# Responding to Mental Health Crises in the Community

Victorian Auditor-General's Report

November 2009

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# Responding to Mental Health Crises in the Community

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Victorian Auditor-General's Office

*Auditing in the Public Interest*

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *Responding to Mental Health Crises in the Community.*

Yours faithfully

D D R PEARSON
*Auditor-General*

11 November 2009

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# Audit summary

## Background

Mental illness touches many lives. Nearly one in five Victorians experience mental illness each year. While many people successfully manage, or recover from, mental illness, there can be times when a person is so acutely unwell they may become a risk to themselves or others. This is a mental health crisis.

A person in mental health crisis needs urgent assistance to maintain their safety and that of others, and to receive assessment and treatment. This often requires responses from Area Mental Health Services (AMHS), which the Department of Health (DOH) fund, and Victoria Police and Ambulance Victoria.

To respond effectively, these agencies need to coordinate and focus on the person's needs, while also addressing any safety risks. The *Mental Health Act 1986* and the *Victorian Charter of Human Rights and Responsibilities Act 2006* describe how agency responses need to minimise restrictions on individual freedoms and interference with people's rights and dignity. Consequently, all relevant agency staff need appropriate training, guidance and feedback.

This audit assessed the coordination, preparation, and effectiveness of police, ambulance and mental health triage and Crisis Assessment and Treatment (CAT) service responses to mental health crises. As such, the audit did not examine the broader mental health service system. It examined DOH, four AMHS, Victoria Police and Ambulance Victoria to assess whether:

- agency responses to mental health crises are coordinated
- agencies are adequately prepared to respond to mental health crises, and respond appropriately
- agencies can show the effectiveness of their responses to mental health crises.

## Conclusions

The *Victorian Mental Health Reform Strategy 2009–2019*, that DOH developed, articulates agency commitment to improving services in mental health. Government investment through the reform strategy should strengthen the broader mental health system, providing better support to prevent and respond to crises. Victoria Police has also started organisational change in responding to mental health issues through the development and implementation of their *Peace of Mind* strategy.

Presently however, responses to mental health crises are not consistently meeting the standards set out in the *Mental Health Act 1986* or in agreed interagency protocols. The needs of the person in crisis at times comes second to other considerations, such as competing demands on time and resources, and historical and cultural practices.

There is demonstratable agency effort to improve responses to mental health crises through reform initiatives, such as DOH's project to expand mental health triage services, Victoria Police's investment in mental health research, and the trial of a new collaborative service model called Police, Ambulance and CAT team Emergency Response, or PACER. However, coordination between agencies can improve, and greater effort is required to make sure agency staff comply with protocols and receive appropriate training.

There is a lack of information showing the effectiveness of triage and CAT services, and police and ambulance responses to mental health crises. This prevents quantitative analysis and robust performance monitoring, allowing service gaps to go unaddressed.

# Main findings

## Measuring effectiveness

DOH lacks useful data about triage and CAT service responses to mental health crises. CAT services have run for 15 years, but DOH does not know the number of urgent referrals received, how services respond, their timeliness or the outcomes. DOH intends to collect this information and set performance indicators as part of its expansion of mental health triage services. DOH needs to make sure indicators targets and benchmarks are relevant and appropriate by basing them on comprehensive and accurate baseline data.

Through their mental health strategy, Victoria Police has identified the need to collect information about its responses to mental health crises. It is working with the Centre for Forensic Behavioural Science at Monash University to research police responses to mental illness, and has started collecting data about apprehensions made under the *Mental Health Act 1986* of people experiencing mental health crises.

Until agencies have access to robust information about response effectiveness, they cannot identify successes or areas to improve in their own crisis response operations, nor can they review their joint performance to identify system-wide issues.

## Preparation

While a mental health crisis is often unpredictable, the response to the crisis should not be.

Victoria Police provides its staff with some training and resources on responding to mental health crises, but people with a mental illness are still over-represented in fatal shootings. While police report that voluntary mental health first aid training is improving their ability to respond to crises, the standard training that they all receive is not meeting the needs of police in the field and does not promote expectations set out in the protocol between Victoria Police and DOH. Victoria Police has begun to improve its standard training.

There are also significant gaps in training for CAT clinicians and ambulance paramedics in responding to mental health crises, such as de-escalation strategies and how to interact with other agencies. Agencies also lack opportunities for interagency learning and exposure to consumer experience.

## Appropriateness of response

The responsiveness of CAT services to mental health crises was an issue frequently raised by police, paramedics and consumers. Police often do not request assistance from CAT services because of long waits for a response, and report hours spent waiting in emergency departments for a mental health assessment to commence. Engagement with mental health services was the number one challenge that police identified in 2009 research into their ability to respond to mental health issues.

Without performance data and clear expectations for CAT service responsiveness, it is impossible to assess CAT service crisis responses. However, some of the dissatisfaction with the service probably reflects unrealistic expectations for immediate, emergency responses that CAT services do not have the capacity to provide. The lack of clear communication about expectations and limitations of CAT services is contributing to negative stakeholder impressions of the service.

The sites used to conduct mental health assessments, and modes of transport used do not always reflect the guidance in agreed agency protocols, and the principles in the *Mental Health Act 1986* and the *Victorian Charter of Human Rights and Responsibilities Act 2006*. Agencies and their staff do not always prioritise the needs of the person when determining their responses. This is often due to the preferences and attitudes of staff, lack of training and awareness of protocols, and pressures on staff resources. As a result, people in mental health crisis may be transported in police divisional vans, and held in police cells, when there is no policing or safety need, and when better options are available.

## Response coordination

There are committees and protocols to support interagency coordination, but agencies can make better use of these to improve outcomes for consumers.

The state-level Interdepartmental Liaison Committee (IDLC) and local area Emergency Service Liaison Committees (ESLC) are bringing police, mental health and ambulance services together to communicate, build relationships and understand each other's roles and ways of working. Similarly, interaction between DOH and Victoria Police to review and revise their interagency protocol has helped them identify and discuss issues that affect people in crisis.

However, DOH and Victoria Police have not shown how they will encourage and monitor compliance with their revised protocol. Given that awareness of, and compliance with, the current protocol is inconsistent; there is a risk staff will not follow the revised protocol. Agencies can strengthen protocols by making sure staff understand their importance, link them to training, and monitor staff compliance. This would help translate these protocols into appropriate staff behaviours and partnerships.

The protocol between Ambulance Victoria and DOH is almost 10-years old and there is confusion among paramedics about roles and responsibilities in mental health crises, demonstrating it is time to review this protocol.

The IDLC is also not effectively monitoring and providing support to ESLCs. There is little communication between the IDLC and ESLCs. This limits identification of system-wide issues and protocol non-compliance, and sharing of good practice. Committees also lack consumer representation, despite it being a requirement under the interagency protocol.

## Recommendations

| Number | Recommendation | Page |
|---|---|---|
| **1.** | DOH and AMHS demonstrate the effectiveness of their responses by:<br>• working together to develop and implement ways to measure demand for, and effectiveness of responses to, mental health crises<br>• using this information to identify and address service gaps and areas for improvement. | 20 |
| **2.** | Victoria Police, as indicated in the Peace of Mind Strategy, develops and uses measures to evaluate their responses to mental health issues. | 20 |
| **3.** | IDLC and ESLCs jointly review performance in responding to mental health issues. | 20 |
| **4.** | All agencies continue collaborative innovation by:<br>• continuing the PACER trial and acting on its evaluation<br>• focusing on opportunities to address issues particular to regional/rural settings. | 20 |
| **5.** | Victoria Police complete enhancements to mental health training to:<br>• support interagency coordination and protocol compliance<br>• improve consistency and quality of responses for consumers. | 34 |
| **6.** | AMHS and Ambulance Victoria address training gaps for paramedic and CAT/triage staff. | 34 |
| **7.** | Each agency incorporates consumer experience and perspective in staff training. | 34 |
| **8.** | DOH, AMHS, Victoria Police and Ambulance Victoria explore and trial opportunities for interagency training/learning opportunities. | 34 |
| **9.** | Ambulance Victoria, DOH and Victoria Police, work together to investigate and trial alternative transport solutions. | 34 |

# Recommendations – *continued*

| Number | Recommendation | Page |
|---|---|---|
| **10.** | DOH, with AMHS, clearly articulates and communicates expectations for CAT service responsiveness to crises. | 34 |
| **11.** | ESLCs, supported and monitored by the IDLC, introduce protocols to minimise police delays at emergency departments. | 34 |
| **12.** | Police should not use divisional vans as mental health transportation unless there is a clear policing or safety need. | 34 |
| **13.** | Police should not use cells to detain persons under section 10 of the *Mental Health Act 1986* unless there is a clear policing or safety need. | 34 |
| **14.** | IDLC formalise and maintain communication, monitoring and reporting processes with ESLCs. | 40 |
| **15.** | All ESLCs and the IDLC incorporate consumer representation. | 40 |
| **16.** | DOH and Victoria Police support their review of the interagency protocol by:<br>• developing a communication strategy to educate stakeholders about the protocol<br>• identifying regions/services where the protocol is not being followed and work with them to address the barriers. | 40 |
| **17.** | DOH and Ambulance Victoria review their joint protocol. | 40 |

# *Audit Act 1994* section 16—submissions and comments

## Introduction

In accordance with section 16(3) of the *Audit Act 1994* a copy of this report, or relevant extracts from the report, was provided to the Department of Health, Victoria Police, Ambulance Victoria, and the four audited health services, with a request for comments or submissions.

The comments and submissions provided are not subject to audit nor the evidentiary standards required to reach an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

## Submissions and comments received

***RESPONSE provided by Chief Commissioner, Victoria Police***

*I would like to acknowledge the objectivity and thoroughness with which the audit team conducted the review. I am aware that the team consulted a cross-section of the organisation and considered a range of material. I therefore welcome the insights and recommendations arising from this independent analysis as a constructive contribution to our commitment to improving our responses in this area of community and organisational concern.*

*As this report recognises, Victoria Police has been taking significant steps to improve its policies, practices and training since nominating mental health as an organisational priority in 2006–07. Staff in stations across the state and in the corporate support areas have been making concerted efforts to address information gaps, smooth referral pathways and seek diverse input into policing processes. It is pleasing that this audit endorses the soundness of these efforts to date.*

*However, the report also highlights the areas in which Victoria Police still has work to do in consolidating these improvements throughout the organisation and in strengthening our partnerships with the other services, at both the state and local level.*

*Above all, the report underscores how important it is that Victoria Police continues to be receptive to feedback and advice from stakeholders and maintains a focus on improving our knowledge and approaches beyond the implementation of the 60 directions in the Victoria Police Mental Health Strategy (April 2007).*

*Based on the validation of our overall approach provided by this audit, I am confident that Victoria Police has the capacity and commitment to realise the outcomes advocated.*

***RESPONSE provided by Chief Executive Officer, Ambulance Victoria***

*Ambulance Victoria (AV) supports the findings and recommendations of the audit, which are consistent with the strategies AV has been pursuing to improve its own and wider system responses to mental health patients.*

***Recommendation 1** – Response effectiveness*

*AV is committed to monitoring the effectiveness of its response to all patients, and this is reflected in the establishment of a comprehensive electronic Clinical Information System. This system has now been rolled out to all career paramedics across the State and ensures detailed clinical data is captured for all patients attended by AV, including mental health patients. Some of the data presented in the audit derives from this system, but the data is now more complete and more refined. This analysis of AV mental health patients is being undertaken. This includes clearer identification of the reasons an emergency response was needed, patients' pre-existing conditions and the treatment provided by paramedics. This analysis will provide the basis for an assessment of AV's service delivery for mental health patients, including dispatching protocols, compliance to clinical guidelines, timeliness of response, use of restraints, interaction with other agencies etc. Work is also in progress to link AV data with hospital data, which will provide further information about the mental health patients attended by AV and the effectiveness of our response.*

*AV is committed to innovation in the provision of our services, and strongly supports collaboration with other agencies to improve response, such as the PACER trial. Another example of innovative collaboration has been the establishment of agreements between AV and a number of metropolitan CAT services in recent years, providing referral options for mental health patients ringing 000. Where appropriate, these agreements facilitate an alternative to an emergency ambulance response with the aim of better meeting the needs of the patient.*

*There are significant service delivery challenges for mental health patients in regional/rural areas, and AV supports the audit recommendation calling for a particular focus on opportunities to address the issues. Work has commenced to consolidate and transfer ambulance call taking and dispatch operations in regional/rural Victoria to the Emergency Services Telecommunications Authority. This will improve the consistency of ambulance response across the State and provide opportunities for innovation, potentially including referral arrangements similar to those available in Melbourne.*

***RESPONSE provided by Chief Executive Officer, Ambulance Victoria – continued***

***Recommendation 2** – Response preparation and appropriateness*

*Ambulance Victoria (AV) acknowledges the critical role that education and training provides in preparing our staff in recognising and managing mental health crises within the community. We have worked closely with our university partners to incorporate this training in undergraduate programs and further build on this training during graduate induction. AV has also provides update training to existing paramedics via their continuing professional education program. We note the recommendations in the report related to training gaps for paramedic staff and will undertake a training needs analysis to identify these in more detail and address any gaps in future education programs. This will include exploring and trialling interagency training/learning opportunities as appropriate.*

*AV also strongly supports the recommendation to investigate and trial alternative transport solutions. Appropriate alternatives to transport in an emergency vehicle have potential benefits for many mental health patients, and may also assist in improving the availability of emergency resources to respond to time critical emergencies.*

***Recommendation 3** – Interagency coordination*

*The recent inclusion of Ambulance Victoria (AV) on the Interdepartmental Liaison Committee (IDLC) has been an important step in strengthening the strategic coordination of responses to mental health patients. Emergency Services Liaison Committees (ESLCs) are an important forum for fostering local relationships between agencies and staff and we will continue to support the committees and the development of better linkages between them and the IDLC. We also support the recommended inclusion of consumer representatives on both the IDLC and the ESLCs.*

*The Department of Health and Ambulance Victoria protocol Ambulance Transport of People with a Mental Illness has played an important role in offering guidance to mental health services and ambulance services on their transport roles and responsibilities. However, the protocol has now been in place since 2002, and we strongly support the recommended review of the protocol. The review should be informed by the data analysis mentioned above, and include input from Victoria Police and consumers.*

*AV is committed to improving its response to mental health patients across the State, and will continue to collaborate with other services to develop more responsive and evidence based services.*

***RESPONSE provided by the Secretary, Department of Health***

*The following is an extract of the response provided by the Secretary of the Department of Health. The full response is provided in Appendix B of this report.*

*The report's recommendations are broadly consistent with the Victorian Mental Health Reform Strategy. The Department will liaise closely with Victoria Police, Ambulance services, consumers, carers and service providers in considering the implementation of these recommendations.*

***Recommendation 1** – DOH and AMHS demonstrate the effectiveness of their responses by:*

- *working together to develop and implement ways to measure demand for, and effectiveness of responses to, mental health crises*
- *using this information to identify and address service gaps and areas for improvement.*

*This recommendation is accepted. The Department has already announced the pending introduction of a standardised triage scale which will enable capture of the type of data needed to measure the timeliness of responses from point of first phone to first face to face contact. This will be operational from mid 2010.*

***Recommendation 3** – IDLC and ESLCs should jointly review performance in responding to mental health issues.*

*This recommendation is accepted.*

***Recommendation 4** – All agencies continue collaborative innovation by:*

- *continuing the PACER trial and acting on its evaluation*
- *focusing on opportunities to address issues particular to regional/rural settings.*

*This recommendation is accepted. The initial PACER trial has already been extended for a further twelve months and will be independently evaluated at the completion of that trial period.*

***Recommendation 6** – AMHS and Ambulance Victoria should address training gaps for paramedic and CAT/triage staff.*

*This recommendation is accepted. The Department in partnership with area mental health services will explore ways in which our existing investment in this area can be further improved. Such focus is fully consistent with commitments given in the Mental Health Reform Strategy and the recently released report Shaping the future: The Victorian mental health workforce strategy (the workforce strategy). One of the guiding principles of the workforce strategy is the need for integration, between mental health services and other organisations.*

***RESPONSE provided by the Secretary, Department of Health – continued***

***Recommendation 7*** *– Each agency incorporates consumer experience and perspective in staff training.*

*This recommendation is accepted. Under the Mental Health Reform Strategy greater consumer inclusion will be pursued across a range of activities.*

***Recommendation 8*** *– DOH, AMHS, Victoria Police and Ambulance Victoria explore and trial opportunities for interagency training/learning opportunities.*

*This recommendation is accepted.*

***Recommendation 11*** *– ESLCs, supported and monitored by the IDLC, need to put in place protocols to minimise police delays at emergency departments.*

*This recommendation is accepted.*

***Recommendation 14*** *– IDLC formalise and maintain communication, monitoring and reporting processes with ESLCs.*

*This recommendation is accepted.*

***Recommendation 15*** *– All ESLCs and IDLC incorporate consumer representation.*

*This recommendation is accepted.*

***Recommendation 16*** *– DOH and Victoria Police support their review of the interagency protocol by:*

- *developing a communication strategy to educate relevant staff about the protocol*
- *identifying regions/services where the protocol is not being followed and work with them to address the barriers.*

*This recommendation is accepted and work has commenced on promotion of the reviewed protocol.*

***Recommendation 17*** *– DOH and Ambulance Victoria review their protocol.*

*This recommendation is accepted.*

# 1 Background

## 1.1 Introduction

### 1.1.1 Mental health in our community

Each year about 19 per cent of Victorians experience some form of mental illness. It is a leading cause of disability in our society, affecting employment, family relationships and social connectedness.

Mental illness spans a range of diagnoses, conditions and experiences. Specifically it refers to a medical condition where a person experiences significant disturbance of thought, mood, perception or memory.

Given the incidence and effect that mental illness has in our community, appropriate care and support are vital. However, the 2006 Victorian Government commissioned report—*Improving Mental Health Outcomes in Victoria*—estimated that 44 per cent of Victorians with severe psychotic disorders or mental-health related disabilities are not accessing services.

### 1.1.2 Responding to crisis

While many people successfully manage, or recover from, mental illness, there can be times when a person is acutely unwell and experiences a mental health crisis. In crisis, a person has thoughts or feelings, or exhibits behaviours that are severely distressing to themselves and often others. In these situations, there is a risk that the person may self-harm, or harm others.

While mental health services are responsible for providing clinical assistance, 24-hour emergency services, such as police and ambulance, are likely to respond first.

When police, ambulance and mental health service staff attend a mental health crisis, their collective aims, informed by legislation, policy and agency protocols should be to:

- prevent harm to the person and any others present, including attending staff
- respond in ways that are supportive and minimise restrictions to the person's freedom
- maintain the dignity and rights of the person.

To meet these aims, agencies, and their staff, need to be well prepared, properly trained and well coordinated.

### Victoria Police

Police may become involved in a mental health crisis:

- when sent from a '000' call – the dispatch may identify that the person has a mental illness, but the call out may be, for example, to attend a disturbance
- at the request of ambulance or mental health service staff, to secure the safety of the person or others at the scene
- by noticing a person who needs assistance while performing other police duties.

### Ambulance Victoria

Ambulance services will attend in response to a '000' call, which may, or may not identify that the situation involves a person experiencing mental illness, or at the request of police or mental health service staff.

### Area Mental Health Services

Crisis Assessment and Treatment (CAT) service staff, from an Area Mental Health Service (AMHS) may attend a crisis following a call to their telephone triage service. CAT staff may also attend at the request of police or ambulance staff.

## 1.2 Agency responses to mental health crises

In any service response involving a range of agencies with different skills and duties working together, it is important that the roles and responsibilities are clear and properly communicated. In responding to mental health crises, police, ambulance and mental health services all have specific roles and responsibilities, identified in legislation and joint protocols between agencies and service descriptions.

## 1.2.1 Victoria Police

Victoria Police objectives include preserving the peace, maintaining public safety and helping those needing assistance. In responding to a mental health crisis, police focus on the safety and needs of the individual, others at the scene, the community and the attending officers.

Under section 10 of the *Mental Health Act 1986,* police can apprehend a person who appears to be mentally ill, if they have reasonable grounds for believing that:

- the person has recently attempted suicide or tried to cause serious bodily harm to themself or another person
- the person is likely, by act or neglect, to attempt suicide or to cause serious bodily harm to themself or another person.

A police officer need only make a judgment that the person appears to be mentally ill, based on their behaviour and appearance. The police can enter any premises and use reasonably necessary force to apprehend the person.

Police also supervise people with an acute mental health issue while they are being transported or are in custody.

### 1.2.2 Ambulance Victoria

Ambulance Victoria is responsible for transporting people experiencing acute mental illness who need urgent hospital care, including involuntary patients. It is the lead agency for transporting mental health patients. Police are only supposed to transport people with an acute mental health issue as a last resort, for example when this is the only safe means of transport.

### 1.2.3 Mental health services

#### Area Mental Health Services

The Department of Health (DOH), previously the Department of Human Services (DHS), funds and oversees AMHS. These services are organised and delivered according to geographical boundaries. Victoria has 21 adult AMHS, which are part of larger health service organisations that operate acute hospitals.

AMHS assess, diagnose, treat and provide clinical case management to people with mental illness. They use a range of care models, including telephone-based mental health triage and CAT services.

##### *Triage*

Mental health triage is a telephone-based system for anyone to make first contact with, or referral to, an AMHS. A triage clinician initially assesses whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required. Depending on the assessment outcome, a triage clinician may:

- refer the person to another organisation or give advice
- arrange for a full assessment, often at the person's home
- refer to police or ambulance for assistance.

Triage clinicians should be contactable on a single free telephone number 24 hours a day, seven days a week.

##### *Crisis Assessment and Treatment services*

CAT services provide community-based assessment and short-term treatment for people with acute mental illness. CAT staff are mental health clinicians with backgrounds in medicine, nursing, social work, occupational therapy and psychology. DOH service descriptions state that CAT services are available 24 hours a day, seven days a week. However, CAT services are not an emergency response service for mental health crises, and staffing and funding reflect this. Instead, CAT services focus on providing care and treatment for individuals in their own homes and avoiding unnecessary hospitalisation.

Most metropolitan AMHS have a dedicated CAT service, while rural CAT services are often part of mental health teams with broader responsibilities.

DOH protocol requires CAT services to prioritise referrals from police for urgent mental health assessments. Following the referral, CAT services should agree on the location for the assessment with police. Assessment locations can include:

- a person's residence, family home or work place
- a community mental health service
- a medical clinic
- a hospital emergency department
- a police station (including police cells).

If police ask a CAT member to come to the scene of a crisis, DOH advises that they should do so as soon as practicable.

### 1.2.4 Interagency protocols

DOH, Ambulance Victoria and Victoria Police have agreed and documented their interactions in responding to mental health issues in two protocols, to instruct their staff about interagency arrangements.

#### Ambulance Transport of People with a Mental Illness protocol

DOH and Ambulance Victoria developed the Ambulance Transport of People with a Mental Illness protocol in 2002. It defines roles, responsibilities and interactions of mental health and ambulance services when transporting mental health patients.

The protocol discusses transport options for mental health patients and the factors that should guide decisions about which form of transport is appropriate. The protocol states that an ambulance should be called when:

- a person cannot be safely transported in any other way
- medical treatment is urgently needed
- an involuntary patient has been sedated by oral, intramuscular or intravenous medication to transport them to an approved mental health service
- a person needs to be mechanically restrained.

The protocol notes that police involvement in patient transport should be a last resort, although paramedics may request police assistance where there is a high risk of harm to the person or others. Police should only use their vehicles for transport if all other options are unsuitable.

### Protocol between Victoria Police and the Department of Human Services Mental Health Branch

Victoria Police and DHS first developed an interagency protocol in 1995. In 2004 DHS and Victoria Police revised this, creating the *Protocol between Victoria Police and the Department of Human Services Mental Health Branch*. This document is commonly referred to as the 'interagency protocol'. The protocol provides guidance on how mental health and police services should respond to people experiencing mental health crises. The protocol's aims are to:

- *'establish clear guidelines for police and mental health services' staff on handling situations where either agency has requested assistance from the other*
- *promote an adequate standard of care to the mentally ill person in situations, which involve both police and mental health services staff*
- *outline agreed procedures for management of psychiatric crises and high-risk situations involving people who have, or are believed to have, a mental illness'.*

Appendix A outlines parts of the protocol relevant to this audit.

DOH and Victoria Police are currently revising this protocol, discussed in Part 4 of the report.

## 1.3 Legislation and policy

As well as protocols, legislation and policy guide responses to mental health crises. They detail the principles that agencies should follow when responding to crises and help protect the rights of individuals with mental illness. Each agency should be aware of these documents and comply with their directions.

### 1.3.1 Legislative framework

#### *The Mental Health Act 1986*

The Victorian *Mental Health Act 1986* provides for the care, treatment and protection of people with a mental illness in Victoria. The Act requires that people with a mental illness receive:

- the best possible care and treatment appropriate to their needs
- care in the least possible restrictive environment and least intrusive way
- care and treatment with minimal interference to their rights, privacy, dignity and self-respect.

In May 2008 the government announced a review of the Act. The review aims to incorporate developments in policy, practice and human rights law. This includes aligning the Act with the *Victorian Charter of Human Rights and Responsibilities Act 2006*. Parliament is due to consider proposed legislative changes in 2010.

### *The Victorian Charter of Human Rights and Responsibilities Act 2006*

The main purpose of the *Victorian Charter of Human Rights and Responsibilities Act 2006* is 'to protect and promote human rights' which includes:

- *'ensuring that all statutory provisions, whenever enacted, are interpreted so far as is possible in a way that is compatible with human rights*
- *imposing an obligation on all public authorities to act in a way that is compatible with human rights'.*

The charter outlines a number of human rights that public authorities, including health services, Ambulance Victoria and Victoria Police, must uphold. These include:

- *'protection from torture and cruel, inhuman or degrading treatment'*
- that *'all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the person'.*

## 1.3.2 Policy framework

### Victoria's mental health reform strategy

In February 2009 the government released *Because Mental Health Matters: Victoria's Mental Health Reform Strategy 2009–2019*. The strategy aims *to 'achieve a more positive, inclusive experience for all consumers…through a mix of service development and redesign, …delivery partnerships and service coordination, …and a shared commitment to whole-of-person care'.* The government has so far committed a total of $258.7 million towards the strategy.

The strategy makes a range of proposals to address important areas for reform. Some of these proposals are particularly relevant to the ability of agencies to respond to mental health crises, such as:

- *'promptly assess and proactively assist those who need a mental health service to access appropriate care through the development of centralised psychiatric triage in AMHS'*
- *'better support people experiencing psychiatric emergencies through more closely coordinated mental health and police emergency responses, targeted to periods and locations of high need'*
- *'work towards better availability of community-based specialist mental health services'*
- *'develop new monitoring and accountability arrangements based on a shared whole-of-system outcomes framework incorporating health and social indicators that reflect broader individual and community goals'.*

As a whole-of-government strategy, this document provides a framework for all public authorities, including health, police and ambulance services.

## 1.4 Audit objective, scope and methods

### 1.4.1 Audit objective and criteria

The objective of the audit was to assess the coordination, preparation, and effectiveness of police, ambulance and mental health service responses to mental health crises in the community. To determine this we examined whether:

- agency responses to mental health crises are coordinated
- agencies are adequately prepared to respond to mental health crises and respond appropriately
- agencies can show the effectiveness of their responses to mental health crises.

### 1.4.2 Audit scope

The audit scope included:

- DOH, particularly the Mental Health and Drugs Division
- Victoria Police
- Ambulance Victoria
- Four AMHS, particularly CAT and triage services.

The audit examined these agencies in the context of their role as 'first responders' to mental health crises in the community. The broader mental health service system was not considered as part of this audit, but it is acknowledged that initiatives outlined in the *Victorian Mental Health Reform Strategy 2009–19* in other areas, for example bed-based services, have the potential to reduce demand for crisis responses.

The audit was performed in accordance with the relevant Australian Auditing Standards. The total cost of the audit was $280 000, which includes staff time, overheads and printing.

### 1.4.3 Audit methods

The audit involved interviews with more than 100 staff across the audited agencies. We also reviewed documents, including records of incidents, policies and procedures, meeting minutes, training materials and where available, relevant data.

The lack of available quantitative data on the effectiveness of responses by each service to mental health crises limited the audit findings. Without this data, we based our findings and conclusions on qualitative evidence.

# 2 Response effectiveness

## At a glance

Responses to people experiencing a mental health crisis vary, from streamlined compassionate care, to inappropriate use of police vans and cells, and long assessment delays. Identifying and targeting areas needing attention is difficult because of a lack of information on service effectiveness. We found that:

- The Department of Health (DOH) does not measure mental health triage and Crisis Assessment and Treatment (CAT) service performance. This means that DOH cannot assess their service effectiveness.
- Police, Ambulance and CAT team Emergency Response, or PACER, a collaborative new service model designed to improve mental health crisis responses, shows the benefit of agencies working together and focusing on consumer needs.
- Victoria Police's new data collection initiatives will help it understand its response effectiveness.

We recommend:

- DOH and Area Mental Health Services (AMHS) demonstrate the effectiveness of their responses by:
  - working together to develop and implement measures of demand for, and effectiveness of responses to, mental health crises
  - using this information to identify and address service gaps and areas for improvement.
- Victoria Police, as indicated in the Peace of Mind Strategy, develops and uses measures to evaluate their responses to mental health issues.
- The Interdepartmental Liaison Committee (IDLC) and Emergency Services Liaison Committees (ESLC) should jointly review performance in responding to mental health issues.
- All agencies continue collaborative innovation by:
  - continuing the PACER trial and acting on its evaluation
  - focusing on opportunities to address issues particular to regional/rural areas.

## 2.1 Introduction

The *Victorian Mental Health Reform Strategy 2009–2019* recognises that mental health service delivery needs improving. One of the strategy's proposals is to *'better support people experiencing psychiatric emergencies through more closely coordinated mental health and police emergency responses, targeted to periods and locations of high need'*.

To achieve this, all the relevant agencies need to understand how effective current service delivery is. Effectiveness of responses to people experiencing mental health crises relates to timeliness, minimising force and avoiding interference to the person's rights and dignity.

Our findings about the effectiveness of agency responses to mental health crises are based on the extent to which each agency understands and measures its service delivery effectiveness.

This part discusses our findings at:

- The Department of Health (DOH) and four Area Mental Health Services (AMHS)
- Victoria Police
- Ambulance Victoria.

This part also explores improvements from new service delivery models.

## 2.2 Conclusion

The effectiveness of agency responses to mental health crises in the community is not being demonstrated. Police, Crisis Assessment and Treatment (CAT), and regional ambulance services cannot provide assurance about the effectiveness of their responses to mental health crises. This is mainly because agencies are not recording this information. DOH and AMHS, the agencies with primary responsibility for mental health services, have not collected data on CAT service responses to mental health crises. Ambulance Victoria has only just started collecting regional data electronically, and Victoria Police, until recently, has not collected data on section 10 apprehensions. Without this information, agencies miss opportunities to monitor and improve their services, build on successes or identify resource needs, to the detriment of consumers.

Victoria Police's new data collection initiatives will show the frequency and type of police responses to mental health crises. This feedback will inform police responses, as well as provide valuable feedback to DOH, AMHS and Ambulance Victoria. DOH plans to start collecting CAT response times as part of enhancements to triage services will also provide new insights to response effectiveness.

Given the reliance of responses on interagency coordination, all three agencies should gather and collate performance information and assess responses at interagency forums, such as the state-level Interdepartmental Liaison Committee (IDLC), and local area Emergency Services Liaison Committees (ESLC).

The success of the Police, Ambulance and CAT team Emergency Response (PACER) trial project demonstrates what can be achieved when agencies work collaboratively and with a patient-centred focus. Preliminary findings of the ability of this interagency service model to improve crisis responses is encouraging and leads the way for further investment in innovation.

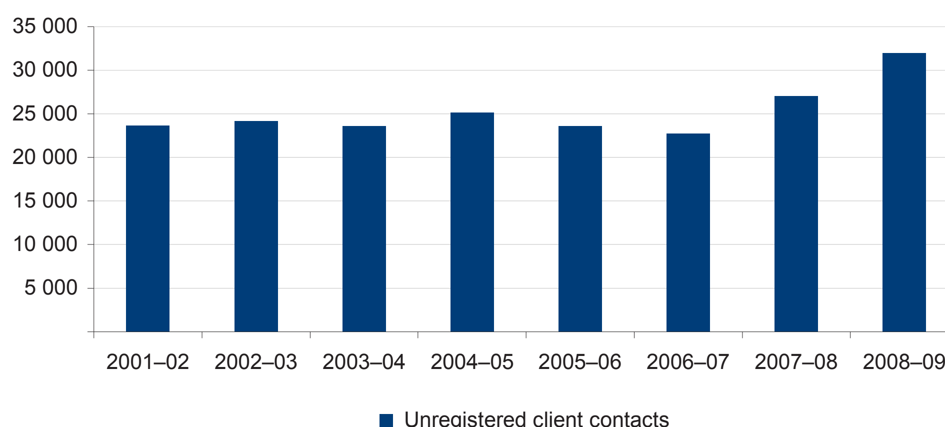
## 2.3 Measuring response effectiveness

### 2.3.1 DOH and AMHS

DOH collects information on the number of intake and assessment contacts that triage, CAT services and emergency department CAT teams (ECATT) have with consumers. This gives an indication of demand on these 'front end' mental health services.

Figure 2A shows the total number of 'unregistered' or new mental health intake and assessment contacts across Victoria. The graph illustrates an increase of more than 8 000 contacts from 2000–01 to 2008–09.

**Figure 2A**
**State-wide new mental health intake and assessment contacts**




*Note:* These figures only indicate mental health service responses to 'mental health crises' as such events are not separately recorded. DOH, however, advised that 'crisis' contacts would be best represented by 'unregistered' contacts.

*Note:* Data represents face-to-face contacts only.

*Source:* Victorian Auditor-General's Office using DOH data.

### Information gaps

DOH has a set of key performance indicators (KPI) to measure mental health service performance. While triage and CAT services contribute, along with other community and inpatient-based services, to the performance of some of these indicators, none of the indicators specifically describes the effectiveness of triage or CAT service responses. While it is not necessary to have specific KPIs for these services, DOH and AMHS should have access to information, which allows them to analyse how these services are operating.

While the information in Figure 2A shows service activity, it does not capture how services are coping with the increased demand, or response effectiveness. Two of the AMHS audited did collect data on the timeliness with which triage call operators answer phone calls, but AMHS and DOH do not routinely collect and use information about:

- outcomes of calls to triage e.g. if CAT services are sent, if the call is referred on to '000', or if only advice is given
- timeliness of CAT service responses to urgent assessment referrals
- where urgent assessments take place e.g. in the community, hospital emergency department or police station
- outcomes of urgent assessments by CAT services e.g. admission, referral to community services etc.

This lack of information means the timeliness and effectiveness of CAT service responses is unknown.

DOH is aware of this information gap. Victorian CAT services have operated for almost 15 years without any specific performance measurement. As part of its initiative to expand mental health triage services DOH intends to collect triage and CAT service response time data and develop performance indicators. It is crucial that DOH prioritises the development and collection of information to identify:

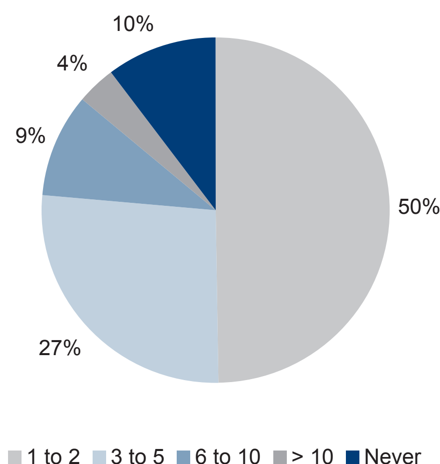
- service demand
- the effectiveness of triage and CAT service responses e.g. timeliness and appropriateness of assessment site
- service gaps and areas of need.

This information can then be used to set appropriate indicator targets and benchmarks. This data collection will be essential to determine and target areas of need as proposed in the *Victorian Mental Health Reform Strategy 2009–2019*.

## 2.3.2 Victoria Police

The Centre of Forensic Behavioural Science's 2009 survey of just over 3 500 police found that 90 per cent have weekly contact with someone who is mentally ill. Figure 2B shows respondent estimates of frequency of contacts.

**Figure 2B**
**Police estimates of weekly contacts with persons experiencing mental illness**




*Source:* Victoria Police and the Centre for Forensic Behavioural Science.

As Victoria Police has a day-to-day role in responding to people with mental illness, it should know how effective its responses are. Victoria Police is starting to collect this information, showing a growing understanding of its role in responding to this community issue.

## Victoria Police Mental Health Strategy: *Peace of Mind*

In 2006–07 Victoria Police prioritised services to people with mental illness and developed a mental health strategy called Peace of Mind. The strategy aims to:

- '*develop a framework that gives direction and structure to Victoria Police's planning, strategies and partnerships for providing services to people with, or affected by, mental disorders*
- *review current policing practice in Victoria and elsewhere to identify what works and what needs to be improved*
- *improve policing systems, processes, knowledge and partnerships in collaboration with relevant areas and agencies*
- *put in place measures to ensure that the framework is self-sustaining and effective'.*

An action plan outlining 60 directions for implementation supports the strategy and Victoria Police has continually monitored its progress with almost all the actions completed. Major achievements are:

- establishment of the Mental Health Strategy Unit, which with high-level support, has implemented the plan and provided a central resource for the agency

- recruitment of 120 Mental Health Liaison Officers from police ranks, to support colleagues and foster relationships with other agencies
- roll out of mental health first aid training
- investment in joint research with the Centre for Forensic Behavioural Science, Monash University, to establish a knowledge base about policing and mental health and identify areas for improvement
- initiation of an innovative service delivery model (see section 2.4)
- implementation of new data collection methods.

The development, implementation, and measurement of progress against this plan demonstrate organisational improvement in the willingness and ability of Victoria Police to respond effectively to mental health crises.

Importantly, Victoria Police is developing an understanding of its responses to people with mental illness, and capacity to collect ongoing data for performance monitoring. Figure 2C lists its main initiatives. Overall, initial research shows that Victorian police have positive attitudes towards people experiencing mental illness and are adept at identifying mental illness. However, people with mental illness are still over-represented among persons fatally wounded by police, highlighting the need for improved training.

**Figure 2C**
**Victoria Police – examples of information collection activities**

| Information collection activity | Status | Aims/outcomes | Partners |
|---|---|---|---|
| Review of fatal shootings 1982–2007 | Completed | Fatalities have halved since the introduction of Victoria Police's Project Beacon to reduce fatal shootings (32 before, 16 after 1995). 82 per cent of those fatally wounded after 1995 had severe psychotic disorders. This is an over-representation. | Monash University |
| Survey of police experience, attitudes and knowledge of mental disorder | Completed | Found that police attitudes towards mental illness are consistent with the wider community. Police attitudes about people with mental illness were positive, but were negative about the mental health system. | Monash University |
| Survey of police contact with persons experiencing mental illness, knowledge about how to respond, and challenges experienced | Completed | About 3 500 police were surveyed. Police spend a lot of time and resources responding to people with mental health issues, and police said their main challenge was getting support from mental health services. | Monash University |
| Study of police responses to videos depicting scenarios involving different levels of mental illness | Completed | Police could identify mental illness and appropriate responses. While most reported they would ideally call a CAT service when detecting a mental health crisis, they said in reality they would apprehend under section 10. | Monash University |
| Review of police section 10 transfers to two metropolitan emergency departments | Completed | Found that 77 per cent of the people police transferred under section 10 needed psychiatric services.<br>80 per cent of section 10 mental health patients arrived at the emergency department in a police van and police conducted 3–4 section 10 transfers to each hospital weekly. | Western Health |
| Recording of police activity data – member activity sheets (MAS) | Started | The MAS will record the time police spend helping people with mental health issues. | Internal |
| Analysis of all police transfers of persons to health facilities under section 10 | Started | This initiative will collect data on all section 10 transfers; transport methods, assessment sites used, wait times for other services e.g. ambulance, CAT and emergency department, and total police time. | Monash University |
| Study of use of force and relationship to persons with mental illness | Started | This study will analyse information in the use of force database to determine if mental health patients are over-represented. | Monash University |

*Source:* Victorian Auditor-General's Office, using Victoria Police data.

### Next steps

These research projects provide baseline information for comparing future performance and reviewing training outcomes. New ongoing data collection activities will help track the extent to which police are responding to mental health crises and the appropriateness of their decision-making in the use of section 10 powers.

There is a gap in information about the use of force by police against people with a mental illness. While Victoria Police reports quarterly data on use of force in the Mental Health Knowledge Bank, the Office of Police Integrity (OPI) found in its 2009 *Review of the Use of Force by and Against Police* that under-reporting limits data usefulness. Given that minimising restrictive practices is an important principle in the interagency protocol and a requirement of the *Mental Health Act 1986* this information source needs improvement and use in performance monitoring.

Next steps in the *Peace of Mind* plan include the use of the information tools developed to:

- monitor service delivery trends
- benchmark against outcomes
- report on outcomes.

Victoria Police must follow these steps to evaluate its investments in the mental health area.

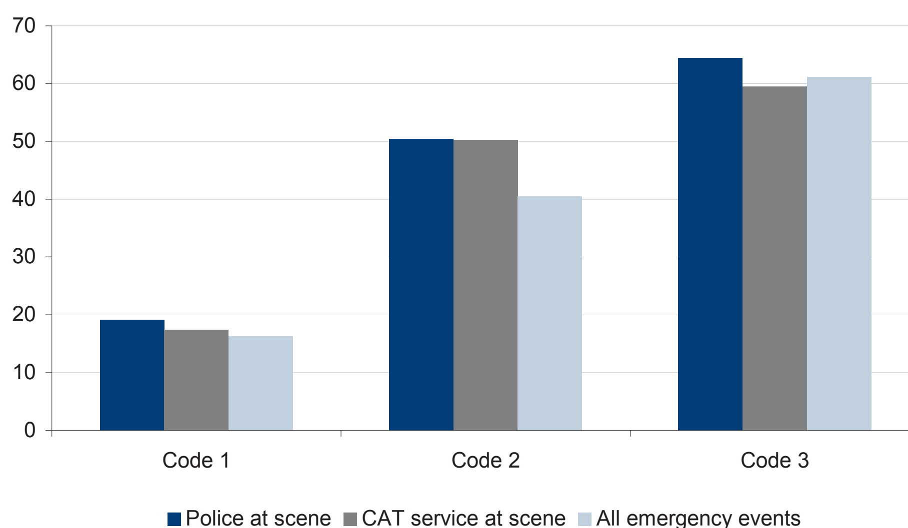
## 2.3.3 Ambulance Victoria

Ambulance Victoria monitors its performance in terms of timeliness. Requests for ambulance transport are categorised by their urgency, ranging from emergency code 1 cases, when an ambulance drives with 'lights and sirens', to non-urgent code 3 transports. Ambulance Victoria responded to 86.4 per cent of code 1 cases within 15 minutes in 2007–08, just under its 90 per cent target.

Ambulance Victoria has no performance indicators specific to mental health patients. This is appropriate, as all patients should receive the same high standard of service. However, Ambulance Victoria is able to identify metropolitan mental health patient transports through its database.

Data obtained for the period 2007–08 showed that on average, Ambulance Victoria responded to code 1 metropolitan mental health situations involving police or CAT services within the 15-minute target. There were few code 1 events and most mental health cases with police or CAT staff in attendance were code 2. Figure 2D shows response times in the 90$^{th}$ percentile, meaning 90 per cent of cases are responded to within this time. The figure compares response times to mental health cases where either police of CAT staff were present, with responses for any metropolitan call-out.

**Figure 2D**
**Metropolitan ambulance response times in minutes at the 90th percentile**




*Source:* Victorian Auditor-General's Office from Ambulance Victoria data.

Figure 2D shows a 10-minute difference between code 2 response times where CAT or police staff are attending a mental health patient, in comparison to any other case. The reason for the difference is unclear; however, this data may support anecdotal police reports about delays waiting for ambulances when requesting transport for a mental health patient. This merits further investigation by Ambulance Victoria.

It was not possible to compare response times between mental health and other cases for regional areas as electronic capture of this data has just started. Given reports about lengthy ambulance delays in the regional area we visited, Ambulance Victoria should review this data as it becomes available.

While specific performance indicators are not warranted, routine monitoring of response times for cases involving people experiencing a mental health crisis, using complete state-wide data, would allow Ambulance Victoria to assess its performance in this area and identify areas for improvement.

## 2.4 Effectiveness of agency collaboration

### 2.4.1 PACER

Victoria Police's *Peace of Mind* plan included testing and evaluating collaborative service models when responding to mental health crises. Victoria Police joined with Ambulance Victoria and Southern Health and researched local and overseas models before developing and testing PACER – Police, Ambulance and Crisis Assessment and Treatment Team Early Response. Figure 2E details the trial's aims, design and findings.

The evaluation of the three-month PACER trial, by Southern Health, Victoria Police and Ambulance Victoria, showed that it had met all its aims. Police and clinical staff involved, and those who had heard about it, showed overwhelming support for the model. Staff believe that the PACER model improved resource use and interagency communication, but most importantly, it created a more person-centred response, where restrictive interventions can be avoided.

DOH has recognised the trial's success and extended funding for 12 months and Victoria Police have also committed resources to continue the trial. The aim is to conduct a more extensive evaluation process, and if warranted, set up the model in other regions. This innovation and interagency cooperation is commendable.

**Figure 2E**
**PACER trial aims, design and findings**

**Aims**

To test the hypotheses that:

- a dual police and mental health response is an effective model for responding to people with a mental disorder
- early intervention and assessment can reduce section 10 apprehensions and police or ambulance transports to emergency departments
- a dual response in the community will reduce the risk of incidents escalating
- a dual response will give staff faster access to mental health database information, improving referral options, and avoiding some section 10 transports
- PACER will improve interagency communication and understanding of different agency service systems.

**Design**

The trial happened between September and December 2007.

The PACER team had one police member and one CAT clinician rostered on for one daily shift, each day of the week, between 2–10pm.

PACER was used as a secondary response unit; with ambulance and police staff responsible for requesting PACER assistance.

The call-out criteria for the PACER team included:

- onsite clinical assessment of a person's mental health
- onsite or telephone advice on mental health referral options
- advice on appropriate transport options
- advice on de-escalation tactics and options
- advice on ways to assist and manage frequent users of emergency services.

The CAT clinician did the clinical assessment and gave advice, checking medical records and arranging referrals. The police member took requests for assistance, did police database checks and maintained safety at scenes.

**Findings**

The unit responded to 279 requests for assistance, an average of three per shift. The average response took 1.5 hours.

Key statistics from the trial were:

- 68 per cent of requests were for onsite assessments
- 55 per cent of cases involved people who met section 10 criteria for apprehension
- 83 per cent of PACER assessments happened in the community
- In 47 per cent of cases the PACER unit was able to free the referrer, e.g. police or ambulance, to respond to other calls
- Force, e.g. handcuffs or capsicum spray, was only needed in 4 per cent of cases
- In 90 per cent of call outs the clinician diagnosed a mental illness or disorder
- The need for transport was avoided in 11 per cent of cases.

*Source:* Victorian Auditor-General's Office, from the *Evaluation report on the trial of PACER: Police, Ambulance and Crisis Assessment Team Early Response*, 2008.

## Recommendations

1. DOH and Area Mental Health Services (AMHS) demonstrate the effectiveness of their responses by:
   - working together to develop and implement ways to measure demand for, and effectiveness of responses to, mental health crises
   - using this information to identify and address service gaps and areas for improvement.
2. Victoria Police, as indicated in the Peace of Mind Strategy, develops and uses measures to evaluate their responses to mental health issues.
3. IDLC and ESLCs jointly review performance in responding to mental health issues.
4. All agencies continue collaborative innovation by:
   - continuing the PACER trial and acting on its evaluation
   - focusing on opportunities to address issues particular to regional/rural areas.

# 3 Response preparation and appropriateness

## At a glance

Responses to mental health crises vary according to the person's needs and the situation. The guiding principles for responses are that actions minimise restrictions on freedom and interference to the rights and dignity of the person. At each agency, we assessed training and responses to see if they follow these principles. We found that:

- agency training needs improving, particularly in the areas of interagency knowledge and coordination
- training needs to be based on better understanding of consumer experiences
- the needs and dignity of the person often do not inform responses, resulting in inappropriate use of police vans and cells.

We recommend that:

- Victoria Police complete enhancements to mental health training to:
  - support interagency coordination and protocol compliance
  - improve the consistency and quality of responses for consumers.
- Area Mental Health Services (AMHS) and Ambulance Victoria address training gaps for paramedic and CAT/triage staff.
- Each agency incorporates consumer experience and perspective in staff training.
- Department of Health (DOH), AMHS, Victoria Police and Ambulance Victoria explore and trial interagency training/learning opportunities.
- Ambulance Victoria, DOH and Victoria Police, work together to investigate and trial alternative transport solutions.
- DOH, with AMHS, clearly articulate and communicate expectations for CAT service responsiveness to crises.
- Emergency Service Liaison Committees (ESLC), supported and monitored by the Interdepartmental Liaison Committee (IDLC), introduce protocols to minimise police delays at emergency departments.
- Police should not use divisional vans for mental health transports unless there is a clear policing or safety need.
- Police should not use cells to detain persons under section 10 of the *Mental Health Act 1986* unless there is a clear policing or safety need.

## 3.1 Introduction

A person in mental health crisis is very distressed and may be experiencing an altered reality state. There may be risk of self-harm or harm to others, possibly requiring the use of physical force to take them into care against their will.

Under the *Mental Health Act 1986*, police, paramedics and mental health staff must respond to such situations with minimal restriction of freedom or interference to the rights and dignity of the person with a mental illness. This means, for example, using physical restraint, or police vans and cells as a last resort. This requires high levels of judgment, understanding and skill.

Another challenge in responding to mental health crises is the stigma attached to mental illness. This has the potential to affect responses in both subtle and obvious ways.

In this part, we examine each agency's preparedness to respond to mental health crises, as well as their actual responses.

## 3.2 Conclusion

Agency preparation and responses are inconsistent.

People experiencing a mental health crisis do not necessarily receive effective and efficient care. Mental health service consumers we spoke to said that responses to crises vary depending on location, the day and time of the crisis and the attitudes and experience of the individual staff who attend. These people's experiences range from getting effective care, to long delays, indifference and degrading treatment.

These impressions match our findings that training, education resources, and compliance of responses with interagency protocols and policy and legislative principles vary greatly.

The needs of the person in distress should direct responses, not the needs or preferences of the agency or its staff. Agencies need to document and assess how resource constraints are affecting responses so they can address service gaps. Unless there is a justifiable cause, police should not use vans or cells to detain people suffering from a mental health crises.

While agencies are making improvements, such as police mental health first aid training and expansion of telephone triage services, they must do more to stop mental health service consumers feeling like the victims of chance and circumstance. Responses need to be of a consistent standard and agencies need to follow agreed ways of working. To achieve this, service providers need better training and education resources. We acknowledge that the *Victorian Mental Health Reform Strategy 2009–2019* aims to address these issues.

## 3.3 Preparation

### 3.3.1 Victoria Police

Many of the skills that police need when responding to mental health crises are similar to those used in general policing duties. They include communication skills, de-escalation techniques and safety strategies. Police recruit education and operational safety and tactics training (OSTT), aim to teach these skills. They are also reinforced with on-the-job experience and supervision. In particular, OSTT allows police to participate in scenario-based training, which previously included mental health crisis scenarios. The Office of Police Integrity's 2009 *Review of Use of Force by and against Victorian Police*, noted that OSTT has not focused on mental health issues since June 2006 and strongly recommended improving this training with a focus on responses to mental illness. Our audit supports these OPI recommendations.

Victoria Police is working to improve OSTT training, including the development of new mental health training scenarios planned for use from January 2010.

#### Mental health training

Victoria Police also provides specific mental health training, outlined in Figure 3A.

**Figure 3A**
**Victoria Police training for responding to mental health issues**

| Training type | Content | Duration | Who is trained |
|---|---|---|---|
| Recruit training<br>Probationary training | • identifying and understanding mental illness<br>• legal requirements<br>• processes for interacting with other services e.g. health services | 6 hours<br>1.5 hours | All members<br>All members |
| Critical incident response training | • identifying and understanding mental illness<br>• simulated critical incident exercises | 8 hours | Force response unit members |
| Negotiator course | • communicating with people with mental illness | 6 hours | Police negotiators |
| Mental health first aid training | • tools for managing crisis situations<br>• development of empathy<br>• listening and communication skills<br>• knowledge of common types of mental illness. | 2 days | Any staff member by expression of interest |

*Source:* The Victorian Auditor-General's Office, using Victoria Police information.

Police members we spoke to, including relatively new staff, could not remember the detail of their recruit or probationary constable training on mental health. Members said the training did not prepare them to manage mental health crises. Victoria Police is currently reviewing its recruit and probationary training, including mental health content, and recently implemented a new recruit mental health-training module. Victoria Police will need to evaluate its changes to mental health training provided at this level to determine if it adequately prepares junior police.

As well as standard training, Victoria Police has introduced voluntary mental health first aid training. Nearly 900 members have completed this training since October 2006, and Victoria Police expects to have 10 per cent of its operational workforce trained by the end of 2009. It focuses on building knowledge, reducing stigma and providing support. At each region we visited, we found police who had completed this training and spoke highly of it. Participants recommended the course and reported that it had changed their response behaviours to mental health crises.

## Other resources

Victoria Police has also chosen more than 100 staff to become Mental Health Liaison Officers across every geographical division. These staff members are responsible for:

- communicating with local mental health service providers and sitting on their local Emergency Service Liaison Committee
- knowing about local processes and interagency arrangements
- supporting local members with mental health advice and education.

Police members we spoke to believed Mental Health Liaison Officers were valuable resources. Staff in this role felt they had better relationships and coordination with other agencies, which they could pass onto their colleagues.

Members can also use an online resource called the Mental Health Knowledge Bank. This resource includes protocol information, links to referral agencies, and mental health service information. Site usage is growing, from about 1 600 hits in 2007–08, its first year, to nearly 3 000 in 2008–09, and a projected 3 900 for 2009–10. Police most commonly look for operational response information, such as answers to frequently asked questions.

Despite these mental health training and education resources, we found staff had different opinions and levels of understanding about best practice, resources and other agencies' roles and responsibilities. Feedback about police responses from mental health staff and consumers also reflected these inconsistencies.

This highlights the need for better communication about available resources, more effective recruit and probationary training, and mental health first aid or other training opportunities for more staff. Training provided needs to cover information in the interagency protocol with the Department of Health (DOH), particularly police interactions with other agencies. Better-prepared police will provide the public with a more consistent, best practice response to mental health crises.

### 3.3.2 Area Mental Health Services

Most triage and Crisis Assessment and Treatment (CAT) clinicians are experienced, with formal academic and clinical training, and learn their roles through mentoring. Triage services use standardised risk assessment tools to decide responses and referrals for people experiencing a mental health crisis. CAT clinicians use standard criteria when making mental health assessments.

However, we found that only one of the mental health services we visited had training for CAT clinicians that addressed the management of mental health crises in the community, such as de-escalation tactics, and none had training to support working with emergency services. While assessment tools are available, education resources are limited. These gaps mean less experienced staff may not be equipped to respond to these situations. Lack of training means AMHS are not addressing issues relevant to CAT and triage service staff, such as inconsistent practices, changing community expectations, and knowledge of interagency processes and communication.

### 3.3.3 Ambulance Victoria

As with police and mental health clinicians, paramedics also need training to provide consistent and appropriate responses for people in mental health crisis.

Like mental health clinicians, paramedics complete academic and clinical training, including a component on mental illness at an undergraduate level. Ambulance Victoria has training focused on managing agitated or aggressive patients, and responding to mental health patients. However, this training has not been provided since 2003.

Ambulance Victoria staff we interviewed believed paramedics need mental health training. It is important that paramedics, as the first on the scene in a crisis, show empathy and understanding, have strong communication and management skills, and coordinate with other agencies.

### 3.3.4 Training together

The audited agencies discussed past arrangements where police and mental health service staff, or mental health staff and paramedics, did joint training. Staff said that these programs helped build interagency relationships and foster better collaboration. These programs stopped because of staff resource issues. Given the benefit for consumers, and the efficiency benefits of coordination between agencies, agencies should find ways to start joint training again.

It is positive that mental health clinicians are participating, as trainers, in police mental health first aid training. This fosters relationship development between frontline personnel.

Training should also include consumer input. Mental health service users can provide first-hand experiences of a mental health crisis and agency responses, and give a consumer's real-life perspective to training.

## 3.4 Appropriate responses

There are a number of resources that guide best practice responses to mental health crises, including state legislation, agency-developed protocols and research. The common message from these resources is that responses must minimise restriction of freedom and maintain the dignity and rights of the person. These are fundamental human rights. We assessed each agency's responses to mental health crises against these legislated principles, as well as the specific processes set out in interagency protocols.

### 3.4.1 Transport

DOH has joint protocols with both Victoria Police and Ambulance Victoria. These documents are clear and consistent about transport methods for people experiencing a mental health crisis. They state:

- Ambulance Victoria has primary responsibility for transporting people with a mental illness who need hospital treatment, regardless of whether the person is being transported voluntarily or involuntarily
- any restrictive actions or interference with a person's privacy, dignity and self-respect should be minimised, while preserving the safety of the person and others
- personal transport methods, including family or friends, or CAT staff vehicles should be considered
- police vehicles should only be used if other options are unsuitable
- if police transportation is necessary then a sedan should be used instead of a divisional van, except where there is unacceptable risk of aggressive or violent behaviour.

Whether agencies follow these transport principles when responding to a mental health crisis depends on the location of the crisis, other demands on emergency services and sometimes on individual attitudes.

#### Police transport decisions

Police practices around the use of ambulances to transport people apprehended under section 10 of the *Mental Health Act 1986* vary. Sometimes police request an ambulance and provide an escort. Other times, police immediately transport people in a divisional van, if there are no identifiable medical issues, such as a drug overdose or lacerations. In 2006 Victoria Police and Western Health evaluated mental health presentations to two metropolitan emergency departments. They found that police vans brought in 80 per cent of the section 10 mental health patients.

If a person is violent or aggressive and safety is an issue, the use of a divisional van for transport is appropriate. However, if safety is not an issue, it is important to consider the possible stigma that transport in a police divisional van attracts.

Police we interviewed gave the following reasons for using divisional vans when there are no clear safety concerns:

- perception that all section 10 transports pose a safety risk requiring a van
- perception or experience of delays waiting for an ambulance
- concern about burdening ambulance resources
- following senior staff's example
- experience that it is quicker to take the person in a van, allowing the van staff to respond to the next call out sooner.

While there was some variation between police's individual transport decisions, most of the variation was between police stations, reflecting the influence of historical practices, leadership and cultural attitudes, and perceptions of ambulance service responsiveness in that area.

## Ambulance and other transport methods

If a CAT clinician, family member or carer cannot take a person experiencing a mental health crisis to hospital for assessment, the person should travel in an ambulance. General feedback from consumers, police and mental health staff on ambulance responses to mental health crises was good. Ambulance requests go through a call centre and standard triage protocols determine their urgency. While metropolitan operators have followed these protocols for some time, they are new to regional centres.

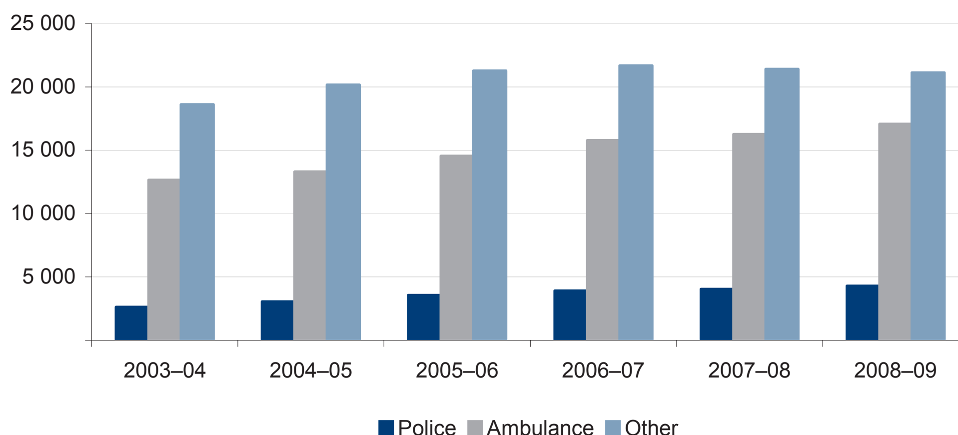
### *Ambulance transport in a regional area*

In the regional area we visited, both police and mental health staff reported long waits for ambulances in situations involving mental health patients. These staff believed that the local ambulance service did not give enough priority to mental health patients. Mental health staff said they had waited hours with patients needing transport, and police said that they avoid requesting ambulances and use divisional vans instead. Ambulance Victoria has acknowledged compliance issues in some regional areas with new triage protocols, which clearly need to be resolved. This issue also highlights the need for ambulance staff to get better mental health training.

### *Alternative transport options*

Ambulance Victoria are concerned that despite the protocol, alternative transport options like travelling with a family member, or in a CAT service car, are not properly considered. Figure 3B shows a recent decline in mental health presentations to emergency departments that arrive by methods other than an ambulance or police vehicle. Police and ambulance transports are increasing. The reason for these changes is unclear.

**Figure 3B**
**Arrival modes for Victorian emergency department mental health presentations**




*Source:* Victorian Auditor-General's Office from DOH's Victorian Emergency Minimum Dataset.

2007–08 Ambulance Victoria data shows 68 per cent of the 14 000 ambulance transports of metropolitan patients experiencing a mental illness did not need clinical intervention by a paramedic. Ambulance transportation is expensive and there are always competing demands for these emergency resources. Ambulance Victoria said it can work with DOH to investigate alternative transport options that meet patient needs. The success of the PACER trial, discussed in Part 2, supports this idea.

## Boundary and catchment area issues

AMHS, police and ambulance services work in catchment areas that do not align. Members of the public move beyond these boundaries, and people may have a mental health crisis outside their area of residence. This can create transportation problems when agency responses are not coordinated.

A common problem for ambulance services, and sometimes police, when they need to take a person in mental health crisis to hospital, is getting to the right hospital first time. Ambulance or police officers usually take a person to the nearest hospital. However, if the person is a patient of an AMHS at another hospital, they, and the accompanying officers, may have to make a second trip to the hospital aligned with their AMHS. An ambulance service in one region solved this problem by calling the mental health service in advance to confirm the destination, avoiding an unnecessary trip. In some areas, police use the mental health triage service to identify the patient's AMHS-aligned hospital. These solutions mean the patient gets care more quickly and resources are more efficiently used. ESLCs should develop locally appropriate solutions to address this issue. Enhancements to triage services will also improve police and paramedic access to information to assist transport decisions.

When agencies do not coordinate their transport responses, patients can suffer. The following case study describes a worst-case scenario reported by a mental health service.

*Case study*

A CAT service received an urgent referral for a patient who needed hospital admission. The referral also requested police assistance because the patient was aggressive.

The attending police realised they would need to leave their patrol area to escort the person to the appropriate hospital.

The attending police asked their sergeant if they could leave their area to accompany the patient in an ambulance to hospital. The sergeant refused, saying the van had to be available to the station's response area.

The sergeant told his staff to take the patient to the border of their area in the divisional van and call an ambulance and police from the neighbouring police area to take the patient to hospital. Police from this area were unavailable and the patient waited in the divisional van, with the attending police, on the side of the road for about two hours. During this time, an ambulance came but left because the police present would not provide an escort out of their area.

Eventually another ambulance came, police from the neighbouring area arrived, and they took the patient to hospital.

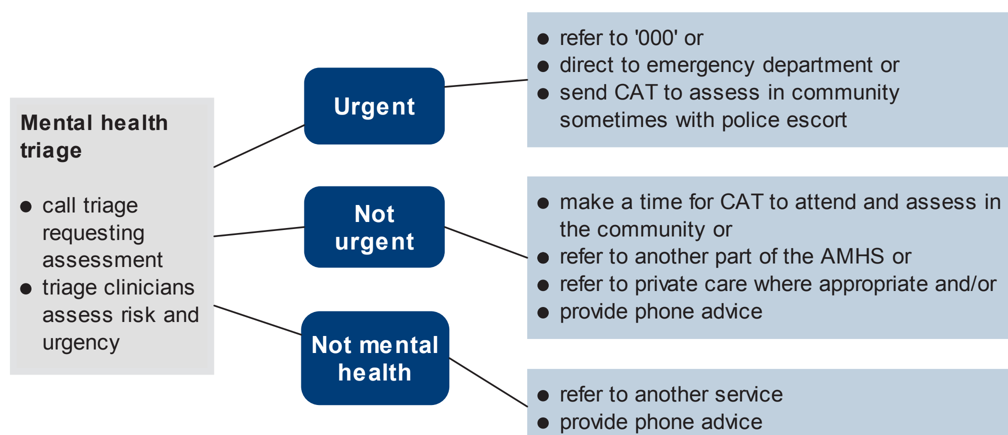
*Source:* Victorian Auditor-General's Office as described by an AMHS.

Mental health service staff said that similar, less severe, incidents have also happened. This example highlights the need for effective interagency coordination, training, and establishment of a culture where the needs of the patient come first.

### 3.4.2 Assessment

When a person has a mental health crisis, the first priority is to do an assessment. This is the gateway to appropriate care and treatment. Figure 3C shows the process to access an AMHS assessment.

**Figure 3C**
**Process for accessing AMHS mental health assessment**




Source: Victorian Auditor-General's Office.

## Triage assessment

All AMHS have phone-based triage and usually a clinician answers immediately. In some areas though, triage clinicians have extra duties, particularly after hours, such as providing mental health services in the emergency department. Staffing and call demand levels can also mean that callers may have to wait. DOH is currently improving access to mental health triage, with the government allocating $16.7 million over five years, from 2008, to increase staffing and standardise triage procedures. The project aims to improve access to the service, as well as the consistency and quality of responses. In addition, DOH is introducing a free mental health advice line, which should relieve triage services from calls requesting general mental health advice and referrals.

## Assessment in the community

Assessment in the community is preferable because it diverts people from hospital emergency departments and supports them in familiar settings. DOH describes CAT services as providing short-term, intensive assessment and treatment in the community for acute mental illness, as an alternative to inpatient care. Policy documents clearly state that CAT services are not an emergency service and can only respond to referrals as soon as possible, with services funded and staffed accordingly.

We acknowledge this, and do not expect CAT services to respond immediately to mental health crises in the way an emergency service would. However, it is important to report that consumers, police and paramedics communicated significant dissatisfaction with the responsiveness of CAT services during the audit.

There are no clear expectations for the timeliness of CAT services responses to urgent referrals, though DOH are developing these as part of the expansion of triage services. This lack of guidance and data on responsiveness makes it impossible to determine whether the timeliness concerns raised reflect the under-performance of CAT services, or unrealistic stakeholder expectations.

Some of the issues raised about CAT service responses during the audit include:

- mental health clinicians feeling torn between responding to crises and maintaining commitments to intensive treatment of patients
- challenges in responding to service demand at a regional mental health service because of difficultly in recruiting enough staff
- police and paramedics not wanting to request CAT for community-based assessments because they have previously experienced long delays, resulting in these agencies directly transporting patients to the emergency department for assessment
- reports of consumers calling ‘000’ for assistance when they cannot get a community-based CAT assessment.

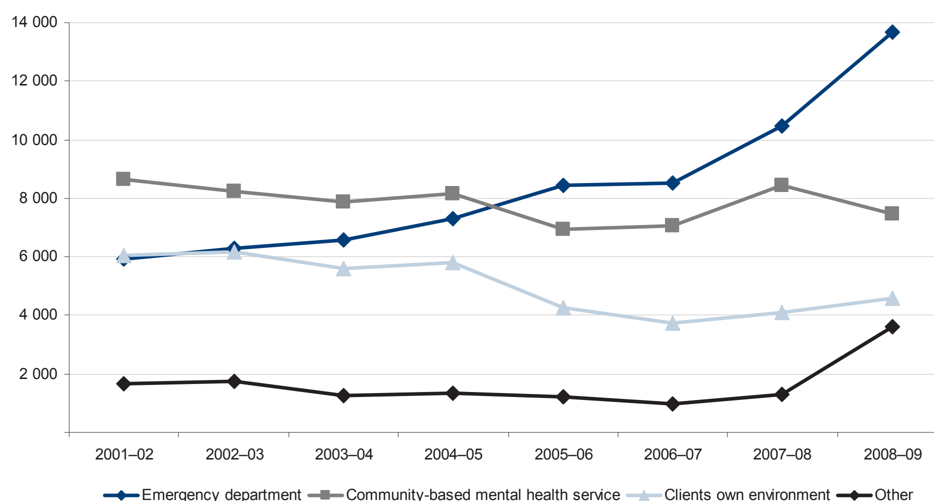
CAT services conduct many community-based assessments in response to urgent referrals, and emergency departments and emergency services are needed to respond to mental health crises, particularly after hours. DOH and AMHS however need a better understanding of whether CAT services are optimising opportunities to respond to crises through community-based assessments, and stakeholders need clear information about what to expect from this service.

## Assessment in emergency departments

While the interagency protocol supports community-based assessments, assessments often happen in hospital emergency departments. DOH recognised the need for specialist mental health services in emergency departments and developed the Emergency Crisis Assessment and Treatment Team (ECATT) model. This model gives mental health patients in an emergency department, direct or on-call, round-the-clock access to a mental health clinician. There are ECATTs in 23 hospitals across Victoria. DOH has also worked to improve emergency department responses to mental health crises with its mental health triage tool that helps triage nurses to prioritise patients. It has also provided funding to increase access to mental health clinicians in emergency departments.

Figure 3D shows where mental health services are providing ‘front end’ services, such as assessment and intake processes.

**Figure 3D**
**Locations for 'front end' mental health service contacts**




*Note:* Data provided is for direct staff contacts with 'unregistered', i.e. new clients, coded as emergency, intake, CAT or triage. Contacts in hospital wards are excluded. 'Other' includes sites such as police stations, shopping centres etc.
*Source:* Victorian Auditor-General's Office using DOH data.

The increase of assessments in emergency departments is probably because of the introduction of ECATTs. Of concern is the drop of nearly 1 500 contacts from 2001–02 and 2008–09, in the 'clients own environment'. The data suggests that service provision is occurring less in the home and more in high cost and busy emergency department settings.

Police in every region we visited said they experience long delays when taking people to emergency departments under section 10 of the *Mental Health Act 1986*. Police report that section 10 handovers to emergency departments usually take more than an hour, sometimes up to three or four hours. This was also an issue raised in focus groups of more than 160 members across the state that Victoria Police held to develop its mental health strategy.

Under the *Mental Health Act 1986,* police have to stay with a patient apprehended under section 10 until:

- a mental health practitioner completes the mental health assessment and advises police to release the person or
- a registered medical practitioner formally accepts duty of care for the person to do a mental health examination.

Police have the following concerns about the length of time spent in emergency departments:

- the patient is stigmatised because they have a police escort
- the patient is distressed because of the delay

- police driving an emergency response vehicle, sometimes the only vehicle in the area, cannot take other calls because they have to wait with the patient.

One of the reasons patients and police have to wait is high demand on emergency departments. Another is that despite the presence of a medical practitioner, in some emergency departments patients have to wait for a mental health clinician to assess them. This may be because of historical practice, health service preference, or the capacity of medical practitioners to feel confident accepting duty of care. In the regional area we visited, this was a significant issue because the on-call mental health clinician was more than an hour's drive away.

A joint protocol between Western Health and local police stations has addressed the issue of timely handovers between police and the emergency department and reportedly reduced police waiting time. This demonstrates that the emergency departments, AMHS and police can improve this process. This should be a priority to allow police to fulfil their emergency service responsibilities.

### Assessment in police cells

Victoria Police data shows that more than 900 people were held in police stations, often in cells, under the *Mental Health Act 1986* in 2008–09. Sometimes this is because a person in mental health crisis behaves violently. If this happens and police cannot calm them it is appropriate for police to take them to a police cell, where a mental health clinician can assess them.

However, police will sometimes hold people in mental health crisis in cells for other reasons, commonly alcohol intoxication. Mental health clinicians in one region we visited instructed police to hold intoxicated persons detained under section 10 in cells until sober. Police from other regions reported similar practices to DOH during review of their interagency protocol.

This practice runs contrary to the Chief Psychiatrist of Victoria's and interagency protocol guidelines. It also runs counter to the principles in the *Mental Health Act 1986*, and the *Victorian Charter of Human Rights and Responsibilities 2006.* Proper practice is for these people to be cared for in a healthcare environment.

## Recommendations

5. Victoria Police complete enhancements to mental health training to:
   - support interagency coordination and protocol compliance
   - improve the consistency and quality of responses for consumers.
6. AMHS and Ambulance Victoria address training gaps for paramedic and CAT/triage staff.
7. Each agency incorporates consumer experience and perspective in staff training.
8. DOH, AMHS, Victoria Police and Ambulance Victoria explore and trial interagency training/learning opportunities.
9. Ambulance Victoria, DOH and Victoria Police, work together to investigate and trial alternative transport solutions.
10. DOH, with AMHS, clearly articulates and communicates expectations for CAT service responsiveness to crises.
11. ESLCs, supported and monitored by IDLC, introduce protocols to minimise police delays at emergency departments.
12. Police should not use divisional vans for mental health transports unless there is a clear policing or safety need.
13. Police should not use cells to detain persons under section 10 of the *Mental Health Act 1986* unless there is a clear policing or safety need.

# 4 Interagency coordination

## At a glance

A person experiencing a mental health crisis often needs help from a combination of mental health, ambulance and police services. This help should be coordinated and streamlined for the benefit of the person and efficient use of resources. We examined how agencies coordinate their responses to mental health crises and found that:

- all the agencies are involved in coordination activities, including state and local level liaison committees, and the Department of Health (DOH) and Victoria Police's review of their interagency protocol
- there is room to improve coordination, particularly:
  - agency compliance with interagency protocols
  - liaison between state and local level forums
  - consumer involvement.

We recommend that:

- The Interdepartmental Liaison Committee (IDLC) formalises and maintains communication, monitoring and reporting processes with the Emergency Services Liaison Committees (ESLC).
- All ESLCs and the IDLC involve consumers
- DOH and Victoria Police support their review of their interagency protocol by:
  - developing a communication strategy to educate stakeholders about the protocol
  - identifying regions/services where the protocol is not being followed and work with them to address the barriers.
- DOH and Ambulance Victoria review their joint protocol.

## 4.1 Introduction

Responses to crises aim to alleviate, not escalate, distress and risk. The level of interagency coordination in managing a crisis affects the achievement of this aim. Effective coordination is also necessary to make the best use of resources.

To work well together, mental health, police and ambulance services need to be clear about each agency's role and responsibilities, agree on how they will coordinate, communicate this to their staff, and monitor the outcomes.

The *Victorian Mental Health Reform Strategy 2009–2019* sets an expectation about interagency coordination, stating, '*good service coordination between agencies will set the foundation for effective care coordination for individuals*'.

This part of the report assesses how well coordinated agencies are in responding to mental health crises.

## 4.2 Conclusion

Interagency coordination can be improved.

Agencies cannot provide optimal interagency responses to mental health crises if they are not communicating, planning, identifying and addressing issues in a coordinated way.

There are protocols and liaison committees that support interagency coordination. However, agencies can improve compliance with these protocols and enhance the effectiveness of liaison committees to achieve better consumer outcomes.

Agencies need to demonstrate that their interagency protocols are effectively applied. Mental health, police and ambulance staff should be aware of, understand, and adopt interagency protocol practices and principles, allowing consumers to benefit from the work invested in developing them. This means the Department of Health (DOH), Victoria Police and Ambulance Victoria need to provide better direction and monitoring of protocol compliance.

Similarly, the state-level Interdepartmental Liaison Committee (IDLC) should engage with local area Emergency Service Liaison Committees (ESLC) and help make these forums effective for the communities they serve and the agencies involved.

## 4.3 Interagency protocols

Each agency's roles, responsibilities and interactions when responding to mental health issues are set out in two protocols, one between DOH and Victoria Police, and another between DOH and Ambulance Victoria.

It is appropriate that these protocols are separate. Each covers information and agency interactions that are broader than crisis responses. A combined protocol for all three agencies would be impractical and have less relevance for each agency.

### 4.3.1 DOH and Victoria Police

The 2004 protocol between Victoria Police and the DOH Mental Health Branch, or the 'interagency protocol', guides police and mental health service interactions in responding to mental health issues. The protocol includes agreed procedures for management of crises and high-risk situations, interagency referral processes and an expectation that detention in police vans and cells is a last resort. Appendix A summarises relevant 2004 protocol content.

Across the four sites we visited, few of the police we interviewed were aware of the interagency protocol and its contents. Some members knew about the protocol, but indicated that they did not use it to guide practice. Mental health service staff awareness of the protocol and its contents was much higher than police awareness, but discussion of their practices revealed instances of non-compliance with the protocol.

In 2008 DOH and Victoria Police agreed to update the existing protocol to make it easier for staff to use. The current protocol, while comprehensive, does not provide information in a clear and concise way, or enough practical guidance. The review involved liaison between DOH mental health staff and the Victoria Police Mental Health Strategy Unit, with input from a working group made up of 'on-the-ground' police and mental health staff.

The review identified several issues, including areas of non-compliance with the protocol, such as inappropriate use of police cells in some areas, and confusion about some practices, such as information sharing between police and clinicians.

The new protocol provides clearer direction to staff; however, weaknesses in the review process mean there is risk that staff will not be aware of, or follow, the revised protocol.

Few police and mental health staff we interviewed were aware of the review. If they knew of the review, they did not know its process. DOH and Victoria Police did not develop a communication plan, to accompany the review, to identify the best ways to communicate the revised protocol to stakeholders and encourage its use. While both agencies intend to communicate the plan after its completion, engaging stakeholders in the process earlier would have enhanced planning and uptake of changes made.

It is also unclear whether, and how, compliance with the revised protocol will be monitored. This is a concern given the issues of awareness of, and compliance with, the 2004 protocol.

DOH believed it was unnecessary to include consumers in the review process because they simply wanted to update the protocol to comply with a new template design. However, given the review has changed protocol content, consumer representation on the working group would have been useful. Given the review started in August 2008, there has been enough time to do this.

### 4.3.2 Ambulance Transport of People with a Mental Illness protocol

The 2002 Ambulance Transport of People with a Mental Illness protocol is an agreement between DOH and Ambulance Victoria. The protocol offers guidance to mental health and ambulance services about appropriate transport options for mental health patients.

While all the paramedics we interviewed were aware of the protocol and relied on it as an important resource, there was confusion about the respective roles and responsibilities of Victoria Police and mental health services when requesting ambulance transport. For example, some paramedics were unsure about when to request a police escort and were unclear about whether some transports were voluntary or involuntary. There are potential safety risks if paramedics do not request police assistance when needed. This lack of clarity, together with the age of the existing protocol, indicates that the protocol needs review, with input from both Victoria Police and consumers.

## 4.4 Interagency collaboration

One way to support coordinated on-the-ground responses is through interagency forums where agencies can plan their processes for interacting, discuss their roles and responsibilities, and identify and address barriers to coordination.

Forums exist at both the state and local levels. The Interdepartmental Liaison Committee (IDLC) is a state-level forum where DOH and Victoria Police discuss mental health service provision. Locally, 21 Emergency Services Liaison Committees (ESLC) operate across Victoria; bringing together police, mental health and ambulance services.

### 4.4.1 Interdepartmental Liaison Committee

IDLC provides a quarterly forum for senior Victoria Police and DOH representatives to discuss common issues in mental health, including crisis responses, and develop strategic responses. This committee has been successful in building relationships and sharing information between the two agencies.

The committee has been less successful in identifying and implementing actions in response to issues. Mental health and police staff we interviewed at the local level could not articulate any impacts that IDLC have had on their practice or their difficulties in responding to mental health issues.

The committee is also limited because Ambulance Victoria is not involved. IDLC has not included Ambulance Victoria, as they are a 'funded agency' under DOH. The DOH Ambulance Services Unit represents Ambulance Victoria at IDLC.

Ambulance Victoria and DOH agree they need to improve their liaison on mental health issues. Ambulance Victoria needs to be better represented so it can discuss problems and solutions. This is essential given its role as the lead agency for transporting people with a mental illness. DOH agrees and during the audit advised that Ambulance Victoria will be included in the forum.

Consumer interests are not represented at the IDLC. This is a missed opportunity given the valuable role consumers can play in informing and shaping policy and service delivery.

### 4.4.2 Emergency Services Liaison Committees

Victoria Police, Ambulance Victoria and Area Mental Health Services (AMHS) participate in local area ESLCs. Under the interagency protocol, these services should hold regular meetings, which include consumer and carer representatives. ESLC meetings allow members to discuss and resolve local mental health service issues.

The majority of members we interviewed see ESLCs as a valuable way of fostering relationships between agencies and staff, and improving understanding of each other's roles and ways of working together. ESLCs worked well when members had developed good relationships, trust and communication practices. When working well the committees:

- develop local protocols as required under the interagency protocol
- identify issues and find ways to address them
- case manage people who are in regular contact with each agency or have complex needs
- debrief members after incidents
- communicate issues affecting each agency e.g. staffing issues and organisational changes.

ESLCs in the four regions we visited did not consistently demonstrate these actions and their effectiveness varied. Examples of reasons why committees were less effective include:

- infrequent meetings
- poor attendance
- lack of attendee continuity
- inability to resolve some long-standing issues
- failure to develop a local protocol and/or terms of reference
- lack of input from, or feedback given to, colleagues outside of the committee.

These committees have the potential to make service improvements for members of the community, strengthen interagency relationships and increase resource efficiencies. For these reasons, committee representatives must address any barriers to effectiveness, making sure their time and energy is reflected in achievements.

ESLCs commonly excluded consumer representation. Although the interagency protocol requires consumer representation, only one of the four regions we visited was complying.

### Communication between state and local committees

Many of the mental health, police and ambulance staff we interviewed felt they had little, if any, opportunity to feed local issues upwards or receive feedback. ESLC members wanted more input and direction from IDLC, especially in resolving issues that could not be solved locally. Although DOH and Victoria Police started a six-monthly reporting process from each ESLC to IDLC in June 2008, the senior police, ambulance and mental health service staff we interviewed in each area were generally unaware of this or believed the communication method was ineffective.

Regular, two-way communication between local and state levels will:

- provide state-level leadership to local areas that need help to resolve issues
- inform the state-level leadership about inconsistent practices and systemic issues that need attention
- communicate innovative practices to state-level leaders to enable wider implementation.

## Recommendations

14. IDLC formalise and maintain communication, monitoring and reporting processes with ESLCs.
15. All ESLCs and IDLC incorporate consumer representation.
16. DOH and Victoria Police support their review of the interagency protocol by:
    - developing a communication strategy to educate stakeholders about the protocol
    - identifying regions/services where the protocol is not being followed and work with them to address the barriers.
17. DOH and Ambulance Victoria review their joint protocol.

# Appendix A. Interagency protocol excerpts

## Protocol between Victoria Police and the Department of Human Services Mental Health Branch 2004

The following are direct excerpts from the 'interagency protocol' that relate to responses to mental health crises.

### Introduction

The protocol aims to:

- establish clear guidelines for police and mental health services' staff on handling situations where either agency has requested assistance from the other
- promote an adequate standard of care to the mentally ill person in situations, which involve both police and mental health services staff
- outline agreed procedures for management of psychiatric crises and high-risk situations involving people who have, or are believed to have, a mental illness.

The protocol is based on the principle that people with a mental illness should receive the best possible care in the least restrictive and least intrusive manner, and in providing for their care, and the protection of members of the public, any restrictions on their rights, privacy and dignity are kept to the minimum necessary in the circumstance.

In general, the protocol rests on the assumptions that:

- mental health services are responsible for providing treatment and care of people with a mental illness and providing consultation and advice about matters relating to mental illness, and
- police are responsible for the protection of the community and have responsibility for managing situations which involve a threat to public safety.

### Interactions between police and mental health services

In situations where police members form the belief that a person is suffering from a mental illness that requires treatment, but are uncertain regarding the best course of action to take, they should consult with mental health services in order to arrange the most appropriate action. Consultation may be with a duty / triage worker, or a Crisis Assessment and Treatment (CAT) service worker. On the basis of the information provided to them by police, mental health services' staff will decide on the appropriate response.

It is important to note that although CAT/triage services will always give top priority to urgent referrals from police, they are not an emergency service and can only provide assistance as soon as practicable.

An urgent referral should be made where a police member forms the belief that:

- a person suffers from a mental illness, and
  - there is a serious risk of harm to others; or
  - there is an immediate or imminent risk of self-harm; or
  - evidence of serious self-neglect; or
  - a serious threat to property; or
  - the person is displaying gross mismanagement of personal affairs.

In these instances police members may reach mental health services through the relevant CAT/ triage worker or through the Police Communications Centre.

The responsibility for providing an urgent response rests with the area's CAT service or clinician performing the CAT function. CAT/triage services are responsible for assessing people at risk of self-harm/suicide and people in psychiatric crisis. It is preferable that the CAT/triage service be involved in all situations requiring urgent assessment.

Where CAT/triage service staff are to conduct an urgent assessment, specific arrangements will need to be negotiated with the police making the referral. This should include where the assessment is to be undertaken, staff who will be involved, the anticipated time of attendance and any other necessary information.

Assessments can be conducted at a range of locations such as at:

- a person's residence, family home or work place
- a community mental health service
- a medical clinic
- a hospital accident and emergency department
- a police station (including in police cells).

Police will ensure that the area is safe for mental health clinicians to undertake the assessment.

Under section 10(1) of the *Mental Health Act 1986*, a member of the police force may apprehend a person who appears to be mentally ill if the member of the police force has reasonable grounds for believing that:

- the person has recently attempted suicide or attempted to cause serious bodily harm to herself or himself or to some other person; or
- the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person.

The *Mental Health Act 1986* specifies that in order to apprehend a person under section 10 of the Act, a member of the police force must form a belief that the person appears to be mentally ill and have reasonable grounds for believing that the person has harmed him/herself or others, or that there is a serious risk that the person is likely to do so in the future.

The member of the police force is not required to exercise any clinical judgment as to whether a person is mentally ill, but need only make a lay judgment that the person appears to be mentally ill based on the behaviour and appearance of the person. A member of the police force may enter any premises and use such force as may be reasonably necessary for the purposes of apprehending a person under section 10 of the Act. A registered medical practitioner or a mental health practitioner may accompany the member of the police force.

## Transport

Ambulance Services Victoria has lead agency responsibility for emergency transport of people with a mental illness. The protocol covering this responsibility is *Ambulance Transport of People with a Mental Illness*, February 2002, Victorian Government, DOH. In all instances, transportation for people with a mental illness should be provided by the least restrictive means possible and in a manner that ensures the safety of the person and others, and minimises interference with the person's privacy, dignity and self-respect.

The decision about the most appropriate form of transport to use in order to transport a person to a psychiatric inpatient facility must be made in the context of existing mental health service/ambulance guidelines. Initial options to be considered include transport provided by family or friends, or for CAT staff to use an agency vehicle.

Police assistance may be required where transport cannot be provided by family, friends, mental health staff or ambulance/MICA paramedic officers alone, due to the risk of harm to the client or others. As per the *Ambulance Transport of People with a Mental Illness* protocol, a police vehicle should only be used for transport after all of these other transport options have been considered as not suitable.

When police assistance is required for transportation, options include:

- a CAT service car with a police escort; or police accompanying the person and CAT service staff in a CAT service vehicle
- ambulance transport with police assistance
- transport in a police vehicle.

If transport in a police vehicle is necessary then a police sedan should be used, except where there is an unacceptable risk of aggressive or violent behaviour. Where physical containment is required and the person has not been sedated, transport in a police divisional van may be necessary.

## Mental Health Services Emergency Liaison Committee

While this protocol provides general guidelines for police/mental health services, from time to time specific issues will arise from particular situations that are best dealt with through local discussion and negotiation. Local agreements should be consistent with the content of this protocol. Early and open communication between police, ambulance services and mental health CAT/triage services is of paramount importance to creating collaborative, coordinated and harmonious service provision.

In this regard, each Area Mental Health Service Emergency Liaison Committee including representatives from the mental health service, police and ambulance services, and consumer and carer representatives will meet on a regular basis to discuss local issues regarding the interaction between services, review all problematic incidents and discuss and resolve any other problems that may arise.

# Appendix B.

# *Audit Act 1994* section 16—submissions and comments

## Submissions and comments received

***RESPONSE provided by the Secretary, Department of Health***

*Overall the report is consistent with the government's policy commitment to reform the broad mental health service system, as articulated in Because mental health matters: the Victorian Mental Health Reform Strategy 2009–2019 (the Reform Strategy) which was released in March 2009, before the commencement of this audit.*

*The Reform Strategy was developed over two years via a process which included an extensive consultation process with service providers, other stakeholders, carers and —most importantly—consumers themselves. It describes a process of extensive reform over the next ten years and identifies the many parts of the service system that require improvement if the government's overall vision for mental health is to be achieved, namely that by 2019:*

> *All Victorians have the opportunities they need to maintain good mental health, while those experiencing mental health problems can access timely, high quality care and support to live successfully in the community.*

*Whilst the Reform Strategy has been noted briefly in the report, the limited focus of this audit has meant that the report does not canvas the breadth of reforms currently underway, and which will lead to the provision of better care and treatment for consumers of mental health services. These include:*

- *The expansion of Prevention and Recovery Care services, which offer consumers at risk of or recovering from a mental health crisis, a less restrictive and more normative environment for the provision of mental health care and treatment;*
- *The growth in inpatient bed numbers across the State, which will increase access to treatment for consumers in crisis;*
- *The significant investment in earlier intervention and prevention through initiatives such as the Child and Youth Demonstration Projects and the development of Youth Mental Health teams; and*
- *The significant investment in services that provide intensive psychosocial and clinical support to consumers in the community—enabling them to continue to live well in the community.*

***RESPONSE provided by the Secretary, Department of Health – continued***

*All of these initiatives are ultimately about improvements in the timeliness, responsiveness and breadth of services—thereby contributing to a reduction in the occurrence of mental health crises in the community over time.*

*The Reform Strategy is very explicit in its identification of the need for improvement in managing mental health crises in the community. Reform area 3 of the Reform Strategy concerns the broad area of Pathways to care and it is important to note that one of the key outcomes the Department will seek to monitor over time as a result of the reforms articulated in that area is a reduction in the proportion of people with mental illness experiencing a psychiatric crisis. Goal 3.4 of the Reform Strategy is to 'Build a robust, integrated emergency service system to respond effectively to people in urgent need', and the Reform Strategy clearly outlines government's intention to achieve reforms that avert preventable crisis; improve management of crises; and better equip all personnel involved in the management of such crises.*

*I welcome the report's acknowledgement of some of the more 'crisis-specific/relevant' reforms under way. In the Reform Strategy, the Government has clearly signalled its commitment to ensuring there is wider, more accessible and easier to navigate pathways to mental health assessment, treatment and support. Investment and activities aimed at streamlining access and emergency responses has been planned accordingly:*

- *The new Mental Health Advice Line (MHAL) will target all Victorians who are seeking ready access to mental health information, advice and referral. As awareness of the MHAL grows, this will free up area mental health triage services to more promptly assess people who have a serious mental illness;*
- *Investment of over $17 million across five years in enhancing area mental health triage services will ensure that triage clinicians are better equipped to make appropriate assessments and referrals. This will, in turn, strengthen the capacity of Crisis Assessment and Treatment (CAT) clinicians to do their job;*
- *A uniform mental health triage scale will be introduced in 2010. The scale will standardise triage data collection on triage outcomes and service responsiveness, allowing for better collection and monitoring of data as recommended by the report. Being able to better monitor the time it takes for CAT clinicians to make first contact with consumers who require a community based intervention will strengthen the overall suite of performance measures the department and area mental health services have access to.*

*With regard to the issue of the measurement of performance, which the report comments on extensively, it is important to note that mental health data collection in Victoria supports the suite of key performance indicators which have been nationally agreed, many of which contribute to an understanding of the way the system supports recovery for people who present in crisis. While the Department will act on the audit's recommendations in this area, other jurisdictions are yet to commit to such a collection which will affect the ability to benchmark nationally.*

***RESPONSE provided by the Secretary, Department of Health – continued***

*Since 2005–06, the Victorian Government has invested an additional $5.4 million recurrent to extend the availability of specialist mental health staff in selected emergency departments across the State. This investment has been complemented by the Department's Mental health care: Framework for emergency department services. The Framework provides a set of overarching guidelines encompassing service delivery and clinical care for patients with mental health presentations in emergency departments to ensure that emergency department and mental health staff collaborate in the delivery of appropriate care to people with mental health needs.*

*The Government has also implemented an Emergency Department Mental Health Triage Tool that ensures that emergency department triage nurses are appropriately equipped to manage mental health presentations and ensures that patients' needs are met appropriately according to their level of acuity. All of these initiatives strengthen service responsiveness to crises at the front end.*

*The issue of public perception of the responsiveness of CAT services is an important theme raised by the report. The report accurately identifies that CAT services are not funded to provide an emergency response in the way that police or ambulance services are able to. However, it also suggests that there is a perception that such a response should be available, and also an expectation from many consumers, carers and emergency services that the timeliness of the response should be improved. This is an important issue and the Department will explore with area mental health services, consumers, police and ambulance the most effective ways in which we can more accurately communicate the functions of CAT, and the responses the community should expect from CAT services, as well as working on ways to further improve performance. The pending release and review of protocols with police and ambulance offers a vehicle for this discussion.*

*The report makes several comments in relation to the adequacy of training and preparation of CAT staff for managing crises in the community. These observations and related recommendations are welcomed and they will form the basis of further discussion with the area mental health services responsible for the provision of staff training and professional development.*

*A commitment to improved training and professional development has existed for some time and is one important feature of the Reform Strategy. The Department, in partnership with services, has established three training clusters to provide education and training to the specialist mental health workforce, including staff of CAT services. A stronger approach to training and development will also be delivered through the future work of the Victorian Institute of Mental Health Workforce Development and Innovation, which will be established in 2010. Announced in the 2009–10 State Budget with $2.4m over four years, the Institute will support the development of a highly skilled and sustainable public clinical and psychiatric disability and rehabilitation workforce.*

***RESPONSE provided by the Secretary, Department of Health – continued***

*The Mental Health Act is currently being reviewed, specifically examining the protection of the human rights of individuals subjected to involuntary mental health treatment. This includes particular safeguards at the point of first entry to the service system and in the early stages of a treatment episode. Provisions in the current Act governing transport of persons believed to require treatment will be retained and strengthened to make it clear, for example, that ambulance is the preferred mode of transport and that police formally hand over the individual to the health service at a particular point.*

*The report's recommendations are broadly consistent with the Reform Strategy. The Department will liaise closely with Victoria Police, Ambulance services, consumers, carers and service providers in considering the implementation of these recommendations.*

***Recommendation 1** – DOH and AMHS demonstrate the effectiveness of their responses by:*

- *working together to develop and implement ways to measure demand for, and effectiveness of responses to, mental health crises*
- *using this information to identify and address service gaps and areas for improvement.*

*This recommendation is accepted. The Department has already announced the pending introduction of a standardised triage scale which will enable capture of the type of data needed to measure the timeliness of responses from point of first phone to first face to face contact. This will be operational from mid 2010.*

***Recommendation 3** – IDLC and ESLCs should jointly review performance in responding to mental health issues.*

*This recommendation is accepted.*

***Recommendation 4** – All agencies continue collaborative innovation by:*

- *continuing the PACER trial and acting on its evaluation*
- *focusing on opportunities to address issues particular to regional/rural settings.*

*This recommendation is accepted. The initial PACER trial has already been extended for a further twelve months and will be independently evaluated at the completion of that trial period.*

***RESPONSE provided by the Secretary, Department of Health – continued***

***Recommendation 6** – AMHS and Ambulance Victoria should address training gaps for paramedic and CAT/triage staff.*

*This recommendation is accepted. The Department in partnership with area mental health services will explore ways in which our existing investment in this area can be further improved. Such focus is fully consistent with commitments given in the Mental Health Reform Strategy and the recently released report Shaping the future: The Victorian mental health workforce strategy (the workforce strategy). One of the guiding principles of the workforce strategy is the need for integration, between mental health services and other organisations.*

***Recommendation 7** – Each agency incorporates consumer experience and perspective in staff training.*

*This recommendation is accepted. Under the Mental Health Reform Strategy greater consumer inclusion will be pursued across a range of activities.*

***Recommendation 8** – DOH, AMHS, Victoria Police and Ambulance Victoria explore and trial opportunities for interagency training/learning opportunities.*

*This recommendation is accepted.*

***Recommendation 11** – ESLCs, supported and monitored by the IDLC, need to put in place protocols to minimise police delays at emergency departments.*

*This recommendation is accepted.*

***Recommendation 14** – IDLC formalise and maintain communication, monitoring and reporting processes with ESLCs.*

*This recommendation is accepted.*

***Recommendation 15** – All ESLCs and IDLC incorporate consumer representation.*

*This recommendation is accepted.*

***Recommendation 16** – DOH and Victoria Police support their review of the interagency protocol by:*

- *developing a communication strategy to educate relevant staff about the protocol*
- *identifying regions/services where the protocol is not being followed and work with them to address the barriers.*

*This recommendation is accepted and work has commenced on promotion of the reviewed protocol.*

***Recommendation 17** – DOH and Ambulance Victoria review their protocol.*

*This recommendation is accepted.*

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## Reports tabled during 2009–10

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|---|---|
| Local Government: Results of the 2008–09 Audits (2009–10:1) | November 2009 |
| Public Hospitals: Results of the 2008–09 (2009–10:2) | November 2009 |
| Towards a ‘smart grid’—*the roll-out of Advanced Metering Infrastructure* (2009–10:3) | November 2009 |

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