MENTAL HEALTH ADVOCACY SERVICE INQUIRY INTO SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE AND COMPLIANCE WITH THE MENTAL HEALTH ACT 2014

FINAL REPORT: JULY 2020

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FOREWORD BY THE CHIEF MENTAL HEALTH ADVOCATE

The Mental Health Advocacy Service (MHAS) is pleased to have undertaken the following work with the aim of improving Aboriginal Mental Health consumers' experiences of, and compliance with their rights by, the Western Australian mental health system.

When the *Mental Health Act 2014* (the Act) came into force, it introduced new rights and a shift in the way Aboriginal people would experience assessment, examination and treatment for mental health issues. The Act required that there must be collaboration with Aboriginal mental health workers and significant people from an Aboriginal person's community, including elders and traditional healers, during any mental health assessment, examination or treatment to the extent it is practicable and appropriate.

These provisions recognise the holistic concept of mental health for Aboriginal people including social, emotional, cultural and spiritual wellbeing issues to be taken into account when assessing, examining or treating an Aboriginal person. It is particularly crucial in view of the very high rates of involuntary hospitalisation of Aboriginal people for mental health problems, the high prevalence of youth suicide and psychological distress, and when people are transferred from regional to metropolitan hospitals.

The inquiry giving rise to this report sought to identify the services available to Aboriginal people, and the extent to which mental health services are complying with the Act. The inquiry has identified that in many cases the Act is not being complied with and overall, Aboriginal consumers are not consistently being offered their rights.

It is evident from the report that trained Aboriginal Mental Health Workers are needed across the mental health system with too much reliance on Wungen Kartup Aboriginal Mental Health service or Aboriginal Liaison Officers without specialist mental health training.

Another notable gap is the engagement of traditional healers. A sector wide collaborative approach to the development and implementation of a workable framework to engage traditional healers is urgently needed. The recommendations around these two gaps will require significant investment, support and leadership to ensure relevant consultation and to drive the change process across the state.

The Director General of the Department of Health, the Acting Mental Health Commissioner and the Chief Executives of the five WA health service providers, provided a detailed and joint response to the report advising they are largely in agreement with the report and all recommendations were supported or supported in principle.

Separate responses were also received from Wungen Kartup Aboriginal Mental Health Service, the Child and Adolescent Health Service and the Chief Executive of the St John of God Midland Hospital supporting the report and recommendations. North Metropolitan Health Service also provided an action plan. Supportive responses were also received from the Chief Psychiatrist and the President of the Mental Health Tribunal.

In answer to a query about funding of the recommendations, the Director General and Acting Mental Health Commissioner advised that "*the responsibility varied between organisations*" and "*As the recommendations progress, this will be identified by our agencies"*. It is clear however that within the agencies there is confusion about funding which is a deterrent to change.

I commend this report to the Minister to inform and drive the reforms required to significantly improve Aboriginal mental health consumers' experiences and observation of rights under the Act.

Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE

ACKNOWLEDGEMENTS

Authorship

The author of this report was Sandy McKnight, MHAS Advocate, in consultation with the Aboriginal Advocate Team: Mark Champion, Lesley-Anne Bernard and Julie Burgoyne. Collation of responses to the survey and the preliminary report recommendations was provided by MHAS staff, Denise Wheldon and Chris Stilian.

Participants

The MHAS would like to thank the following health service provider and hospital chief executives, the Mental Health Tribunal President, Karen Whitney, the Acting Mental Health Commissioner, Jen McGrath, the Director General of the Department of Health, Dr David Russell-Weisz and the Chief Psychiatrist of Western Australian, Dr Nathan Gibson, for responding to this important inquiry into services for Aboriginal and Torres Strait Islander people and compliance with the Mental Health Act 2014.

Jen McGrath	Acting Mental Health Commissioner, Mental Health Commission (MHC)
Dr David Russell-Weisz	Director General, Department of Health (DOH)
Dr Nathan Gibson	Chief Psychiatrist, Office of the Chief Psychiatrist
Karen Whitney	President, Mental Health Tribunal
Jeff Moffet	Chief Executive, WA Country Health Service
Liz MacLeod	Chief Executive, East Metropolitan Area Health Service
Dr Robyn Lawrence	Chief Executive, North Metropolitan Area Health Service
Dr Paul Forden	Chief Executive, South Metropolitan Area Health Service
Dr Aresh Anwar	Chief Executive, Child and Adolescent Health Service
Michael Hogan	Chief Executive Officer, St John of God Healthcare

We would also like to thank all the staff who assisted with the completion of the survey, and those who provided feedback to the preliminary report, including Wungen Kartup Aboriginal Mental Health Service.

MHAS wish to acknowledge the traditional custodians of this land & pay respect to the elders, past, present & emerging.

EXECUTIVE SUMMARY

The Mental Health Act 2014 (the Act) clearly articulates rights for Aboriginal mental health consumers to access cultural support and collaboration during their assessment, examination and treatment along with the recognition of family, culture and community in any healing process. Anecdotal information provided to MHAS Advocates suggested that the Act was not being complied with. The inquiry aimed to ascertain if this was the case and to identify the barriers and opportunities to improve the rights of Aboriginal people to access culturally safe, appropriately supported care in accordance with the Act.

The report confirms the anecdotal information that the Act is not being complied with and identifies the findings and best practice and makes 15 recommendations from the inquiry which was undertaken throughout 2019. Service providers responsible for funding, developing policy and resources, monitoring quality and compliance or providing clinical care to Aboriginal mental health consumers were consulted and their responses are included.

FINDINGS

Based primarily on data from the health service providers (HSPs) and consumer feedback to Advocates, the Act is not being complied with and overall Aboriginal consumers are not consistently being offered their rights. While some initial progress has been made towards fulfilling the promise of the Act, and there are some positive examples of collaboration, there is still a long way to go before all Aboriginal people being assessed, examined and treated have access to the rights offered by the Act.

The first issue noted from the survey was that few mental health services have Aboriginal Mental Health Workers (AMHWs) with relevant qualifications/training and regular involvement in mental health assessment, examination and treatment:

- Only two of the 11 metropolitan hospitals with authorised mental health wards had AMHWs - most rely on Aboriginal Liaison Officers (ALOs) whose remit may cover a wide range of health service areas. ALOs do not generally have specific mental health training and expertise, and time on mental health wards may be limited.
- Three hospitals and some community health clinics rely solely on Wungen Kartup Specialist Aboriginal Mental Health Service (metropolitan), but delays were reported in accessing these services due to the time involved in the referral process, the availability of AMHWs, and their capacity/resources to assist.
- The majority of AMHWs are working in the WA Country Health Service (WACHS) and Child and Adolescent Community Mental Health Services (CAMHS). However many Aboriginal people with mental illness are transferred to metropolitan hospitals for treatment due to the lack of mental health services in remote and regional areas. Separated from family, community and culture they also have less access to appropriate services and observation of their rights under the Act.
- AMHWs are also generally not routinely available outside of usual business hours and mental health assessments, examinations and admissions may occur at any time, often in emergency departments. This must mean that many Aboriginal consumers are not able to access their rights under the Act in relation to the assessment and examination process, and has the potential for a person being unnecessarily admitted, not admitted, and/or made involuntary under the Act. Trauma as a result of the process may also be more likely.

The next issue noted was that there did not appear to be a common collaborative approach of treating teams working in partnership with traditional healers, elders and other significant community members in the mental health assessment, examination and care of Aboriginal people:

- Very few mental health services could point to examples of elders and traditional healers being involved with consumers and there was little data collected or available. Problems were reported in identifying and accessing traditional healers, and there was no clear or uniform practice for the payment of traditional healers or elders involved in assessment, examination or treatment.
- Again WACHS and CAMHS were the only HSPs that had established policies and procedures on collaboration with AMHWs and significant members of an Aboriginal consumer's community, including elders and traditional healers.
- It appears that there is no procedure in most mental health wards to guide clinical teams on the process for collaboration in assessment, examination and treatment required under the Act. The lack of policy guidelines, as well as consumer feedback to MHAS, suggests that Aboriginal people are not consistently being offered their rights, and it appears that the Act is not being complied with in many cases.

On a positive note, all services have implemented eLearning for staff on Aboriginal cultural awareness. Some also provide cultural training workshops; however there is a need for development of greater staff awareness of the specific requirements of the Act for Aboriginal people.

In general, there also did not appear to be any leaflets, posters, or resource materials for Aboriginal consumers advising them of their rights.

One of the limitations of the Inquiry is that services do not routinely collect and report data required for a full picture to emerge. There is therefore a need for better data collection to determine the extent to which Aboriginal consumers rights are being met. Nevertheless, services have provided enough data to indicate areas of strength and areas where there are significant gaps.

RECOMMENDATIONS

The report identifies 15 recommendations aimed at ensuring all Aboriginal consumers rights under the Act to access AMHWs and significant community members (including elders and traditional healers) in their assessment, examination and treatment by mental health services can be complied with:

1. The number of AMHW positions in metropolitan authorised hospitals and community mental health clinics be increased, particularly in those services with no AMHWs. Alternatively, HSPs review the role, requirements and time availability for ALO positions covering mental health wards to ensure capacity to meet the requirements of sections 50, 81 and 189 of the Act, and appropriate skills/training/qualifications. These positions should become designated as AMHW positions and appropriately funded. Their job description to specify responsibility for collaboration in assessment, examination and treatment, in accordance with the requirements of the Act.
2. HSPs to assess and plan to ensure availability of AMHWs in the triage/admission process and in assessment/examination to determine involuntary status so they comply with the Act.
3. WACHS and HSPs to review and identify ways of providing more cultural support to Aboriginal mental health consumers transferred from country areas to metropolitan hospitals.

4. HSPs and Wungen Kartup to identify ways to improve access to traditional healers/elders, taking into account gender balance and more traditional healers to call on from different regions.
5. The MHC and Wungen Kartup to review and clarify the payment process for traditional healers/elders who are involved in collaboration with the mental health treating team in assessment, examination and/or treatment or cultural healing ; and an appropriate budget be allocated.
6. The DOH and HSPs to review and improve data collection to enable reporting on involvement of AMHWs, and traditional healers, in addition to (or as an enhancement of), the data collection on significant members of a person's community.
7. HSPs to develop policies and procedures/guidelines, where these do not exist, for asking Aboriginal consumers if they would like an AMHW involved in their mental health assessment, examination and treatment; and the process for involving the AMHW.
8. HSPs to develop policies and procedures/guidelines, where these do not exist, for asking Aboriginal consumers if they would like significant members of their community, including elders and traditional healers, involved in their assessment, examination and treatment; and the process for involvement. This should include consideration of the meaning of *"significant members of the person's community",* as this right is in addition to the right to the involvement of family members and carers under the Act.
9. The Chief Psychiatrist to amend all forms relating to assessment and examination (e.g. Forms 1A, 3C, 5A, 5B, 6A, 6B, 6C, 6D), so that Aboriginal consumers rights to have an AMHW, elder, traditional healer and other significant community member involved or present, are prominently stated upfront and in the notes and checklists.
10. HSPs to consider a process for documenting reasons in the consumer's medical record, if it was not considered appropriate or practicable to involve an AMHW, and significant members of the consumer's community in assessment and examination for determining involuntary status, or in treatment.
11. The DOH and HSPs consider the development/use of a Treatment Support and Discharge Plan template for Aboriginal consumers, focusing on relevant cultural information, rights for involvement/collaboration in treatment, and appropriate design in consultation with Aboriginal people.
12. The MHC in conjunction with the DOH, to produce resource materials (e.g. brochures, posters) for Aboriginal consumers on their rights under the Act, incorporating e.g. Aboriginal art work and appropriate language, and co-designed with Aboriginal people.
13. HSPs to include in-patient information packs for Aboriginal consumers, information about their rights, including the right to have an AMHW and significant members of their community, including elders and traditional healers, involved in their assessment, examination and treatment.
14. HSPs and Wungen Kartup to develop/arrange for training of treating teams on the role of Aboriginal traditional healers and ways of involving them in mental health care.
15. HSPs to provide training for treating teams on the local process for involving AMHW/ALO and significant community members including elders and traditional healers in assessment, examination and treatment, and on culturally appropriate practices in care.

RESPONSES TO THE REPORT AND RECOMMENDATIONS

The preliminary report was circulated to the DOH, MHC, HSPs, CEOs of St John of God (SJOG) Midland and Joondalup hospitals, Wungen Kartup Aboriginal Mental Health Service, the Chief Psychiatrist and President of the Mental Health Tribunal for feedback. All recommendations were supported or supported in principle with a number of detailed responses confirming or adding to the issues identified in the report and/or impediments to the Act being fully complied with as well as providing some further suggestions for improvement.

A number of common themes were evident.

- HSPs identified funding requirements as a barrier for increasing the number of AMHW's across the metropolitan area to enable full implementation of Aboriginal consumers' rights under the Act. Additionally increasing AMHW availability into the evenings and nights will require a change of entitlements based on shift work and create further funding implications.
- It is evident there is a lack of clarity regarding who is responsible for funding additional positions. This needs to be determined as a matter of priority and be equitable and transparent across the state.
- A need for appropriate training and education was a comment made throughout the feedback for multiple recommendations. This included training to ensure Aboriginal consumer rights were understood by clinicians and treating teams. Wungen Kartup notes they would be an appropriate service to develop training.
- All HSPs agreed that improved data collection and documentation would assist in their ability to monitor compliance with Aboriginal consumers' rights under the Act. Development of an appropriate consumer experience data collection tool would inform future service development and training opportunities for staff.
- There was overwhelming support for the involvement of traditional healers and language interpreters but a lack of clear payment and engagement process and access to lists of appropriate and available traditional healers was a barrier to implementation. Development of a state-wide policy framework with capacity for regional considerations was proposed. Access to traditional healers/elders for Aboriginal consumers who are off country needs to be considered in the framework along with immediate access options in the moment that the traditional healer is required whether this be during office hours or after hours.
- Whilst all supported the recommendation about a treatment support and discharge plan template across the HSPs, there were concerns as the development of a specific template that suits the needs of all regions. It will require considerable consultation and co-design.

In other responses to the report:

- The Chief Psychiatrist supported the collection of valid and verifiable data in enhancing the ability to oversee standards of care to Aboriginal and Torres Strait Islander people and noted that he intends to ensure the forms prescribed under the Act are included in the 5-year review of the Act (due to start later this year) and to include Aboriginal consumer rights on all the relevant forms.
- The DOH:
    - undertook to review data collection and reporting via the Mental Health Data Management Group including a review of the Standardised Statewide Clinical Documentation to include Aboriginal specific information
    - reported it is producing resource material with a distinctive Aboriginal design and is currently liaising with the MHC to develop brochures, posters and other resource materials that outline the rights of Aboriginal consumers under the Act.

- The MHC:
    - confirmed that it is intending to progress work on reviewing the current brochures relating to the Act regarding their 'cultural security'
    - proposed that a working group be established to deal with a number of the recommendations.
- The President of the Mental Health Tribunal advised that she was committed to ensuring compliance with the Act and had provided guidelines for best practice to legal members of the Tribunal and amended a standard adjournment order to allow for an Aboriginal or Torres Strait Islander patient to be provided with assessment, examination and treatment in accordance with the Act.
- East Metropolitan Health Service (EMHS) which operates and governs Wungen Kartup offered to meet with MHAS with the aim of developing an action plan with interagency involvement including the Chief Psychiatrist, MHC and HSPs to progress change.

More detail about the responses are included in the body of the report.

INTRODUCTION

The aims of the Inquiry were to:

- identify and report on services available to assist in the assessment, examination and treatment of Aboriginal people in accordance with the requirements of the Act
- promote the rights of Aboriginal people to access Aboriginal mental health workers and significant members of their community, including elders and traditional healers, in their mental health care, and assess the extent to which those rights are being observed.

Aboriginal people are reported to be around 2.5 times more likely to access mental health services than other Australians[1]. The *Overcoming Indigenous Disadvantage: Key Indicators Report 2016* showed a hospitalisation rate for mental and behavioural disorders for Aboriginal West Australians which was 3.2 times the rate for non-Aboriginal West Australians[2]. The rate of contact with community based mental health services in WA was more than 2.7 times the rate for non-Aboriginal West Australians.

Some of the complex issues surrounding Aboriginal mental health and culturally appropriate services are outlined in the publication, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*[3]. In particular, Parker and Milroy note that:

> *Management of the issues of mental illness requires a strong emphasis on cultural safety, along with the recognition of family, culture and community in any healing process*.[4]

The rights of people to be treated in a culturally appropriate way when receiving a mental health service are provided for in the Act. The assessment, examination and treatment of a person who is of Aboriginal or Torres Strait Islander descent must be conducted, where appropriate and practicable:

> *…..in collaboration with Aboriginal or Torres Strait Islander mental health workers; and significant members of the person's community, including elders and traditional healers.* [5]

The Charter of Mental Health Care Principles, in schedule 1 to the Act, also states:

> ***Principle 7: People of Aboriginal or Torres Strait Islander Descent***
>
> *A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.*

A mental health service must make every effort to comply with the Charter of Mental Health Care Principles when providing treatment, care and support to patients.[6]

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[1] In this Inquiry report, reference to Aboriginal people includes people who identify as Aboriginal and Torres Strait Islander.
[2] Productivity Commission, Overcoming Indigenous Disadvantage: Key Indicators Report, 2016, Table 8A.7.28 and Table 8A.7.35.
[3] Pat Dudgeon, Helen Milroy and Roz Walker (Eds), Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, 2014.
[4] Robert Parker and Helen Milroy, in Pat Dudgeon, Helen Milroy and Roz Walker (Eds), Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, 2014, p 121.
[5] Mental Health Act 2014, sections 50, 81 and 189.
[6] Mental Health Act2014, section 12(2) and Schedule 1 - Charter of Mental Health Care Principles.

Role of the Mental Health Advocacy Service (MHAS)

It is a legislative function of the Chief Mental Health Advocate to promote compliance with the Charter of Mental Health Care Principles, and Mental Health Advocates have the function under s352 of the Act to inquire into and investigate the extent to which identified persons' rights are observed. This includes involuntary patients and those referred for assessment under the Act, among others.[7]

MHAS has engaged specialist Aboriginal Advocates to assist Aboriginal consumers, and provide culturally appropriate advice to other Advocates.

Issues leading to the Inquiry

Concerns have been raised by MHAS Advocates about whether mental health services are consistently offering Aboriginal consumers their rights under ss50, 81 and 189 of the Act to have assessments, examinations and treatment provided in collaboration with Aboriginal mental health workers and/or significant members of the person's community.

Advocate feedback indicated that the Act was not always being complied with and, in some cases the MHAS Aboriginal Advocate was the only Aboriginal contact for consumers. This was particularly so at hospitals with no ready access to Aboriginal mental health workers or liaison officers.

In one case, the matter was part of an investigation of a complaint made to the complaints body designated under the Act, HaDSCO[8]. HaDSCO concluded that because the mental health service did not employ an Aboriginal or Torres Strait Islander mental health worker, 'the application of section 50 of the Act was not practicable and appropriate in the circumstances'.

MHAS proposed that a list of all Aboriginal mental health workers and/or services available at, or to, each authorised hospital be developed to help advocate for compliance with the Act and facilitate access to such services.

Subsequently, the *Post-Implementation Review of the Act* published in March 2018 recommended that MHAS conduct an inquiry into and prepare a report on services available to assist in the assessment, examination and treatment of Aboriginal and Torres Strait Islander people, in accordance with the requirements of the Act. [9]

Inquiry process

The Inquiry process comprised the following:

1. A survey of all HSPs[10] where involuntary inpatient orders can be made (authorised hospitals) or community treatment orders supervised, was conducted in May-June 2019 asking questions including:
    - the number of Aboriginal people who received mental health services in 2017/2018
    - the number of Aboriginal mental health workers and where they worked
    - the number of Aboriginal and Torres Strait Islander people who had a significant member of their community, including an elder or traditional healer, (Significant Person) involved in their care

[7] Mental Health Act 2014, section 348.
[8] The Health and Disability Services Complaints Office (HaDSCO).
[9] Mental Health Commission, *Post Implementation Review of the Mental Health Act 2014*, March 2018.
[10] The North, East, South, WA Country Health and Child and Adolescent health services.

- policies or procedures for:
    - identifying a patient as Aboriginal or Torres Strait Islander
    - involving and collaborating with an Aboriginal and Torres Strait Islander mental health worker and the patient and/or carer/personal support person
    - involving and collaborating with a significant member of the persons community such as an elder or traditional healer and whether they were paid for their time
- training of other staff

2. Follow up inquiries and interviews
3. Aboriginal consumer feedback to Aboriginal Advocates.

The results of the survey findings and other inquiries, along with recommendations, are set out below. The Inquiry report has been broken into 4 parts:

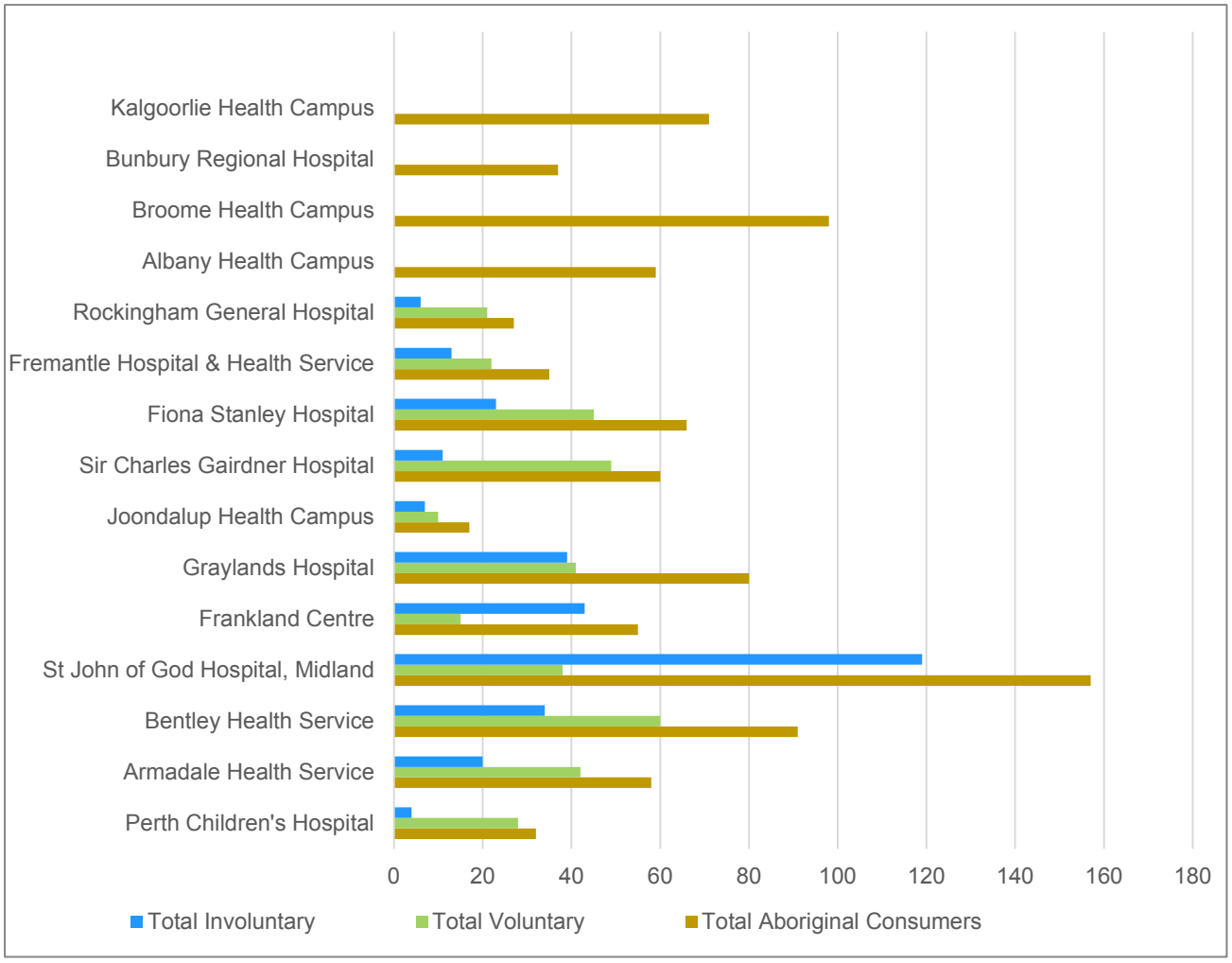
1. Access to Aboriginal mental health workers by Aboriginal people receiving mental health services
2. Involvement of a significant member of the community including an elder or traditional healer
3. Policies and procedures
4. Training and resources.

PART 1 – ACCESS TO ABORIGINAL MENTAL HEALTH WORKERS BY ABORIGINAL PEOPLE RECEIVING MENTAL HEALTH SERVICES

THE NUMBER OF ABORIGINAL PEOPLE RECEIVING MENTAL HEALTH SERVICES

In response to the survey, it was reported by the State's five HSPs that 2,659 Aboriginal people received mental health services in a hospital or community mental health service in 2017/2018.[11] [12] The biggest numbers of inpatients were treated in Midland, Broome and Bentley hospitals. See table 1 and Appendix 1.

Table 1: Voluntary and Involuntary Aboriginal Inpatients (consumers) by Authorised Hospital and health status 2017/18[13]



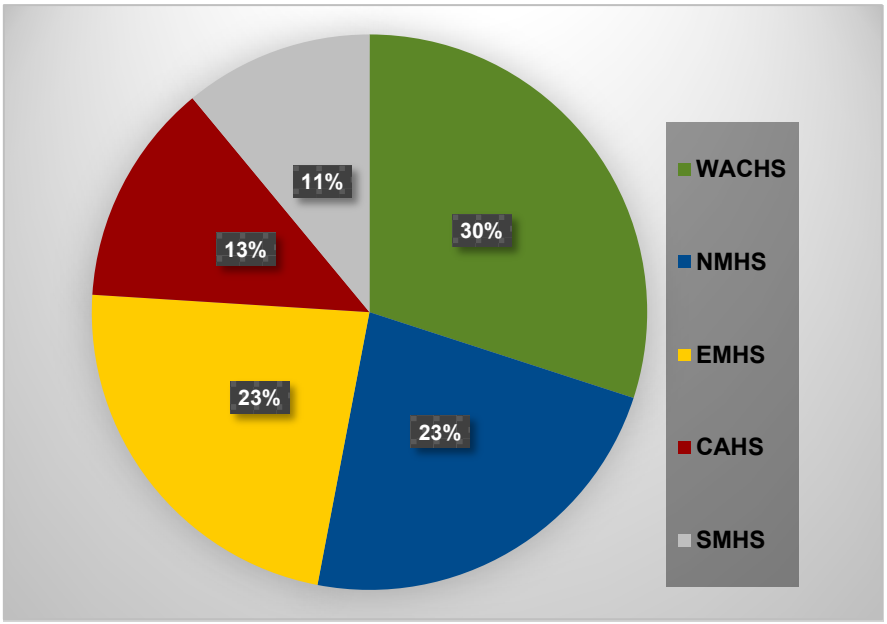
[11] Data is based on compilation of figures provided to MHAS by mental health service providers in June 2019 in response to the survey question "What was the total number of people who were identified as Aboriginal or Torres Strait Islander and who separated from a mental health ward or community mental health service (CMHS) in 2017-18 in each of the following categories: Total number of Aboriginal or Torres Strait Islander patients, Voluntary people (only ever voluntary during their admission), Involuntary people (at any time during their admission), Male, Female, Other (gender), Aged under 18 years, Aged 18 to 24 years, Aged 25 to 64 years, Aged over 65 years. *NOTE: MHAS understands that people will have been both a patient in hospital and with a CMHS during the period and would therefore be counted multiple times. Please include people who spent time in a mental health ward or CMHS (and have separated).*"

[12] Figures may not be comparable between health services and rely on self- identification and HSP recording of the data; they do not include people who were receiving treatment in 2017/18 and were not discharged from the service during that time period.

[13] A breakdown by voluntary and involuntary status was not available for WACHS authorised hospitals in regional areas.

A large proportion of the services provided to Aboriginal people were in country areas by HSP, WACHS (30%). In the metropolitan area, East Metropolitan Health Service (EMHS) and North Metropolitan Health Service (NMHS) each provided 23% of services reported for inpatient and community mental health services. Aboriginal children (under 18 years) accounted for 13% of the services which were provided by the Child and Adolescent Health Service (CAHS); South Metropolitan Health Service (SMHS) reported the lowest numbers at 11% of the mental health services provided.

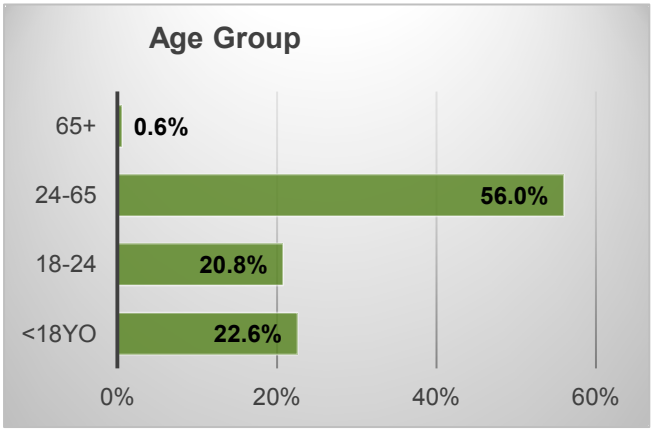
Table 2: Aboriginal Mental Health Consumers by HSP



A relatively large number of Aboriginal consumers were young people under 18 (23%), and youth, aged 18 to 24 (21%). See table 3. The majority of young people were seen by the Child and Adolescent Mental Health Service (CAMHS) and the WA Country Health Service (WACHS).

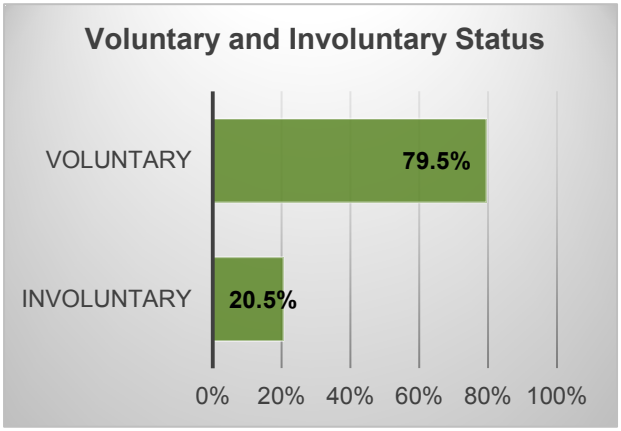
Some headspace centres were also contacted for the survey. Of those that responded, Joondalup headspace and Osborne Park headspace reported providing services to relatively large numbers of Aboriginal people in 2017/18. Aboriginal young people were also seen as part of the headspace Youth Early Psychosis Program. Very few of the Aboriginal young people seen by headspace were involuntary patients.

Table 3: Aboriginal Mental Health Consumers 2017/18 by age



Of the total number of Aboriginal people who received mental health services, 545 (20.5%) were involuntary patients.[14] See table 4.

Table 4: Aboriginal Mental Health Consumers 2017/18 by status



Hospital Services – Metropolitan

It was reported that inpatient mental health services were provided to 990 Aboriginal people, of whom 73% were in the Perth metropolitan area. Of these, 44% were involuntary patients (i.e. people on an inpatient treatment order or form 6A or 6B).

Metropolitan authorised hospitals reporting the largest numbers of Aboriginal involuntary consumers were: St John of God (SJOG) Midland, the Frankland Centre, Graylands Hospital, Bentley Health Service, Fiona Stanley Hospital, and Armadale Health Service. Other hospitals which had smaller numbers of involuntary consumers but significant overall numbers of Aboriginal mental health consumers included Sir Charles Gairdner Hospital (SCGH), Fremantle Hospital, Rockingham General Hospital, Perth Children's Hospital and Joondalup Health Campus. See Appendix 1.

[14] People who were reported as being involuntary at any time during their admission to the health service.

Hospital Services – Regional

It was reported that mental health services were provided to 784 Aboriginal people in country areas, of whom 34% were inpatients. The overall proportion of involuntary patients, including those on community treatment orders was reported as being 26%[15]. Country hospitals reporting the largest numbers of Aboriginal consumers were Broome Health Campus and Kalgoorlie Health Campus. Significant numbers were also reported at Albany Health Campus and Bunbury Health Campus.

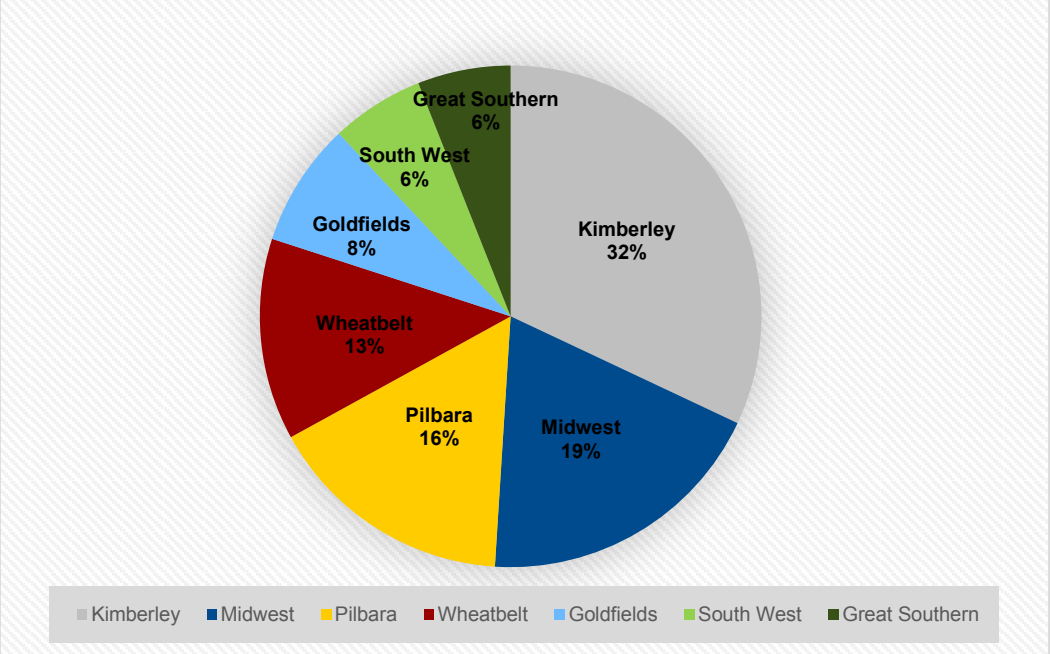
Community Mental Health Services

It was reported that 1669 Aboriginal people were provided with services in community mental health clinics in 2017/2018. Of these 69% were provided in the Perth metropolitan area and 31% were provided in country areas. While many community mental health services reported relatively large numbers of Aboriginal consumers, the numbers of Aboriginal involuntary consumers (i.e. people on a community treatment order or form 5A) were generally low.

Metropolitan community mental health clinics reporting the largest numbers overall of Aboriginal consumers were: Fremantle, Armadale, Bentley and Midland. There were also significant numbers reported by CAMHS as well as City East, Osborne Park, Rockingham, Peel and Joondalup community mental health services.

In regional areas, WACHS community mental health clinics reporting the largest number of services to Aboriginal consumers were in the Kimberley region (32% of country services). The Midwest (19%), Pilbara (16%) and Wheatbelt (13%) also had large numbers of Aboriginal consumers, followed by the Goldfields (8%), South West (6%) and Great Southern (6%). [16]

Table 5: WACHS Services to Aboriginal Mental Health Consumers 2017/18 by Region



[15] Includes involuntary inpatients and people on a community treatment order.
[16] Aboriginal consumers discharged from WACHS mental health community services in 2017/2018.

ABORIGINAL MENTAL HEALTH WORKERS – AND WHERE THEY WORK

Many hospitals and some community mental health clinics reported that they had now established Aboriginal Mental Health Worker (AMHW) and/or Aboriginal Liaison Officer (ALO) positions. The roles and job titles of the AMHW and ALO positions varied in different services. In general, AMHWs were working specifically within mental health clinical teams, while ALOs generally worked across the whole hospital or HSP site, including mental health.

AMHWs – Examples

Both WACHS and CAMHS reported they had AMHWs working within their mental health services teams. The role of the AMHW included, for example[17]:

- Working cooperatively with other members of the mental health clinical team to enhance culturally appropriate assessment, treatment and case management of Aboriginal consumers.

AMHWs also had the role of providing cultural support and advocating for Aboriginal consumers and their families/carers.

Examples of skills and qualifications for AMHWs included:[18]

- an understanding of the practical emotional impact of mental disorders on individuals and their families
- experience in human services indicating a capacity to develop skills in dealing with people with serious mental health disorders
- formal qualifications in mental health or other relevant health qualifications were generally desirable, and were an essential qualification for some senior positions.

Examples were provided of cases in which having an AMHW involved in the assessment/examination process enabled pertinent information to be disclosed, resulting in a more accurate diagnosis and a better consumer experience. As well as promoting a culturally safe environment for Aboriginal consumers, AMHWs assisted the clinical team in communication and understanding of cultural issues in diagnosis and treatment.

ALOs – Examples

ALOs, or similar positions, were reported at many hospitals. The positions varied between health services. Their role was generally hospital or HSP site/area wide, including mental health, and included for example:[19]

- acting as an advocate, interpreter and advisor within the HSP to provide the link between Aboriginal consumers, communities and health service staff
- providing orientation to Aboriginal clients and families to various health/services programs
- acting as a resource and/or cultural advocate for Aboriginal consumers, families and communities, promoting health services and providing appropriate information.

[17] Job Description Forms for WACHS Aboriginal Mental Health Worker.
[18] CAHS and WACHS Aboriginal Mental Health Worker Job Description Forms.
[19] Eg, WACHS Aboriginal Liaison Officer Job Description Form.

Hospital Services – Metropolitan

There were 11 metropolitan authorised hospital services where inpatient involuntary orders were made or supervised in 2017/2018. See Appendix 1. Of these:

- 2 hospitals (Rockingham and Fremantle) reported having AMHW or equivalent positions working specifically in mental health services
- 6 hospitals reported having ALO or similar positions covering the hospital
- 3 hospitals (Graylands Hospital, the Frankland Centre, and SCGH) had no AMHW or ALO positions, and reported that they referred to Wungen Kartup Specialist Aboriginal Mental Health Service.

Hospital Services – Regional

There were 4 country hospital services where inpatient involuntary orders were made or supervised in 2017/2018. Of these:

- 2 had AMHW teams located within the hospital (Broome and Kalgoorlie), and 2 had AMHW teams located in the community mental health service (Albany and Bunbury), with inreach to the hospitals as required.

Child, Adolescent and Youth Mental Health Services

CAMHS, headspace centres and youth community mental health services were surveyed:

- 6 out of 10 CAMHS community mental health services reported having an AMHW, 2 reported an Aboriginal Senior Social Worker position, and 2 reported having no Aboriginal workers
- Of the 2 with no Aboriginal workers, Fremantle CAMHS reported having involuntary Aboriginal consumers in 2017/18, and an unfilled AMHW position; services were provided to Fremantle by the Shenton CAMHS Aboriginal worker
- Youthlink and Youth Reach South reported having AMHWs
- Of the headspace centres that responded to the survey, 2 reported having Aboriginal specific positions.

Community Mental Health Clinics

- AMHWs were located in each of the WACHS regions[20]
- 2 metropolitan community mental health services (Stirling and Peel) had AMHWs
- AMHWs and ALOs in 4 of the metropolitan hospitals were reported to also cover community mental health clinics in their health service area.

Specialist Services

Wungen Kartup Specialist Aboriginal Mental Health Service (Metropolitan)

Wungen Kartup is located at De Grey House, Graylands Health Campus. It is a specialist Aboriginal mental health service with AMHWs who can assist Aboriginal consumers in authorised hospitals and

[20] See Appendix 3 for locations.

community mental health services by referral from HSPs. Consumers and family members may also ring direct for referral. It was reported that Wungen Kartup:

- supports Aboriginal consumers and carers in accessing mainstream mental health services
- provides statewide consultation and liaison with service providers and the community, and advocacy for Aboriginal consumers
- operates with cultural integrity using strategies to include brokering of elders, and traditional healers to participate in particular clinical cases[21].

It is noted that three hospitals (Graylands, Frankland and SCGH) rely solely on Wungen Kartup but a number of other hospitals and community mental health services noted that they also use Wungen Kartup for specialist support.

List of AMHWs and ALOs

A list of AMHWs and ALOs available at, or to, mental health service providers has been compiled and provided to Mental Health Advocates to assist them in advocating on behalf of Aboriginal consumers in relation to their rights under the Act. The list is attached at Appendix 3.

ISSUES WITH ACCESS TO AMHWS

ALOs vs AMHWs in metropolitan hospitals

AMHWs or similar positions, working specifically in mental health services, were reported at only 2 of the 11 metropolitan authorised hospitals. While ALOs or similar positions were reported at 6 hospitals issues raised included:

- ALOs (unlike AMHW positions) often covered all areas of a hospital or hospital group, and in some cases time on mental health wards may be limited
- Mental health qualifications, training and experience were generally not a requirement for ALO positions
- ALOs may not be involved in an assessment or examination to determine whether an Aboriginal person should be made involuntary, unless they had specific mental health expertise and/or time available.

Inreach and referral

It was reported that AMHWs in CAMHS and community mental health services provided inreach services to authorised hospitals as required. This was particularly so where their consumers were hospitalised; support and liaison was provided to the hospital clinical team but it was unclear how much inreach involved direct contact with the consumer.

HSPs reported that Wungen Kartup assisted in providing cultural support to Aboriginal consumers in collaboration with the treating team but:

- Referral to Wungen Kartup may take some time to organise and process, e.g. 2 – 4 days, and there may be delays in accessing services
- Wungen Kartup AMHWs may not always be available
- Access to Wungen Kartup was limited by their resources and capacity to assist.

[21] Information provided at https://emhs.health.wa.gov.au/Hospitals-and-Services/Mental-Health/SAMHS,last access 24 October 2019.

Availability of AMHWs

Some of the barriers to complying with the requirements of the Act identified by HSPs also included:

- Having no funding or gazetted AMHW positions within the hospital
- Positions may not be filled or have the funding to be filled
- AMHWs were not routinely available outside of usual business hours and mental health assessments and examinations (which is when the Act requires an AMHW) and admissions may occur at any time.

MHAS Advocates have also raised concerns about an AMHW at one large hospital being unavailable for long periods due to extended leave, and the position not being covered. We are informed that this position has been temporarily filled.

Gender Issues

HSPs raised the importance of providing a gender appropriate service for Aboriginal consumers, and some had designated female and male positions. This was more readily accommodated in services where there was an Aboriginal mental health team or an ALO team.

Geographic location

Approximately 65% of Western Australia's Aboriginal people reside in rural and remote regions, outside the Perth metropolitan area.[22] WACHS has an Aboriginal Mental Health Coordinator in each region. They are part of the Aboriginal Mental Health Advisory Group, and responsible for ensuring Aboriginal mental health workers involvement, and oversight of service provision to Aboriginal consumers.

A barrier identified by WACHS was that the geographic location of the patient and Aboriginal health worker may prevent involvement. Lack of access to mental health services in remote and rural areas means many people need to travel long distances to seek specialist care. In some cases, specialist mental health care is not available, leaving GPs and smaller hospitals reliant on the Royal Flying Doctor Service to transport unwell patients to metropolitan centres.[23] Many of these were young males in the 20 to 24 age group, and Aboriginal people.

It was reported to MHAS that some 51 Aboriginal people were transferred from WA regional areas to metropolitan hospitals for mental health reasons in 2017/2018[24]. Of these, 37% were aged under 25 years, and 25% were children under 18 years. Hospitals with the largest numbers of Aboriginal consumers transferred from regional areas were Graylands Hospital (41%), Fiona Stanley Hospital (18%) and Perth Children's Hospital (14%).

Issues relating to Aboriginal consumers transferred from regional areas include:

- separation from family, culture, land and community
- language and interpreter issues
- cultural safety and security

[22] Model of Care – Aboriginal Mental Health, WA Country Health Service 2013.
[23] Professor Coleman, in UWA News 26 August 2019 and the article: Fergus W Gardiner, Mathew Coleman, Narcissus Teoh, Abby Harwood, Neil T Coffee, Lauren Gale, Lara Bishop and Martin Laverty "Aeromedical retrievals of people for mental health care and the low level of clinical support in rural and remote Australia", Medical Journal of Australia, 26 August 2019.
[24] Figures reported to MHAS by health service providers are based on people discharged from mental health inpatient facilities in 2017/18, individuals who had multiple admissions may be counted more than once.

- availability of AMHWs with knowledge of culture and community of these Aboriginal consumers.

HSPs reported that in these situations the AMHW or ALO:

- acknowledges this and seeks to understand from the patient and family what they would do in their community
- liaises with family, elders and known contacts in other communities
- draws from other members of the ALO team where appropriate
- contacts external Aboriginal community service agencies, in particular Wungen Kartup Specialist Aboriginal Mental Health Service and interpreter services.

It was noted that cultural practices can differ widely, and cultural knowledge and practices appropriate to one consumer/ community can be different to that for another consumer, and may not be known or disclosed to someone from a different geographic area.

Lack of access to mental health services in regional areas, and the consequent separation from family, culture and community supports of those transferred for treatment, are likely to have a negative impact on the assessment, severity and recovery from mental illness for many Aboriginal people. It is important that efforts are made to ensure their rights under the Act to involve appropriate AMHWs and significant community members are upheld.

PART 1 : RECOMMENDATIONS 1, 2 and 3

It is recommended that:

1. The number of AMHW positions in metropolitan authorised hospitals and community mental health clinics, be increased particularly in those services with no AMHWs. Alternatively, HSPs review the role, requirements and time availability for ALO positions covering mental health wards, to ensure capacity to meet the requirements of sections 50, 81 and 189 of the Act, and appropriate skills/training/qualifications. These positions should become designated as AMHW positions and appropriately funded. Their job description to specify responsibility for collaboration in assessment, examination and treatment, in accordance with the requirements of the Act.
2. HSPs to assess and plan to ensure availability of AMHWs in the triage/admission process for Aboriginal consumers, and in assessment/examination to determine involuntary status so they comply with the Act.
3. WACHS and HSPs to review and identify ways of providing more cultural support to Aboriginal mental health consumers transferred from country areas to metropolitan hospitals.

PART 1 : RESPONSES TO RECOMMENDATIONS 1, 2 and 3

All recommendations were supported or supported in principle.

All HSPs supported an increase in AMHW positions across inpatient and community mental health services but identified funding requirements as a barrier. Increasing AMHW availability to 24/7 to enable consumer support through the assessment and examination stages will also require a change of entitlements based on shift work and create further funding implications.

It is evident there is a lack of clarity regarding who is responsible for funding additional positions. This needs to be determined as a matter of urgency and be equitable and transparent across the state.

The MHC proposed a working group to obtain further information in order to understand the effectiveness of ALOs and AMHWs. They suggested that an independent consultant could carry out this research and identify best practice and training needs.

CAHS advised that a dedicated AMHW had been approved for Perth Children's Hospital mental health ward and was being recruited. They also noted that they provided AMHWs at five of the 10 community CAMHS clinics and an audit had shown that there were 2.1 times as many referrals of Aboriginal children and young people to clinics with AMHWs compared to those without. Their budget had been increased temporarily by the MHC for 12 months to enable an AMHW to be employed at all 10 community mental health services.

Wungen Kartup noted that the over-representation of Aboriginal people in the criminal justice system supported the forensic service being identified as a priority area and that in this regard there was an over-reliance by the NMHS on Wungen Kartup staff to provide for both the cultural and welfare requirements of admitted Aboriginal consumers.

EMHS advised that a review of the Wungen Kartup services (model of care and FTE) was underway.

NMHS provided a plan of action for reviewing service needs including exploring the option of Aboriginal peer support workers.

SJOG Midland advised it had extended the scope of the hospital's Aboriginal health team to ensure coverage on the mental health unit and emergency department to 7 days a week.

The DOH commented that the DOH Aboriginal Workforce policy aims to increase the representation of Aboriginal people at all levels of the workforce but implementing the recommendation will be contingent on developing selecting, recruiting and retaining appropriately skilled workforce in sufficient numbers and this may take time.

PART 2 - INVOLVEMENT OF A SIGNIFICANT MEMBER OF THE COMMUNITY, INCLUDING AN ELDER OR TRADITIONAL HEALER

The Act requires collaboration with significant members of an Aboriginal consumer's community, including elders and traditional healers, to the extent that it is appropriate and practicable to do so, in mental health assessment, examination and treatment. Aboriginal healers are primarily engaged to assist in providing cultural healing.

The Royal Australian and New Zealand College of Psychiatrists notes in its ethical guidelines that there is need for a broader understanding of mental health within Aboriginal and Torres Strait Islander communities that involves a holistic construct of social, emotional, cultural and spiritual wellbeing[25]. In particular, it states that it is important for psychiatrists and psychiatric trainees to:

- recognise that traditional healing practices of Aboriginal and Torres Strait Islander people may have much to offer in the treatment of mental health and social and emotional problems
- seek out and utilise Aboriginal and Torres Strait Islander expertise including traditional and contemporary practitioners.

Examples of collaboration

In response to the survey, examples were provided of positive outcomes from the use of traditional healers working in partnership with the treating team. In one case after listening to a family's concerns about cultural events that had impacted on a consumer's mental health and wellbeing, AMHWs and the clinical team in Broome asked questions about appropriate cultural interventions via teleconference. With the family's permission, a local cultural healer was invited to see the consumer. Involving the healer as part of the treatment plan complemented the hospital treatment, and had a positive impact on the consumer, their family, and the treatment outcome.

Positive results have also been reported from the involvement of traditional healers in mental health care in the Perth metropolitan area. Research was conducted by Jones, McGlade and Davison in collaboration with Curtin University, UWA and NMHS mental health, and focussed on how the use of traditional Aboriginal healers in conjunction with Western mental health care has assisted in the treatment of mental illness.[26]

The Health Consumers' Council of WA and some mental health services are exploring options for ways of improving access to traditional healers. For example, in South Australia, Aboriginal traditional healers, known as Ngangkari, are working in partnership with health professionals to treat patients in hospitals and healthcare facilities across the Northern Adelaide Local Health Network (NALHN) and other areas.[27] A formal agreement has been set up, and NALHN Director of Critical Care, Dr Simon Jenkins, said: "Doctors, nurses and allied health staff across NALHN can now refer patients for an appointment with a Ngangkari to support their recovery and help patients get better quicker" and "Ngangkari methods of healing have a profound effect on patients and complement mainstream treatment."

Traditional healing

Traditional healing practices may include, among others:

[25] RANZCP Ethical Guideline 11 – Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health, April 2014.
[26] Presentation to MHAS by Dr Hannah McGlade of Curtin University and Dr Jocelyn Jones of UWA, on 14 June 2019, on research findings and forthcoming publication on Aboriginal Traditional Healing in Mental Health Care in Western Australia.
[27] SA Health Media Release, Friday 22 February 2019, and https://www.antac.org.au/ngangkai-services/ngangkari-services.

- spiritual healing processes
- traditional medicine using native plants
- touch/massage therapies
- wildflower treatment
- cleansing and smoking ceremonies.

There has been some research on traditional Aboriginal medicines and interest in ways it can complement mainstream medicines.[28] [29]

Elders

Work is currently underway involving elders in the development and provision of mental health services to Aboriginal people. For example:

- the MHC's Elders in Residence program
- the innovative research project, '*Our Journey, Our Story: Building bridges to improve Aboriginal youth mental health and wellbeing*', led by Dr Michael Wright of Curtin University, in which Aboriginal Elders and young people will collaborate with youth mental health service providers on improving the mental health and wellbeing of Aboriginal youth.

The extent to which elders and significant community members have been involved in assessment, examination and treatment of mental health consumers, however, is not clear.

Survey findings

Mental health services were asked:

- how many Aboriginal people had a significant member of their community, including an elder or traditional healer (significant person) involved in their care in 2017/18
- whether this occurred during assessment , examination or treatment, and
- whether the significant person was paid for their involvement.

The findings were as follows:

- the majority of health services in both metropolitan and country areas reported that this data was not collected, or not available
- 3 hospitals reported that, in total, a significant person was involved in assessment 4 times, examination 3 times, and treatment 15 times.
- payment was made at 2 of the 3 hospitals reporting involvement of a significant person.

Where data was not collected or available:

- a number of mental health services indicated that they would contact Wungen Kartup if a traditional healer/significant person was required

[28] Vivienne Hansen and John Horsfall, "Noongar Bush Medicine: Medicinal Plants of the South-west of Western Australia", UWA publishing 2016.
[29] Locher, C, Semple, S J, & Simpson, B S, "Traditional Australian Aboriginal medicinal plants: An untapped resource for novel therapeutic compounds?" *Future Medicinal Chemistry*, 2013, *5*(7), 733-736.

- one community service reported that they had close ties and had worked in collaboration with an elder at Derbarl Yerrigan
- one hospital service reported that one of their AMHWs was an elder in the community.

ISSUES INVOLVING A SIGNIFICANT PERSON

Access

Barriers identified in collaborating with elders, traditional healers, and other significant community members in a consumer's care included:

- problems in identifying a suitable person
- the significant person requested was unavailable
- lack of access to a healer of the same gender
- delays in obtaining access
- geographic distance prevented involvement, particularly where a consumer had been transferred from a regional or remote area to a metropolitan hospital
- lack of knowledge regarding the role of traditional healers
- difficulties in determining a process for engaging traditional healers
- short timeframes, e.g. for assessment and examination to determine involuntary status, and for length of stay.

Payment

There did not appear to be a clear or uniform practice for the payment of traditional healers or elders/significant people involved in assessment, examination or treatment:

- one mental health service reported that a significant person could be paid for their time/involvement, however, this was negotiated between the service, the patient and family/carers
- a number of health services indicated that Wungen Kartup would organise the significant person and arrange for payment
- one regional mental health service reported that while they provide assistance and support to access traditional healers, payment was the responsibility of the consumer and family/carer.

Meaning of "significant members"

The Act does not define the term "significant members of a person's community", other than that it must include elders and traditional healers. Its meaning is clearly broader than a family member/ next of kin. Carers and close family members have the right to be involved in matters relating to treatment and care for all consumers, not just Aboriginal people. For Aboriginal people a much wider definition of family members is included in the Act, including any person regarded as equivalent under customary law, tradition or kinship[30].

[30] Mental Health Act 2014, s 281.

MHAS was provided with an updated copy of the Mental Health Assessment Form[31]. It now includes a question for Aboriginal consumers asking whether they were offered the involvement of a significant member of their community, and if so was the offer accepted.

Concerns include:

- there is no definition as to what is meant by a "significant member" on the form
- there is no way to identify whether a traditional healer was involved
- there may be misunderstanding of the meaning of significant member and over-counting if health services tick this box when a family member/carer is contacted, (as would be the case for all consumers).

PART 2 : RECOMMENDATIONS 4, 5 and 6

It is recommended that:

4. HSPs and Wungen Kartup to identify ways to improve access to traditional healers/elders, taking into account gender balance and more traditional healers to call on from different regions.
5. The MHC and Wungen Kartup to review and clarify the payment process for traditional healers/elders who are involved in collaboration with the mental health treating team in assessment, examination and/or treatment; and an appropriate budget be allocated.
6. The DOH and HSPs to review and improve data collection to enable reporting on involvement of AMHWs, and traditional healers, in addition to (or as an enhancement of), the data collection on significant members of a person's community.

PART 2 : RESPONSES TO RECOMMENDATIONS 4, 5 and 6

All recommendations were supported or supported in principle.

There was overwhelming support for the involvement of traditional healers and language interpreters but a lack of clear payment and engagement process and access to lists of appropriate and available traditional healers were stated as barriers to implementation.

Development of a state-wide policy framework with capacity for regional considerations was proposed. Wungen Kartup advised that it has commenced work on a framework for engaging traditional healers and there was support for Wungen Kartup leading this work in collaboration with HSPs and possibly with the help of a working group proposed by the MHC.

Wungen Kartup said it frequently utilises the services of traditional healers and will arrange to do for HSPs but do not involve healers in the assessment or examination stage as referred to in the Act. They confirmed that they pay the traditional healers but there is no consistency. Identifying a range of persons from different genders and Aboriginal kinship groups is necessary along with issues such as suitability for the consumer's needs and number of sessions.

Access to traditional healers/elders for Aboriginal consumers who are off country also need to be considered in the framework along with immediate access options in the moment that the traditional healer is required whether this be during office hours or after hours. Significant investment, support and leadership to ensure relevant consultation and to drive the change process across the state will be needed.

[31] SMHMR902.

The Chief Psychiatrist supported the collection of valid and verifiable data in enhancing the ability to oversee standards of care to Aboriginal and Torres Strait Islander people and all HSP's agreed that improved data collection and documentation would assist monitoring of Aboriginal consumers' rights under the Act.

It was suggested that a reportable key performance indicator or statewide policy would be needed to ensure the information is collected and reported in a systematic way.

The DOH:

- undertook to review data collection and reporting via the Mental Health Data Management Group. Recommendations arising from the review may require application and system changes
- said that significant work had been undertaken by the DOH and HSPs to review Statewide Standardised Clinical Documentation to include Aboriginal specific information including whether they had been offered the involvement of a significant member of their community.

PART 3 - POLICIES AND PROCEDURES

IDENTIFYING A PATIENT AS ABORIGINAL OR TORRES STRAIT ISLANDER

Collection of accurate data regarding Aboriginal consumers has been an important issue in health data collections throughout Australia. Historically there have been significant data quality issues with the collection of this data, resulting in unreliable measures of Aboriginal inpatient activity.[32] For example, CAMHS noted that obtaining accurate data about the services provided by community CAMHS to Aboriginal children and their families is challenging, as the identification of Aboriginal clients has been unreliable.[33]

The DOH requires that all mental HSPs use State-wide Standardised Clinical Documentation to document care provided by the clinical team.[34] This includes various forms such as the Mental Health Assessment Form,[35] which includes the requirement for information about whether a person is Aboriginal or Torres Strait Islander.

Survey findings

Mental health service providers were asked whether they had an existing policy or procedure for identifying a person as Aboriginal or Torres Strait Islander:

- All inpatient services reported that they collected data on Aboriginal status on referral, assessment and admission forms.
- Community mental health services reported that they collected data on referral, assessment and/or patient registration forms.
- 3 health services provided written policies/procedures for identifying a person as Aboriginal.
- 1 mental health service reported they used DOH guidelines.
- 1 mental health service reported they collected the information but did not have written policies/procedures.

Positive Examples

Positive examples included:

- Perth Children's Hospital provided a CAHS leaflet "Are you Aboriginal or Torres Strait Islander? Why we ask this question". It used Aboriginal artwork and photos, and included information about privacy and reasons for asking, including: *If there are culturally specific services available to Aboriginal and Torres Strait people, for example, an Aboriginal hospital liaison officer or Aboriginal health worker, these services may then be offered*. Also *your answers may also help to refer you to appropriate services when you are discharged*. While the hospital name details on the copy provided were out of date, this appears a positive approach.
- The Royal Perth Bentley Group *Nursing Practice Standard for Admission, Discharge and Transfer* notes Aboriginal identification is a shared responsibility, and the quiz at the end of the Standard includes questions about the process to be used and reasons it is important.

[32] Department of Health "Hospital Morbidity Data System" (HMDS) Reference Manual 2018-19 V1.1, p 85.
[33] CAMHS Aboriginal Mental Health Service Model of Care, p 7.
[34] WA Department of Health Operational Directive 0562/14.
[35] SMHMR902.

- Most health services had strategies included in their Aboriginal Health and Wellbeing Framework action Plans to address the under-identification of Aboriginal people. For example, NMHS and SMHS strategies included information sessions and resources for clinicians, and EMHS included a focus on policy, processes, resources and research.

Barriers

Barriers to obtaining reliable data included:

- questions about Aboriginal identity may not always be asked of all consumers
- confidentiality concerns by consumers
- mistrust of health services by Aboriginal consumers
- Aboriginal consumers may not want their family/community to be aware of psychiatric treatment
- stigma or shame associated with mental illness.

The presence of AMHWs, ALOs and other Aboriginal staff in hospitals can assist in providing a more culturally secure environment, making it more likely that cultural information will be provided and available to enhance services for consumers.

INVOLVING AND COLLABORATING WITH AN AMHW AND THE PATIENT AND/OR CARER/PERSONAL SUPPORT PERSON

Mental health service providers were asked whether they had a current policy or procedure for involving and collaborating with an AMHW and the patient and/or carer/personal support person in assessment, examination and treatment.

Survey findings

Health Services

- 2 HSP, (CAMHS and WACHS), had service-wide policies/procedures for collaboration with AMHWs
- 2 HSPs reported service-wide policies relating to providing culturally sensitive care, but there was no specific reference to involvement of an AMHW in assessment, examination and treatment for involuntary consumers[36]
- 1 HSP reported no policy or procedure.

Hospitals

In addition, some hospitals reported their own policies/procedures:

- 1 hospital (KEMH) provided detailed policies on collaboration
- 1 hospital (Graylands) referred to documents regarding working with Wungen Kartup

Several hospitals with no written policies, reported that ALOs made direct contact with consumers listed as Aboriginal, or made contact if they received a referral. Some others with no written policy/procedure reported that they referred to Wungen Kartup if required.

[36] Pertaining to sections 50, 81 and 189 of the Mental Health Act 2014.

Positive examples

Positive examples of policies included:

Assessment and Examination

- It is mandatory to offer the services of an AMHW to all Aboriginal consumers under WACHS policy guidelines.[37] Where possible this is to be a gender appropriate service. The Clinician/Case Manager must consult with the AMHW to ensure culturally informed practice throughout each episode of care, including: assessment, diagnosis, management planning and reviews, discharge planning, transfer of care and post discharge follow up.
- A "Cultural Information Gathering Tool" has been developed by WACHS Mental Health for Aboriginal consumers. It is used is to acknowledge and provide information that will inform culturally appropriate assessment and management planning.
- AMHWs are to be the first point of contact for Aboriginal children and their families referred to CAMHS, under their Aboriginal Health Service Model of Care.
- All assessment instruments or inventories used with Aboriginal children should be culturally appropriate, and where feasible culturally validated, under CAMHS Clinical Assessment Guidelines.[38]
- Good practice questions for clinicians in assessing and treating Aboriginal people at KEMH mental health services include: whether the presentation, assessment and treatment has been considered in the context of the person's culture; and how has the clinician engaged the Aboriginal community or workers in providing advice, support or gaining a second opinion.[39]

Treatment

- Case managers are expected to actively seek the advice and support of the AMHWs in developing the treatment, support and discharge plan (TSDP) for Aboriginal young people, at YouthLink and Youth Reach South.[40]
- "My Wellness Plan", is a care plan designed for Aboriginal people with consumer and carer involvement, used by AMHWs and clinicians in the Kimberley. It uses Aboriginal artwork, pictures and simple consumer focussed language.
- Where possible Kimberley Mental Health clinicians are to be accompanied by an AMHW when visiting a remote area.[41]

[37] WACHS Mental Health – Aboriginal Consultation Guideline, June 2019.
[38] CAMHS, Clinical Assessment Policy, October 2018.
[39] KEMH, Aboriginal Cultural Awareness – Mental Health, Clinical Practice Guideline, August 2016.
[40] YouthLink and Youth Reach South, Youth Mental Health Model of Care, 2016.
[41] WACHS Kimberley, Shared Care of Mental Health Clients in Regional Area Settings Procedure, 2016.

INVOLVING AND COLLABORATING WITH SIGNIFICANT MEMBERS OF A CONSUMER'S COMMUNITY, INCLUDING ELDERS AND TRADITIONAL HEALERS

Mental health service providers were asked whether they had a current policy or procedure for:

- asking an Aboriginal consumer if they want a significant person from their community, including an elder or traditional healer involved
- identifying the significant person; and
- involving and collaborating with the significant person in assessment, examination and treatment.

Survey findings

Health Services

- 2 health services, (WACHS and CAMHS), had service-wide policies/procedures which included identification and collaboration with a significant person, including elders and traditional healers
- 3 health services did not have service-wide policies/procedures which specifically referred to involvement of significant community members including elders and traditional healers, in assessment, examination and treatment[42]
- these 3 health services reported policies/procedures regarding:
    - the collection and recording of next of kin/personal support person/carer information on assessment/admission for all involuntary consumers
    - the rights of carers and close family members to receive information and be involved in support, options for treatment and care, and preparation and review of the TSDP.

Hospitals

In addition, some hospitals reported their own policies/procedures:

- 1 hospital (KEMH) provided clinical practice guidelines covering collaboration with significant members of a consumer's community, such as important family members, traditional healers or elders identified by the consumer/family
- 1 hospital (Graylands) referred to documents regarding working with Wungen Kartup.

Positive examples

Positive examples of policies included:

Assessment and Examination

- Where the consumer has consented, a carer, close family member or other personal support person, interpreters and traditional healers are used in the assessment and treatment process, under WACHS remote area guidelines.[43]

[42] Pertaining to sections 50, 81 and 189 of the Mental Health Act 2014.
[43] Shared Care of Mental Health Clients in Remote Settings Procedure – Kimberley.

- Admission guidelines for the KEMH Mother and Baby Unit have a section on considering the views of the consumer's family, and to the extent it is practicable and appropriate, AMHWs (including the KEMH ALO, Wungen Kartup and WACHS specialist workers as required) and significant members of their community, including elders and traditional healers.[44]
- WACHS Cultural Information Gathering Tool asks on the form whether a traditional healer is involved/ requested.

Treatment

- The role of the AMHW includes: "Assisting consumers and carers in identifying appropriate cultural supports; i.e. engaging elders, traditional healers and/or interpreters", under WACHS guidelines.[45]
- In cases where the child and family or significant others are not involved in the collaborative development of a management plan, reasons for this must be documented in the child's medical record. Attempts to continue to engage collaboratively must be ongoing and recorded, under CAMHS Clinical Assessment Policy.[46]
- Mental health staff are to work collaboratively and in partnership with Aboriginal people with mental illness and must recognise the value of traditional healing practices in the treatment of mental health, under KEMH Clinical Practice Guidelines.[47]

ISSUES WITH POLICIES AND PROCEDURES

- 3 out of 4 metropolitan health services had no written policies/procedures on collaboration with AMHWs and significant members of an Aboriginal consumer's community, including elders and traditional healers in the assessment, examination and treatment of Aboriginal people.
- It appears that there is no procedure in many authorised hospitals to guide clinical teams on the process for collaboration in assessment, examination and treatment required under the Act.
- There is no information or checklist on any of the Chief Psychiatrist's forms relating to assessment or examination (E.g. Forms 1A, 3C, 5A, 5B, 6A, 6B, 6C, 6D), which state the rights and requirements for Aboriginal consumers under the Act.

The lack of policy guidelines and requirements, as well as consumer feedback to MHAS, suggests that Aboriginal people are not consistently being offered their rights, and it appears that the Act is not being complied with in many cases.

PART 3 : RECOMMENDATIONS 7, 8, 9, 10, and 11

It is recommended that:

7. HSPs to develop policies and procedures/guidelines, where these do not exist, for asking Aboriginal consumers if they would like an AMHW involved in their mental health assessment, examination and treatment; and the process for involving the AMHW.

[44] KEMH, Clinical Practice Guideline, Admission to the Mother Baby Unit, 2017.
[45] WACHS Mental Health - Aboriginal Mental Health Consultation Guideline, 2019.
[46] CAMHS, Clinical Assessment Policy, October 2018.
[47] KEMH, Clinical Practice Guideline, Aboriginal Cultural Awareness – Mental Health, 2016.

8. HSPs to develop policies and procedures/guidelines, where these do not exist, for asking Aboriginal consumers if they would like significant members of their community, including elders and traditional healers, involved in their assessment, examination and treatment; and the process for involvement. This should include consideration of the meaning of *"significant members of the person's community",* as this right is in addition to the right to the involvement of family members and carers under the Act.
9. The Chief Psychiatrist to amend all forms relating to assessment and examination (e.g. Forms 1A, 3C, 5A, 5B, 6A, 6B, 6C, 6D), so that Aboriginal consumers rights to have an AMHW, elder, traditional healer and other significant community member involved or present, are prominently stated upfront and in the notes and checklists.
10. HSPs to consider a process for documenting reasons in the consumer's medical record, if it was not considered appropriate or practicable to involve an AMHW, and significant members of the consumer's community in assessment and examination for determining involuntary status, or in treatment.
11. The DOH and HSPs consider the development/use of a Treatment Support and Discharge Plan template for Aboriginal consumers, focusing on relevant cultural information, rights for involvement/collaboration in treatment, and appropriate design in consultation with Aboriginal people.

PART 3: RESPONSES TO RECOMMENDATIONS 7, 8, 9, 10, and 11

All recommendations were supported or supported in principle.

Increased staff training on the Act, along with culturally appropriate skills and communications, were identified as required to promote compliance with Aboriginal consumer rights and facilitate appropriate documentation in the medical records.

The Chief Psychiatrist advised that he intends to ask the MHC to review the Mental Health Act forms as part of the 5-year review of the Act due to begin later this year and would take into account the report recommendations to include Aboriginal consumer rights on all relevant forms. Specifically he was supportive of the recommendation to consider the meaning of 'significant persons'.

There was differing opinion about a treatment support and discharge plan template across the HSPs and DOH. Whilst all supported the recommendation, the development of a specific template that suits the needs of all regions is going to be problematic and difficult to develop. It will require considerable consultation and co-design.

WACHS advised that it has a 'wellness plan' developed and designed by Aboriginal consumers.

Wungen Kartup said it had been utilising the Stay Strong App developed by the Menzies School of Health Research and is hoping to have the Stay Strong Plan document in PSOLIS which can be used as a collaborative tool to be incorporated in a treatment, support and discharge plan.

PART 4 - TRAINING & RESOURCES

Staff training and resources are key components for promoting care that is appropriate to and consistent with cultural and spiritual beliefs and practices, and Aboriginal consumers' rights under the Act.

Aboriginal Cultural eLearning – *a healthier future* (ACeL), is an online training module of approximately 1.5 hours duration that is mandatory for all WA Health staff to complete within six months of commencement.[48]

Survey findings

Mental health service providers were asked – what percentage of staff:

- had completed the AceL, as at 1 May 2019
- had completed the AceL within 6 months of their commencement date, as at 1 May 2019.

Overall Completion

- On average it was reported that around 93% of staff had completed the AceL training module.[49]
- There was some variation between and within health services and hospitals completion rates.
- Joondalup Health Campus reported that Ramsay Health Care had created a Cultural Diversity eLearning module the equivalent of AceL, which was compulsory for all staff to complete by 1 November 2019.
- SJOG Midland reported that they had no eLearning module, and that local cultural training and support was provided by the Aboriginal Health Team and 1 day Aboriginal Cultural Awareness formation training.

Completion within 6 Months

- Most mental health services surveyed reported that this data could not be accessed or retrieved.
- All mental health services reported that completion within 6 months was a mandatory training requirement for staff.

RESOURCES FOR ABORIGINAL CONSUMERS

In general, there did not appear to be any leaflets, posters, or resource materials for Aboriginal consumers specifically focussing on their rights under the Act.

Other training and resources

In their responses, some mental health services referred to Aboriginal cultural training, workshops and other resources, for example:

[48] WA Department of Health, OD 0599/15 Aboriginal Cultural eLearning – A Healthier Future.
[49] This figure is an average of percentages reported across mental health services.

- Rockingham Hospital and community mental health services in the Rockingham/Peel area reported that the service had commenced a program of full day cultural training in partnership with Dumbartung Aboriginal Corporation.
- Wungen Kartup (Metropolitan) provides 1 day Aboriginal Mental Health Training each month.
- YouthLink offered workshops on a variety of youth mental health issues, including working with Aboriginal young people.
- Providing, or contributing to, cultural training for HSP staff is part of the role of some AMHWs and ALOs.
- Some health services included strategies for Aboriginal cultural training for staff in their Aboriginal Health and Wellbeing Framework Action Plans.

PART 4 : RECOMMENDATIONS 12, 13, 14 and 15

It is recommended that:

12. The MHC in conjunction with the DOH, produce resource materials (eg brochures, posters) for Aboriginal consumers on their rights under the Act, incorporating Aboriginal art work and appropriate language, co-designed with Aboriginal people.
13. HSPs to include in-patient information packs for Aboriginal consumers, information about their rights, including the right to have an AMHW and significant members of their community, including elders and traditional healers, involved in their assessment, examination and treatment.
14. HSPs and Wungen Kartup to develop/arrange for training of treating teams on the role of Aboriginal traditional healers and ways of involving them in mental health care.
15. HSPs to provide training for treating teams on the local process for involving AMHW/ALO and significant community members including elders and traditional healers in assessment, examination and treatment, and on culturally appropriate practices in care.

PART 4 : RESPONSES TO RECOMMENDATIONS 12, 13, 14 and 15

All recommendations were supported or supported in principle.

The MHC confirmed it is intending to progress recommendation 12. The DOH reported that its Communications Unit already produces resource material with a distinctive Aboriginal design and is currently liaising with the MHC to develop brochures, posters and other resource materials that outline the rights of Aboriginal consumers under the Act.

The need for appropriate training and education was a common theme throughout the feedback on the report recommendations. This included training to ensure Aboriginal consumer rights were understood by clinicians and treating teams. Training in the appropriate use of traditional healers and elders and protocols of when and how to use them including considering gender and kinship groups was raised. Wungen Kartup stated they would be appropriate to develop this type of training. WACHS proposed that their Mental Health Aboriginal Advisory group and regional Aboriginal Health Consultants and traditional healers be involved.

In relation to in-patient packs it was noted that consideration needed to be given to Aboriginal consumers with literacy issues and some preferences for face to face communication.

Appendix 1: Aboriginal mental health inpatients seen at authorised hospitals 2017/18 – as reported to MHAS June 2019[50] [51]

Health Service	Total Aboriginal	Total Voluntary	Total Involuntary
CAHS	**32**	**28**	**<5**
Perth Children's Hospital	32	28	<5
EMHS	**306**	**140**	**173**
Armadale Health Service	58	42	20
Bentley Health Service	91	60	34
St John of God Hospital, Midland	157	38	119
NMHS	**212**	**115**	**100**
Frankland Centre	55	15	43
Graylands Hospital	80	41	39
Joondalup Health Campus	17	10	7
Sir Charles Gairdner Hospital	60	49	11
SMHS	**128**	**88**	**42**
Fiona Stanley Hospital	66	45	23
Fremantle Hospital & Health Service	35	22	13
Rockingham General Hospital	27	21	6
WACHS[52]	**265**		
Albany Health Campus	59		
Broome Health Campus	98		
Bunbury Regional Hospital	37		
Kalgoorlie Health Campus	71		
Total	**943**		

[50] Hospitals in this table reported that they provided services to Aboriginal involuntary patients in 2017/18. Figures were provided in response to the question "*What was the total number of people who were identified as Aboriginal or Torres Strait Islander and who separated from a mental health ward or community mental health service (CMHS) in 2017-18 in each of the following categories: Total number of Aboriginal or Torres Strait Islander patients, Voluntary people (only ever voluntary during their admission), Involuntary people (at any time during their admission), Male, Female, Other (gender), Aged under 18 years, Aged 18 to 24 years, Aged 25 to 64 years, Aged over 65 years. NOTE: MHAS understands that people will have been both a patient in hospital and with a CMHS during the period and would therefore be counted multiple times. Please include people who spent time in a mental health ward or CMHS (and have separated).*

[51] Figures may not be comparable between health services and rely on self-identification and HSP recording of the data; they do not include people who were receiving treatment in 2017/18 and were not discharged from the service during that time period.

[52] Total Aboriginal consumer numbers were provided by WACHS for inpatient mental health units for each region. It was reported that the overall proportion of involuntary patients, including those on community treatment orders was 26%.

Appendix 2 - Aboriginal Mental Health Workers and Aboriginal Liaison Officers in Authorised Hospitals – as reported to MHAS in June 2019[53] [54]

HSP/Hospital	Number Aboriginal Mental Health Workers/Liaison Officers (FTE)	Aboriginal Mental Health Worker/Liaison Officer Title	Hours/ week spent on mental health ward	Wards/hospitals and community based services covered
CAHS				
Perth Children's Hospital	2	Senior Aboriginal Liaison Officer, Aboriginal Liaison Officer	Approx 2 hours a week with CAMHS IPU Ward 5A patients / families	Ward 5A, PCH wide (Emergency Department, inpatient units and outpatient clinics), Community CAMHS, CAHS Community Health sites.
EMHS				
Armadale Health Service	2	Aboriginal Health Liaison Officer	3-4 hours	All AHS inpatients, including mental health
Bentley Health Service*	1	Aboriginal Health Liaison Officer	Data not available	*ALO based at RPH, and shared across BHS and Bentley CMHS
St John of God Hospital, Midland	3.9	Aboriginal Health Coordinator, and Aboriginal Engagement & Cultural Advisors x 2.9	Average 10 hours	SJOG Midland Public & Private Hospital wards: - Mental Health wards (adult, secure and older adult), Emergency Dept, General Medical, Aged Care and Rehab wards Maternity, and Surgical wards

[53] Includes Aboriginal Mental Health Workers, Aboriginal Liaison Officers and similar positions in, or covering, mental health services in authorised hospitals, which are designated positions and filled by an Aboriginal or Torres Strait Islander person.
[54] Reported to MHAS in response to the survey questions:
Current number of Aboriginal mental health workers (by FTE) - includes Aboriginal Liaison Officers or similar positions which are designated positions occupied by an Aboriginal or Torres Strait Islander person; Job title and description for each position; Wards/hospitals and community based services serviced by the Aboriginal mental health worker(s) (including non-mental health wards or services); Average or total hours per week spent on mental health ward with mental health consumers.

HSP/Hospital	Number Aboriginal Mental Health Workers/Liaison Officers (FTE)	Aboriginal Mental Health Worker/Liaison Officer Title	Hours/ week spent on mental health ward	Wards/hospitals and community based services covered
NMHS				
Frankland Centre	0			Refer to Wungen Kartup SAMHS
Graylands Hospital	0			Refer to Wungen Kartup SAMHS
Joondalup Health Campus	3	Aboriginal Liaison Officer	When referral received	Covers JHC, including the Mental Health Unit
Sir Charles Gairdner Hospital	0			Refer to Wungen Kartup SAMHS
SMHS				
Fiona Stanley Hospital	0.4	Aboriginal Hospital Liaison Officer	Approx 14 hours but as required	Specific worker for mental health units, Adult Assessment, Mother and Baby and Youth Unit.
Fremantle Hospital & Health Service	1	Aboriginal Liaison Officer (Mental Health)	0.5 time	Specific worker for mental health inpatient and CMHS
Rockingham General Hospital	2	Aboriginal Mental Health Liaison Officer (Male) Aboriginal Mental Health Liaison Officer (Female)	5-6 hours per day across the service, go to ward as required	Both ALOs cover mental health Inpatients and Community in Rockingham and Peel

HSP/Hospital	Number Aboriginal Mental Health Workers/Liaison Officers (FTE)	Aboriginal Mental Health Worker/Liaison Officer Title	Hours/ week spent on mental health ward	Wards/hospitals and community based services covered
WACHS[55]				
Albany Health Campus*	0			*Inpatient and CMHS covered by Great Southern Mental Health Services Albany (2) positions - Aboriginal Mental Health Coordinator, and Aboriginal Mental Health Worker
Broome Health Campus	11	Aboriginal Mental Health Coordinators x 2, Senior Aboriginal Mental Health Worker, Aboriginal Mental Health Workers x 3, Aboriginal Mental Health Liaison Officers x 6	Mental health specific service	Covers mental health inpatient, and outreach across the region
Bunbury Regional Health Campus*	0			*Inpatient and CMHS covered by Bunbury Mental Health Service (4) positions - Aboriginal Mental Health Coordinator, Senior Aboriginal Mental Health Worker and Aboriginal Mental Health Workers x 2
Kalgoorlie Health Campus	4	Aboriginal Mental Health Coordinator, Senior Aboriginal Mental Health Worker, and Aboriginal Mental Health Workers x 2	Mental health specific service	Covers mental health inpatient and outreach across the region

[55] Data for WACHS shows number of positions.

Appendix 3 - List of Aboriginal Mental Health Workers and Aboriginal Liaison Officers – as reported to MHAS in June 2019[56]

CHILD AND ADOLESCENT HEALTH SERVICE

Armadale CAMHS, Tel 9391 2455

Aboriginal Mental Health Worker

- covers Armadale CAMHS and Perth Children's Hospital Ward 5A as required

Bentley Family Clinic CAMHS, Tel 9416 3900

Aboriginal Mental Health Worker

- covers Bentley Family Clinic and Perth Children's Hospital Ward 5A as required

Clarkson CAMHS, Tel 9304 6200

Aboriginal Senior Social Worker

- covers Clarkson CAMHS and Perth Children's Hospital Ward 5A as required

Peel CAMHS, Tel 6559 5100

Aboriginal Mental Health Worker x 0.8

- covers Peel CAMHS and Perth Children's Hospital Ward 5A as required

Perth Children's Hospital, Tel 6456 2222

Senior Aboriginal Liaison Officer and Aboriginal Liaison Officer

- covers Perth Children's Hospital inc Ward 5A, community CAMHS, CAHS community health sites

Rockingham CAMHS, Tel 6559 5100

Aboriginal Mental Health Worker

- covers Rockingham CAMHS and Perth Children's Hospital Ward 5A as required

Shenton CAMHS, Tel 9381 7055

Aboriginal Senior Social Worker x 0.8

- covers Shenton CAMHS, Fremantle CAMHS and Perth Children's Hospital Ward 5A as required

Swan CAMHS, Tel 9250 5777

Aboriginal Mental Health Worker

- covers Swan CAMHS and Perth Children's Hospital Ward 5A as required

Warwick CAMHS, Tel 9448 5544

Aboriginal Mental Health Worker

- covers Warwick CAMHS and Perth Children's Hospital Ward 5A as required

[56] Includes AMHWs, ALOs and similar positions in, or covering, mental health services in authorised hospitals and community mental health centres, which are designated positions and filled by an Aboriginal or Torres Strait Islander person.

headspace

headspace Osborne Park, Tel 9208 9555

Youth Access Worker x 0.4

- covers headspace Osborne Park

headspace Pilbara, Tel 1800 290 626

Youth Engagement Trainee x 0.8

- covers headspace Pilbara

EAST METROPOLITAN HEALTH SERVICE

Armadale Health Service, Tel 9391 2609

Aboriginal Health Liaison Officers x 2

- covers the Armadale Kelmscott Group Health Service

Royal Perth Hospital, Tel 9224 2711

Aboriginal Health Liaison Officer

- covers the Bentley and Royal Perth Group health service sites, including mental health

SJOG Hospital, Midland, Tel 9462 4098

Aboriginal Health Coordinator x 1, and Aboriginal Engagement and Cultural Advisors x 2.9

- covers SJOG Midland Public and Private Hospital wards, including mental health

NORTH METROPOLITAN HEALTH SERVICE

Joondalup Health Campus, Tel 9400 9485

Aboriginal Liaison Officers x 3

- covers JHC, including the Mental Health Unit

King Edward Memorial Hospital, Tel 6458 2777

Aboriginal Liaison Officer

- covers KEMH wards and clinics, including Psychological Medicine and Childbirth Mental Illness Antenatal clinic

Stirling CMHS, Tel 9344 5400

Aboriginal Mental Health Worker

- covers Osborne CMHS and Mirrabooka CMHS, and in-reach to inpatients

Youthlink, Tel 9227 4300

Aboriginal Mental Health Professional and Senior Aboriginal Mental Health Professional

- covers Youthlink, and in-reach to inpatient and community mental health services north of the river

Youth Reach South, Tel 9499 4274

Aboriginal Mental Health Professional

- covers Youth Reach South, and in-reach to inpatient and community mental health services south of the river

SOUTH METROPOLITAN HEALTH SERVICE

Fiona Stanley Hospital, Tel 6152 5527

Aboriginal Hospital Liaison Officer x 0.4 (part of Aboriginal Health Liaison Unit at FSH)

- covers Mental Health units, Adult Assessment, Mother and Baby and Youth Unit at FSH

Fremantle Mental Health Service – Alma Street, Tel 9431 3333, Mob 0404 890 187

Aboriginal Liaison Officer (specific to mental health)

- covers mental health services at Alma Street, Fremantle CMHS, and Fremantle Older Adult CMHS

Peel Health Campus, Tel 9531 8080

Aboriginal Mental Health Liaison Officer

- covers inpatient and community services in Peel, assists in Rockingham/Kwinana as required

Rockingham Kwinana Mental Health Service, Tel 9528 0600

Aboriginal Mental Health Liaison Officer

- covers inpatient and community services in Rockingham, assists in Peel as required

SPECIALIST SERVICES

Wungen Kartup Specialist Aboriginal Mental Health Service (Metropolitan) Tel 9235 2400

- supports Aboriginal consumers and carers in accessing mainstream mental health services, as well as providing statewide consultation and liaison with service providers and advocacy for Aboriginal consumers; services include brokering of elders, and traditional healers; Aboriginal Mental Health Workers can assist Aboriginal consumers in metropolitan authorised hospitals and community mental health services through referral by service providers, or self-referral by consumers/family

WA COUNTRY HEALTH SERVICE

GOLDFIELDS

Esperance Community Mental Health Service, Tel 9071 0444

Aboriginal Mental Health Worker

- covers Esperance and outreach across the region

Kalgoorlie Health Campus, Tel 9088 6200

Aboriginal Mental Health Coordinator, Senior Aboriginal Mental Health Worker, and Aboriginal Mental Health Workers x 2

- covers inpatient and community mental health and outreach across the region

GREAT SOUTHERN

Great Southern Mental Health Services - Albany, Tel 9892 2440

Aboriginal Mental Health Co-ordinator, and Senior Aboriginal Mental Health Worker

- covers Albany inpatient and community mental health, and outreach across the region

Great Southern Mental Health Services - Katanning, Tel 9821 6341

Aboriginal Mental Health Worker

- covers Katanning and outreach across the region

KIMBERLEY

Broome Hospital, Mabu Liyan Mental Health Unit, Tel 9194 2640

Aboriginal Mental Health Coordinators x 2, Senior Aboriginal Mental Health Worker, Aboriginal Mental Health Workers x 3, Aboriginal Mental Health Liaison Officers x 6

- covers Broome and outreach across the region

Kimberley Mental Health and Drug Service – Derby, Tel 9193 3605

Senior Aboriginal Mental Health Worker and Aboriginal Mental Health Worker

- covers Derby and outreach across the region

Kimberley Mental Health and Drug Service – Fitzroy Crossing, Tel 9194 2867

Aboriginal Mental Health Worker

- covers Fitzroy Crossing and outreach across the region

Kimberley Mental Health and Drug Service – Halls Creek, Tel 9166 4688

Aboriginal Mental Health Worker

- covers Halls Creek and outreach across the region

Kimberley Mental Health and Drug Service – Kununurra, Tel 9166 4350

Aboriginal Mental Health Worker

- covers Kununurra and outreach across the region

MIDWEST

Meekatharra Mental Health Service, Tel 9981 0625

Aboriginal Mental Health Workers x 2

- covers Meekatharra and outreach across the region

Midwest Mental Health and CADS – Carnarvon, Tel 9941 6600

Senior Aboriginal Mental Health Worker and Aboriginal Mental Health Worker

- covers Carnarvon and outreach across the region

Midwest Mental Health and CADS – Geraldton, Tel 9956 1999

Aboriginal Mental Health Co-ordinator, and Aboriginal Mental Health Workers x 3

- covers Geraldton and outreach across the region

PILBARA

Pilbara Mental Health and Drug Service – Karratha, Tel 91447800

Senior Aboriginal Mental Health Worker and Aboriginal Mental Health Worker

- covers Karratha and outreach across the region

Pilbara Mental Health and Drug Service – South Hedland, Tel 9174 1240

Aboriginal Mental Health Coordinator, Senior Aboriginal Mental Health Worker and Aboriginal Mental Health Workers x 2

- covers Port Hedland and outreach across the region

SOUTH WEST

Bunbury Community Mental Health Service, Tel 9722 1300

Aboriginal Mental Health Coordinator, Senior Aboriginal Mental Health Worker, and Aboriginal Mental Health Workers x 2

- covers Bunbury inpatient and community mental health, and outreach across the region

Busselton Community Mental Health Service, Tel 9753 6400

Aboriginal Mental Health Worker

- covers Busselton and outreach across the region

WHEATBELT

Wheatbelt Mental Health Service - Merredin, Tel 9081 3222

Aboriginal Mental Health Worker

- covers Merredin and outreach across the region

Wheatbelt Mental Health Service - Northam, Tel 9621 0999

Aboriginal Mental Health Coordinator, Senior Aboriginal Mental Health Workers x 2, and Aboriginal Mental health Workers x 2

- covers Northam and outreach across the region