Western Australian Auditor General's Report

Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services

Report 10 – October 2009

THE PRESIDENT
LEGISLATIVE COUNCIL

THE SPEAKER
LEGISLATIVE ASSEMBLY

PERFORMANCE EXAMINATION – ADULT COMMUNITY MENTAL HEALTH TEAMS: AVAILABILITY, ACCESSIBILITY AND EFFECTIVENESS OF SERVICES

This report has been prepared for submission to Parliament under the provisions of section 25 of the *Auditor General Act 2006*.

Performance examinations are an integral part of the overall performance auditing program and seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities thereby identifying opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance parliamentary decision-making to the benefit of all Western Australians.

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AUDITOR GENERAL
14 October 2009

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Auditor General's Overview

Despite one in five Australians experiencing mental illness, historically there has been significant stigma around mental illness. Traditionally care was delivered in institutions, removing people from their communities. Both these things are changing. There is more education and less stigma about mental illness and the vast majority of people with mental illness are now cared for in the community.

Although attitudes and approaches to care are changing, the consequences for individuals and the community of not helping people with mental illness to live meaningfully in their communities remain the same. Without help they will often struggle to be part of their families and social groups, look after themselves, get jobs and somewhere to live. In severe cases they will be at greater risk of self-harm, suicide and ending up homeless or in jail.

People with mental illness are particularly vulnerable to not being heard. The nature of their illness often leaves them unable to articulate and assert their needs, and find the right services. They, and their carers, are not adequately involved in their own care.

Gaps in service availability and access mean there are still too many people for whom the experience of care is not a good one, and who slip into crisis before getting help. Making sure that people with mental illness can get the care they need, when and where they need it is not easy or quick to achieve, and the Department of Health has not yet got it right.

The Director General of Health in his response to this report has said that mental health care is on the threshold of significant reform. The reform presents an opportunity to get it right by better understanding and meeting the needs of people with mental illness, their carers and the community.

Executive Summary

Introduction

Mental illness will affect 20 per cent of Australian adults in any one year. One-fifth of those will suffer from a severe mental illness. Mental illness includes a range of disorders which affect an individual's cognitive, emotional or social abilities. It includes illnesses such as anxiety and depression, bipolar disorder and schizophrenia.

The consequences of not providing care for people suffering from mental illness are likely to be significant for them and the community. Mental illness can affect a person's capacity to interact with their family and friends, look after themselves, to get and keep a job and a place to live. In more severe cases and without adequate help, people with mental illness can be hospitalised for long periods, be at higher risk of self-harm and suicide, and be more likely to be homeless or in jail.

The approach to providing mental health care has changed. It has moved away from providing care in institutions to community-based care. Some people still spend time in hospital, but each year three times more mental health care consumers are cared for in the community than in hospitals.

The main objectives of community mental health care are to enable consumers to receive care in their own communities rather than hospital, and to provide care that helps consumers stay and participate in their communities. These are demanding objectives given the range of illnesses and because mental illnesses are often long-term and many consumers do not fully recover.

The shift to community-based care is reflected in the allocation of funding. The State Government allocated $189 million to community mental health services in 2008-09. Based on the budget allocation for 2009-10, funding will have increased by 45 per cent since 2005-06. WA Health needs to be confident that this increased investment is targeted at identified areas of need, and is effective.

To enable consumers to live locally and engage with the community means that a wide range of services has to be consistently provided across the state. This places different demands on the way services are planned and provided, and changes the ways consumers access them.

For community-based care, planning what services to provide and how to do so has to be more focused on existing and likely future needs in a community, so that the right services are available in the right place at the right time. Mental illness can diminish a consumer's capacity to access the services they need, so standard models of healthcare involving referral to centralised specialist services are not always practical or effective.

Clinical treatment in the community, to be effective, often has to be supported by non-clinical services such as accommodation and help with employment, social and personal skills. This involves coordinating services from other agencies and non-government organisations with those provided by Community Mental Health Teams (CMHTs).

To deliver the majority of community mental health services, WA Health relies on CMHTs at 39 locations across the state. They provide services including initial assessment, treatment (clinical and therapeutic interventions and rehabilitation) and referral to other services (such as housing, education, training and employment). In 2007-08, these teams provided services to 28 500 adults, approximately 2.1 per cent of the state's population.

The definition of a team in this report is 'a multidisciplinary group of professionals providing care to consumers in a defined area'. CMHTs are multidisciplinary including a range of clinicians and allied health professionals. They provide services including initial assessment, treatment (psychology, clinical intervention and rehabilitation) and referral to other services (such as education, training and employment). We excluded centralised teams who provide care throughout the state.

We examined adult (age 18 to 64) CMHTs. We assessed the services provided by each of the three Area Health Services, as well as the support provided to adult CMHTs by the Mental Health Division and the Office of the Chief Psychiatrist. We focused on three key questions:

- Are the CMHT services available – are the services that consumers might need consistently in place and offered to them?
- Are the services offered by CMHTs accessible to consumers – can consumers get the services they need when they need them?
- Are CMHT services effectively delivered to provide quality care and achieve good outcomes – is care well-planned, are consumers and carers engaged and are measures of effectiveness defined and monitored?

In assessing these questions we reviewed information from two perspectives:

- We reviewed WA Health's planning, provision and evaluation/monitoring of CMHT services through their strategy, plans, policies and performance measurement.
- We assessed consumers' and carers' experience of CMHT services through patient file reviews, focus groups and interviews.

We have not examined the quality of individual clinical care provided to consumers. The clinical care provided to consumers is covered in clinical protocols published by the Chief Psychiatrist and in his clinical governance reviews.

Audit Conclusion

The geographical spread of the CMHTs ensures that general mental health services are available locally in most communities. However, WA Health does not have the planning and resourcing mechanisms in place to ensure that the mix of services provided by CMHTs consistently reflects the consumer needs they are trying to meet.

The consumer experience of CMHTs varies. Consumers recognise the efforts of individual clinicians, but often have difficulty in finding and getting the right services at the right time. This can lead to consumers being in crisis before they get help. The care consumers receive can depend more on where they live than their needs. Consumers and carers are not adequately involved in the planning and review of care.

What CMHTs are trying to achieve, beyond providing care to individual consumers, is unclear. WA Health has not put in place consistent overall objectives for CMHTs. WA Health does not have a framework for evaluating CMHT service delivery and does not monitor their overall effectiveness. It is not clear that the increased investment in community mental health is being targeted to the most efficient and effective services.

Key Findings

- CMHTs make assessment and general services available locally in most communities from 39 locations throughout the state.
- WA Health does not have the planning and resourcing mechanisms in place to ensure that CMHT services consistently reflect community needs, leading to gaps in the availability of services:
  - The range of services available in each CMHT has developed in an ad hoc way in each location rather than being planned to make the right mix of services available.
  - The services that a CMHT provides and its resourcing are not based on analysis of community need, leading to variation in service availability.
- For consumers, gaps in the availability of services mean that their care is often driven more by where they live than their assessed needs.
- Over 80 per cent of services provided by CMHTs focus on acute care and only six per cent on rehabilitation, so care is often crisis-driven.
- CMHTs accept referrals from a number of sources which means consumers are not restricted to a single pathway.

- Inconsistent access to adult CMHTs means consumers have difficulty finding and getting the care they need when they need it:
    - Access criteria are inconsistent across CMHTs so consumers with the same needs are likely to receive different treatment depending on where they live.
    - The time it takes consumers to access services puts them at risk of deteriorating into crisis before they get the care they need.
    - WA Health is not ensuring consumers get timely access to services after discharge from hospital. They have not met their target for contacting 70 per cent of consumers within 14 days after their discharge from hospital.
    - Almost half of mental health consumers do not receive good information and find it difficult to get the services they need.
- Consumers often need more services than just those provided by CMHTs, but the sharing of information and coordination between services is often limited, making it harder for consumers to access all the services they need.
- Gaps in care planning and consumer and carer involvement reduce the quality of care delivery:
    - Care planning is not yet consistent for all consumers reducing the likelihood they will get the right care – 22 per cent of our sample did not have a care plan.
    - Consumers and carers are not adequately involved in planning and reviewing their care. Consumer involvement and ownership of their care plan is important to its success.
- WA Health does not know if funding is being targeted to the most efficient and effective CMHT services:
    - A comprehensive set of CMHT objectives that link to broader WA Mental Health objectives is not in place.
    - WA Health does not monitor the overall performance of CMHTs and does not have a framework for doing so.
- CMHTs monitor individual consumer progress, but there is no overall assessment of the effectiveness of services, reducing the potential for effective services to be replicated more widely.
- Independent reviews and complaints about CMHTs do not consistently prompt operational change and improvement.

Recommendations

WA Health should:

- define the standard set of services which should be available from CMHTs
- revise its planning processes so that service availability and resource allocation explicitly reflect community need
- finalise the 2010-2020 strategy for WA mental health services, currently under development, in a timely manner
- ensure that the minimum standards contained in the National Standards for Mental Health Services are monitored and reported as part of an overall service evaluation framework across CMHTs
- help consumers avoid deteriorating into crisis by:
  - assessing and providing an appropriate mix of assessment, early intervention, acute and rehabilitation services
  - identifying ways of providing CMHT services to consumers with a severe mental illness without a diagnosis if they have an assessed need
- provide consistent access to services regardless of where a consumer lives
- contact consumers within seven days of hospital discharge in line with agreed national good practice targets
- provide clear information about services and treatment options to all CMHT consumers
- effectively coordinate access to clinical (assessment, treatment, rehabilitation, dual diagnosis) and support services (accommodation, training) for consumers so they receive all the services they need
- ensure that every consumer has a consistent care plan which is agreed with them and is regularly reviewed and updated
- develop and implement a framework and suite of performance measures for monitoring and reporting the efficiency and effectiveness of CMHT services
- systematically track and monitor the outcomes of reviews and complaints so they feed into improvements in service delivery.

Response from the Department of Health

It is well accepted that many of the determinants of good mental health and of mental illness, are influenced by factors beyond the health system. A whole of government approach is required to address the complex nature of mental health and mental wellbeing and to ensure optimal service provision for people with mental illness. The examination of adult community mental health teams was conducted during a period when the mental health sector is on the threshold of significant reform both at a national and state level which reflects this approach.

The Department of Health welcomes the findings of the performance examination. The recommendations will be used to inform the development of the State Mental Health Policy and the Mental Health Strategic Plan 2010-2020 for WA.

Introduction

Mental illness covers a range of disorders and mental illness will affect one in five Australians during their life

Mental illness is a term used to describe a number of disorders which significantly interfere with an individual's cognitive, emotional or social abilities. It includes illnesses such as anxiety and depression, bipolar disorder and schizophrenia.

Mental illness will affect 20 per cent of Australian adults in any one year. One-fifth (21 per cent) of those people will suffer from a severe mental illness, one-third (33 per cent) a moderate illness and just under half (46 per cent) will experience a mild illness.

In 2007-08, around 28 500 Western Australian adults (2.1 per cent of the adult population) had contact with adult community mental health teams (CMHTs) and 9 700 adults had an inpatient stay for a mental illness. The majority of adult CMHT consumers are located in metropolitan areas, and a quarter in rural areas. Around 16 per cent of CMHT consumers moved between the three Area Health Services (AHS) in 2007-08.

In Western Australia mental health services are delivered by state government organisations, private providers and community-based non-government organisations (Figure 1).

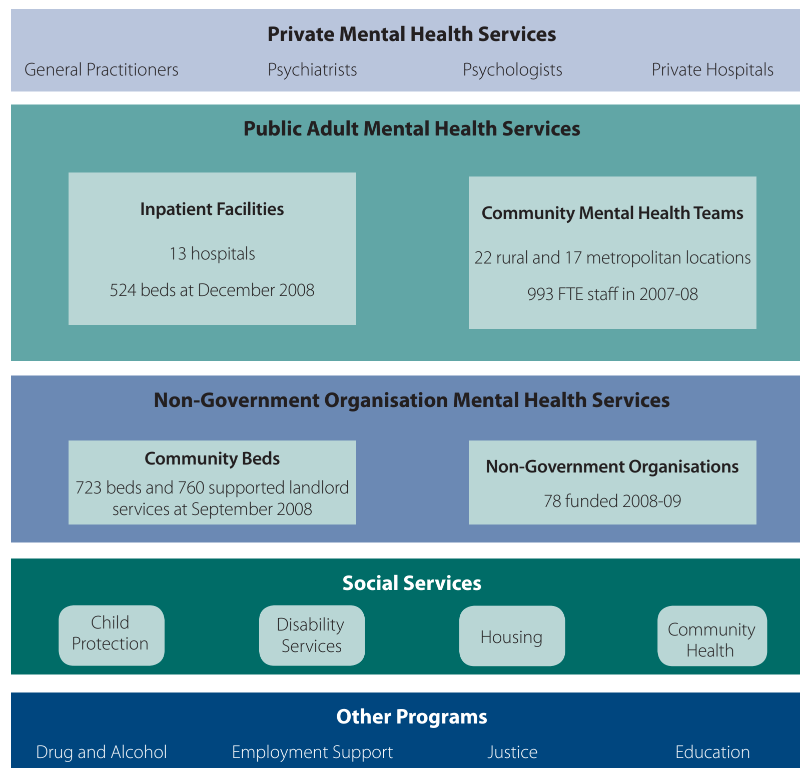

Figure 1: Government and private mental health and related services

A wide range of services are available for adults with a mental illness.

Source: OAG adapted from *Improving Mental Health Outcomes in Victoria*, 2006

The consequences of not providing care can be significant for consumers and the community

The consequences of not providing care for people suffering from mental illness can be significant for them and the community. Mental illness can affect a person's capacity to interact with their family and friends, look after themselves, and get and keep a job and a place to live. In more severe cases and without adequate help, people with mental illness can end up being hospitalised for long periods, be at higher risk of suicide, and be more likely to be homeless or in jail.

Based on a national survey of mental health and wellbeing for people who had experienced a mental disorder within a given 12-month period:

- One-third reported having no family members upon whom they can rely compared to five per cent of the general population.
- One-third also had a physical illness.
- People with a mental disorder are over three times more likely to be suicidal than the general population (8.6 per cent compared to 2.3 per cent).
- The prevalence of mental illness in the homeless (54 per cent) was two-and-a half times more than the general population (20 per cent).

Other research indicates that 15 per cent of people in prison have a severe mental illness, three to five times the incidence among the general population.

The approach to delivering mental health care has changed to community rather than institutional care, changing the demands on the mental health care system

Historically, mental health care was provided in hospitals and institutions. This approach has changed to community-based care. Some people still spend time in hospital, but the vast majority of mental health care consumers in Western Australia are cared for in the community.

The main objectives of community mental health care are to enable consumers to receive care in their own communities rather than hospital, and to provide care that helps consumers stay and participate in their communities. These are demanding objectives to achieve. To ensure that consumers are able to live locally and engage in their community means that a wide range of services has to be consistently provided across the state. If these services are not available or accessible the alternative for many consumers is either no care or hospitalisation.

Moving care into the community has impacted on the way mental health services are planned and provided, and consequently the ways consumers access them has also had to change. To make sure services are appropriate and increased investment is well used, the mix of services provided has to be needs-based, which requires WA Health to have a good understanding of existing consumer needs and likely trends in future demand for services.

Mental illness can also diminish a consumer's capacity to access the services they need, so standard models of healthcare involving referral to centralised specialist services are not always practical or effective. For instance, due to their illnesses, mental health consumers can find it difficult to access transport and travel to centralised locations. This means a broader range of services has to be provided in more places when care is based in the community.

To ensure a consumer can remain in the community, clinical treatment often has to be supported by supportive non-clinical services such as accommodation and help with employment, social and personal skills. This involves coordinating services from non-government organisations and other agencies with those provided by CMHTs. As more care has been moved into the community, the need for these kinds of services and their effective coordination has grown.

The shift to community-based care is reflected in the allocation of funding. Between 2005-06 and 2009-10 there was a 45 per cent increase in the budget allocation for community mental health services from $128 million to $185 million. This included funding for government and non-government services and child and adolescent, adult and elderly services.

Based on data provided by AHSs in 2007-08 as part of the National Minimum Data Set, WA Health estimated that almost 80 per cent ($128 million of the $161 million allocated as part of the State Budget for all community mental health services in that year) of community mental health service funding was spent on government CMHT services. A further $30 million was allocated to non-government organisations for both community and inpatient care.

CMHTs provide services to consumers with the most severe mental illness in the community

Adult CMHTs provide services to consumers with severe mental illness in the community. Severe mental illnesses include the most severe manifestations of psychotic illness such as schizophrenia as well as severe depression and anxiety disorders. These illnesses affect around two per cent of the adult population at any one time.

CMHTs are based at 39 locations (17 metropolitan and 22 rural) and rural teams also travel to outlying areas on a rotational basis to provide sessional care. There is no standard definition for a 'team'. For this report a team is a multidisciplinary group of professionals providing care to consumers in a defined area. We excluded centralised teams who provided care throughout the state.

Teams are made up of staff from different disciplines including medical, nursing and allied health staff such as social workers, psychologists and occupational therapists. In some areas these staff are supported by other professionals, for example Indigenous Support Workers.

The teams provide a range of services which include initial assessment and treatment (psychology, clinical intervention, and rehabilitation) as well as referral to other services (accommodation, social skills, employment training) provided by non-government organisations and other government agencies. CMHTs also provide support to the carers and families of consumers with a mental disorder.

The Department of Health objectives for mental health services are to:

- be a national leader of integrated, high quality mental health programs that are developed in partnership and effectively and efficiently promote mental health and wellbeing and reduce the incidence of mental illnesses
- ensure safe, reliable and timely mental health services
- enable optimum recovery and minimise the impact of disability and disadvantage.

Some mental illnesses are more resource intensive than others

The number of consumers within a particular diagnosis does not drive the level of care required. Some diagnoses require that consumers receive more resources than others. For example in 2007-08, consumers with schizophrenia accounted for 13 per cent of consumers but had 30 per cent of the occasions of service (Figure 2).

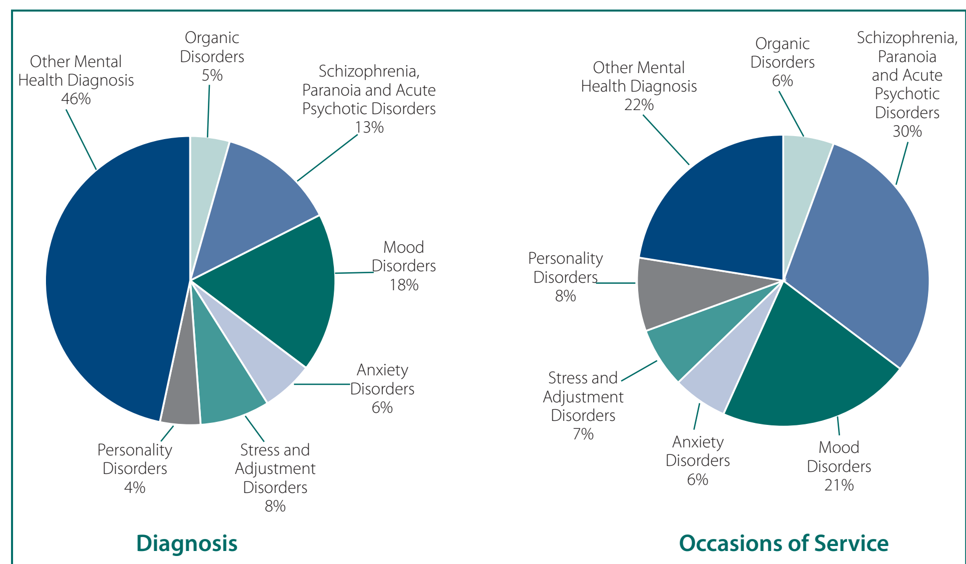

Figure 2: Diagnosis and occasions of service of consumers using adult community mental health services 2007-08

Occasions of service do not occur in direct proportion to number of consumers with a particular diagnosis.

Source: OAG

Examination focus and scope

We examined adult (ages 18 to 64) CMHTs. We conducted the examination between January and May 2009. We assessed the services provided by each of the three AHSs (North Metropolitan, South Metropolitan and WA Country Health), as well as the support provided to adult CMHTs by the Mental Health Division and the Office of the Chief Psychiatrist.

We focused on three key questions:

- Are the CMHT services available – are the services that consumers might need consistently in place and offered to them?
- Are the services offered by CMHTs accessible to consumers – can consumers get the services they need when they need them?
- Are CMHT services effectively delivered to provide quality care and achieve good outcomes – is care well planned, are consumers and carers engaged and are measures of effectiveness defined and monitored?

In assessing these questions we reviewed information from two perspectives:

- We reviewed WA Health's planning, provision and evaluation/monitoring of CMHT services through their strategy, plans, policies and performance measurement.
- We assessed consumers' and carers' experience of CMHT services through patient file reviews, focus groups and interviews.

In conducting the examination we:

- visited community mental health teams and interviewed a range of staff including managers, clinicians and support staff
- visited metropolitan and rural hospital emergency departments and held interviews with staff
- held focus groups with consumers, carers and non-government organisations
- conducted document and data analysis.

We considered the following national guidelines and policies:

- National Standards for Mental Health Services (1996)
- Key Performance Indicators for Australian Public Mental Health Services (2005)
- Draft National Standards for Mental Health Services (2008)
- Draft Fourth National Mental Health Plan 2009-2014 (2009).

We have not examined the quality of individual clinical care provided to consumers. The clinical care provided to consumers is covered in clinical protocols published by the Chief Psychiatrist and in his clinical governance reviews.

The examination did not assess related services for mental health consumers such as inpatient care, community accommodation, psychosocial support, disability or drug and alcohol services. However, we assessed the liaison and interaction CMHTs interface have with these services.

We conducted the examination in accordance with the Australian Auditing Standards.

There are gaps in the services available to consumers because the planning and resourcing of CMHTs have not been based on community needs

Findings

- CMHTs make assessment and general services available locally in most communities from 39 locations throughout the state.
- WA Health does not have the planning and resourcing mechanisms in place to ensure that CMHT services consistently reflect community needs, leading to gaps in the availability of services:
  - The range of services available in each CMHT has developed in an ad hoc way in each location rather than being planned to make the right mix of services available.
  - The services that a CMHT provides and its resourcing are not based on analysis of community need, leading to variation in service availability.
- For consumers, gaps in the availability of services mean that their care is often driven more by where they live than their assessed needs.
- Over 80 per cent of services provided by CMHTs focus on acute care and only six per cent on rehabilitation, so care is often crisis-driven.

Recommendations

WA Health should:

- define the standard set of services which should be available from CMHTs
- revise its planning processes so that service availability and resource allocation explicitly reflect community need
- finalise the 2010-2020 strategy for WA mental health services, currently under development, in a timely manner
- ensure that minimum standards contained in the National Standards for Mental Health Services are monitored and reported as part of an overall service evaluation framework across CMHTs
- help consumers avoid deteriorating into crisis by assessing and providing an appropriate mix of assessment, early intervention, acute and rehabilitation services.

Community mental health teams make assessment and general services available locally in most communities from 39 locations throughout the state

The majority of the 39 CMHT locations are on sites away from or separate to hospital or acute care facilities. Nine of the sites are located in the North Metropolitan Area Health Service (NMAHS), eight in the South Metropolitan Area Health Service (SMAHS) and 22 in the WA Country Health Service (WACHS). At each site there may be more than one team providing services. Teams provide initial assessment and some general treatment services, and the number and spread of teams makes these services locally available in most communities.

The variation between country and metropolitan services partly reflect the difficulties in making services locally available to low population density communities spread over wide geographical areas.

WA Health does not have the planning and resourcing mechanisms in place to ensure that CMHT services consistently reflect community needs, leading to gaps in the availability of services

The range of services available in each CMHT has developed in an ad hoc way in each location rather than being planned to make the right mix of services available

The mental health needs of the population vary from location to location so CMHT services need to be tailored to meet those needs. This means that there should be some variation in the services provided by CMHTs. We found that current service availability is not driven by consumer demand and the variation in service provision does not result from a planned approach to matching services to community needs.

Variations in the services available tend to be historical, pilot programs have continued, but not been applied to all CMHTs where there is demand for them. For example, the SMAHS accounts for 44 per cent of metropolitan consumers, but has twice the number of rehabilitation services of the NMAHS which has 56 per cent of metropolitan consumers (Table 1).

Service Type		NMAHS	SMAHS	WACHS	Total
Early Intervention	Early Intervention Services	1	3	0	4
	Community Emergency Response Teams	5	6	0	11
Acute Care	Assessment Services	12	21	20	53
	Acute General Services	14	15	29	58
	Acute Specialist Services	3	5	0	8
Rehabilitation	Rehabilitation Services	2	4	2	8
Total		**37**	**54**	**51**	**142**

Table 1: Overview of CMHT services by Area Health Service 2008

A range of services are provided by CMHTs, but not on a uniform basis.

Source: OAG

The National Standards for Mental Health Services indicate that there should be a strategy for service development and delivery. The last strategy in Western Australia expired in 2007 and there has been no framework to guide service development since then. WA Health is currently developing a 10-year plan which will run from 2010-2020.

The services that a CMHT provides and its resourcing are not based on analysis of community need, leading to variation in service availability

Current processes for resource allocation do not explicitly consider community and consumer need, local demographics or socio-economic conditions. Research indicates that there are relationships between the incidence of mental illness demographics and socio-economic conditions. Neither the Mental Health Division, Area Health Services nor individual CMHTs have undertaken a wide-ranging analysis of the needs of the community. Without an understanding of community and consumer need and demand for services, it is not possible to determine whether the mix of services provided meets the needs of the population.

I moved from one Area Health Service to another. I found that the rehabilitation services I had in the first weren't available when I moved. There was a rehabilitation service which was meant to service my CMHT as well; however the resources weren't sufficient to also cater to the service I was in.

CMHT Consumer

In my time as a mental health professional I've found that services have developed based on individuals' knowledge of where to get funding and not always on what services are most needed in the area. We are very reactionary and initiative driven.

Mental Health Professional

Text Box 1: Consumer and staff comments on service availability and development

Source: Consumer Focus Groups and Staff Interviews

In the absence of a resource allocation process that reflects local needs, it is not possible to determine whether the differences between the Area Health Services reflect differences in community need or consumer demand. The SMAHS has higher funding and has more staff on a per consumer basis than the other two Area Health Services. The SMAHS also has more early intervention and specialist services than the others which may explain some of the differences (Table 2).

	NMAHS	SMAHS	WACHS	Total
Proportion of total CMHT consumers	51%	41%	24%	116%[1]
Proportion of Expenditure	39%	43%	18%	100%
Spend per Consumer	$3 456	$4 739	$3 217	$4 477
CMHT Staff (FTE) per 1 000 consumers	28	34	27	35

1 Percentages do not add to 100 per cent because when consumers move they are counted in each Area Health Service on more than one occasion, but in the total only once.

Table 2: Overview of CMHT resources by Area Health Service 2007-08

Resource allocation is not demand driven.

Source: OAG

For consumers, gaps in the availability of services mean that their care is often driven more by where they live than their assessed needs

The state's CMHTs do not provide a standard set of mental health care services. In the absence of consistently available services, mental health consumers or their carers must shop around for the service they need. However, finding these services is made difficult by the lack of any widely accessible description of services available at each CMHT.

Although initial assessment and general CMHT services are available from all 39 locations, the availability of other more specialist services is patchy. Care pathways are often unclear. Consumers and carers do not know what services they can expect and where or from whom to get those services.

Consumers either have to travel to get services, or do not have those services available to them. For instance, formal early discharge programs are available from only one CMHT and early intervention services from only four CMHTs (Table 3). Travelling to get services can be a barrier for mental health consumers because their illnesses may impact their capacity to do so.

All but 39 of the 524 designated inpatient beds are located in metropolitan areas, so rural consumers have to travel for inpatient care. This takes them away from their support network including friends and family. This in part reflects the difficulties in providing a full range of services locally in rural and remote areas of low population density.

Services Available Across All CMHTs	Services Available Only from Some CMHTs	Dual Diagnosis Services Not Available from CMHTs
Triage Assessment General treatments Liaison eg. with general practitioners	For example: Early intervention services Acute/Intensive recovery programs Dialectical Behaviour Therapy Early discharge program Rehabilitation / living skills After hours services (Telephone Advice, Metropolitan CERT Teams, Emergency Departments)	For example mental illness and: Physical illness Drug and alcohol Disability / intellectually delayed

Table 3: Examples of CMHT services and their availability

Assessment and general services are available in all CMHTs, specialist services in some, and integrated dual diagnosis services in none.

Source: OAG

A mental health crisis can occur at any time so consumers need care to be available after hours, but specialist after hours services are variable. While telephone advice is available to all consumers and carers in both metropolitan and rural areas, there is patchy availability of specialist advice in emergency departments, particularly in rural locations.

Analysis of information from 2007-08 across a sample of seven emergency departments where specialist advice was available found that less than half (42 per cent) of the attendees with a principal mental health diagnosis were assessed by specialist psychiatric staff. This was an improvement from the 26 per cent who were assessed in 2003-04. Because of the broad definitions used to classify mental health patients in emergency departments, not all require specialist assessment. However, WA Health does not monitor or measure the effectiveness of the emergency department teams to ensure that those mental health patients requiring access to specialist assessment actually receive it.

Over 80 per cent of services provided by CMHTs focus on acute care and only six per cent on rehabilitation, so care is often crisis-driven

WA Health's community mental health care approach is based on an acute care cycle where assessment precedes diagnosis, which is followed by treatment leading to discharge. The recently released Draft National Mental Health Plan promotes a recovery-based model. A recovery-based model focuses on the whole person, including greater consideration for social and environmental factors which impact on mental illness, and seeks to avoid crisis.

Rehabilitation services are not widely available to consumers. CMHT services in 2007-08 mostly related to acute care (84 per cent) with limited availability of rehabilitation (six per cent) or emergency response and early intervention (10 per cent). The funding directed to non-government organisations for community activities in 2007-08 showed relatively more directed at prevention and early intervention (27 per cent of funding) and rehabilitation (32 per cent of funding) services, although the largest proportion (41 per cent) was still directed at acute care services.

Consumers find it difficult to access the care they need when they need it, and are not adequately involved in planning and reviewing their care

Findings

- CMHTs accept referrals from a number of sources so consumers are not restricted to a single pathway.
- Inconsistent access to adult CMHTs means consumers have difficulty finding and getting the care they need when they need it:
  - Access criteria are inconsistent across CMHTs so consumers with the same needs are likely to receive different treatment depending on where they live.
  - The time it takes consumers to access services puts them at risk of deteriorating into crisis before they get the care they need.
  - WA Health is not ensuring consumers get timely access to services after discharge from hospital. They have not met their target for contacting 70 per cent of consumers within 14 days after their discharge from hospital.
  - Almost half of mental health consumers do not receive good information and find it difficult to get the services they need.
- Consumers often need more services than just those provided by CMHTs, but the sharing of information and coordination between services is often limited, making it harder for consumers to access all the services they need.
- Gaps in care planning and consumer and carer involvement reduce the quality of care delivery:
  - Care planning is not yet consistent for all consumers reducing the likelihood they will get the right care – 22 per cent of our sample did not have a care plan.
  - Consumers and carers are not adequately involved in planning and reviewing their care. Consumer involvement and ownership of their care plan is important to its success.

Recommendations

WA Health should:

- provide consistent access to services regardless of where a consumer lives
- help consumers avoid deteriorating into crisis by identifying ways to provide CMHT services without a diagnosis if a consumer has an assessed need
- contact consumers within seven days of hospital discharge in line with agreed national good practice targets
- provide clear information about services and treatment options to all CMHT consumers

- effectively coordinate access to clinical (assessment, treatment, rehabilitation, dual diagnosis) and support services (accommodation, training) for consumers so they receive all the services they need
- ensure that every consumer has a consistent care plan which is agreed with them and is regularly reviewed and updated.

CMHTs accept referrals from a number of sources so consumers are not restricted to a single pathway

Consumers can access CMHTs from a wide range of sources and anyone with a concern or query can make contact with a mental health professional (Figure 3). Early contact is particularly important for consumers who need urgent intervention.

CMHTs accept consumers from inpatient units, general practitioners, non-government organisations and self-referral. In each CMHT there is a triage or intake officer on duty each day. After hours there are a range of services available including telephone advice lines, community emergency response teams in metropolitan areas and specialist psychiatric liaison teams in some metropolitan and rural emergency departments.

Figure 3: Overview of referral sources to Community Mental Health Teams
CMHTs accept referrals from a wide range of sources.

Source: OAG

CMHTs seek to meet consumer's individual cultural needs and there are measures in place to assist consumers and carers with specific cultural backgrounds. These include employment of specialist Indigenous Support Workers, provision of information in community languages and training for staff on specific cultures which are established in their local community.

Indigenous Australians accounted for six per cent of all consumers seen by CMHTs in 2007-08, despite comprising only 3.8 per cent of the total WA population. It is important that this particular group of consumers have culturally appropriate assistance accessible to them.

Indigenous Support Workers are important team members in areas where there is a high proportion of Indigenous Australians, particularly in rural areas where staff turnover can be high. Indigenous Support Workers promote continuity of care, act as a bridge between cultures and ensure that staff maintain and adhere to the values and customs embedded in local communities. Indigenous Support Workers are also able to adapt service delivery methods to local needs and support Indigenous Australians in a system designed on an European model of care.

However, the lack of formal training and a career structure for Indigenous Support Workers was a restrictive factor in their development. One mental health region had sought to address this issue by providing distance education through an accredited university course in Queensland.

Text Box 2: Responding to cultural needs

Source: OAG

Inconsistent access to adult CMHTs means consumers have difficulty finding and getting the care they need when they need it

Access criteria are inconsistent across CMHTs so consumers with the same needs are likely to receive different treatment depending on where they live

Each CMHT develops and implements its own access criteria for its services. The criteria vary leading to different levels of access to care across the CMHTs and the potential for the same type of consumer receiving different care in different locations. Access criteria are not always documented and provided to consumers so they do not always know what they are entitled to.

Different access criteria between teams also means that individual consumers may be denied services that they have previously received in another area. For example, a consumer in one area may have received a rehabilitation service, but upon moving to another area is denied that service because their level of illness does not meet that area's criteria. Consistent access criteria across CMHTs would improve consumer access and provide continuity of care when consumers move between areas.

Access criteria for Community Emergency Response Teams also vary. In metropolitan areas eleven Community Emergency Response Teams are available to visit individuals in their home but there are no consistent agreed guidelines or protocols for their despatch. This variance in protocols is likely to be a partial reason explaining why the North Metropolitan Area Health Service (NMAHS) accounted for 65 per cent of home visits in 2008, despite having only 56 per cent of metropolitan consumers. The relative lack of early intervention and specialist services in the NMAHS, only four compared with eight in the South Metropolitan Area Health Service (SMAHS), (see Table 1) may also be a factor.

The time it takes consumers to access services puts them at risk of deteriorating into crisis before they get the care they need

In many cases consumers have to be in crisis to access services. Earlier intervention may help prevent deterioration and reduce the need for more intensive acute treatment. Consumers exhibiting signs of deterioration are unable to access an increased level of intervention from a CMHT in a timely manner. The consumer must wait until their condition deteriorates to the point of crisis, at which stage they are able to access services again.

When you get someone sliding, they get right back down in the gutter before they get treatment.
CMHT Consumer

There is a scale for recognition of sliding, but no services, you get right back to crisis before services are available.
CMHT Consumer

Text Box 3: Consumer experience of service accessibility

Source: OAG Interviews with Staff and Consumers

A formal diagnosis provided by medical staff is required as part of the access criteria for many services. Consumers identified that it sometimes takes an extended period of time to be diagnosed, and in the period awaiting diagnosis, they are unable to access services despite having a clear need for care, as determined at the assessment stage.

The Department of Health does not monitor the number of consumers awaiting services so the precise extent of delays in receiving care is unknown.

> My daughter has had multiple diagnoses over the years. Some clinicians diagnosed her with schizophrenia, but others diagnosed her with a different disorder. She needed a single diagnosis of schizophrenia to get access to services, but there was no agreement amongst clinicians. This meant that even though she needed the services they were suggesting, she was unable to access them.
> *Carer of CMHT Consumer*
>
> You can't access community mental health services. Access is diagnosis driven rather than needs driven.
> *CMHT Consumer*

Text Box 4: Consumer comments on accessing services without a formal diagnosis

Source: OAG Focus Group with Consumers and Carers

WA Health is not ensuring consumers get timely access to services after discharge from hospital. They have not met their target for contacting 70 per cent of consumers within 14 days after their discharge from hospital

WA Health has not met its targets for contacting consumers within seven or 14 days of discharge from specialist inpatient units. Timely contact after discharge helps consumers access the services they need in the period immediately after hospitalisation. Research indicates that consumers are at their highest risk of suicide up to two weeks after discharge from hospital, and without timely contact, their risk increases.

From information collected as part of a national survey, almost one in ten (8.6 per cent) people with a mental illness reported being suicidal in the previous 12 months. This is three and a half times the rate of the general population (2.4 per cent). Of those who attempted suicide, 73 per cent had been in contact with mental health services in the previous 12 months. Only one in four people who attempted suicide had not been in contact with mental health services in the previous 12 months.

> By the time a person is discharged and picked up by community health, they've gone through the crack.
> *CMHT Consumer*

Text Box 5: Consumer's experience of contact with CMHT after hospital discharge

Source: OAG Interviews with Staff and Consumers

Although there has been gradual improvement, since 2005 WA Health has not met either of its targets of contacting 60 per cent of consumers within seven days of discharge from specialist inpatient facilities, and 70 per cent within 14 days (Figure 4). All the reported contact data covers all community mental health services.

In 2007, 56 per cent of consumers discharged from specialist inpatient units were contacted within seven days, and 68 per cent within 14 days of discharge. Around 10 per cent of consumers were never contacted though some of these consumers may have been referred to private treatment or to general practitioners after discharge. At the time of the audit the Department of Health was unable to provide validated information for 2008 although preliminary data indicated the trend towards meeting the set targets continuing.

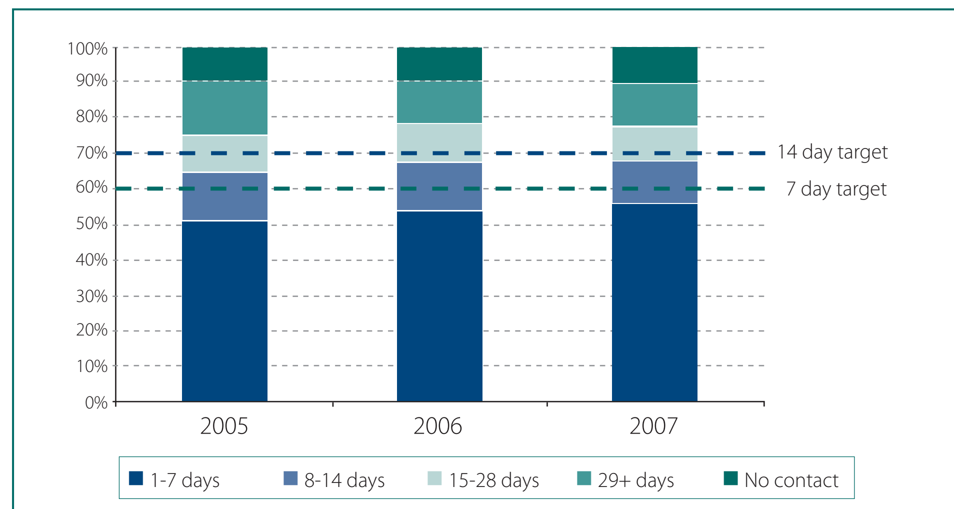

Figure 4: Time taken for contact from CMHTs after discharge 2005-07

The Department of Health has not met its own targets for timely contact by CMHTs for consumers discharged from inpatient care.

Source: OAG

WA Health's targets for contacting consumers are lower than the good practice targets from the National Mental Health Benchmarking Project (2008) and the Key Performance Indicators for Australian Public Mental Health Services (2005). Both recommended that consumers should be contacted within seven days of discharge. The National Benchmarking Project, although acknowledging the target as preliminary, recommends that 90 per cent of consumers be contacted within seven days. It is not clear why the WA Health target has not been updated to reflect these national good practice benchmarks.

Almost half of mental health consumers do not receive good information and find it difficult to get the services they need

In a national health and wellbeing survey, 43 per cent of mental health consumers reported that they do not receive the information they need about services available, treatments or their illness. The Mental Health Division and Area Health Services do not have a comprehensive list of services offered by teams and supported by non-government organisations. There is no single place from which consumers can obtain a list of services they can access, such as through a website.

The difficulty finding services is made worse for consumers because CMHTs are not always aware of available support services. This can include services from Commonwealth agencies, local government and non-government organisations. In 2008, there were 76 non-government organisations centrally funded by the Department of Health to provide a range of community mental health services. The number of separate organisations and variability in services provided mean that teams are not aware of all services offered by these organisations. If teams are not aware of what is available they are unable to direct consumers to the services. Consumers may not get all the services they need.

> There is a lack of consistency in what's provided and in who to go to for services. It is a fractured mosaic of services. You need to work out what your needs are. You need to ring each month to find out whether services are still provided.
> *CMHT Consumer*

Text Box 6: Consumer comment on service information

Source: Consumer Focus Groups and Staff Interviews

Consumers often need more services than just those provided by CMHTs, but the sharing of information and coordination between services is often limited, making it harder for consumers to access all the services they need

CMHTs do not provide coordinated dual diagnosis care, such as mental health care along with drug and alcohol services. A national survey found that one-third (34 per cent) of people with a mental illness have a physical illness, and one in five (22 per cent) have two mental health illnesses (including substance use disorders, anxiety disorders or affective disorders) concurrent with each other.

Dual diagnosis services are important for consumers because the failure to appropriately respond to either one of the illnesses will impact on the effectiveness of the care of the other. There have been recent changes in some rural areas to provide a joined-up approach for mental health and drug and alcohol services.

The coordination of services and sharing of information between CMHTs and other services is not effective. The information shared between teams, non-government organisations and other agencies depends on the particular CMHT, and the links they have established with other service providers. Information from inpatient care does not always follow the patient to the CMHT or other providers. A lack of information sharing results in disjointed care for the consumer.

Disjointed care means that consumers have to retell their stories over and over again to different healthcare providers. This is particularly the case for those consumers with dual diagnoses, such as physical illness, alcohol and drug dependency, eating disorders or intellectual disability. The time taken to tell these stories can mean treatment is delayed.

If support to an individual is not timely with good information sharing, poor care in one area can have a negative effect on the overall treatment outcome and the consumer gets worse rather than better. Agencies need to work together and provide continuity of care with information from one provider seamlessly flowing to the next.

Gaps in care planning and consumer and carer involvement reduce the quality of care delivery

Care planning is not yet consistent for all consumers reducing the likelihood they will get the right care – 22 per cent of our sample did not have a care plan

WA Health policy states that all consumers should have a care plan, but our sample testing showed over one in five did not have one. Where care plans are in place, their content varies between and sometimes within CMHTs, reducing the availability of key information.

Care plans are important because they summarise the history, treatment and goals for an individual consumer. Inconsistencies in care plans mean that staff do not always have all the information they need to provide the right care. Guidance on the minimum content of a care plan would assist CMHTs in ensuring a minimum level of detail is available on each consumer.

Although there is no agreed definition of a care plan, as part of an individual's clinical record it should document the consumer's relevant history, assessment, diagnosis, treatment and support services required, other service providers, progress, follow up details and outcomes.

We reviewed a sample of 73 consumers' case files and found that 22 per cent did not have a care plan. In 77 per cent of cases, essential information such as what to do and who to contact in an emergency, was not recorded (see Table 4). Although 86 per cent of consumers with a care plan had received a comprehensive assessment, including an assessment of risk, there is no agreed and standardised clinical risk assessment tool (although a policy is in place across WA Health). This means that risk is not uniformly assessed so some patients may not receive the appropriate care.

Evidence of CMHTs sharing care plans with other professionals, such as general practitioners, to promote continuity of care was patchy (19 per cent) and criteria for progress for a consumer to be discharged were often not well covered (11 per cent).

The care plans we reviewed often did not indicate if consumers were receiving the support services for their needs. For instance, in addition to clinical care, consumers may need accommodation to help recovery. The lack of these support services can undermine the effectiveness of clinical care.

Criteria	Percentage of Files	Comments
Care Plan based on comprehensive assessment	86%	There is no agreed standardised Clinical Risk Assessment tool in place..
Evidence of sharing with other professionals (eg the general practitioner)	19%	There was a lack of evidence of sharing of care plans with other professionals, in particular general practitioners.
Arrangements for accommodation	65%	Although these areas of need were commonly considered, plans did not indicate whether they were being met.
Identification of daily living needs	70%	
Information on what to do and who to contact in an emergency	23%	This included information on who the carer could contact in an emergency.
Evidence of information on what has to happen for the consumer to be discharged	11%	Goals for individuals were identified, but it was not clear at what point the consumer would be considered for discharge from the CMHT.

Table 4: Overview of consumer care plans

There is significant variation in the content of care plans.

Source: OAG

Consumers and carers are not adequately involved in planning and reviewing their care. Consumer involvement and ownership of their care plan is important to its success

Consumers are not consistently involved in the development of their care plan. A lack of involvement can reduce consumer ownership of their treatment. At its extreme, this can result in non-compliance with treatment, and social and health problems become more prevalent.

Of the 57 care plans we reviewed, only 23 per cent had evidence of consumer involvement or consent to their plan. Only three of 57 consumers received a copy of their care plan.

The extent of consumer involvement in the review of their care plan was variable. In some instances the consumer was involved in the review, and in others the review was carried out by a CMHT case conference, which did not involve the consumer. There is no agreed guidance on who should be involved in a care plan review or what process the review should follow.

The involvement of carers was poor. There was evidence in only six instances of carer involvement in development of the care plan. In a national survey two-thirds (66 per cent) of mental health consumers reported having family upon whom they could rely on or confide in and three quarters (75 per cent) reported having friends upon whom they could rely. The involvement of family and/or friends in care is essential.

In 2007, the Office of the Chief Psychiatrist issued guidance that outlined the requirements under the *Carers Recognition Act 2004* for engaging with carers and sharing information. This guidance is not consistently followed by teams. The Chief Psychiatrist identified the benefits of good engagement with consumers and carers as including facilitating a diagnosis, improving consumers' overall health, ability to identify changes in the consumer's behaviour, reducing relapses and reducing adverse effects of caring on carers and families.

WA Health's understanding of the effectiveness of CMHTs is limited, increasing the risk that funding is not targeted to the most effective services

Findings

- WA Health does not know if funding is being targeted to the most efficient and effective CMHT services:
  - A comprehensive set of CMHT objectives that link to broader WA Mental Health objectives is not in place.
  - WA Health does not monitor the overall performance of CMHTs and does not have a framework for doing so.
- CMHTs monitor individual consumer progress, but there is no overall assessment of the effectiveness of services, reducing the potential for effective services to be replicated more widely.
- Independent reviews and complaints about CMHTs do not consistently prompt operational change and improvement.

Recommendations

WA Health should:

- develop and implement a framework and suite of performance measures for monitoring and reporting the efficiency and effectiveness of CMHT services
- systematically track and monitor the outcomes of reviews and complaints so they feed into improvements in service delivery.

WA Health does not know if funding is being targeted to the most efficient and effective CMHT services

Between 2005-06 and 2009-10 there was a 45 per cent increase in community mental health service funding with the budget allocation increasing from $128 million to $185 million. This included funding for government and non-government services and child and adolescent, adult and elderly services.

Based on data provided by Area Health Services in 2007-08 as part of the National Minimum Data Set, WA Health estimated that almost 80 per cent ($128 million of the $161 million allocated as part of the State Budget for all community mental health services in that year) of community mental health service funding was spent on government CMHT services. A further $30 million was allocated to non-government organisations for both community and inpatient care. In the period between 2005-06 and 2007-08, CMHT staffing increased six per cent to 993 full time equivalent staff.

A comprehensive set of CMHT objectives that link to broader WA Mental Health objectives is not in place

Beyond providing care to individuals, there is no overarching set of objectives for CMHTs, and each team has differing aims and objectives. As a result there is no clear link between team achievements and the overall objectives of WA Mental Health Services. Teams set their own goals rather than WA Health having a common set which clearly aligns with broader Mental Health Service objectives.

The absence of comprehensive, consistent objectives for CMHTs makes it difficult to assess their overall effectiveness and measure performance of teams. If service effectiveness cannot be measured, then areas of good practice cannot be consistently identified and applied more widely, or poor performance addressed.

WA Health does not monitor the overall performance of CMHTs and does not have a framework for doing so

WA Health does not have a framework for evaluating the performance of CMHTs. They monitor the operations of individual CMHTs through the Australian Council on Healthcare Standards EQuIP Accreditation and the Chief Psychiatrist Clinical Governance Reviews. Neither of these frameworks is used across teams to assess the overall performance of service provision. WA Health has also contributed to the National Standards for Mental Health Services and the Fourth Draft National Mental Health Plan but these are also not systematically used to assess overall performance.

A significant amount of data is collected on consumers and CMHT services, as the basis for service monitoring and evaluation, and teams have a robust clinical mental health information system and written patient files. However, this information is not used to support service evaluation or provide management information. As a result:

- WA Health cannot demonstrate whether the increased funding directed to CMHTs or specific areas is having the desired results. Unless monitored there may be poor resource allocation decisions in the future.
- Consumers receive different levels of service because it is not known which CMHTs work most effectively.
- Good practice is not shared because it is not consistently identified. In some teams, consumers may receive a less than effective service because better practices occurring in other CMHTs is not shared or replicated.
- Areas of concern are not identified and addressed so poor practices become embedded in service delivery.

CMHTs monitor individual consumer progress, but there is no overall assessment of the effectiveness of services, reducing the potential for effective services to be replicated more widely

Consumer treatment is regularly monitored by clinicians so staff are aware of individuals' achievements. But there is no systems level monitoring so WA Health does not know how effective CMHTs are overall, and whether there is consistency in consumer outcomes between teams.

National Outcomes Casemix Collection data has been collected since 2003 to enable effectiveness of care to be monitored at the assessment, review and discharge stages of treatment. Although WA Health submits this data for national use, it does not use the information collected to monitor or review CMHTs. This reduces the incentive for staff to provide outcomes information because it is not used as a means to improve services.

While it is important to monitor individuals, service delivery needs to be monitored and evaluated to ensure that there is equity of outcomes across the entire service. WA Health does not monitor and evaluate across teams in this way. So to get an indication of the overall effectiveness of CMHTs, we reviewed admissions to hospital and re-admissions after discharge from hospital.

One aim of community mental health care is to reduce the number of admissions an individual consumer has, as well as the total number of consumers needing admission. The data indicates that CMHT services are assisting consumers to live in the community, but there are no accepted national benchmarks for assessing the WA performance. Of the consumers who were hospitalised in 2007-08, the majority (65 per cent) had only one or two inpatient episodes and this was largely unchanged from 2006-07 (Figure 5). The number of consumers (9 669) having an inpatient stay was also largely unchanged between 2006-07 and 2007-08.

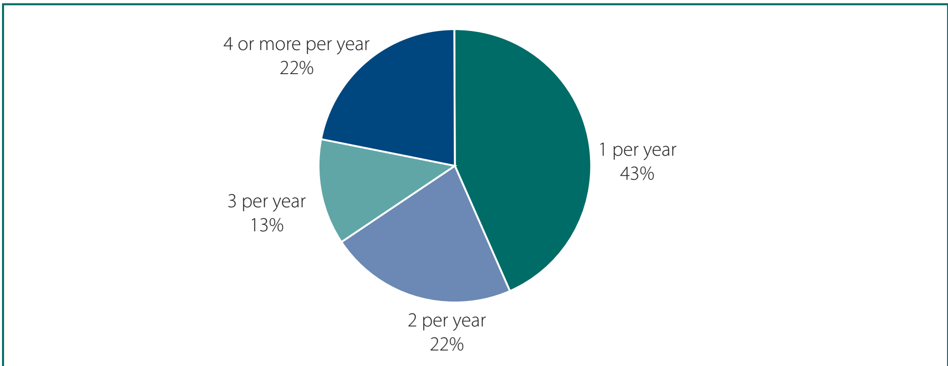

Figure 5: Number of adult episodes of care in hospital in a year 2007-08

The majority of consumers had only one to two episodes in hospital per annum.

Source: Department of Health

Planned and unplanned re-admission rates of consumers after discharge is also an indicator of effectiveness. The 28-day re-admission rate for all community services fell from 13 per cent in 2005-06 to nine per cent in 2007-08, which is below the National Mental Health Benchmarking Project's target of 10 per cent. This indicator suggests that CMHTs are preventing re-admission to hospital after discharge for many consumers.

Implementation of new projects is undertaken separately by the Department of Health, Area Health Services and CMHTs. Because new projects are implemented separately initiatives are not always coordinated and those which work well may not be replicated across other teams. For example, early intervention services have been implemented in four CMHTs in different ways. However, it is not clear which way works best so it can be replicated in other areas. Without coordination and evaluation WA Health cannot know whether the increased funding for CMHTs has been well targeted at the most efficient and effective services.

Independent reviews and complaints about CMHTs do not consistently prompt operational change and improvement

CMHTs participate in a number of internal and independent reviews including Clinical Governance Reviews by the Office of the Chief Psychiatrist and accreditation by the Australian Council on Healthcare Standards. However, these reviews, conducted on an individual site basis, are not shared or integrated into the operations of all teams to promote learning and continuous service improvement.

Between 2003 and 2006, the Office of the Chief Psychiatrist carried out 10 clinical governance reviews and identified 300 recommendations. At February 2008, over two thirds of recommendations made prior to 2006 had not been implemented, only partially implemented or their status was not known:

- 32 per cent (95 recommendations) had been fully implemented
- 38 per cent (115 recommendations) had been partially implemented
- five per cent (16 recommendations) had not been implemented
- the status of 25 per cent (74 recommendations) was unknown.

It can be difficult for consumers and carers to provide feedback, and limited responses to this feedback have meant many consumers and carers do not believe that their feedback results in change. For example, consumers and carers face difficulties contacting the state-wide consumer advocate because the number is unlisted, there is no answering machine and no one to take messages.

Consumers can make complaints through more than one route (Area Health Services, Office of Safety and Quality, Chief Psychiatrist) which means that they are not confined to a single process. However, disparate information systems and complaints processes means it is not possible to identify the total number of individual complaints made about mental health services. In the first quarter of 2008-09, the Chief Psychiatrist received 100 complaints about mental health services.

The system of complaints is not working. There is a lack of communication and we do not receive feedback when we complain.
CMHT Consumer

Text Box 7: Consumer experience of making a complaint

Source: OAG Focus Group with Consumers and Carers

There is inconsistency between the Area Health Services in the collection, analysis and reporting of information on complaints. The Mental Health Division does not monitor complaints and is not aware of the nature or number of mental health complaints. Implementation of the Statewide Complaints Policy, developed by the Office of Safety and Quality, has been inconsistent making it difficult to identify trends in complaints.

Area Health Services identified that they have been working to improve the recording of complaints with review and investigation occurring at a local level. Although information on the number of complaints and their responses are tracked within Area Health Services, they are not consistently reported across Areas Health Services to identify organisational trends and issues. Additionally, the outcomes of investigations are not communicated to consumers. Complaints should be able to be tracked and trends identified across Area Health Services to improve practice and service delivery in all community mental health teams.

Appendix 1: Structural Overview

- WA Health refers to all government provided health services. It includes the Department of Health and the three Area Health Services.
  - The Department of Health is the principle policy setting body for WA Health. In the context of CMHTs the two divisions having a role are the Mental Health Division and Office of the Chief Psychiatrist. Neither of these divisions delivers services directly to the public.
  - Area Health Services refer to the three operational organisations which deliver services to the public: North Metropolitan Area Health Service (NMAHS), South Metropolitan Area Health Service (SMAHS) and WA Country Health Service (WACHS).
- Community Mental Health Services, according to national definitions, include specialised mental health services that provide ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.
- Community Mental Health Teams (CMHTs) are the multidisciplinary teams who provide clinical services to consumers in the community. Community based mental health teams are spread throughout the metropolitan area and in country locations. In addition to managerial and administrative staff, the teams consist of professional staff including psychiatrists, social workers, mental health nurses, clinical psychologists and occupational therapists. Together these staff provide assessment, diagnosis, treatment, rehabilitation and ongoing support to consumers of services. In some areas there is specialist support staff such as Indigenous Support Workers.

Reports of the Auditor General

2009

Report	Date
Every Day Counts: Managing Student Attendance in Western Australian Public Schools	19 August 2009
Opinion on Ministerial Notification: Ministerial Decision to not Provide Information to Parliament – Country Age Pension Fuel Card	19 August 2009
Second Public Sector Performance Report – Dangerous Goods Safety – Compliance in Western Australia's Commercial and Recreational Fisheries	25 June 2009
Maintaining the State Road Network	17 June 2009
Rich and Rare: Conservation of Threatened Species	10 June 2009
Coming, Ready or Not: Preparing for Large-scale Emergencies	20 May 2009
Audit Results Report – 31 December 2008 Assurance Audits and other audits completed since 3 November 2008	6 May 2009
Information Systems Audit Report	8 April 2009
Public Sector Performance Report 2009 – Management of Water Resources in Western Australia – Follow-up – Administration of the Metropolitan Region Scheme by the Department for Planning and Infrastructure – Management of Fringe Benefits Tax	1 April 2009

Reports of the Auditor General

2008

Second Public Sector Performance Report 2008 – Complaints Management in Shared Service Centres – Funding and Purchasing Health Services from Non-Government and Not-For-Profit Organisations – Management of Traffic Infringements for Government Vehicles and Staff	3 December 2008
Responding to changes in attraction, retention and achievement in Vocational Education and Training	12 November 2008
Audit Results – Assurance Audits completed at 3 November 2008 – Opinions of Ministerial Notifications	12 November 2008
Improving Resource Project Approvals	7 October 2008
The Juvenile Justice System: Dealing with Young People under the Young Offenders Act 1994	18 June 2008
Lost in Transition: State Services for Humanitarian Entrants	11 June 2008
Audit Results Report on Universities and TAFE Colleges and other audits completed since 19 November 2007 and Performance Examinations of Risk Management, Delegation of Authority and Records Management	7 May 2008
Public Sector Performance Report 2008 – Regulation of Security Workers – Information Security: Disposal of Government Hard Drives	19 March 2008

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