

## Rockingham

The community mental health service team at Rockingham includes a brief intervention officer, who follows up patients who have presented to the ED and ensures they have attended their appointment with their GP. However, community mental health services are not always notified when patients are admitted or discharged from hospital; when they are aware, they see the patient within five to seven days. Lack of notification occurs most often when a patient's discharge date has been changed.

## Sir Charles Gairdner

The Mental Health in the Home program at Sir Charles Gairdner Hospital has four virtual beds, with 3.5 FTE providing care seven days a week. Patients in these programs receive care in their home to stabilise acute phases of their illness, include clinical psychology, and link patients to other services such as Centrelink. Clinicians explained the current demand indicates a need for eight beds. The service is limited to Osborne Park, Subiaco and Mirrabooka and operates between 8.30 am and 9 pm. After-hours care is therefore dependent upon emergency services.

Community mental health services must bypass their triage process when patients are transferred between mental health services and provide appointment times to the referring services and patient on request, especially for patients discharged.

Interim discharge summaries with treatment plans and medication regimes should be made available on PSOLIS and at the treatment clinics to which the patient is referred at the time of discharge.

The patient should be given a copy of the discharge summary when they are leaving the hospital (ARAFMI).

The Review heard from parents, forensic community mental health services, prisons, members of the Western Australian Mental Health Association and mental health clinicians that patients are sometimes discharged from facilities when they have no place of residence.

*See Recommendation: 1 Governance (1.2); Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.*

## 3.13 Community mental health services – adult

*Gaps in service availability and access mean that there are still too many people for whom the experience of care is not a good one, and who slip into crises before getting help (Auditor General's Report on Adult Community Mental Health Teams 2009).*

Since the 1970s, there has been a shift away from institutionalised care and mental health care is increasingly provided in the community (Doessel et al. 2005; Lawrence et al. 2001; Smith et al. 2011a). The first outpatient clinic in WA was opened in 1956. The vision for community mental health services is to extend the traditional stand-alone outpatient clinics to become integrated services delivering case-managed mental health treatment and tailored rehabilitation (Lawrence et al. 2001).

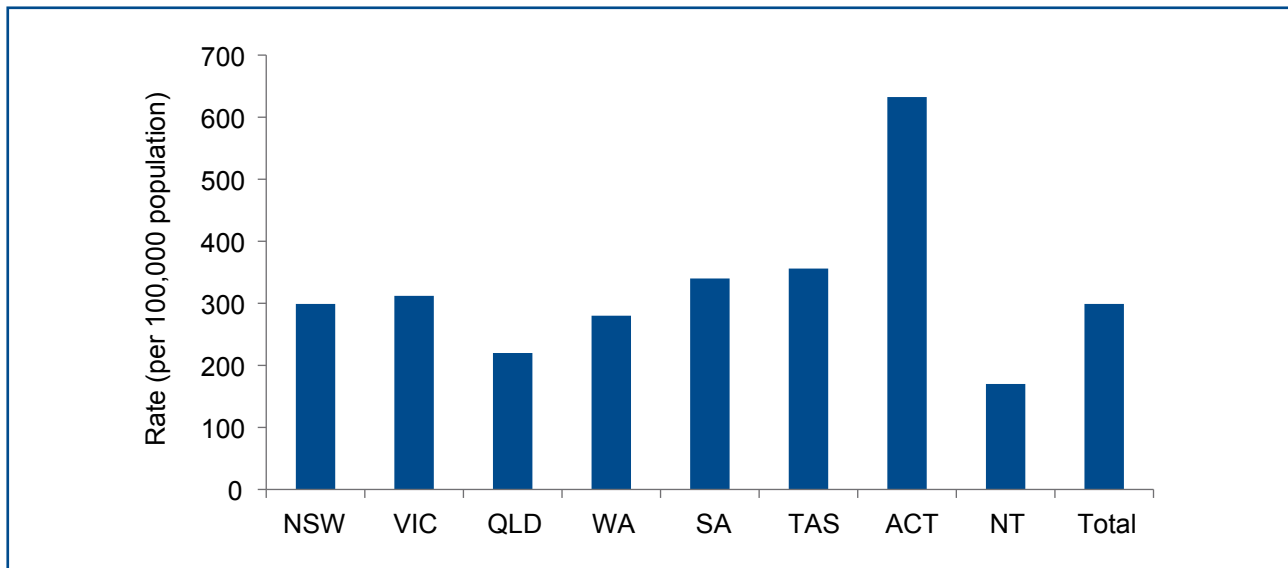
People with mental illness need assistance in the community to:

- continue treatment
- monitor side effects of treatment
- interact with family and friends
- look after themselves
- obtain and keep employment
- obtain and keep accommodation
- obtain specialist hospital care when their illness gets severe
- secure protection from homelessness and crime.

The challenge for community mental health services is to provide a coordinated approach with non-government organisations to enable optimal community service of treatment, rehabilitation and independent management.

In Australia, 336,000 persons received 6 million contacts in 2008–09, an average of 17.86 occasions of service per person (Australian Government 2011a). The mean number of service occasions in WA is 16.87 per community mental health patient (Australian Government 2011a; AIHW 2010 see Figure 37).

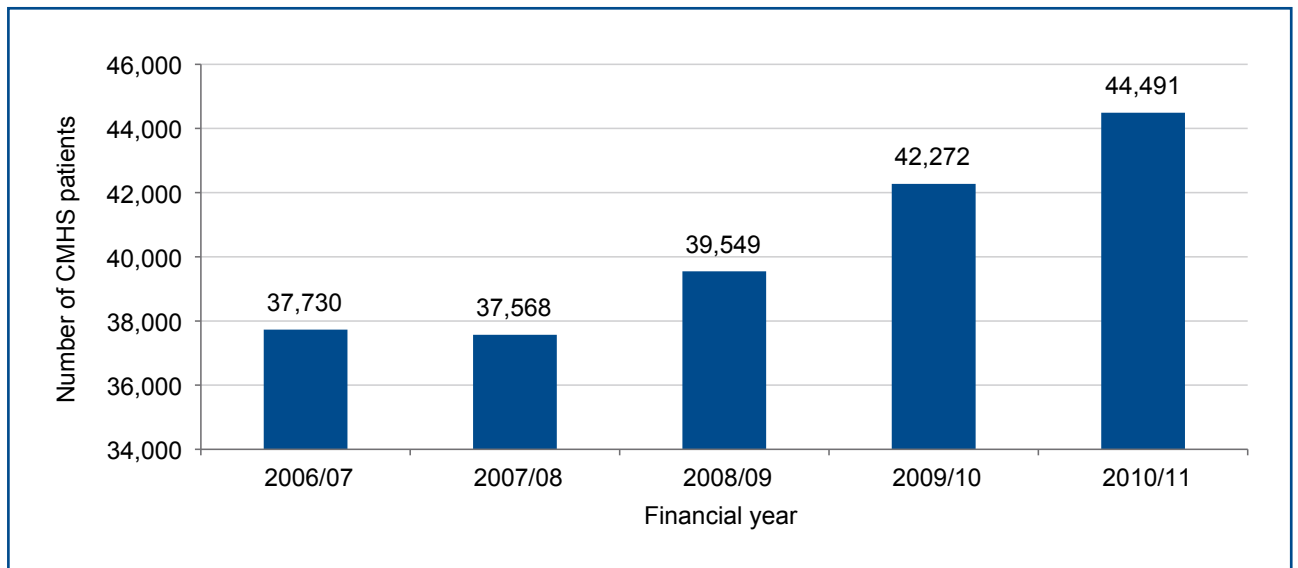
Figure 37 **Occasions of service per 100,000 in community mental health services, Australia, 2008/09**



Source: AIHW (2011).

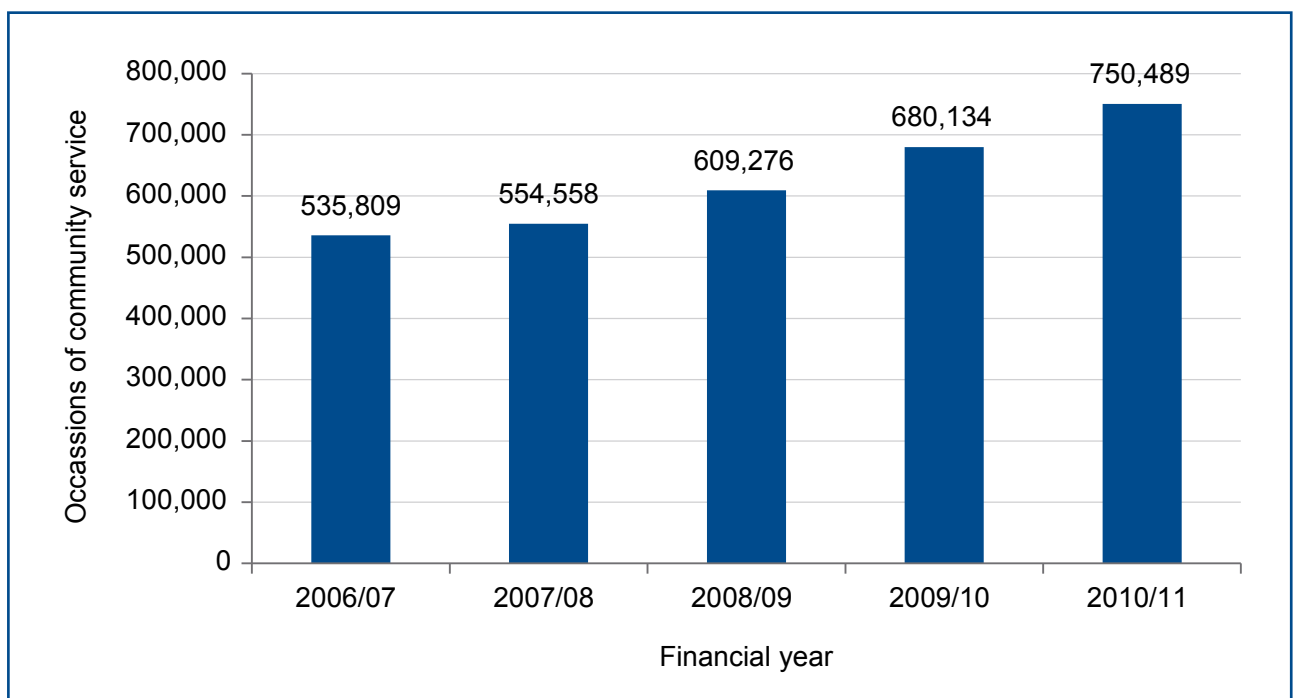
In WA, 44,491 patients received 750,489 contacts during 2012–11 (MHIS 2012; Figures 38 and 39). As one clinician told the Review, there are increasing rates of presentations to both inpatient and community health services. Community mental health service activity has increased substantially during the past five financial periods. There are now 17.91 per cent more patients receiving 40.06 per cent more occasions of services (see Figure 38).

Figure 38 Number of community mental health service patients WA, 2006–11



Source: MHIS DoH (2012).

Figure 39 Number of occasions of service in community mental health services WA, 2006–11

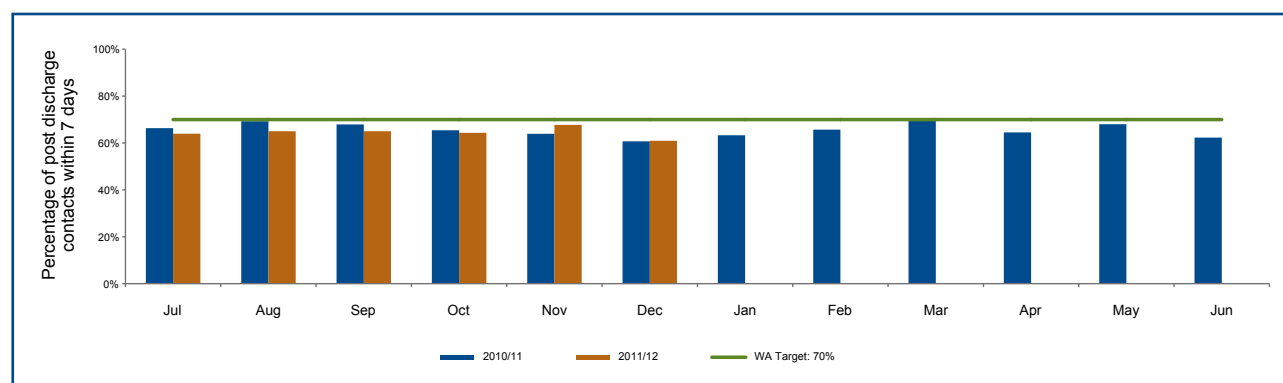


Source: MHIS DoH (2012).

### 3.13.1 Post-discharge follow-up

Patients can access community mental health services directly from the community and by referral after an episode of inpatient care. Post-hospital follow-up is an important national efficiency indicator measuring the continuity of care between hospital and community mental health services. The current target is for 70 per cent of patients to be followed up within seven days (Government Budget Statement 2011–12). Figure 40 illustrates Western Australia's performance against this target has not improved significantly.

**Figure 40 Post-discharge follow-up within 7 days by community mental health services, 2010–12**



Notes: Please note that data is preliminary and not fully complete due to coding delays. Historic data has been updated in the current report.

Data does not include patients referred to the private sector.

Source: MHIS DoH (2012).

In an effort to improve this aspect of the system, specialist mental health hospitals have employed discharge liaison officers and developed other outreach programs to achieve more timely and specialist follow-up.

Clinicians at one community mental health service explained that the duty officer at triage gives priority to post-hospital follow-up and assigns referrals directly to the psychiatric consultant. That health service achieves follow-up within five days for all post-hospital patients.

These efforts are set to improve the mental health system’s ability to meet nationally agreed targets, improve the system of care and improve the experiences and outcomes for patients.

*See Recommendation 1: Governance (1.2); Recommendation 4: Clinicians and professional development (4.7); and Recommendation 7: Acute issues and suicide prevention (7.5; 7.10.4; 7.11.4).*

### 3.13.2 CMHS clinics and home visits

Community mental health services are provided by outpatient clinics and home-visiting services. Patients are deemed eligible for service by the mental health triage process described in Section 3.12.4. To receive community mental health service, the patient must have a residential address and therefore accommodation is a primary concern at the time of hospital discharge. The CMHS teams comprise a multidisciplinary team of social workers, welfare officers, nurses, occupational therapists, psychologists, consultant psychiatrist and psychiatrist in training.

Clinicians informed the Review that care is often short term and targeted to patients with severe illness. When a patient’s conditions stabilises they are referred to their GP for ongoing management.

Lack of certainty that the patient would receive timely services was an expressed concern of clinicians and GPs who referred to community mental health services. Referring clinicians also said they did not always receive feedback on referrals and this exacerbated their uncertainty. The Medical Records Audit undertaken by this Review also indicated that feedback is not always provided to the referrer.

To achieve improved patient transitions, integration between mental health hospitals and community mental health services needs to occur, along with the development of protocols and policies that align across transition points.

The Review was informed that intense caseloads and limited staffing within community mental health services has limited patient access and the intensity and longevity of service provision. One psychiatrist informed the Review that staff work in a reactive rather than proactive mode 'putting out fires' and often referred deteriorating patients to hospital.

All community mental health services have waiting lists and these vary from three weeks to 12 months. At one CMHS, 73 per cent of the referred patients are assessed within two weeks and this is a comparably good outcome.

The caseloads of community mental health services vary between 160 and 700 patients at a time, and each psychiatrist can expect a case load between 34 and 60 patients.

Clinicians said that ideally all hospital referrals for community services should be accepted before discharge and a case manager assigned. The case manager could then inreach into the hospital to meet the patient and participate in discharge planning. In most teams, the patient is allocated a case manager after the triage process. The case manager engages with the patient, monitors their care, and fulfils administrative tasks, such as patient registration, scheduling review meetings, and patient documentation.

Most patients attend CMHS clinics to receive care. When patients are too unwell or have difficulty with clinic visits, clinicians visit them in the community. Most home visits are undertaken by a single staff member and, where safety is a concern, by two staff members.

Most psychiatrists see 20 per cent of patients in the patient's home and 80 per cent in the clinic. This proportion is reversed for community mental health nurses. Nurses visit 80–90 per cent of patients in the patient's home and see 20 per cent in the clinic.

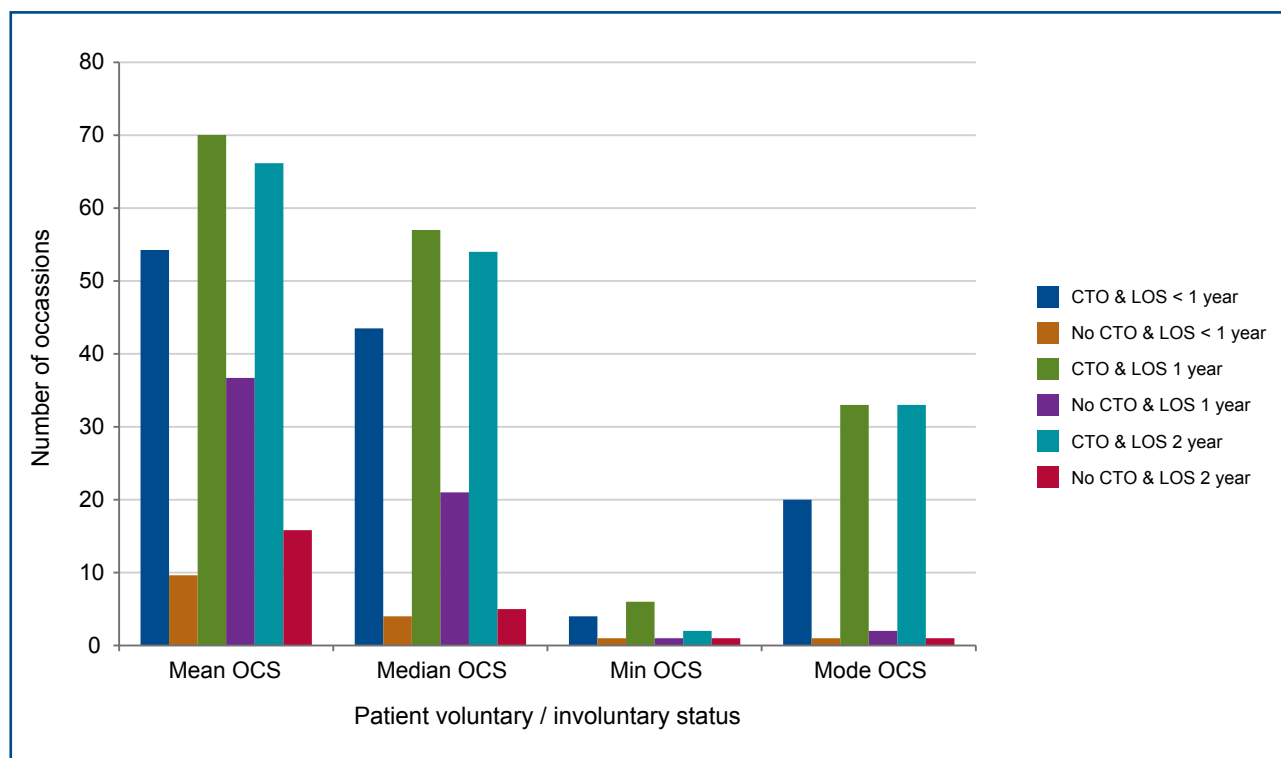
During the community visits, the clinicians involve family, when available, in care planning and interventions in accordance with the patient wishes. Contact with family continues through telephone calls and CMHS staff informed the Review that they most often have good relationships with the patients' families.

When a patient is referred on a community treatment order (CTO), the referring psychiatrist speaks directly with the receiving psychiatrist and discusses patient treatment. Community appointments are scheduled before the patient is discharged from hospital, and there is confidence that the patient will receive community treatment.

For these CTO patients, community mental health services ensure appointments are attended. When patients are on CTOs and do not arrive for appointments, the health service conducts a home visit and attempts to contact family to locate patients. In these situations, the CERT team are also alerted and continue the attempts of follow-up after hours. It is rare that patients on CTOs are not able to be followed up.

Figure 41 illustrates that patients on CTOs receive more occasions of service than voluntary patients. Voluntary patients are likely to receive an average of five to 10 occasions of service in a year.

Figure 41 Length of stay (LOS) in community mental health service CTOs and non-CTOs 2011



Note: CTO = community treatment order (involuntary status); OCS = occasions of service; LOS = length of stay  
 Source: MHIS DoH (2012).

### Missed patient appointments

Clinicians remarked that in addition to scheduled appointments, community mental health services respond to urgent calls and new admissions as assigned by triage. To achieve this, current appointments need to be rescheduled. However, systems to inform patients of changed appointments are insufficient and sometimes do not occur, thus disrupting treatment. Therefore, metropolitan community mental health services have extended their ability to provide an emergency response without interrupting regular appointments.

This improvement occurred in response to an audit by the Auditor General (2009). That review observed that ‘Mental illness can diminish a patient’s capacity to access the services they need’ and successful models will reach patients innovatively and locally (Auditor General 2009). Metropolitan community mental health services have increased the number and availability of services by augmenting assertive and emergency response teams.

For example, Rockingham CMHS includes an ‘on-call team’ who are available to provide same-day services for urgent referrals. In addition, the community mental health services at Rockingham and Peel leave emergency slots in their schedules so that the psychiatric liaison nurses in the emergency departments can make appointments directly into their diaries (this enables the patient to receive a clear plan of care before they leave the ED). This emergency response is similar to the added capacity recently commenced in the North and South Metropolitan Health Areas and the ACIT team at Princess Margaret Hospital to manage urgent visits. With these systems, scheduled patient appointments are not interrupted.

## Variation in service provision

Community mental health services vary in size and governance:

- Some provide psychiatric liaison in local EDs.
- Some provide mental health support to GPs for patients in crises, that is, the emergency team attend the GP rooms in addition to providing phone advice.
- Some provide programs of carer education and training.
- Some are colocated on hospital sites and this eases communication, improves patient flow and provides access to services and information, such as laboratories and pharmaceutical support.
- After hours, most adult community mental health services extend services to children and adolescents.
- In rural areas, where specialist occupational therapy, physiotherapist and social workers are not part of the CMHS, these specialties can be accessed from the general hospital, when needed.

Similar to the Auditor General's Report, this Review was informed that community mental health services were crises-driven and provided variable services. The Auditor General's review (2009) identified the need for strategically planned community services, standardisation of service types, innovation, service coordination and improved quality and risk management processes.

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.

In the opinion of Mirrabooka community mental health service clinicians, colocating with a hospital would improve the interface between inpatients and community mental health service, foster mutual understanding, and encourage innovative practice. Neither Osborne Park nor Mirrabooka community mental health services have integral relationship with any inpatient service and expressed difficulty in obtaining discharge information and in locating an inpatient bed when patients require admission. They perceived themselves as a nuisance to the inpatient services and the psychiatrist explained that they carry a lot of risk without the support of clinical governance.

By contrast, community mental health services located on hospital grounds are well integrated to the health systems. To enable continuity of care, clinicians from those community mental health services attend ward and the psychiatrists communicate directly with one another. Some psychiatrists provide continuity of care by sessions in both inpatient and outpatient settings.

Offsite community mental health services attend team meetings by video-link, and this method is also used to link rural and remote services to metropolitan specialist services.

The links are important to continuing care. For example, discharge summaries are needed by the community mental health services within 14 days in order that prescriptions can be completed and treatment regimes maintained.

Clinicians in hospital-based community mental health services have access to the inpatient electronic discharge summary. Where services are not colocated, clinicians said that ensuring good communications requires continuous efforts. One psychiatrist explained how he made efforts to visit the inpatient setting intermittently, and this has developed relationships and improved the timeliness of discharge summaries.

Currently, private mental health services do not have access to PSOLIS, and inpatient care information is therefore not available to other components of the mental health system. Without formal interconnectivity, information flows are impaired, as demonstrated by the difficulties experienced by community mental health services and private mental health services. With no community mental health service involvement in discharge planning at the hospital and minimum discharge summaries limited to nursing information, continuity of care is challenged. To bridge the gap, the community mental health service contacts the inpatient services to receive verbal patient discharge information. Communication could be improved if private hospitals used the same information systems as the public mental health system.

Some CMHS clinicians expressed concern that they could not always provide recovery support because they were continuously managing crises. Recovery programs are frequently provided in step-down units and non-government organisations provide rehabilitation programs.

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.

*Recommendation: 1 Governance (1.2); Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; and Recommendation 7: Acute issues and suicide prevention.*

### **3.13.3 Public mental health services step- down units and short-term supported accommodation**

*Integration of patients with mental illness into the community is not something that can be bought. It requires a whole of society acceptance and industry support (Health and Disability Services Complaints Office 2012).*

Clinicians and community providers informed this Review that the roles and functions between mental health services and step-down units are clear and communication is smooth. The same is not true between these mental health services and long-term hostel accommodation.

There is a statewide rehabilitation facility at Hampton Road in Fremantle for patients with significant functional decline. The facility provides respite and rehabilitation. Patients have a community-based (CMHS) case manager and a discharge plan before entry. The unit is staffed 24 hours a day by nurses and therapy assistants. Staffs of the CMHS and the step-down unit communicate throughout the care episode in an effective and professional manner.

Local community mental health services also provide inreach and case management to step-down units managed by non-government organisations (NGOs). The health services and NGO providers operate in concert in a network of patient support. The health services provide mental health treatment and care planning and the NGO provides patient assistance with activities of daily living, rehabilitative programs and hostel services.

The health services case manager (or liaison workers) visits the patient in the accommodation regularly to monitor progress and attend weekly meetings with NGO staff and to discuss patient progress and guide practice. Some health services also meet regularly with the managers of the NGO accommodation to ensure inter-agency relations run smoothly.



For example, at the Armadale step-down unit Graylands clinicians provide clinical governance for the first three months of patient transition and then refer the patients to the Armadale community mental health services for ongoing management of their mental health. The CMHS nurse operates as the case manager and works closely with the psychiatric teams at Graylands during the transition period, and meets weekly with the NGO staff to resolve patient management issues such as behaviours and risk-management strategies.

It is the opinion of the Reviewer, step-down units are an essential element in the mental health system and future clinical services plans must ensure that sufficient step-down units and supported accommodation is available within each region to meet the needs of patients.

*See Recommendation 4: Clinicians and professional development (4.7; 4.8; 4.9; 4.10; 4.12); Recommendation 5: Beds and Clinical Services Plan (5.4; 5.5); and Recommendation 7: Acute issues and suicide prevention (7.9).*

### **3.13.4 Long-term supported accommodation – hostels**

Specialist mental health services do not appear to acknowledge and engage hostel care providers as members of the patient's health care team. This results in poor communication and poor continuity of patient care, insufficient hospital discharge information and variation in community mental health service provision. This concerns hostel managers, and sometimes leads to deterioration in a patient's condition, which often results in their admission to hospital.

The Review was informed that a range of communication problems exists between hostels and community mental health services and there is a need for stronger collaboration between these system components. For example, a hostel manager described how one patient was discovered to have a comorbid alcohol problem that had not been disclosed by the referring mental health service. Without awareness of the problem, the hostel had not supervised the patient's behaviour, which led to criminal offenses. The fractured communication between services was emphasised when the hostel requested assistance for the patient from the community mental health services and was refused.

There are two types of hostel accommodation: Hospital Licensed Psychiatric Hostels and mental health service-funded NGOs.

NGOs operate as a slow-stream step-down aiming to transition the patient to independent living within 12 months. Psychiatric hostels are more often long-term or permanent supported accommodation.

All hostels use case management models. Hostels licensed by the Department of Health provide case management with staff within their services, and patients in NGOs receive case management from community mental health services where NGO staffing does not include case managers<sup>6</sup>.

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<sup>6</sup> Some NGO hostels employ experienced mental health nurses, and most of the direct care workforce has attained a TAFE Mental Health Certificate level 4. The Mental Health NGO workforce project is the first national study workforce for the mental health accommodation sector (National Health Workforce Planning and Research Collaboration 2011). That there is high variability of workforce and workforce structures within NGO psychiatric hostel accommodation is a finding of the workforce project.

Key findings of the Mental Health NGO workforce project include:

- 39% of organisations employ staff with some type of mental health qualifications, and professional employees include psychologists, registered nurses, social workers and occupational therapists
- 78% had staff training plans
- 77% of services are supported by volunteers.

## Variation in support to hostel patients

Mental health care is provided to patients in hostels by the local community mental health services. However, the Licensing and Accreditation Regulatory Unit (LARU) informed this Review that the frequency of health service provision to hostels varies.

Residents in some hostels are visited weekly by the health service psychiatrist and several times a week by the mental health nurse. In addition, the CMHS responds to calls for urgent intervention and assists the patient's admission to hospital where needed.

In other hostels, community mental health services visit less frequently. For example, psychiatrists visit two to three monthly, and the CMHS nurse visits fortnightly. For new patients, hospital follow-up does not always occur and the hostels' request for urgent assessment is often met with the instruction by the CMHS to send the patient to an ED (Licensing and Accreditation Regulatory Unit, DoH April 2012).

The variations of CMHS services to psychiatric hostels require further exploration.

The Reviewer was informed that most hostels will refuse patients admission unless they can be guaranteed of community mental health service assistance. If patients are in a mental health hospital and are 'out of area', they often cannot move to a hostel of their choice unless accepted by the CMHS in the area of the hostel.

To address these communication issues, some hostels have developed memorandums of understandings with the local mental health services. Some also liaise with the mental health services regularly. For example, St Vincent de Paul meets with Swan mental health services weekly to discuss potential discharges. In addition to this collaborative strategy, St Vincent de Paul reserves two beds for sudden arrivals, noting that sudden hospital discharges are commonplace.

## Complexity of patient care

The patients referred to hostels are often complex and the clinicians in the inpatient setting must have confidence that the hostel is the best place of care for each individual (personal communication Richmond Fellowship 2012).

NGO staff explained to the Review that clinicians in acute mental health services do not always understand the capacity and limitations of hostels, particularly in relation to providing a safe and responsive service for patients with higher complexity and levels of acuity (pers. comm. Richmond Fellowship 2012). NGOs are perceived by some clinicians to be reluctant to accept patients who are impulsive and at high risk of harm and some specialist mental health clinicians are concerned about the level of training or core competencies of NGO staff to care for complex patients.

The community accommodation workforce should also be beneficiaries of a relevant and effective education and training framework to ensure a sustainable and skilled workforce.

Where CMHS relationships with NGOs have been formalised, patients are well supported in their mental health needs. Facilitated information-sharing sessions that aim to enable better understanding between acute services and NGOs are needed to inform each service of the other's capacities and strengths.

NGOs and hostels also need to align their intake processes and eligibility criteria to improve understanding of their service accessibility (personal communication Clinical Cluster Lead SMAHS).

## Communication between community service providers

Communication problems also exist between community providers. For example, a hostel manager described to this Review that a community provider had negotiated a patient's transition from the psychiatric hostel to a Department of Housing unit without discussion or involvement of the hostel services. A number of such transitions have failed and the residents have requested a return to the supported hostel.

In the opinion of the Reviewer, no single agency involved in patient care is central, and all services involved in patient care should be informed and involved when patient care plans are renegotiated.

Improved communication systems to better coordinate patient care within and across the mental health system need to be formalised (personal communication Richmond Fellowship & WAAMH).

*See Recommendation 4: Clinicians and professional development (4.7; 4.8; 4.9; 4.10; 4.11; 4.12); and Recommendation 5: Beds and Clinical Services Plan (5.5).*

### 3.13.4 Supportive housing and recovery programs

Resolving the need for supportive housing have been an ongoing difficulty for many patients with mental illness. A number of NGO services provide services to assist patients in finding accommodation and also provide community support. The Review felt that the services provided by RUAH were very satisfactory as were those of other NGOs.

For example, RUAH has six local teams across the metropolitan area and provides services to patients with mental illness. Eighty-five per cent of the team members have tertiary qualifications (e.g. social worker, psychology, occupational therapist and counsellor). Caseloads are 10 to 12 patients per clinician. Peer support workers are also employed and operate with four clients each.

Services include recovery programs, intense support, social and family programs, help with drug abuse, personal helpers, mentors, employment services, and homelessness programs. The programs aim to connect the individual into the community using a case management model.

In other mental health programs run by RUAH:

- Early Psychosis Initiative funding enables caseworkers to engage with patients and with the treatment team during hospitalisation and discharge planning. Referrals are also received from GPs. Many patients have comorbid conditions and have not received specialist mental health services in the past. There are 10 FTE case managers in the EPIC (Early Episode Psychosis Program) with caseloads of six to eight patients each. The staff engage with the patients to establish therapeutic relationships, provide medication assistance and help the patients to access local community mental health services.
- NGO intensive-housing programs have housed 100 patients since 2010 and RUAH is proud that all of these patients have remained housed.
- A Street to Home Program supports and houses people who are sleeping rough. RUAH also manages two female refuges.
- A contract with the Department of Corrective Services allows RUAH to assist women in prison. The patient involvement commences three to six months before their release.

- Recovery programs include WRAP, which is a wellness recovery action plan where the client is helped to understand the symptoms of deterioration and determines who needs to know when they act in a certain way and need help.

RUAH employees commented that it is sometimes difficult to get community mental health services for patients once they have been housed due to the long waiting lists for services.

Other NGOs also provide community services including:

- personal helpers and mentoring programs. These programs include carer education aimed at broadening carers' capacity to manage patient behaviour and in-home respite care (personal communication Richmond Fellowship 2012)
- community support groups such as Hearing Voices Network and Independent Living Skills Support
- prevention and health promotion activities
- prevocational training.

### **Personalised funding**

The Review was informed that there are insufficient numbers of supported accommodations places (personal communication Clinical Cluster Lead SMAHS & Richmond Fellowship) and already the Minister for Mental Health is making endeavours to correct this with funding allocated to purchase 100 homes and \$25 million to provide support services.

The Hon. Helen Morton informed the Review that a current trial of personalised funding in the community shows significant promise.

The program involves community coordinators who assist the patient and carer to navigate the system and broker community resources in accordance with individual's needs for as long as required. This structure enables patients buy the service/s they need. The coordinator also monitors patient progress in concert with the GP and assists in the patient's transition to acute services where required.

*See Recommendation 1: Governance (1.1.1).*