CHIEF PSYCHIATRIST
of Western Australia

INFORM

NEWSLETTER OF THE CHIEF PSYCHIATRIST

Summer 2018

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Editorial – Dr Sophie Davison, Deputy Chief Psychiatrist

Welcome to 2018 summer edition of the Chief Psychiatrist's newsletter.

Last year was a busy one for our office as I am sure it was for all those involved in mental health services. The Chief Psychiatrist's mission is to ensure that all Western Australians receive the highest standard of mental health treatment and care. This newsletter provides a snapshot of the work of the different programs within the office, working towards this goal. This year, we aim to complete the Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy (ECT), complete the review of the Chief Psychiatrist's standards of authorisation for hospitals under the MHA 2014 and commence visits to re-approve ECT suites.

We are delighted to introduce Dr Geoff Smith and Ms. Theresa Williams who joined the office in September 2017. They are heading up our new research and strategy program. We are very pleased to have their experience and expertise in supporting the delivery of safe high quality treatment and care.

Risk Assessment and Management and Transfer of Care

In this edition, we are shining the light on two crucial areas of clinical practice: risk assessment and management and transfer of care. Times of transition are often times of increased risk and the transition needs to be carefully managed with clear management plans, handovers, and effective communication with the consumer, carers, within the multidisciplinary team and with other services. We have highlighted the key issues that have been identified from reviews of clinical incidents over recent years, and outlined the expectations of the Chief Psychiatrist in relation to both areas, with reference to the relevant standards.

I would like to commend the dedication and hard work of all our colleagues at the OCP as well as all those clinicians and other stakeholders who are all striving towards the same goal of safe, high-quality mental health care in WA.

Risk and the West Australian Mental Health Clinician – Dr Nathan Gibson

Risk can be defined as the likelihood of an adverse event or outcome (Flewett, Clinical Risk Management, 2010). Risk assessment and management is currently, like it or not, a central component of practice in mental health.

The comments made about risk assessment and management (and associated documentation) by clinicians to my office over recent years have been varied and include that risk:

- detracts from 'more relevant' clinical decision making
- fosters defensive and unhelpful clinical practice
- is a post-hoc justification at coronial hearings
- is purely cross-sectional for that moment in time

Risk documentation is often characterised by frenzied regulation in clinical governance frameworks, with administrators having at times almost deified the forms used, and yet it is held with intense ambivalence by clinicians. Australian commentators such as Large and Ryan (the latter a Psychiatrist) have described clinical risk management as a process providing results only slightly better than chance- virtually equivalent to the toss of a coin. Why is there such a disparity between systems approaches to risk management and clinician views?

Risk assessment and management in mental health has been intimately bound up in philosophical and ethical debates about individual autonomy. Increasing regulation around standardised documentation has been driven repeatedly by innumerable (and often very robust) post-adverse outcome review processes identifying inconsistent approaches to risk, a lack of consistency in documentation around risk, and deficits in handover of risk as potentially contributory factors to poor patient outcomes, notwithstanding any personal autonomy factors considered.

There will always be uncertainty in health and mental health. "Certainty management," as described by the Royal College of Psychiatrists, is not possible in clinical practice. Risk management does not imply removal of risk. Thus, we manage risk. What is acceptable or manageable risk- and how we manage this- is primarily a discussion, and wherever possible an agreement, among the treating clinician, the patient, family and other relevant people involved.

Practically, we mostly measure the uncommon negative outcomes in the context of risk assessment and management, and do not consider how existing actions within therapeutic relationships and services mitigate risk in the majority of situations. The value of the interpersonal relationship between patient and clinician, as far as mitigating risk, is often impossible to measure. There are many complexities in working with an individual, whose risk is chronically elevated. In an individual case, the primary role of clinical decision-making is importantly informed but not supplanted by actuarial risk analysis.

What I have noted from review of clinical incidents over recent years regarding risk assessment and management are the following:

- Most risk documentation captures assessment, but there is often **poor documentation of a risk management plan**
- Risk assessment **documents sometimes do not reflect the risks as highlighted in the clinical notes**- there is internal inconsistency in the medical record
- Risk assessments **do not always capture or weight significant historical risk factors**:
    - There is not a consistent systemic capture of important risk events in a simple summarised way to alert clinicians going forward
    - Clinical judgement sometimes "expires" risks prematurely, e.g. "carrying a knife around when psychotic occurred 18 months ago, therefore it is not a relevant matter now (when a patient is potentially psychotic)"
- **Inherently risky phases of care may not always be given weight**, e.g. a patient admitted to hospital for a suicide attempt is rated as "low risk" at discharge 5 days later, or where a fragile individual is transitioning

from a longstanding, trusted case manager to an new case manager- these discharge or transition points are known phases of inherently increased risk
- Risk management plans often **do not carry basic handover information**:
    - What factors will increase risk for this person (what are the situations)?
    - What are the signs of increased risk (what to look for), and when should a clinician escalate concern for this individual (what is the tipping point)?
    - What are the most effective strategies that reduce risk for this person (what to do)?
- Risk is **not always escalated** to Consultant Psychiatrists when it has recently increased.

From the perspective of my Office, these are my expectations:

- Risk management must follow risk assessment
- Risk management is a handover document for our colleagues- to consider what information would you need to know upfront when seeing a patient for the first time
- Risk management will document, wherever possible:
    - What factors will increase risk for this person, e.g. "John's risk of self-harm increases when …"
    - What are the signs of increased risk, and when should a clinician escalate concern for this individual?
    - What are the most effective strategies that reduce risk for this person?
- Every individual should have an automatically accessible summary of historical risk events within the medical record
- Where there is a significant escalation of risk, a Consultant Psychiatrist should consider the matter promptly.

The principle is clear: considering potential consequences of clinical decisions, and preparing contingencies for that, has always been, and remains, a core part of clinical practice.

I am aware of the huge amount of effort put in by clinicians on a daily basis to mitigate risk for their patients, and I wish to strongly acknowledge this. I would alert clinicians to the statutory Chief Psychiatrist Clinical Standard "Risk Assessment and Management", the Department of Health WA "Clinical Risk Assessment and Management Policy" (CRAM 2008 - still relevant) and "*Clinical Care of People Who May Be Suicidal"* policy 2017.

Chief Psychiatrist's Research and Strategy Program

Introducing Dr Geoff Smith and Theresa Williams

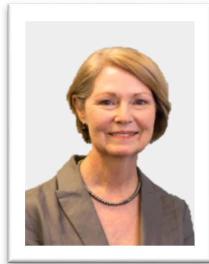
In September 2017, the Chief Psychiatrist welcomed the appointment of Dr Geoff Smith (Senior Psychiatrist) and Theresa Williams (Director) to jointly lead the establishment of a Research and Strategy Program within the Office of the Chief Psychiatrist.

This new program area will undertake strategic research and system-wide, service level and individual reviews and investigations to support the delivery of safe, high quality treatment and care.

Geoff and Theresa will be known to many in the mental health sector for their work over the past decade at the WA Centre for Mental Health Policy Research.

Geoff has extensive experience both as a clinician in South Australia and in the UK and as a senior executive in WA Health including Director of Mental Health Services and Chief Medical Adviser in Strategic Planning and Evaluation. Areas of special

interest include person-centred care and implementation science. He has an appointment as Clinical Associate Professor in the Division of Psychiatry at the University of Western Australia.



Theresa is a Clinical Psychologist who has worked as a clinician in both public and private mental health and in the education and disability sectors. She has extensive experience as a senior executive within WA Health in mental health and general health policy, planning and system reform. At the international level, she was funded by the WHO to advise the Malaysian Government on person-centred care in their hospital system. In 2012, she was awarded a Churchill Fellowship to visit a number of European countries to study self-directed support in mental health. Theresa currently holds an appointment as Adjunct Associate Professor in the Division of Psychiatry at the University of Western Australia.

Chief Psychiatrist's Monitoring Program

– Standards Monitoring and Review Team (SMaRT)

Under the *Mental Health Act 2014* (s.515), the Chief Psychiatrist has oversight of the treatment and care of mental health patients within Western Australia. To meet this legislative responsibility, the Chief Psychiatrist carries out monitoring of all mental health services within the State.

The Chief Psychiatrist implemented a new clinical monitoring program in 2016, which reflects contemporary mental health standards, and all mental health services within Western Australia will be reviewed against these standards.

Mental health services are grouped by Health Service Provider (HSP), with all mental health services belonging to the HSP reviewed together and the report provided to the HSP executive. The Chief Psychiatrist set a goal to review all West Australian public mental health services by June 2018 and is currently on track to meet this target.

The WA Country Health Service (WACHS) was reviewed in 2016. The Child and Adolescent Mental Health Service (CAMHS), South Metropolitan Area Mental Health Service (SMHS) and North Metropolitan Health Service (NMHS) reviewed in 2017. Reports have been provided to WACHS and CAMHS with the SMHS and NMHS reports soon to be released.

Senior WA mental health clinicians are seconded to collect data on adherence to clinical standards for the Chief Psychiatrist. These staff bring their clinical expertise to the review process. During the review, they also have the opportunity to observe areas of good practice in the service they are reviewing, contributing to system-wide learning. The information they collect is analysed by OCP staff and reported back to services, along with recommendations for improvement.

At the completion of the clinical review cycle of all services, it is the intention of the Chief Psychiatrist to conduct thematic reviews focussing on particular clinical areas in order to support services to improve clinical practice.

The terms of reference for the Chief Psychiatrist's Clinical Monitoring program are available on the Chief Psychiatrist's website: http://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/chief-psychiatrists-clinical-monitoring-program/

headspace Youth Early Psychosis Program (hYEPP) Service – Dr Gordon Shymko

(Dr Shymko is the Clinical Director for the hYEPP and also Clinical Director for the Peel and Rockingham Mental Health Service Early Psychosis Program)

headspace Background

headspace provides mental health services to young people aged 12 – 25. headspace services cover four main areas:

- mental health,
- physical health,
- work and study support and;

- alcohol and other drug services.

headspace centres are located across various parts of Western Australia including Albany, Armadale, Broome, Bunbury, Fremantle, Geraldton, Kalgoorlie, Midland, Osborne Park and Rockingham. Essentially headspace is a one-stop shop for young people to address their mental and physical health needs and where they can self-present for timely, free and confidential support. They can also be referred to headspace by a General Practitioner.

hYEPP Background

The headspace Youth Early Psychosis Program (hYEPP) is a specialty program that works within headspace and has been operational since January 2015.

Overall hYEPP is an up to 2 – 5 year program for 12 to 25 year olds who are either:

- experiencing their first episode of psychosis; or
- are at ultra-high risk of developing psychosis; this may include young people who have a family history of psychosis, have a decline in functionality, and/or have transient psychotic symptoms.

The ages between 15 and 24 are a crucial time in the development of a young person and this coincides with the peak onset of serious mental illness, including a first episode of psychosis.

Evidence shows that early intervention and access to specialised early psychosis treatments can change the course of the illness, generating greater personal, social and economic benefits than intervention at any other time in the lifespan. Psychosis is a significant public health issue and has been made all the worse by the near endemic utilization of substances particularly stimulant based substances such as methamphetamine.

The hYEPP services are North and East Metropolitan based and situated in three headspace sites, a 'hub' in headspace Joondalup with two 'spokes' in headspace Osborne Park and headspace Midland. These services are non-government and are managed by Black Swan Health and Youth Focus.

The hYEPP model has three components:

- The ***Mobile Assessment Treatment Team*** (MATT), which is the entry point primarily for public sector services (ED, inpatients and community services). Following that assessment, clients are either maintained in the hYEPP program or transitioned to another service.
- If they are transitioned to our service, the ***Continuing Care Team*** (CTT), which is the majority of services we provide, maintain clients from six months to five years, depending on their needs.
- We also have a wraparound program, the ***Functional Recovery Program*** (FRP), comprised more of psychosocial recovery measures to assist the person to recover and includes youth engagement, peer support, carer support, group support and, importantly, employment counselling and support. This program helps a person re-integrate into the things that were important to them prior to developing the illness.

The range of services offered within the hYEPP framework includes home-based assessment and care, multi-disciplinary care coordination and medical management, psychological Interventions, group programs, family programs, youth participation and peer support. Workers are able to provide drug and alcohol counselling and support.

The full continuum of community-based care can be provided for these clients and includes; the provision of psychotropic medication, including depot antipsychotic medications and Clozapine, as well as the utilization of the Mental Health Act 2014 when required.

To date hundreds of young people have accessed the service since its opening. There have been a number of positive outcomes for young people and their families within hYEPP.

General Practitioners can make referrals to the hYEPP program easily, through the headspace programs in Joondalup, Osborne Park and Midland however clients can self-refer as well.

Other Early Episode Psychosis services function within public mental health services at Bentley, Fremantle and Peel and Rockingham Kwinana Mental Health Services. These are not headspace based, and referrals can be made directly to these

services. WA Primary Health Alliance (WAPHA) is collaborating with public sector services in seeking to establish a program similar to the FRP at hYEPP.

Further details on the hYEPP program are available on the headspace website: https://www.headspace.org.au/

AMHP AMPLIFIER

Clinical, Statutory Education and Authorisations Team (CSEAT)

AMHP Register

Currently there are 528 active AMHPs in Western Australia. As per the requirements of MHA 2014, the Chief Psychiatrist is required to maintain a 'Register' of Authorised Mental Health Practitioners. This register is available on the Chief Psychiatrist website and is the 'Official Register' for AMHPs.

Let us know

Please advise the Chief Psychiatrist if you;

- Have recently changed your name
- Have changed your place of employment
- No longer work in a clinical position
- No longer conduct face to face assessment for referral to a psychiatrist
- Are taking extended leave of more than 12 months e.g. maternity leave or LWOP etc.

Forms located on the Chief Psychiatrist website

Queries regarding the AMHP program are directed to Cate Wray - Consultant Statutory Authorisations and Approvals or email; amhp@ocp.wa.gov.au

AMHP Audit Update

The Chief Psychiatrist has produced a report on the outcomes of the 2016-2017 audit of AMHP's. A copy of the report will be provided to CEOs of Health Service Providers and all AMHPs.

The audit highlighted two areas of non-compliance as required by the MHA 2014 Regulations which were:

- Reporting of Clinical Supervision sessions undertaken for the year and;
- Continuing Professional Development activities.

A requirement of maintaining AMHP status is to have regard to Regulation 17 of the Mental Health Regulations 2015, which states:

(1) For section 539(4)(a) of the Act, the Chief Psychiatrist must have regard to the following training when deciding whether to make or amend an order under section 539(1) –

(a) The completion of a course of training approved by the Chief Psychiatrist;

(b) The completion of annual continuing professional development approved by the Chief Psychiatrist;

(c) The completion of annual clinical supervision approved by the Chief Psychiatrist.

Clinical Supervision (CS) is recognised by the Chief Psychiatrist as having a focus on professional growth for the AMHP. Regular supervision is critical for the examination of practice and improved competency when discharging the AMHP functions. It is recommended that supervision meetings are facilitated on a regular monthly basis for at least an hour.

AMHPs are expected to undertake regular Continued Professional Development (CPD) activities directly relevant their role and function in order to improve and broaden their knowledge, expertise and competency required to maintain AMHP gazettal.

The onus is on the AMHP to complete CPD and attend CS. Clinical Supervision is a shared responsibility between employer and employee.

IMPORTANT

If an AMHP is not contactable or has not responded to correspondence from the Chief Psychiatrist their gazettal will be revoked on 30 October 2018.

Preparing For 1 July 2017-30 June 2018 Audit

A self-report survey will be conducted in 2018 for reporting period 1 July 2017 to 30 June 2018.

AMHPs will be emailed a link to a self-report survey in the first week of July 2018. The link will remain open for 3 weeks. Once the link has closed at least 10% of AMHPs will be randomly selected to participate in an audit. AMHPs selected for auditing will be required to provide;

- evidence of Continued Professional Development and;
- Clinical Supervision sessions undertaken.

The Chief Psychiatrist can revoke an AMHPs gazettal if they have failed to comply with the requirements of Regulation 17 of the Mental Health Act 2014. The Chief Psychiatrist may also revoke an AMHPs gazettal on any of the following grounds;

- mental or physical incapacity
- incompetence
- neglect of duty or misconduct.

In readiness for the audit, AMHPs should be familiar with the *Requirements and Expectations of an Authorised Mental Health Practitioner* document available on the Chief Psychiatrist website.

Out and about with the Chief Psychiatrist

The Chief Psychiatrist and staff of the Office of the Chief Psychiatrist continue to visit mental health services in Western Australia. The visits include meeting with mental health consumers, carers, and clinicians to discuss the Standards of Clinical Care.

Since July 2017 the Chief Psychiatrist has visited, Wheatbelt Mental Health Services, Armadale Mental Health Services, Alma Street Mental Health Services, Bentley Mental Health Services, King Edward Mother Baby Unit.

For 2018 visits planned thus far are, the Specialist Aboriginal Mental Health Services located at Graylands. Staff who are unable to attend the meeting will have the opportunity of teleconferencing in to it. There will also be a focus on visits to rural and remote areas including Bunbury Mental Health Service, Albany Mental Health Service and later in the year to Fitzroy Crossing and Balgo.

Further to visits to mental health services, the Chief Psychiatrist is commencing direct teleconferencing, to both regional and metro mental health services. These sessions will be conducted on a Q&A format. Services who would like to participate can contact reception@ocp.wa.gov.au

Work in Progress

We are making great progress to the Chief Psychiatrist's *Guidelines for the use of Electroconvulsive Therapy in Western Australia*. This is an additional large body of work being undertaken in collaboration with consumers, carers and clinicians from public and private mental health services, who dedicate their time despite their busy schedules. We are extremely grateful for their contribution, time, and effort.

We are also busily revising the Chief Psychiatrist's *Standards for the Authorisation of Hospitals Under the Mental Health Act 2014*. The process is currently in a consultative phase with the focus group comprising of consumers, carers and mental health clinicians.

A process for the Re-Approval of ECT suites will commence in early 2018. The Mental Health Act 2014 s.544 requires the Chief Psychiatrist to approve any mental health service that provides electroconvulsive therapy (ECT). Services will be notified of the process and receive a Self-Report Assessment document in March 2018. The Chief Psychiatrist will commence visits to currently approved services in October 2018. The register of Approved ECT Suites is available on the Chief Psychiatrist website.

Education and Training

Education and Training are vital components to the suite of services offered to clinicians by the Office of the Chief Psychiatrist.

The Principal Officer -Statutory Education, provides an education in-reach service where clinical staff attend at Nash Street for short courses and an outreach service, going out into the services when invited, to provide education, information and support sessions. The education is based on issues

regarding the Mental Health Act 2014 (MHA14) and over the last year included:

- Authorised Mental Health Practitioner (AMHP) Initial Training;
- AMHP Refresher Training;
- Community Treatment Orders - a clinical and legal perspective;
- Capacity Forums;
- Clinical and AMHP Question and Answer sessions;
- Treatment Support and Discharge Planning;
- MHA14 training for Graduate Program for Nurses;
- Mental Health Training for Paramedics; and
- MHA14 info for Aboriginal Mental Health Trainees.

In this financial year to date (July 2017 to December 2017) 208 clinicians have attended education sessions conducted by the OCP. In addition, 60 + clinicians attended a special event organised by the OCP of 2 visiting professors from the UK who presented on health policy and sexual violence.

In 2018 further education programmes are being developed to complement the suite of programmes already offered on a regular basis.

IN FOCUS………

Chief Psychiatrist's Standards for Clinical Care – Transfer of Care

The *Mental Health Act 2014* requires the Chief Psychiatrist to publish a set of standards for treatment and care provided by Mental Health Services and to oversee compliance with those standards.

Standards are a basic reference point for safe and quality care, for the benefit of consumers and carers. It is the responsibility of services to consistently strive to meet or exceed standards.

The Chief Psychiatrist of Western Australia has accepted the ***National Standards for Mental Health Services*** (NSMHS) as the overarching standards relevant for the Mental Health Act 2014. In addition, the ***Chief Psychiatrist's Standards for Clinical Care*** have been developed and published to enhance the NSMHS, covering certain areas that the Chief Psychiatrist deems to be of central importance or requiring local jurisdictional focus.

The Chief Psychiatrist's ***Transfer of Care*** standard is defined as '*a person-centred, recovery focused process used for the timely, safe and effective discharge and handover of care between all service providers. Service providers may include clinical and non-clinical services*.'

Transfer of care is known to be a high-risk period for mental health consumers. In a recent report by the WA Health Patient Safety Surveillance Unit (PSSU), *SAC1 Clinical Incidents Describing the Unexpected Death of a Mental Health Client (July 2015 – June 2016)*, frequently occurring health care contributing factors included:

- **Issues around discharge**: problems include a lack of or inadequate management plan, lack of communication with family members, delays in sending discharge documentation and referrals to other care providers and lack of follow-up post discharge (36%)
- **MDT Communication:** problems with communication between the multidisciplinary team treating the patient, including lack of discussion at the point of discharge and unstructured clinical handovers or handover policies not followed (21%)
- **Communication with other agencies:** difficulties communicating with other agencies involved in the care of the patient (18%)

Healthcare factors contributing to unexpected deaths of WA mental health consumers 2015/16

1 in 2.8
Issues around discharge

1 in 4.8
MDT communication

1 in 5.5
Communication with other agencies

Source: SAC1 Clinical Incidents Describing the Unexpected Death of a Mental Health Client (July 2015 – June 2016), WA Health PSSU

The purpose of the ***Transfer of Care*** standard is to ensure continuity, safety and quality of care for consumers is maintained during transfer either between or within services. Note that this standard does not ONLY apply to discharge from inpatient services, but ANY situation where care is transferred – which includes handover to non-clinical services.

The referring service retains responsibility for the consumer until the handover is accepted by the receiving service or the consumer decides on an alternative process.

To facilitate continuity, mental health services must ensure that information such as discharge or transfer summaries, are provided to the receiving service before the transfer occurs, and facilitate follow-up within seven days of transfer.

Consumers and carers are central to the handover process. Partnership with consumers is essential, and clinicians must actively try to identify carers and seek collaboration.

Self-Assessment

What are the transfers of care, which frequently occur in my service? These may include (but are not limited to):

- Discharge from an inpatient service
- Discharge to the care of a GP
- Change of Case Manager
- Referral to another organisation

While providing care, do I consider the person's ongoing needs, including clinical, psychosocial and welfare? Do I think about what supports the person has in their network and what additional supports they may need?

Do I communicate my thoughts to the consumer and carer? How do I find out whether they agree with my plan for how support will be provided in future? Do I document the plan and give them a copy?

Do I make referrals and ensure I receive confirmation that the referral has been accepted, before transfer occurs? Do I ensure the discharge documentation is communicated to the receiving service before transfer?

Do I consider the potential for increased risk at the time of transfer? Do I have an understanding of what signs may indicate the person's risk level is increasing and communicate these to the receiving service? Do I talk with the consumer, their carer and the receiving service about coping strategies to use during the transition period and how to seek additional support if needed?

Do I make arrangements for follow-up within seven days after the transfer? How will I know whether the consumer has kept to the plan? If they change their mind, what do I do?

Further Information

You can read the full ***Transfer of Care*** standard in the *Chief Psychiatrist's Standards for Clinical Care* located on the OCP website.

End of Life Decisions

The Chief Psychiatrist's position on voluntary assistant dying, as given in evidence to the Joint Select Committee on End of Life Choices, is summarised below. Please note that nothing should be taken as explicit or implied support for the legalisation of physician assisted suicide.

The Chief Psychiatrist of WA calls for robust mental health services to be available to individuals requiring palliative care for physical illnesses. Consistent with the RANZCP Position Statement on physician assisted suicide, the Chief Psychiatrist considers that the primary role of medical practitioners in end of life care is to facilitate the provision of high quality patient-centred care.

In the context of any future potential legislation regarding voluntary assisted dying, the following principles apply:

- mental illness, 'demoralisation' or 'loss of hope' must never be a legislated reason to allow assisted suicide
- mental illnesses must not be classified as terminal illnesses for the purposes of legislation
- any legislation regarding assisted suicide must ensure an extremely robust assessment of capacity and screening for mental illness

- psychiatrists are appropriately qualified to assess capacity
- no physician must ever be coerced into undertaking an end of life capacity assessment
- individuals with mental illness have a right to be considered without stigma or discrimination in society.

The Chief Psychiatrist recommends that psychiatrists refer to the RANZCP Position Statement 67 on physician assisted suicide for further information available at;

https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-67-Physician-Assisted-Suicide-Feb-2016.aspx