

## Monitoring of Care Standards in Licensed Psychiatric Hostels

The Office of the Chief Psychiatrist commenced a regular program of standards monitoring visits to private licensed psychiatric hostels in September 2003. The visits assess the standards of care provided in each facility. Two visits have already been undertaken and a program is planned to achieve four visits per year.

The regular monitoring of care standards, under the *Mental Health Act 1996*, is one of a number of measures the Chief Psychiatrist undertakes in his broader obligations for residents in licensed psychiatric hostels. Standard monitoring visits are intended to support service improvement and the quality of care provided. The Office of the Chief Psychiatrist developed the standards in consultation with hostels and consumers. A framework and a set of standards guide a standards monitoring visit.

There are 5 Standards and 23 subsequent Outcome Standards. The 5 Standards are:

- **Freedom of choice and opportunity to exercise rights.**  
Each consumer is to have active control of his or her own life.
- **Care Needs**  
The personal care and community living needs of each consumer are to be identified and met.
- **Dignity and Privacy**  
The dignity and privacy of each consumer is to be respected.
- **Social Independence and Variety of Experience**  
Each consumer should exercise maximum social independence and have opportunity to participate in the variety of activities and experiences of interest to them.
- **Home-Like Environment**  
A licensed psychiatric hostel is to assist in the provision of a home-like environment for the comfort, safety and well being of the consumer.

For a complete list of the Outcome Standards please go to [www.chiefpsychiatrist.health.wa.gov.au](http://www.chiefpsychiatrist.health.wa.gov.au) and follow the prompts.

## Education and Training

The Office of the Chief Psychiatrist provides a number of different education and training experiences as part of the activities of the office.

**Mental Health Act (MHA)**- Training on issues in relation to the MHA include an Overview of the MHA, Detailed examination of the MHA for Clinicians, Issue on Referral and Police Powers, and Management of Community Treatment Orders. For further information contact Tim Rolfe (9222 4217).

**Clinical Governance Reviews**- Information on the Clinical Governance Review Framework and how it applies to your service. Contact Dr. Theresa Marshall (9222 4120).

**Overview and Strategic Direction of the Office of the Chief Psychiatrist**- Short information session contact Ms Janet Peacock (9222 4079).

## Clinical Governance Reviews

Ensuring that mental health patients receive the highest quality care is a core component of the Chief Psychiatrist's responsibility under the *Mental Health Act 1996*. Every patient who is treated in the West Australian (WA) mental health system wants to know that they can rely on receiving high quality care whenever they need it. Every part of the mental health system and everyone, who works in it, is expected to take responsibility for achieving continuous improvement to quality.

Clinical governance seeks to involve everyone in the system in continually finding better ways of doing things. It encompasses everything from managing and minimising risk to ensuring decisions are based on evidence and promoting life-long learning. It is about listening to the patient's experience and supporting staff at all levels. It is about changing the way people work throughout the organisation, and in so doing, altering its very culture.

Within a WA context Clinical Governance has been defined as:

*"A systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes".*

In order to assess the mental health services level of clinical governance implementation the Office of the Chief Psychiatrist has developed a clinical governance review framework and associated methodology. The review process is an amendment to the previous clinical review process, and examines whether the treatment and care of people afflicted with a mental illness are consistent with the objects and principles in the *Mental Health Act 1996 (the Act)* the National Standards for Mental Health Services (1996), the Clinical Governance for Mental Health framework and other relevant policies. This process supports the role of the Chief Psychiatrist in monitoring the standards of psychiatric care provided throughout the State of WA.

Clinical governance reviews collect and synthesise information, which enable an assessment to be made of an organisation's clinical governance arrangements. In particular, the Chief Psychiatrist is focused on an organisation's capacity for continuous improvement. This means that an organisation will not be assessed on any absolute level of performance but on whether it can improve on its current position regardless of its starting point.



# IN-FORM

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This is the First Edition of **IN-FORM** which contains information on legislative, clinical, training and education activities of the Office of the Chief Psychiatrist.

## Who is the Chief Psychiatrist?

The Chief Psychiatrist of Western Australia is Dr Rowan Davidson. He is located in the Department of Health at 189 Royal Street, East Perth.

## The Role of the Chief Psychiatrist

The Chief Psychiatrist has a statutory role under the *Mental Health Act 1996*. The Chief Psychiatrist is responsible for the medical care and welfare of all involuntary patients and in respect to other patients he is required to monitor the standards of psychiatric care provided throughout the State.

## Office of the Chief Psychiatrist

The following staff assist the Chief Psychiatrist:

**Mrs Janet Peacock, Manager**

**Mr Tim Rolfe, Clinical Consultant**

**Ms Yvonne Pallier, Information & Research Analyst**

**Dr Theresa Marshall, Clinical Governance Coordinator**

**Ms Doris Remse, Personal Assistant**

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## MANDATORY REPORTING TO THE CHIEF PSYCHIATRIST

In line with the monitoring activities of the Chief Psychiatrist are expectations on services for mandatory reporting. These are outlined in Operational Circular OP1646/03.

There are two categories for mandatory reporting, unexpected deaths and serious incidents.

- **Unexpected death of a patient in any mental health service must be reported as a matter of priority.**
- **Serious incidents are incidents, which are likely to reflect on the standards of mental health care.** They include but are not confined to incidents such as-
  - Serious assaults on or by staff, other patients or visitors,
  - Any alleged sexual assault,
  - Serious medication error,
  - The absconding of any forensic patient,
  - The absconding of any detained involuntary patient at serious risk of self-harm or harm to others,
  - A serious misuse or mistake of a function performed under the Mental Health Act,
  - Involvement of any government or non-government organisation which is contrary to functions under the Mental Health Act,
  - Criminal activity reported at a mental health facility and
  - Any incident which by its nature may receive attention by the media or the wider community.

Notification should be by e-mail or phone call to the Chief Psychiatrist with a cc to Janet Peacock. If you have any queries of this mandatory requirement contact Janet Peacock on 9222 4079

## Legislative Update 1 Detaining Powers under Form 1



the referred person making reasonable judgements about his or her own welfare. If the person does suffer from such incapacity (a person exhibiting behaviour the result of a florid mental illness typically but not necessarily falls into this category), then the person may be detained in order to ensure that appropriate treatment is

provided if that is assessed to be in the best interest of the referred person.

No additional factors are required. Details of the basis on which it is assessed that the person lacks capacity to consent should be recorded.

If a person has the relevant capacity but has indicated an intention not to stay until police arrive, there may exist circumstances that would justify the person being detained against his or her will. Those circumstances are where there is an imminent threat to the health and safety of the person or others if the person is not detained. The mere fact, for example, that detention for the purposes of ensuring a prompt psychiatric assessment in hospital would be, or was indicated to be, to the person's benefit would not be sufficient justification for detention. The detention and manner of detention must not be out of proportion to the peril to be avoided.

To avoid the possibility of legal liability for detaining a person, who has the relevant capacity, the clinician must ensure that he or she only detains the person where there is clear evidence of significant risk. It is important to document the reasons for detaining of a person.

Risk factors that may justify detention of a referred person with capacity could include fresh threats made to physically harm him/herself or others and a previous history of such threats or actual harm. A referred person's history of risk-taking behaviour would be an important factor in deciding if a person should be detained. Behaviour such as spending money in a manic state, approaching strangers or being sexually permissive may not in itself be serious enough behaviour to justify detention, but will be relevant to an assessment of the risks of the referred person or others.

- Consider the development of a framework for the Chief Psychiatrist to monitor the practice of ECT throughout the state;
- Other activities as requested by the Chief Psychiatrist or Director General of Health.

The advisory group has met on a number of occasions and divided into sub-groups to consider specific aspects of the process.

The groups are considering information and advice from other sources and it is proposed that the end result will be the production of a ring binder document for use around the State.

In the future the Chief Psychiatrist when reviewing services will use these standards to monitor the use of ECT.

## Legislative Update 2 Emergency Psychiatric Treatment in Emergency Department

When confronting behavioural disturbance Medical Practitioners in Emergency Departments may choose to use medication to control the person invoking their responsibilities in relation to duty of care or the use of Emergency Psychiatric Treatment (EPT) under the *Mental Health Act 1996* (MHA).

Here are some points of clarifications as to these processes. Although there is certainly a responsibility of a duty of care toward the behaviourally disturbed person and others which entitles the use of common law powers, it may leave the staff member exercising these powers in a more legally vulnerable position than using statutory powers under the MHA. Advice from the State Solicitor is that it is always preferred to use statutory powers such as given under the MHA rather than common law powers.

The use of EPT under the MHA is specifically for the sorts of situations which staff in EDs may need to manage in relation to persons with mental health problems. In effect EPT means psychiatric treatment, primarily sedating medication, necessary to give to a person to either save the person's life or prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person. EPT may be given, if necessary, without the consent of the person.

EPT can be given to either a voluntary patient, a referred person or to a person prior to making the decision as to whether a person should be referred. Although primarily envisioned as a one-off procedure it may be used again if the criteria are met. In effect the important issue here is safety from harm for the person or other persons which include staff.

There are some duties which support accountability for the person or staff member giving EPT and a report needs to be provided to the Mental Health Review Board (MHRB). Most Authorised Hospitals have a standard form, which is used to record when EPT is used and a copy of that form is sent to the MHRB. If your service does not have an EPT Report form a template can be provided from this office.

Essentially the person giving the EPT needs to record particulars of the treatment, the time and place at which, and the circumstances in which, the treatment was given and the names of the person involved in the giving of the treatment. It is usual then for a copy of this report to be maintained on the Medical file and a copy forwarded to the MHRB.

In the view of the Chief Psychiatrist this is a preferred way of managing the issue of giving medication to behaviourally disturbed mental health patients rather than using duty of care. It is not only legally more sound but it also results in the use of EPT being tracked by an independent body.

## Dangerous and Severe Personality Disorder (DSPD) Advisory Group

The Minister for Health requested that the Chief Psychiatrist commence detailed consideration as to whether alternative detaining powers such as those envisaged by the United Kingdoms Home Office may if introduced in Western Australia (WA) result in the detention of people with Dangerous and Severe Personality Disorders (DSPD).

No such specific legislation is provided in WA. Persons with a primary diagnosis of ASPD may if they meet the criteria of section 26 of the *Mental Health Act 1996* (MHA) be referred for examination by a psychiatrist and be made an involuntary patient. In those circumstances it is usual for the person to also suffer from a mental illness for which treatment as an involuntary patient can be provided.

The Chief Psychiatrist's initial report referred to detaining legislation for a small group of persons with anti-social personality disorder who could be best described as persons with Dangerous and Severe Personality Disorder (DSPD). Research indicates that there is limited effective treatment for persons with this disorder other than living in a therapeutic community, a treatment option not practicable as an involuntary patient under the MHA.

In order to report on this matter by December 2004 the Chief Psychiatrist has invited a small number of clinicians, academics and representatives from government and non-government organisations to sit on an advisory committee. The task of the committee will be to examine:

- A possible legal framework for the management of persons with DSPD;
- The applicability of any such proposed legislation to WA;
- The human rights issues raised by any such proposed legislation;
- The resource implications of any such proposed legislation.

To assist the committee and to inform persons who may be interested a webpage has been developed on the Chief Psychiatrist's website which gives further information on this subject. Entitled DSPD this webpage covers reports, journal articles and links. It will be updated regularly.

If you have views on this issue, which you wish to express, please feel free to write to the Chief Psychiatrist expressing these views and what options the advisory group should consider.



ECT is a treatment, which continues to raise community concerns despite its proven efficacy as a psychiatric treatment. In recognition of this issue and the lack of statewide standards and guidelines the Chief psychiatrist instituted in 2003 an advisory group made up of clinicians, both public and private and representatives of consumers and carer groups. The terms of reference for the group are

- The development of a set of standards in relation to the practice of ECT throughout the state;
- The development of best practice Guidelines in relation to ECT;
- Consider and report on the contentious issues in relation to ECT;
- Consider the development of an Accreditation Process in relation to clinicians and services who practice ECT;