3.10 Governance – corporate and operational

In each health area, the operational offices of mental health care have adopted a different model for the provision of mental health services. The North Metropolitan model is based on a program structure of adult and older adult psychiatric care and incorporates some statewide services. The South Metropolitan model is a district model. The WA Country Area Health Service (WACHS) operates on a regional model and the Child and Adolescent Health Service (CAHS) operates on an integrated model.

During a recent review of Department of Health committees where members are paid to attend the meetings, it was noted a large number of managerial and community advisory committees. For example, it noted a project working group; a clinical governance committee; a community advisory group; and a steering committee for mental health services, all of which had significant numbers of mental health staff as members.

All of these groups had more than 18 members, the majority of whom were staff. One project working group has been meeting for almost four years—a very long project. There seems to be a significant number of groups meeting to discuss a variety of mental health management issues and yet little is seen to have altered as a result.

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.

The Department of Health and the OCP provide clinical guidelines and directives to WA mental health services. Each mental health area has developed policies and procedures for the services within their area—for example, North Metropolitan's assertive patient flow, admission procedures and discharge policy. In addition, specialist mental health services have developed local policies and procedures within each service.

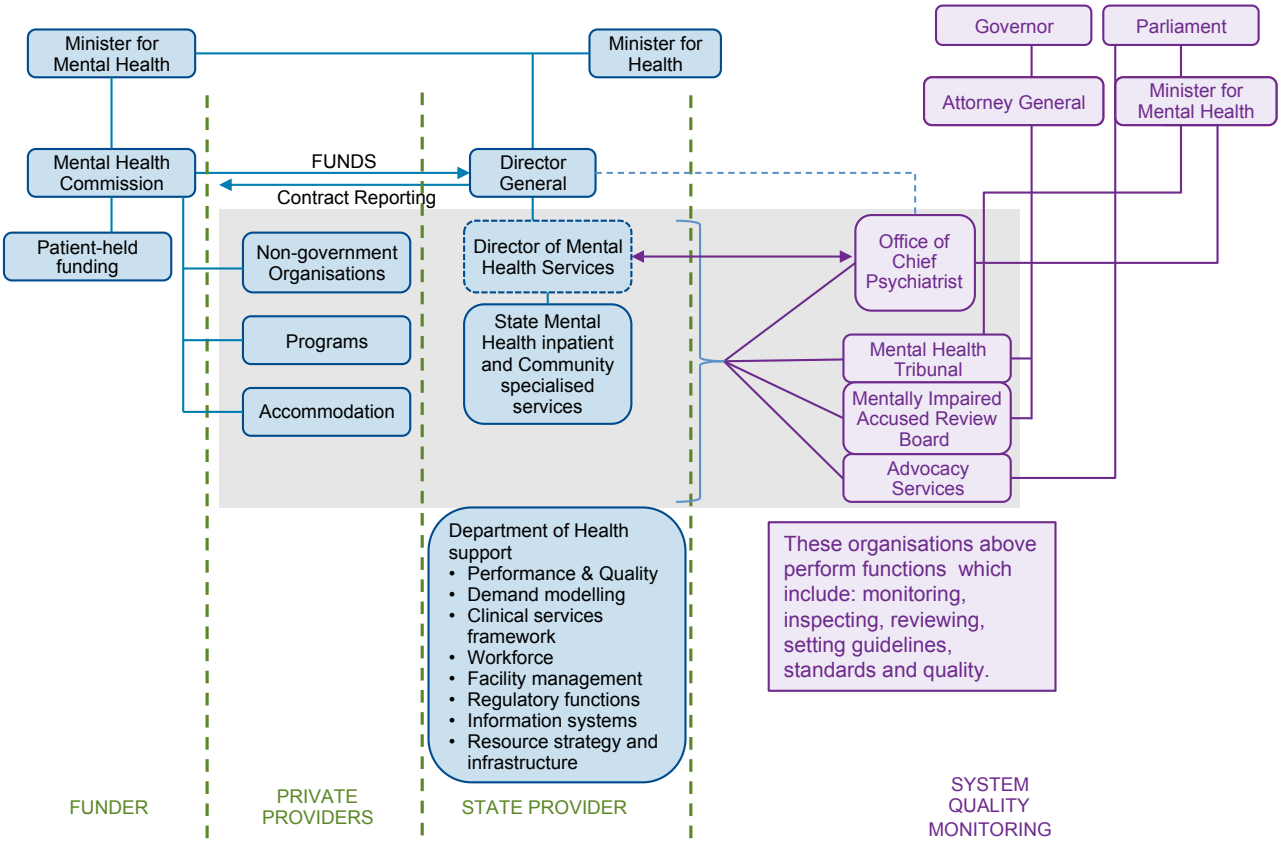
This results in the disparate application of protocols and policies. It appears essential that as the principal provider of public mental health care, the Department of Health has overall governance of policy-setting in the provision of care, both in the hospital setting and in the community clinic setting. There is no overall cohesive link between many of the acute inpatient facilities and the community mental health clinics, such that the clinics sometimes will not accept patients for ongoing care after discharge from the inpatient setting.

Across the system, governance is fragmented and overall leadership and the ability to make things happen is lacking. 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.

A single line of accountability is required for WA mental clinical service provision and this should be present within the Department of Health. The Department should take responsibility for clinical outcomes, policies and procedures, workforce planning and support, strategic management, quality improvement, and service development. The proposed unit should have the authority to hold services accountable for mental health care outcomes. It is recommended that a new directorate be established in the Department of Health with a Director reporting directly to the Director General of Health and the member of the State Executive Health Forum (SHEF).

The following diagram illustrates the role and reporting relationship of the Mental Health Operations Directorate in the Department of Health. The Mental Health Commission would work closely with the Directorate of Mental Health Services in formulating service agreements.

Figure 23 **Proposed governance structure pending passage of Mental Health Bill 2011**



See Recommendation 1: Governance (1.1; 1.7).

3.10.1 Mental health State funding

The State Government budget for mental health in 2011/12 is $528 million. Of this, $457 million (including $80 million to Joondalup) funds public health, and inpatient and community mental health services via service agreements.

The remaining funds are distributed to:

- corporate costs
- policy initiatives, for example, suicide prevention
- non-government organisations via service agreements.

In WA emergency departments, mental and general health are integrated. The mental health system does not purchase the services provided within EDs as occurs within the Queensland health system, where designated psychiatric emergency care centres form part of the mental health services. For mental health, casemix funding will commence in WA EDs in 2012–13 and episodes of community care will be activity-based funded (ABF).

Funding of inpatient services by the Department of Health is activity-based and clinical diagnosis of patients' mental illness are grouped within ICD-10 Diagnostic Related Groups (International Classification of Diseases, see Appendix 4).

Community mental health services are funded on a formula of historical escalation. The historically-based community funding model differentiates between cost variations such as larger populations, number of sites and geographical size.

The Mental Health Commission purchases mental health services based on the historical model. Historically, mental health services for inpatients have been identified as units, that is, wards in a hospital, and funded in accordance with the number of patients treated rather than by diagnostic group.

Community mental health services are funded by identifying past expenditure that is then escalated forward, rather than calculated by activity-based funding. Progressing to ABF funding is part of the national agenda and the data to enable this to occur is due in 2013.

Capital costs and the subset of mental health services provided in EDs are not recognised by the Mental Health Commission, and are funded by the Department of Health.

The budget is therefore based on two components with inpatient funding by episode and International Classification of Diseases (ICD). The historically-based community mental health budget has increases in revenue escalated in line with demand (such as escalating operating costs, activity costs and costs of workforce), in addition to the indexation rate.

The Department of Health would require the proposed Executive Director of Mental Health in the Department to work in a triumvirate fashion with the Director of the Performance Activity and Quality Division and the Mental Health Commission to ensure that funding is appropriate to develop safe and quality mental health care delivery.

See Recommendation 1: Governance (1.1.8).

3.10.2 State bed management policy

In 2011 the Department of Health bed management policy (Mental Health, DoH 2011b) was made operational in WA. Named the Assertive Patient Flow Bed Demand Management for Adult Services, these guidelines were developed in response to bed occupancy consistently exceeding 95 per cent and a need to reduce the waiting time of patients in EDs. The policy was cooperatively developed by the chief executives of the Area Health Services and was endorsed by the State Health Executive Forum (SHEF) in the Department of Health.

Bed utilisation is centrally coordinated by the Nurse Director, Mental Health Patient Flow Monday to Friday 8.30 am to 5.30 pm. After hours, the beds are coordinated by the Mental Health Bed Management Medical Director, a senior psychiatrist who is available to discuss needs once all other options have been explored.

The State Bed Manager coordinates bed movements with local hospital-designated bed managers in a daily teleconference. At this meeting, expected discharges and vacant beds (such as those where the patient is on leave) are flagged. The local bed managers are responsible for negotiating the expected date of discharge with their local treatment teams.

BEDVIEW is the centralised electronic system that provides the status of beds throughout the State. Joondalup Mental Health Service is not included and verbal contact is necessary to obtain bed status figures from Joondalup.

According to one group of clinicians, the State bed system works better than the previous system, providing the ‘power to perceive the entire State’s bed stock’ and less time is spent by individual clinicians attempting to locate a bed.

ED clinicians informed the Review that the assertive bed management policy, with the mental health services taking ownership of the problem, reduced the amount of communication required of ED staff to locate a vacant bed for a patient. Clinicians also said that the system has sadly not reduced the amount of time patients spend in the ED while waiting for a bed.

Some clinicians characterised the bed management system as one more pressure that adds to them feeling pushed to assess patients frequently for readiness for discharge and scrutinise referrals more closely in an effort to reduce the number of admissions.

Bed pressure has an impact when patients go on planned leave. The demand for beds will very often mean an admission of a new patient to the bed made vacant by leave. The effect can be a disruption to continuity of care for the returning patient who will be transferred to a different bed, often in a different location. At one facility, eight patients can return from leave on the same day and the change in bed allocation for the returning individuals is disruptive.

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. In the past, patients from the Pilbara were admitted at Graylands where their families could be accommodated onsite and clinicians had a good knowledge of the Pilbara.

With commencement of the bed management system, these patients are admitted to any available bed in the State. The outcome for patients and families may be significant given that the patient may be located away from their family and friends as well as their usual treating psychiatrist. Often confusion has occurred among family members who do not know where to look for their relative and they have difficulties finding conveniently located accommodation.

The response of some EDs to restricted bed access is to admit patients into the general wards rather than to await a specialist mental health bed (for one service, this is 50 per cent of inpatients with mental illness).

A pull system, with clinical pathways to guide length of stay and expected date of discharge identified on admission, would provide a more predictable patient flow within inpatient mental health and would ensure best practice principles underpin decisions about care.

Individual variation could then update information in the BEDVIEW system. Such a process would also decrease the labour-intensive bed management processes currently required by inpatient clinicians to meet the patient flow policy guidelines and could relieve psychiatrists from the regular meetings to discuss patients whose length of stay has exceeded 28 days.

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

A project control group (‘Statewide Standardised Clinical Documentation Mental Health’) is developing standardised documentation for implementation across mental health services in WA. The group is a working group of the Mental Health Operation Review Committee (MH ORC).

In 2010 the group trialled 30 evidenced-based standardised documents at five sites in WA. The evaluation of this trial found that clinicians agreed that standardised documentation is a valued and necessary component of best practice. The current strategy is informed by that evaluation and plans a graduated implementation of paper-based and electronic forms (Mental Health DoH 2011a).

Clinicians also informed this Review that there should be standardised processes for admission and discharge rather than each service’s ‘home-grown’ products. Clinicians told the Review that they need everyone to be using the same documentation across the State.

The first seven mandatory documents to be implemented are:

- Triage
- Assessment
- Risk Assessment
- Care/Management Plan
- Transfer/Discharge Summary
- Physical Appearance (Community) / Physical Examination (Inpatient)
- Consent Form.

The review was informed by the Director of Mental Health for WACHS that these documents, based on mental health clinical documentation (from NSW Health) were being finalised to ensure they meet WA guidelines, reflect best practice, suit specific age cohorts, that is, children, adults and older patients, and can be adopted into the PSOLIS. A rollout is anticipated later this year.

Once the core documents have been successfully embedded into practice, the process for improving the quality and consistency of medical records will be pursued to implement the remaining forms.

The Minister for Mental Health and the Mental Health Commission support the concept of standardised documentation. However, funding for implementation is required (Statewide Standardised Clinical Documentation briefing note for MH ORC 2011). The project group has requested a full-time project coordinator to manage the implementation as well as funds to develop an electronic entry point for PSOLIS and for printing the finalised documents.

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.

The Mental Health Operations Review Committee (MH ORC) does not possess the authority, capacity or resources to implement change.

This Review supports the development and implementation of standardised documentation in all mental health services and facilities in WA. The standardised documentation project can increase quality and safety of patient care by greater adherence to standards of care, improved intra- and interdisciplinary communication and therefore better informed clinical decisions (Keenan et al. 2008).

See Recommendation 1: Governance (1.1.3).

3.10.4 Co-occurring drug and alcohol abuse with mental illness and other dual diagnoses

Combined drug and alcohol and mental illness is complex and access to services is difficult for patients with both these condition (personal communication Mental Health Commissioner 2012).

In most WA hospitals, the psychiatry liaison team works closely with the dedicated positions of drug and alcohol (D & A) services to assess patients. D & A services are not just co-located but work closely with other health professionals to provide a seamless service. However, they are not available in all hospitals and there is variation in practice by some individuals and services, for example, there are no drug and alcohol services at Albany.

ED clinicians also informed the review that some hospitals do not have a drug and alcohol program and there are no other dedicated resources for patients with these conditions.

There are fewer problems in managing patients with dual diagnosis in Geraldton because the process of liaison between D & A and mental health services has improved. One staff mental health team member is also employed with Drug and Alcohol Office and the rehabilitation facility. With one mental health member specialising in D & A, knowledge-sharing within the team has improved knowledge and response capacity.

In the Midwest and in Port Hedland in the Pilbara, the drug and alcohol and mental health services also demonstrate collaboration. In addition, D & A clinicians attend patient review meetings with the mental health service. In the Midwest, mental health teams obtain immediate response to referral to a D & A team. The ongoing cross-referrals facilitate the cooperative relationship. The D & A services focus on counselling, and recovery models are yet to be developed in these areas.

To determine who ought to case-manage a patient with both mental health and D & A problems, the patient is assessed by the mental health and D & A clinicians together. The current or prominent illness is identified and a case manager assigned from either service based on the expression of the patient's symptoms. Training occurs to upskill mental health and D & A staff in each others' specialties.

D & A office build capacity within other services such as WA Police, Corrective Services, Child Protection and mental health services by providing formal and informal education in the course of their day-to-day work. Memorandums of Understanding (MOUs) between services clarify roles and processes.

Similar strategies are needed for patients with comorbid conditions such as head injury or intellectual disability where collaboration and boundary negotiations currently challenge services. For example, some behaviour associated with intellectual disability is outside of the remit of the mental health services.

The framework for managing dual diagnosis is embedded in the Mental Health Strategic Plan 2020 (Action 3 p. 36) and the State Dual Diagnosis Planning Group has developed a framework to identify entry points, needs and gaps, commencing June 2012.

Improved liaison between mental health and D & A services and worker willingness to cooperatively provide care and intervention for patients with dual conditions must be enabled and encouraged.

There are regions without drug and alcohol services, for example, in Kalgoorlie and the Wheatbelt where the service has been unable to recruit sufficient staff.

See Recommendation 1: Governance (1.5; 1.6); Recommendation 4: Clinicians and professional development (4.11); Recommendation 7: Acute issues and suicide prevention (7.7); and Recommendation 8: Children and youth; Recommendation (8.10.9).

3.10.5 Clinical models of care

There are few standardised protocols for the treatment of mental illness in WA, for example, Complex Attention and Hyperactivity Disorders Service (DoH 2009). Where clinical models are not adopted, treatment is guided by the expertise of the psychiatrist rather than agreed evidenced-based best-practice care models. 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. The clinical leadership of a Director of Mental Health Services could ensure WA participates in consultations such as the Clinical Practice Guidelines being developed by the National Health and Medical Research Council for the Management of Borderline Personality Disorders and to ensure finalised guidelines are implemented across the State's mental health services (see http://www.nhmrc.gov.au/nics/nics-programs/clinical-practice-guideline-management-borderline-personality-disorder).

See Recommendation 1: Governance (1.4).

3.10.6 Electronic information system: PSOLIS

Mental health services record vital patient information in an electronic information system named PSOLIS (Psychiatric Services Online Information System). PSOLIS was developed as a component of WA's response to the Second National Mental Health Plan (2004) agreed to by the Australian Health Ministers Conference. That plan introduced a nationwide requirement for collecting, recording and reporting of National Outcomes and Casemix Collection (NOCC) data. The WA Department of Health formulated a development plan known as the Mental Health Information Development Plan which had three key components: (1) PSOLIS, which evolved out of an already existing information system (LAMHIS); (2) training of all mental health clinicians in NOCC; and (3) business process re-engineering to meet the requirements of the new system and new data collection.

A PSOLIS support team based at Health Information Network undertakes ongoing business support, program development and functional upgrades with a recurrent budget of about $1.5 million. It is a Class 1 enterprise application with 24/7 support. PSOLIS is supported by five FTE Java developers and a four-FTE business support team (pers. comm. 2012). The Mental Health Operations Review Committee (MH ORC) provides program leadership and the Executive Director of Performance Activity and Quality Division is the executive custodian of PSOLIS data.

The South Metropolitan Area Health Service (SMAHS) developed a parallel quality and safety management information system to PSOLIS called LASSO. LASSO assists with the recording and reporting of activity related to quality, safety and clinical governance. This latter system appears to have been developed without the imprimatur of the MH ORC. The Reviewer is of the view that two systems are unnecessary and all required functionality can be achieved in the one system, which currently is PSOLIS.

Clinicians and administrators have tiered access to PSOLIS. The first tier gives all clinicians throughout mental health services access to global information on a 'read only' basis via their HE (health employee) number. This includes basic demographics, history of contact and alerts. Clinicians on the next tier access detailed information within their stream and 'write' information at levels that vary widely throughout mental health. Some administrators at executive level and clinicians across metro-wide services, for example, the Mental Health Emergency Response Line (MHERL), are authorised to access all information.

PSOLIS has the engineered capacity to meet mental health services requirement for a fully functional information system that would include:

- an electronic information records system with standardised documentation for history, mental state examination, physical examination, and risk assessment/management and risk alerts.
- care planning, referrals to other providers, discharge planning and electronic discharge summary.
- incident reporting and AIMS software reporting to meet critical incident reporting requirements to groups such as , for example, the Office of the Chief Psychiatrist and the National Minimum Data Set (NMDS).
- data collection/reporting to populate the mental health information system that informs the NMDS, NOCC and the Australian Mental Health Outcomes and Classification Network (AHOCN).
- functional capability to interface with planned information system developments such as an information system for non-government organisations.
- an electronic prescribing system and access to laboratory results.
- tiered access to specific information by specific services, for example, full access for frontline workers in community emergency response teams or Court diversion; limited access to care and discharge plans by non-government organisations or hostel staff.

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.

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.

Currently, more than 120 requests for program repairs and enhancements are outstanding. A number of other concerns were raised to the Review. The issues of concern include:

- the information system lacks governance and requests for improvement have no authorising person to provide approval
- limitations to clinicians' level of access complicates access to patient information
- inconsistent or inadequate patient information is available within the system
- variation in the amount of training clinicians receive and the knowledge they have about the program's functions. The program does not link with other information such as laboratory test results
- the system needs to include mental health forms to assist standardisation
- PSOLIS needs to be more user-friendly with easier and more flexible data entry to decrease duplication by clinicians and standardise documentation.

The review was informed that governance of PSOLIS has floundered since the Mental Health Division was restructured in 2011. PSOLIS has not been allocated a sponsor and MH ORC has placed an embargo on all new developments.

The user interface of PSOLIS is considered by clinicians to be laborious, time-consuming, and not user-friendly. For example, consultant psychiatrists in one service spend up to three hours a week scanning documents into PSOLIS. One service suggested they need administrative support to undertake the upload of information into PSOLIS to improve the timeliness and quality of information.

Clinicians said that when information in PSOLIS is incomplete, the system becomes less useful in informing clinical care. Inconsistent or inadequate information is partly related to the limited information clinicians can enter in PSOLIS. Inconsistency is in part related to the available program choices. For instance, there are seven different risk screens in PSOLIS; the brief risk assessment (BRA) and psychological examination are most frequently used.

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.

In addition, data fields are character limited requiring clinicians to summarise patient information. Further, although referrals are visible, clinicians cannot access information about the referral outcome.

Triage teams informed the Review that patients' records are sometimes only activated in the PSOLIS system when the patient has had three occasions of service, and therefore there is an absence of information about patients' request for assistance. This can be problematic when patients approach more than one service in order to obtain services. While this has not been verified, it remains a concern.

Data entry is optional and varies between sites. The mode of data entry also varies. At most mental health services, the clinician performing clinical care enters data in the course of their work. Some services have clerks who enter patient information during multidisciplinary team meetings.

Access to PSOLIS is not provided to physicians in EDs nor to private psychiatric hospitals. In addition, GPs and general hospital clinicians cannot access PSOLIS information to enable continuity of care. Further, many allied health staff such as mental health occupational therapists and social workers do not access PSOLIS even though guidelines indicate they can and currently these clinicians record information into a different database. At a minimum, the inclusion of allied health information would improve the quality of discharge summaries and follow-up care.

The Child and Adolescent Mental Health Service (CAMHS) can only access the electronic information related to the patients in their local areas and not that of patients from other areas who are referred for service. Since the Bentley Adolescent Unit is unable to store documents in PSOLIS, little information is available for CAMHS.

All information in PSOLIS is not accessible between mental health services. For example, clinicians at one mental health service explained they were unable to view community mental health service data even though the CMHSs could see inpatient data. However, CMHS clinicians cannot view all data either. Broome staff can see that files exist for their patients in Kununurra; however, they are not able to access the files, including the crisis management plan.

A public mental health service in a private hospital recently obtained access to PSOLIS as 'read only'. However, they are unable to contribute data to the program. Since Joondalup cannot enter data into the PSOLIS program, Mirrabooka CMHS are unable to access the patient information they require to provide continuity of care after discharge of the patient.

In addition to the information in PSOLIS, mental health clinicians need emergency and general hospital admission data, such as test results and hospital care episodes. At the same time, staff in general hospitals require patients' mental health care information, particularly their risk management plan.

Training: Many clinicians said they require training in PSOLIS. While some staff use PSOLIS expertly, adding good management plans that are regularly updated, others have not received the same level of training. The Review was informed that country services are provided fewer training opportunities than metropolitan services and therefore not all staff can use the program.

The delivery of training for PSOLIS needs to be equitable and available throughout the State.

PSOLIS does not interface with prison information systems. This link would enable mainstream community mental health services and forensic mental health services to provide continuity of care for patients once they are released from prison (see Department of Corrective Services 3.11.3).

The Reviewer is of the opinion the mental health electronic information system requires governance. It is essential that the access levels to PSOLIS are reviewed to enable clinicians' access to required patient data and the opportunity to add information necessary to continuity of care.

Remote access to PSOLIS should be made possible so that clinicians in the community can access and enter information in a timely fashion.

Staff also need access to general hospital information systems to gain information about patient emergency presentations and hospital admissions.

The reporting capacity of PSOLIS should enable clinicians to obtain feedback, for example, NOCC reports.

Carers WA also recommend that PSOLIS be upgraded to provide a field to identify the carer and to enable staff to record carer-related clinical activity (Carers WA Submission 2012).

PSOLIS was originally governed by the Mental Health Division. The dissolution of the division led to a significant breakdown of governance of the strategic development of PSOLIS. Three options to improve the operational management and strategic development of PSOLIS were presented to the executive directors of MH ORC (Briefing Note MH ORC 2011). Of these, Option 2 is supported by this Review.

That is, to create a mental health information directorate within the Department of Health. This directorate should be responsible for developing a functional PSOLIS management and development framework.

See Recommendation 1: Governance (1.1.9); and Recommendation 4: Clinicians and professional development (4.4; 4.5).

3.10.7 Telephone assistance and emergency calls

The Mental Health Emergency Response Line (MHERL) and RuralLink (country MHERL) are telephone response lines staffed 24 hours a day, seven days a week in Perth.

The service has four numbers, including a 1800 number (where connection and duration of calls are charged to MHERL and free to the caller) and a 1300 number (where connection fees are charged to MHERL call charges are not free to caller). During office hours, the 1800 number diverts the caller to the local triage service, and MHERL provides support for the State after hours. Ideally, the service wants a completely free call service for the caller.

Patients and carers sometimes complain that they do not have enough credit on their mobile phones to enable them to contact the team. Although MHERL will accept reverse calls, the initial connection of the call requires the person to have credit on their phone. Currently, the legislated 000 emergency is the only number that can be called without phone credit. The service organisations contacted on 000 would transfer the caller to the MHERL line, based on their assessment of need or request. The 000 number is a legislated responsibility of Telstra (Telecommunications Emergency Call Service Determination 2009). Providing a free call that is accessible free of charge is a complex process that the team at MHERL are pursuing.

When first developed, this service was aligned with the psychiatric emergency team that provided face-to-face assessment and treatment for patients in urgent need. This emergency service has been decentralised to community emergency response teams (CERTs) operating in the north and south metropolitan areas. The Northern CERTs are at Osborne Park, Swan, Joondalup and Inner City; the Southern teams are at Rockingham and Fremantle. These teams are attached to the triage teams at the local community mental health services.

MHERL receives more than 4000 calls per month and makes 2500 outgoing calls for patient referrals. In total, there are 65,000 calls per year on 20 incoming lines.

Phone access provides triage and counselling for callers and refers urgent situations to CERTs.

Clinical nurses experienced in mental health operate the phones. Phone support includes information about health services (system navigation); advice on treatment, including medications; behavioural modification strategies; and referral to community mental health services. The service also provides clinical advice to doctors and psychiatrists

Clinical governance is provided by 0.3 FTE psychiatrists, including decision support, and education and advice to the triage staff as well as GPs and patients. Clinicians explained to this Review that they meet daily to discuss the outcome of calls and ensure follow-up is provided where necessary. Clinicians follow up referrals by contacting the services to ask if the client has attended and, if not, request the service to follow up with the client.

When MHERL refers an emergency to CERT, the referrals are triaged again and patients do not always receive the intervention planned by MHERL (see triage discussion 3.12.3).

The MHERL team do not have the mandate to ensure interventions occur as planned. MHERL clinicians would prefer that CERT respond to their assessment with minimum delay and to be able to reassure callers with certainty that assistance is on its way (see also Smith et al. 2011b).

The Review was informed that a separate phone line is currently being established for the Child and Adolescent Health Service (CAHS) supported by the acute community intervention team who can provide emergency assessment and intervention in the community.

In addition to MHERL and RuralLink, the public have access to *healthdirect Australia* telephone advice.

The *healthdirect Australia* service is staffed by generalist nurses who are trained to handle mental health calls using triage guidelines. They use a research-based computer triage protocol underpinned by Australian standards to assess the caller's need and then recommend a course of action (disposition). Disposition may include Activate 000; Attend ED immediately; See mental health provider immediately; See Doctor immediately, See Doctor within four, 24 or 72 hours; See Doctor within two weeks; or Self/home care advice (pers. comm. Dr G. Karabatsos, Medibank Health Solutions Telehealth 2012). The dispositions vary in accordance with the urgency of the need for face-to-face assessment.

Callers can be referred or transferred to the mental health services for triage and management, including the CERTs (personal communication Dr G. Karabatsos, Medibank Health Solutions Telehealth 2012).

When medical issues are concurrent, EDs are the preferred disposition, for example, when the patient has disorganised thoughts, possibly delirium and drug and alcohol intoxication.

The Reviewer is of the opinion that the State telephone lines of MHERL and RuralLink need to be governed by the Mental Health Governance Unit in the Department of Health.

Reconfigurations of reporting lines should ensure MHERL, RuralLink and community emergency services are clearly linked and that MHERL can mandate CERT to respond to calls.

MHERL may require an update in skills with respect to particular local conditions and safety concerns that the CERTs require being included in the assessment for community visits.

Promotional activities to increase the public awareness of MHERL, for example, print media on mental health should also be encouraged.

See Recommendation 1: Governance; Recommendation 2: Patients; Recommendation 3: Carers and families (3.5); Recommendation 7: Acute issues and suicide; and Recommendation 8: Children and youth (8.1).

3.10.8 Local management in mental health facilities

Many facilities act like silos and create barriers, resulting in fragmented service delivery across mental health.

Mental health services are optimal when practised and coordinated within a holistic service model comprising:

- emergency departments
- 24-hour telephone assistance
- community emergency response teams
- outpatient clinics
- inpatient mental health beds
- general hospitals accepting care of mentally ill patients
- community service practitioners linked to inpatient services
- rehabilitation and step-down beds and services
- supported living arrangements.

In facilities with the full suite of services, there appears to be greater continuity of care and a sense of responsibility for the patients along their entire treatment journey. It is in these settings that this Review observed innovative practice and more consistent admission, discharge, transfer and referral processes. An example is the Rockingham-Kwinana mental health service where there appeared to be a greater sense of cooperation between the staff and a natural involvement of patients and carers within acute care and rehabilitative programs.

Statewide, the division into health areas and then 'catchment' areas has effectively created a category of persons who are 'in' or 'out of' an area. Clinicians in one area are unable to assure 'out of area' persons that any planned care and treatment will be continued when they are referred to their local area mental health service. The notion of a 'catchment area' also affects the clinician's ability to take responsibility for the patient's continuity of care when they move or are transferred 'out of area'.

Clinicians at one inpatient facility described working as a team with the community mental health service operating nearby until the health area divisions occurred. However, since the division of health areas, each now has different line management. The inpatient and community mental health clinicians no longer communicate well and patients referred to either service cannot be assured they will receive services.

The current model of governance also affects the clinicians' ability to initiate improvement. For example, the district model (SMAHS) appears less responsive to program-specific issues such as the care of older adults.

The Review was informed that psychiatrists are often the clinical head within mental health inpatient services. However, there is no clinical governance for the psychiatrist and psychiatrists are not always represented on the medical advisory committees of hospitals.

When mental health services are colocated with general hospital services, the reporting model for clinicians is via their disciplines, that is, nurses report to the nursing department. There is no single point of accountability for teams; each discipline reports within their discipline lines. This creates difficulties when cross-disciplinary clinical supervision is necessary, and the inpatient unit manager has no authority over the staff. This model demands the team coordinator use their personal influence to obtain cooperation since

they have no authority over staff. This situation has been untenable for a number of coordinators and the Review was informed there is a high rate of staff turnover at the team leader level.

The dichotomy of clinical and line management affects clinicians employed in a mental health unit within general hospitals with respect to professional support and onsite quality management. For example, clinicians told the Review that the general hospital administration did not always support the training needs of mental health staff, such as suicide prevention training.

In some rural areas, mental health services were well integrated with the general hospital in relation to Quality and Safety Reviews and the general hospital assessed all the safety risks and adverse events in all inpatient areas, including mental health.

In some rural hospitals, psychiatrists do not have admitting rights into the specialty mental health unit unless the patient requires involuntary care; voluntary patients are admitted under the GP and the GP requests psychiatric consultation and community mental health services if required.

Continuity of patient care is currently achieved for the majority of patients across inpatient and community services at Rockingham, Fremantle and Bentley mental health services where the psychiatrists work across inpatient and outpatients. The mental health hospital clinicians provide outreach into the community services and the community mental health services reach in to provide input to care when patients are in hospital. The limitation to continuity is when inpatients are from other regions, as discussed above.

Clinicians in the Great Southern are hopeful that the development of the new hospital at Albany will provide an opportunity to redesign the management of general and mental health services. It is planned that the existing nine beds will expand to 16 (12 open and four secure).

Variations in models of service delivery are reflected in policy and procedures that influence practice and lead to differences in service responses. This is experienced by patients as very confusing.

See Recommendation 1: Governance (1.7).

3.10.9 Review of admission, discharge, transfer and referral within each service

The Office of the Chief Psychiatrist informed this Review that there has not been a statewide approach to the development of policies and procedures for admission, discharge, transfer and referrals beyond the general Department of Health's statewide admission and discharge policy. Clinicians informed the Review that there are some Area health guidelines and these are interpreted variously within services resulting in:

- historical variation between each health area according to their structure
- adjustments for the authorised/unauthorised streams of care
- adjustments for elder care
- adjustments for general health streams.

The historical approach reflects locally implemented policy variation aimed to 'best fit each program and mode of governance' and to reflect the history and culture of specific practice environments, that is, the local operation and specific service components of each service. For example, where Graylands has voluntary and involuntary patients, a 'walk-up' triage and no ED, their policies differ from those of a public hospital that is restricted to voluntary patients and ED entry (personal communication clinician 2012).

Clinicians informed the Review that the procedures that provide directives enabling policies to be translated into practice are developed within the silos of clinical disciplines.

This Review included an analysis of each mental health service's policies and procedures. The audit revealed that the documents varied considerably and did not include essential elements reflective of the State admission, discharge, transfer and referrals policy, and many did not reflect the national standards or the Clinical Risk Assessment and Management Policy (CRAM). It was also apparent that the documents had not undergone regular review and none had been updated since the introduction of the Admission, Readmission, Discharge and Transfer Policy for WA Health Services (ARDT) released in September 2011 (DoH 2011a).

This Review suggests local clinical policies and procedures should be updated and that the new Executive Director of Mental Health regularly monitors the policies and procedures of all mental health facilities and services to ensure they comply with state and national guidelines and best practice.

The ARDT policy should be consistent with the:

- *Carers Recognition Act 2004* [WA]
- National Standards for Mental Health Services 2010
- WA Department of Health Language Services Policy 2011
- WA Department of Health Clinical Handover Policy

(Carers WA 2012 submission).

In addition, a representative of Carers WA suggests that the term 'carer' be added to the glossary of the ARDT policy and be defined and used consistently with the Carers Recognition Act 2004.

See Recommendation 1: Governance (1.1.2; 1.1.3; 1.1.4).

3.10.10 Audit of admission, discharge, referral and transfer practices

A clinical record audit was undertaken as part of this Review into admission, discharge, referral and transfer practices of public mental health services in WA (see Appendix 5).

The purpose of the audit was to gain an understanding of what was documented in the clinical record in relation to specific aspects of patient care which were identified for review by the project team and which were determined to be important to the Review's overall objectives. It should be noted that:

- the audit does not measure compliance
- lack of evidence in documentation of aspects of care does not mean that the care did not take place.

A random sample of 500 (200 inpatient and 300 community mental health service) records was drawn from the total number of patient separations and occasions of service from selected inpatient units and mental health services across the Department of Health for the 2010/11 financial year. Sites were selected to represent tertiary, non-tertiary, adult, child and adolescent services but on a random basis.

This audit looked at the documentation in relation to specific patient admission, discharge, referral and transfer criteria. In relation to referrals, the majority of both inpatients and community mental health patients had evidence of written referrals into the service, with most inpatients being admitted within one day of referral. However, an area for improvement would appear to be in feedback to the referrer of an admission, which was evident in less than half of the records audited. Feedback to the referrer could form part of a robust electronic system.

In relation to assessments, admission psychiatric and clinical risk assessments, these were undertaken on the majority of patients with most completed within a day of admission. Inpatients had a higher rate of full assessment, as opposed to partial assessment, than did community mental health patients. In contrast, documented evidence for physical assessments occurred in half of the inpatients and none of the community mental health patients, with several records in the community group indicating that this was not applicable as the patient was under the care of a GP or specialist.

As for assessments, the large majority of records indicated that patients had evidence of a clinical risk plan and, while there was evidence that patients had contributed to the plan, evidence for carer input was less.

For both inpatient and community mental health patients, the majority received a full or partial risk assessment within a day of discharge. Again, physical assessments were not evident for the majority of patients.

See Recommendation 1: Governance; and Recommendation 2: Patients.

3.11 The judicial system and forensic mental health services

Forensic mental health care encompasses the humane and safe care of individuals who come in contact with the criminal justice system. It involves the assessment, care and rehabilitation of defendants who face charges in the courts; mentally ill offenders who are in prison or in the community; and individuals who have been found unfit to stand trial or who have been found not guilty by reason of unsoundness of mind in the District and Supreme Courts and placed on custody orders (*Criminal Law Mentally Impaired Accused Act 1996*).

Mentally ill individuals are over-represented in the criminal justice system at all levels. Of those who offend, court data cross-linked with the mental health database show that 85 per cent of court attendees have had contact at some previous stage with mental health services (Morgan et al. 2008). A UK survey of attendees at a Manchester Court showed about 5 per cent on any one day were psychotic and in urgent need of mental health care (Shaw et al. 1999).

Australian and New Zealand data clearly demonstrates the high incidence of serious mental illness in prison populations, running at around seven per cent for psychosis and 20 per cent for depressive disorders (NZ Prison Survey, Department of Corrections, Butler et al. 2005). Evidence also clearly shows that mentally ill people are consistently disadvantaged when they find themselves in the criminal justice system with higher arrest rates, higher conviction rates, higher incarceration rates and longer effective sentences because of reduced opportunities to access parole.

Furthermore, service provision to mentally ill defendants and offenders has lagged behind the provision of services to the general population and has led to the observation that mentally ill people who come in contact with the criminal justice system are among the most disadvantaged in our society.