



CHIEF PSYCHIATRIST
of Western Australia

Targeted Review

**Homicides allegedly
committed by people who
have had contact with, or
were being treated by, WA
Mental Health Services
during 2018**

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Foreword

Homicides by individuals with serious mental illness are rare; but when they do occur they generally involve family members or people well known to the individual. The result has far reaching and devastating effects, not only for those left behind, but also for the individual with the mental illness.

It is important, however, to recognise that the vast majority of people with mental illness never offend during their lifetime: but when individuals do, the problem should not be seen simply as an individual one, recognising that the current mix and operation of mental health services does not work as intended for all people.

This is highlighted by a Western Australian study of people referred by the Courts for admission to the secure forensic mental health unit which found that nearly 60% of people charged with committing serious offences had been discharged from care within 3 months of the offence or were considered 'lost to follow-up' by mental health services, while 41% were homeless at the time of the offence.

In 2018, Western Australia experienced a spike in homicides allegedly associated with individuals who were patients of, or had recent contact with public sector mental health services. Despite the subsequent fall in homicides in 2019, I felt that it was necessary to undertake a review of this spike in homicides with a view to providing all of us involved in the planning and delivery of mental health services with an opportunity to learn from these events.

The Review found that the mental health system is under significant pressure, across Emergency Departments, specialist clinical community mental health services and inpatient facilities. The factors identified in this Review were similar to those that have been identified as leading to a range of poor outcomes in many previous reviews, including reviews undertaken by my Office, by the Auditor General of WA and Professor Bryant Stokes. Rarely do these factors lead to death, but they significantly raise the likelihood of poor outcomes for individuals with mental illness, their families and supports, and the community.

What we have seen from previous reviews is that their recommendations have rarely resulted in sustainable change. We have, therefore, taken a different approach which evidence would suggest has a greater chance of facilitating change. We are of the view that, if we address the systemic issues - including restoring clinical leadership, establishing contemporary, fit-for-purpose public mental health services and building a culture of improvement - WA will be in a much stronger position to build a safer, high quality mental health system.



A handwritten signature in black ink, appearing to read 'Nathan Gibson', written in a cursive style.

Dr Nathan Gibson
Chief Psychiatrist of Western Australia

1. Purpose and Background

In 2018, there were 9 homicides allegedly committed by 7 people who had had contact with, or were being treated by, WA mental health services. This compares with a total of 9 deaths in the preceding 3 years (3 in 2015, 4 in 2016 and 2 in 2017) and represents a 2 to 4½ times increase.

The number of homicides allegedly committed by patients of mental health services during the years 2015 to 2017 was essentially stable at around 1 per million general population which is consistent with the 2014 UK figures reported in the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (2016).¹

Three of the homicides were allegedly committed by one individual who was being treated by WA mental health services. Another of the individuals was also charged with attempted murder. Of the 9 victims, 7 were family members (parent 2, siblings 2, spouse 2 and aunt 1), one was a mental health worker and one was a person unknown to the accused. The preponderance of family members and people known to the accused is consistent with national and international findings.

This preliminary Review of the Root Cause Analyses (RCAs) and other documentation completed by the Health Service Providers (HSPs) has been initiated by the Chief Psychiatrist as a means of informing him on whether there is a need for a broader review process in an attempt to clarify, if possible, what factors may be associated with this spike in homicides by persons with a history of mental illness.



1 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2016). *Annual Report: England, Northern Ireland, Scotland and Wales*. Centre for Mental Health and Safety, Manchester: Manchester University.

2. Scope

Completion of RCAs are required for all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. Such incidents are designated Severity Assessment Code 1 (SAC1). This report is based on an examination of 7 RCAs completed by the respective HSPs following the homicides and independent reviews of two of the cases conducted by senior mental health professionals from outside the reporting HSP.

Under Australian law people charged with crimes are innocent until proven guilty. None of the individuals have been tried yet and we do not intend in any way to pre-empt or prejudice the findings of the court. The Review has not looked at any of the details of the alleged events, rather at the quality of mental health care of the individuals prior to the alleged events. Homicide cases can take many months to come to court. The apparent spike in homicides allegedly perpetrated by people in contact with mental health services is, however, concerning enough to warrant an immediate preliminary review of the cases to determine if there are any systemic service issues that need addressing urgently.

This Review has been undertaken by the following staff from the Office of the Chief Psychiatrist:

- Adjunct Associate Professor Theresa Williams, Director, Research and Strategy;
- Clinical Associate Professor Geoffrey Smith, Senior Psychiatrist, Research and Strategy;
- Dr Sophie Davison, Deputy Chief Psychiatrist; and
- Ms Maggie O'Dea, Principal Officer, Intergovernmental Relations.

Homicide by people with psychotic disorders is a rare event and, like suicide, it is impossible to predict in any single treatment event. With such small numbers of events, it is not possible to determine whether the rise in the number of annual homicides allegedly perpetrated by people with mental illness represents a real upward trend or whether it is simply part of normal variation. The causes of this apparent rise during 2018 is, accordingly, not able to be determined. What the Review team has done, however, is to look at the clinical care as documented in the RCAs and independent reviews and identify some common themes which they believe, if addressed, would improve the safety and quality of care.



3. Research Literature

Studies of lethal assaults arising as a result of acute mental illness have identified the following factors as being significant:²

- Evolving delusional beliefs that led the person to believe that their life is under threat or that someone else has control of them are strongly associated with homicide.
- The rates of contact with a doctor or mental health worker in the 2 weeks prior to the offence are high.
- High levels of drug misuse, particularly of cannabis and amphetamines.
- Previous history of violence, particularly arrests for violence.
- Loss to follow-up (drop out, discharge) associated with lack of treatment and cessation of medication.



2 Nielssen O, Westmore B, Large M, Hayes R (2007). Homicides during psychotic illness in New South Wales between 1993 and 2002. MJA; 186(6): 301-304.

4. Emerging Themes

4.1 Failure to respond adequately to evidence of clinical deterioration

Recognising and responding to signs of deterioration in a person's mental state is an essential core skill for all mental health professionals. In a number of the RCAs, it is clear that the individual's mental state was deteriorating and that, had this been adequately appreciated, a more rigorous treatment approach could have been implemented that may have changed the outcome. This lack of recognition is evidenced in such practices as repeated assessment and treatment in the Emergency Department without adequate engagement of other key parts of the mental health service, reluctance to respond adequately to concerns by family members/carers and inappropriate timing of transfer of care between providers.

There is evidence from the RCAs of a number of plausible reasons for this failure to adequately respond to clinical deterioration:

(i) *Lack of long-term perspective in delivering care*

Failure to take a long-term perspective in care delivery, with each part of the service concentrating on its own particular function and episode of care and not considering the overall course of the patient's illness over time. This is particularly problematic in the Emergency Department presentations, but does impact on other parts of the service. A number of studies looking at long-term care observed that there is generally a similarity in clinical presentation in a given patient, with virtually identical signs and symptoms, from one episode of psychotic illness to the next - essentially a 'personal signature'.³ An historical perspective of each person's 'personal signature' in the planning and management of his/her care might well have resulted in a different approach to care with a higher quality and safer outcome for all concerned.

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In a number of the RCAs, it is clear that the individual's mental state was deteriorating and that, had this been adequately appreciated, a more rigorous treatment approach could have been implemented that may have changed the outcome.

3 Cutler N, Post R (1982). Life course of illness in untreated manic-depressive patients. *Comprehensive Psychiatry*; 23(2): 101-115.

(ii) Drug use negates recognition of underlying mental illness

While it can be difficult to separate *drug-induced psychotic states* from *drug-precipitated mental illness*, a history of symptoms that are persistent rather than transient and associated with auditory hallucinations and bizarre and enduring delusional beliefs and incongruous affect should give weight to the likelihood of a psychotic illness requiring longer term observation and care.

A significant proportion of people admitted to hospital with a diagnosis of drug-precipitated psychosis either have, or go on to develop, chronic and relapsing psychotic illness (RANZCP Guidelines on Schizophrenia and Related Disorders). From at least 3 of the RCAs, there is evidence that the person's underlying mental illness was not given due weight in their assessment and management; but rather they were treated as having a 'drug toxicity' and underlying personality disorder, even where they had previously had a clear diagnosis of Schizophrenia or Shizoaffective Disorder. Obtaining a full mental health history, seeking collateral information from family members/carers wherever possible and allowing a longer period for observation would go a considerable way to clarifying a person's diagnosis.

(iii) Reluctance to treat

It was clear in several of the RCAs that there was a reluctance to admit the patient to community or inpatient services. Hence we see people assessed and managed repeatedly in the Emergency Department when admission may have been a more appropriate option; or advice given to seek assessment from a GP when assessment by the Community Mental Health Team may have been warranted.

(iv) Lack of adequate supervision

Most of the RCAs suggest that staff supervision/consultation for front-line health staff (e.g. Psychiatric Registrars, ED medical staff, Psychiatric Liaison Nurses and Mental Health Triage Officers) is not adequate or readily available, particularly outside regular office hours. Supervision, second opinions and working in teams have been found to be important safeguards.⁴

4.2 Inadequate risk assessment and management

There is no evidence from any of the RCAs that an effective risk assessment was carried out in the period leading up to the homicide. There still appears to be an over-reliance on the use of checklist risk assessment tools (e.g. the Brief Risk Assessment or BRA), particularly those that provide a grading of risk level (from low to high) which has been found to be meaningless as a predictor. Nor do any of the RCAs provide evidence of proper formulation of risk and development of a risk management plan. It is clear from

4 Maden A: *Treating Violence: a guide to risk management in mental health*. Oxford University Press Inc, New York, 2007 (Pg 159).

the RCAs and associated reports that the Department of Health's recent policies on risk assessments and management for suicide and for violence and aggression have not been widely implemented by the HSPs.

In assessing the risk of violence what is required is a comprehensive psychiatric assessment, a full psycho-social assessment and a full, longitudinal risk assessment and formulation based on such issues as history of aggression or violence, history of abuse and self-harm, developmental history, triggers and previous response to treatment, warning signs that signal increasing or imminent risk and events or occurrences that might increase or decrease risk. This should inform the development of a risk management/safety plan in collaboration, as far as possible, with the consumer and family or carer. The plan should clearly articulate what actions should be taken to maintain safety, including identifying triggers and circumstances that compromise safety, what to do in a crisis and strategies to reduce risk.

4.3 Inadequate response to family/carers concern

There were several instances of an inadequate response by services to family members reporting concerns about their relatives deteriorating mental state and seeking assistance. This is contrary to the principles and values advocated in the Chief Psychiatrist's Standards for Clinical Care.

4.4 Lack of coordination between services

There were clear instances of a lack of communication between EDs, community mental health services and other agencies involved (e.g. Police, Child Protection, GPs, MHERL) leading to an uncoordinated and inappropriate response to deterioration. There were instances in which referral between services with multiple triage resulted in delays and a failure to adequately recognise and respond to clinical deterioration. In cases with known domestic violence issues, there was a lack of interagency engagement in discharge planning.

4.5 Questioning the value of the current approach to the RCA process

SAC 1s, for which completion of RCAs are required, include all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. Three of the RCAs recommended declassification of the RCA as they could find no causative factors in the care provided that contributed to the outcome. The purpose of RCAs is to identify system vulnerabilities so that they can be eliminated or mitigated; the review is not supposed to be used to focus on, or address, individual performance. Several RCAs appear to be prefaced on the latter; to protect the individuals and services from any 'adverse' finding. This detracts significantly from the value and usefulness of the whole exercise.



5. Findings

While it is not possible, with the limited information available to the Reviewers, to reach a position on whether these homicides could have been prevented, there is evidence that good clinical treatment and care, effectively delivered, does reduce the likelihood of harm to self or to others.⁵

The Review Team found that the treatment and care received by the alleged offenders did not meet the Chief Psychiatrist's Standards for Clinical Care in at least one, and generally multiple areas, including (i) Assessment; (ii) Care Planning; (iii) Consumer and Carer Involvement; (iv) Risk Assessment and Management; and (v) Transfer of Care. In none of the cases was there evidence of a comprehensive assessment of the person's mental state, nor an appropriate risk assessment, formulation and management plan.

Two of the themes identified above, namely the **lack of a long-term perspective in delivering care** and the **lack of coordination of care** appear to be part of a common problem; the 'fragmentation' or 'siloing' of treatment and care, with each service focusing on its own particular part in a patient's 'journey', with little attention to the other parts of the system. Hence, we see a cross-sectional approach to assessment and formulation, with little learning from a patient's earlier treatment history, failure to recognize the patient or carer's lived experience, inadequate recognition of the needs and pitfalls for transfer of care or for longer-term planning. In the words of the independent investigation into the care and treatment of Daniel Gonzales (NHS South East Coast):

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There is evidence that good clinical treatment and care, effectively delivered, does reduce the likelihood of harm to self or to others.

What is required is a focus on each individual patient as a whole person (person-centred care) with a 'past' and a 'future' as well as a 'present'; and, in recognition of the complexity of the care system, a commitment to the coordination of his/her care, including wherever possible, working with families and carers.

5 Scott-Moncrieff L, Briscoe J, Daniels G. *An independent investigation into the care and treatment of Daniel Gonzales*. NHS South East Coast, and Surrey County Council, UK, January 2009.

“Modern specialist mental health care and treatment is delivered through ... a jigsaw puzzle of interlocking services with everything ... [in theory] ... fitting together and no pieces missing. In reality, there are gaps, overlaps, and disjunctions in the different parts of the service that make up the whole, and because the services are operated by fallible human beings there are endless opportunities for mistakes, misunderstandings and miscommunications.”⁶

Another major problem is the limitation of the current practice of risk assessment and management. The two policies released by the Department of Health, the Clinical Care of People Who May Be Suicidal Policy (October, 2017) and the Clinical Care of People with Mental Health Problems Who May be at Risk of Becoming Violent or Aggressive Policy (January, 2019) have had limited uptake into clinical practice. Services are still using risk assessment tools that purport to provide a gradation of risk, despite overwhelming evidence to the contrary. As the Review Team identified in a number of the cases, an assessment of low risk almost invariably militates against the development of a risk management plan.

The policies and associated guidance on suicide and violence and aggression need to be promulgated by the Department and the Health Service Providers for implementation into practice. Both these policies stress the importance of engaging consumers and carers in the risk assessment and management processes.



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6 Scott-Moncrieff L, Briscoe J, Daniels G. *An independent investigation into the care and treatment of Daniel Gonzales*. NHS South East Coast, and Surrey County Council, UK, January 2009.

6. Putting these findings in context

This finding of a shortfall in standards is not unique to the treatment provided to the individuals in this Review, but is a common and longstanding problem in WA that has been identified in previous clinical reviews of individual patients and services. While these shortcomings in the quality of treatment and care rarely lead to such tragic outcomes, they can, nonetheless, have other serious consequences for the individual, his/her family or others in the community.

A study of serious offending in patients with suspected mental disorders referred by the WA Courts to the Frankland Centre over a 30 month period found that among the 131 individuals, significant physical assaults were the most common offence (45%), followed by criminal damage (31%), with homicide related offences the 5th most common (7%).⁷

Significantly, 68% of these individuals had some direct or indirect contact with mental health services in the 3 months preceding offending; that is, they were active with Community Mental Health Services (CMHS), were admitted to hospital, presented to services and/or had third parties contacting mental health services with concerns about them. Some 20% of them had been discharged from CMHS within 3 months prior to offending, and an additional 38% were considered to be lost to follow-up by services at the time of offending.

The study concluded:

“.... there exists a sub-group of patients who are at high risk of serious offending, and that special interventions within mainstream mental health services may reduce this risk. These interventions could include a lower threshold for inpatient admission, the use of involuntary treatment, more assertive follow-up from CMHS to minimise loss to follow-up For many of this cohort, life-long follow-up by mental health services may be required.”

There has been no shortage of reviews and recommendations aimed at addressing mental health service standards, including audits and reviews by the Chief Psychiatrist, Coronial Inquiries, reports by the Mental Health Advocacy Service and reviews by the Department of Health (e.g. the Stokes' Review). These reports have generally identified similar problems and made similar recommendations with the expectation that Health Service Providers will implement them. However, these recommendations have not resulted in sustainable practice changes. The question could legitimately be asked about why all these reviews and reports have not been able to significantly change the quality and safety of mental health services – and more importantly, what do we need to do to facilitate the change.

⁷ Griffiths R. *Mental disorder and serious offending in Western Australia: factors preceding serious offending in patients with suspected mental disorders admitted by the Courts to a Western Australian inpatient forensic mental health unit 2018.*

6.1. A system under pressure

6.1.1. Emergency departments

In 2018, the Australasian College of Emergency Medicine (ACEM) released a media statement calling for a new approach in managing the presentations of people with mental health problems in EDs:

“Researchers took a snapshot of emergency departments in December 2017, with 65 Australian emergency departments reporting on the number of patients present at that time. While only 4% were mental health presentations, they comprised 19% of patients waiting for beds and 28% of those experiencing access block. The problem of access block was worse in some jurisdictions compared with others, and particularly notable in Western Australia (66.7%) and Queensland (38.7%).”⁸

The primary causes of the pressures on EDs are not to be found in the ED itself, but in the difficulty experienced across the mental health system in accessing psychiatric beds (including the ‘right’ kind of beds), in the lack of alternative community-based mental health services, particularly after hours, and in the difficulty that people experience in accessing community services in a timely manner, even when they are available.

6.1.2. Community services

Over recent years there has been little additional investment in specialist public community mental health services (1.2% increase in funding over the 3 years to 2016/17) despite reports from services that there is steadily increasing demand.⁹ Current services are under-resourced, fragmented and have limited capacity to respond to emergencies, particularly after hours. What we are seeing as a result is a reluctance to admit patients to community mental health services and an assertive community discharge policy, which often does not adequately address the needs of people with severe mental illness and can lead to an over-reliance on the ED as the ‘service of last resort’.

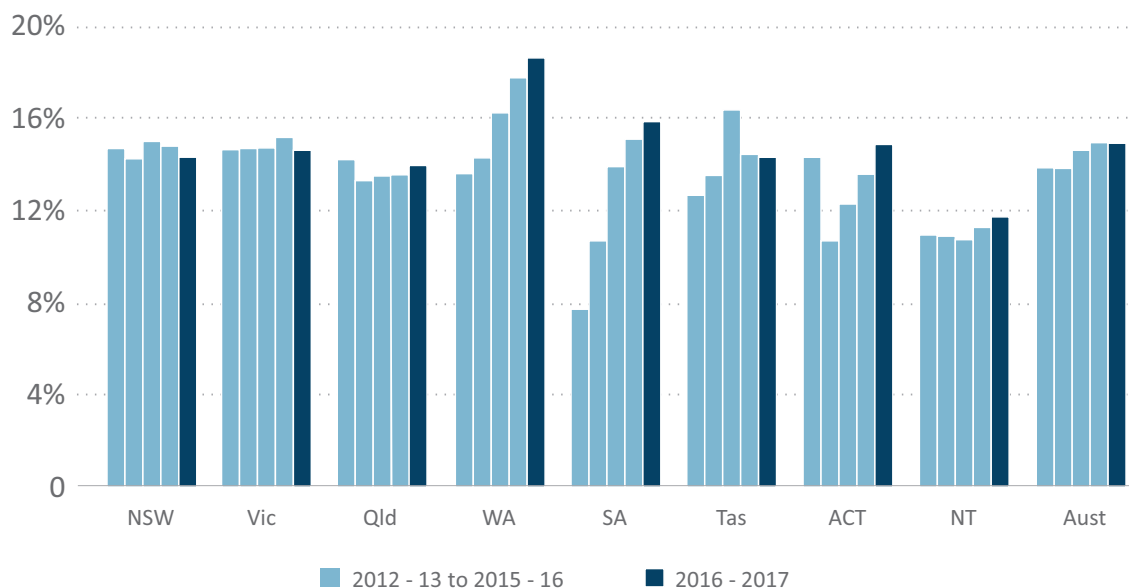
8 Australasian College for Emergency Medicine. (2018). ACEM calls for new approach to mental health in ED. Melbourne, Victoria: ACEM. Available at: <https://acem.org.au/News/Feb-2018/ACEM-mental-health-care-access-block.aspx>

9 Productivity Commission. (2019). *Report on Government Services, Part E Health: Mental Health Management*. Canberra, ACT.

6.1.3. Inpatient beds

The latest Report on Government Services for the 5 year period 2013/14 to 2016/2017 showed that WA currently has the highest rate of re-admission within 28 days of discharge of all Australian States/Territories (at 18.6 % compared with national average of 14.9%). The Figure below shows that the WA 28-day re-admission rate has been consistently trending up over the 5-year period.

Readmissions to acute psychiatric units within 28 days of discharge



Source: Report on Government Services 2019, Productivity Commission

Part of the problem is that the current overall bed numbers, including the lack of specialist rehabilitation beds, combined with a model of care that focuses on symptomatic treatment and short length of stay, do not work well for people with chronic and relapsing mental illness and complex needs. Step-up/step-down beds are no substitute for inpatient rehabilitation beds staffed by mental health professionals.

Paraphrasing the words of Dr Danielle Ofri, in the pressurised world of contemporary public mental health services, there is simply no time to think. With every patient, clinicians *“race to cover the bare minimum, sprinting in subsistence-level intellectual mode because that’s all that’s sustainable Time to think seems quaint in our metrics-driven, pay-for-performance, throughput-obsessed health care system.”*¹⁰

10 Ofri, D (2019). Perchance to think. N Engl J Med; 380: 1197-1119.

6.2 Clinical leadership and engagement

Organisational and governance changes in recent years have led to a reduction in the voice of clinical leaders within mental health. This has resulted in a sense of powerlessness and a lack of engagement amongst clinicians. This is particularly concerning given the strong relationships between staff engagement and clinical performance and between staff well-being and patient and organisational outcomes.^{11,12,13} The evidence shows that the more engaged staff are with their organisation, the better the outcomes for both patients and the organization, including better patient experience, fewer errors, lower patient mortality, better patient outcomes, stronger financial management, and lower staff absenteeism and turnover. The current organisational and governance structures present a major impediment to addressing the shortfall in the standard of clinical treatment and care.



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- 11 West M and Dawson J. *Employee engagement and NHS performance*. London: The King's Fund, 2012.
- 12 West M, Eckert R, Steward K, et al. *Developing collective leadership for health care*. London: The King's Fund, 2014.
- 13 Maben J, Peccei R, Adams M, et al. *Patients' experience of care and the influence of staff motivation, affect and well-being*. NIHR Service Delivery and Organisation programme; 2012.

7. The way forward

“In one sense, it does not matter that serious violence by mentally ill people is rare – plane crashes are rare, but we expect airlines to do everything they can to improve safety. The response of mental health services should be similar and the results should be better, more comprehensive packages of care for many patients, prevention of catastrophe for a few.”¹⁴

Essentially, reducing the risk of homicide, and indeed of any serious adverse outcome, will require lifting the standard of care for all patients.¹⁴

In order to lift the standard of care, the Office of the Chief Psychiatrist will:

- Ensure that the findings of this Review are incorporated in the revision of its Standards for Clinical Care and work with the HSPs on increasing their uptake into practice.
- Work with the Department of Health to promote the uptake of its risk assessment and management policies (including the revision of the risk assessment and management component of the Statewide Standardised Clinical Documentation).

These initiatives alone will not be sufficient. As outlined above, the quality and safety gaps identified in this Review have been the subject of recommendations in numerous reviews and reports, and yet, despite all efforts to implement change through mandatory policies, protocols, procedures, standardised documentation, etc., they still persist. In the words of Professor Braithwaite, *“dealing with this stagnation has proved remarkably difficult – so we need to tackle it in a new way”*

Three core strategies are recommended with the objective of creating an environment that supports safe, contemporary, compassionate treatment and care: - central to this is a strong clinical, consumer and carer voice.



¹⁴ Appleby L. in Maden A. Treating violence: A guide to risk management in mental health. Oxford, UK: Oxford University Press. page.v.

Strategy 1:

Restoring clinical leadership and governance

High performing health services require clinical and collaborative leadership, including strong, visible and engaged leadership with a deep understanding of the complexity of the mental health system. Clinical leadership is needed at all levels including management and governance and in the commissioning, planning and development processes.

Restoring a strong clinical voice in the WA mental health system is an important challenge for the Clinical Governance Review.

Strategy 2:

Establishing contemporary, fit-for-purpose public mental health services

The current WA Mental Health, Alcohol and Other Services Plan 2015-2025 (MHAOSP), which has a broad remit, does not adequately address a number of critical service gaps facing public mental health services, including important areas such as services for people with serious mental illness and challenging behaviours, comorbid mental illness and substance misuse, personality disorders, forensic, emergency department and consultation/liaison services. Nor does it provide the level of detailed deliberation and planning necessary for the establishment of a 'roadmap' for service development and transformation which is necessary to build a public mental health service system that is safe, high quality, sustainable and fit-for-purpose for the next decade.

There is a pressing need for a public mental health services plan to operationalise the WA Mental Health, Alcohol and Other Services Plan, which articulates a vision for service development and transformation, that addresses the critical gaps in services and provides guidance on models of care, service standards and resourcing.

There is a pressing need for a public mental health services plan to operationalise the MHAOSP, which articulates a vision for service development and transformation, that addresses the critical gaps in services and provides guidance on models of care, service standards and resourcing. The Department of Health, as system manager, should lead the process, working in collaboration with key stakeholders.

Strategy 3: Building a culture of improvement

While addressing the structural issues is vital, this alone is not sufficient. Quality Improvement (QI), which builds a learning environment through the engagement of front-line staff and consumers and carers in the change process, offers a promising approach to raising the safety and quality of clinical care. There is growing momentum nationally and internationally in the use of QI as a sustainable way of addressing complex quality and safety issues in mental health care.

The development of a system-wide Mental Health QI Program in WA would go a long way to ensuring that continuous improvement happens at scale and becomes part of the standard way of working.

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