Establishing an Urgent Mental Health Care Centre in Perth

Alternatives to Emergency Departments for People Experiencing Mental Health Crisis

September 2024

Consumers of Mental Health WA

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1. Introduction

1.1 About us

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress, neurodivergence and psychosocial disability). We are a not-for-profit, systemic advocacy group independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

1.2 Our language

CoMHWA uses the term mental health consumer throughout this paper. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological or emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include 'peer,' 'survivor,' 'person with a lived experience' and 'expert by experience.' This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

2. Summary

There are increasing numbers of consumers seeking support for mental health crises presenting to emergency departments (hereafter referred to as EDs) in WA. EDs are under pressure, with costs, wait times and ambulance ramping all increasing. These factors, alongside issues in hospital culture and understandings of mental health, contribute to consumers having negative experiences in EDs, which have enduring effects on wellbeing. A range of WA state and Federal strategies call for alternatives to EDs for consumers experiencing mental health crises or distress, and while some options exist in WA, these all have significant accessibility and availability constraints.

An Urgent Mental Health Care Centre (hereafter referred to as UMHCC) for Perth, based on a model similar to Adelaide's UMHCC, would provide a true alternative that is open 24/7, centrally located and offering a welcoming and calming space where consumers could get mental health support from both Peer and clinical staff. The UMHCC would be co-designed with people with lived experience of mental health crisis and distress to better meet the needs of consumers. Research and outcomes from existing examples of this model demonstrate that a UMHCC would reduce costs, alleviate pressure on EDs, and provide high-quality, recovery-oriented support to consumers.

3. WA EDs in crisis

Emergency Departments are ill-equipped to respond appropriately to individuals experiencing mental health distress, however, they are also often the only place those individuals can go in the hopes of receiving support when they are experiencing mental health crisis. WA has the second highest rates of mental health ED presentations in the country,[1] highlighting the absence of alternative emergency

[1] Australian Institute of Health and Welfare. (2024). *State and territory mental health presentations*. Retrieved 29 August 2024 from https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments/state-and-territory-data

responses. WA has, since 2021 seen a dramatic spike in ambulance ramping caused by over-crowded ED settings.[2]

There are limited alternatives to ED for mental health crisis support in WA. The main alternatives are Safe Haven Cafés, which work alongside Emergency Departments to support people experiencing mental health distress. However, there are only two Safe Haven Cafés in WA, and these are open for limited hours, 3 days per week, leaving consumers with no option besides ED when they are closed.[3] There is urgent need to provide alternative options for consumers seeking mental health support during a crisis. Tailored urgent mental health crisis care support that is available 24/7 would better meet consumer needs while alleviating ED demand.

Alternatives to ED for mental health crisis are supported by both Peer and clinical peaks. The Consensus statement from ACEM and RANZCP on Mental Health in the Emergency Department recommends that "additional community based mental health care, particularly after-hours crisis services, for people experiencing mental health problems should be developed as a viable alternative to EDs."[4]

3.1 Consumer experiences in EDs

In Australia and internationally, experiences of people presenting to EDs for mental health support are typically poor.[5] The environment and the culture of EDs are unsuited to the provision of effective, safe, appropriate mental health support for those experiencing crisis.[6] Yet, EDs are often only places that consumers can go when they are experiencing crisis, and the pathway to ED is reinforced by crisis line services, community mental health, emergency services and GPs.[7] The pathway to ED is often distressing, as mental health consumers are more likely to arrive in ED via ambulance services or police than other patients.[8]

Poor experiences in ED can compound mental health distress and cause trauma and other negative emotional impacts. They also prevent future help-seeking.[9] Where consumers are presenting to EDs for suicide-related behaviours, this is particularly concerning as risk of dying by suicide is increased within the year following presentation to ED, and negative experiences in ED can increase the likelihood of future suicide attempts and deaths.[10]

[2] Zimmerman, J. (2024, June 30). *Hospitals Struggle amid Record Levels of Ambulance Ramping*. The West Australian. https://thewest.com.au/news/health/ambulance-ramping-reaches-record-levels-in-june-as-hospitals-struggle-with-surging-winter-demand-c-15192504

Australian Medical Association. (2023). *Ambulance Ramping Report Card 2023*. https://www.ama.com.au/sites/default/files/2023-11/Ambulance%20Ramping%20Report%20Card%202023_Final_0.pdf

[3] WA Mental Health Commission. (2024). *Safe Haven Cafés*. https://www.mhc.wa.gov.au/getting-help/hospital-mental-health-alcohol-and-other-drug-services/safe-haven-cafes/

[4] Australian College for Emergency Medicine and Royal Australia and New Zealand College of Psychiatrists. (2020). *Mental Health in the Emergency Department Consensus Statement.* https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Mental-Health-in-the-Emergency-Department/Mental-Health-in-the-Emergency-Department-Consensu

[5] Bull, C., Goh, J. Y., Warren, N., & Kisely, S. (2024). Experiences of individuals presenting to the emergency department for mental health reasons: A systematic mixed studies review. *Australian & New Zealand Journal of Psychiatry*. https://doi.org/10.1177/00048674241259918

[6] Australian College for Emergency Medicine. (2018). *The long wait: An analysis of mental health presentations to Australian Emergency Departments.* https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018

[7] Duggan, M., Harris, B., Chislett, W.K. & Calder, R. (2020). Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments. https://acem.org.au/getmedia/5ad5d20e-778c-4a2e-b76a-a7283799f60c/Nowhere-else-to-go-report_final_September-2020

[8] Ibid.

[9] Roennfeldt, H., Wyder, M., Byrne, L., Hill, N., Randall, R., & Hamilton, B. (2021). Subjective Experiences of Mental Health Crisis Care in Emergency Departments: A Narrative Review of the Qualitative Literature. *International Journal of Environmental Research and Public Health*, *18*(18), 9650. https://doi.org/10.3390/ijerph18189650

[10] Hill, N.T.M, Shand, F., Torok, M., Halliday, L. & Reavley, N.J. (2023). *Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings.* Black Dog Institute.

Freeman, J., Strauss, P., Hamilton, S., Pugh, C., Browne, K., Caren, S., Harris, C., Millett, L., Smith, W., & Lin, A. (2022). They Told Me "This Isn't a Hotel": Young People's Experiences and Perceptions of Care When Presenting to the Emergency Department with Suicide-Related Behaviour. *International Journal of Environmental Research and Public Health*, *19*(3), 1377. https://doi.org/10.3390/ijerph19031377

Consumers of Mental Health WA often hears from our members about their negative experiences in EDs. A review of recent research shows that their experiences are unfortunately widespread among consumers in Australia, and include:

- **Significant wait times** for people in ED settings[11] with 10% of people spending over 18 hours while waiting for mental health support,[12] and with Western Australia performing worst in Australia in providing on-time ED mental health responses.[13]
- **The use of force** in ED settings that is both harmful and sometimes unlawful.[14] Lack of staff training and understanding, combined with stigma around mental health and insufficient monitoring and legislating boundaries can also contribute towards use of restrictive practices in EDs, which are often unlawful, harmful and traumatising.[15] The presence of security guards can contribute to this and results in consumers feeling unsafe.[16] One consumer quoted in a recent Australian study shared:

  > *I often say to people, when you turn up to ED in a mental health episode, you just feel like a criminal…There's security guards placed around, watching you. Sitting outside the room or directly in the same cubicle as you*.[17]

- **Stigma and discrimination.** Consumers report that they experience their needs being dismissed as either too complex or as not serious enough when attending EDs because of mental health crisis.[18] When they attend EDs experiencing physical symptoms, they experience diagnostic overshadowing.[19] In 2023, the Australasian College for Emergency Medicine wrote:

  > *ACEM is concerned about the appropriateness and timeliness of mental health care provided to people in Australian EDs, and these issues play a major role in peoples experiences of stigma and discrimination … EDs are often not the best place for a person in mental health crisis and other services beyond the ED need to be made available at all times*.[20]

[11] National Mental Health Commission. (2024). *National Report Card 2023: Monitoring the Performance of Australia's Mental Health System*. https://apo.org.au/node/327498

[12] Australian Institute of Health and Welfare. (2024). *Emergency Department Care Access.* https://www.aihw.gov.au/reports-data/myhospitals/intersection/access/ed

[13] Australian Institute of Health and Welfare. (2024). *Emergency Departments - Mental Health*. https://www.aihw.gov.au/mental-health/topic-areas/emergency-departments

[14] Weber, D. (2023, June 19). *Warning for WA Health Workers over Keeping Patients in Hospital against Their Will.* ABC News. https://www.abc.net.au/news/2023-06-20/warning-for-wa-health-workers-over-unlawful-detention-hospitals/102497536

Knott, J., Gerdtz, M., Dobson, S., Daniel, C., Graudins, A., Mitra, B., Bartley, B., & Chapman, P. (2020). Restrictive interventions in Victorian emergency departments: A study of current clinical practice. *Emergency Medicine Australasia*, *32*(3), 393–400. https://doi.org/10.1111/1742-6723.13412

[15] Ibid.

[16] Weber, D. (2023). *Court case highlights concerns over patients being held unlawfully in WA hospitals*. ABC News. https://www.abc.net.au/news/2023-01-21/concerns-over-unlawful-detention-of-patients-in-perth-hospitals/101861020

[17] McIntyre, H., Loughhead, M., Hayes, L., Allen, C., Barton-Smith, D., Bickley, B., Vega, L., Smith, J., Wharton, U., & Procter, N. (2024). I have not come here because I have nothing better to do: The lived experience of presenting to the emergency department for people with a psychosocial disability and an NDIS plan—A qualitative study. *International Journal of Mental Health Nursing*, *33*(3), 624–635. https://doi.org/10.1111/inm.13264, p. 629.

[18] Kaine, C. & Lawn, S. (2021). *The 'Missing Middle' Lived Experience Perspectives*. Lived Experience Australia Ltd, p. 24.

[19] McIntyre et al., 2024. I have not come here because I have nothing better to do: The lived experience of presenting to the emergency department for people with a psychosocial disability and an NDIS plan—A qualitative study, p. 627.

[20] Australian College for Emergency Medicine. (2023). Submission to the National Stigma and Discrimination Reduction Strategy Draft Consultation. https://acem.org.au/getmedia/85e3d6b8-2cbf-4c01-9911-92a9bf993847/230202_SJudkins_Submission_to_Stigma_and_Discrimination_Reduction_Strategy, p. 4.

This year, one of our Individual Advocates who was supporting a person accessing their medical records discovered through the name of a file path on one of the documents that a hospital had a folder named 'problem patient' and was using this to categorise consumers. This is indicative of a negative culture in EDs in which people with mental health issues are, at a time when they most need support, instead receiving discriminatory treatment.[21]

- **Low-quality support and care** because ED staff are not always adequately trained or resourced to respond to those experiencing mental health crises. Without training, staff have reported that they do not feel confident in responding to mental health and suicide-related ED presentations.[22] Lack of time, staffing, and resources can also make it challenging for staff to respond in a timely and appropriate manner.
- **Lack of follow-up support and referral**, leading to their needs going unmet, which causes further distress and repeat presentations**.** A 2021 survey revealed almost half of consumers receive no follow up and 42% receive no further referral after ED.[23] One consumer CoMHWA heard from described being discharged to a service who was not able to help, which then left the consumer with no other options: "I have been discharged to another service before but my last admission they discharged me with a referral to community mental health but community MH declined me so I was back in the same position as before."
- **Physical environments that are busy, distressing and lack privacy.** Once consumers are in EDs, the long wait, environment, and lack of privacy make self-management of distress difficult. Busy, clinical ED environments are not suitable spaces for the care of people experiencing mental health crises, where the physical environment of the space is important to establishing a sense of comfort and safety.[24] Lack of privacy in the ED causes patients to feel vulnerable and increases distress.[25]

  In 2024, a review following the stabbing of two women in South Australia by a man who had been released from hospital for mental health treatment two days prior highlighted that the ED model of care at the hospital was not equipped to timely, effective and quality care for mental health consumers, and that its custodial approach, which involved having security guards monitor consumers in the ED, was not therapeutic, The review recommended establishing a service level agreement between the hospital and the UMHCC and noted:

  > *The opportunities to engage therapeutically and safely with people in crisis who may be suicidal are illustrated by the UMHCC approach which is in stark contrast to the ED model of care. Being passively observed by a security guard to prevent a person from absconding, engaging in aggressive behaviour or noting deterioration in behaviours is a very custodial model of care which is out of place in a modern hospital environment and does not promote early intervention if increasing arousal or distress indicators are observed.*[26]

- **Aboriginal and Torres Strait Islander consumers experience treatment that is not culturally appropriate or respectful.** Consumers note a lack of empathy, understanding of their needs and cultures, and stigmatising or racist treatment. Aboriginal and Torres Strait Islander people are

[21] Sacre, M., Albert, R. and Hoe, J. (2022). What are the experiences and the perceptions of service users attending Emergency Department for a mental health crisis? A systematic review. *Int J Mental Health Nurs*, *31*, 400-423. https://doi.org/10.1111/inm.12968

[22] Hill, N.T.M., Shand, F., Torok, M., Halliday, L. & Reavley, N.J. (2023). *Recommendations for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings.* Black Dog Institute.

[23] Kaine, C. & Lawn, S. (2021). *The 'Missing Middle' Lived Experience Perspectives*. Lived Experience Australia, p. 23.

[24] Roennfeldt, H., Hill, N., Byrne, L., & Hamilton, B. (2024). Exploring the lived experience of receiving mental health crisis care at emergency departments, crisis phone lines and crisis care alternatives. *Health Expect*ations, 27(2), e14045. https://doi.org/10.1111/hex.14045

Sacre, M., Albert, R., & Hoe, J. (2022). What are the experiences and the perceptions of service users attending Emergency Department for a mental health crisis? A systematic review.

[25] Roennfeldt et al., 2021. Subjective Experiences of Mental Health Crisis Care in Emergency Departments: A Narrative Review of the Qualitative Literature.

[26] Office of the Chief Psychiatrist, South Australia. (2024). *Summary Report: Independent Review into the Care of Mr Shaun Michael Dunk*, p. 11.

proportionately overrepresented in mental health-related ED presentation rates,[27] suggesting that they are not adequately supported by mental health service systems or by ED responses.

In 2021, CoMHWA heard from a consumer who had presented to ED multiple times in distress, as the consumer had nowhere else to go. She has been discharged from the mental health ward at Sir Charles Gairdiner several times. The consumer shared that she was rushed out of hospital without a clear discharge plan, with staff promising they would call to follow up, which did not happen. Upon discharge, she was given a large amount of medication in a large zip-lock bag that was, "enough to do some serious damage with if I wanted to." The list on the bag did not match the list of medications given to her. She was forced to re-present to ED because nobody called her and she did not feel safe, and was told again that there was nowhere else to go.

3.2 Cost and Impact of Emergency Department Presentations

The stark impact of ED costs has prompted a range of government efforts to rein in spending and direct people to less acute alternatives. The cost of ED presentations in relation to mental health has been a key issue taken up in the Productivity Commission report into Mental Health,[28] as well as in other commissioned economic reports such as the KPMG report into mental health reform.[29] Beyond the inefficient expenditure of limited resources, ED presentations have the potential to be profoundly traumatic for consumers in mental health distress. EDs are fundamentally ill-suited to help consumers experiencing acute mental health distress—the environment of EDs is loud, bright and relentlessly urgent, offering little opportunity for employment of de-escalation strategies while simultaneously risking unproductive responses to crisis via restrictive practices.

Impact on Consumers

As discussed above, the often traumatising impact of negative experiences in EDs on consumers underscores the need for a UMHCC. In their report into mental health, the Productivity Commission noted that "…for people with mental illness, the stimuli in EDs can exacerbate their distress and worsen the symptoms of mental illness."[30] A pilot study into the impact of teaching ED nurses to practice Trauma Informed Care (TIC) in Victorian hospitals revealed that the offering care in a trauma informed fashion was deeply challenging for these staff. The difficulties centred around the nature of the ED environment, where time constraints led many in the study to question whether trauma informed care could be successfully and consistently practiced in these settings.[31] A UMHCC would offer trauma-informed Peer and clinical services in an environment co-designed with consumers, avoiding the distressing stimuli and dehumanising treatment that can sometimes characterise consumer experiences in EDs.

[27] Higgins, O., Sheather-Reid, R.B., Chalup, S.K. & Wilson, R.L. (2024) Disproportionate mental health presentations to emergency departments in a coastal regional community in Australia of first nation people. *International Journal of Mental Health Nursing*, *00*, 1–8. https://doi.org/10.1111/inm.13362

[28] Productivity Commission. (2020, June). *Mental Health.* Report no. 95, Volume 3. Commonwealth of Australia. https://www.pc.gov.au/inquiries/completed/mental-health/report. pp. 597–598.

[29] KPMG. (2018). *Investing to Save: The Economic Benefits for Australia of Investment into Mental Health Reform Final Report*. Mental Health Australia and KPMG. https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018

[30] Productivity Commission. (2020, June). *Mental Health.* Report no. 95, Volume 3. Commonwealth of Australia. https://www.pc.gov.au/inquiries/completed/mental-health/report. p. 587.

[31] Hall, A., McKenna, B., Dearie, V., Maguire, T., Charleston, R., & Furness, T. (2016). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: a pilot study. *BMC Nursing*, *15*(1), 21. https://doi.org/10.1186/s12912-016-0141-y

Economic Cost to Western Australia

The National Hospital Cost Data Collection (NHCDC) reveals that, between 2020-21, the average cost of a presentation to a WA Emergency Department was $894.[32] The total expenditure for WA ED presentations for this period was estimated at 719 million dollars, taking up 12.4% of the 5.78 billion dollars that the State spent on funding public hospitals. The impact of spending on emergency departments was a key issue raised in the exhaustive 2020 Productivity Commission Report into mental health, which recommends State governments develop, as a priority, alternatives to EDs for people experiencing acute mental health distress.[33] While the Productivity Commission's figures for cost savings are developed for services distinct from UMHCC's, such as Safe Haven Cafés, there is good cause to expect that more robust alternatives will offer savings broadly in line with this modelling.

Additional Impacts on Ambulance Ramping and Bed Availability

The high number of ED presentations for people experiencing mental health distress contributes to problematic flow-on effects, such as ambulance ramping and bed shortages, that negatively impact the provision of health services in WA. Ambulance ramping refers to situations where the time spent waiting to transfer people from ambulances to the ED exceeds the 30-minute target.[34] In the 2023/24 financial year, Royal Perth Hospital alone experienced a total of 2620 hours of ambulance ramping, significantly exceeding the previous 2022/23 FYTD total of 1751 hours.[35] The redirection of ambulances to a UMHCC would help to alleviate the WA's ED capacity issues. Beyond ambulance ramping, a UMHCC would also help to address bed shortages and the related concern of 'access blocks'—that is, where EDs become overwhelmed because other health settings, such as dedicated mental health hospitals, are at full capacity.[36] Access blocks can prevent EDs from being able to discharge people to other services and settings, and in turn mean that consumers are kept in EDs for inappropriately long periods of time.[37]

3.3 Limitations to Existing Approaches

There have been a range of efforts in Western Australia to address the impact of people attending emergency departments in mental health distress, such as the 'Do I need the ED?' campaign, the establishment of Safe Haven Cafés in 2020, and the 'WA Virtual Emergency Department/ (WAVED) program. While these are worthwhile supports, by themselves these approaches do not meet demand in providing a true 24/7 alternative to ED. A UMHCC would enhance and supplement these approaches to managing mental health presentations to EDs.

- **'Do I need the ED?'** — The 'Do I need the ED?' campaign has been promoted since 2023, and is intended to make people aware that there may be different, more appropriate pathways to receive

[32] Independent Health and Aged Care Pricing Authority. (2022). *National Hospital Cost Data Collection 2020-21 Financial Year Report*. https://www.ihacpa.gov.au/sites/default/files/2023-06/nhcdc_infographic_2020-21.pdf
[33] Productivity Commission. (2020, June). *Mental Health.* Report no. 95, Volume 3. Commonwealth of Australia. https://www.pc.gov.au/inquiries/completed/mental-health/report. p. 222.
[34] St. John (2024). *Extended Transfer of Care (Ramping)*. Retrieved 29 August 2024 from https://news.stjohnwa.com.au/public-information/extended-transfer-of-care/
[35] St. John (2024). *Ambulance Activity and Response Times*. Retrieved 30 August 2024 from https://stjohnwa.com.au/ambulance-and-health-services/metro-ambulance-service/ambulance-activity-and-response-times
[36] Australian College of Emergency Medicine (2021). *Access Block*. https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block
[37] Productivity Commission. (2020, June). *Mental Health.* Report no. 95, Volume 3. Commonwealth of Australia. https://www.pc.gov.au/inquiries/completed/mental-health/report. Pp. 587–588.

care than through emergency departments.[38] The suggestions made through this campaign centre on the promotion of GP visits to address non-emergency situations, and the Healthdirect phone service as a way to guide people to the most appropriate care given their circumstances. However, people attending emergency departments because they are experiencing mental health distress are often presenting in these locations because they are the only service available to them that is open, or that does not require payment. Accordingly, an UMHCC would afford consumers attending EDs stochastically for these reasons an alternative and more appropriate 'front door' to access mental health support.

- **WAVED**—The 'WAVED' program stands for Western Australian Virtual Emergency Department. Virtual Emergency Medicine is the practice of using video teleconferencing between people calling ambulances to attend ED and medical professionals, in order to screen those who want to present to this setting.[39] By conducting a teleconference consultation, a determination is made as to whether their in-person attendance at the ED is necessary or suitable. The WAVED program has recently been expanded to directly address people experiencing mental health distress.[40] The WAVED program is intended to reduce presentation at Emergency Department's by directing consumers to more 'relevant' intakes, however alternative options for care for mental health consumers are frequently unavailable or at capacity. Alongside this limitation, WAVED can only serve to divert people from the ED when they first call to arrange ambulance transport or otherwise establish contact prior to presentation. The nature of mental health distress often entails that consumers will lack the means or comportment to pursue communication prior to presentation. Consequently, the WAVED program may offer limited benefits to many mental health consumers who present to EDs.
- **Safe Haven Cafés**—Safe Haven Cafés were developed to assist in alleviating stress on emergency departments by helping to provide more appropriate care and resources to consumers who present with mild to moderate mental health concerns.[41] As noted above, the Safe Haven Cafes operating in WA have had limitations on opening hours that have limited the extent to which they can ameliorate ED presentations for mental health concerns. The Productivity Commission report into Mental Health noted this issue in relation to Safe Havens operating in Melbourne, noting that they, like those in WA, were not open on "…Friday and Saturday nights, which are peak times for mental health crises."[42] A UMHCC would supplement the services offered by Safe Haven Cafés by providing after hours care at these crucial times.

[38] WA Department of Health (2024). '*Do I need the ED?' alternatives to emergency campaign*. Retrieved 30 August 2024 from https://www.health.wa.gov.au/Articles/A_E/Campaign-Do-I-need-the-ED

[39] WA Department of Health (2024). *WA Virtual Emergency Department*. Retrieved 29 August 2024 from https://www.health.wa.gov.au/Improving-WA-Health/WA-Virtual-Emergency-Department

[40] Government of WA (2024). *WA Virtual ED to expand into mental health*. Retrieved 29 August 2024 from https://www.wa.gov.au/government/media-statements/Cook-Labor-Government/WA-Virtual-ED-to-expand-into-mental-health-20240502#:~:text=In%20a%20Western%20Australian%20first,the%20State%20Health%20Operations%20Centre

[41] WA Mental Health Commission (2024). *Safe Haven Cafés*. Retrieved 29 August 2024 from https://www.mhc.wa.gov.au/getting-help/hospital-mental-health-alcohol-and-other-drug-services/safe-haven-cafes/

[42] Productivity Commission. (2020, June). *Mental Health*. Report no. 95, Volume 3. Commonwealth of Australia. https://www.pc.gov.au/inquiries/completed/mental-health/report. p. 599.

4. Urgent Mental Health Care Centres

Urgent Mental Health Care Centres are alternatives to EDs which combine Peer and clinical approaches and are tailored to provide support for people experiencing mental health crisis. They have a proven track record of upholding human rights and promoting recovery-based approaches to supporting those experiencing mental health crisis. Key features of this model include:

- Co-creation with people with lived experience
- Staffing that is an equal mix of clinicians and Peers
- Person-centred and recovery-oriented support
- Welcoming, non-clinical, 'loungeroom-like' environment
- 24/7 operation, location prioritises accessibility and the service is free
- Options for walk-ins, self-referral and ED, police, emergency services referrals.

4.1 Key features and impact of the model

Only a couple of services based on these models have been established in Australia in recent years, and while outcomes from these services are promising, WA has the opportunity to be a leader in the evaluation and research of an Urgent Mental Health Care Centre in Perth and contribute to an emerging global evidence base. The existing evidence base from international examples of urgent mental health crisis centres demonstrates the effectiveness of the model in improving consumer experiences and outcomes, and mental health system capacity.

1. **Co-designed with people who have lived experience of mental health crisis, with governance models that ensure accountability.**

Why it's important: Lived Experience input in co-design and governance means that the needs, rights and perspectives of consumers direct the way the service operates.

Services that are co-designed with people with lived experience are better able to respond to consumer needs, provide improved quality of care and enable more positive experiences of care.[43] The involvement of people with lived experience, especially in leadership and decision-making, protects the human rights of consumers and reduces restrictive and coercive practices.[44] Alternatives to emergency departments for mental health such as UMHCCs have been found to reduce coercion in mental health services.[45]

2. **Facilities chosen and designed to create a welcoming, sensory friendly, lounge-room like space, where there are spaces for private conversations.**

Why it's important: Welcoming spaces provide a trauma-informed environment that prioritises the emotional safety and comfort of consumers

[43] Modigh, A., Sampaio, F., Moberg, L. & Fredriksson, M. (2021). The impact of patient and public involvement in health research versus healthcare: a scoping review of reviews. *Health Pol.*, *125*(9), 1208-1221, https://doi.org/10.1016/j.healthpol.2021.07.008

[44] WA Mental Health Commission. (2022). *The Western Australian Lived Experience (Peer) Workforces Framework For the mental health, alcohol and other drug, suicide prevention systems.* https://livedexperienceworkforces.com.au/wp-content/uploads/2022/10/mhc-lived_experience-pw-framework-oct2022-digital.pdf

[45] Gooding, P., McSherry, B., & Roper, C. (2020). Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies. *Acta Psychiatrica Scandinavica*, *142*(1), 27–39. https://doi.org/10.1111/acps.13152

UMHCCs can provide a 'lounge-room-like' space which is more welcoming than the overtly clinical space of the ED.[46] This space is better able to meet consumer preferences for physical design of the space prioritise availability of private spaces where conversations can't be overheard, gentle lighting, comfortable seating and furniture, and a non-clinical appearance.[47] Consumers want to access a place of safety where they can experience human responses to crisis.[48]

Crisis support spaces with non-clinical environments and Peer support have been found to be effective in alleviating crises as the development of welcoming, non-clinical spaces reduces the need for clinical mental health interventions and results in consumers experiencing less distress by the end of their visit.[49] Consumers describe their positive experiences of feeling welcomed and included in such spaces, and having a welcoming space to access reduces further need for EDs.[50]

3. **Staff that are an equal mix of Peer Workers who have Lived Experience expertise and training, and Clinical staff with mental health care training and experience.**

Why it's important: Consumers can access evidence-based, high-quality clinical support and engaging and empathetic Peer support.

Having Peer Workers on staff means that consumers are able to get the kind of support they want from a mental health service, with 84% on consumers consulted about preferences for alternatives to EDs in 2019 stating a preference for peer support services to be available.[51] Peer Workers support mental health recovery outcomes, and ensure that consumers feel heard and feel their preferences and needs are understood, reducing service disengagement.[52] Peer Workers contribute to reduction of stigma in services, and promote recovery-oriented ways of working.[53] The person-centred support provided by peer workers, rather than support provided through a biomedical model, allow for experiences of crisis care that are less likely to be traumatising and distressing.[54] Peer workers and clinical staff that represent a diversity of lived experiences and identities are able to provide more respectful, culturally safe and appropriate support to

[46] Urgent Mental Health Care Centre (n.d.) *Approach*. Retrieved 30 August 2024, from https://umhcc.org.au/approach/

[47] Consumers of Mental Health WA. (2019). *Alternatives to Emergency Departments Project Report September 2019*. https://www.mhc.wa.gov.au/media/2993/alt-to-ed-and-safe-havens-final-report-2019.pdf

[48] Roennfeldt, H., Hamilton, B. E., Hill, N., Castles, C., Glover, H., Byrne, L., & Roper, C. (2024). Our Wished-for Responses: Recommendations for Creating a Lived and Embodied Sense of Safety During Mental Health Crisis. *Health expectations*, *27*(3), e14122. https://doi.org/10.1111/hex.14122

[49] Roennfeldt et al., 2024. Exploring the lived experience of receiving mental health crisis care at emergency departments, crisis phone lines and crisis care alternatives.

Heyland, M., Emery, C., & Shattell, M. (2013). The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments. *Global Journal of Community Psychology Practice*, *4*(3), 1–8. https://www.gjcpp.org/pdfs/2013-007-final-20130930.pdf

Heyland, M., & Johnson, M. (2017). Evaluating an Alternative to the Emergency Department for Adults in Mental Health Crisis. *Issues in Mental Health Nursing*, *38*(7), 557–561. https://doi.org/10.1080/01612840.2017.1300841

[50] Roennfeldt et al., 2024. Exploring the lived experience of receiving mental health crisis care at emergency departments, crisis phone lines and crisis care alternatives.

[51] CoMHWA, 2019. *Alternatives to Emergency Departments Project Report September 2019*.

[52] White, S., Foster, R., Marks, J., Morshead, R., Goldsmith, L., Barlow, S., Sin, J., & Gillard, S. (2020). The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis. *BMC Psychiatry*, *20*(1), 534. https://doi.org/10.1186/s12888-020-02923-3

[53] Thornicroft, G., Sunkel, C., Alikhon Aliev, A., Baker, S., Brohan, E., El Chammay, R., Davies, K., Demissie, M., Duncan, J., Fekadu, W., Gronholm, P. C., Guerrero, Z., Gurung, D., Habtamu, K., Hanlon, C., Heim, E., Henderson, C., Hijazi, Z., Hoffman, C., … Winkler, P. (2022). The Lancet Commission on ending stigma and discrimination in mental health. *The Lancet, 400*(10361), 1438–1480. https://doi.org/10.1016/S0140-6736(22)01470-2

Hancock, N., Berry, B., Banfield, M., Pike-Rowney, G., Scanlan, J. N., & Norris, S. (2022). Peer Worker-Supported Transition from Hospital to Home-Outcomes for Service Users. *International journal of environmental research and public health*, *19*(5), 2743. https://doi.org/10.3390/ijerph19052743

[54] McIntyre et al., 2024. I have not come here because I have nothing better to do: The lived experience of presenting to the emergency department for people with a psychosocial disability and an NDIS plan—A qualitative study.

consumers with diverse experiences and identities. Employing Aboriginal and Torres Strait Islander staff improves access to culturally safe and appropriate support for Aboriginal and Torres Strait Islander people.[55]

Consumers have more positive experiences when they receive care from staff with specific mental health training and expertise compared to when they receive care in EDs from staff without such training.[56] Staff that work in person-centred and recovery-oriented ways are able to undertake meaningful assessment aimed at treatment planning rather than managing risk.

In South Australia's UMHCC, the fusion staffing model comprises 50% clinical and 50% Peer staff:

- Peer Support Workers with lived experience of mental health challenges and recovery support each guest throughout their stay at the UMHCC, and contribute to every aspect of their care, including safety assessments. UMHCC works on a Peer-first, Peer-last model, where gusts are supported by Peers throughout their whole journey, from entry to leaving the service.
- Clinical staff, including mental health nurses, social workers, nurse practitioners and occupational therapists, oversee the welcome and triage process for each guest, conduct safety and clinical assessments and provide a range of mental health interventions.
- Mental health nurses play a specific role in physical health screening and supporting the management of any physical medical concerns for guests.
- Psychiatrists provide consultancy, high-level policy and procedure advice, supervision of clinical staff and Peer Support Workers and training. They are also part of the complex service committee, review all Inpatient Treatment Orders (ITOs), and conduct research activities.
- RMOs engage predominantly with high acuity guests. They manage medication prescription, provide medical management of physical concerns, take part in exit huddle planning, have an overview of safety and risk assessments and provide training for skills including code blue management (in the event of a medical emergency). RMOs also liaise with medical staff from other services such as GP practices and emergency departments when a guest needs to be transferred.

4. **Opening hours are 24/7 and choice of location prioritises accessibility and safety in a community area away from hospital settings.**

Why it's important: Consumers can access timely support whenever they need it, in an easy-to access and safe location.

Some crisis alternatives to ED in Australia are promising in providing appropriate responses to people experiencing mental health crisis, but they can be difficult for individuals to access, especially if they are not open when people need them.[57] While central and accessible locations are important, locating an

[55] Upton, P., Ford, L., Wallace, R., Jackson, S., Richard, J., Upton, D. (2021). *Improving Indigenous mental health outcomes with an Indigenous mental health workforce.* Australian Institute of Health and Welfare. https://www.indigenousmhspc.gov.au/getattachment/1bc22960-458e-4563-a6b4-e4e2fcbf8a56/upton-et-al-2021-mental-health-workforce-20210802.pdf?v=1531

[56] Sacre et al., 2022. What are the experiences and the perceptions of service users attending Emergency Department for a mental health crisis? A systematic review.

Happell, B., Summers, M., & Pinikahana, J. (2002). The triage of psychiatric patients in the hospital emergency department: a comparison between emergency department nurses and psychiatric nurse consultants. *Accident and Emergency Nursing*, *10*(2), 65–71. https://doi.org/10.1054/aaen.2001.0336

[57] Roennfeldt et al., 2024. *Exploring the lived experience of receiving mental health crisis care at emergency departments, crisis phone lines and crisis care alternatives.*

alternative crisis support option within a hospital or in the space of the ED could prevent UMHCCs from acting as meaningfully non-clinical alternatives. Locating UMHCCs out of hospital precincts removes barriers such as prior negative associations with hospitals and lowers the risk of re-traumatisation. Consumer consultations on alternatives to ED revealed that less than 50% wanted an ED alternative near a hospital, and what was most important was that the service was easy to find, safe at night, and near to public transport and parking.[58]

5. **Referral pathways that enable ED, emergency services and police referral as well as self-presentation**

Why it's important: barriers to consumers accessing the service are removed and referral pathways reduce pressure and costs on EDs, mental health services, policing and other systems.

Individuals experiencing mental health crisis can seek support by presenting to the UMHCC instead of to ED or can be referred to the Centre by ED if they do not need a mental health admission. Referrals can be made by emergency services, and they can provide dedicated emergency services entrances. Such referral pathways alleviate pressure on EDs, and are cost-effective by comparison to EDs.[59]

6. **Partnerships are created that support smooth linkages with other parts of the mental health and social support systems.**

Why it's important: Consumers are provided with robust follow-up support and connections.

A dedicated UMHCC would have the capacity to create stronger linkages within the system enabling better connections into the service system, where regular EDs lack this capacity because of service overwhelm, lack of time and lack of staff training. Staff can negotiate follow-up options with consumers, collaborating on a plan that works for them and provides relevant and timely supports, and meaningfully involves carers/family/friends and other support persons. Consumers want solid referral options to mental health services and linkage to community services so that they are properly supported when they leave a crisis support facility.[60] Referral and follow-up services and support are essential to provide meaningful care and reduce the likelihood of crisis and distress in the future.

7. **Care and support for Aboriginal and Torres Strait Islander consumers is underpinned by understandings of the meaning and importance of Social and Emotional Wellbeing.**

Why it's important: Aboriginal and Torres Strait Islander consumers are provided with culturally safe and appropriate support for social and emotional wellbeing.

UMHCCs are able to offer support that responds to the cultural needs and wishes of consumers.[61] When approaches to care are co-designed with Aboriginal and Torres Strait Islander consumers, they are able to embed capacity to support social and emotional wellbeing. Social and emotional wellbeing is a concept

[58] CoMHWA, 2019. *Alternatives to Emergency Departments Project Report September 2019*.

[59] Heyland et al., 2013. The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments. Heyland & Johnson. (2017). Evaluating an Alternative to the Emergency Department for Adults in Mental Health Crisis.

[60] CoMHWA, 2019. *Alternatives to Emergency Departments Project Report September 2019*.

[61] South Australia Health. (2022). *A Co-created Philosophy of Care, Version Two*. https://mcusercontent.com/537a82c124f0b50964756e439/files/5017dc82-9074-9c86-077a-fcabc2e13ef5/23072_Philosopy_of_Care_Report_V3.pdf p. 11.

distinct from biomedical approaches to mental health and is able to address the needs and determinants of holistic wellbeing for Aboriginal and Torres Strait Islander people in culturally safe and appropriate ways.[62]

4.2 South Australia's Urgent Mental Health Care Centre

Background

South Australia's Urgent Mental Health Care Centre was the first centre of its kind to be established in Australia. The service opened in 2021 with capacity to provide care for up to 18 people at one time, and was initially open 12 hours a day. A funding increase enabled the service to open 24/7 from March 2022.

The UMHCC was funded by the federal Government's 2019 budget, which allocated funds for the establishment of eight community mental health walk-in centres across Australia over 5 years from 2020-2021. The centre received strong support from South Australia's Chief Psychiatrist.

The UMHCC is guided by a Philosophy of Care that was co-created with people with lived experience of mental health challenges.[63] Co-creation was led by SA state peak body representing mental health consumers, Lived Experience Leadership and Advocacy Network (LELAN), and the Australian Centre for Social Innovation (TACSI). The Philosophy of Care informed service delivery contractor Neami's co-design plans to create a Model of Care. The Model of care and the Philosophy of Care directed site selection, fit-out, team recruitment, training and operations.[64]

Service Model

- The fusion staffing model (described on page 10) allows guests to access high-quality, evidence-based clinical care and high-engagement Peer support in the same place. The combined clinical and Peer support team support people with resources and techniques to stabilise, an assessment and safety plan, connections to services and follow-up calls for three days post-exit. The Philosophy of Care establishes that diverse lived experiences, identities and cultural needs should be represented in and understood by the team.[65] One guest reflected in feedback the difference this made to their experience: "I felt safe and listened to."
- Site selection, fit-out and design were informed by a co-design process, and lighting, sound and fit-out have been carefully considered to create a low-stimulus environment where guests can feel safe, calm and welcome. This is an environment that looks and feels very different to hospital settings, which improves guests' experiences and outcomes.
- The UMHCC offers a 'no wrong door' approach and prioritises accessibility:
    - The service is free.
    - It is open 24/7.
    - Guests can walk in, self-refer or be referred by other services. It has a formal working relationship with South Australian Ambulance Service (SAAS), South Australian Police (SAPOL), the Mental Health Triage Service and metropolitan-based emergency departments, easing pressures within the system.
    - There are no catchment area restrictions.
- It is the first non-governmental organisation in Australia to be accredited to the National Safety and Quality Health Service (NSQHS) Standards.

[62] Dudgeon, P., Boe, M., & Walker, R. (2020). Addressing Inequities in Indigenous Mental Health and Wellbeing through Transformative and Decolonising Research and Practice. *Research in Health Science*, *5*(3). https://doi.org/10.22158/rhs.v5n3p48

[63] South Australia Health, 2022. *A Co-created Philosophy of Care, Version Two.*

[64] Office of the Chief Psychiatrist, Department for Health and Wellbeing, Government of South Australia. (2021). *Annual Report of the Chief Psychiatrist of South Australia, 2020-21*. https://s3-ap-southeast-2.amazonaws.com/sahealth-ocp-assets/general-downloads/Chief-Psychiatrist-of-South-Australia-Annual-Report-2020-21.pdf

[65] South Australia Health, 2022. *A Co-created Philosophy of Care, Version Two,* p. 5.

- The service has governance mechanisms in place to support complex needs and care review, along with a governance committee that includes 50% lived experience and 50% partner agency representatives. The governance committee holds the organisation accountable to the Philosophy of Care.
- The service has diverse 'referral out' partnerships and pathways including with GPs, community health, homelessness, and other specialist mental health services.

Outcomes

Since its opening in March 2021, up until 10 August 2023, UMHCC has received 11,278 referrals, and through collaborative triage provided direct support to 8,813 people.[66]

Data from early evaluation of the service shows:

- 44% would not have sought help if they didn't come to UMHCC
- 42% would have gone to a hospital emergency department if they didn't come to UMHCC.

Consumer feedback identifies that the strengths of the service include:

- "The people. They're wonderful and kind. I never have to worry anymore because I can go to the UMHCC."
- "The staff and their ability to listen, empathise and just make you feel like you're not on your own."
- "The attitude of the staff, the validation they provided as well as the practical solution focused resources they provided as well."

5. Establishing an Urgent Mental Health Care Centre in Perth

5.1 Opportunities for Action

The Western Australian Government should make a landmark investment in a community-led alternative to ED settings for people in emotional crisis. The Western Australian Government should draw on comprehensive models such as the Urgent Mental Health Care Centre.

Establishing an Urgent Mental Health Care Centre in Perth would contribute to a Western Australian mental health system where:

- People in crisis are able to access timely non-coercive support that upholds their dignity and safety
- Crisis supports are co-led by people with lived experience of mental health issues and crisis
- Crisis supports transcend current risk-focused approaches to prioritising care and connection
- People in crisis do not spend their time in unsafe, untimely and unresponsive emergency department settings
- Hospital admissions are avoided through more holistic and rights-based responses to emotional crisis.

[66] Ibid.

5.2 Alignment with established National and State Mental Health Plans and Strategies

The development of an UMHCC for Perth would help to support key principles and actions from established plans, strategies and agreements the State Government has endorsed to improve the mental health support provided in Western Australia. These include:

- **WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024:** a UMHCC would cohere with the push to develop alternatives to emergency departments outlined in the 'WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024' document. This work identifies immediate priorities and key rationale for reforming the mental health and AoD sector in the state.[67] The rationale offered for providing alternatives to ED in this document revolve around the impact that redirecting consumers away from EDs will have on government expenditure and the availability of emergency department services for the broader community. A UMHCC would accordingly help to address the potential for hospital gridlock and capacity issues by diverting people experiencing mental health distress away from the ED and into a more suitable environment.
- **Sustainable Health Review:** a Perth-based UMHCC would cohere with the findings and recommendations of the 2019 Sustainable Health Review relating to providing consumers with the most appropriate setting to receive support.[68] Specifically, developing a 24-hour alternative to ED that utilises both clinical and peer-led responses would align well with the priorities outlined in recommendation seven of this review.
- **National Mental Health and Suicide Prevention Agreement:** a UMHCC developed for Western Australia would also support the delivery of targets outlined in the National Mental Health and Suicide Prevention Agreement, to which WA is a signatory.[69] Specifically, an UMHCC would support WA in addressing point 'f' of the 'Gaps in the System' section of the National Priorities by offering a facility that will reduce ED presentations through reliably offering whole-of-person support. This would be achieved through the combined deployment of Peer workers alongside traditional clinical treatment options, as outlined above in section 4.1. This is once again proposed to offer economic benefits by reducing overarching health system costs related to ED presentations.
- **Vision 2030**: a Perth-based UMHCC would additionally support a number of the outcomes suggested in the National Mental Health Commission's Vision 2030 Report.[70] This report presents rationale about the actions that Federal, State and Territory governments should pursue as a way to provide better mental health support to people living in Australia. Specifically, the report notes that providing consumers with safe treatment that they feel good about would be indicated by a reduction in the use of emergency services. An UMHCC for Perth would serve to achieve this diversion from emergency care, and address the associated instances of restrictive practices that

[67] Government of Western Australia. (2020). *WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024.* https://www.mhc.wa.gov.au/media/2951/wa-state-priorities-mh-aod-2020.pdf pp. 5, 10–11.
[68] Sustainable Health Review. (2019). *Sustainable Health Review: Final Report to the Western Australian Government*. Department of Health WA. https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Sustainable-Health-Review/Final-report/sustainable-health-review-final-report.pdf
[69] The Australian Government. (2022). *National Mental Health and Suicide Prevention Agreement*. https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement p. 27.
[70] National Mental Health Commission. (2023). *Vision 2030: for Mental Health and Suicide Prevention in Australia*. https://www.mentalhealthcommission.gov.au/publications/vision-2030

can occur in EDs and lead to iatrogenic harms and trauma. Moreover, a UMHCC would support the expansion of the peer workforce, another key priority outlined within the Vision 2030 report.

Finally, it is worth noting that there is ongoing work being conducted for the 'Roadmap for community mental health treatment services, including emergency response services' project (CTER Roadmap). While the CTER Roadmap is still being developed, a UMHCC could address many of the concerns about ED presentations and acute crisis responses that this project is exploring.[71]

5.3 Resources and Networks

The WA Government could be supported in scoping and planning this work by resources and networks, including:

- Stakeholders involved in the planning and implementation of Adelaide's Urgent Mental Health Care Centre, in particular, Neami National, South Australia's Chief Psychiatrist, and LELAN.
- WA Peer Supporter's Network (WAPSN), which has connections within WA's mental health, community services and Peer sectors and can engage stakeholders to understand perspectives on the issues facing WA's EDs and mental health services and proposed models to address those issues.
- CoMHWA, as the peak body by and for people with lived experience of mental health challenges, is uniquely placed to undertake consultation and collaboration with consumers, as we have extensive consumer advisory networks and over 2000 members. CoMHWA's staff have the expertise and capability to lead co-design processes to ensure that an alternative to ED is developed with people with lived experience of mental health crisis.

[71] WA Mental Health Commission. (2021). *CTER Roadmap Project Roadmap for community mental health treatment services, including emergency response services: Project Terms of Reference*. https://www.mhc.wa.gov.au/media/3802/cter-roadmap-project-terms-of-reference.pdf

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