Executive summary

In November 2011, the Minister for Mental Health requested three reviews about the suicides of people who had been discharged from mental health services in Western Australia (WA):

1. The Chief Psychiatrist's examination of four cases of patients who died unexpectedly following presentation at Fremantle Hospital.
2. The Chief Psychiatrist's review of the clinical decisions made around the admissions and discharges at Fremantle Hospital over the past 12 months in which people have died subsequent to their discharge.
3. This independent statewide review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in WA.

(See Terms of Reference, Appendix 1).

While this Review has revealed an array of challenges and imperatives for mental health care in WA, it is important to acknowledge that the all-pervasive and multifaceted nature of psychiatric illness and required support and care is not the responsibility of any one person, service or agency (Coid 1994). Mental health treatment is one component of a broader framework to support people with mental illness. Other components, such as social support, housing and employment, each play a crucial part.

This Review considered the efforts of staff, observing that staff are committed to the care and rehabilitation of people who are mentally unwell.

In the context of limited resources, the mental health system is under considerable stress, particularly in relation to staff already stretched, endeavouring to adhere to formal policies, procedures, legislative requirements and their own professional expectations and the expectations of patients and carers.

This Review notes that within the hospital and clinic situations there appears to be an absence of a single point of authority with a described responsibility for accountability for patient care and for consistency of process and practices. Best practice demands clinical and corporate governance remain separate entities, while a single point of authority must ensure linkages across a mental health system to deliver patient-focused care.

These tensions in the current system are exacerbated by demand outstripping provision of acute inpatient facilities, step-down units and rehabilitation services. The system must also address the imperatives of an adequate workforce and improved workforce training.

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

This Review of the admission or referral to and the discharge and transfer practices of public mental health facilities and services in WA offers recommendations to improve processes of care of the patient with mental illness and concurrently their family and carers. The recommendations are based on the opinions, views and evidence presented by the 891 persons interviewed, the data of 255 individuals who suicided in 2009, patients' medical record documentation and the 29 submissions received by this Review (see Appendixes 2 and 3). There are also reports and data presented by interview participants.

In Australia, one-third of the population experience mental illness at some time in their lives and mental illness 'accounts for 13 per cent of the total burden of disease … and it is the largest single cause of disability' (Australian Government 2011a, p. 1). The illness affects all ages across a lifetime and is the greatest risk factor for suicide (Australian Government 2011a, p. 10).

Mental illness has far-reaching effects on WA's community. Currently, mental disorders rank fourth highest burden of disease for men after cancer, cardiovascular disease and neurological disorders and is predicted to rank third by 2016. In 2006, mental disorders ranked second highest for women after cancer. By 2016 these rankings are projected to be reversed, with mental disorders accounting for the greatest burden[1] (Epidemiology Branch 2012).

In all states of Australia, people who access the mental health systems experience them as largely crisis driven. There appear to be significant barriers to accessing services, which contribute to poor health outcomes (Commonwealth Government of Australia, 2011a; PHAA 2009). Traditionally, Australian mental health services acknowledge social and psychological risk factors of mental illness and the need to focus on diagnosis, treatment and support for the individual in recovery.

Mental health services in WA consist of acute inpatient services, community mental health services, recovery/rehabilitation services, and non-government organisations (NGOs). NGOs provide supported accommodation, psychological support, disease education, prevention, rehabilitation services and in-home assistance. Other contributors to mental health care include general practitioners (GPs) and other private services.

The demand on emergency departments (EDs) of mental health-related care increased by 5.5 per cent per annum between 2004–05 and 2008–09 across Australia (Government 2011; AIHW 2011a). More people are admitted into WA specialist mental health inpatient units each year.

The number of persons admitted for treatment of their mental health condition has increased in WA by 23.69 per cent since 2006 and separations have increased by 17.46 per cent. In the last financial year (2010/11), 1021 children and 8364 adults (under 64) were discharged from specialist mental health hospitals. In addition, 44,491 persons received a total of 750,486 occasions of service from the community mental health service (CMHS) (Mental Health Information System 2012).

Increasing demand for services is a challenge to current mental health resources. This is most evident in the health system by the difficulty of admitting patients into a mental health bed from EDs and urgent cases from the community, especially for young people.

Patients with mental illness and other conditions such as drug and alcohol issues, and especially those under the influence of methylamphetamine, require intensive management.

The open layout of EDs is not conducive to managing mentally ill patients and, at times, places other patients at risk. A separate area within the ED for patients with mental illness, some of whom may also be under the influence of drugs and alcohol, would better meet the safety needs of all patients.

[1] NOCC are agreed data items for the National Minimum Data Set for Mental Health for mandatory collection and reporting by the service providers and HoNOS is a mandatory rating system that measures the severity mental illness symptoms (operationaal directive OD0206/09, DoH).

Patients: The Review heard patients concerns about the inconsistent response of mental health services to their presentation and that assistance was often not available until they were at their most vulnerable and in crisis.

Some were comforted by kind staff who listened to them and made them feel safe and secure. For many others, the difficulties of accessing services, the long wait for assessment, little information about their psychiatric treatment or physical health, and scant rehabilitative services raised concern that the WA mental health system was unable to assist them to recover or improve.

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

While the Review received a considerable weight of negative carer and family experiences, a number of contributions to the Review did describe receiving positive and supportive care.

Of the many persons interviewed in this Review, a common theme from carers and patients was that they were not singularly or severally involved in planning of risk, care and treatment. Nor were they involved in discharge planning. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The sanctity of patient confidentiality should not be used as a reason for not informing the carer that the patient is going on leave or is to be discharged. It is to be noted, however, that many services do this well, although not uniformly across the system.

Carers were concerned they had no teaching about what may constitute triggers for a relapse in their patient and what to note as possible signs of impending deterioration.

Clinicians: Throughout this Review, clinicians consistently expressed a desire to provide the best possible care for patients and to improve the quality of care and service provision. However, they repeatedly expressed dismay at resource shortfalls, management and governance issues, workforce shortages, increasing demand, and prevalence of mental illness. The overriding message from clinicians is that these features all intertwine to effectively prevent mental health workers from achieving their aims.

This Review acknowledges mental health clinicians for their dedication and commitment to work in often-complex scenarios and volatile environments.

The Review also observed that while imperatives of professional skill and knowledge are a crucial factor, clinicians share a strong desire to work within the mental health system. Clinicians described their colleagues as committed and patient centred, and their teams as cohesive. Supporting the mental health workforce is an imperative that should be continually addressed, particularly if sustainable improvement in the delivery of mental health services is to be achieved.

The Review found the current mental health workforce is inadequate to meet the mental health needs of WA. There are fewer mental health nurse full-time equivalents (FTEs) and the second lowest psychiatrist FTE per 100,000 people compared with other states (Australian Institute of Health and Welfare (AIHW) 2012).

The Reviewer wishes to commend the Rockingham–Kwinana Mental Health Service on their overall excellent management and provision of inpatient and community services.

Mental health clinicians are severely overworked in almost all areas, which invariably has led to incomplete services being supplied to patients in some areas. This is most apparent in many rural areas where clinicians find it difficult to carry out any rehabilitation as they are already stretched to provide often only basic mental health care. One clinician said all their working time was spent dealing with acute mental health problems and 'putting out bushfires'.

Mental health beds: In order to provide meaningful comparative bed numbers, reference is made to Andrews and Tolkien II Team's (2011) contemporary Australian modelling and based on the WA population of 2,366,900 (Australian Bureau of Statistics (ABS) 2011). An ideal bed stock of 3197 places is required in a stepped configuration as follows:

	Existing places	Recommended places/100,000	Optimal places	Change required
Inpatient services				
Acute	469	15	355	–114
Non-acute	130	10	237	+107
Community rehabilitation				
Clinical staffed 24/7	111[1]	15	355	+244
Staffed <12 hours	79[2]	15	355	+276
Supported permanent housing				
Supported public housing	174[3]	20	474	+300
Supervised hostels	748[4]	20	474	–274
Permanent housing	n/a	40	947	n/a
Total places		**95/100,000**	**3197**	

Notes: Private hospitals are omitted from this equation because they 'do not admit people as involuntary patients and the level of acuity is less than in the public sector. There are no data as to the offset that private beds make to dealing with the burden of mental disorders' (Andrews and the Tolkien II Team 2011, p. 11).

This table excludes specific services for older persons and persons with dementia. (Andrews and the Tolkien II Team 2011).

1. Based on figures 14 and 15.
2. Based on figures 14 and 15.
3. Based on 34.5 per 100,000 AIHW 2008–09 and population 2.17 million in 2008 accessed at: http://mhsa.aihw.gov.au/resources/facilities/beds.
4. Based on AIHW 2009–10 Data Cube.

WA requires more non-acute beds, community rehabilitation beds and more supported housing based on the current population. Two important qualifications are that:

- supported accommodation beds would need to be operational before a reduction in acute beds would be feasible
- places must be configured to account for the population growth.

Deciding upon the best mix and distribution of bed stock is outside the terms of reference of this Review. However, it is essential that a consistent methodology and definition of ideal bed stock is determined within the mental health clinical services framework.

A range of accommodation is needed within each region of the State and there is a need to properly negotiate a formulated 10-year clinical services plan that:

- articulates the services purchasing intentions and reform agenda of the Mental Health Commission
- defines the required capital investments and infrastructure build over the next 10 years
- provides facilities and services that allow best-practice clinical mental health care
- defines how the configuration of services and investment in services best meet contemporary best-practice care models and future demand.

Transport: The transport of involuntary patients under the *Mental Health Act 1996* authorises the police to escort patients with a transport order. The Act only authorises police to undertake the order but does not compel them and so other escorts are able to transport patients when the risk is less. The Mental Health Bill 2011 proposes the use of other authorised persons to assist in transporting patients with mental illness in the future. It is clear that the police are best placed to intervene in the community where community safety is the primary concern, and WA Police undertake the task whenever community or personal safety is at risk.

Inter-hospital transfers could be undertaken by hospital security personnel who are appropriately authorised and trained in mental health first aid and soft restraint.

Trained hospital security personnel also could provide security for the patient within the hospital setting until the patient can be assessed by a psychiatric team. The transport issue is discussed further in Section 3.7.

Documentation: This Review supports the development and implementation of standardised documentation in all mental health services and facilities in WA. Standardised documentation increases quality and safety of patient care by greater adherence to standards of care, improved intra- and interdisciplinary communication and better-informed clinical decisions.

In addition to hand-written medical records, the main electronic information system used within the WA mental health service is PSOLIS. The system is designed to collect demographic information and treatment-related history from patients in order to support optimum care. It is essential that information is available and accessible to all clinicians involved in a patient's care. However, clinicians currently experience inconsistencies, limited access and delays in information entry. An absence of mobile equipment to facilitate on-the-spot data entry and information access, and insufficient staff training, inhibit the program's full utility and potential.

It is crucial that the mental health system has one universally accepted, mandated and well-utilised information system. LASSO, a program introduced in the South Metropolitan Area, is a quality information system but 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.

General practitioners: These are often the first health service to whom patients with mental illness present and are the mainstay health provider in most patients' lives. Communication has to improve between GPs and the mental health services.

GPs would benefit from direct communication with psychiatrists to ensure continuity of care and to receive expert advice. This Review gathered evidence that the current process is patchy and varies between mental health services. Some do report and communicate with GPs very well – many do not.

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

This results in the disparate application of protocols and policies. As the principal provider of public mental health care, it is essential that the Department of Health has responsibility for overall governance of policy setting in the provision of care for hospital and community clinic settings.

Currently, there are two types of mental health governance in the metropolitan area. One is program based; the other geographically based. This leads to confusion in governance, particularly as mental health patients tend to move frequently across the system.

Across the mental health system, overall leadership is lacking, as is the ability to make things happen. Many mental health facilities act as if they work in a silo. Their relationships with each other are fragmented so that patients moving from one facility to another are frequently subjected to repeated history taking and changing care.

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

The Reviewer is concerned at the large number of managers in all mental health settings and is uncertain of the need for such numbers. A functional review of these positions and functions needs to be undertaken.

A significant number of management groups meet to discuss a variety of mental health management issues and yet little is seen to have altered as a result.

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

The Review is concerned at the reported frequency of patients who are triaged at community mental health clinics without input from a psychiatrist or registrar-in-training.

Despite the training of non-psychiatrist mental health clinicians, in the opinion of the Reviewer, this increases the level of risk for the patient, especially when presenting with a risk of self-harm. This scenario is particularly common in rural settings.

There is no overall cohesive link between many of the acute inpatient facilities and the community mental health clinics. This results in clinics sometimes not accepting patients for ongoing care after discharge from the inpatient setting.

Rural Areas: The delivery of mental health clinical services is more difficult because of vast distances and scattered populations in WA. This is particularly the case in the Kimberley, the Pilbara and the Goldfields. The difficulty in attracting and retaining mental health staff makes the delivery of services insecure. In some areas, such as Kalgoorlie, fly-in fly-out psychiatrists support the service. With many chronic mental health conditions, this is not satisfactory for continued patient care. In one case, a patient saw five different psychiatrists over a three-week period.

The rural population makes up about 28 per cent of the State's population and many are Aboriginal persons requiring special attention. The difficulty of administering mental health care in the area north-east of Kalgoorlie is sometimes confounded by the fact that the area is managed for health and policing by three bordering states. Cohesive policies as well as the legislative provisions of three different mental health Acts seem difficult to implement.

Aboriginal mental health: Apart from the comments above, the care of Aboriginal patients from rural or remote areas is made much more difficult because hospitalisation may require transfer to acute facilities in Perth. Fear of incarceration and separation from family and networks adds heavily to a patient's stress as well as to that of the family.

Of concern to the Reviewer is the care of Aboriginal people with mental illness. The development of specific care models that integrate family and trusted members of the community to accompany the persons with mental illness throughout their psychiatric/ specialist treatment is needed. In order that cultural methods of care can be applied alongside conventional psychiatry, the system needs to be augmented by trained Aboriginal psychologists, psychiatrists and mental health nurses.

General physical and dental health of patients: Patients with mental illness have a very high incidence of general medical conditions and often poor dental hygiene and care (Mai, Holman, Sanfilippo & Emery 2011; Morgan et al. 2011; Boulter & Sultana 2012).

In some inpatient services, this issue is well attended to but in others there is a lack of general medical input on a regular basis. In the community clinics, mental health clinicians rely on the patient's GP to provide that general health service. However, many patients do not have a GP. The metabolic syndrome (combination of medical disorders) associated with some psychiatric drugs appears well understood by clinicians but carers and patients seem ill informed of this. Clinicians need to attend to this aspect of information delivery to both patients and carers.

Dental care is often neglected, and while this is also true in the rest of the community, it is greater in patients with mental illness, as research has shown (Boulter & Sultana 2012).

Conversely, patients with a mental illness who are admitted to a general hospital for treatment of some other condition often have their mental illness overlooked, which may lead to very serious side effects.

This Review outlines the case of one such elderly patient admitted to a general hospital for a simple procedure whose long-standing mental condition destabilised and was not recognised (see Section 3.4).

Prisoners of Corrective Services: It is estimated that between 20 and 25 per cent of prisoners have mental health conditions or acquire such. While they have psychiatric care in prison, treatment may cease on release, despite the best attempts of the Corrective Service's Clinical Service Division to ensure follow-up by a GP or mental health facility.

Of significance are those patients on remand who are suddenly released at a bail hearing and who do not get any medical or mental health follow-up as the critical services may not be informed of their release.

The Director, Medical Services, Department for Corrective Services, Dr Roslyn Carbon, is to be congratulated on how this care of prisoners is being improved.