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Appendix 1

Terms of Reference: Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ services in Western Australia.

The Review team, led by Professor Bryant Stokes AM, will prepare a report for the consideration of the Director General of Health and the Mental Health Commissioner, who will in turn advise the Minister for Mental Health.

The Review is to include recommendations for the refinement and improvement to the admission and referral practices for public mental health patients to public hospital EDs and/or authorised mental health facilities/services and the discharge or transfer of public mental health patients from the public hospital EDs, mental health facilities or services.

The scope of the Review is to examine services provided at the following:

- South Metropolitan Area Health Service (SMAHS) with the tertiary sites of Royal Perth Hospital (RPH) and Fremantle Hospital (FH) and the secondary sites of Armadale Kelmscott Memorial Hospital (AKMH), Rockingham General Hospital (RGH), Bentley Hospital.
- North Metropolitan Area Health Service (NMAHS) with the tertiary sites of Sir Charles Gairdner Hospital (SCGH), Graylands Hospital, including the Frankland Centre, King Edward Memorial Hospital's Mother and Baby Unit and the secondary sites of Osborne Park Hospital (OPH) and Swan Districts Hospital (SDH).
- WA Country Health Service (WACHS) with sites/services within all regions but specifically at the authorised mental health units of Bunbury, Albany, Kalgoorlie and Broome (March 2012), and review the application of the policy and processes in remote communities.
- Child and Adolescent Health Service in relation to the transition of child and adolescent mental health patients to adult services and the child and adolescent services provided at both Bentley Adolescent Unit (BAU) and Princess Margaret Hospital (PMH).

The Review team will first consider the findings of the Chief Psychiatrist's thematic review of discharge planning (December 2011) and provide a workplan/scope of work in context of its findings.

The Reviewers will consult with key stakeholders to gather views, information and evidence sufficient to:

1. Investigate whether the prescribed admission and discharge policies for public patients are being consistently adhered to. (Admission, Readmission, Discharge and Transfer Policy for WA Health Services (ARDT) OD 0343/11, superseding 1572/02).
2. Examine the current referral rates and patterns from the hospital EDs to both inpatient mental health services and community mental health services to ensure that all 'at risk' patients are treated.
3. Examine the practices and policies for the transition of mental health patients from child and adolescent mental health services to adult services.
4. Examine and contrast discharge planning policy and processes in place for child and adolescent and adult services.

5. Examine the use of community assessment and preadmission services such as the Community Emergency Response Teams (CERT), and the telephone clinical advice and referral services such as the Mental Health Emergency Response lines, (including Ruralink for country patients and clinicians).
6. Review the support systems currently in place to assist with admission and discharge referral practices with regard to the involvement of carers and families and that the use of primary care and community support services for the follow-up of patients is appropriate.
7. Make recommendations regarding improvements identified as part of the Review to ensure compliance with policy and appropriateness of its application in an operational setting.
8. Provide a final report including recommendations to the Director General of Health and the Mental Health Commissioner. It is expected the Review will take four months.

The key stakeholders will include:

- Key staff at all Area Health Services, that is NMAHS, SMAHS and WACHS, including, but not exclusively, the Chief Executives, the Executive Directors of the sites, the Executive Directors of Mental Health, the Heads of the EDs, the Heads of the community mental health services and other clinicians within each Area Health Service.
- The Chief Psychiatrist, the ED Performance Activity and Quality (PAQ), and the ED of the WA Health Mental Health Strategic Business Unit.
- The Mental Health Commissioner and senior staff at the Mental Health Commission.
- Mental health patients, carers and their families, the Council of Official Visitors (COOV), the Health Patients Council and peak mental health patient bodies such as the Association of Relatives and Friends of the Mentally Ill (ARAFMI), Carers WA, and the WA Association for Mental Health (WAAMH), the Mental Health Advisory Council (MHAC) and the WA Association of Mental Health Patients (WAMHC).
- Others as the Review team consider appropriate such as Corrective Services for the Frankland Centre.

The Reviewer may also examine the admission/referral and discharge and/or transfer practices provided at the ED and the authorised inpatient mental health facilities/services at Joondalup Health Campus and the interface and interaction between the SMAHS community mental health services and the ED at Peel Health Campus, but permission will be sought prior to these occurring.

Appendix 2

Individuals, organisations and service participants involved in the Review

- Patients, carers and family members
- Aboriginal Health Council of Western Australia
- Aboriginal Psychologist, Darrell Henry
- Acacia Prison, Director Peter McMullin
- AMA
- Association of Relatives and Friends of the Mentally Ill (ARAFMI)
- Australian College of Mental Health Nurses, Kim Ryan
- Carers WA
- Centre for Aboriginal Medical and Dental Health, Winthrop Professor Helen Milroy
- Children's Court, Judge Denis Reynolds
- Commissioner of Children and Young People, Michelle Scott
- Council of Official Visitors (COOV)
- Deberl Yerrigan Aboriginal Health Services
- Department of Corrective Services, Dr Roslyn Carbon and Dr Gosia
- Department of Health, Strategic System Support, Sally Skevington
- Deputy State Coroner, Evelyn Vicker
- Director of Aboriginal Services
- Director General of Health, Kim Snowball
- Drug and Alcohol Office
- Ethnic Disability Advocacy Services
- Headspace Fremantle
- Health and Disability Complaint Office, Anne Donaldson
- Inspire WA
- Mental Health Advisory Council
- Mental Health Commissioner, Eddie Bartnick
- Mental Health Commission
- Mental Health Law Centre
- Mental Health Matters 2
- Mental Health Multicultural Access Service
- Mental Health Strategic Business Unit
- Mental Health Review Board
- Mental Illness Fellowship of Western Australia (MIFWA)
- Minister for Mental Health, the Hon. Helen Morton
- Office of the Chief Psychiatrist
- President of Private Psychiatric Hostels, Judith Baalfe
- Richmond Fellowship

- Romily House
- Royal Flying Doctor Service
- RUAH Community Services
- St Batholomew's
- St John Ambulance operations staff
- St Jude's
- St Vincent de Paul
- Statewide Indigenous Services
- Suicide Prevention Council Chairman, Peter Fitzpatrick
- Western Australian Association for Mental Health (WAAMH)
- WA GP Network, Chief Executive, Debra Selway
- Western Australia Police

Chief Executives of:

- Child and Adolescent Health Service
- North Metropolitan Area Health Service
- South Metropolitan Area Heath Service
- Western Australian Country Health Service

Mental Health executives and operations staff:

- Managers and operations staff Western Australian Country Mental Health Service
- Managers and operations staff Mental North Metropolitan Area Mental Health Service
- Managers and operations staff South Metropolitan Area Mental Heath Service
- Managers and operations staff Child and Adolescent Mental Health Service
- Standardised Documentation Committee, Chair and members PSOLIS, Application Manager, System Adviser, system information and administrators and HIN (Health Information Network) Manager
- Senior Project Coordinator SMAHS, Joel Gurr
- Clinical Cluster Lead for Mental Health SMAHS, Dr Nigel Armstrong
- State Bed Manager, Kieran Byrne
- Performance Activity and Quality Division, Dr Dorothy Jones
- ABF/ABM System Lead, Performance Activity and Quality Division, Beress Brooks
- Resource Strategy and Infrastructure, Wayne Salvage, Mark Miller
- Consumer Representative to the development of Review Audit tool, Liza McStravick
- Mental Health Information Services, Tom Pinder
- Department of Epidemiology, Peter Somerford
- Chief Medical Officer, Dr Simon Towler.

In the following list, the clinicians of mental health services include those at community emergency response teams, triage, psychiatric liaison teams, hospital psychiatric liaison teams, inpatient services, community mental health services, child and adolescent community health services, outreach and in-reach programs, rehabilitation services, GP liaison.

- Albany, Katanning mental health clinicians and ED heads
- Alma Street Centre, clinicians and Fremantle ED heads
- Armadale Hospital mental health clinicians and ED heads
- Bentley mental health clinicians and ED heads
- Bentley Adolescent Unit mental health clinicians
- Bunbury mental health clinicians and ED heads
- Bunbury Council of Official Visitors representative
- Kalgoorlie, Goldfields mental health clinicians and ED heads
- Kimberley, Broome, Derby, Kununurra mental health clinicians and ED Heads
- Frankland Centre mental health clinicians
- Graylands Hospital mental health clinicians
- Hampton Road Service, Fremantle
- Inner City CMHS
- Joondalup Health Campus mental health clinicians and ED head
- King Edward Memorial Hospital Mother and Baby Unit
- Mental Health Emergency Response Line (MHERL) mental health clinicians
- Mirrabooka CMHS mental health clinicians
- Midwest, mental health clinicians
- Osborne Park CMHS mental health clinicians
- Peel Health Campus mental health clinicians and ED head
- Pilbara, Meekatharra, Port Hedland, Karratha, Newman, Tom Price mental health clinicians and ED heads
- Port Hedland Manager
- Princess Margaret Hospital mental health clinicians and ED head
- Rockingham mental health clinicians and ED heads
- Royal Perth Hospital mental health clinicians and ED heads
- Sir Charles Gairdner Hospital mental health clinicians and ED heads
- State Forensic Mental Health Service
- Swan Valley Centre mental health clinicians and ED heads
- Horizons, Armadale
- South Guildford Centre mental health clinicians
- Youthlink
- Viveash mental health clinicians
- Wheatbelt, Northam mental health clinicians and ED heads.

Appendix 3

Written Submissions to the Review

- Anonymous
- Alan Robinson
- Association of Relatives and Friends of the Mentally Ill
- Association of Relatives and Friends of the Mentally Ill. Kimberley Mental Health Carers
- Carers WA
- Commissioner for Children and Young People
- Council of Official Visitors
- Geoff Diver
- Geraldine Casey
- Goldfield's Mental Health Services
- Hugh Cook
- Kim Ryan
- Mental Health Strategic Business Unit
- Mental Health Commission
- Mental Health Law Centre
- Mental Health Matters 2 (2)
- North Area Health Service
- Osborne Clinic
- Paul Whitley
- Richmond Fellowship
- Royal Flying Doctor Service
- Russell Clemens
- State Forensic Mental Health Service
- Suicide Prevention
- Transcultural Mental Health Centre
- WA GP Network
- WA Police
- Western Australian Association of Mental Health Services

Appendix 4

ICD-10 Diagnosis for mental health

The principle diagnoses of the ICD-10 related groups classed into 10 mental diagnoses with subdivisions (see Commonwealth of Australia 2008, *Australian Refined Diagnosis Related Groups Version 6 Definitions Manual,* vol. 2 (DRGs J01A-Z65Z).

The 10 mental health DRG groups are:

1. Mental health treatment, same day with ECT – U4OZ
2. Mental health treatment same day without ECT – U6 OZ
3. Schizophrenia disorders – U61Z
4. Paranoia and acute psychotic disorders (Cat or severe CC or mental health legal status voluntary – U624, involuntary U62B
5. Major affective disorders – U63Z
6. Other affective and somatoform disorders – U64Z
7. Anxiety disorders – U65Z
8. Eating and obsessive/compulsive disorders – U66Z
9. Personality disorders and acute reactions – U67Z
10. Childhood mental disorders – U68Z.

The Mental Health Commission explained they are intent on gaining better mental health system traction (alignment) by diversifying the service base, improving control of hospital purchased services and increasing investment into community. For example, in 2011–12, the $9 million growth funding for hospital care was redirected, with 60 per cent given to health for community services, and the remainder to private community health services. To decrease reliance on public hospital beds, some are planned to close. At present, there is no growth in inpatient funding.

The costs of new beds at Rockingham and Broome are expected to be accommodated by transferring current funding to those areas; the idea being that patients currently cared for in the metropolitan areas will be repatriated. No funding has been allocated to meet the expected increase service demand when the mental health services become available in those areas.

Kathy Eager, Centre for Health Service Development, at the University of Wollongong (2011) published a paper on the implication of ABF/ABM funding for mental health and notes that the COAG agreement does not place specialist mental health services into any one distinct activity for ABF. Eager proposed that mental health should be considered as one service and receive Block Grants until mental health is 'nationally recognised as a distinct "activity" for ABF purposes and as a specific type'.

DRG Classification is a poor predictor of the cost of mental health care that is not used for this purpose in any Australian state or in other comparable countries such as the UK or the USA. ... With mental health being split across the five different activity types, the outcome will be to fragment integrated hospital and community services by applying different funding arrangements across service components. There will also be incentives to treat patients in settings that are the most profitable. For example, introduction of ABF in acute admitted psychiatric services without an equivalent ABF model in the community will create incentives to hospitalise, resulting in an increase in hospital admission and a decrease in care in the community. These incentives are not consistent with national or state mental health policies and are not compatible with either good clinical practice or current mental health legislation, which requires the least restrictive form of care consistent with safe and effective treatment ... A specific approach needs to be developed that aligns ABF with national policy directions which have explicitly aimed to bring hospital and community services together in a single system (Eager et al. 2011).

Appendix 5

Clinical Record Audit

A clinical record audit was undertaken as part of this Review into admission, discharge, referral and transfer practices of public mental health services in Western Australia.

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 that were identified for review by the project team and that were determined to be important to the Review's overall objectives. It should be noted that:

- this 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 patient) records was drawn from the total number of patient separations and occasions of service from selected inpatient units and community mental health services across The Department of Health, WAHealth for the 2010/11 financial year. Sites were selected to represent tertiary, non-tertiary, adult and child and adolescent services. Records were audited for admission criteria and the discharge, transfer and referral criteria that, where these occurred, were associated with that admission. Some records were audited for more than one criterion. Analyses for admission and referral criteria were conducted on 165 inpatient and 201 community mental health (CMH) records for patients admitted into a service during the 2009/10 and 2010/11 financial years, on 152 inpatient and 78 CMH records for the discharge criteria and on 11 inpatients for the transfer criteria. Records were excluded from analyses where they were found to be outside of the audit time period or, for inpatient records, had a length of stay of zero days and were therefore not considered to be inpatients.

Results

Referrals

Inpatients: More than 85 per cent of patients had written referrals into the service with the majority (86.7%) admitted within one day of referral. Records indicated that in only 20.1 per cent of cases did referrers receive feedback of the admission.

CMHS: Written referrals were evident in 73.2 per cent of the records with the time between referral and admission to the service ranging from zero to 541 days (median of 10 days). Records indicated that in only 39.3 per cent of cases did referrers receive feedback of the admission.

Admission Assessments

Inpatients: A full or partial psychiatric assessment was evident in 95.7 per cent of records with the assessment being completed within one day of admission for 98.7 per cent of patients. Physical assessments were undertaken on half of the patients (50.3%) with 3.6 per cent of these being partial assessments (circulatory and respiratory systems). For clinical risk assessment, 98.8 per cent of patients had an assessment undertaken with 6.1 per cent of these partial (level of suicide risk and current protective factors).

CMHS: A full or partial psychiatric assessment was evident in 94.1 per cent of records with the assessment being completed within one day of admission for 87.8 per cent of patients. None of the CMH patient records indicated that patients had received a physical assessment with 26 records indicating that this was not applicable because the patient was under the care of a GP or specialist. For clinical risk assessment, 96.5 per cent of patients had an assessment undertaken with 43.8 per cent of these partial assessments.

Clinical Risk Plan

Inpatients: The large majority of patients (97%) had evidence of a risk plan. While there was evidence that the patient had contributed in most cases to the risk plan (94.4%), this was not the case for carer input where, excluding no patient consent and no identified carer, about one-third of the records had evidence of carer participation.

CMHS: Again, the large majority of records (94.5%) had evidence of a risk plan with patient participation in most cases (98.4%). As for inpatient records, excluding carers not identified or present, carer input was less evident with just under a half of the records indicating involvement.

Discharge assessments

Inpatients: The majority of patients (94.1%) received a full or partial risk assessment on discharge with most of these being completed within a day of discharge (89.1%). Only seven patients had a full or partial physical assessment at the time of discharge. Records for 97.4 per cent of the cases had evidence of a discharge plan with patient and carer input into these in 93.2 per cent and 33.3 per cent of cases respectively.

CMHS: As for inpatients, most CMH records (85.9%) had evidence that patients received a full or partial risk assessment on discharge with most of these being completed within a day of discharge (89.1%). Only one patient had evidence of a partial physical assessment at the time of discharge. Records for 80.8 per cent of the cases had evidence of a discharge plan with patient and carer input into these in 69.8 per cent and 28 per cent of cases respectively.

Patient transfer

Ten of the 11 patients had evidence of a risk assessment being performed before transfer. Seven patients had evidence of a transfer plan in their records with all of these patients involved in the development of their plan. Carer involvement was evident in two instances only with one case recording no consent for carer involvement.

Conclusions

This audit looked at the documentation in patient clinical records 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.

In relation to assessments, admission psychiatric and clinical risk assessments were undertaken on the majority of patients with most of these completed within a day of admission. Inpatients had a higher rate of full assessments, as opposed to partial assessments, than did community mental health patients. In contrast, documented evidence for physical assessments occurred in half of the inpatients and none of the CMH patients, with several records in the latter 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.

Limitations

While this audit has identified information on aspects of admission, discharge, referral and transfer practices that are being documented in patient's clinical records, methodological limitations warrant caution in the interpretation and generalisation of the results. These limitations relate to:

- the small sample size and the number of records lost to analysis further reducing this size
- the sample being drawn from selected sites and not therefore inclusive of all mental health services in WA
- the fact that while criteria were audited for evidence of documentation in the clinical record, this review did not cover the level or depth of involvement patients or carers had in any of their assessments or plans.

Because of these limitations, definite conclusions about documentation and evidence of the practices audited cannot be made here. Instead, this audit should be read as providing a tendency for such practices.