The ED and mental health staff who participated in this Review supported the concept of an inter-hospital transport team as outlined in section 3.7.1. They postulated that hospital-trained staff in a hospital vehicle would ease many problems involving patient transfer between hospitals and mental health services. Although patients may still wait, an assurance of a pick-up time would ease tension. In addition, it would reduce demands on police and ambulance services, enabling them to attend to other priorities. With a more certain time of departure, ED clinicians could provide more appropriate sedation and have a clearer understanding of the resources needed, such as the level of security.

Among comments by carers was a concern that authorised persons described in the Mental Health Bill 2011 should be well trained and not private security guards. In addition, clinicians suggested that using hospital security personnel to ensure safety might have an effect of reducing the 'criminalising' of mental health behaviours.

This Review considers that mental health services should develop a safe and quality transport system in the metropolitan area with hospital staff trained in mental health and soft restraint.

A need to ensure adequate mental health-focused training of security personnel is mandatory for such a system to be efficient and safe.

See Recommendation 1: Governance (1.3).

3.8 Specific issues

3.8.1 Mental health services in remote areas

Irrespective of geographic location, provision of regular patient assessment and care intervention, emergency response, and carer training and support are core aspirations of mental health services.

The capacity of the mental health system is directly affected by the effectiveness of a workforce strategy that results in securing and retaining a skilled and qualified workforce across WA. This Review was made acutely aware of workforce and MHS capacity issues in remote areas.

The tyranny of distance is a feature of WA that acts to reduce capacity to provide optimal psychiatric care to communities in remote regions such as the Kimberley, the Pilbara and the Goldfields.

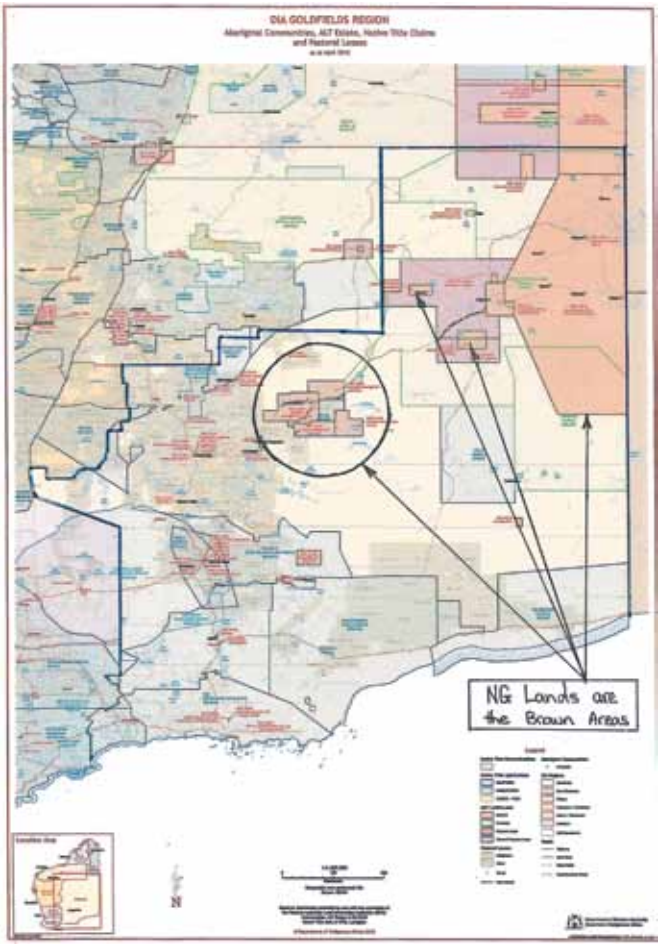
The rural and remote population makes up 28 per cent of WA's population and includes many Aboriginal persons who require special attention.

Mental health services in remote areas are intermittently provided by fly-in or drive-in practitioners and emergency responses include RuralLink telephone support, the RFDS and some volunteer-operated ambulance services.

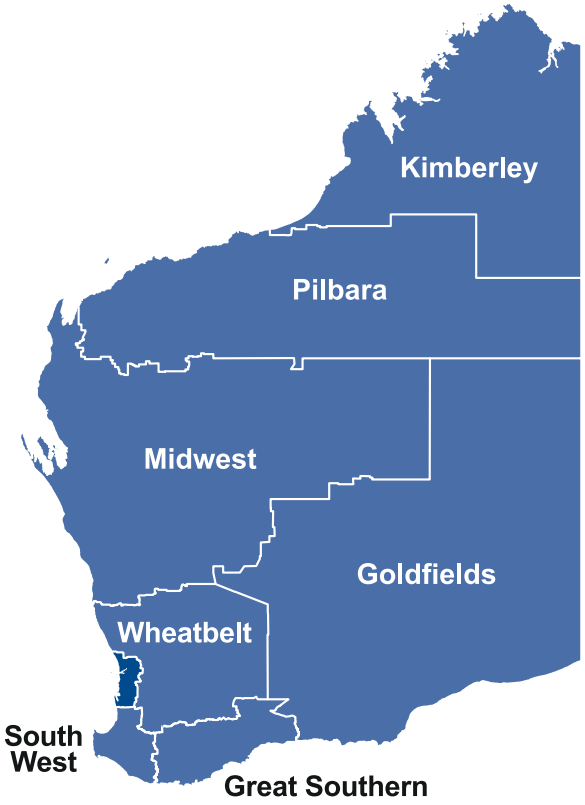
Remote area mental health care is provided in a hub-and-spoke model. Clinics are based in larger towns and staff travel to smaller towns and communities for a number of days at a time at regular intervals. The scarcity of GPs and lengthy travel by clinicians create obstacles to timely mental health care and there are virtually no after-hour services. Mental health care tends to focus on acute illness management and relies on frequent and regular communication with the GPs.

Figure 22 **Map 1 Tripartite lands & Map 2 WA country health region, 2012**

Map 1 *



Map 2



* Source: Map 1 supplied by Sidney J Carruth, Aboriginal Mental Health Coordinator, Kalgoorlie Hospital (2012).

Mental health care provision in the area to the north-east of Kalgoorlie is complicated by the influence of health and policing legislation of the three bordering states (tripartite lands). Australian states have disparate Mental Health Acts and, although cooperation between states exists, mental health workers in tripartite lands must manage three acts in addition to Commonwealth, State and local government legislation.

Each state provides services and it is not uncommon for several programs to be targeting different members of the same family, while many families receive no services. This complexity leads to staff tension in regards to who has the mandate, funding and capacity to provide services.

The Review was informed that there are occasions when services debate about who should be providing care, resulting in patients left to wait for services and increasing stress for the patient and for the family. These tensions are exacerbated by numerous service providers, each with a narrow focus, which sometimes results in each family member within a household receiving sporadic service from different agencies.

Mental health clinicians expressed concern to the Review about the difficulty of attracting and retaining mental health staff, rendering delivery of services uncertain. For example, they said services in Derby are insufficient to meet the current high level of self-harm. At present, there are two FTE mental health staff and one youth counsellor in Derby. These services are supplemented by fly-in consultant psychiatry and drug and alcohol services. Funding has been granted to rebuild the mental health clinic. However, expensive housing and the high cost of living in remote towns is believed to deter applicants from applying for vacancies.

Clinicians informed the Review that in some areas of the Great Southern mental health services are not currently available because of workforce shortages.

Fly-in, fly-out psychiatrists support the Kalgoorlie mental health service. For many patients with chronic mental health conditions, this is not a satisfactory arrangement for continuity of care, with patients likely to see different psychiatrists at each visit. For example, one patient saw five different psychiatrists over a three-week period. There is also a high turnover of staff, a loss of corporate knowledge and little knowledge about individual patients over time.

This shortcoming is constantly being addressed by services through clearly articulated processes and careful patient health documentation. The weakness of the fly-in, fly-out model is the discontinuity of care delivery by the same psychiatrist, and therefore written documentation and close liaison with the mental health team is essential.

In the Kimberley, psychiatrists reside in Broome and fly to Kununurra, Wyndham, Oombulgurri, Halls Creek, Kununurra and Kalumburru on alternate weeks. They also visit Derby, Fitzroy Crossing and Balgo via fly-in, fly-out visits every six weeks. Adult and child mental health clinicians and drug and alcohol clinicians stay in Balgo for three days every six weeks. The further outback is visited three monthly.

In the Pilbara and Goldfields, psychiatric care is also provided in a fly-in, fly-out model. The Western Desert and Canning Stock Route communities and Marble Bar receive three monthly visits (to bigger communities).

Psychiatrists are available one to two monthly in remote areas of the Great Southern and most referrals for patient assessment are received from GPs who prescribe medications informed by the psychiatrists' assessment and recommendations.

Carers in rural and remote areas told the Review that they feel particularly isolated and sometimes experience high levels of stigma. The provision of carer support and training is not a viable proposition when carers need to drive 400 km or so to attend centrally provided sessions (personal communication MIFWA representative 2012). It is also difficult for them to obtain assistance with health and caring issues.

Inpatient care in rural and remote areas is often provided in general hospital where patients are admitted under a GP and the psychiatrist provides consultation.

Mental health services provide assessments in EDs in addition to providing consultation to hospital patients. Flow charts and shared care guidelines clarify roles and responsibilities. To enhance collaboration, there are opportunities for general staff to orientate to the mental health service. Orientation of mental health clinicians to hospital services has recently commenced at Port Hedland.

Advances in technology have enabled some inreach of expertise into remote areas. Video-links enable assessment by psychiatrists for remote patients, who are transported by community mental health services to the nearest hospital with video-link capability.

Remote communities are supported by the comprehensive physical and mental health services from the metropolitan area, for example, RuralLink support, video-link assessment and on-call psychiatry advice 24 hours a day, and these should be promoted and actively offered.

Alcohol and cognitive impairment contribute to the enormous levels of cognitive disability, especially in the Kimberley, and there is no specific service for these conditions; instead, general hospital, community and mental health services provide the care.

The ED staff in all areas, and in particular the rural areas, should be required to complete education and competency testing in the skills of mental health assessment and de-escalating techniques.

ED medical officers and GPs in rural and remote areas should be encouraged to participate in the development of a clinical protocol for patients who present with behaviours associated with methylamphetamine and other drug-induced psychosis.

See Recommendation 1: Governance (1.1.6); Recommendation 2: Patients (all, particularly 2.7); Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development (4.11); Recommendation 5: Beds and Clinical Services Plan; Recommendation 7: Acute issues and suicide prevention (7.5, 7.7, 8.2); and Recommendation 8: Children and youth (8.8).

3.8.2 Aboriginal people and mental illness

When Aboriginal people experience mental illness, their symptoms are expressed within their cultural milieu and many prefer treatment within a family and community. In this cultural context, Western medicine continues to dominate and Aboriginal people do not have a place to receive cultural healing. This Review gave attention to the stories and views of contributors in this often-complex area for mental health service provision.

Improving the care of Aboriginal people with mental illness will require development of specific care models that integrate family and trusted members of the community to accompany and vouch for the persons with mental illness throughout their psychiatric/specialist treatment. The effectiveness of care models should depend upon a workforce of Aboriginal persons trained as psychologists, psychiatrists and mental health nurses, so that cultural methods of care can be applied alongside conventional psychiatry.

Note that while much of the focus of this Review in relation to Aboriginal people and mental health issues is on those in rural and remote areas, the importance of Aboriginal persons residing in metropolitan and large regional centres should not be diminished.

A young carer explained that in his community in Broome and the Central Desert, mental illness is accepted as always present within communities, and community members are constantly exposed to the symptoms and associated issues.

Community members, he said, were comfortable to accommodate members with mental illness in whatever capacity they could. Professor Helen Milroy, Winthrop Professor and Director of the Centre for Aboriginal Medical and Dental Health at the University of WA, also explained to the Review that communities have a long history of high tolerance to behaviours and symptoms of mental illness.

Past hospital admissions are remembered as poor experiences and the community lives with the intergenerational anxiety of the stolen generation and high rates of incarceration (personal communication A/Professor Wilkes & M Mitchell 2012).

Based on his experience as an Aboriginal psychologist, teacher and researcher, Darrell Henry identified that mental illness may manifest as a generalised anxiety and Aboriginal people often have multiple layers of trauma, some of which are generationally experienced. Issues include racism and a sense of minority and alienation.

Professor Milroy, who is a consultant child and adolescent psychiatrist with the Specialist Aboriginal Mental Health Service (SAMHS), is also concerned about the multilayered issues of Indigenous mental health that often lead patients to present late in an acute state and often requiring involuntary care.

Similar to other populations, young Aboriginal people with mental illness may have comorbid recreational drug and alcohol issues (personal communication R Menasse 2012). This experience can also be compounded by issues of unemployment, cultural destruction and relationship difficulties (personal communication R Menasse 2012).

The SAMHS is funded under the Closing the Gap National Partnership agreement until 2013. The treatment philosophy is ‘whole of life, whole of family’. This statewide program is governed by the North Metropolitan Area Health Service (NMAHS) and the WA Country Health Service (WACHS). Clinical governance is provided by the SAMHS Deputy Area Executive Director.

The aim of the program is to provide cultural security and integrity in MHS delivery by increasing the number of university-qualified Aboriginal mental health practitioners. Service provision includes: triage and brief interventions; consultation; liaison and shared care; inreach to Aboriginal people within inpatient settings, particularly the Frankland Centre; and contributing to multidisciplinary community mental health services, including case management.

Professor Milroy described the SAMHS program to be building capacity in the mental health workforce with Aboriginal clinicians undertaking university-level three-year courses. The program increases the responsiveness of mainstream services and supplies cultural consultation to them. The program also provides cultural training, including family systems and phenomenology, in line with overseas psychiatry courses.

Inviting families from remote areas to accommodation at Graylands is an initiative that seeks to demystify and destigmatise mental health treatment while the patient is in hospital.

Families are informed about the importance of continuing medication, even though the patient feels well. The program also ensures that SAMHS workers are part of the reception when the patient is discharged home. Obtaining accommodation for those that are sleeping rough is critical to ensuring follow-up occurs, as is escorting patients to their accommodation on discharge.

Aboriginal culture includes a personalisation of everything they do. Mr Henry remarked that when Aboriginal persons require assistance they will seek a receptive person who will assist them beyond the mental illness symptoms with the wider stressors of accommodation and drug problems. He explained that some Aboriginal people fear the mental health services, and it is important that mental health workers develop therapeutic alliances with the community.

Mr Henry said one of the skills taught in the care of Aboriginal people is the importance of listening to inner stories. Inner stories can be difficult to identify unless the clinicians work very closely with the community. In this environment, it is possible to develop an openness and network to support the person with mental illness and the community. Mr Henry noted the importance of providing courses and training to Aboriginal health workers.

A young carer said explanations about mental illness from a Western cultural perspective are not always culturally appropriate. For Aboriginal people, it is more important that the disease be explained in the context of what are useful and not-so-useful activities for the individual and community to do. The young carer proposed that the community was the best place of care for most Aboriginal people and more could be done to support the community in their care of members with mental illness.

The care of Aboriginal patients with mental health issues is made much more difficult for those who live in rural and remote areas because hospitalisation may require transfer to acute facilities in Perth and the fear of incarceration and separation from family and lands adds heavily to a patient's stress as well as to that of their family.

Associate Professor Ted Wilkes, a proud Noongar man and a Prime Ministerial appointment to the Australian National Council on Drugs and the Derbarl Yerrigan Health Service in Perth. He explained that Aboriginal people often use services when they are in crisis and do not return for follow-up treatment. To support ongoing care, communities need to establish partnerships with mental health services that also foster development of appropriate service models to be able to respond effectively to the needs of Aboriginal people who have mental illness.

Moreover, the written communication style of mainstream services, such as referral letters and discharge plans, in addition to phone calls, do not suit the culture of communities who rarely answer telephones or letters and who are itinerant. An executive of MHS suggested that in addition to encouraging individuals to seek help and support, parenting programs and mental health first-aid courses are needed by communities to assist them to support their members with mental illness.

Aboriginal people's degree of disadvantage is such that that they require special pathways to assist them (personal communication Professor Wilkes 2012). Communities require a structure to enable Elders to form positive pathways (personal communication Professor Wilkes 2012).

Suicide is occurring in younger children and children as young as six play 'hanging games'. Professor Milroy commented that such acting out results from multiple exposures to the volatile state of adolescents. In addition, there is much concern about the high numbers of

Aboriginal persons in the juvenile justice system and on remand. For example, there is a high number of Noongar boys at Banksia Hill Detention Centre (40% of population).

One view expressed to the Review was that the lack of Elders within Aboriginal communities has depleted the presence of mentors and many children and young people are subject to antisocial behaviours, violence, aggression and illicit drugs. When mentors are available, children fare better and are able to achieve educational and vocational goals. However, with the shortened lifespan of Aboriginal persons, along with high levels of chronic illness and high numbers of young adults in jail, there are few Elders to guide young people.

It was proposed by a contributor to the Review that cultural healing centres be strategically placed on Noongar land in areas in the south-west, such as Esperance, Katanning, Swan River and Albany. A similar strategy has been successful in New Zealand where Mäori healing centres have been established. It would be sensible in WA for mia mias (shelters) to be constructed to provide a place for spiritual and cultural healing (personal communication Professor Wilkes 2012).

There is in-principle support for a culturally appropriate model of mental health care. However, best practice models are yet to be identified (personal communication Professor Wilkes 2012). Current services have an emphasis on acute care and it is important that Aboriginal people are engaged in the development of any plan to improve their mental health.

The Deputy State Coroner remarked that there are no specific training programs to assist Aboriginal people with mental health issues in their environment. The Review acknowledges this absence of training programs, noting that an important theme for the future is to ensure that patients and carers have sufficient and practical access to targeted training programs.

Capacity building is an important concept when considering improving the delivery of mental health services.

The Review notes other areas that should be afforded considered and serious attention:

- Cultural sensitivity and cultural competence must be core competencies of practice.
- Development of the SAMHS suicide intervention team, including the support of Aboriginal Elders, specialist mental health services and government and non-government services, is supported (Commissioner for Children and Young People 2011).
- Concerted attention directed at factors such as substance abuse, foetal alcohol disorders and head injuries should be part of improving the mental health for Aboriginal communities (Commissioner for Children and Young People 2011).
- Ensure that admission, referral, discharge and transfer policies, practices and procedures of mental health services are attentive to and meet the cultural needs of Aboriginal children and young people (Commissioner for Children and Young People 2011).
- Ensure that SAMHS and the Infant, Child, Adolescent and Youth Mental Health Service establish a close working relationship and seamless referral process to ensure the best possible outcomes for Aboriginal children and young people (Commissioner for Children and Young People 2011).

See Recommendation 3: Carers and families; Recommendation 7: Acute issues and suicide prevention (7.6, 7.7, 7.8); and Recommendation 5: Beds and Clinical Services Plan and Recommendation (8.10.3; 8.10.4).

3.8.3 People from culturally and linguistically diverse backgrounds (CALD) and mental illness

Patient and families' understanding of mental illness, associated issues of consent, understanding of available care, legal rights and myriad related aspects are potentially inhibited when the patient and family are from culturally and linguistically diverse backgrounds.

The Ethnic Disability Advocacy Centre advised the Review that navigating the mental health system and understanding what care is provided can be particularly difficult and traumatic for people of a CALD background. The language and terminology or jargon used by clinicians to explain mental illness and treatment are at times complex and unfamiliar. In the absence of language and cultural interpretation, a person of a CALD background is unlikely to understand or to be adequately informed, rendering them impotent in relation to understanding their illness and treatment.

The advocacy service advised the Review that CALD patients require assistance to navigate the complexities of the mental health system and to understand care and follow-up treatment. Ethnically sensitive interpreters with expertise in mental health issues are frequently used within mental health care services.

This Review did not explore the full extent of the CALD population and associated cultural features of various population groups. The Reviewer did attend the Mental Health Access Multicultural Centre in Fremantle where a group of patients shared their experiences of migration and refuge in Australia. When mental illness further complicated their lives, these patients were assisted by the multicultural centre to navigate the system. Overall, the patients were satisfied with mental health services and the support they received from the multicultural services.

The issues they experienced included difficulties communicating with inpatient staff about a patient's general health issues; discharge occurring before symptoms were controlled; comorbid pain exacerbating mental illness; income; and accommodation.

To increase staff knowledge and sensitivity to the needs of patients from CALD backgrounds, courses on multicultural issues have been provided to staff in mental health services. These training programs on managing cultural diversity are mandatory.

This Review also received a submission from the Mental Health Law Centre about CALD patients. That submission asserted that mental health practitioners should be trained in cultural and linguistic diversity and the use of interpreters. The National Cultural Competency Tool for mental health services (Multicultural Mental Health 2010) should be implemented.

The Review considers that cultural competency should be emphasised in ongoing mental health education and that appropriately qualified interpreters be used to ensure that CALD patients and families receive information in a form, written or verbal, to enable them every opportunity to be fully informed and engaged in care.

The Review also supports the West Australian Transcultural Mental Health Centre's recommendation that translated information about the mental health services role, the patient's condition and treatment should be made available to the patient and carer and that the use of interpreters to convey information is imperative.

See Recommendation 1: Governance (1.5).