



CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist's Standards for Clinical Care

As required under Section 547 of the Mental Health Act 2014

November 2015

Acknowledgement

This document would not have been possible without the invaluable contribution from the Chief Psychiatrist's Standards and Guidelines Working Group, and the broader agencies and individuals involved in feedback. Acknowledgement is also made to the Statewide Aboriginal Mental Health Service.

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Message from the Chief Psychiatrist

The Mental Health Act 2014 requires the Chief Psychiatrist to be responsible for overseeing the treatment and care to a range of users of mental health services. I am required to discharge that responsibility by publishing a set of standards for treatment and care provided by Mental Health Services and overseeing compliance with those standards.

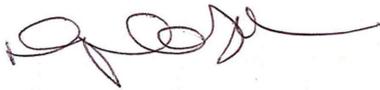
The job of standards in this context is to be a basic reference point seeking to consistently leverage safe and quality care for the benefit of consumers and carers. It is the responsibility of services to consistently strive to meet or exceed standards.

Standards are one component of a strong, consumer-focussed mental health system, and articulate with other essential parts such as quality training, service culture, resource management and personal responsibility. As Chief Psychiatrist, I value the skill and commitment of Mental Health Service Staff. They, together with the central role of consumers and carers in shared decision making, represent the greatest assets available to Mental Health Services.

It is important to note that as Chief Psychiatrist of Western Australia I have accepted the National Standards for Mental Health Services 2010 (NSMHS) as the overarching standards relevant for the Mental Health Act 2014. The subsequent following specific Chief Psychiatrist's Standards have been developed with particular purpose, and their context must be noted:

- The specific Chief Psychiatrist's Standards are not designed to replace the NSMHS but enhance them where local development is identified as needed
- They cover certain areas the Chief Psychiatrist deems to be either of central importance or requiring local jurisdictional focus
- They are designed to leverage quality clinical care and are purposefully and predominantly targeted towards clinical practice
- They are designed to be easily and quickly read by clinicians, and also by consumers and carers- hence they are relatively brief, not exhaustive
- They will be reviewed in a timely way, initially after 12 months following implementation

These standards complement and must be read in conjunction with the existing National Practice Standards for the Mental Health Workforce 2013 and the National Safety and Quality Health Service Standards 2012. While these standards have statutory relevance for Mental Health Services as defined by the MHA 2014, I commend these standards to the broader mental health sector for consideration.



Dr Nathan Gibson
CHIEF PSYCHIATRIST

30 November 2015

Chief Psychiatrist's Standards and Guidelines Working Group (CPSGWG)

The CPSGWG was established to develop the Chief Psychiatrist's Standards and Guidelines as required under Section 547 of the Mental Health Act 2014 (the Act).

The purpose of the Guidelines and Standards is to assist in the development and implementation of appropriate practices and to guide continuous quality improvement in mental health services. They focus on:

- Ensuring there is consumer and carer involvement;
- The principles underpinning service delivery;
- Meeting the expected standards of communication and consent; and
- Monitoring and governance.

The CPSGWG membership was comprised of:

- Mental health professionals;
- Consumers;
- Family and carers.

The consumer and carer representatives on CPSGWG, while acting as individual experts, were members of wider networks including:

- Consumers of Mental Health WA (CoMHWA);
- Carers WA;
- Children of Parents with a Mental Illness (COPMI);
- Mental Health Carers Arafmji; and
- Health Consumers' Council.

There was also representation from the Lived Experience Advisory Group (LEAG) and the Mental Health Bill Implementation Reference Group (MHBIRG).

The process and context for the development of the Standards and Guidelines was:

1. The development of the Guidelines specified in Section 547(1) of the Act;
2. The development of the Standards and required under Section 547(2) of the Act.
3. The National Practice Standards for the Mental Health Workforce (NPSMHW) and the National Standards for Mental Health Services (NSMHS) have had significant national consumer and carer input into their development and these Standards have been accepted by the Chief Psychiatrist.
4. There was appropriate consultation by CPSGWG with individuals and relevant bodies external to the Group to further refine the Standards and Guidelines developed by CPSGWG.

Standard: Aboriginal Practice

Definition

All Western Australian mental health services and service providers are within scope for this Practice Standard, which defines the service context, criteria and measures for best practice in responding to the cultural needs of Aboriginal people with mental illness and their carer's, families and communities.

Purpose

To facilitate equitable access and improved mental health outcomes for Aboriginal people with mental illness, and their carer's, families and communities, by defining Practice Standards for:

- Delivering mental health services that take into account the cultural and social diversity of Aboriginal people with mental illness and meeting their needs and those of their carer's and community throughout all phases of care.¹
- Actively and respectfully reducing barriers to access, providing culturally secure systems of care, and improving social and emotional wellbeing.²

Context

Mental health services and providers should:

- Work collaboratively and in partnership with Aboriginal people with mental illness and their carers to improve the safety and quality of care.³
- Practice in accordance with the National framework for recovery-oriented mental health services.⁴
- Have regard to the Charter of Mental Health Care Principles.⁵
- Recognise the potential value of traditional healing practices in the treatment of mental health and social and emotional problems; understand the mental health implications of the history of contact between Aboriginal communities and Australia's mainstream society; and acknowledge that understanding of mental health within Aboriginal communities involves a holistic construct of social, emotional, cultural and spiritual wellbeing.^{6,7,8,9,10}
- Provide trauma-informed care and practice in a strengths-based framework.¹¹

1 Australian Government (2010) National Standards for Mental Health Services.

2 Australian Government (2013) National Practice Standards for the Mental Health Workforce.

3 Australian Commission on Safety and Quality in Health Care (ACSQHC) (September 2011), National Safety and Quality Health Service Standards, ACSQHC, Sydney.

4 [A National Framework for Recovery-oriented mental health services 2013.](#)

5 Western Australia Mental Health Bill 2014.

6 RANZCP Principles and Guidelines for Aboriginal and Torres Strait Islander Mental Health 2014

7 [Working Together: Aboriginal and Torres Strait Islander Mental health and Wellbeing Principles and Practice.](#)

8 [WA Aboriginal Health and Wellbeing Framework 2015-2030](#)

9 [National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023](#)

10 [Social and emotional wellbeing framework 2004-2009](#)

11 Mental Health Coordinating Council (MHCC) 2013, Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)

Criteria

1. Access
 - 1.1. Enhancing access to and engagement with mental health services for Aboriginal people and communities.
 - 1.2. Culturally appropriate resource development (Aboriginal community education and awareness, clinical resources).
 - 1.3. Interpreter services (well-resourced and readily accessible).
 - 1.4. Interdisciplinary care.⁷
2. Governance
 - 2.1. Leadership in Aboriginal mental health service delivery.
 - 2.1.1. Dedicated Aboriginal leadership positions in mental health.
 - 2.1.2. Community engagement in the development, planning, delivery and evaluation of services.
 - 2.1.3. Consumer and carer involvement in the development, planning, delivery and evaluation of services.
 - 2.2. Partnership to deliver coordinated culturally capable health care.
 - 2.2.1. Traditional Healers.
 - 2.2.2. Consumer, family, carer and community.
 - 2.2.3. Interagency and intersector partnerships in service delivery.
3. Workforce
 - 3.1. Cultural supervision for all mental health workers.
 - 3.2. Interpreter services training for all mental health workers.
 - 3.3. Cultural competence for non-Aboriginal mental health workforce.
 - 3.3.1. Cultural awareness training.
 - 3.3.2. Organisational culture that is supportive of cultural competence.
 - 3.4. Aboriginal mental health workforce development.
 - 3.4.1. Maximise the potential for providing culturally responsive, safe and capable services through the recruitment and retention of Aboriginal mental health workers.
 - 3.4.2. Mental health workforce competency framework.⁸
 - 3.4.3. Participation in an Aboriginal Mental Health Network (for peer mentoring and support).
 - 3.4.4. Workplace/organisational support to obtain clinical qualifications.
 - 3.4.5. Establish a cross-sectoral career structure for Aboriginal Mental Health Workers.
4. Data and information collection, use and analysis
 - 4.1. Identification of Aboriginal consumers.
 - 4.2. Culturally-informed information collection for epidemiological and clinical purposes.
 - 4.3. Culturally-informed clinical assessment, care planning and review.
 - 4.4. Monitoring, analysis and use of such data and information in health service planning, patient safety and continuous quality improvement.

12 Schultz C, Walker R, Bessarab D, McMillan F, MacLeod J & Marriott R (2014) Interdisciplinary Care to Enhance Mental Health and Social and Emotional Wellbeing. In Australian Government (2013) National Practice Standards for the Mental Health Workforce.

Measures

Criterion	Measure
Access	<ul style="list-style-type: none">• The number of Aboriginal consumers accessing and engaging with alcohol, drug and/or mental health services; the proportion of cases with input from an Aboriginal mental health worker, family member, carer, elder, community member and/or traditional healer; and expressing satisfaction with the level of cultural appropriateness of service delivery.
Governance	<ul style="list-style-type: none">• Number and proportion of Aboriginal leadership position(s) reflected in the organisational chart and influencing service delivery through cultural supervision/mentoring contracts/plans developed and successfully acquitted.
Workforce	<ul style="list-style-type: none">• Proportion of Aboriginal workforce retained, the number of workforce development initiatives/opportunities for Aboriginal staff provided by organisation and the proportion of Aboriginal staff completing/demonstrating satisfactory progress.

Review Date: 12 months from the date of publication

Standard: Assessment

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition

Assessment: Process by which the characteristics and needs of a consumer and their family or carer are evaluated and determined so that they can be addressed. The assessment forms the basis of treatment, care and recovery planning.^{9,10}

Purpose of the Standard

To provide comprehensive individualised assessment of the consumer to ensure holistic care planning.

Context

1. A comprehensive assessment may occur over a number of treatment sessions.
2. The consumer will be involved in all aspects of their assessment.
3. Carers have the right to contribute to the assessment of the consumer.¹¹
4. An assessment may include components provided by a range of multidisciplinary clinicians.
5. Cultural, language and social diversity will be taken into account in both the process and understanding of the assessment.^{12,13,14,15}
6. Timely and appropriate reassessment will occur as required.¹⁶
7. Assessment will be undertaken in the context of trauma informed care principles.¹⁶
8. If a consumer is under the legal care of a parent or guardian,¹⁷ the clinician must involve the parent or guardian in the assessment.
9. There may be an exception to this Standard where an assessment is being conducted for an additional specific or specified purpose.

Criteria

1. Assessments conducted:
 - 1.1 Are age-appropriate.
 - 1.2 Use broadly accepted methods and tools.
 - 1.3 Have regard to internationally accepted disease classification systems used in clinical practice.¹⁸
 - 1.4 Will consider biopsychosocial and cultural aspects of an individual's life.
2. Assessments must:
 - 2.1 Be written in plain English.
 - 2.2 Be legible.
 - 2.3 Be compliant with service documentation standards.

⁹ National Standards for Mental Health Services 2010

¹⁰ Mental Health Act 2014, Part 6 Division 2

¹¹ Carers Recognition Act 2004

¹² Mental Health Act 2014, Part 4 s.11

¹³ Schedule 1: Charter of Mental Health Care Principles

¹⁴ Mental Health Act 2014, Part 6 Division 2 s50

¹⁵ National Standards for Mental Health Services 2010, Standard 4 Diversity responsiveness

¹⁶ Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia, Prof Bryant Stokes July 2012

¹⁷ Guardianship and Administration Act 1990

¹⁸ National Practice Standards for the Mental Health Workforce 2013, Standard 6

3. A comprehensive assessment must include a mental state examination and documentation.
4. Assessments will contain a succinct summary of prior treatment – it is generally not appropriate to use the phrase “see previous summary”.
5. Assessments are conducted by mental health clinicians and where possible in the consumer’s preferred setting with consideration for the safety of all involved.¹⁹
6. A timely assessment is to be made in accordance with risk, urgency, distress and dysfunction.²⁰
7. Assessments of consumers will include communication where available with:
 - 7.1 Primary care clinicians.
 - 7.2 Specialist clinicians.
 - 7.3 Other workers involved in the consumer’s care.²¹
 - 7.4 Significant members of the consumer’s cultural community with consumer’s consent.⁴
8. The assessment must be of sufficient depth and breadth to be able to inform treatment, care and recovery planning.
9. The assessment must include consideration of dependents and commitments of the consumer. This is to include children and other caring roles.
10. The assessment must include consideration of the needs of the carer in the context of their caring role.
11. Physical health care needs will be identified with equal priority.¹²
12. A risk assessment and management must accompany the initial assessment.¹⁰
13. Assessments will include a written integrated formulation of the issues and an associated diagnosis.
14. Assessments will consider co-occurring issues particularly alcohol, other drugs and other health issues including physical, intellectual and developmental disability.⁵

Future/Potential Measures

1. Completion of standardised or equivalent assessment tool.

Review Date: 12 months from the date of publication

¹⁹ Risk Assessment and Management Standard 2014

²⁰ National Standards for Mental Health Services 2010, Standard 10 Delivery of Care

²¹ Physical Health Care of Mental Health Consumers Standard 2014

Standard: Care Planning

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition

Care Plan: A written statement developed with the involvement of consumers, carers and relevant others, for consumers, which outlines the treatment and support to be undertaken, the health outcomes to be achieved and review of care which will occur at regular intervals.²²

Recovery: *Personal Recovery* – Being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.²³

Purpose of the Standard

To define a holistic, shared care planning process which is personalised and recovery focussed.

Context

1. The consumer will be a partner in the care planning process.
2. A clinician will facilitate carer involvement or contribution to care planning.
3. A clinician will involve consumers in individual, shared or supported decision-making and encourage self-determination, cooperation and choice.²⁴
4. *The Consumer and Carer Involvement in Individual Care Standard* is to be used as an overarching standard for treatment, care and recovery planning.

Service

1. All consumers will have a written care plan using a standardised template or equivalent, taking into consideration their language and literary requirements.
2. Services will recognise the need for the carer to receive a copy of the care plan after taking into consideration consumer consent and risk issues.
3. Services will ensure that the care plan is kept on both the clinical record and on PSOLIS²⁵ Where applicable.
4. The care plan will be reviewed, as a minimum, every three months.
5. The care plan will have multidisciplinary team input wherever possible.
6. Services will provide appropriate oversight of the care plan by a psychiatrist.
7. Services must use the principles of recovery oriented mental health practice by:²⁴
 - 7.1 Upholding a person-centred focus with a view to obtaining the best possible outcomes for consumers, by recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal-oriented treatment, care and support.
 - 7.2 Promoting positive attitudes towards mental illness, including recognising that consumers can lead full and productive lives and make meaningful contributions to the community.
8. The service will provide access to a range of evidence based treatments.²²
9. The service will take into account the cultural and social diversity of its consumers, carers and community^{24, 26, 27}

²² National Standards for Mental Health Services 2010

²³ A National Framework for Recovery-Oriented Mental Health Services – Policy and Theory

²⁴ Charter of Mental Health Principles – Schedule 1 Mental Health Act 2014.

²⁵ Review of the admission or referral to and the discharge and transfer practices of public mental facilities/services in Western Australia, Prof Bryant Stokes July 2012

²⁶ National Standards for Mental Health Services 2010, Standard 4 Diversity Responsiveness

10. The service will uphold the rights of the consumer and carer.^{28, 29, 30, 31}

Criteria

3. The service has a process which includes the commencement of development of a discharge plan from the time the consumer enters the service.³²
4. The consumer and their carer are provided with relevant and appropriate information on the range of services and support that are suitable and available in their community.³²
5. The clinician has a responsibility to facilitate a pathway to relevant and accessible services.
6. The clinician will, whilst undertaking treatment, care and recovery planning:
 - 4.1 Provide evidence based treatment with ongoing assessments.
 - 6.2 Provide individualised planning on a strength based approach.
 - 6.3 Proactively involve relevant, other service providers (e.g. non-government organisations, community supports and primary care services).
7. Care planning will consider the issue of continuity and the standard regarding the transfer of care.
8. Care planning will include physical health care assessment and management.
9. Care planning will consider the issues of medication and treatment safety.
10. Where there are unresolved differences in perspective, on aspects of the care plan among consumers, carers and clinicians, these differences will be acknowledged in the care plan.

Measures

1. Review of care plan within three months.

Future/Potential Measures

1. Care plans developed with consumers.
2. Care plans developed with carers.

Review Date: 12 months from the date of publication

²⁷ Mental Health Act 2014, Part 6 Division 2 s 50

²⁸ National Standards for Mental Health Services 2010, Standard 1 Rights and Responsibilities

²⁹ National Standards for Mental Health Services 2010, Standard 6 Consumers

³⁰ National Standards for Mental Health Services 2010, Standard 7 Carers

³¹ Carers Recognition Act 2004

³² National Standards for Mental Health Services, Standard 10 Delivery of Care

Standard: Consumer and Carer Involvement in Individual Care

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition

1. Consumer:
For the purpose of this standard a consumer is referred to under the Mental Health Act 2014 as a “*patient*”.
Patient means -
 - a) An involuntary patient; or
 - b) A mentally impaired accused person required under the Mentally Impaired Accused Act 1996 to be detained at an authorised hospital; or
 - c) A voluntary patient including a referred person³³
2. Carer:
For the purpose of this standard a carer is a person who is an individual who provides ongoing care or assistance to a person with a mental illness as defined under the Mental Health Act 2014.³³

Purpose of the Standard

Create a service that is responsive to consumer and carer input and needs.³⁴

Context

1. Mental health services are required to work collaboratively and in partnership with consumers and/or carers irrespective of whether the consumer is a voluntary or involuntary patient.
2. There should always be an emphasis on recovery orientated care.³⁵ This involves active partnership with consumers and carers by services²
3. All services must have regard to the principles in the Charter of Mental Health Care Principles.³⁶
4. It is a requirement that consumers, carers, clinicians and other associated staff operate in an environment of mutual respect.

Criteria

1. The mental health service ensures staff capability in working with consumers and carers through the provision of information, education and supervision.
2. Consumer
 - 2.1 Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.³⁷
 - 2.2 Consumers have the right to receive service free from abuse, exploitation, discrimination coercion, harassment and neglect.⁵

³³ Mental Health Act 2014, Part 2, Division 1 Section 4

³⁴ Australian Commission on Safety and Quality in Health Care, Partnering with Consumers; Standard 2

³⁵ A National Framework for Recovery-oriented mental health services 2013. Page 3

³⁶ Mental Health Act 2014, Part 4, Section 11 and Schedule 1: Charter of Mental Health Care Principles, National Standards for Mental Health Services, 2010 Standard 4

³⁷ National Standards for Mental Health Services, 2010; Standard 6. Consumers

- 2.3 Consumers are partners in the management of all aspects of their treatment, care and recovery planning.⁵
- 2.4 Informed consent is actively sought from consumers prior to any intervention provided or any changes in care delivery.⁵
- 2.5 Consumers are provided with current and accurate information on the care being delivered.⁵
3. Carer
 - 3.1. Carers need recognition and respect, and their support is valued and important to the wellbeing, treatment and recovery of consumers.³⁸
 - 3.1.1 The mental health service actively seeks information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and records that information in the consumer's health record.⁶
 - 3.1.2 The mental health service engages carers in discharge planning, involving crisis management and continuing care, prior to transfer of or discharge from all episodes of care.⁶
 - 3.2 Where the consumer actively declines carer involvement the service will consider any appropriate strategies to engage the carer.
 - 3.3 Clinicians and other associated staff will record significant information provided by carers.
 - 3.3.1 Clinicians will give due consideration to confidentiality regarding information provided by carers.

Measures

1. Measurement of consumer and carer satisfaction.

Future/Potential Measures

1. Staff attend training regarding engagement with consumers and carers.
2. Consumer and Carer signatures on Treatment, Support and Discharge Plans.
3. The percentage of staff attending clinical supervision. This measure is under development.

Review Date: 12 months from the date of publication

³⁸ National Standards for Mental Health Services 2010; Standard 7 Carers

Standard: Physical Health Care of Mental Health Consumers

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Purpose of the Standard

To improve the physical health outcomes of consumers who experience mental illness.

Context

1. All mental health consumers have the right to physical (including dental) health care that is equal to the care provided to the general population.
2. Mental and physical health care will be coordinated with equal priority to support individual recovery.
3. All mental health clinicians will recognize the role of carers in the assessment and management of physical health care needs.
4. All mental health clinicians must consider the impact of mental illness on physical health.
5. All mental health clinicians must ensure that the physical wellbeing (including dental) of all patients under their care is regularly assessed and where appropriate referred to appropriate specialist clinicians.³⁹
6. Appropriate consent must be obtained prior to physical examination of the consumer.

Criteria

1. Systemic Criteria:
 - 1.1 The mental health service will have clear pathways for appropriate assessment and treatment of physical illnesses by general practitioners and specialist clinicians.
 - 1.2 Mental health clinicians have a responsibility to advocate for and facilitate equity in access to physical health care.
 - 1.3 Mental health services will ensure that staff take into account and are informed on matters such as medication adverse effects that will impact the physical health of consumers with mental illness.
 - 1.4 Mental health services will recognise the co-morbid use of substances, the use of non-prescribed medications and lifestyle choices in the overall management of the consumer.
 - 1.5 There will be a standardized approach to regular physical screening and in particular metabolic screening.
 - 1.5.1 Measurement of Body Mass Index (BMI).
 - 1.5.2 Measurement of waist circumference.
 - 1.5.3 Regular age appropriate screening relative to the medications prescribed.
 - 1.6 Treatment, Support and Discharge Plans, and other Care Plans (including transfer of care documents) will specifically address physical health care needs.
2. Personal Criteria:
 - 2.1 Assessment of consumers will include communication with general practitioners and specialist clinicians involved with their care.
 - 2.2 Assessment of consumers will include communication with carers.

³⁹ Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health, Professor Stokes B (2012)

- 2.3 Consumers unable to engage with a primary health care provider including a general practitioner will have their ongoing physical health care needs coordinated by the treating community mental health service.
- 2.4 All consumers will have at least yearly physical assessments and appropriate screening.
- 2.5 All consumers will have regular oral health assessments.¹
- 2.6 All consumers will have a physical assessment on admission to an inpatient service.
- 2.7 All consumers and carers will receive timely information on the impact of medications on physical health.¹
- 2.8 Where a consumer with capacity to consent declines assessment of their physical health care needs despite appropriate advice, the clinician must consider what ongoing strategies will best assist that consumer and carer to manage the physical health care in the future

Measures

1. Physical examination documented within 12 hours of admission.

Future/Potential Measures

1. Incorporation of physical health care components in the Care and Treatment, Support and Discharge Plans.
2. Evidence of appropriate treatment for abnormal physical health states.
3. Communication with primary care providers.

Review Date: 12 months from the date of publication

Standard: Risk Assessment and Management

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition ⁴⁰

1. **Risk:** The likelihood of an event occurring, which may have harmful outcomes for the person or others.
2. **Risk Assessment:** A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to a consumer and their family or carers, and the context in which they may occur. This process requires linking historical information to current circumstances, to anticipate possible future change.
3. **Risk Management:** Clinical risk management aims to minimise the likelihood of adverse events within the context of overall management of a consumer. It provides the opportunity for targeted intervention to minimise the causative factors to achieve the best outcome and deliver safe, appropriate, effective care. Risk management can be both at an individual and systemic level.

Purpose of the Standard

To assess, minimise and manage the risks in relation to risk to self, to others and from others.

Context

Mental health services are never risk-free and clinical risks like suicide and violence cannot be predicted with 100% accuracy. Instead, good clinical risk management is based on effective treatment that is focused on an individual's history and current circumstances.¹

1. Risk may include:
 - 1.1. Risk to self: includes self-harm, suicide and attempted suicide, repetitive self-injury; self-neglect; missing and people absent without leave⁴¹; physical deterioration including drug and alcohol misuse and medical conditions (including medical conditions secondary to eating disorders); and quality of life including dignity, reputation, social and financial status.
 - 1.2. Risk to others: includes harassment; stalking or predatory intent; violence and aggression; property damage; and public nuisance and reckless behaviour that endangers others.
 - 1.3. Risk from others, especially considering vulnerable persons: includes physical, sexual or emotional harm or abuse by others and social or financial abuse or neglect by others.¹
2. Risk assessment and management must be legally, ethically and evidence-based.¹
3. The practice of risk assessment and management is to be person-centred and acknowledge the balance of risk, choice and dignity.¹
4. Risk assessment and management is a shared, systemic responsibility, underpinned by a 'no-blame' culture.¹
5. Sentinel incidents and adverse events are reviewed and considered as opportunities for improvement.¹
6. Risk assessment and management is regarded as a core competency for all mental health clinicians.¹
7. The principles of risk assessment should underpin the practice of all services providing mental health care.

⁴⁰ Clinical Risk Assessment Management in Western Australia

⁴¹ Mental Health Act 2014 s. 97

8. The mental health service should conduct risk assessments of all patients throughout all stages of the care continuum, including patients who are being formally discharged from the service, exiting the service temporarily and/or are being transferred to another service.¹
9. Risk management during transportation must be compliant with relevant Commonwealth and state transport policies and guidelines, including the current National Safe Transport Principles.⁴²

Criteria

1. Staff undertaking risk assessments will seek, consider and respond appropriately to information from:
 - 1.1. The patient.
 - 1.2. Carers, families and personal support persons.
 - 1.3. Other records including referring letters and PSOLIS where applicable.
 - 1.4. Other professional assessments.
 - 1.5. Any other person or body considered relevant.
2. Staff will use standardised or equivalent contemporary risk assessment tools and guides, that are appropriate to age and context, which support clinical judgement and clinical decision making and inform a shared management plan. Noting that actuarial risk assessment tools are of limited predictive value on their own.
3. Staff will use trauma informed care principles.
4. Staff will undertake a holistic risk assessment with consideration of the cultural, diverse and individual needs of the consumer, carer and family as part of the assessment.
5. Staff will always take into account the consumer's views and needs regarding risk including when:
 - 5.1. They lack capacity.
 - 5.2. They are under 18 years of age.
 - 5.3. In the context of an Advance Health Directive.
6. Staff are to include physical health as equal priority in the assessment as outlined in the Standard for Physical Health Care.
7. Risk assessments and reviews of shared management plans will occur regularly and whenever a significant change in the consumer's circumstances is identified which might impact upon risk.
8. Outcomes and changes in risk assessment and management are required to be communicated in a timely way to affected persons and agencies.
9. Following an adverse event, sentinel or critical incident involving serious assault or abuse, injury or death, the restoration and maximisation of the well-being and mental health of all involved is a priority.

Future/Potential Measures

1. The audit of compliance with the specified risk assessment and management tools.

Review Date: 12 months from the date of publication

⁴² National Standards for Mental Health Services

Standard: Seclusion and Bodily Restraint Reduction

This Standard applies to all authorised public and private mental health services as defined by the Mental Health Act 2014.

Definition

1. **Seclusion:** is defined as confinement of a person, who is being provided with treatment or care at an authorised hospital, by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave.⁴³
2. **Bodily restraint:** is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.¹
3. **Physical restraint:** is the application of bodily force to the person's body to restrict the person's movement.¹
4. **Mechanical restraint:** is the application of a device, to restrict the person's movement, such as a belt, harness, manacle, sheet or strap. Mechanical restraint does not include either the appropriate use of medical or surgical appliances or the appropriate use of furniture to restrict a person such as cot sides or a chair fitted with a table. It also does not include physical or mechanical restraint by a police officer.¹

Purpose of the Standard

Reduction of seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint.

Context

1. Mental health services will endeavour to reduce the use of, and where possible, eliminate seclusion and restraint.⁴⁴
2. Seclusion and restraint are interventions not therapies.
3. Risk of trauma and physical harm to staff and patients can be increased by use of seclusion and restraint.
4. If and when pro re nata (as needed) medication is used, it should be judiciously administered for the purpose of calming and not sedating.
5. Where there are no appropriate alternatives to seclusion or restraint they should be administered in the most safe, dignified and respectful manner as possible by appropriately trained staff.
6. Restraint techniques will be standardised across all Authorised Hospitals to minimize error.

Criteria

1. Management and staff of all Authorised Hospitals:
 - 1.1. Will comply with mental health legislation requirements relating to seclusion and restraint.
 - 1.2. Will conduct, with all relevant staff, an approved age-appropriate training program for prevention of aggression and early intervention in a crisis situation. The training program will include the following elements:
 - 1.2.1 The majority of time will be focused on strategies such as de-escalation that prevent exacerbation of a crisis.
 - 1.2.2 The training program will incorporate trauma-informed care principles.

⁴³ Mental Health Act 2014 Part 14 Division 5 & 6

⁴⁴ National Standards for Mental Health Services Standard 2.2

- 1.2.3 Ongoing competency updates will include a training component undertaken in the ward environment.
 - 1.2.4 Peer Support Workers or persons with lived experience will contribute to the training wherever possible.
 - 1.2.5 There will be an explicit differentiation for staff between seclusion and time-out.
 - 1.3. Will have a Sensory Modulation or equivalently named area and/or mobile sensory modulation equipment with an appropriate quiet space in which it can be used.
 - 1.4. Will utilise a Patient Safety Plan (or equivalently named template identifying patient-driven strategies to prevent or reduce distress or agitation) drafted collaboratively between a patient and staff and where appropriate the carer, as soon as possible after admission.
 - 1.5. Will debrief patients, relevant support persons and staff after seclusion and restraint events, and document this process.
 - 1.6. Will not use neck holds.
 - 1.7. Will avoid the use of prone restraint whenever possible to minimize the risk of respiratory compromise.
 - 1.8. Will ensure monitoring and recording of physical observations and wellbeing during restraint.
 - 1.9. Will, where appropriate and/or requested, advise the patient's carer, and/or personal support person of the seclusion and restraint event.
2. Medical staff will take a proactive role in seclusion and restraint minimisation:
 - 2.1. The Treating or Duty Psychiatrist will take an active leadership role in facilitating strategies for an individual patient that reduces seclusion and restraint.
 - 2.2. Medical staff will attend a clinical unit, at the earliest possible time, when there is evidence of escalating risk not settling with remote support.
 - 2.3. Medical staff will take an active decision making role early in the Seclusion and Restraint process.
3. Mental Health Units will hold a Service Executive Review of all seclusion and restraint events:
 - 3.1. Focusing on collaborative reduction, and not a blaming process.
 - 3.2. Held at least weekly with the staff involved in the seclusion and restraint events participating, whenever possible.
 - 3.3. Include the presence of a Peer Support Worker or individual with lived experience at the Review, whenever possible.
 - 3.4. Will publish local quarterly de-identified seclusion and restraint data at the service which is available to staff, patients and the general public.
 - 3.4.1 This data will be forwarded to the Chief Psychiatrist.

Measures

1. Episodes of seclusions and restraint (per 1000 bed days as denominator).
2. Designated time periods in seclusion and restraint.

Future/Potential Measures

1. Compliance with the Service Executive Reviews of seclusion and restraint. This measure is under development.

Review Date: 12 months from the date of publication

Standard: Transfer of Care

This Standard applies to all public and private mental health services as defined by the Mental Health Act 2014.

Definition

A person-centered, 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.

Purpose of the Standard

To ensure continuity, safety and quality of care for consumers and carers is maintained during transfer either between or within services.

Context

1. Consumers may be at higher risk during transfer of care.
2. The consumer, and where relevant the guardian, will partner in the drafting and ownership of the transfer information is essential.
3. Carer collaboration in this process must always be actively sought.⁴⁵
4. Different service providers in the continuum of care may require different aspects of information.⁴⁶ Transfer of information will recognize other relevant privacy legislation and policy.
5. The referring service retains the responsibility for the consumer until handover to the receiving service or practitioner or the consumer decides on an alternative process.
6. The mental health service, in conjunction with the treating clinician, will facilitate appropriate follow-up for all consumers within seven (7) days after transfer.
7. When a consumer does not keep the planned follow-up arrangements there must be active consideration and management of risk in accordance with *the Risk Assessment and Management Standard*.
8. Referral and provision of handover information should occur prior to transfer from the referring service, exceptional circumstances permitting.
9. In the context of appropriate assessment and risk assessment duplicate triaging will be avoided.
10. Any unresolved debate regarding clinical responsibility or appropriateness of transfer, must be resolved in a timely manner and must not impact on safety and access to care.
11. Multiple care plans should be merged wherever possible.
12. Agencies will make every attempt to work collaboratively with each other, in a person-centered approach.
13. The use of standardised transfer of care documents is recommended.

Criteria

Discharge, transfer and equivalent plans will include reference to:

1. A case formulation, including a brief summary of those factors which are essential for understanding the patient as an individual and within their social and cultural environment.
2. Standardised clinical diagnoses.
3. Mental state examination changes from admission to discharge.

⁴⁵ Consumer Carer Involvement in Individual Care Standard, Chief Psychiatrist 2015

⁴⁶ National Standards for Mental Health Services 2010 Standard 10 6.2

4. Therapies used and ceased, including reasons for this, adverse effects and any significant clinical incidents.
5. Physical healthcare assessment and management.⁴⁷
6. Risk assessment and management.
7. Known signs and symptoms which indicate potential mental health deterioration (relapse signature).
8. Contingency strategies/ crisis plans.
9. Post discharge follow-up arrangements.
10. Contact details for consumer, carer and guardian where relevant.

The plans must be clear, directive and suitable for the needs of the consumer and receiving services involved in the individual's care including general practitioners, and other clinical services. Transfer information to non-clinical services should reflect the needs of the consumer within that service.

Measure

1. Transfer summary provided to receiving service.

Future/Potential Measures

1. Documented relapse signature and contingency strategy.
2. Information handover prior to consumer exiting the service.

Review Date: 12 months from the date of publication

⁴⁷ Physical Health Care of Mental Health Consumers Standard, Chief Psychiatrist 2015