, as well as allow mental health consumers to exercise some control over care, at times, when they are deemed to be incompetent. It is recognised that for consumers with episodic mental illnesses, trusted health care providers and surrogate decision makers can follow their wishes when instructional directives and durable power of attorney have been established. The authors contend that as long as the consumer’s expressed wishes are not inconsistent with accepted medical practice, given the available resources, health providers are legally expected to comply with PADs. Mental health nurses should be fully informed of the PADs intended purpose and benefits as well as the possible drawbacks of them.</td>
</tr>
<tr>
<td>directives, <em>Journal of American Psychiatric</em></td>
<td></td>
</tr>
<tr>
<td><em>Nurses Associations</em>, Vol 9, No 2, 55-59.</td>
<td></td>
</tr>
<tr>
<td><strong>Wauchope, B., O’Kearney, R., Bone, L., &amp; Urbanc, A., (2011). Advance agreements for mental health care: an examination of process and outcomes, Australian and New Zealand Journal of Psychiatry, 45, 281–288.</strong></td>
<td>This study examined the processes and outcomes of the introduction of structured mental health advance agreements in the Australian Capital Territory. 33 consumers with serious mental illnesses collaborated with a key clinician to develop advance agreements. Education, workbooks and materials were supplied. The process and outcomes associated with developing and completing the agreement were evaluated with consumers and mental health workers being interviewed and using self-report measures. The process was strongly accepted by the consumers with only 16% discontinuing for reasons related to the advance agreement. Both consumer and worker research participants strongly endorsed the benefits of the plan in illness management and at a personal level (for the consumers.) Service level impediments, particularly clinician acceptance, limited treatment options, and the lack of</td>
</tr>
</tbody>
</table>
legal force of the agreement were identified. When supported, consumers are able to work collaboratively with clinicians to produce anticipatory treatment requests which they considered beneficial, realistic and consistent with good care. The authors concluded that effective implementation of this process requires service-level changes to promote clinician acceptance and to embed practices which facilitate the tools as part of routine intervention.

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health legislation is currently being reviewed across Australia. To date, only the ACT and Victoria have seriously countenanced the legislative recognition of advance directives. A debate between rights and risks in psychiatry ensues. The article outlines relevant laws and developments that have occurred in Scotland, England, Wales, New Zealand, Canada and the USA. In concluding, it is argued that across the world there have been challenges with implementation. Effective law reform in Australia should attend to international precedences while being mindful of the deeper human rights principles represented by the psychiatric advance directives movement.</td>
</tr>
</tbody>
</table>
## Consumer participation

<table>
<thead>
<tr>
<th>Article</th>
<th>Summary/key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Browne, C., and Hemsley, G., (2008). Consumer participation in mental health in Australia: What progress is being made? <em>The Royal Australian and New Zealand College of Psychiatrists</em>, Vol 16, No 6, 446-449.</td>
<td>In reviewing historical developments and recent literature the authors concluded that despite public policy, mental health consumers being central to decision making occurs in only a limited capacity. The implications for the practice of psychiatry, and therefore mental health services, of the demands for meaningful participation are profound. Consumer participation challenges the social covenants under which mental health services have historically been delivered. Recently, the ANZ College of Psychiatrists has developed policies that aim to ensure that the rights of people living with a mental disorder are respected. These policies also acknowledge that effective health care requires collaboration with consumers.</td>
</tr>
</tbody>
</table>
| Happell, B., and Roper, C., (2007). Consumer participation in mental health research: articulating a model to guide practice. *Australasian Psychiatry*. Vol 15, No 3, 237-241. | This paper is the result of a qualitative review of the literature relating to consumer involvement in mental health research. The literature identified a number of important benefits and some significant barriers to consumer involvement in mental health research. The authors found that a clear model to articulate definitions of consumer involvement was lacking but did identify four distinct levels of consumer involvement in mental health research being:  
  - consumer advisory  
  - consumer consultation  
  - consumer collaboration  
  - consumer led. |
| Lloyd, C., and King, K., (2003). Consumer and carer participation in mental health services. *Australasian Psychiatry*. Vol 11, No 2, 180-184. | Consumer participation is defined, reasons why this is valuable are explored, barriers to implementation and means of overcoming these are discussed. There are three reasons why mental health consumer involvement is important: |
there are no market forces in MH allowing consumers to reject unsatisfactory services
consumers often have long term/ ongoing involvement with services
participation is empowering and is a way for consumers to socially re-engage.

Collaboration with consumers and carers involves commitment of a significant amount of
time to a process that is both ethically and logistically complex for health professionals. To
ensure better consumer participation the authors suggest:

- incorporating collaboration & partnership considerations into core clinical accountability
  processes
- making collaboration and partnership indicators a feature of performance appraisals
- establishing working parties to work on specific aspects of consumer and carer
  participation
- establishing programmes/ activities that consumers can participate in so staff can see the
  value of participation
- forming strong links with the non-government sector
- involving consumers in staff education and training.

Consumer and carer involvement is multilayered including consumer:

- access to promotional material
- involvement in service planning, evaluation, surveys, forums and committees
- roles as consultants or peer workers
- involvement in staff training, promotion, prevention and early intervention, research and
  program development.

Active recruitment of consumers and support for those in consumer roles results in
the best outcomes for the consumers and organisations.

This paper describes the fundamental components of a system to ensure consumer participation in mental health service evaluation and quality improvement. The requirement for services to be responsive to consumers is fundamentally about consumer participation in service evaluation and quality improvement. To ensure “responsiveness to consumers” (a key national indicator) the authors identified 7 fundamental components of a service evaluation and quality improvement systems being that:

- it is a consumer driven process (consumers identified important needs are listen to)
- a standardized tool is used (based on national indicators)
- a clear cyclical quality process is used
- the process ensures feedback gathered from consumers is directed to the service at all levels with action plans
- it is incorporated into the local quality improvement and participation systems
- it is based on a partnership between consumers, mangers and staff


The paper presents the findings of a survey of consumers of mental health services who were working (in either paid or unpaid positions) in NSW Health and in the Community Managed Organisation sector in NSW. A survey was distributed through the NSW Consumer Advisory Group newsletter to elicit roles and assess the training needs of consumer employees, as well as those who were working in voluntary capacities as consumer representatives, within the mental health system in NSW. Data was collected from 35 surveys. One third of respondents were in paid consumer roles. Respondents indicated that many of them had been placed in the untenable position of being engaged in representation and/or advocacy roles but had unclear job descriptions and no training. The majority of consumers wanted a code of ethics and performance standards for consumer workers. Effective and timely strategies that ensures that consumer involvement is underpinned by relevant training and supportive infrastructure is required to ensure effective consumer participation.
The CAP project and links to the Stokes Report (2012)

The model of the Crisis Awareness Plan (CAP) which has been trialled does provide a solution to many of the issues raised in the recent Stokes\textsuperscript{1} review. This detailed and thoughtful report was highly critical of the endemic poor coordination and lack of shared standardised processes in mental health services. Crisis Awareness Plans involve individuals (especially the carer) and services other than the consumer and Mental Health Service clinicians. If a shared standardised approach in developing Crisis Awareness Plans with the consumer and carers is adopted by both government and non government service providers many of the service gaps and difficulties described in the Stokes report will be addressed.

This document details specific references and descriptions of poor service provision described and recommended by the Stokes Report. In summary, if the CAP model is adopted it will directly tackle the following issues highlighted in the Stokes report.

- Consumers and Carers will be directly involved in developing each CAP. It is a consumer focussed (and owned) approach.
- Shared standardised documentation in developing a crisis plan CAP) will help in ensuring consistency of response across services during crises.
- The CAP is developed by each consumer with input from a variety of others so cultural (Indigenous and CALD) and age related developmental issues will be addressed.
- If a standardised CAP model is adopted by government and non government agencies it can be ‘posted’ in PSOLIS ensuring access by all emergency services in times of crises. It is a tool that directly addresses fragmentation of response and approach.
- If a standardised CAP were developed for each consumer to a good standard, the need for multiple triages or re-assessments that consumers and carers described as unnecessary could be reduced significantly.
- ‘Timeliness of response’ in crises is more likely to occur. Barriers to appropriate service responses will be reduced.
- In some cases streamlining of admission processes will occur.
- If developed thoughtfully with specific input from the Case Manager the CAP will help the consumers and carers in navigating the complex health system.
- The names and contact numbers of all involved supporters and agencies will be available immediately

\textsuperscript{1} Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia - Professor Bryant Stokes, AM July 2012
• A CAP, to a significant extent, if developed in partnership with the consumer and carer, will address many of the deputy coroners concerns highlighted below.

• A CAP, if completed according to the standard recommended fields in partnership with the consumer, will address those concerns raised by the Chief Psychiatrist’s re risk assessment and context and effective discharge planning (see below).

• A CAP, if completed to a good standard, could also provide valuable direction and clinical advice to the Royal Flying Doctor Services (RFDS) alleviating some of their concerns.

Below are direct quotes transcribed from the Stokes Report. In all cases adoption of a standardised Crisis Awareness Plan approach, as described in the pilot project can help address the problems and inconsistencies described. Highlighted are statements directly referring to the need for a Crisis Plan.

From the Executive summary

Information management across mental health is a key area for improvement. Ensuring that there is an accessible and effective system-wide information management system is an important challenge that must be addressed (p1).

More people are admitted into WA specialist mental health inpatient units each year. (p2)

The Review heard patients concerns about the inconsistent response of mental health services to their presentation and that assistance was often not available until they were at their most vulnerable and in crisis. Some were comforted by kind staff who listened to them and made them feel safe and secure. For many others, the difficulties of accessing services, the long wait for assessment, little information about their psychiatric treatment or physical health, and scant rehabilitative services raised concern that the WA mental health system was unable to assist them to recover or improve.(p3)

For some, an unhesitating opinion was that the system, by virtue of not providing adequate, timely and preventive care, was a major contributing factor to a patient’s suicide.(p3)

Of the many persons interviewed in this Review, a common theme from carers and patients was that they were not singularly or severally involved in planning of risk, care and treatment. Nor were they involved in discharge planning. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity.

The sanctity of patient confidentiality should not be used as a reason for not informing the carer that the patient is going on leave or is to be discharged. It is to be noted, however, that many services do this well, although not uniformly across the system.

Carers were concerned they had no teaching about what may constitute triggers for a relapse in their patient and what to note as possible signs of impending deterioration.
This Review supports the development and implementation of standardised documentation in all mental health services and facilities in WA.

Standardised documentation increases quality and safety of patient care by greater adherence to standards of care, improved intra- and interdisciplinary communication and better-informed clinical decisions. (p5)

In addition to hand-written medical records, the main electronic information system used within the WA mental health service is PSOLIS. The system is designed to collect demographic information and treatment-related history from patients in order to support optimum care. It is essential that information is available and accessible to all clinicians involved in a patient’s care. It is crucial that the mental health system has one universally accepted, mandated and well-utilised information system.

This Review gathered evidence that the current process is patchy and varies between mental health services. Some do report and communicate with GPs very well – many do not. (p5).

Clinical governance: The Review concludes that the governance of public mental health in WA is fragmented, variable in type and method of service delivery, and that there is no robust uniform clinical accountability across the system. (p5)

Many mental health facilities act as if they work in a silo. Their relationships with each other are fragmented so that patients moving from one facility to another are frequently subjected to repeated history taking and changing care. (p6)

There is disparate implementation of policies across sites even within the same area of mental health service. A stark example lies in the use of different risk assessment processes.

There is sufficient comment from carers and patients to indicate that their involvement with management planning is lacking in many instances. This is partly due to the enormous workload on clinicians. However, these aspects are often not acted upon, leaving the patients and carers vulnerable in their care processes. (p6)

Of concern to the Reviewer is the care of Aboriginal people with mental illness. The development of specific care models that integrate family and trusted members of the community to accompany the persons with mental illness throughout their psychiatric/specialist treatment is needed.

Recommendations of this Review address the refinement and improvement of admission, referral, discharge and transfer practices for public mental health patients in hospital EDs, authorised public mental health facilities/services, and general hospitals.

There appears to be no articulated Clinical Service Plan for Mental Health which embraces the aims of the Mental Health Commission and encompasses the clinical care responsibilities of the Department of Health. Such a plan is crucial to providing a comprehensive and safe service for all West Australians irrespective of personal and geographical diversity. (p8).
Recommendations

Below are Recommendations in the Stokes Report that could or would be improved if a CAP process was adopted throughout Government and Non Government Services.

Recommendation 1: Clinical governance

1.1.3 Developing standard documentation for service provision, including model of care, patient risk assessment and risk management.

1.1.9 Ensuring the development of a robust information system (including electronic) with flexibility for ease of use by all mental health practitioners including those who practice in areas of public mental health managed by a private provider (see Section 3.10.6). (p8)

1.2 Works closely with other service providers such as GPs, private hospitals, and CMOs to ensure the system has solid links between inpatient and community mental health clinics (so there is a seamless flow of patients between them) and establishes and monitors those links.

1.5 The new Executive Director of Mental Health Services of the Department of Health needs to ensure there are bridge programs that associate mental health with disability and culturally and linguistically diverse services.

Recommendation 2: Patients

2.1 That the new Executive Director of Mental Health Services mandates the policy development of a patient-focused service that insists every patient is involved in care planning and discharge planning. (p10)

2.2 Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan, the carer is also involved, as appropriate.

2.10 No patient is to be discharged from an ED or another facility without an adequate care plan. Where there is a carer clearly involved, the carer should be included in the discussion of the care plan and the discharge plan. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The sanctity of patient confidentiality should not be used as a reason for not communicating with carers in these situations.

2.12 The names and contacts of carers should be recorded for each patient where appropriate.
Recommendation 3: Carers and families

3.1 While the patient is the primary focus of care, the views of the carer must also be considered.

3.2 Carers must be involved in care planning and most significantly in a patient’s discharge plan, including the place, day and time of discharge.

3.3 The carers of patients need education, training and information about the ‘patient’s condition’ as well as what are the signs of relapse and triggers that may cause relapse.

3.5 The governance of the system should provide to carers, patients and GPs an appropriate way to navigate the mental health system in seeking advice and support, particularly in crises.

3.6 A carer should have equal status with the patient in reporting triggers that might indicate a deterioration in the patient’s condition.

3.7 Carer communication by mental health clinicians is mandatory for the system to be robust and provide patient best practice.

3.8 Patients may demand confidentiality of care and treatment but mental health clinicians in this situation need to understand and take into account the requirements and vulnerability of carers. Mental health practitioners must be aware of the rights and safety of carers.

Recommendation 4: Clinicians and professional development

4.3 Clinicians must ensure within their area of work that the service is totally patient centred and that patients and carer’s rights and responsibilities are understood and respected.

Recommendation 7: Acute issues and suicide prevention

7.3 The care plan must accompany the patient between community and other treatment settings; and be communicated to new clinicians at the time of transition. This ensures the care passport maintains treatment continuity.

7.4 Every patient should have an identified case manager.

7.5 The assessment, care plan and decision to refer a patient from one public mental health service to another should be seamless. The patient should not experience further assessments as barriers to entry. There should be no requirement to repeat triage.

7.10 Deputy State Coroner’s Recommendations:

7.10.4 Recommendation
Where a person has undergone risk assessment in an ED and is not to be admitted to any facility but referred to a CMHS (community mental health service), the person and their carer are to be provided with written advice as to their relevant CMHS and contact numbers and their proposed management plan and relevant time frames.

7.10.5 Recommendation

The contact numbers should include 24-hour service emergency numbers and people should be advised these can be accessed by anybody at any time and trained workers, who have the ability to call out emergency teams if necessary, will respond. These should be a reality.

7.10.6 Recommendation

Ultimately all community health services should be funded to respond holistically to crises. Families, as well as patients, need support, especially on discharge of a patient back into their care. Carers need to know the people involved with the care of their patient.

7.10.7 Recommendation

No person should leave an ED without being provided with written advice as to who to contact in case of a crisis

7.11 Office of the Chief Psychiatrist Recommendations:

7.11.2 Recommendation: Risk management

b. The MHS ensures that, where indicated, patients have a current risk management plan, separate from the Individual Management Plan (IMP).

c. Risk management plans are updated or revised with any new information relevant to that individual patient.

7.11.4 Recommendation: Discharge planning processes

b. The MHS provides patients, their carers and other service providers involved in follow-up with information on the process for facilitating re-entry to the MHS if required and other resources such as crisis supports are provided (NSMHS 10.6.5).
Below are descriptions from the body of the Stokes Report describing the fragmentation of services and people’s experiences which would be helped if a CAP model were adopted across government and non-government services.

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

The CRAM Policy requires clinicians to assess patients for risk on admission routinely, when their condition changes and before discharge. Informed by this assessment, clinicians develop an individual risk management plan in collaboration with the patient (and family, where legal and where patient wishes allow). The policy is underpinned by standard 10.4.5 of the National Standards for Mental Health Services, which also requires that treatment be reviewed in relation to assessment outcomes.(p34)

3.1 Risk screening assessment and management

In a sense, mental health workers are perpetually working with people at risk and ‘continuously walking a tightrope’ with all patients (Mental Health Clinician).

Mental health care has been increasingly required to respond to a need to appropriately assess and manage risk. The risks may be to the individual, to carers and families, to staff in mental health services and to the community. The primary reason an individual is admitted to hospital in western society is because they are at risk of self-harm or harm to others; and the Mental Health Act 1996 cites risk of harm to self or others as essential precursors to involuntary status. Risk assessments and individual management plans minimise risks to patients, other persons and mental health services (personal communication, Dr S Towler, Department of Health 2012).(p37)

This Review supports the requirement of risk assessments for all patients who present for mental health care and, where indicated, a comprehensive assessment to quantify the level of risk and inform the individual risk management plan. Mental health practitioners in training should be supervised in their practice of risk and comprehensive assessment, to ensure practice wisdom is incorporated into assessment and treatment plans. It is imperative to strengthen the clinical governance of mental health services to avoid disparate practice and to guide the clinical discourse to improve risk management across the State. This will enhance mandatory compliance with policy and provide the forums for discussions that can lead to clearly articulated frameworks for practice change. (p38)
It is imperative to strengthen the clinical governance of mental health services to avoid disparate practice and to guide the clinical discourse to improve risk management across the State. This will enhance mandatory compliance with policy and provide the forums for discussions that can lead to clearly articulated frameworks for practice change.

3.3 Patients’ experiences

The Review heard patients’ descriptions of experiencing inconsistent responses of mental health services to their presentation, with assistance not available until they were at their most vulnerable and in crisis. For others, the difficulties of accessing services, long waits for assessment, little information about their psychiatric treatment or physical health, and scant rehabilitative services raises important questions that must be addressed by the mental health system.

In each of these situations, parents expressed concern that the difficulty in accessing timely services was a major flaw in the system that contributed to the patients’ suicides. Delays receiving assistance culminated in some patients’ behaviour escalating and WA Police intervening to de-escalate the situation and, in some cases, transport the patient to a mental health facility or ED for assessment. One mother described her son sitting on the bonnet of a police vehicle in the rain for an hour while he waited for a mental health service to assess him. (p47)

Admission to inpatient units

Acknowledging that each patient’s circumstance is unique, a common thread of feeling alone through an admission episode may be an important catalyst in considering patient advocacy and patient navigation from the point of admission. Every patient needs access to individual advocacy services to assist with navigation through the system and with the development of a care plan.(p 49)

Inconsistency in staff interaction with patients was described to the Review. For example, during one admission to hospital, nurses rarely interacted with one youth. However, during an admission to another hospital, the nurses were supportive of the same patient. Another patient found staff to be unsympathetic. There was also inconsistency in involving the patient’s family in care. A patient and carer wrote to the Review with concern that family and carers were not involved in her admission or plans for discharge.

Emphasised by a number of patients was that that admission to the mental health system can occur very abruptly, causing considerable disruption and distress that is exacerbated by not being able to sort out domestic issues. In the crisis of admission, patients are often incapacitated or do not have the opportunity to prepare for a hospital admission. They often cannot carry out their responsibilities for childcare, pet care, payment for
accommodation (rent or mortgage) and other bills and securing their employment and lifestyle (personal communication Dr S Patchett; and S. Boulter Mental Health Law Centre, 2012).

Where no family members are available or aware of admission, fulfilment of these day-today responsibilities of living does not occur, causing untold stress. There are occasions when the outcome includes recovered patients not having a home to return to when they are ready for discharge, or with home circumstances in considerable disarray.

Follow-up

Patients are often left to self-direct their care, and it would better to have a care coordinator with whom to discuss feelings and get assistance to navigate the system. Patients and families’ perception that the system is complex is supported by the Review’s observation that the system is complex and difficult to navigate. The patients consistently refer to a need for someone who could assist them to find their way or to navigate the system. This further emphasises the need for effective case management that extends through patients’ transition from inpatient care and beyond into the community.

3.4 Carers and family experiences

The Review heard clearly that there are areas of service where carers and families believe that considerable improvements need to be made. For some, an unhesitating opinion was that the system, by virtue of not providing adequate timely and preventive care, was a major contributing factor to the patient’s suicide.

The prominent theme for carers and families was a concern for the safety and wellbeing of the patient and a persistent sense of powerlessness within the system. They expressed a need for information about admissions, treatment, referrals and discharge/transfer plans.

Access

Carers and family members describe a system that will often respond only when dramatic circumstances prevail, and that the response is often not consistent with what they would have expected.

The patient and others can be endangered while waiting for emergency intervention. There are times when a patient’s deterioration places not only the patient at risk of harm but also carers, family and others.
One mother explained to the Review that the Mental Health Emergency Response Line (MHERL) does not always respond in the way that she expected. She said they seem to listen to her but did not offer to assess her son or advise her about what to do.

Carers reported it was difficult to access mental health community services after hours and on weekends and even when community emergency response teams (CERTs) are available they do not always come, or cannot come soon enough. In these circumstances, patients and carers rely on the EDs of hospitals to gain access to mental health services and this is a very serious deficiency.

A mother expressed dismay at the delay in CERT’s arrival time after she had made an urgent request. The CERT visited the son’s home 48 hours after she had them called and they contacted her to tell her the patient was not at home when they arrived. She expressed surprise that the team said they would not make any further attempts to locate her son despite her description of the urgency. In fact, her son had presented himself to a mental health hospital and had been admitted as an involuntary patient.

The lack of assertive follow-up to an emergency call combined with the lack of communication from inpatient services to inform the CERT of the patient’s whereabouts demonstrate system fragmentation. In an illustrative case, the florid symptoms of a patient prevented him from being able to engage with reception staff at an ED. The result was that he could not provide details that would enable access to ED services. His father offered the required information but the administrative staff member insisted the patient must provide the information himself. The father’s action, born out of his serious concern for his son’s welfare, was to remain in the ED with his son. It was only when his son’s behaviour attracted the attention of the security guard that he was brought into the treatment area in restraints.

A Council of Official Visitors’ representative from Kalgoorlie described two recent occasions where patients who had sought assistance did not receive care until they had broken the law and were taken by police to the ED. The inability of mental health services to provide care when it was needed and sought led to untreated conditions with escalating symptoms.

A lack of after-hours mental health services in an ED seemed to contribute to a young mother’s increasing distress at the lack of response to her presentation and request for help. It was not until she took particularly dramatic action placing her child at risk of harm on her third presentation that she received assessment.

A proprietor of a psychiatric hostel said difficulty in obtaining timely mental health care for a resident with deteriorating mental illness is a major concern. The patient required hospitalisation and was told to wait in the community until a bed became available. The resident’s behaviour escalated out of control and led to harm to another person. The patient was arrested and ordered by the magistrate to be assessed at the Frankland Centre. An earlier response from the system could have avoided this, such as community visits and treatment commencement by a community mental health service.
The Review notes that amid the array of expressed concerns by carers they have also pointed out attempts to improve communication and involvement. For example, after experiencing confused communications resulting from a patient not listing very involved and supportive carers as his contacts, the carer became involved in a Patient and Carer Committee.(p55)

3.5 Clinicians

The RFDS expressed a number of concerns to the Review, including that:

- Mental health issues appear to be increasing in our community. It is an observation of RFDS personnel that substance abuse is exacerbating the behaviour of many patients and resulting in increased levels of violence.
- It can be difficult to obtain police escorts from country centres.
- Patients are transported a long way from their social networks.
- There is a ‘revolving’ door scenario in many cases, with patients receiving a brief period of treatment in the metropolitan hospital and are then discharged home to rural areas, only to present again a short time later.
- There should be opportunities for commencing antipsychotic medication earlier with supportive expert psychiatric advice. Tele-psychiatry may have a role.

Increasing the capacity of rural hospitals could avoid some of the air travel.

3.8.2 Aboriginal people and mental illness

When Aboriginal people experience mental illness, their symptoms are expressed within their cultural milieu and many prefer treatment within a family and community. In this cultural context, Western medicine continues to dominate and Aboriginal people do not have a place to receive cultural healing. This Review gave attention to the stories and views of contributors in this often-complex area for mental health service provision.

Improving the care of Aboriginal people with mental illness will require development of specific care models that integrate family and trusted members of the community to accompany and vouch for the persons with mental illness throughout their psychiatric/specialist treatment. The effectiveness of care models should depend upon a workforce of Aboriginal persons trained as psychologists, psychiatrists and mental health nurses, so that cultural methods of care can be applied alongside conventional psychiatry.
Moreover, the written communication style of mainstream services, such as referral letters and discharge plans, in addition to phone calls, do not suit the culture of communities who rarely answer telephones or letters and who are itinerant.

3.8.3 People from culturally and linguistically diverse backgrounds (CALD) and mental illness

The advocacy service advised the Review that CALD patients require assistance to navigate the complexities of the mental health system and to understand care and follow up treatment. Ethnically sensitive interpreters with expertise in mental health issues are frequently used within mental health care services.

3.10 Governance – corporate and operational

The Review concludes that the governance of public mental health provision is fragmented, variable in type and method of service delivery, and there is no robust uniform clinical accountability across the system.

Many mental health facilities act like silos and the relationships with each other are fragmented so that patients moving from one facility to another are frequently subjected to repeated history-taking and triage.

3.10.2 State bed management policy

Implementation of the bed management system was described as fracturing of previously established systems and communication between rural community mental health services, the communities and metropolitan hospitals.

3.10.3 Standardisation of admission, referral, discharge and transfer processes and documents

The Minister for Mental Health and the Mental Health Commission support the concept of standardised documentation.

Clinicians informed this Review that the standardised documents have resulted in a common language within and between services and this has been helpful in communicating between the various disciplines that participate in care provision.
The Chief Psychiatrist supports the standardisation of documentation and informed the Review that these will ease orientation within the highly mobile WA workforce and promote high-quality patient information within medical records.

3.10.5 Clinical models of care

There are few standardised protocols for the treatment of mental illness in WA........ . In effect, there is variation in treatment types, lengths of hospital stay, place of care and support services offered for patients with similar conditions. For example, a youth moving from the north to the south of Perth or vice versa would be offered a different model of care at each site.

Clinicians informed the Review that opinions vary about the merit of hospitalisation for specific mental illness conditions. The development of standardised treatment protocols guided by best practice would assist mental health services to plan patient care and service demand, and explain variances in relation to individual patient responses. The development of the protocols would also provide opportunities for clinicians to discuss and align their clinical practice.

3.10.6 Electronic information system: PSOLIS

Clinicians value the PSOLIS system, and services rely on it to measure activity and access important risk and discharge information. Psychiatric liaison teams use PSOLIS to record service events, referrals and brief histories and to link discharge summaries (attached as PDF documents). This information is crucial to safe and effective continuity in health care. Electronic access to this information is especially useful with a patient cohort that sometimes moves frequently across the system and for information access across mental health inpatient and community settings.(p103)

As a minimum, the risk management plan and discharge summary were highly valued. However, clinicians said there was sometimes a delay of 28 days before patient information was available in PSOLIS.

Risk management plans are not always present and even though PSOLIS has the facility to link discharge summaries these are not always uploaded. PSOLIS links with hospital electronic discharge systems—for example, TEDS (treatment episode data sets) and CGMS (clinical governance management system)—need to be enabled so that completed discharge summaries can be uploaded.

3.12.1 Community emergency response team

Increasing demand for urgent assessment and management of mental illness in the community has necessitated expansion of emergency response services. Hours of availability have
increased in the North Metropolitan and South Metropolitan mental health areas (Western Australian Auditor General 2009; Smith, Williams & Lefay 2011a).

CERT clinicians explained to the Review that on receiving referrals from MHERL, their response is to re-triage the incident. This includes obtaining collateral information from PSOLIS (previous risk screen, risk management plans and the names of practitioners involved in care); contacting the original caller; and reassessing the urgency and need for attendance. CERT clinicians informed the Review they needed to ensure the situation was safe to attend; for example, to know of the presence of dogs on the property. However, this activity duplicates assessments, delays attendance and often confuses the patient and carer with conflicting dispositions (courses of action).

The Reviewer is concerned that in crises, mental health services perform multiple triage/assessment processes and do not immediately assure the patient/carer that assistance will be provided promptly. It is also confusing to anyone navigating the mental health system, let alone those in crises, that each of these services have varying names, such as CATT (Crisis Assessment and Treatment Team), ACIT (Acute Community Intervention Team) and CERT. Uniformity should be established.

3.12.2 Presentation with mental illness at emergency departments

While every effort is being made to improve the system, it is apparent that more people with mental illness are directed to EDs to access mental health services and there is inconsistency in the response to mental illness in each ED across WA.

3.12.2.1 Comorbid conditions in the ED

The pressure to move people through ED is not conducive to good mental health assessments. Clinicians explained that it can take days to assess and admit a patient to a mental health bed. Some patients need to sober up or detoxify from illicit drugs; others require urgent treatment for overdose or other self-harm injuries. There is a need to alleviate patient stressors to enable a comprehensive assessment and provisional diagnosis to be made and for a treatment plan to be developed.

Of concern, however, are the situations where patients admitted with a physical illness, either medical or surgical, also have a concomitant mental illness. These patients may quickly destabilise during their generalist treatment and this may fail to be recognised, with severe consequences.

3.12.5.1 Involving patients in admission processes
Nurturing self-governance is an important therapeutic factor in the restoration of a sense of self, including self-preservation and a sense of wellbeing (Holstein 1998). As medication and treatment take effect, the ability for self-governance re-emerges. It is expected the patients will be politely and respectfully engaged in their care and treatment plan (to the extent of their ability) as an essential aspect of care. (p143)

3.12.5.7 Discharge from hospital and community mental health care

This Review also found fragmentation between mental health services. The fragmentation frustrates ED and hospital staff who are not confident that patients will receive continuity of care and treatment after hospitalisation. More importantly, patients and families are uncertain if treatment will continue to be provided as they are moved across care settings.

Community mental health services function optimally when they are integrated with mental health inpatient services. In the opinion of the Reviewer, they need to be better integrated with inpatient services as well as preventive and recovery programs provided by non-government organisations.

Communication between community service providers

Improved communication systems to better coordinate patient care within and across the mental health system need to be formalised.
My Crisis Awareness Plan and consumer pamphlet

The following pages include PDF attachments of the reviewed template. The new template format takes into account as much feedback from the evaluation as was possible. Some services may continue to use their own consumer wellness or WRAP documents but for services that have no standard template it is recommended that these forms are used.

The consumer pamphlet is preferred by many consumers but is not designed to replace the CAP done with a case manager or consumer consultant. It is hoped that it, however, prompts consumers to reflect on their own stories and their own wishes in preparation for conversations with their workers and families. Overwhelmingly consumers preferred simply formatted plans, whether they were typed or handwritten.

These plans may not meet the needs of after hours treatment services so in the short term there is still a need to put CAPs on PSOLIS. Services may wish to continue to work with PSOLIS custodians around the issue of whether plans can be attached as PDF documents. There may well be developments in terms of technology and documentation standardisation, in the near future, that supersede these forms. Printable copies are embedded in this document if you receive it in electronic format.

hdwa.health.wa.gov.au\users\Home17\he75081\2012 project\Template\My CAP Feb 2013 version 6.doc
hdwa.health.wa.gov.au\users\Home17\he75081\2012 project\Pamphlet\Pamphlet Feb 18.doc

My CAP template  Consumer pamphlet
# My Crisis Awareness Plan:

<table>
<thead>
<tr>
<th>My Name and Address or UMRN</th>
<th>My Workers names, addresses and phone numbers, delegations and signatures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date completed:</td>
</tr>
<tr>
<td></td>
<td>Date to be reviewed:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fields</th>
<th>My description and wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brief History</td>
<td></td>
</tr>
<tr>
<td><strong>The things workers need to know about me in helping manage a crisis are...</strong></td>
<td></td>
</tr>
<tr>
<td>2. Stable presentation</td>
<td></td>
</tr>
<tr>
<td><strong>When I’m well I notice...</strong></td>
<td></td>
</tr>
<tr>
<td>3. Trigger/ Symptoms &amp; Early Warning Signs</td>
<td></td>
</tr>
<tr>
<td><strong>The things I notice when becoming unwell are...</strong></td>
<td></td>
</tr>
<tr>
<td>4. Self Nurture</td>
<td></td>
</tr>
<tr>
<td><strong>What I can do to help myself is...</strong></td>
<td></td>
</tr>
</tbody>
</table>

NMHS AMH CAP Feb 2013 Version 6
<table>
<thead>
<tr>
<th>5. Supports and Contact details</th>
<th>Name:</th>
<th>Address:</th>
<th>Ph numbers:</th>
<th>Reason for contact:</th>
<th>Agreed/Not:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The contact details of people who can help me when things aren't going well and how they can help are...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. De-escalation and Intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What others can do to help me is...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Managing safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In managing a crisis, my wishes in regard to community and/hospital treatment are...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Unhelpful approaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Things that others do or say that can make things worse are...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Other comments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My current medications, dosage and times are...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Useful contact numbers</td>
<td>Mental Health Emergency Response Line (MHERL) 1300555788</td>
<td>RuralLink (rural resident) 18005520002</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner/Spouse</td>
<td>Name and phone number for partner/spouse to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mum/Dad</td>
<td>Name and phone number for Mum/Dad to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister/Brother</td>
<td>Name and phone number for sister/brother to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child/Children</td>
<td>Name and phone number for child/children to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boss/Workmate</td>
<td>Name and phone number for boss/workmate to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td>Name and phone number for friends to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Manager</td>
<td>Name and phone number for case manager to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Worker</td>
<td>Name and phone number for support worker to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td>Name and phone number for general practitioner to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist/Clinic Doctor</td>
<td>Name and phone number for psychiatrist or clinic doctor to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostel/Housing Worker</td>
<td>Name and phone number for hostel/housing worker to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church Minister</td>
<td>Name and phone number for church minister to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Support Worker</td>
<td>Name and phone number for peer support worker to be contacted during crisis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In mental health, the people who help manage a crisis are not always those who know you well. If I have a crisis, other people need to know...

---

**Crisis Awareness Planning**

Preparing ahead

Give your ideas to your worker or take them to your next appointment.

---

**My Crisis Awareness Plan**

Name: ____________________

Signature: ____________________

Worker Name: ____________________

Workers Signature: ____________________

Todays Date: ____________________

People to have a copy of this plan:

- ____________________
- ____________________
- ____________________

Date to check this is up to date: ____________________

Mental health telephone services which can help you in a crisis:

- MHERL (Mental Health Emergency Response Line): 1300 555 788 or 1800 676 822 for Peel Residents
- RuralLink (rural residents): 1800 552 002

Produced Feb 2013. For review Feb 2014 or prior. Review via NMHS AMH CAP Project or SQRM.
When I'm well I notice...
Get out of bed, shower daily, follow sports, pay bills, watch TV, enjoy time with family, go to work/group/study, mix with friends.

Signs of me becoming unwell (that I notice and that other important people have told me are):
Stay in my room, snap at people, wear headphones/dark glasses, my voice gets louder, buy unneeded things, don't shower, think people are against me, feel scared, close curtains and doors, feel very energetic, don't do housework, stop doing things, can't sort out problems, sleep poorly or not at all, worry all the time.

My personal early warning signs are:

If I ever require inpatient care/treatment my wishes in regard to this are:
- Go to a certain unit
- Go voluntarily
- Get to go home to get my clothes, money and toiletries
- Get taken by my family
- Get taken by my worker
- *(Talk to your worker about why you want to go to a certain unit, bed availability, the MH Act and how you can work together)*

The things that other people can do that make me feel safe include:
- Helping me make my house secure
- Offer medication
- Be understanding
- Give me emergency number
- Listen to my fears & help me check them out

Things that people do and say which make things worse for me when I'm in crisis are:
- Say my fears aren't real
- Touch me
- Keep me waiting
- Talk loud
- Rush me
- Don't tell what's going on
- Stand too close
- *(Talk to your worker about your fears and past experiences, the MH Act and how you can work together)*

My current medications are:

When I have relapsed in the past, as required medication, was used. This was:

Doctors name and signature:

Date:
This document can be made available in alternative formats on request for a person with a disability.