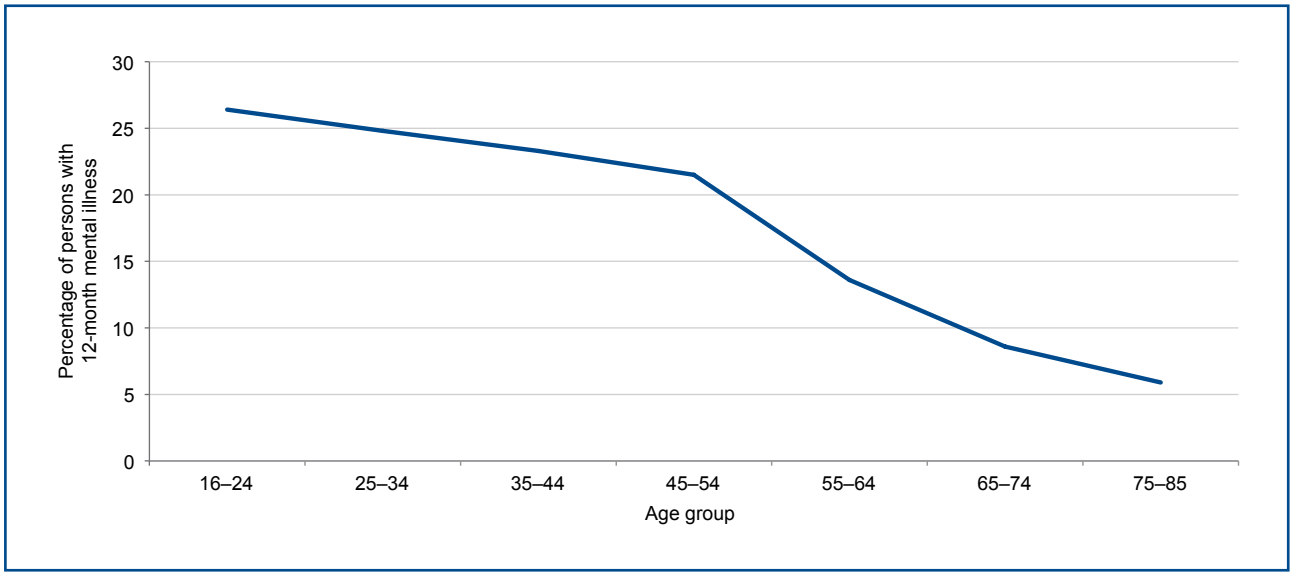
2. Background

2.1 Mental illness and the current mental health system

Mental illness is defined as a clinical diagnosable disorder that significantly interferes with individuals' cognitive, emotional or social abilities (Council of Australian Governments' 2006). 'One in five Australians continue to experience a mental illness in any given year' (Australian Bureau of Statistics 2007; Australia Government 2009). This indicates that in any one year 450,000 Western Australians experience mental illness (ABS 2010). The prevalence of mental disorder is highest among young people aged 16 to 24 and many young people (17%) have severe levels of impairment (ABS media release, 19 July 2010, see Figure 1).

Figure 1 **Prevalence of mental health disorders in Australia, 2007**



Notes: People aged 16–85 years who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview.

A person may have had more than one disorder.

Source: Australian Bureau of Statistics (2010b).

Chronic mental illness is sometimes experienced by people who also have another disability (43%) that restricts their ability to self-care, mobilise and communicate. It affects schooling and employment (ABS 2007). These people have comorbidities such as chronic medical illness and substance use disorders. 'Of the 16 million Australians aged 16–85 years [….] 11.7 per cent (1.9 million) had both a mental disorder and a physical condition (ABS 2007 p. 22).

The mortality rate for patients with mental illness and associated comorbid chronic illness is 2.5 higher than the general population. The higher levels of morbidity and mortality among mentally ill Australians is compounded by the more frequent incidence of health-risk behaviours including smoking, alcohol and substance abuse, poor hygiene, inadequate diet and lack of exercise (Morgan et al. 2011). In addition, some patients with mental illness are also at risk of self-harm (Mental Health Division, CRAM Policy 2008).

Mental illnesses can occur as isolated or intermittent episodes, with or without partial recovery; and as a continuous, sometimes deteriorating, chronic disease illness (Morgan et al. 2011).

While well understood, the course of mental illness and associated social impacts are complex to manage. A recent WA study revealed the higher incidence of concomitant factors and debility that patients with psychosis experience when compared to patients without psychosis. A study of 1825 participants demonstrated higher rates of financial problems (42.7%), loneliness and social isolation (37.2%); unemployment (35.1%); poor physical health and disease (27.4%); uncontrollable symptoms of mental illness (25.7%), lack of housing (18.1%); stigma and discrimination (11.6%) and lack of family or carer (6.2 %) (Morgan et al. 2011).

Mental illness has far-reaching effects and places a growing burden of disease on WA's community. Currently, mental disorders rank fourth highest for men after cancer, cardiovascular disease and neurological disorders and is predicted to become the third highest burden of disease by 2016. In 2006 mental disorders for women ranked second after cancer. By 2016 these rankings are projected to be reversed with mental disorders accounting for the greatest burden[2] (Epidemiology Branch, DoH 2012).

These known potential impacts of mental illness on lifestyle should be catalysts for the mental health system to design quality services to:

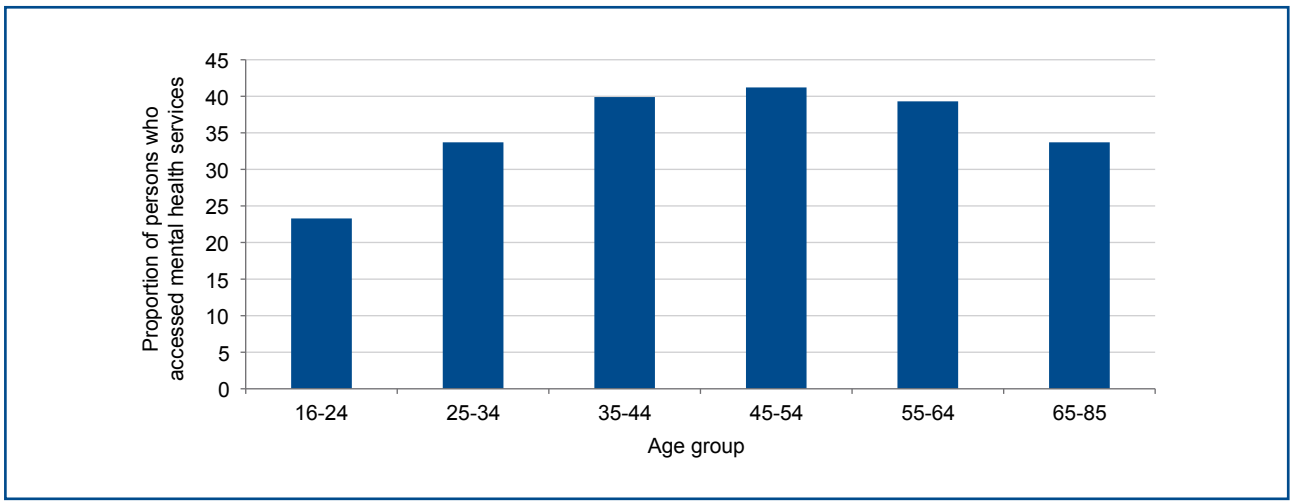
- strengthen and support patients' abilities
- promote and enhance protective factors (such as patients' social networks)
- provide recovery programs
- ensure service flexibility to respond to patients' changing needs
- smooth and expedite access to hospital care to treat severe disease.

A mix of public and private services delivers mental health care in WA. These include Commonwealth-funded primary care services; GPs and allied health professionals; state-funded hospitals and community services; private hospitals; and private psychiatrists. In addition, non-government organisations (NGOs) provide accommodation, support, rehabilitation and respite services that receive some funding from the State and Commonwealth governments.

There is variation in the use of mental health services by Australians who experience mental illness. More than half the persons in any age group do not access mental health services and young people seek them less often than adults (23% of young people compared with 41% of people aged 45–54 years) (ABS 2007, see Figure 2). Most people consult their GP for assistance with mental health issues.

[2] 'Burden of disease reflects the impact of an illness or disability on a population's life expectancy and quality of life. The Disability Adjusted Life Years (DALY) is a measure of burden of disease in the population, which integrates both mortality (Years of Life Lost) and disability (Years Lost due to Disability). One DALY equates to one year of healthy life lost. The sum of DALYs in the population is a gap measure used to quantify the difference between current health and ideal health situations' (Epidemiology Branch, 2012).

Figure 2 **Proportion of persons by age group, with mental health disorders who accessed mental health services in Australia, 2007**



Note: People aged 16–85 years who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview.

A person may have had more than one disorder.

Source: Australian Bureau of Statistics (2010b)

The public mental health system in WA provides a range of services to assess, diagnose and treat mental illness in inpatient and community settings. Quality and effective admission, referral, discharge and transfer processes are crucial to ensuring patients obtain the treatment and care they require when they need it.

2.2 Governance of Western Australian mental health services

Before June 1984, mental health services in WA were governed by a Director in a distinct government department directly responsible to a Minister. When the Department of Health was created in 1984, mental health amalgamated and mainstreamed with medical and public health operating in a regional structure. Some mental health services were colocated with general health locations such as Royal Perth Hospital, Sir Charles Gairdner and Fremantle hospitals. The administration of the services was integrated with acute medical services. At the same time, Lawrence et al. (2001) claimed the funding for mental health services was significantly reduced and, over the following years, services became outdated and inadequate, and there were breakdowns in care.

At that time a Ministerial Taskforce on Mental Health declared community mental health was severely underfunded and the increasingly heavy workloads made it difficult to retain sufficient psychiatrists (Lawrence et al. 2001).

In response to the taskforce report, the Mental Health Division was segregated from general health and became a distinct entity headed by the Chief Psychiatrist with a separate budget. The Chief Psychiatrist was responsible to the Commissioner for Health. Additional psychiatrists were attracted to the services by a new award. The *Mental Health Act 1996* became operational in 1997. The Act frames mental health care provision in WA.

The Act legislates the governing structure of mental health care. It also legislates admission, treatment and post-discharge support in relation to involuntary patient care and community treatment orders specifically.

It empowers the Minister for Health to promote and encourage, develop and coordinate to ensure delivery of mental health services in WA. Provisions of the Act do not specify the care and support of families. However, they stipulate the ministerial obligation to develop community services (s 1).

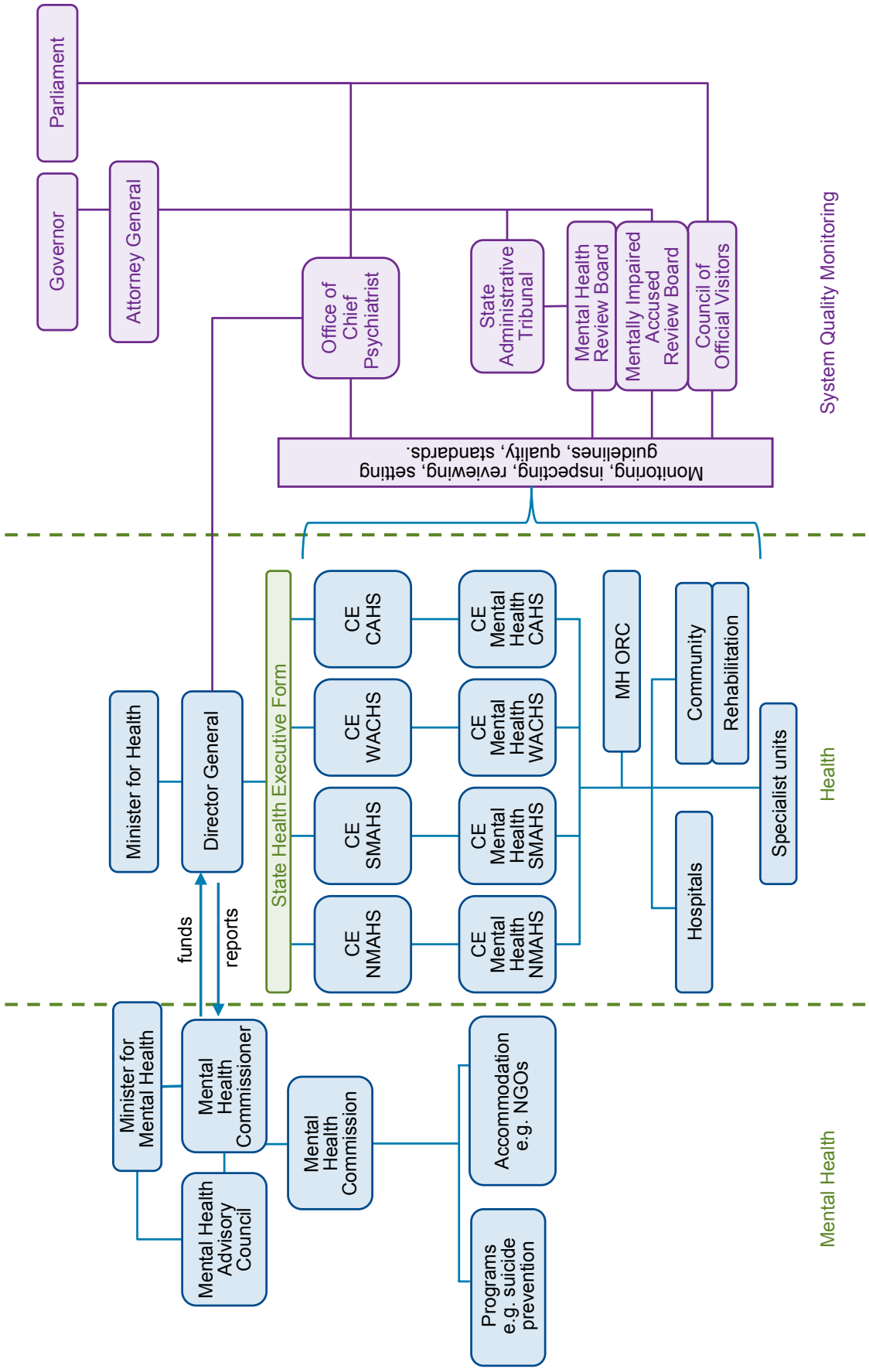
At the time of this Review, the draft Mental Health Bill 2011 was released for public comment.

The State Government budget for Mental Health in 2011/12 is $528 million, of which $457 million funds public health, and inpatient and community mental health services via service agreements; $80 million goes to Joondalup; and the remaining funds are distributed to:

- corporate costs
- policy initiatives, such as suicide prevention
- non-government organisations via service agreements.

Figure 3 illustrates the components of the mental health system in WA. A summary is offered to explain the interrelationships between the corporate governance, operational and clinical governance, and service providers.

Figure 3 **WA mental health governance structure, 2012**



Notes: NGOs = non-government organisations; CE = chief executive; NMAHS = North Metropolitan Area Health Service; SMAHS = South Metropolitan Area Health Service; WACHS = Western Australian Country Health Service; CAHS = Child and Adolescent Area Health Service; MH ORC= Mental Health Operations Review Committee.

In accordance with the *Mental Health Act 1996*, the **Governor of Western Australia** appoints a president and other members to the Mental Health Review Board on recommendation of the Minister for Health (Pt 6, Div 1, Sd 1, s 26).

The Minister for Mental Health appoints the Mental Health Commissioner (who purchases services from the Department of Health, private providers and non-government providers). The Minister also receives reports from the Council of Official Visitors.

The Minister for Health appoints the Director General of Health who in turn is responsible for the **Department of Health** providing public health services.

The Mentally Impaired Accused Review Board: Chairperson and members are appointed by the Attorney General and empowered by the *Criminal Law (Mentally Impaired Accused) Act 1996* to review the place and conditions of custody of patients subject to custody orders. The board advises the Governor about the release of mentally impaired accused persons.

The Council of Official Visitors (COOV) is empowered by the *Mental Health Act 1996* to provide advocacy for people with mental illness who are admitted as involuntary patients. In addition, they regularly inspect the inpatient environment of mental health facilities and provide recommendations for improvement. The COOV is funded by the Department of Health and reports to Parliament.

The Office of the Chief Psychiatrist (OCP) has legislated responsibilities for the clinical management and welfare of involuntary patients, and for monitoring the standards of psychiatric care throughout the State, including inspection of facilities (*Mental Health Act 1996* Pt 2, Div 2, s 9). Located in the Department of Health and reporting to the Director General of Health, the OCP also reports to the Mental Health Review Board about the care and welfare of involuntary patients. The OCP provides clinical guidelines and directives to mental health practitioners in WA.

Mental Health Strategic Business Unit: The interface between the Mental Health Commission and the specialised public mental health services has been limited and carried out by the Mental Health Strategic Business Unit (‘the unit’). It was planned that its main functions be quality control and risk mitigation and to provide liaison between Area mental health services and the Department of Health, Western Australia Police, Drug and Alcohol services and non-government services.

The unit was planned to negotiate the annual Memorandum of Agreement between the Mental Health Commission and the Department of Health and respond to the Commission’s service purchasing intentions on behalf of the Department of Health. This includes collation of business cases and developing service priorities for the Area mental health services. It was expected that the unit would undertake development of memorandums of understanding with the Performance Activity and Quality Division of the Department of Health.

Further, the intention was for the unit to collaborate with Area offices of the mental health service and the Mental Health Commission to develop frameworks for systematic monitoring, benchmarking and reporting on key performance indicators and outcomes.

The unit would also fulfil a central coordination role for the mental health information system (MHIS) and PSOLIS, and support inter-Area health and statewide projects with project management.

The Unit was also tasked with reporting on clinical reform initiatives such as the current recommendations of the Western Australian Auditor General for improving the performance of adult community mental health teams (Western Australian Auditor General (W.A.A.G.) 2009).

Western Australian Health Services are structured into four health areas:

1. North Metropolitan Area Health Service (NMAHS)
2. South Metropolitan Area Health Service (SMAHS)
3. Western Australian Country Area Health Service (WACHS)
4. Child and Adolescent Health Service (CAHS) merged child services from NMAHS and SMAHS into a discrete unit in February 2011. CAHS also supports WACHS. On 1 July 2012, NMAHS and SMAHS are expected to take responsibility for youth mental health services (16 years and over).

As of 1 July 2012, there will be two country health services: the Southern Country Health Service will include the WACHS regions of the Great Southern, South West and the Wheatbelt; the Northern and Remote Country Health Services will include the regions of the Goldfields, Kimberley, Midwest and Pilbara.

The Area Health Service (AHS) chief executives of each of these areas meet and report regularly at the State Health Executive Forum (SHEF) chaired by the Director General of Health.

The corporate governance of the AHS is mirrored in the operational offices for mental health. Each health area has a Mental Health Area Executive Director with offices of Deputy Executive Directors, Clinical Directors of Programs, Director of Nurse, Finance Director and Quality Assurance. These offices are responsible for the operation of the public inpatient and community mental health services within their regions.

Following the introduction of the Mental Health Commission, the mental health directors have continued the Mental Health Operations Review Committee (MH ORC) to discuss statewide issues. MH ORC has developed a statewide bed management policy for mental health. This committee no longer reports to SHEF and subsequently the line of communication to the Director General has been severed.

Since 1992 mental health services have reported quality data to the Australian Government under the National Health Care Agreement to the National Minimum Data Sets.[3] This includes the National Minimum Data Set for Mental Health Care and National Outcome and Casemix Collection (NOCC) data, such as the percentage of patients who are successfully followed up post-discharge within seven days (Department of Health 2009).

[3] National Minimum Data Set is a minimum set of data elements agreed for mandatory collection and reporting at a national level by the service providers.

Public mental health services and facilities in WA include:

Inpatient services

Graylands Hospital
The Frankland Centre
The Selby Older Adult
Joondalup Hospital
The Swan Valley Centre & The Boronia
The Ursula Frayne Unit, Mercy
20D Sir Charles Gairdner Hospital
Osborne Lodge
The Alma Street Centre
Ward 4.3 Fremantle Hospital
Leschen Unit, Armadale
Karri Mental Health Rehabilitation Unit (Armadale)
Banksia Ward (Armadale)
The Mills Street Centre, Bentley
Bentley Older Adult Mental Health Services
Mimidi Park, Rockingham
4 K Royal Perth Hospital
Albany Mental Health Unit
Princess Margaret Hospital
Kalgoorlie Hospital Mental Health
The South West Area Health Service – Acute Psychiatric Unit, Bunbury
Bentley Adolescent Unit/Families at work
Mother and Baby Unit King Edward Memorial Hospital

Adult community mental health services

Armadale
Bentley
Clarkson
Fremantle
Kalamunda
Hillarys
Inspire
Peel & Rockingham–Kwinana
Northbridge
Shenton
Stirling Street
Subiaco
Joondalup
ReachOut
Swan Valley
Warwick
Headspace
YouthLink
Youth Reach South

Child and adolescent community mental health services

Armadale
Fremantle
Kalamunda
Hillarys
Inspire
Peel & Rockingham–Kwinana
Northbridge
Subiaco
Joondalup
ReachOut
Swan Valley
Warwick
Headspace
YouthLink
Youth Reach South

Mental health rehabilitation services

Alma Street Centre Group Program
Bentley, Youth Transition
Centre for Clinical Interventions, Northbridge
East Victoria Park
Fremantle Living Skills Program
Hampton Road Service, Fremantle
Harrow House Living Skills, Subiaco
Horizons, Armadale
Kwinana Living Skills Centre
Mandurah Living Skills Centre
Scarborough Rehabilitation Service
South Guildford Centre
Viveash Rehabilitation Centre

(For all Western Australia mental health services see http://www.mentalhealth.wa.gov.au/getting_help/directory/SearchResults.aspx?ServiceType&Region=4)

2.3 Current admission, readmission, discharge and transfer policy for WA health services

The Admission, Readmission, Discharge and Transfer Policy (ARDT) for WA Health Services (Department of Health 2011a) provides an overarching framework for the rules and criteria that govern 'counting and labelling' of activity across the State.[4] The policy acknowledges the importance of the clinician's role in decision making and responsibility for clinical documentation, which enables accurate recording of service activity. This framework requires policy and decision rules to be developed within health services.

A summary of the framework's clinical requirements as they relate to this Review follows:

Mandatory recording at admission

The policy describes the broad categories for admission. It is expected that the clinician responsible for admission records the reason for admission and the expected length of time the patient will be in hospital at the time of admission (Department of Health 2011, p. 8).

Urgency of admission

Clinicians determine treatment and urgency and decide if the admission is elective (can be delayed for 24 hours or longer); emergency (should occur within 24 hours); or that the patient does not fit admission criteria—non-admitted patients.

Reasons for admission

Mental health patients may fit the criterion for physically unwell patients as well as ARDT s 2.5.3 reasons such as social factors, risk of self-harm and harm to others as factors that may influence the clinicians' decision to admit.

Care type

Clinicians must determine patient care types within several categories. Acute care is defined when treatment intent is to cure illness, reduce severity of illness or protect against exacerbation or complication of an illness that could threaten life or normal function; or to perform diagnostic and therapeutic procedures.

Rehabilitation is classified as sub-acute care (s 2.6.2). There are also provisions for maintenance care types, such as respite care, and care for patients with stable but severe levels of impairment and exceptional circumstances (s 2.7.9).

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[4] It is helpful to understand the many modes by which patients access the MHS. These access modes include:

- presenting to a GP and being referred to mental health services
- presenting to a hospital emergency department
- contacting help lines e.g. MERHL, RuralLink or healthdirect
- visits by community emergency response team (CERT)
- admission to hospital for physical care and obtaining a Hospital Psychiatric Liaison consult
- presenting to a community clinic or triage service in a mental health service
- being picked up by police and taken to a hospital emergency department
- being ordered to have a psychiatric assessment by a magistrate.

Triage in mental health services receives referrals for patients with mental illness.They contact the patient and undertake a risk assessment. This assessment determines the urgency of the referral and need for appointments with a specialist mental health clinician.

It is from the point that referral is accepted that the admission, readmission, discharge and transfer policy for WA health services applies.

Discharge destination

ARDT Pt 3 provides a definition of discharge ('separation'). When a patient is separated, the hospital ceases to be responsible for the patient's care and the patient is discharged from hospital accommodation. Formally, patients are discharged to private accommodation (their usual home) or another residence; transferred to another hospital, health service or other health care accommodation; dies; leaves against medical advice and does not return for continued treatment within seven days (leave without permission); or fails to return from leave within seven days (leaves with permission).

Discharge summaries

All admissions require that the Medical Officer complete a discharge summary at discharge (Department of Health 2011, pp. 47–48).

The summary must contain a statement:

a. that the intention is to not readmit the patient within 28 days or
b. the intention to readmit the patient within 28 days. Where patients with progressive/chronic conditions are expected to return to the hospital at some stage and an admission date is not planned, these patients are not routinely classified as planned readmissions.

Patient transfers

ARDT s 3.1 guides the recording of patient transfer between hospitals or health campuses. The definition of a transfer is when patients have been assessed or have received care and treatment in the first hospital and it is intended that the patient be admitted to the second hospital.

2.4 WA policy for clinical risk assessment and management

Risk assessment is guided by the WA Clinical Risk Assessment and Management Policy (CRAM) that prescribes a standardised approach for mental health services to assess and manage clinical risk. It takes the form of a framework that can be tailored to the specific requirements of each service. The framework is based on good risk management and treatment is based on the individual's history and circumstances. It acknowledges that mental health services are never risk free and that clinical risks such as suicide and violence cannot be predicted with 100 per cent accuracy (Mental Health Division 2008).

The CRAM Policy defines three major risk areas:

- risk of harm to self
- risk of harm to others
- risk of harm by others.

The policy also recognises system risks and risks 'that arise' in treatment that need to be considered. Risks are managed in a five-step process:

1. Establish the context.
2. Identify the risks.
3. Analyse the risks.
4. Evaluate and prioritise the risks.
5. Treat the risks.

The processes of admission and discharge of patients within MHS are recognised in the CRAM Policy as important steps in care delivery as defined by the policy. The policy and national standards for mental health services require that risk assessments and risk management plans are reviewed on the discharge or transfer of patients from mental health services.

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

Thematic review

In 2011 the Office of the Chief Psychiatrist (OCP) conducted a thematic review of admission, risk assessment, management plans, outcome measures, application of the *Mental Health Act 1996* and discharge planning processes within public mental health services in WA. The OCP's thematic review made 18 recommendations to standardise documentation and align practices across WA. In summary:

- Mental health patients should receive a comprehensive psychiatric assessment at every episode of care.
- Each patient should receive risk assessment in line with the CRAM Policy.
- All patients should have a current risk management plan.
- All patients should have an individual management plan on their record and on PSOLIS, including those that are 'Medical Only'.
- On patient discharge, there should be documented evidence in the medical file that the treating team is in agreement with the decision to discharge the patient. Alternatively, patient records should reflect why a decision different from the team plan for discharge was made.

That mental health services should ensure that carers are involved in discharge planning, where appropriate and patient consent is provided.