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Department of Health
Office of the Chief Psychiatrist

INFORM

NEWSLETTER OF THE CHIEF PSYCHIATRIST

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Contents

Communication, Change and Challenges

Dr Nathan Gibson, Chief Psychiatrist

With much thanks and gratitude to the staff of the Office of the Chief Psychiatrist do I begin this belated edition of INFORM. This dedicated team has pulled together to play a significant role in Mental Health Act 2014 (MHA 2014, the "Act") implementation, as well as beginning the transition of the Chief Psychiatrist to become a separate statutory entity. All this has been done while maintaining business as usual. It has not been an easy time, and this work has been undertaken with minimal additional resources.

We welcome Stephanie Fehr to the Office of the Chief Psychiatrist. She has formally commenced as the Mandatory Reporting Officer. Also, Rosalind Bell, who has taken up the challenging role of Transition Officer. We acknowledge Colleen O'Leary for her fine work acting in the OCP Manager role in recent months.

We look forward to 30 November 2015 with the commencement of MHA 2014. The new Act brings increased and welcomed focus on individual and carer rights; ushers in a new era in WA of capacity-based legislation; and increases the accountability requirements for clinicians. We have to be realistic: the latter does create an increased administrative impact for clinical staff. There is a focus on a rigorous ICT structure to support clinicians and minimise the administrative burden in order to ensure they can spend appropriate therapeutic time with consumers, their families and carers.

The community expectations on clinicians are high. While the WA community, and I, have a reasonable expectation that statutes are followed, there are potential risks if an excessively disproportionate focus on compliance issues is taken, overshadowing the primacy of therapeutic relationships among clinicians, consumers and carers. It is inevitable that a new, significantly more detailed Act will face a period of post-commencement adjustment for clinicians, consumers and families, regardless of the extensive preparation that has and continues to be rolled out before 30 November.

It is important to understand the MHA 2014 in its role to amplify safety and quality. MHA 2014 must be respected as law, but will be more

successful if considered by all as a statute enhancing rights and clinical care, an opportunity for enriched dialogue and a vehicle to increase shared decision making. Mental health legislation is not intended, nor should it ever be expected to over-regulate the necessary nuances of frequently complex, often ambiguous and always individual clinical situations.

The Clinicians' Practice Guide (CPG), 1st Edition, is now live and can be accessed by the community from the Chief Psychiatrist's website. It is anticipated that there will be regular updating of the CPG as the practicalities of translating the Act become clear with experience. The CPG includes the Chief Psychiatrist's Standards and Guidelines.

I am aware that clinical staff and the community are eager to know about MHA 2014. In addition to the CPG, the clinicians' education package includes an e-learning package, face-to-face training and brief "just-in-time" information (the latter for clinicians who may not require to consider the Act regularly, but who still need timely information). There will be a roll-out of training across the State in the three months leading up to 30 November 2015. This training will be developed for a range of service providers. I am very grateful to the clinicians (and the services that have agreed) who've provided their time to hone the clinicians' education package. The Mental Health Commission is developing a range of resources, both online and direct, for consumers, carers, community-managed organisations and the general community.

The recent Capacity Workshop run by Dr Chris Ryan from Westmead Hospital, initiated by Dr Helen McGowan and sponsored by NMHS MH and the Chief Psychiatrist, was attended by more than 80 senior clinicians and other stakeholders. It was a lively and useful discussion, highlighting a paradigm shift for WA.

As part of MHA 2014, the Chief Psychiatrist will become a separate statutory entity on 30 November 2015. The Office of the Chief Psychiatrist will physically re-locate to 1 Nash St, Perth, in March 2016. While becoming an independent entity, the Chief Psychiatrist and the associated Office will continue to proactively engage with consumers, carers, clinicians and key agencies.

Another exciting development is the Mental Health Network, which is establishing itself as a relevant body, growing cohesion and engagement opportunities across the sector. I am looking forward to the establishment of the Clinician's Reference Group.

Again, my thanks to everyone who has been a part of this process of change. I'm not really sure we can call this time business as usual.

Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across Western Australia (WA). This includes monitoring of serious incidents and deaths of mental health patients. Under the new *Mental Health Act 2014* the Chief Psychiatrist must also provide an annual report to the Minister for Mental Health, including information on all reported notifiable incidents.

Until 2015, serious incidents and deaths were reported to the Office of the Chief Psychiatrist (OCP) through completion of an OCP incident form. These incidents, if clinical in nature, have, since February 2014, been reported by mental health staff through the online clinical incident management system Datix CIMS. The monitoring team at the OCP identified the need for a more efficient and consistent reporting process that enhanced compliance with reporting. A pilot study conducted in July 2014 compared the number of serious clinical incidents and deaths of mental health patients reported through Datix CIMS and the number reported directly to the OCP. The study found three times the number of serious clinical incidents and deaths reported through Datix CIMS than were reported directly to the OCP.

On 16 February 2015, reporting to the OCP changed to directly using Datix CIMS for all serious clinical incidents and unexpected deaths (e.g. suicide, unnatural, and violent deaths) of mental health patients. All serious non-clinical incidents will continue to be reported through the incident form located on the OCP website. Non-clinical incidents include: incidents related to staff misconduct; criminal activity; breach of the MHA; the expected or natural death of a mental health patient not

related to a clinical incident and the unexpected death of a mental health patient within three months of their discharge. The operational directive, policy, and links to reporting forms can be found on the OCP website: http://dev.intranet.health.wa.gov.au/OCP/reporting/incidents.cfm

The OCP monitoring team is continuing to evaluate the effect of reporting notifiable clinical incidents through Datix CIMS. During January there were 25 notifiable incidents reported directly to the Chief Psychiatrist via the OCP reporting forms. In comparison, within the first four weeks since transitioning to Datix CIMS on 16 February there were 268 notifiable incidents reported to the OCP. This indicates a ten-fold increase in reported notifiable incidents since transitioning to Datix CIMS.

The monitoring team is currently comparing the number of clinical incidents reported through Datix CIMS between July 1 2014 and 15 February 2015 and those that were reported through the OCP incident forms. This will allow us to determine trends in the reporting of notifiable incidents over time and the extent to which reporting through Datix CIMS has improved ascertainment.

Obtaining reports of serious clinical incidents and deaths of mental health patients through Datix CIMS has resulted in better ascertainment of notifications. This will provide more accurate data for the Chief Psychiatrist and enhance monitoring and evaluation of trends and risk factors.

Chief Psychiatrist's Targeted Review of Mental Health Presentations to Emergency Departments

The *Mental Health Act 1996* (MHA) prescribes the Chief Psychiatrist with the responsibility of monitoring the standards of psychiatric care provided throughout the State of Western Australia, with particular focus on the medical care and welfare of involuntary patients.

The Chief Psychiatrist is currently conducting a Targeted Review of mental health presentations to Emergency Departments (ED). The specific areas we will be focusing on are the:

- ED pathway for mental health patients
- management of mental health patients
- management of Sentinel Events
- wait time for mental health patients.

An analysis of data collected in all Emergency Departments within Western Australia between September 2013 – February 2014 identified 23 Emergency Departments with a significant number of mental health presentations (over 20 per month), and these hospitals have been included as part of the review – 9 metropolitan and 14 rural hospitals.

Senior clinical reviewers have reviewed the content of clinical records from Emergency Departments within those hospitals as well as interviewing both mental health and non mental health staff working within the Emergency Departments.

The data collection phase of the review was completed in March 2015, and data analysis has commenced. Both individual service reports and an overarching statewide report will be made available in the second half of the year.

Seclusion and Restraint

In December 2014 the Chief Psychiatrist's Seclusion and Restraint Quarterly Report was published for the first time and made available to consumers, carers and the general public via the Office of the Chief Psychiatrist website.

The Western Australian Mental Health Act 1996 (s.119) and Mental Health Regulations 1997 (s.17) set out the requirements for authorised mental health services to maintain suitable records of authorised seclusions including seclusion register. The Chief Psychiatrist has responsibility under the Mental Health Act 1996, to monitor standards of psychiatric care across the State of Western Australia. As part of this responsibility the Office of the Chief Psychiatrist monitors reports on the use of seclusion and restraint practices in authorised mental health hospitals in WA.

WA is performing well in reducing the rate of seclusion when compared with other states and was 3.6 per 1000 bed days under the national average in 2012–2013. The rate of seclusion in WA

has decreased steadily between 2008 and 2013, decreasing by 67 per cent, and this decrease was maintained in 2013–14 with a statewide rate of 5.0 per 1,000 bed days.

Although there has been a slight increase in the rate of seclusion in subsequent 2014 – 2015 quarters, 1st Quarter, 6.15 per 1,000 bed days, and 2nd Quarter, 6.51 per 1,000 bed days, the increase may be the result of improved notification and reporting processes being implemented across mental health services. The Standards and Monitoring Team at the Office of the Chief Psychiatrist is monitoring the rates and is working with services to ensure the objective of reducing the rate of seclusion and restraint is maintained in WA. Current seclusion data can be viewed at WA Rates of Seclusion Data.

With the slight increase, mental health services in WA have made a concerted effort to introduce reflective practice to reduce the use of seclusion. This has resulted in improvements in the rate of seclusion, which is evident by 70 per cent of Western Australian mental health services achieving rates of seclusion that are below the state average and among the lowest in Australia.

Alternatives to seclusion have been implemented across WA mental health units. The environment of a mental health ward is confronting and can have an adverse effect on mental state. When patients are admitted to a mental health facility care is taken to make this as comfortable as possible for the patient, family and carers. Research indicates that training mental health staff in management of aggression and de-escalation techniques helps to reduce the need for seclusion and or restraint. For a list of the education, strategies and initiatives that services have implemented please visit Seclusion and Restraint Quarterly Report April 2014 to June 2014

It is important to note the rate of restraint was not published. At the time of reporting the Chief Psychiatrist decision to omit restraint data from the reports was based on the inconsistencies of reporting restraint within the mental health services. A more standardised approach is required across all authorised mental health units. The Standards and Monitoring Team are working with mental health services to resolve the problem and find a solution to improve reporting and eliminate the inconsistencies.

The Standards and Monitoring team looks forward to providing quarterly updates on the rates of seclusion and eventually the rates of restraint via the OCP website.

Fiona Stanley Hospital (FSH) Mental Health Unit was Authorised 23rd December 2014.

Fiona Stanley Hospital (FSH) Mental Health Unit has a total of 30 beds, providing specialist perinatal, youth and acute care services. There has been a phased opening of beds commencing on 3 February 2015 and 142 patients have been admitted to the unit from 3 Feb to 29 March 2015.

The Mental Health Assessment Unit (MHAU) provides a safe venue for the assessment, stabilisation, and short-term treatment of patients in the adult age range, for up to 72 hours. MHAU patients are either discharged or transferred to their catchment area inpatient services after this time.

The Mother and Baby Unit (MBU) will have eight beds when fully open. It provides planned admissions, primarily for patients living in the South Metropolitan region. The MBU provides MH services for mothers of new babies who have signs and symptoms of acute mental illness. The MBU model focuses on attachment between the mother and baby and supports admission of the baby as a boarder.

The Mental Health Youth Unit (YoU) has a total of 14 beds with a phased opening beginning on 8 April 2015. The MH YoU provides specialist mental health assessment, acute inpatient care, and short-term community management for young people aged 16 to 24 years living in the South Metropolitan region.

Additionally, the FSH Mental Health Service has a very active liaison team, which assesses and manages the mental health of patients in State Rehabilitation Service, medical and surgical wards within the Main Hospital and the Emergency Department and sees patients from all age spectrums 24 hours a day.

The mental health teams are familiarising themselves with new ICT technologies, roles and processes, and the mood and culture of the service is very positive. Staff are enjoying working in a dynamic, integrated, and multidisciplinary environment.

The Chief Psychiatrist's Standards and Guidelines Working Group

The Chief Psychiatrist's Standards and Guidelines Working Group (the Working Group) was established to develop the Chief Psychiatrist's Standards and Guidelines as required under the *Mental Health Act 2014* (MHA 2014). Under section 515 of the MHA 2014 the Chief Psychiatrist is responsible for overseeing the treatment and care of all mental health patients including those in the private mental health sector. The publication of the Standards and Guidelines is required to discharge that responsibility. The Standards form the basis for the development of the set of statutorily required guidelines.

The purpose of the Standards and Guidelines is to assist in the development and implementation of appropriate practices and to guide continuous quality improvement in mental health services. The Standards are designed to be read easily and quickly. They are aimed at ensuring there is consumer and carer involvement in patient care and treatment and enhancement of good clinical practice. A number of draft Standards have been developed by the Working Group and have undergone a consultation process through the public and private mental health sectors.

The Guidelines were drafted by the Chief Psychiatrist with extensive clinical, consumer, and carer input. The purpose of the Guidelines is to provide specialist advice on various aspects of clinical service and to inform mental health clinicians and services about the operation and clinical issues in relation to the MHA 2014. Clinicians must comply with the Standards and have regard to the Guidelines when performing functions under the MHA 2014.

The Standards and Guidelines will be reviewed 12 months from the date of publication. The Chief Psychiatrists Standards and Guidelines for the MHA 2014 will be readily available on the Chief Psychiatrist website before the commencement date for the MHA 2014.

Physical Health Screening Model of Care – Central West MHS Geraldton

Sharon Thomson
Nurse Practitioner

Metabolic risk assessments in mental health services have faced a number of barriers for both psychiatrists and mental health clinicians. Barriers identified included clinicians' concerns that this may bring about extra workload along with the view that physical health was not considered part of the culture or core business of mental health care. When staff at Central West Mental Health Service (CWMHS) were initially asked to carry out routine monitoring many staff expressed concerns that they did not have the necessary skills and that there may be inconsistencies in approach with limited confidence in their ability to interpret abnormal screening results.

In response to these concerns all staff were provided with education and laminated "cheat" sheets outlining the correct process for collecting measurements along with a guide to the normal ranges were displayed in the treatment room. A baseline medical record audit was completed in 2012 that indicated the compliance rate for the collection of physical health screening data was relatively poor.

In order to improve the service's compliance with these requirements and assist mental health clients to access physical health care, a GP clinic was set up on a fortnightly basis, providing free care to mental health clients who had not previously accessed a GP in the community. Although this initiative proved very successful with significant positive outcomes, funding restraints rendered the clinic unsustainable and it was forced to close after only seven months.

The service supported the introduction of a Nurse Practitioner on a trial basis and a physical health screening clinic was set up at the commencement of 2013. Upon admission and, when possible, prior to the commencement of pharmacological treatment clients are asked to attend for baseline

blood testing. The testing is conducted prior to the clinic so results can be discussed with them on the day. The focus of the clinic is to ensure the client is empowered through ongoing education and support and, where necessary link them in with a GP and allied health staff including physiotherapists and dieticians who assist in providing appropriate care.

Carers are encouraged to attend the clinic and be involved with the client in goal setting and development of their individual management plans. At the clinic clients are also assessed for side effects of medication along with their current support network within the community. An appointment is organised for an ECG to be conducted off site and arrangements made to ensure that this is bulk billed.

Physical health screening has also been included in the clinical review process. All staff are required to ensure their clients have attended for metabolic screening within the past 12 months and that there is evidence of this within the medical file. Clients flagged to have increased risk factors of metabolic syndrome will have monitoring increased to 3-6 monthly depending on previous results and interventions are put in place to assist the client to improve their overall health.

Clinicians are also able to access funding through the Participation and Leisure Service (PALS) program (administered by Midwest Community Living). This provides gym memberships and access to the local swimming pool to the value of $500 per annum. The Aboriginal Mental Health Worker has also commenced a ladies swimming session on a weekly basis that has excellent attendance and which provides a forum for discussion around healthy eating and exercise.

A further benefit has been the significant shift in the attitude of staff at CWMHS towards physical health which has resulted in a very positive flow on affect with clients of the service.

The most recent audit of physical health screening, completed at the end of 2014 showed a 200 per cent rise in compliance since the initial 2012 audit results.

While one of the outcomes of routine monitoring and the collection of data is to improve physical health it has also been a major factor in improving staff awareness with confirmed diagnoses made, which have included diabetes, hyperthyroidism, pericarditis, hyperprolactinemia and hypertension. These outcomes have assisted the clinical team to rethink treatment options thereby improving the overall client experience and journey.

WA Police Policy Regarding Firearms Whilst Attending Mental Health Services (WAMHPAR) Forum

For the purpose of ensuring the highest firearm safety, it is WA Police policy that officers will have their accoutrements including firearms on their persons at all times when attending Department of Health services including hospitals.

WA Police have advised that they are unable to remove their firearms when attending health services as this places them in breach of their legislative responsibility under the Firearms Act. The only exception is police escorts involving Royal Flying Doctor Service aircraft where the CASA legislation takes precedence.

AMHP Mandatory Reporting to the Chief Psychiatrist

Authorised Mental Health Practitioners (AMHPs) are reminded that section 20(4)(c) of the *Mental Health Act 1996* and Regulation 5 of the Mental Health Act Regulations, require them to notify the Chief Psychiatrist or his representative on the following matters which have occurred within the six months preceding each 30 June and 31 December:

a) The number of people that an AMHP has personally examined for the purpose of forming an opinion as to whether the person should be referred for examination by a psychiatrist
b) The number of **actual** people referred for examination by a psychiatrist under section 29, using a Form 1 – *Referral for examination by a psychiatrist*

c) The number of people that the AMHP has examined under section 63 of the *Mental Health Act 1996*, for the purpose of providing a written opinion (whether a person on leave of absence from an authorised unit should continue to be detained as an involuntarily patient)

d) The actual number of written opinions provided under section 63

e) The number of Transport Orders made under section 34 using a Form 3 –*Transport Order*

f) The number of unusual events experienced by an AMHP and a brief case history of each event.

The above notifications are a statutory responsibility of all AMHPs and failure to comply may result in review of a person's status as an AMHP.

We also request that you proactively contact the Clinical Consultant at the Office of the Chief Psychiatrist to:

- verify your current AMHP status on the Register of Authorised Mental Health Practitioners
- advise of your current work location and contact details, to enable us to maintain the currency of our Register of Authorised Mental Health Practitioners.

For any queries regarding AMHP issues contact Kay Pak on Kay.Pak@health.wa.gov.au or through the Helpdesk on 9222 4462.

Community Mental Health Welfare Checks: Role of Mental Health Clinicians

In the light of a coronial recommendation, Operational Directive *OD 0556/14 Community Mental Health Welfare Checks: Role of Mental Health Clinicians* has been developed. The essence of this directive is that where there is concern for a patient or individual currently in the community (whether an inpatient on leave or a community patient) and that person requires follow up regarding their mental state, mental health services are required to take a primary role in reviewing the patient and not rely on police to perform a "welfare check". While there are certain exceptions to this (explained in the directive), it is an important principle that mental health staff should be undertaking mental health assessments rather than relying on police to assess welfare in the context of mental state. Even in situations of high risk where it is entirely appropriate for police (or ambulance if associated physical illness or injury) to intervene, mental health services must be proactive in their involvement, providing assistance wherever possible. Mental Health Staff are encouraged to read this directive. While a police-mental health co-response model has been announced but not yet established, there will always need to be a strong relationship between mental health services and first-responder agencies such as the police and ambulance.