Government of **Western Australia**
Department of **Health**
Office of the Chief Psychiatrist

inform

Newsletter of the Chief Psychiatrist

Summer 2014

Contents

Delivering a **Healthy WA**

Communication, Change and Challenges…

Dr Nathan Gibson, Chief Psychiatrist

'INFORM' – the newsletter of the Chief Psychiatrist, was initially published by the Office of the Chief Psychiatrist (OCP) in the Spring of 2004 and launched by my predecessor Dr Rowan Davidson. There are 16 publications all of which are posted on the Chief Psychiatrist's webpage at http://www.chiefpsychiatrist.health.wa.gov.au.

As I peruse the back copies there is much information about the activities of the OCP and general updates. I envisage this publication will continue to be a helpful means of communicating with Clinicians and students. I will also use this publication as one of the means to communicate medication updates that I am required to disseminate and information on my statutory responsibilities.

The year 2014 will be a critical and challenging year for the Chief Psychiatrist with both the Stokes Report and the new Mental Health (Green) Bill as clear templates for mental health direction. Clinical leadership is the essence of high quality clinical service delivery and in times of reform an imperative and I am considering what activities could be offered for Psychiatrists to support their vital role as clinical leaders. Seventy Consultant Psychiatrists working in the public system attended a forum held at Grace Vaughan House on the 2 September 2013 where issues and service models were raised. Meetings such as these are critical components in reinforcing clinical leadership.

There will be challenges from a resourcing perspective for Clinicians already experiencing large clinical case loads, as they integrate the requirements of the new legislation. Similarly the Office of the Chief Psychiatrist is managing the challenge of increased reporting and standards/guidelines development required by the legislation and this will be outlined in future editions of INFORM.

The Mental Health Bill and the Stokes implementation process will irrefutably dominate the landscape, but having now completed nine months in the role of Chief Psychiatrist, I am clear about three aspects of quality care which will be a strong focus for the Chief Psychiatrist in 2014:

- **Reducing Seclusion and Restraint**
- **Physical Healthcare**
- **Care Planning**

These are aspects which burrow to the core of reducing patient trauma, improving mortality outcomes, and strengthening focus on both patient and family-centred care. I will discuss these in greater depth in upcoming editions of INFORM.

Visiting services every week, I have been discussing those issues, in addition to both the Stokes Report and the Mental Health Bill. It has been extremely important to hear directly from the coalface.

Having spoken with hundreds of patients, families and Clinicians across WA in recent months, I remain deeply concerned about the pressures on acute sector staff and services. It is a clear systemic responsibility to ensure acute Mental Health Services are developed in conjunction with other aspects of mental health care. Clinician engagement is vital for the success of any model, including the recovery paradigm.

I and the staff of the Office of the Chief Psychiatrist welcome staff of the Office of Mental Health. Our respective offices, whist having very separate roles, have benefited from a collaborative approach around a range of issues.

In recognition of the need for clarity regarding the roles of the Office of Mental Health, Department of Health and the Mental Health Commission with the Office of the Chief Psychiatrist activities, we have developed the *Chief Psychiatrist Operational Framework (2013)* which supersedes the Chief Psychiatrist Strategic Framework (2005). The Operational Framework (2013) is located on the website, and demonstrates the Chief Psychiatrist's focus on the statutory responsibilities under the *Mental Health Act 1996* and activities in two program areas underpinned by clinical facilitation, support and education activities in a climate of consumer, carer and stakeholder collaboration. The presentation of the Operation Framework is demonstrated through the Quality feedback loop.

Clinical leadership, collaboration, compassion, integrity and impartiality are reflected in the values of the Office with which we underpin the activities of the Office depicted on the reverse of the Operational Framework (2013).

It is a time for change. Dr Theresa Marshall, our Monitoring Coordinator, has left the Office of the Chief Psychiatrist after 11 years. Theresa's contribution to the quality care of West Australians has been enormous, and we thank her sincerely. The Chief Psychiatrist's monitoring program will be further reviewed with the appointment of a new coordinator.

I look forward to working with the experienced staff of the Office, and with patients, families, Clinicians, and a range of agencies as we build on the foundations of care.

Chief psychiatrist's forum

Dr Nathan Gibson, Chief Psychiatrist invited Consultant Psychiatrist's working in the public system to a forum at Grace Vaughan House on 2 September 2013. There were 50 attendees and 23 via 11 video conference sites.

The session was aimed at opening up communication between the newly appointed Chief Psychiatrist and Psychiatrists around issues influencing clinical care. Issues highlighted for possible discussion included the

Stokes Review process; Models of Care; Care in Emergency Departments (ED); Clinical Care in the Community; Engagement with Patients and Carers; Coordination of care across Public, Private and Non Government sectors; and Physical Health Care.

Dr Gibson commenced the proceedings with a brief summary around his areas of focus as the incoming Chief Psychiatrist such as Care Plans to include reference to the engagement of patient and families in the planning process. Also the Monitoring Program is conducting a review of Clinician compliance with processes under the *Mental Health Act (MHA) 1996*. The session was then opened for attendee discussion.

Attendees raised access to mental health services and exit opportunities from Emergency Departments (EDs) particularly for adolescents, as a significant pressure point evident in the mental health system. Pathways of care are not as seamless as they could be and the tensions this causes between services and colleagues and additional risks to patients when they are at their most vulnerable. Good Consultation and Liaison in EDs was acknowledged as essential and the development of metro-wide business rules for portals into services. The better use of Medicare Locals was suggested and community care options.

The availability of services to adult patients with Attention Deficit Hyperactivity Disorder (ADHD) through the public sector was reiterated as a long term, unresolved issue with concern that there is discrimination that economically disadvantages this group of patients. The previous Chief Psychiatrist raised with services that ADHD is a mental illness and consideration is to be given to alternative ways of providing service to stimulant prescription.

Dr Gibson is aware of the capacity for Psychiatrist's already with extreme case loads taking on an additional patient group and the difficulties of maintaining the goodwill of practitioners who express that they are at their workload limits.

The Stokes Report was acknowledged as being a positive and giving 'a voice' to what Psychiatrists had already identified – the issue of resources. The Activity Based Funding (ABF) model and the challenge for Mental Health Services, given the unpredictability of length of stay was raised. One attendee pointing out that this has been raised with the Commonwealth on many occasions.

Attendees highlighting the potential for Psychiatrists to leave the public sector when they found it untenable that they could not provide the best care for their patients and were not able to influence decisions about service planning resulted in suggestions of liaison with professional bodies as an opportunity to offer opinions to influence change.

Following the Forum, Psychiatrists offered article's published in this edition of INFORM including up-skilling and multi-skilling of Psychiatrists, standardised procedures and models of care.

PICUs and PECCs

Dr Fenner and Dr Hodgson

Dr Nigel Armstrong would say "the hamburger you buy north of the river should be the same as the hamburger you buy south of the river".

In terms of mental health care, the services provided north of the river should be broadly comparable to services south of the river. Additionally, there should be a number of specialist or tertiary Mental Health Services that adopt consistent, evidence based models with a statewide approach.

Currently, both North and South Metro mental health are going through a major change process. Now is the opportune time to develop both innovative and evidence based programs to meet the mental health needs of the rapidly growing Western Australian population.

PICUs (Psychiatric Intensive Care Units) and PECCs (Psychiatric Emergency Care Units) are evidence based models that have been shown to improve patient outcomes and reduce the reliance on inpatient beds.

PICUs are short stay secure wards that cater for aggressive and disruptive patients in a low

stimulus environment with a high staff to patient ratio. Patients are returned to normal secure wards as soon as their behaviour has settled. The majority of PICU patients are males who have a major psychiatric illness exacerbated by substance use. These patients can be very disruptive on normal secure wards and thus worsen the outcomes and length of stay for all patients on the ward.

PECCs are short stay wards attached to Emergency Departments. These wards provide a low stimulus therapeutic environment allowing patients to settle quickly. Many PECC patients will settle sufficiently to be discharged home with appropriate supports. Others will settle to the degree that they no longer need to be managed on a secure ward.

PICUs and PECCs have the ability to improve outcomes for patients, reduce hospital admissions and reduce the length of stay of patients in hospitals. They also reduce the demand for both open and secure hospital beds.

For PICUs and PECCs to be effective, business rules need to be developed to prevent bed block. The Sir Charles Gairdner Hospital (SCGH) PICU will have an average length of stay of 5 days. There will also be a North Metro business rule that ensures that other locked wards will take their patient back from the PICU within 24 hours of being notified that their patient no longer needs PICU care.

Similarly, PECCs should have a length of stay of between 48 and 72 hours, and a business rule that forces mental health units to accept patients within 24 hours of being notified that a PECC patient requires an inpatient bed.

Clearly, the above are major changes to the way the system operates. Currently, multidisciplinary teams discharge patients when they feel the patient no longer needs hospital care, and the Psychiatrist as the lead Clinician in the team carries the risk if the discharge goes wrong. In the new system, the least sick patient on the ward will be discharged in order to make way for a sicker patient from a PICU or PECC (sickest patient gets the bed). The Psychiatrist and the multidisciplinary team determine who should go home with increased community supports, however, the risk—if something were to go wrong—would be carried by the system. Because of the shift in risk, there needs to be reporting mechanisms to the Area Executive and the OCP to ensure that demand and outcomes are being monitored. Failure to monitor demand and outcomes could result in a system that fails to adapt to increasing need.

For the sake of research into the development of evidence based models of care it is important that units are named appropriately. Medical ICUs and CCUs are similar the world over and, as specialist units, research is an important aspect of their work.

PICUs and PECCs are also fairly standardised in their approach allowing for research and comparison between units. Unfortunately, SCGH have called their PECC a MHOA (Mental Health Observation Area) and given it a maximum 48 hours length of stay, whereas Fiona Stanley (FSH) has an Acute Care Unit with a 72 hour length of stay.

SCGH PICU has a five day length of stay and only caters for severely disturbed patients who are likely to settle within that time frame. However, FSH has a PICU with a 14 day length of stay and a mixed cohort of patients. Additionally, business rules around discharge are likely to be different between SCGH and FSH, hence the PICU and PECCs in the two hospitals are unlikely to accept out-of-area patients. The PECCs are also unlikely to accept patients without an exit strategy (and this may impact on older adult patients and adolescent patients).

In summary, the hamburger you get north of the river will be branded differently and will taste differently to the hamburger you get south of the river. However, we hope that the proof is in the pudding that PICUs and PECCs will provide an improvement in the mental health care of patients in Western Australia and reduce demand on overstretched hospital Emergency Departments and mental health wards.

Statewide Clinical Services Enhancement Program (SCSEP)

Dr Prue Stone

SCSEP It is a four-month Video Conferencing Training Program in core clinical competencies for WACHS Child and Adolescent Mental Health Service (CAMHS), that includes an understanding of normal development and the impact of adverse environment on personality development. Most of it is scenario based, covering most clinical situations likely to be encountered, and is interactive using modern learning technique.

It is run twice a year (2½ hours per week plus quite a lot of reading) and is open to any WACHS Mental Health Clinicians (Not just CAMHS Clinicians). A number of adult Psychiatrists have participated in the program that takes eight participants at a time.

The SCSEP site can be found on the WACHS Intranet site.

Alternative Models of Care

Dr Geoff Smith

Dr Smith informed the Forum of two services – one based in Victoria – *Prevention and Recovery Centres* (PARCs) which are a series of area-based step-up, step-down units. These are eight to ten bed units operated by NGOs, but supported by the Crisis Assessment Teams. In some units, the CATs are based in the PARC. Part of their role is to support 'early discharge' from hospital.

Adult prevention and recovery care (PARC) services framework and operational guidelines 2010 is available at:
http://www.health.vic.gov.au/mentalhealth/services/parc.pdf

The other service is a system based in the United Kingdom known as *Crisis Resolution Home Treatment Teams* (CRHT). This service provides short-term intensive community support for people in crisis who would otherwise require admission to hospital. An evaluation of this service can be found within: The British Journal of Psychiatry. 2006 Nov; 189:441-5. *Crisis resolution/home treatment teams and psychiatric admission rates in England*. By Glover, Arts and Babu of North East Public Health Observatory, Wolfson Research Institute, University Boulevard, Stockton-on-Tees TS17 6BH, UK. Gyles.Glover@gmail.com.

Also of relevance to Western Australia is Western Australian Centre for Mental Health Policy Research *A Review of Services in North Metropolitan Perth* February 2010 *Emergency Mental Health*. By Geoff Smith, Theresa Williams and Linley Lefay.

Available at:
http://www.health.wa.gov.au/mhpr/docs/Review_Emergency_MH_Services_North_Metro_2010.pdf

Trauma Informed Care

Dr Felice Watt

Trauma informed care has emerged in response to the recognition that a large percentage of people accessing Mental Health Services have a history of psychologically traumatic experience which significantly impacts on their mental health presentations and has implications for management. Psychologically traumatic experiences are usually interpersonal in nature and include sexual and physical abuse and neglect. These experiences often occur over a period of time, generally beginning in childhood or adolescence and contribute to the onset and perpetuation of mental and physical health difficulties and substance misuse.

Trauma informed services are those in which all members of the organisation share an understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual human being. This shared understanding is used as a platform to assess and modify every part of the organisation's management and service delivery system to be more supportive of the individual seeking treatment and to avoid re-traumatisation.

"Trauma informed programs and services internationally represent the new generation of transformed mental health and allied human services organisations and programs."
Mental Health Coordinating Council, NSW

Current literature on trauma informed care includes the following –

Centre for Addiction and Mental Health Knowledge Exchange, *Becoming Trauma Informed.* Available from: http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/documents/becoming_trauma_informed.pdf

The Institute for Health and Recovery, *Developing Trauma Informed Organizations: A Tool Kit.* Available from: http://www.healthrecovery.org/services_and_products/products/detailTrue.asp?ProductID=30

Public Health Agency of Canada, *Handbook on Sensitive Practice for Health Care Practitioner: Lessons from Adult Survivors of Childhood Sexual Abuse.* Available from: http://www.oregon.gov/oha/amh/recovery/handbook-sensitivve-practices4healthcare.pdf

Stephanie S. Covington PhD LCSW, *Helping Men Recover: A Program for Treating Addiction* Available from: http://www.stephaniecovington.com/b_helping_men.php

Seeking Safety, *The Seeking Safety model (description and implementation).* Available from: http://www.seekingsafety.org/

Jean Tweed Centre, *Trauma Matters.* Available at: http://www.jeantweed.com/LinkClick.aspx

The Manitoba Trauma Information and Education Centre, *The Trauma Toolkit* (1st and 2nd Edition). Available at: www.trauma-informed.ca/

The Sanctuary Model, *The Sanctuary Model*. Available at: http://sanctuaryweb.com/

Adults Surviving Child Abuse, *Practice Guidelines For Treatment Of Complex Trauma And Trauma Informed Care And Service Delivery.* Available at: www.asca.org.au

Womens Health and Family Service, *Trauma-Informed Treatment Guide for Working with Women with Alcohol and Other Drug Issues*. Available at: http://www.whfs.org.au/files/userfiles/Trauma%20Guide%20Order%20Form%202nd%20edition.pdf

Guardianship

Dr Russell Date

People with decision-making disabilities may be unable to maintain a reasonable quality of life for themselves, and are often dependent on varying levels of support from others in order to achieve this.

Public Mental Health Services have contact with many people with impaired decision-making, which might arise as a result of intellectual disability, mental illness, acquired brain injury or dementia.

The *Guardianship and Administration Act* of Western Australia provides for the appointment of guardians to safeguard the best interests of adults with decision-making disabilities.

It recognises that people who are not capable of making reasoned decisions for themselves may need additional support and assistance not only to ensure their quality of life is maintained, but also to protect them from the risk of neglect, exploitation and abuse, and gives the State Administrative Tribunal legal powers to appoint guardians.

In order to provide the best care, and to make their decisions accountable and defensible, Psychiatrists need to be aware of when to recommend guardianship and how to involve guardians in treatment decisions. Older Adult Psychiatric Services routinely identify those who will benefit from appointment of a guardian, but it is possible that individuals with impaired decision-making in the Adult stream whose quality of life might be improved by having a guardian might not be adequately identified. This might also lead to unsatisfactory processes for making treatment and other decisions.

Medication used in psychiatry

Antipsychotic medication: "Five Things Physicians and Patients Should Question".

On the 20 September 2013 the American Psychiatric Association (APA) under publicly released a list of specific uses of antipsychotic medications that are common, but potentially unnecessary and sometimes harmful. It is entitled *"Five Things Physicians and Patients Should Question"*.

The APA's list includes the following five recommendations:

- Don't prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.
- Don't routinely prescribe two or more antipsychotic medications concurrently.
- Don't use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.
- Don't routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults.
- Don't routinely prescribe antipsychotic medications as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders.

The APA website relevant to this is http://www.psychiatry.org/choosingwisely.

Atomoxetine

Prescription of Strattera – The Therapeutic Goods Administration advises of reports of Serious Adverse Events.

Serious adverse events reported to the Therapeutic Goods Administration (TGA) including one case involving the death of a child, reinforce the importance of health professionals adequately informing parents and caregivers of the risks of suicidal ideation and behaviour in children and adolescents being prescribed atomoxetine (Strattera).

Atomoxetine is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD), as defined by DSM-IV criteria, in children aged six years and over, adolescents and adults.

The risks of suicidal ideation and behaviour with atomoxetine are well known and are reinforced in the **Product Information** in the precautions section, as well as in a boxed warning.

When considering prescribing atomoxetine in children and adolescents, health professionals should carefully weigh the risks of suicidality against the benefits of atomoxetine therapy.

Patients who are prescribed atomoxetine should be carefully monitored for suicidality, especially in the first few months of treatment and whenever there is a change in dose.

Parents and caregivers should be warned of the risks and alerted to the need to monitor for signs of unusual changes in behaviour or precursors of suicidality, such as anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia, hypomania or mania. Parents and caregivers should also be advised of the importance of seeking immediate medical attention if such signs are identified.

Health professionals are encouraged to report all adverse events associated with atomoxetine to the TGA.

Therapeutic Goods Administration (TGA) Medicines Safety Update, Volume 4, Number 5, October 2013

Clinical senate

Physical Health Care

The third meeting of the Clinical Senate of Western Australia for 2013 was held on 9 August 2013 at the University Club of Western Australia. The topic for debate – *"Let's get physical – Addressing the physical health needs of West Australians with mental illness"*.

The Clinical Senate recognises that the poor physical health status of people with a persistent mental illness is a human rights issue and determined 11 strategies to address physical health care.

The Executive Summary Report and Recommendations is available from:

http://www.clinicalsenate.health.wa.gov.au/debates/aug13.cfm

National developments

The Chief Psychiatrist represents the Department of Health on the Safety and Quality Partnership Standing Committee (SQPSC) whose principal role is to provide expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health. The SQPSC is a national committee with representation from all the key mental health sectors. The SQPSC reports to the Mental Health Drug and Alcohol Principal Committee (MHDAPC).

Some of the current national developments and deliberations include:

MHDAPC

- In relation to the review of the Fourth National Mental Health Plan a project steering committee is being established to project oversight to the review which will be undertaken in the latter part of 2013.
- The Public release of National and State/Territory seclusion and restraint data is a matter that was referred to the MHDAPC from the SQPSC. The release of this data has now been approved and will be reported annually on the Australian Institute of Health and Welfare website.

Australian Commission on Safety and Quality in Health Care (ACSQHC)

- ACSQHC is undertaking a scoping study focusing on recognising and responding to deterioration in mental state for inpatients in acute health facilities. WA has already provided feedback to this project.
- The release of The National Adult Clozapine Titration Chart was advised at the November 2012 meeting (WA will be proceeding with the Graylands/Fremantle Hospital Clozapine Titration Chart as it is already well established).

Mental Health Information Strategy Standing Committee (MHISSC)

- The MHISSC are progressing these matters:
  - A national project to measure Consumers' experience of care – findings due MHISSC October 2013.
  - A project to measure Carers' experience of care – concept trial results due October 2013.
  - A Consumer self-report measure focussing on the social inclusion aspects of recovery – statistical analysis due October 2013.
  - Mental Health Non-Government Organisation (NGO) Establishments National Minimum Data Set Project – final decision about proceeding due October 2013.
  - National NGO Outcome Measurement Project – report due October 2013.
  - National Outcome Casemix Collection (2012–2024) Review – Consultation report to be reviewed by MHISSC October 2013.
  - National Mental Health Report to be printed July 2013.

National Standards

- National Standards for Mental Health Services (NSMHS) – Scoping Study on Implementation: at Focus Group phase.
- Draft Accreditation Workbook for Mental Health Services linking NSMHS and National Safety and Quality Health Service (NSQHS) Standards – consultation concluded, and final version now being drafted.

Tailored Standards and Performance Pathways Mental Health Portal Pilot Project

- Project developing a tool to assist NGOs services to prepare for accreditation against standards.

SQPSC Workforce Oversight Subcommittee

- Will take over the development of:
  - Mental Health Professional Online Development (MHPOD) Project (rolling out nationally, being developed as postgraduate qualification).
  - National Practice Standards for the Mental Health Workforce (implementation planning commenced).

National Mental Health Recovery Framework

- The Framework was launched at TheMHS Conference in August 2013.
- Includes Policy and Guidelines.
- WA Representatives had significant input in drafting Clinician's Guide.
- Implementation strategy is being developed.

National Peer Worker Qualification

- Reference Group has been formed led by National Mental Health Commission and Community Mental Health Australia.
- Aim to have an Australia-wide curriculum and resource for training.

Physical Health and Wellbeing

- National Summit held Sydney in May 2013.
- National targets to be developed.

Seclusion and Restraint

- 9th National Seclusion and Restraint Reduction Forum: 28-29 November 2013, Canberra.
- Public release of mental health seclusion data has been approved by the Australian Health Ministers' Advisory Council.
- SQPSC via working groups developing guiding restraint principles (including national definitions almost at consensus) and revisiting chemical restraint (no consensus as yet on this definition).

Reducing Adverse Medication Events in Mental Health (RAMEMHWP)

- Priority area regarding antidepressant use in Children and Adolescents to be referred for consideration by Royal Australian and New Zealand College of Psychiatrists (RANZCP) and other National groups.
- RAMEMHWP Chair will write to jurisdictions regarding National Clozapine Titration Chart – WA will recommend use of its own established tool locally.
- Capturing comprehensive adverse events data – unresolved.
- ASQHCS reviewing Indicators for Quality Use of Medicines in Australian Hospitals (previous document 2007) – ASQHCS to liaise with RAMEMHWP.

Reducing Suicide and Self Harm in Mental Health Services

- Evaluation of National Suicide Prevention Program being carried out.
- Release of National Aboriginal and Torres Strait Islander Suicide Prevention Strategy launched 23 May 2013.
- Taking Action To Tackle Suicide (TATS) Community Prevention activities for high risk groups initiative (Indigenous suicide prevention) – 143 applications, processed closed.
- $7.6m Commonwealth commitment to improve safety at suicide hotspots- announced 7 June 2013.

Safe Transport

- Endorsement of draft supplementary Safe Transport Principles to be sought from MHDAPC.
- When Project Officer support available, there will be further activity including:
  - Communication of Principles,
  - Investigating Royal Flying Doctor Service undertaking a project relating to safe transport, and
  - Developing a list of mental health issues relating to safe transport.

Chief Psychiatrist's clinical guideline – Communicating with carers and families

This Guideline was developed by the Chief Psychiatrist as part of his responsibility to ensure mental health consumers receive psychiatric treatment and care from Mental Health Services that is directed by policy, procedures and legislative clinical best practice. The Chief Psychiatrist had been advised by carers and carers' advocacy agencies that at times carers and families have not been able to contribute to Mental Health Service care as they would have wished despite their vital role in the care of consumers. This concern was a significant driver for the development of this guideline for action.

The purpose of the Guideline is to raise Mental Health Services' awareness of the importance of working closely with carers and families, to facilitate the involvement of carers and families in the consumer's care and treatment as much as possible and to outline a number of actions that will enable the development of these close working relationships.

The Guideline is intended to be used by mental health Clinicians in conjunction with the *Communicating with Carers and Families Booklet* which was developed in 2007 by a consortium including the Office of the Chief Psychiatrist, Carers WA, the then Mental Health Division and the University of WA as an overarching framework for assisting mental health Clinicians in working with carers and families. At the same time as developing the above booklet the consortium also developed the *Carers Guide to Information Sharing with Mental Health Clinicians* for the purpose of assisting families and carers in managing the complexities around information sharing in regard to their family member's ongoing care.

It is felt that together the three resources will be helpful in enhancing the collaboration between carers, families and Clinicians thereby facilitating a more positive outcome for the mental health consumer. The Guideline and the other two booklets can be accessed on the Office of the Chief Psychiatrist website.

Clinical monitoring

Chief Psychiatrist's Thematic Review – Clinical Governance Climate in WA Mental Health Services

The Chief Psychiatrist has responsibility under the *Mental Health Act 1996* to monitor standards of psychiatric care across the State of Western Australia. In exercising this responsibility he conducts Clinical Governance, Thematic and Targeted Reviews of Mental Health Services (MHS) in Western Australia (WA).

In August – September 2012, the Chief Psychiatrist conducted a thematic review to assess the Clinical Governance Climate in WA Mental Health Services, focusing on the following areas:

1. Organisational Culture
2. Organisational Risk Management
3. Communication
4. Clinical Supervision

The survey was carried out via an online questionnaire which was made available to all Staff working within WA Mental Health Services. A total of 1,117 staff completed the questionnaire, with 854 clinical and 263 non clinical Staff responding.

Following analysis of the feedback, the Chief Psychiatrist has made eight recommendations for implementation across all Mental Health Services.

A report detailing the findings of the report has been published, and is now available on the Chief Psychiatrist's website: http://www.chiefpsychiatrist.health.wa.gov.au/standards/thematic.cfm

A total of eight recommendations were made with one in the area of Leadership and Organisational Capability, two in the area of Clinical Risk Management, one in Clinical Performance and Evaluation – *Research and*

Effectiveness, two in the area of Professional Development and Management – *Staffing and Staff Management* and two in the area of Professional Development and Management – *Education, Training and Professional Development*. Details of the recommendations are presented in the final section of the report.

This Report, following approval by the Director General of Health, will be sent to the all WA MHSs with a request that they complete the Action Plan located in Appendix A with implementation of the Recommendations scheduled for audit in 2013.

Mental health act 1996

Procedural Compliance

The Chief Psychiatrist is currently reviewing Mental Health Services' application and compliance with the requirements set out under the *Mental Health Act (1996)*, including:

Documentation

- Use of correct MHA forms
- Completeness of MHA forms

Information Provision

- Consumers and carers
- Mental Health Review Board

Mental Health Review Board Reports

- Timeliness of reports
- Quality of information provided

Compliance with intent – MHA

Education and training *Mental Health Act 1996*

Creswell Surrao, Clinical Consultant

Mental Health Act 1996 – Education and Training

The Office of the Chief Psychiatrist has run several sessions on an overview of the Mental Health Act 1996, for various stakeholders from both the mental health and non-mental health sector. These sessions focussed on many of the myths that prevail in relation to applying the various provisions of the Act. Common among those is the ability of just 'anyone' to make alterations to, or amend the content of mental health Act forms. Specifically, alterations to 'place of referral' on the *Referral for examination by a psychiatrist* (Form 1). It appears commonplace for people (other than the referrer) to make changes by simply scoring through the 'place of referral' and substituting it with another, which is illegal and renders the form invalid. It is only the referrer who can alter or make an amendment to a Mental Health Act form. In the absence of the referrer, should there be a need to change the place of referral, another Form 1 may be completed by a Medical Practitioner or Authorised Mental Health Practitioner, and the original form made 'void' and retained in the patient's medical record with a copy sent – faxed or scanned and emailed to the Office of the Chief Psychiatrist.

The Office has held a number of 'Authorised Mental Health Practitioner (AMHP) – Review of Skills Training' for those Clinicians wishing to become AMHPs. It is heartening to note that despite robust reform within mental health services and demand on clinician time, they are still willing to take on the role of an AMHP to facilitate as smooth a pathway for acutely unwell patients to be examined by a Psychiatrist as soon as possible. It is important for AMHPs to remember that the primary function of their role is 'referral for examination by a Psychiatrist' and to establish the availability of a Psychiatrist to fulfil this function, rather than engage in discussions around admission into an Authorised Hospital or the availability of a bed, which is the responsibility of the examining Psychiatrist.

The tabling of the Mental Health Bill in State Parliament in October 2013, has necessitated that the Chief Psychiatrist and his Office begin to focus on the training and compliance processes to be developed for the new Bill. No further AMHP Training relating to the current Mental Health Act (MHA) 1996 will be offered through 2014, but the Office of the Chief Psychiatrist remains committed to supporting all existing AMHPs as required in terms of their role and function.

Authorised Mental Health Practitioners 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 6 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 should continue to be detained as an involuntarily)
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.

May we also request that you proactively contact the Clinical Consultant at the Office of the Chief Psychiatrist to advise of your current work location and contact details, to enable us to maintain the currency of our Register of Authorised Mental Health Practitioners.

Farewell to Theresa Marshall, Coordinator Standards Monitoring

The success of the Chief Psychiatrist Monitoring Program for the past 11 years rests with Theresa and her team. Theresa has overseen numerous clinical, Thematic and Targeted Reviews and is well-known to Clinicians around Western Australia. With a Clinical Psychology background, and her previous role at Inner City Community Mental Health, Theresa was well-placed to understand the practical realities of monitoring and improving Standards. She translated this by engaging Clinicians as part of her review teams and looking in depth at the care provided. She can leave the Office of the Chief Psychiatrist knowing she has made a significant contribution to quality practice. We wish her every success as she moves into a private sector role.

Welcome to:

Natasha Cunningham
Standards Monitor Mandatory Reporting

and

Colleen O'Leary
Coordinator Standards Monitoring

This document can be made available in alternative formats on request for a person with a disability.

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