MJA
The Medical Journal of Australia

Appendix

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Griffiths KM, Mendoza J, Carron-Arthur B. Whereto mental health reform in Australia: is anyone listening to our independent auditors? *Med J Aust* 2015; 202: 172-174. doi: 10.5694/mja14.01034.

Appendix: Summary of the audit review findings [Adapted from p. 149 to 180][1]

Community mental health awareness

- Community programs required to increase public awareness that:
  - children and young people can suffer from a mental illness;[2]
  - children are capable of completing suicide;[3]
  - young people and children frequently signal their intention of doing so prior to the act;[3]
  - it is essential to take a child's threat of suicide seriously.[3]
- Children often use social media to communicate their intent to suicide; education programs should encourage young people to advise others in such circumstances.[4]

Prevention

- Programs for preventing mental illness are inadequate:
  - Evidence-based depression, anxiety and anti-bullying prevention programs targeting young people should be implemented;[2]
  - Parenting programs are inadequately integrated across agencies.[2]

Community-based mental health care

Inadequate access:

- Services in the community are frequently not accessible to a consumer until a problem has escalated to crisis point;[5]
- Access is often diagnosis- rather than needs-driven;[5]
- Those in justice settings have particularly poor access to mental health services[2,6-9] across the country. Young people,[2] those from rural and remote regions,[2] Indigenous or culturally and linguistically diverse background also have poor access;[2]
- Inequitable distribution of the workforce across community and hospital-based services in NSW with the bulk of the workforce located in acute settings;[10]
- Insufficient mental health professionals to address need;[2,10,11]
- Strategies designed to reduce demand for capped Access to Allied Psychological Referrals (ATAPS) services have compromised consistent and equitable access to care and sometimes its quality.[12] ATAPS referral typically managed by GPs, limiting its accessibility to those who infrequently visit GPs (eg, young people).[12]

Inadequate continuity of care and interagency cooperation

- Need to improve continuity of care and interagency cooperation in the community sector;[5,10]
- Lack of follow-up of consumers discharged from acute care,[5,10] failure to provide feedback to referring agencies[5,11] and to share care plans across services [5], and failure to agree on the division of responsibilities.[10]

Inadequate training

- Need for training and up-skilling of staff across a range of sectors.[2,5,7,9,11-13]

Inadequate monitoring, and reporting

- Inadequate monitoring, analysis and reporting of service data:[5,10-12,14]
  - eg, poor quality precluded one audit from determining the size of the mental health workforce in NSW;[10] WA Health did not monitor the numbers of consumer waiting for mental health services or the delays in receiving such care;[5] and in other jurisdictions there were gaps in assessing the outcomes of treatment.[11,12]

Other problems

- Lack of:
  - information about a service for consumers, carers[5,11] and health practitioners; [11]
  - clarity regarding mental health service entry and exit criteria;[5,11]

- formal mechanisms for prioritizing referrals; [11]
- assessments;[2,5,11]
- care plans.[5]

Crisis services

Human rights concerns

- Human rights concerns as follows:
  - 'Indifference and degrading' treatment[15] of some consumers;
  - Contrary to the service protocol, consumers sometimes transferred to hospital by police van rather than ambulance in the absence of safety concerns[15];
  - In a violation of the relevant Charter of Human Rights,[15] some consumers who were intoxicated but not dangerous were - by request of Crisis Assessment and Treatment Team (CATT) members - held in police cells rather than provided with healthcare.

Lack of timeliness

- Delays in CATT attendance.[15]

Inadequate inter and intra- agency cooperation

- Examples of agency cooperation included:
  - lack of awareness of or compliance with interagency protocols;
  - lack of representation of ambulance and consumers on health/police liaison committees;[15]
  - lengthy delays when a police car which ordered to transport a consumer only to the border of the adjacent police area and to wait there for the attendance of a police car and ambulance.[15]

Training gaps

- CATT staff and police inadequately trained in practical de-escalation strategies;[15]
- Police training should incorporate exposure to consumer perspectives.[15]

Inadequate monitoring

- Failure to keep records of CATT response time or outcomes of attendance;[15]
- Inadequate records for rural ambulance response times.[15]

Emergency hospital units

Lack of Timeliness

- Lengthy delays for emergency personnel to accept duty of care when consumers are transported to hospital by police. Police cannot leave until the formal transfer occurs. Their continued presence may distress consumers and the delays preclude the Police from taking other callouts. Interagency protocols are required to address this.[15]

Inadequate continuity of care & follow up

- Lack of access to diagnoses from other agencies (eg, from a forensic facility for a consumer presenting to hospital emergency);[7]
- Failure of staff to refer young people presenting to emergency unit for appropriate treatment or follow up.[2,7]

Inpatient hospital care

Inadequate access

- Lack of suitable facilities for young people,[2] those from rural and remote regions[5] and those in forensic settings[2,7,9] due to a lack of suitable facilities for these groups or settings;
- Older people unable to access inpatient care due an absence of community places for the existing consumers currently occupying inpatient beds.[11]

Lack of Timeliness

- Lengthy waits in Emergency units following a decision by hospital staff to admit a consumer.[7,13]

Assessment

- Inadequate protocols for physical assessment with some assessments clinically inadequate.[13]

Inappropriate or less than optimal care

- Inappropriate admission of children to an adult psychiatry unit[13] or transfer of older adolescents to an adult ward regardless of their readiness.[2]
- Low staff interaction with consumers and lack of responsiveness to consumers and carers.[13]

Human rights issues

- Need to improve practice with respect to informing consumers about their rights;[13]
- Lack of privacy and separate rooms for clinical consultations and interactions, the latter in violation of National Standards for Mental Health and Privacy legislation;[13]
- Voluntarily admitted consumers placed in locked wards;[13]
- Lack of an overall policy framework and protocols with respect to searching of consumers;[13]
- Instances of wrongful shackling of prisoners with a mental illness in hospital;[7,16]
- Perceived discrimination against forensic consumers.[13]

Inadequate continuity of care & lack of discharge planning

- Prison psychiatrists unable to access the electronic health care record system; these records need to be rolled out within the forensic system.[7]
- Lack of step-down or other facilities to which to refer young clients discharged from hospital linked to suicide.[2]
- Consumers discharged from hospital prematurely ('least unwell') due to pressure on beds and associated inadequate preparation for return to community.[13] Some consumers discharged from hospital without recovery plans;[10] 3.7% discharged homeless;[10]
- Lack of advice to carers that the consumer for whom they care has been discharged.[13] Staff insufficiently proactive in seeking consumer permissions to enable legal sharing of information currently and in the future.[13] A guide required to explain confidentiality issues to carers.[13]

Inadequate physical infrastructure

- Below standard facility with respect to physical state, cleanliness and design including restricted access to sunlight and clean air ([13], since rectified with new building);
- Adolescent ward described as 'looks and feels like a prison' with inadequate outdoor space ([2], since refurbished). Inquiry recommended young people participate in design of new service.

Workforce pressure

- Understaffing due to difficulty filling allied health positions.[13]

Inadequate policies

- Out of date, inconsistent policies, guidelines, protocols (eg, incorrect number for seeking emergency assistance on the ward).[13]

Housing

- *Access*: Substantial percentage of current inpatients inappropriately accommodated in hospital beds due to lack of access to supported accommodation.[17] This in turn creates a bottleneck for hospital access for other consumers.
- *Human rights*: Inequitable treatment of people with psychiatric compared to physical disabilities.
    - Systemic (policy) denial of disability accommodation to mental health consumers based on their primary

diagnosis, described by Ombudsman as a fundamental denial of human rights of consumers in NSW.[17]

- Inappropriately issuing 'tenancy breach' notices to clients with a mental illness as a means of 'coercing' consumers to rectify a fault or to prompt other services to support client.[17]

- *Interagency cooperation*: Need to improve co-operation and methods for information sharing between health and disability services and for disability services to accept responsibility for providing supported accommodation for mental health consumers.[17]
- *Staff training*: Need for practical training of housing staff to assist them to liaise with health and acquire practical strategies to support consumers; training for health staff to negotiate housing system.[17]

Social security

- *Barriers to engagement and communication*: Engaging with social security can be distressing and embarrassing for consumers (eg, retelling story repeatedly; lack of tailoring of communication methods for the condition such as face-to-face services for a person with agoraphobia).[18] Need to remove these barriers.[18]
- *Training*: Staff require training to recognise mental illness, to improve engagement and to create an environment in which clients are comfortable disclosing a mental illness to ensure they receive the services to which they are entitled.[18]

Wrongful immigration detention

- Multiple cases of wrongful detention due to poor administration and poor recognition of mental health issues by the Department of Immigration and Multicultural Affairs.[19] Gaps included:
  - Training: Staff require training in recognition of mental illness.[19]
  - Medical assessment: Any detainee suspected of being 'delusional' should be medically assessed.[19]
  - Records: Missing detainee records noted. Record keeping requires improvement; all records should document detainee's health and wellbeing.[19]

Veteran's program

- Department of Veterans' Affairs (DVA) mental health programs described as 'small', 'disparate' and of limited effectiveness with low program awareness and access by veterans and inadequate coordination of programs and services across the DVA. Also a lack of reliable mental health data;[20]
- Veterans consistently reported feeling abandoned by the Australian Defence Force when they were discharged on mental health grounds;[20]
- Communication strategy required to increase awareness of DVA programs among younger veterans.[20]

Child protection services and children at risk

- Inadequate mental health and risk assessment,[14,21-23] lack of suitable or timely access to therapy,[14,23] and inadequate care planning,[14] continuity of care,[23] and interagency cooperation,[4,21,23,24] for children requiring protection;
- Need staff training across sectors;[22,24,25]
- Services need to recognise the role of the multiple risk factors - family violence, substance misuse, mental illness – in the deaths of children.[24] Psychiatric services should incorporate a review of an adult consumer's child care responsibilities in their assessments;[22]
- Need to monitor staff training and awareness and adherence to child safety guidelines.[22,24]

Restraint through Taser use

- A high percentage of people tasered had a history of mental illness;[26]
- Tasers are usually deployed in accordance with standard procedures and there are strong accountability processes.[26] However, there have been some breaches of criteria for use (eg, repeated discharges with insufficient time for person to comply with instructions; use for ignoring instructions);[26]
- There is a need for Taser training to incorporate training in de-escalation strategies to avert the need to use Tasers. All general duty officers should undergo mental health training.[26]

References

1. Griffiths KM, Carron-Arthur B, Mendoza J. A systematic review of independent audits of mental health and associated services by statutory and related authorities. In: Mendoza J, Bresnan A, Rosenberg S, et al., editors. Obsessive-Hope Disorder: Reflections on 30 Years of Australian Mental Health Reform and Visions for the Future. Caloundra: ConNetica; 2013.
2. Commissioner for Children and Young People Western Australia. Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia. Perth: Commissioner for Children and Young People Western Australia, 2011.
3. Commission for Children and Young People and Child Guardian. Annual Report: Deaths of children and young people Queensland 2011–12. Brisbane: Commission for Children and Young People and Child Guardian, 2012.
4. Ombudsman Western Australia. Annual report 2011-2012. Perth: Ombudsman Western Australia, 2012.
5. Auditor General Western Australia. Health Teams: Availability, Accessibility and Effectiveness of Services. Perth: Auditor General Western Australia, 2009.
6. ACT Human Rights Commission. The ACT Youth Justice System 2011: A Report to the ACT Legislative Assembly by the ACT Human Rights Commission. Canberra: ACT Human Rights Commission, 2011.
7. Guardian for Children and Young People. Report of the Case File Audit of Mental Health Services for Children and Young People in Care. Adelaide: Guardian for Children and Young People, 2011.
8. NSW Ombudsman. Report of reviewable deaths in 2010 and 2011. Sydney: NSW Ombudsman, 2013.
9. Victorian Ombudsman. Investigation into prisoner access to health care. Melbourne: Victorian Ombudsman, 2011.
10. Audit Office of New South Wales. Mental Health Workforce: NSW Health. Sydney: Audit Office of New South Wales, 2010.
11. ACT Auditor-General's Office. Delivery of Mental Health Services to Older Persons. Canberra: ACT Auditor-General's Office, 2010.
12. Australian National Audit Office. Administration of the Access to Allied Psychological Services Program. Canberra: Australian National Audit Office, 2011.
13. ACT Human Rights Commission. Review of the ACT Psychiatric Services Unit. Canberra: ACT Human Rights Commission, 2009.
14. Child Death Case Review Committee (CDCRC). Annual Report 2011–12. Brisbane: Commission for Children and Young People and Child Guardian, 2012.
15. Victorian Auditor-General's Office. Responding to Mental Health Crises in the Community. Melbourne: Victorian Auditor-General's Office, 2009.
16. Ombudsman SA. Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals. Adelaide: Ombudsman SA, 2012.
17. NSW Ombudsman. Denial of rights: the need to improve accommodation and support for people with psychiatric disability. Sydney: NSW Ombudsman, 2012.
18. Commonwealth Ombudsman. Falling through the cracks: Centrelink, DEEWR and FAHCSIA: Engaging with customers with a mental illness in the social security system. Canberra: Commonwealth Ombudsman, 2010.
19. Commonwealth and Immigration Ombudsman. Report Into Referred Immigration Cases: Mental Health And Incapacity. Canberra: Commonwealth Ombudsman, 2006.
20. Australian National Audit Office. Administration of Mental Health Initiatives to Support Younger Veterans. Canberra: Australian National Audit Office, 2012.
21. Commission for Children and Young People and Child Guardian. Children of Parents with Mental Health Issues. Brisbane: Commission for Children and Young People and Child Guardian, 2008.
22. Commissioner for Children and Young People Western Australia. Annual report 2011-2012. Perth: Commissioner for Children and Young People, 2012.
23. Office of the Child Safety Commissioner Victoria. Connecting services: Learning from child death inquiries when the co-existing parental characteristics of family violence, substance misuse and mental illness place children at risk. Melbourne: Office of the Child Safety Commissioner Victoria, 2012.
24. NSW Child Death Review Team (CDRT). Annual Report 2009. Sydney: Commission for Children and Young People, 2010.
25. Commission for Children and Young People and Child Guardian. Follow up review of children of parents with mental health issues. Brisbane: Commission for Children and Young People and Child Guardian, 2009.
26. NSW Ombudsman. How are Taser weapons used by the NSW Police Force? Sydney: NSW Ombudsman, 2012.