



CHIEF PSYCHIATRIST
of Western Australia

‘Ensuring Safe and High Quality Mental Health Care’

**Annual Report of the Chief Psychiatrist
of Western Australia**

01 July 2016 – 30 June 2017




Statement of Compliance

**HON ROGER COOK MLA
DEPUTY PREMIER;
MINISTER FOR HEALTH; MENTAL HEALTH**

In accordance with section 533 and 534 of *the Mental Health Act 2014*, I hereby submit for your information and presentation to Parliament, the Annual Report of the Chief Psychiatrist for the financial year ended 30 June 2017.

The Annual Report has been prepared in accordance with the provisions of *the Mental Health Act 2014*.

A handwritten signature in black ink, appearing to read 'Nathan Gibson', with a long horizontal stroke extending to the right.

Dr Nathan Gibson
**CHIEF PSYCHIATRIST
ACCOUNTABLE AUTHORITY**

September 2017

Declaration of Financial Accountability

In accordance with section 61(3) of the *Financial Management Act 2006*, I declare that the Annual Report of the Mental Health Commission includes a report for the financial year ended 30 June 2017 information prescribed by the Treasurer's instructions, in respect of the Office of the Chief Psychiatrist, an affiliated body of the Mental Health Commission.

At the date of declaration, I am not aware of any information, which would render the particulars included in the financial report relating to the Office of the Chief Psychiatrist as misleading or inaccurate.



Ms Marie Falconer
CHIEF FINANCE OFFICER
ACCOUNTABLE AUTHORITY

September 2017

Disclosures and Legal Compliance

Record Keeping

The Chief Psychiatrist has complied with the statutory record keeping practices in accordance with the *State Records Act 2000* and the standards and policies of the State Records Office of Western Australia.

In the reporting period the State Records Office, in accordance with section 28 of the *State Records Act 2000*, has approved the Record Keeping Plan and Record Keeping Procedures for the Office of the Chief Psychiatrist.

Board and Committee Remuneration

In Accordance with disclosure under section 61 of the *Financial Management Act 2006* and parts IX and XI of the treasurer's instruction there has been no remuneration for Board or Committee members.

Legal and Government policy requirements and financial disclosures

Treasurers instruction 903 (12) requires the Office of the Chief Psychiatrist to disclose information on any Ministerial Directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities.

Section 516 of the *Mental Health Act 2014* permits the Minister for Mental Health to issue written directions about general policy to be followed by the Chief Psychiatrist, and the Chief Psychiatrist may request the Minister to issue a direction. The Minister must cause the text of such a direction to be laid before each House of Parliament.

The Minister issued no such directives to the Chief Psychiatrist nor did the Chief Psychiatrist make such a request to the Minister for the reporting period.

Conflicts of Interest with Senior Officers

In accordance with section 31(1) of the *Public Sector Management Act 1994*, the Office of the Chief Psychiatrist fully complied with the public sector standards and the Western Australian Code of Ethics.

Compliance with Public Sector Standards and Ethical Codes

In accordance with section 31(1) of the *Public Sector Management Act 1994*, the Office of the Chief Psychiatrist fully complied with the public sector standards and the Public Sector Commission Commissioner's Instruction No. 7 Code of Ethics.

Staff of the Office of the Chief Psychiatrist, comply with the Mental Health Commission's Code of Conduct, whilst demonstrating public service professionalism and probity.

Occupational Safety, Health, and Injury Management

For the reporting period, the Office of the Chief Psychiatrist was compliant with the *Occupational Safety and Health Act 1984*. All new staff to the Office are provided with a comprehensive induction and orientation.

Contents

Record Keeping	1
Board and Committee Remuneration	1
Legal and Government policy requirements and financial disclosures.....	1
Conflicts of Interest with Senior Officers	1
Compliance with Public Sector Standards and Ethical Codes	1
Occupational Safety, Health, and Injury Management	1
Foreword	4
Executive summary	6
Our drivers for safe quality care	11
The Mental Health Act 2014	11
The Charter of Mental Health Care Principles	11
Chief Psychiatrist's Standards for Clinical Care	11
National Standards for Mental Health Services	11
Who we are	12
Our People	14
Our Support for staff in our Office	16
Our Collaborations	17
Our Performance at a glance	18
Our vision for the future	20
A Snapshot of Western Australia's Mental Health Services	21
Inpatient Mental Health Services	21
Community Mental Health Services	22
Emergency Department Mental Health Presentations	23
Our activities	24
Clinical, Statutory Authorisations and Education Program	25
Our engagement with Consumers, Carers and Personal Support Persons	25
Our provision of Clinical Support and Engagement.....	28
Who contacted the Clinical Helpdesk.....	29
Chief Psychiatrist Visits	31
Our Statutory Authorisations.....	34
Authorised Mental Health Practitioners.....	34
Psychiatrists who require gazettal	36
Authorised Hospitals in Western Australia.....	37
Approved Electroconvulsive Therapy suites.....	37
Further Opinions	38

Our engagement with other services and with the Western Australian community	39
Our Standards Monitoring and Evaluation Program.....	41
Our Clinical Monitoring Program.....	42
Clinical Review of WA Country Health Service	43
Clinical Review of Child and Adolescent Mental Health Service.....	44
Clinical Review of South Metropolitan Health Service.....	46
Planned Clinical Reviews for 2017/18.....	47
Our Thematic and Targeted Clinical Case Reviews	48
Our Statutory Monitoring.....	48
Electroconvulsive Therapy (ECT)	49
Restrictive Practices	52
Seclusion	52
Seclusion Episodes - Total Population (All Ages)	54
Seclusion Episodes – Patients under 18 Years	55
Seclusion Episodes – Patients 18 – 65 Years.....	55
Seclusion Episodes – Patients over 65 Years.....	55
National Key Performance Indicators for Seclusion Episodes	56
Restraint	56
Restraint Episodes – Total Population (All Ages)	57
Restraint Episodes – Patients under 18 Years.....	59
Restraint Episodes – Patients 18 – 65 Years.....	59
Restraint Episodes – Patients Over 65 Years.....	60
National Key Performance Indicators for Restraint episodes.....	60
Notifiable incidents reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017	62
Deaths	63
Other Notifiable Incidents	65
Other Statutory Reporting to the Chief Psychiatrist.....	75
Other initiatives to ensure safe, high quality care	77
Ensuring safe, high quality care for patients of mental health services – Goals for 2017-18.....	78
Working Groups and Committees	79
Appendices.....	80
Appendix A: Emergency Psychiatric Treatment Reporting Requirements	80
Appendix B: Urgent Non-Psychiatric Treatment Reporting Requirements	80
Glossary of terms used.....	81
References.....	82

Foreword

My vision is mental health care to the highest standard.

My role as Chief Psychiatrist is to keep a watchful eye on the standards of mental health care in defined mental health services, and to reflect back to services so they can continuously recalibrate their care for the better. I seek to avoid blame cultures in services because we know from bitter international experience that this leads to poor quality care. Staff, consumers¹ and carers² need to feel that they can openly discuss standards of care in an environment that fosters quality improvement. I seek to leverage quality care through engagement with and facilitation of clinical leadership at all levels. I advocate for the consumer and carer voice to be heard clearly in the therapeutic relationship.

With over 14,000 mental health inpatient admissions, over 60,000 community mental health patients receiving care in the public sector (not including private specialist or primary care), and over 50,000 mental health presentations to Emergency Departments in WA during 2016-17, the majority of mental health care in Western Australia is, on balance, good quality care. The care provided across our five private psychiatric hospitals, and through the 80+ non-government mental health organisations across the state is good quality care. I believe this, but how can I say this? Is this just rhetoric? We do not measure the satisfaction of everyone going through the system. We should. Services should do this. Most people that have a good experience never report it. As well, most people who have a bad experience never report it. I believe that care overall is good because every day I am looking in depth at the quality of care for individual people, and specific groups. I hear the commitment of clinicians. I receive data on poor outcomes. I review the performance of mental health services. I regularly meet with consumers, carers and clinicians in community and inpatient settings.

There have been numerous instances throughout 2016-17 in Western Australia where mental health care has broken down, and has not met the needs of individuals and the people close to them. In some instances, harm has been caused by poor quality care or where a part of the system is not well-structured for the needs of consumers and carers. In some instances, harm has occurred even though the quality of care by clinicians has been good. Mental health is complex. Things can, and do, go wrong in systems even where there is predominantly good quality care.

I do not ascribe to a view that mental health services are in chaos or that the “mental health system is broken” in Western Australia. To say this neither respects the full range of experiences of individuals with lived experience of mental illness, nor the work undertaken by tens of thousands of clinicians and service providers within the public, private and community managed sector who seek to provide quality and safe care for individuals with mental illness and the people who support them. That’s not to say we don’t have significant gaps in our system. For an individual or their family, when there is a bad outcome, the disappointment, the frustration, the distress, the anger, and, at times, trauma- these are the reality and they must be acknowledged.

1 The term ‘consumer’ is used routinely in mental health practice. The Mental Health Act 2014 uses the term ‘patient’ so this term will also be used in this report.

2 The term ‘carer’ is used interchangeably with the term Personal Support Person, ‘family member’ and significant other.

2016-17 was not an unusually bad- or good- year when we look at our data, and we have much, much work to do to. There are many challenges.

- Challenges in 2016-17 have come with the restructuring of health services. I need Health Service Boards to remain committed to consistent standards of care, and not become siloed, as this leads to poor quality outcomes. Continuity and navigation across services and with primary care remains a challenge.
- I am very concerned that individuals in prison do not get equivalent mental health care as the rest of the community. Forensic mental health service provision is a challenge for clinicians, particularly in the prison setting, because of fragmented care and low numbers of forensic mental health beds relative to most other jurisdictions. The cross-sector work done on the Prisons Health Project in 2016-17 was extremely important and must continue.
- Youth mental health services remain in a developmental stage and WA Health must maintain its clear commitment to a coordinated approach for youth across Health Service Providers to ensure equity and timely access to care.
- Rural and regional suicide rates continue to concern me. The majority of people who suicide in Western Australia have not had prior contact with a mental health service. I urge all services to adopt evidence-based strategies for suicide prevention.
- WA has taken a lead by hosting the *Towards Elimination of Restrictive Practice 11th National Forum* in Perth in May 2017. Seclusion and restraint data is a somewhat raw but a useful indicator of the quality of person-centered and trauma-informed care. Where seclusion and restraint rates are low, that is where care is often at its best. We must commit to further reducing trauma and reducing restrictive practice in our mental health services.
- Transition between services and communication remain common thematic areas in negative outcomes

Going forward, I commit to being timelier in providing feedback to services and individuals following review processes.

It behoves me to thank the staff of the Office of the Chief Psychiatrist, led by the Manager of the Office, Mr. Cres Surrao. The individuals in my Office are a highly talented team who are, to a person, committed to mental health care to the highest standard. I thank the clinicians and service providers who have been so open with us and I ask them to continue to maintain their rigour, skills and respect, to be patient-focused and to be open to new models of care as they arise. I thank the consumers and carers who make this worthwhile, and to you, I commit to improving our own performance and providing strong value to Western Australians.

I trust this report will assist the Minister, Parliament and the Western Australian community.

Dr Nathan Gibson
CHIEF PSYCHIATRIST

Executive summary

The Chief Psychiatrist is an independent statutory officer who holds powers and duties as prescribed by the *Mental Health Act 2014* (MHA 2014) reporting to Parliament through the Minister for Mental Health. The Chief Psychiatrist was supported in 2016/2017 by an office consisting of 13.5FTE staff.

The Chief Psychiatrist, has statutory responsibility for overseeing the treatment and care of all voluntary patients being provided with treatment or care by a mental health service (in the community or as an inpatient), all involuntary patients, all mentally impaired accused detained at an authorised hospital, and all persons referred under sections 26(2) or 26(3)(a) or 36(2) for examination by a psychiatrist. The Chief Psychiatrist's mission is aiming to ensure that all Western Australians receive the highest standard of mental health care. In order to leverage standards and fulfill the Chief Psychiatrist's statutory obligations the Office of the Chief Psychiatrist provides:

- Clinical leadership to ensure continuous improvement in the quality and safety of mental health services
- Support for best practice through the Chief Psychiatrist's Standards and Guidelines and authorisation and approval processes for authorised mental health practitioners, hospitals and ECT services
- Support and education for clinicians applying the Mental Health Act 2014
- Clinical reviews and audits, service visits and investigations to monitor standards
- Monitoring restrictive practices, electroconvulsive therapy, and a range of reportable matters and notifiable incidents
- Working collaboratively with stakeholders within WA and nationally to improve the safety and quality of mental health services

During 2016-17 the mental health services overseen by the Chief Psychiatrist treated approximately 60,000 patients, of whom about 9000 received care as an inpatient at some point.

Our activities in 2016-17 in brief:

Clinical Helpdesk

We assisted clinicians in providing safe, quality care by responding to queries about legal, clinical and ethical issues encountered in applying the *Mental Health Act 2014*.

The Clinical Helpdesk responded to 502 enquiries of which 157 were about community treatment orders and 112 about electroconvulsive therapy.

Education

In response to the types of calls received we designed an education package on Community Treatment Orders (CTO). A total of 199 clinicians have attended one of 7 CTO education sessions across the State. We hosted two capacity forums; provided 5 training sessions to St Johns Ambulance paramedics; provided input into training for Mental Health Advocates in relation to treatment, support and discharge plans and provided training to non-mental health clinicians about the *Mental Health Act 2014*.

Chief Psychiatrist Visits

We visited 21 mental health services to meet with staff and consumers and personal support persons to discuss both concerns about services and positive initiatives taken by the services to address issues of quality care.

Engagement with consumers and personal support persons (PSP)

The Chief Psychiatrist has actively sought opportunities to engage with consumers and personal support persons, primarily through visits to mental health services. Where concerns have been raised the Chief Psychiatrist has relayed them to health service executives in the context of the *Chief Psychiatrists Standards for Clinical Care*. In 2016-17 the Chief Psychiatrist raised the concerns expressed by consumers and PSPs about the accessibility of peer support workers with health service executives advocating for peer support workers to be available.

Authorised Mental Health Practitioners (AMHs)

For the reporting period there were 545 AMHPs. Ninety-four new AMHPs were gazetted and we delivered 10 refresher courses to 188 AMHPs. We established a mechanism for auditing the compliance of AMHPs with the requirements for training, supervision and professional development.

Authorised Hospitals

We did not receive any new applications for authorisation of a hospital in Western Australia. We continued to provide advice and support to authorised hospitals in maintaining their standards and provided input in relation to the pending authorisation of the Perth Children's Hospital.

Standards and guidelines

A working party was set up to oversee the review of the Chief Psychiatrists Guidelines for the use of electroconvulsive therapy in Western Australia to reflect new clinical evidence and changes in technology and to align with the requirements of the MHA 2014.

Chief Psychiatrist's Clinical Standards and Service Reviews

The Office of the Chief Psychiatrist reviews services to monitor the standards of clinical care. Areas of notable practice are identified which can be shared with other services and recommendations are made to guide improvement in safety and quality of services.

During the reporting period we completed reviews of:

- WA Country Health Service (WACHS) Mental Health Services, identifying five areas of notable practice and making seven recommendations for quality improvement.
- South Metropolitan Health Service Mental Health Services, with review data currently being analysed.

Statutory Monitoring

Under the *Mental Health Act 2014* services are required to report a number of notifiable incidents, including where there may be a negative outcome; as well as certain processes and treatments, detailed below. The Chief Psychiatrist monitors for trends or notifications that may sit outside the range of normal standards. In these cases there is direct inquiry to the service and intervention where required.

Electroconvulsive Therapy

For the reporting period just over 550 courses of ECT were reported amounting to 5459 individual ECT treatments. The majority were for adult voluntary patients and conducted in a private hospital.

Seclusion

The Chief Psychiatrist is committed to reducing the rate of seclusion and where possible eliminating the use of restrictive practices in mental health services across WA. During the reporting period there were 1008 episodes of seclusion reported with a median duration of 115 minutes. 28 patients under 18 years of age were secluded in 124 episodes. In WA there were 5.1 seclusion events per 1000 bed days when compared with the national figure of 8.1 seclusion events per 1000 bed days in 2015-16 (AIHW).

Restraint

During the reporting period a total of 416 patients were restrained in 951 episodes of restraint with the median duration being 3 minutes. Forty-eight patients under the age of 18 were restrained in 172 episodes.

Notifiable incidents

193 deaths of patients of mental health services were reported. The majority were either active community patients or had been discharged from a mental health service. Overall 27% were due to suspected or completed suicide, 32% physical unnatural or unknown cause and 41% due to natural or medical causes. Further details are in the report.

Our collaborations

During 2016-17 the Office of the Chief Psychiatrist continued to engage with key stakeholders within Western Australia and nationally to improve safety and quality of services.

The Office of the Chief Psychiatrist was the lead agency co-sponsoring the Towards Elimination of Restrictive Practices 11th National Forum. This was attended by approximately 300 clinicians, consumers and carers from across Australia and provided a forum to share best practice and work collectively towards eliminating restrictive practices.

Other collaborations included participating in the National Safety and Quality Partnerships Standing Committee, the WA Therapeutics Advisory Group, the WA Psychotropic Drug Committee; the WA Clinical Senate; the Health Pathways Project; providing input into a review of the Criminal Law Mentally Impaired Accused Act and into the WA Department of Health WA Review of Safety and Quality in the WA health system.

The following total number of incidents of different types were reported. Further details are in the report.

Attempted suicide	321
Non suicidal self-injury	475
Aggressive behaviour/assault	2139
Allegations of unreasonable use of force by staff	<5
Sexual contact/Alleged sexual assault by a patient of a mental health service	103
Allegations of unlawful sexual contact between a patient and a staff member	<5
Absence without leave of involuntary and referred patients	415
Deaths of patients absent without leave	<5
Missing voluntary patients at high risk	14
Serious medication errors	15

Other statutory reporting

During the reporting period the following processes were reported to the Chief Psychiatrist.

Psychosurgery for treatment of mental illness	0
Treatment decisions different to advanced health directive of involuntary patients	0
Children admitted to an adult facility	11
Off-label treatment provided to a child who is an involuntary patient	7
Involuntary treatment orders in a general hospital	97
Emergency Psychiatric Treatment	176
Urgent non-psychiatric treatment of involuntary patients in an authorised hospital	23

The Chief Psychiatrist remains committed to working with mental health service providers, consumers, carers and other stakeholders to ensure safe and high quality standards of care for consumers of mental health services.



Our drivers for safe quality care

The Mental Health Act 2014

In its first full year of operation, the Chief Psychiatrist has played a significant role in supporting clinicians in the application of the provisions of the Act ³. This is expanded upon further in this report.

The Chief Psychiatrist has also contributed to the current 'Post-Implementation Review of the Act' and to the development of a series of proposed amendments in collaboration with the Mental Health Commission.

The Charter of Mental Health Care Principles

(Part 4 – Charter of Mental Health Care Principles, sections 11 and 12)

The Charter of Mental Health Care Principles guides the provision of mental health services across the State of Western Australia. A person performing a function under this Act must have regard to the principles set out in the Charter of Mental Health Care Principles.

A mental health service provider must make every effort to comply with the Charter when providing treatment, care and support to patients.

The Chief Psychiatrist has strengthened his commitment to supporting mental health services make every effort to comply with the Charter.

Chief Psychiatrist's Standards for Clinical Care

Standards are one component of a strong, consumer-focused mental health system. 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.

The Chief Psychiatrist discharges that responsibility by publishing a set of standards for treatment and care provided by Mental Health Services and overseeing compliance with those standards.

National Standards for Mental Health Services

These Standards have been developed to be applied across the broad range of mental health services. The expectation that the Standards will be incorporated across the broad range of mental health services marks a significant shift, and one that will need to be developed over time.

The Chief Psychiatrist has endorsed these standards as part of his statutory responsibilities under the *Mental Health Act 2014*.

³ The Mental Health Act 2014 is referred to as 'the Act' and as the 'MHA 2014' as appropriate, throughout this document.

Who we are

The Chief Psychiatrist is a statutory officer who holds powers and duties as prescribed by the *Mental Health Act 2014* (MHA 2014). The Chief Psychiatrist is supported by an Office that is a public sector department and reports to Parliament through the Minister for Mental Health.

The Chief Psychiatrist, pursuant to section 515 of the MHA 2014 is responsible for overseeing the treatment and care of all voluntary patients, involuntary patients, mentally impaired accused detained at an authorised hospital, and all persons referred under sections 26(2) or 26(3)(a) or 36(2) for examination by a psychiatrist. This means the Chief Psychiatrist provides oversight of the treatment and care for patients within public community and inpatient mental health services, non-government organisations funded to provide public mental health care, private psychiatric hospitals, and certain individuals within private psychiatric hostels.

The Chief Psychiatrist discharges the above responsibility by publishing under section 547(2) of the Act, the *Chief Psychiatrist's Standards for Clinical Care* to be provided by mental health services and overseeing compliance with those standards. The Chief Psychiatrist views matters through a safety and quality lens, considering both the individuals' needs (consumer, carer, clinician) and broader systemic issues (e.g. equity of access to services).

Office of the Chief Psychiatrist

A Deputy Chief Psychiatrist and a team of staff assist the Chief Psychiatrist in the discharge of his statutory responsibilities whilst ensuring the rights of people with lived experience of mental illness are upheld and services are delivering safe quality care.

The Chief Psychiatrist leverages standards through a number of functions and strategies, including:

A Reporting System

Clinicians and service providers are, by statute, required to report to the Chief Psychiatrist on a range of notifiable incidents, including where there may be a negative outcome. They are also required to track certain processes and treatments (e.g. Electroconvulsive Therapy (ECT), segregation of children from adult inpatients, off-label prescribing to children who are involuntary patients, and emergency psychiatric treatment, among others).

A Review System

We undertake regular, formal Clinical Monitoring Reviews of mental health services, as well as routine visits to services as a mechanism for two-way feedback with consumers, carers and clinicians. The Clinical Monitoring Reviews involve site visits, medical record scrutiny and interviews with staff, consumers and carers, by a team of senior clinical reviewers. Recommendations are provided to services following these Reviews.

From time to time, the Chief Psychiatrist undertakes a Targeted Review into a particular individual case under exceptional circumstances.

An Authorisation and Approval System

Clinicians wishing to be Authorised Mental Health Practitioners and perform functions pertinent to their role under the MHA 2014, may only do so by order of the Chief Psychiatrist following a stringent application and training process.

Should a service require gazettal as an Authorised Mental Health facility for the purposes of receiving and treating patients on an involuntary basis, the Chief Psychiatrist is the pathway by making recommendations to the Governor of Western Australia.

The Chief Psychiatrist has a statutory responsibility to approve a mental health service wishing to provide Electroconvulsive Therapy (ECT).

A Support System

We provide a Helpdesk staffed by experienced clinicians to support clinical staff in discussions of complex clinical cases, ethical and MHA 2014 interface issues.

We provide targeted education sessions on the MHA 2014 and standards for treatment and clinical care.

An Inter-jurisdictional Role

A mental health safety and quality interface with other agencies both intra- and interstate, including reporting de-identified aggregate data of national relevance.

The Chief Psychiatrist is not a primary complaint agency. However, the Office of the Chief Psychiatrist provides advice to the Health and Disability Services Complaints Office (HaDSCO), and has a role in certain complex situations relating to individuals where standards of care are relevant.



We achieve all of the above on a budget of \$2.2 million and 13.5FTE of staff servicing, approximately 6,000 clinicians, and 60, 0000 consumers across the State of Western Australia.

Our People

We aim to provide a workplace that offers fulfilling and challenging work, as well as promoting professional and personal development opportunities for our staff. We meet our statutory responsibility to Parliament and to the Western Australian community by delivering services efficiently and with good effect. We recognise that our employees are our greatest asset, are highly skilled and competent, to support the work we do.

The 2016-17 reporting period was our first full year of operation as an independent office. It has not been without its challenges, and we did not expect a smooth transition without an impact on business continuity. The dedication of our staff who rose to the many challenges, is acknowledged and appreciated.

Our Vision

‘Mental Health Care to the highest standard.’

Our Mission

‘The Chief Psychiatrist aims to ensure that all Western Australians receive the highest standard of mental health treatment and care.’

Our Values



Leadership



Integrity



Respect

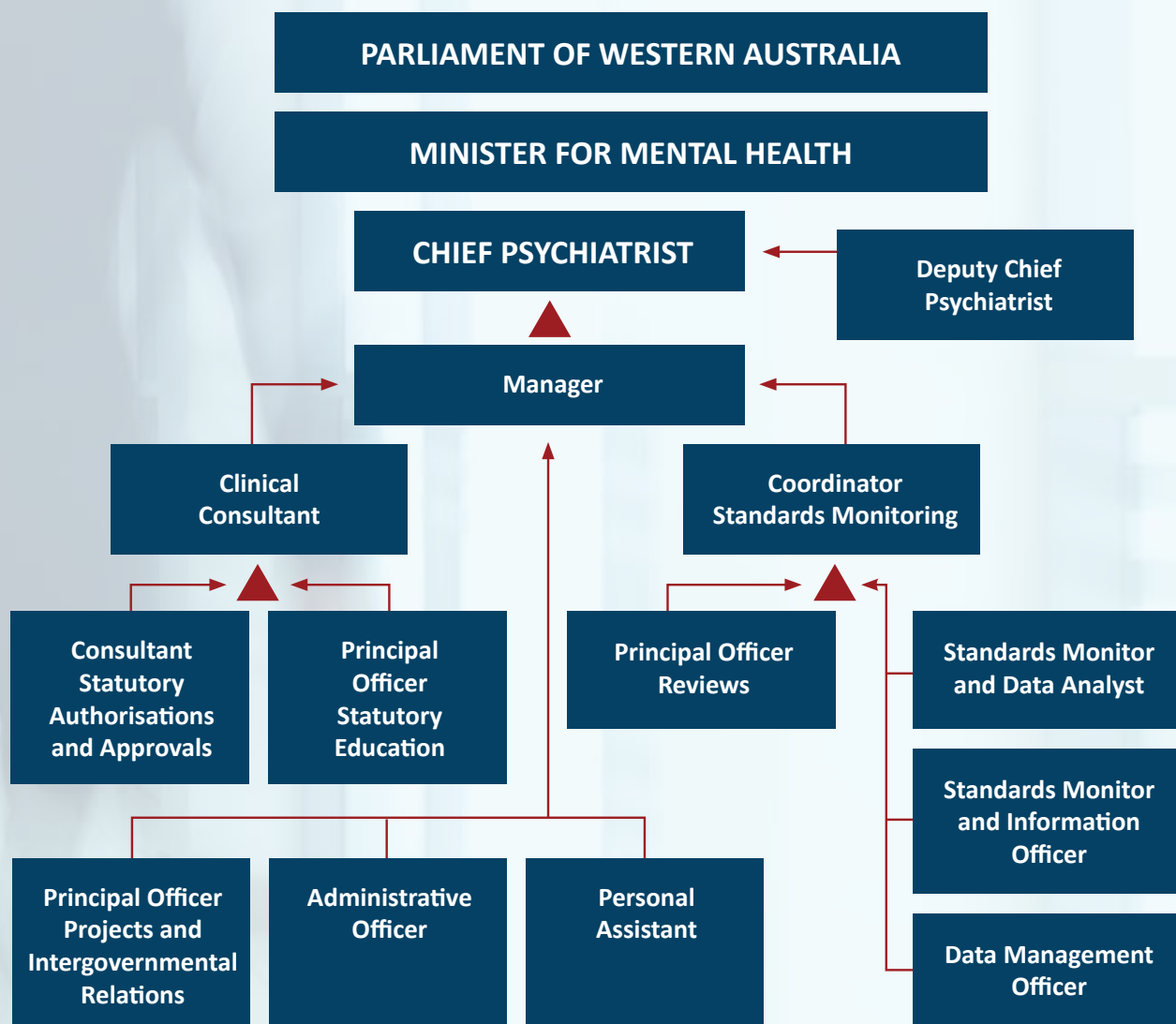


Accountability



Commitment

Chief Psychiatrist Organisational Structure



Our Support for staff in our Office

Secondments in and out of the Office

Our relationships with our key stakeholder agencies, has meant that we were able to offer secondments to and from the Office. We regard secondment opportunities as enhancing the skills and abilities of our people and highlighting what we do, to build the capacity of people seconded into our Office.

Clinical audit reviewers for example are seconded into our Office for the period of a clinical review and on return to their home agency take with them knowledge of this Office's statutory responsibilities and ability to apply those to enhancing the safety and quality of mental health care delivered to consumers.

Separations and Appointments

Two members of staff exited our Office and we welcomed two more. We are fortunate to attract and retain talented staff by offering an intellectually stimulating and fulfilling workplace.

Pressures and Demands

Significant aspects of our work, with an immediate alignment to this office, took, out of necessity, a backseat, whilst we consolidated our independence and discharged our statutory responsibilities.

Where we have underperformed with particular regard to the timely publication of clinical audit review reports, this has been due to the pressure of competing demands for this Office and internal consolidation of the team.



**We are committed to a process of
prioritising an office environment,
in keeping with our values and mission.**

Our Collaborations

Collaborating with our stakeholders is integral to the way the Office of the Chief Psychiatrist operates. Delivering on our mission *‘the Chief Psychiatrist aims to ensure that all Western Australians receive the highest standard of mental health treatment and care’* would not be possible without strong relationships with our key stakeholders. The solid foundations of enabling legislation and robust strategy on which our relationships are built, assist in the aim of delivering high quality mental health services and outcomes for all Western Australians.

We engage closely with;

- Consumer and Carer organisations
- The Community Services Sector namely through licensed psychiatric hostels
- State government departments with responsibility for health, mental health, community services and justice
- Health service providers, professionals and organisations
- Academic institutions
- Peak bodies

Our strong relationships with health service providers are critical to our activities. Much of the work we do via our Clinical Statutory Education and Authorisations Team and Monitoring and Evaluation team, relates to the services provided by health services, including the data collected and reported by us.

Nationally - we have



Participated
in the National
Safety and Quality
Partnerships Standing
Committee (SQPSC)



Participated
in the National
Mental Health
Commission's 'Housing,
Homelessness and
Mental Health'
jurisdictional workshops



Led the
coordination
of the '11th National
Forum on Restrictive
Practices - Towards
Eliminating Seclusion &
Restraint.'



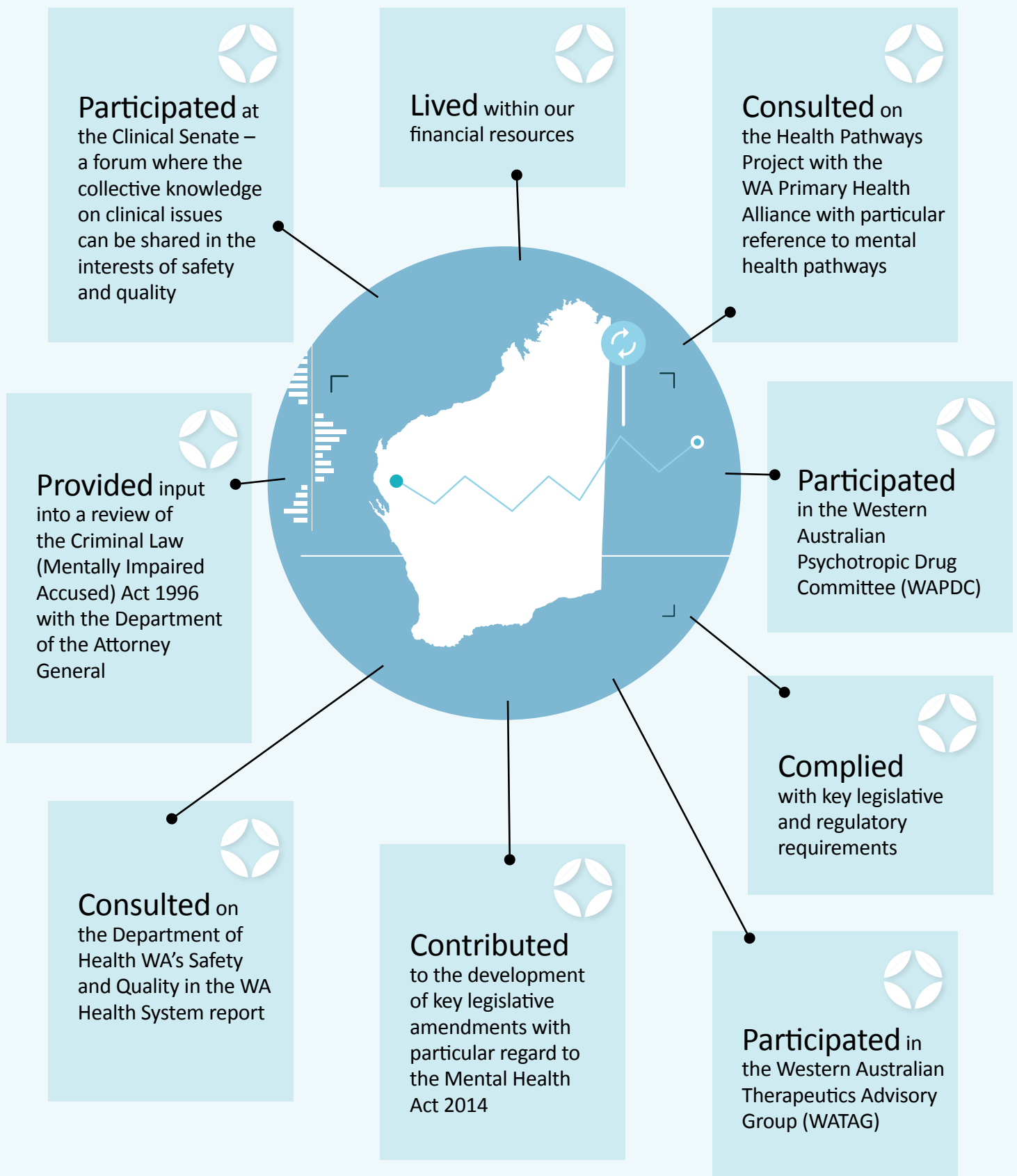
Participated in the
development of the *National
Principles for Communicating about
Restrictive Practices with Consumers
and Carers* and the *National Principles
to Support the Goal of Eliminating
Mechanical and Physical Restraint in
Mental Health Services*



Consulted on the National
Consensus Statement: Essential
Elements for Recognising and
Responding to Deterioration in a
Person's Mental State – Australian
Commission of Safety and Quality in
Health care



State-wide - we have



Our vision for the future

Guiding the Office of the Chief Psychiatrist forward in 2017-18

Our primary areas of concern in terms of the future strategic direction for our Office are;

- Live our values within the Office
- Identify our key performance indicators
- Continue our contribution to the safety and quality governance of mental health services
- Developing sexual safety guidelines and a standard, for mental health services
- Continue working towards the delivery of safe high quality care to persons with a mental illness in prisons
- Continue working towards the delivery of safe, high quality care to persons with a mental illness in private psychiatric hostels through the development of a Memorandum of Understanding between the three key stakeholders: the Chief Psychiatrist, the Department of Health and the Mental Health Commission
- Ensure regular feedback to mental health services providers on data collected, recorded, and reported to the Chief Psychiatrist
- Other initiatives of the Chief Psychiatrist and the Office are discussed throughout this report.

A Snapshot of Western Australia's Mental Health Services

Mental health is fluid and can result in an individual transitioning between tiers of service (i.e. primary care to specialised mental health inpatient services⁴) and legal status (voluntary, involuntary, and discharged). The information provided here is obtained from the Department of Health central data collections - *Mental Health Information Data Collection* (MIND) and *Hospital Morbidity Data Collection* (HMDC). Data sourced from MIND and HMDC is subject to data cleansing (for quality), data linkage and clinical coding processes. Therefore only 2016 calendar year (January – December 2016) figures are reported, as data reporting for financial year 2016-17 is not available.

Public mental health services are accessible throughout metropolitan and regional Western Australia (WA). During 2016-17, metropolitan Perth was divided into four area health services: North Metropolitan Health Service (NMHS); South Metropolitan Health Service (SMHS); East Metropolitan Health Service (EMHS)⁵; and Child and Adolescent Health Services (CAHS) and regional Western Australia is covered by WA Country Health Service (WACHS) which includes services for children and adolescents.

There are three publicly contracted private providers of health services in metropolitan Perth which are: the Mental Health Unit - Joondalup Health Campus (Ramsay Health Care), the Ursula Frayne Unit - St John of God Hospital, Mount Lawley and the Mental Health Unit - St John of God Midland Public Hospital. Public patient activity data by these services is included in this section of the report.

For the 2016 calendar year, 58,088 individuals received care from a mental health service setting, including community mental health settings.

Inpatient Mental Health Services

For the 2016 calendar year there were 14,228 mental health inpatient separations (discharges) from mental health inpatient services for a total of 8,371 individuals across WA. Of those, 6,913 were voluntary at some point during their admitted episode of care, and 2,193 patients were involuntary at some point during their admitted episode of care⁶.

There was an average of 751 available specialised mental health inpatient beds in WA during 2016 calendar year, when compared to 868 specialised mental health inpatient beds for the 2015 calendar year.

4 Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. <http://meteor.aihw.gov.au/content/index.phtml/itemId/288889>

5 EMHS came into existence on 01 July 2016 and comprises Royal Perth Hospital, Armadale Health Service, St John of God Midland, Bentley Health Service, Kalamunda Hospital

6 It should be noted that some patients can have both a voluntary and involuntary status within one episode of care.

The distribution of beds across the area health services is shown in the table below.

Area Health Service	Beds
North Metropolitan Health Service	300
South Metropolitan Health Service	114
East Metropolitan Health Service	147
WA Country Health Service	62
Child and Adolescent Health Service	14
Public/Private Partnerships	114
Total Average	751

Table 1: Number of specialised mental health beds by area health service

Source: BedState, DoHWA

Community Mental Health Services

Due to changes in reporting systems, data presented in this part of the report cover the 2016-17 financial year. For the 2016-17 reporting period, there were 62,264 community patients of mental health services. Of these, 62,170 voluntary patients received a total of 908,857 service contacts with specialised community mental health service clinicians. There were also 1,052 patients on a Community Treatment Order⁷. Some patients may transition from a voluntary status to being on a Community Treatment Order within a single community episode of care.

⁷ Data for the number of Community Treatment Orders provided by the Mental Health Tribunal

Emergency Department Mental Health Presentations⁸

There were 52,477⁹ mental health presentations to an ED during the reporting period, accounting for 5.1% of the total number of presentations ED (n=1,026,138) during this period.

The median length of a mental health presentation for an ED episode of care was 217 minutes. The majority of mental health presentations were admitted (30.7%), were discharged following their ED presentation (56.6%) and for patients who had a range of other outcomes (12.7%) those are described in the table below.

Episode End Status	2016-17 Financial Year
Admitted to ward/other admitted patient unit	10,278
Left at own risk	1,522
ED service event completed; departed under own care	29,738
Transferred to another hospital for admission	3,527
Admitted to ED OBS	5,860
Did not wait to be attended by medical officer	1,433
Discharged after admission	<10*
Died in ED	<10*
Unknown	30
Returned to Hospital in the Home (HITH)	44
Admitted to Hospital in the Home	<10*
Nursing Home	35
Total	52,467

Table 2: ED episode end status for mental health presentations for 2016-17 financial year

* Actual number has been suppressed when less than 10

Source: Emergency Department Data Collections, Data Integrity Directorate

⁸ Data presented in this section covers the 2016-17 financial year and were obtained from the *Emergency Department Data Collections* (EDDC) Data Integrity Directorate, Department of Health WA. The data include the number of mental health emergency department (ED) presentations (including drug and alcohol presentations). For the reporting period, a number of WACHS hospitals transitioned from the 'HCARE' data feeder system to a web based patient administration system 'WebPAS' which may have resulted in an undercount of mental health presentations in ED during the data migration period.

⁹ To ensure confidentiality, where <10 instances of an event occurred, the actual figure is not reported. Therefore, the total number of mental health presentations to EDs in table 2 does not equal the total number reported for WA mental health presentations

Our activities



**Your interest and acknowledgement
was genuine. Thank you.**

Personal Support Person



**They may forget your name,
but they will never forget
how you made them feel.**

Maya Angelou

Clinical, Statutory Authorisations and Education Program

The Clinical, Statutory Authorisations and Education Program comprises of the *Clinical Consultant, Principal Officer Statutory Education* and the *Consultant Statutory Authorisations and Approvals*. The team works closely with the Monitoring and Evaluation Program to support the Chief Psychiatrist in discharging his statutory functions and takes a three-pronged approach to improving the safety and quality of mental health care for those experiencing mental illness in Western Australia.

Consumer and Personal Support Person Engagement

We actively seek to engage consumers and personal support persons (PSPs) (including carers) to help drive safety and quality improvements for mental health care provided across Western Australia.

Clinical Support and Engagement

We ensure clinicians and services have access to relevant MHA 2014 information, timely advice/support and appropriate targeted education, which enables them to apply the provisions of the Act, to provide safe quality care.

Statutory Authorisations and Approvals

We are statutorily required under the MHA 2014 to authorise hospitals, approve ECT suites, gazette psychiatrists who have 'provisional and other registration types' from the Australian Health Practitioner Regulation Agency (APHRA) and authorise appropriately experienced and trained mental health clinicians as Authorised Mental Health Practitioners. Authorisations and approvals provide governance and consistency to ensure safe, quality care.

Our engagement with Consumers, Carers and Personal Support Persons¹⁰

The Chief Psychiatrist acknowledges the crucial role consumers and Personal Support Persons (PSPs) have in improving the provision of safe quality mental health care.

The Chief Psychiatrist actively seeks opportunities to engage with consumers and PSPs, primarily through visits to mental health services and through other more formal and informal mechanisms.

What we have done

The Chief Psychiatrist has routinely visited mental health services to meet and hear the views of consumers, PSPs and local staff. Where concerns are raised, the Chief Psychiatrist has taken them on board and introduced initiatives to address them within his office or more broadly has advocated for change at a systems level.

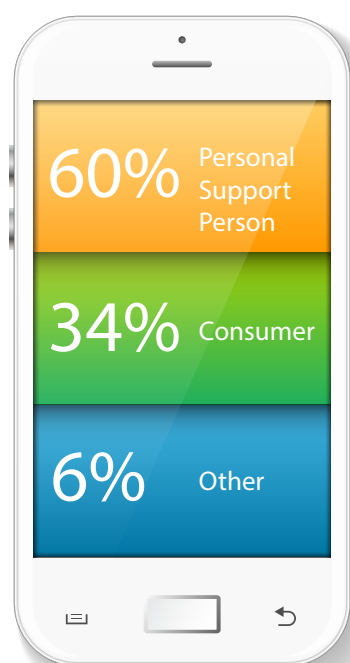
- The Office of the Chief Psychiatrist has established stringent internal processes to prioritise, manage, record, review and respond to correspondence from consumers and PSPs.
- Where consumers and PSPs raised matters of concern the Chief Psychiatrist relayed these to health service executives in the context of the Chief Psychiatrist's Standards for Clinical Care.
- In response to concerns about the availability of Peer Support Workers, the Chief Psychiatrist has raised the matter with health service executives indicating his support for the program of having a person with 'lived experience' assisting consumers in navigating the mental health system.

10 Personal Support Person is a generic term used to describe family members, carers, nominated persons and significant others.

Who contacts us

For the reporting period 1 January 2017 to 30 June 2017 when data collection commenced, we received 50 contacts from consumers and PSPs. PSPs contacted us almost twice as often as consumers, as demonstrated below;

Consumer and Personal support person*



*Data inclusive from 1 January 2017 to 30 June 2017

What we do

We direct phone calls from consumers and PSPs to the most appropriate agency at the point of contact, often to the responsible mental health service or to the Health and Disability Services Complaints Office (HaDSCO). The *Mental Health Act 2014* prescribes HaDSCO with responsibility to manage complaints about mental health services in Western Australia.

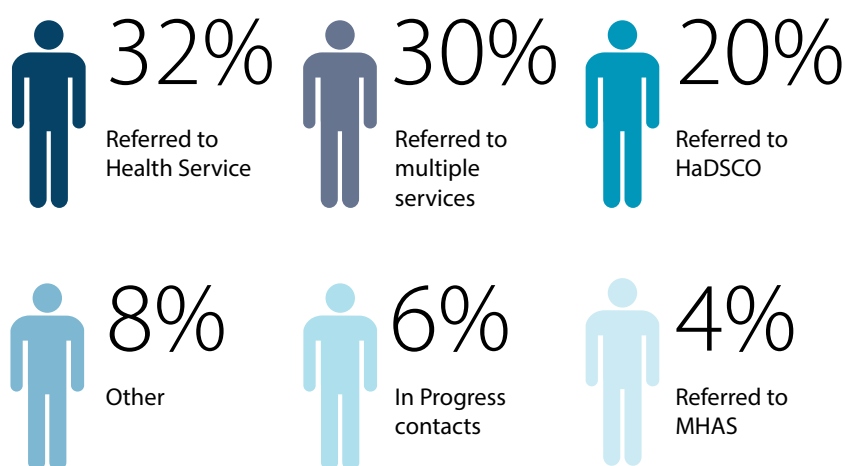
We have managed, recorded, reviewed and responded to correspondence from consumers and PSPs that were not re-directed to a different agency at point of contact.

We aim to respond to all correspondence from consumers and PSPs promptly. Unforeseen circumstances can sometimes cause delays in responding to consumers and PSPs. We recognise these delays and the impact they can have on consumers and PSPs. This has prompted us to introduce a more streamlined process for handling contacts from consumers and PSPs as demonstrated below;

In almost two thirds of contacts, consumers and PSPs were directed to the health service responsible for their care or to HaDSCO, to address their concerns. The Chief Psychiatrist recognises that concerns resolved locally, will often result in a more satisfactory outcome for the person.

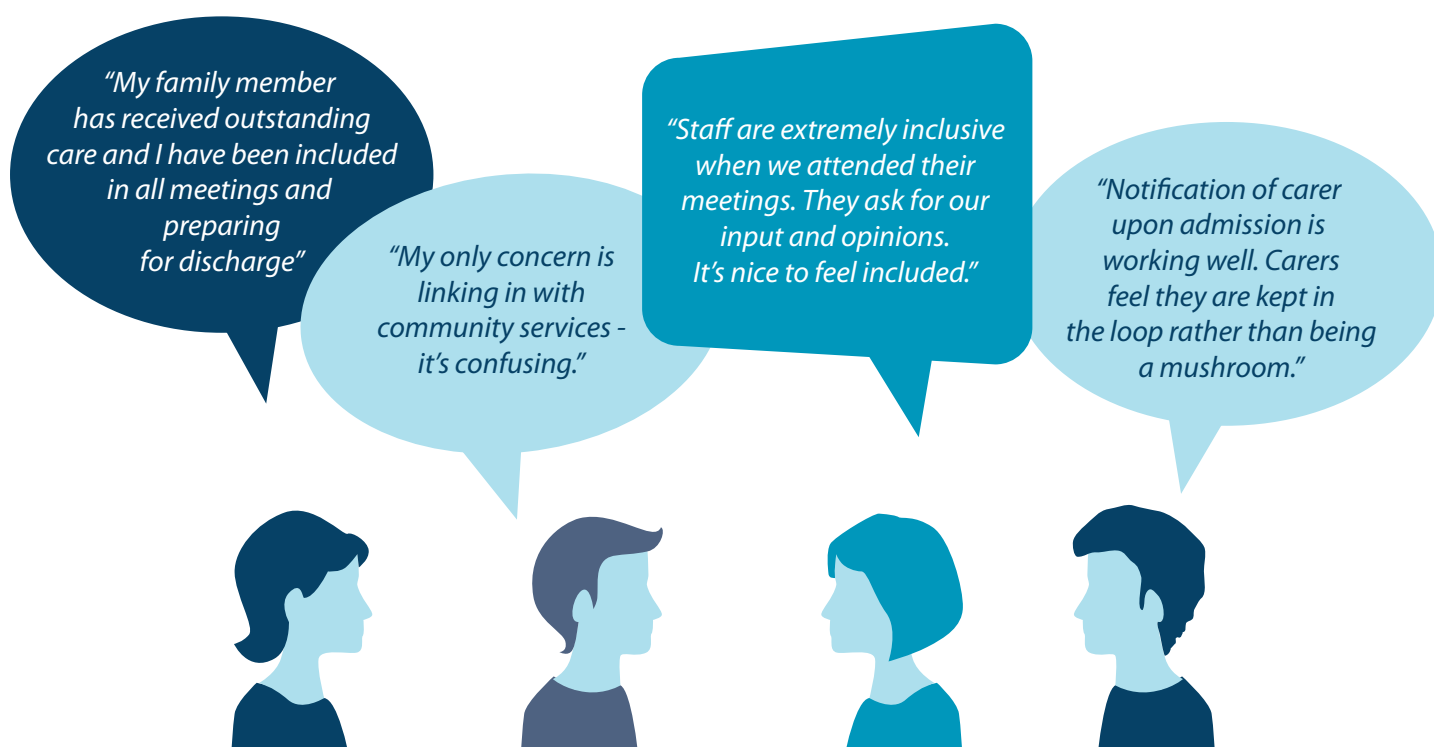
Management of consumer and personal support person*

* Data inclusive of 1 January 2017 to 30 June 2017



What we heard

The Chief psychiatrist has met with several consumer and PSPs during visits to Mental Health Services. The feedback from consumers and PSPs during these visits was very complimentary of staff and the treatment of care they have or were receiving.



What we will do

We are committed to engaging with consumers and PSPs;

- We will hold public forums with consumers and PSPs to provide an overview of the role of Chief Psychiatrist and obtain feedback.
- All correspondence received from consumers and PSPs will be addressed as a matter of priority and processes currently in place reviewed for effectiveness.
- We will continue to request services make available appropriate times and venues to meet with consumer and carer groups when we visit services.
- We will continue to advocate with health service executives to promote the need for peer support workers.

Our provision of Clinical Support and Engagement

We take a pro-active approach to engaging clinicians and clinical services to provide safe quality care. We responded to phone calls and correspondence from clinicians and service providers for ensuring an appropriate application of the provisions of the Act. We also actively visit services outside of our monitoring function to meet with staff, consumers and PSPs to canvas their views and to provide education and support to clinicians.


Main reasons for contact with the Clinical Helpdesk

For the reporting period, the Clinical Helpdesk responded to 502 enquiries via email or phone from clinicians. We provided clinical advice in the context of the MHA 2014. Over 150 enquiries asked about Community Treatments Orders (CTOs), whilst 112 related to Electroconvulsive therapy.

Some of the main reasons clinicians contacted us was:

Types of Query	Number
Community Treatment Orders	157
Electroconvulsive Therapy	112
Referral for examination by a psychiatrist	88
Inpatient Treatment Orders in a General Hospital setting	34
Role of the Authorised Mental Health Practitioner	23

Table 3: Some of the main types of queries we received at the Clinical Helpdesk



**You treat a disease, you win, you lose.
You treat a person, I guarantee you,
you'll win, no matter what the outcome.**

Patch Adams

What we have done

In response to the type of calls and correspondence received we designed and rolled out an education package on Community Treatment Orders. The course was first delivered in February 2017 and in the first 4 months of rollout has reached almost 200 clinicians across the State of Western Australia.

CTO course	Number	Attendees
Metropolitan	4	85
WACHS	3	114

Table 4: Attendance at education session on Community Treatment Orders

Who contacted the Clinical Helpdesk

Clinician contacts;

The primary users of the *Mental Health Act 2014* are Consultant Psychiatrists, who account for almost 50% of enquiries to the helpdesk. We see this as reflecting the desire of psychiatrists to provide safe quality care within a robust legislative framework.

For the reporting period we received contacts from clinicians from all professional disciplines as represented below.

Enquiries by profession



*Medical Officers includes Psychiatric Registrars, Duty Medical Officers and General Practitioners

Service-level contacts;

The helpdesk received calls from all area health services including publically contracted private providers of mental health services. We note that enquiries from the private sector are very limited, but acknowledges this is to be expected as their use of the MHA 2014 is limited.

Enquiries by Service	Number
North Metropolitan Area Health Service (NMAHS)	114
South Metropolitan Area Health Service (SMAHS)	97
WA Country Health Service (WACHS)	86
East Metropolitan Area Health Service (EMAHS)	56*
Public/Private partnership	38
Child and Adolescent Health Services (CAHS)	14

Table 5: Some of the services who contacted the Clinical Helpdesk

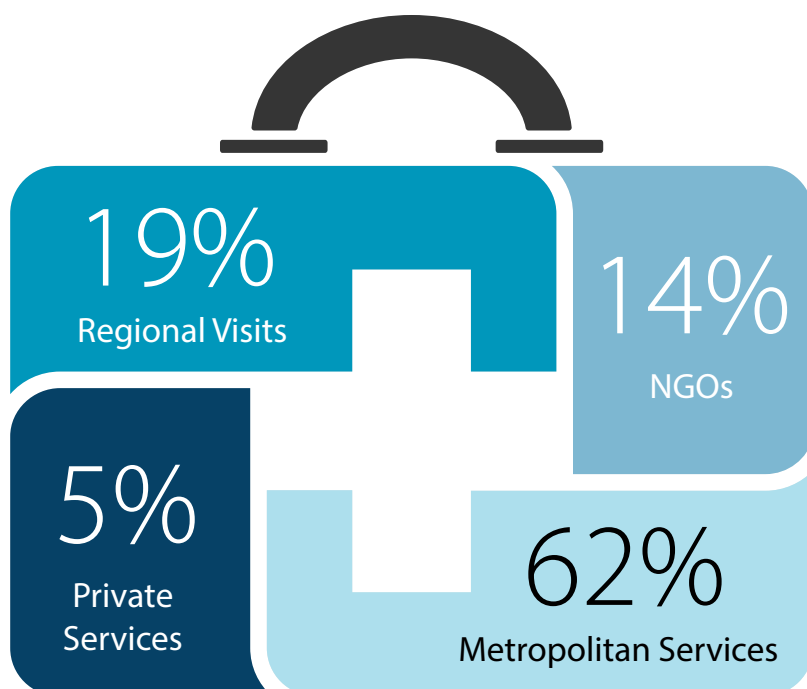
* East Metro data is part way through the reporting period

The above data represents clinicians from area mental health service providers who contacted the Clinical Helpdesk. We needed to reconfigure our database to include the creation of the East Metropolitan region and therefore data for this region was collected part way through the reporting period.

Chief Psychiatrist Visits

For the reporting period 2016-17 we visited 21 mental health services. These comprise of public mental health services (both metropolitan and regional), private mental health services and other non-government services providing mental health care. The purpose of the visits was to meet with staff to discuss the role of the Chief Psychiatrist and provide an avenue for staff to raise questions about the role and priorities of the Office and respond to queries about the *Chief Psychiatrist's Standards for Clinical Care*. These visits did not form any part of a review or authorisation process and are designed to build and capitalise on established relationships.

Of the 21 services visited during the reporting period, the majority were from metropolitan Perth accounting for 62% of the visits. Generally the visits were well received by key stakeholders and points of discussions centered on both concerns about services and positive initiatives taken by the services to address issues of safe quality care.



Date	Service Visited
July 2016	Goldfields Mental Health Services (Kalgoorlie Regional Hospital, Community Mental Health Services and NGO services)
August 2016	Ursula Frayne Unit, St John of God Mount Lawley
September 2016	Perth Clinic
October 2016	St John of God Hospital Midland Public and Private Health Campus
November 2016	North Metropolitan Health Service (Graylands Campus, Osborne Park Hospital and Selby Lemnos Older Adult Mental Health Service)
March 2017	Broome Regional Hospital, Community Mental Health Services and NGO services
	Derby Mental Health Service
	Bentley Adolescent Unit
April 2017	Geraldton Regional Hospital
	Fiona Stanley Hospital
	Next Step Inpatient Unit
May 2017	Sir Charles Gairdner Hospital
	Rockingham Hospital and Park Community Mental Health
	Drug and Alcohol Youth Services (DAYS)
June 2017	Graylands Hospital
	Joondalup Health Campus

Table 6: Chief Psychiatrist site visits for the reporting period

What we have done

We informed and educated services about the role of Chief Psychiatrist with particular reference to the *Chief Psychiatrist's Standards for Clinical Care*.

Following a visit, we provide feedback acknowledging the work being done and highlighted areas of concern.

We actively engaged with services and provided opportunities to clinical staff to raise matters pertaining to the *Mental Health Act 2014*.

Outcomes

- The Chief Psychiatrist or Deputy Chief Psychiatrist conducted the health service visits and discussed the *Chief Psychiatrist Standards for Clinical Care* with a particular focus on the Transfer of Care Standard.
- The visits were generally well received by staff, consumers, PSPs and other stakeholders such as non-government organisations (NGOs)
- The feedback from consumers and PSPs was largely positive about services. It included compliments about high standards of care, good engagement and positive experiences.
- Consumers, PSPs, NGOs and staff across services raised some concerns. These included
 - ▶ Recruitment and retention of staff – particularly in WACHS regions
 - ▶ Lack of child and adolescent beds available for inpatient admissions
 - ▶ Delays in the opening of new services such as step up/step down facilities
 - ▶ Transfer of patients from community settings to hospital – particularly in WACHS regions
 - ▶ Patients under the Mental Health Act 2014 being held in Emergency Departments
 - ▶ Lack of Peer Support Workers in some health services
 - ▶ Additional administrative burden on services since the implementation of the Mental Health Act 2014
 - ▶ Increase in the number of referrals some services receive with no increase in human and/or service resources
 - ▶ Increasing number of patients with drug, alcohol and mental illness co-morbidities however, some areas were losing drug and alcohol resources

The Chief Psychiatrist wrote to all services after the visits and ensured these issues were raised with the relevant health service executives

- The Chief Psychiatrist's expertise in safe quality care was relied on to review and provide advice to five of the health services visited
- There was evidence of services working cohesively within their service but also collaboratively with NGOs and other service providers

What we will do

We will continue to monitor the types of queries received by the clinical helpdesk and tailor future education sessions to reflect the learning needs of clinicians and mental health services

We will continue to visit public and private mental health facilities across the state to engage with clinicians, health staff, consumers and personal support persons.

Our Statutory Authorisations

Authorised Mental Health Practitioners

The Authorised Mental Health Practitioner (AMHP) role is to assess and refer a person suspected of having a mental illness for examination by a psychiatrist among other specified clinical roles. The Chief Psychiatrist views the role of the AMHP as critically important and acknowledges the high level of skill and professionalism that accompanies this role.

The Office of the Chief Psychiatrist is statutorily required to provide training and continuing professional development opportunities to AMHPs.

In December 2016, we conducted an audit of all registered AMHPs with an emphasis on those currently engaged in clinical work and actively applying the provisions of the MHA 2014. This was to encourage those AMHPs, who currently work non-clinical roles to consider relinquishing their AMHP status.

We have streamlined our process for clinician approval when requesting to be gazetted as an AMHP in consultation and collaboration with mental health service providers.

For the reporting period 2016-17, the *Chief Psychiatrist Register for Authorised Mental Health Practitioners* had 545 AMHPs. The Register is a public document and can be found on the Chief Psychiatrist website. The table below provides a spread of AMHPs by professional discipline.

AMHP Profession	Number
Registered Nurse	470
Social Worker	51
Occupational Therapist	17
Psychologist	7

AMHP by professional discipline.

Training Provided

For the reporting period we delivered four Initial training courses for clinicians seeking to become an AMHP. This resulted in the Chief Psychiatrist gazetting 94 new clinicians as an Authorised Mental Health Practitioner.

We provide continuing skills enhancement courses to gazetted AMHPs in the form of a Refresher Course. During the reporting period, we delivered ten AMHP refresher courses across the state, reaching almost two hundred AMHPs.

Region where AMHP refresher course held	Number of courses	Number of Attendees
Metropolitan	7	124
WACHS	3	64

Table 7: Refresher Courses for AMHPs



What we have done

- We delivered *Initial Training* for clinicians seeking to become AMHPs.
- We delivered *Refresher Courses* for established AMHPs as a skills enhancement initiative.
- We audited and maintained a register of AMHPs.
- We created a summary sheet to assist AMHPs and services to understand and meet the requirements to remain an AMHP.

What we will do

- We will continue to provide the training for new AMHPs.
- We have established a self-reporting audit tool for AMHPs to advise us of their compliance with the requirements for training, supervision and professional development.
- We will randomly audit AMHPs, ensuring compliance with the *Mental Health Act Regulations 2015* for training, supervision and professional development.
- We will continue to work with mental health services to ensure those who are AMHPs meet the MHA 2014 regulatory requirements to be an AMHP.

Psychiatrists who require gazettal

The *Mental Health Act 2014* states only the following psychiatrists can administer the Act:

- A Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), or
- A psychiatrist with specific 'Specialist' or 'Limited' registration with the Australian Health Practitioners Regulation Agency (AHPRA), or
- Psychiatrists who have been prescribed by the *Mental Health Act Regulations 2015* to administer the provisions of the Act.

Mental Health Services are responsible for ensuring psychiatrists employed in their service are appropriately credentialed and licensed to practice as a psychiatrist. They are also required to ensure that psychiatrists receive training in the MHA 2014 with access to regular refresher training.

A psychiatrist with 'Provisional', 'General' or any other registration type, may only administer the Act following vetting by the Chief Psychiatrist and recommendation by him for gazettal as a psychiatrist authorised to administer the Act

What we have done

- Chief Executives of Health Service Providers were required to provide the Chief Psychiatrist with a list of all Psychiatrists employed in their service with 'Provisional' or other types of registration as prescribed by Australian Health Practitioners Regulatory Agency (AHPRA).
- The above enabled us to establish a database of all psychiatrists with *Provisional* or other types of registration.
- We have published the required process for gazettal recommendation for psychiatrists on our website.

What we will do

- We will continue to vet and recommend for gazettal, a psychiatrist with Provisional or other type of registration.
- We will work with the Mental Health Commission to further streamline the Gazettal process to ensure a more timely and efficient process is in place.

Authorised Hospitals in Western Australia

We did not receive any new applications for the Authorisation of a hospital in Western Australia. For the reporting period, we continued to provide advice and support to health services and continued to provide expert advice and input into the pending Authorisation of the Perth Children's Hospital (PCH).

We are currently updating the '*Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 1996*' to comply with the requirements for the MHA 2014. Significant work has gone into incorporating the use of modern techniques and advancements in terms of providing a safe and suitable environment for patients, PSPs and visitors. It is expected the review of the Standards will be complete by December 2017.

Our website provides an up-to-date Register of the 16 Authorised Mental Health Inpatient Services.

What we will do

We will initiate a program for re-authorisation of hospitals previously authorised under the *Mental Health Act 1996* to align with the revised *Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014*. The process will be the first of its kind in Western Australia. The aim is to ensure that all Western Australians receive the highest standard of safe quality care.

Approved Electroconvulsive Therapy suites

Under the MHA 2014, the Chief Psychiatrist approves all mental health services performing Electroconvulsive Therapy (ECT), by order published in the Government Gazette. This order may specify conditions under which ECT can be performed on a patient.

ECT sites must as far as possible comply with the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy*.

Approved ECT Site	Date of Approval for ECT	Date Due for Re-approval
Albany Health Campus	30/11/2015	29/11/2018
Bentley Hospital	30/11/2015	29/11/2018
Fremantle Hospital	30/11/2015	29/11/2018
Hollywood Clinic	30/11/2015	29/11/2018
Joondalup Health Campus	30/11/2015	29/11/2018
The Marian Centre	30/11/2015	29/11/2018
Perth Clinic	30/11/2015	29/11/2018
Rockingham General Hospital	30/11/2015	29/11/2018
Sir Charles Gairdner Hospital	30/11/2015	29/11/2018
St. John of God Midland Public Hospital	30/11/2015	29/11/2018
Fiona Stanley Hospital*	12/02/2016	17/05/2017 (revoked)

Table 9: Approved ECT sites *Fiona Stanley Hospital in collaboration with the Chief Psychiatrist sought to have their approved status revoked

In March 2017, we constituted a Working Party, chaired by the Chief Psychiatrist, to oversee the review of the *Guidelines for the use of Electroconvulsive Therapy in Western Australia*.

The purpose for the review is to reflect changes in modern technology and clinical advancements made in providing ECT, and to align with the requirements of MHA 2014. The Working Party consists of consumers, PSPs and clinicians from both the public and private sector providers of mental health services.

What we will do

We will review approved ECT sites in preparation for re-approval in November 2018. Services seeking re-approval will be required to meet the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy*.

The Working Party reviewing the guidelines for the use of ECT, will provide a report to the Chief Psychiatrist early 2018.

Further Opinions

The MHA 2014 provides for patients of a mental health service to request an alternative opinion as to their need for treatment and care.

Patients with the following MHA 2014 status may request a Further Opinion;

- an involuntary inpatient;
- an involuntary community patient; and
- a mentally impaired accused patient in an authorised hospital.

A patient may seek or have a PSP or an advocate, request a further opinion. Usually such requests are made via the mental health service providing treatment and care.

The MHA 2014 also provides that requests for further opinions may be made to the Chief Psychiatrist. The Chief Psychiatrist does not provide the further opinion but facilitates the provision of one by ensuring that it is provided in a timely manner, it is objectively independent and reviews any refusals to provide a further opinion by the mental health service.

Patients are afforded the following options when requesting a further opinion;

- A further opinion from a psychiatrist at the same health service
- A further opinion from a psychiatrist from a different health service
- A further opinion from a private psychiatrist (at patient's own cost)

In considering a request for a further opinion mental health services are required to adhere to the Department of Health's Operational Directive (OD: 0637/15) *Further Opinions Under the Mental Health Act 2014*.

For the reporting period 2016-17, we received a total of 18 requests for a Further Opinion, 4 of which were an oral request and 14 were in written form. The table below details the sources of those requests.

Request for a Further Opinion from the patient	Mental Health Advocacy Service	Mental Health Law Centre	Total Number of Further Opinions
6	10	2	18

Table 8: Requests for Further Opinions received by the Chief Psychiatrist 2016-17

Our engagement with other services and with the Western Australian community

We acknowledge that to improve the safety and quality of mental health care delivered to Western Australians affected by mental illness, there needs to be engagement with the wider community. This includes creating and strengthening relationships with health service providers outside of mental health settings, working with, sharing and exchanging knowledge with other affiliated bodies, and providing opportunities for education that is mutually beneficial.

What we have done

Focussing on Capacity

The MHA 2014 introduced 'capacity' as a criterion in which to assess an individual's need for involuntary admission to a mental health facility. The concept of capacity, whilst broadly understood by clinicians, was identified as an area requiring further development in the context of the Act.

For the reporting period, we hosted two capacity forums, reaching 83 people working within the mental health sector. The target audience was not limited to clinicians but included the broader mental health community – e.g. staff from the Mental Health Law Centre.

Met the needs of allied services

We provided five training sessions to St John Ambulance paramedics-in-training, during the reporting time. The feedback was positive and sessions have continued into the new reporting year.

We provided input into the training for Mental Health Advocates with particular reference to treatment, support and discharge plans.

We worked with HaDSCO to build an understanding of our individual services to meet mutually beneficial training requirements.

We provided an education session to non-mental health clinicians at Fiona Stanley Hospital to promote an understanding of the provisions of the MHA 2014.

We provided an education session on an overview of the MHA 2014 to staff of the Statewide Burns Unit.

In recognition of our expertise in safe quality care, we were invited to review and provide advice to Drug and Alcohol Services – Next Step and Drug and Alcohol Youth Service.

What we will do

- We will continue to engage the broader community through mutually beneficial educational opportunities.
- We will continue to engage and work with other MHA 2014 affiliated bodies such as the Mental Health Tribunal and the Mental Health Advocacy Service.



The feedback was excellent and they found it a very worthwhile session.
*St John's Ambulance
Peramedic Trainer*



Our Standards Monitoring and Evaluation Program

We work to ensure safe high quality care is provided by Western Australian mental health services. We do this through monitoring and evaluation of service delivery within the context of the *National Standards for Mental Health Services*, the *Chief Psychiatrist's Standards for Clinical Care* and recommendations from the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia (Stokes 2012)*.

The three primary components of the Program focus on the monitoring and evaluation of:

- ▶ Psychiatric treatments and interventions as stipulated in the MHA 2014, including reporting rates for seclusion and restraint annually to the Australian Institute for Health and Welfare (AIHW);
- ▶ Notifiable incidents; and
- ▶ Routine and ad hoc service clinical reviews.

The primary objectives of the program are to:

- Maximise compliance with the MHA 2014 through supporting services to provide accurate and timely data that complies with legislative requirements;
- Provide a prevention system by monitoring standards of care that enables services to become aware of trends, issues and other aspects of service delivery that may come to the attention of the Chief Psychiatrist; and
- Provide a quality improvement feedback loop to support safe high quality care to all patients of mental health services.

We achieve these aims by:

- Collaborating with key stakeholders to enable comprehensive monitoring of standards of psychiatric care by the Office of the Chief Psychiatrist
- Reporting monitoring results in a format that informs services of their strengths and weaknesses, and highlights specific areas for risk mitigation
- Evaluating the relationship between standards of psychiatric care and (i) patient outcomes (ii) frequency of notifiable incidents, and (iii) staff culture and attitudes
- Conducting ad hoc targeted reviews of contentious issues/cases reported to the Chief Psychiatrist

The Standards Monitoring and Evaluation Program is comprised of the Coordinator Standards Monitoring, Principal Officer Reviews, Standards Monitor and Data Analyst, Standards Monitor and Information Officer and Data Management Officer. We are assisted in our Clinical Reviews by senior clinicians who are recruited from across mental health services. We work closely with CSEAT to support the Chief Psychiatrist in discharging his statutory functions.

Our Clinical Monitoring Program

It is a requirement of section 515 of the MHA 2014, for the Chief Psychiatrist to publish standards for the treatment and care to be provided by mental health services and oversee compliance with those standards.

The Clinical Monitoring Program is an essential strategy for the monitoring of the standards for treatment and clinical care of mental health patients. The components of the program are:

- Clinical Standards and Service Reviews
- Targeted Clinical and Case Reviews
- Thematic Reviews.

Within health care, administrative and regulatory duplication is a significant risk. Our clinical review process differs from other review processes, such as accreditation, by undertaking a greater degree of inquiry into specific clinical issues. It differs from internal monitoring completed for other purposes, such as performance reporting, by recruiting independent senior clinicians to undertake the data collection. Additionally, the clinical review process facilitates sharing ideas between mental health services in Western Australia.

Senior clinicians are appointed as reviewers and it is their experience, which assists the depth of the review process. Participation gives reviewers an insight into service delivery by other mental health services. This in turn provides an opportunity to compare processes with their own service and share improvements across the system.

Planning for quality improvement is always based on evaluation of data. The reviews utilise a combination of qualitative and quantitative methods to establish a rich understanding of current service delivery. The reviewers use tools based on the *Chief Psychiatrist's Standards for Clinical Care*, the *Chief Psychiatrist's Guidelines* and are aligned with *National Standards for Mental Health Services (2010)*. Data is analysed and used to identify areas of notable practice, which can be shared with other mental health

services and recommendations to guide service improvement.

While services have a statutory obligation to comply with standards related to the MHA 2014, the Chief Psychiatrist does not necessarily have a statutory remit to direct recommendations that sit outside of these standards. Notwithstanding, in the interests of high quality care, if the review reveals a need for action outside of our remit, we will make a recommendation and actively seek follow up by those services involved.

Our Clinical Standards and Service Reviews

In November 2015, the *Chief Psychiatrists Standards for Clinical Care* were published as per the requirements of the Act. It is intended that the standards will be reviewed during the 2017-18 financial year. The Chief Psychiatrist's Guidelines were published in December 2015.

In 2016, we implemented a new clinical monitoring program – the *Chief Psychiatrist's Clinical Standards and Service Review*. It is our intention that all mental health services within WA will be reviewed within two years of the implementation of the clinical monitoring program (due June 2018), with the reviews consisting of a comprehensive clinical record review and face-to-face staff feedback, undertaken by trained reviewers.



**It is not enough for
safety and quality to be
assured because people
are assured in other
people that they know
and know are capable.**

*Review of Safety and Quality in the
WA Health system,
Professor Hugo Mascie-Taylor*

Comprehensive Clinical Record Review

The focus of the 'Comprehensive Clinical Record Review' is to review the quality of clinical care as evidenced within the written clinical record. The following areas are assessed:

- Patient and carer/support person engagement
- Mental state assessment
- Physical assessment and ongoing physical management
- Risk assessment and management
- Care Planning
- Discharge (including discharge planning, referral and follow up)

Face-to-Face Staff Feedback

Face-to-face feedback is gathered from selected staff working within the mental health service, with questions designed to provide feedback to managers on key areas of clinical governance.

Trained Senior Clinical Reviewers

Senior clinicians are appointed as clinical reviewers, bringing their knowledge and clinical experience to the review process. Prior to each review the appointed clinicians undertake thorough training in the requirements of the *Chief Psychiatrist's Standards for Clinical Care*, interpretation of the clinical record review criteria and procedures for collecting face-to-face feedback.

Clinical Review of WA Country Health Service

The WA Country Health Service (WACHS) was the first area health service to be reviewed by the Chief Psychiatrist since the commencement of the Act. All seven mental health regions within the WACHS region were reviewed between May–July 2016 by 10 senior clinical reviewers. Following a data analysis period, reports of the review were provided to the WACHS Executive.

A total of 216 clinical records were reviewed and 85 staff (70 clinical, 15 non-clinical) were interviewed during the course of the review. The review identified five areas of notable practice:

Mental health assessment

- Mental health assessment
- Contact details for a variety of supports
- Physical healthcare – metabolic monitoring
- Discharge/transfer of care – clarification of accommodation
- Balancing confidentiality with carer involvement

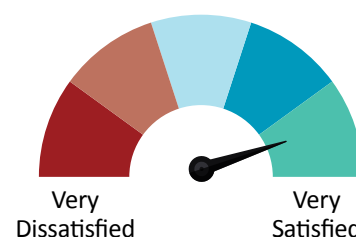
Seven recommendations were made, in the areas of drug and alcohol screening, physical examination of inpatients, risk assessment, patient involvement and discharge planning. The services' actions to address the recommendations will be monitored over the next 12 months.

Clinical Review of Child and Adolescent Mental Health Service

The Child and Adolescent Mental Health Service (CAMHS) was reviewed by us in May 2017. All 10 Community Child and Adolescent Mental Health Services in the metropolitan Perth, along with 6 Specialist Child and Adolescent Mental Health Services and the Bentley Adolescent Inpatient Unit, were reviewed by 17 senior clinical reviewers. Following a data analysis period, reports will be provided to the CAMHS Executive.

To achieve consistency across the review process, training was provided to the appointed senior clinical reviewers prior to the review being conducted. Post-training feedback indicated that the reviewers were satisfied with the training content and felt confident to undertake the review.

CAMHS Reviewer Training Feedback



The content of the training program was appropriate given the tasks that OCP undertakes during a review.



Having completed the training course I feel that I have acquired the necessary skills to carry out the site visit.



"The best elements were the collegial atmosphere and being able to hear about previous experiences (all positive) from the experienced clinical reviewers."



"I really enjoy connecting to other services and with other staff and have made some strong contacts with clinicians from my previous review in the country. We maintain contact and share resources when needed to assist both our services. This is invaluable and the personal side of the reviews that is not measurable."

A total of 244 clinical records were reviewed and 102 staff (85 clinical and 17 non-clinical) were interviewed during the course of the review. The results are being analysed.



Community MHS	No. Records
Armadale CAMHS	7
Bentley Family Clinic	12
Clarkson CAMHS	10
Fremantle CAMHS	17
Hillarys CAMHS	14
Peel CAMHS	19
Rockingham CAMHS	15
Shenton CAMHS	17
Swan CAMHS	19
Warwick CAMHS	10
Specialist MHS	No. Records
Complex Attention & Hyperactivity Disorders Service	19
Eating Disorders Program	17
Gender Diversity Service	10
Multisystemic Therapy	20
Pathways Day Program	10
Touchstone	9
Inpatient MHS	No. Records
Bentley Adolescent Unit	19
TOTAL	244

Clinical Review of South Metropolitan Health Service

The Chief Psychiatrist reviewed the mental health services within the South Metropolitan Health Service (SMHS) in May/June 2017. Nine senior clinical reviewers visited Fiona Stanley Mental Health Unit, Fremantle Mental Health Service and Peel, Rockingham & Kwinana Mental Health Service (Table 10). Analysis of the data is underway, with reports to be provided to the SMHS Executive during the 2017-18 financial year.

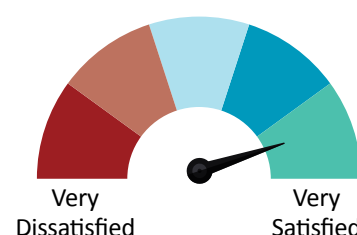
Similar to the CAMHS review, preparation training was provided to the SMHS-appointed senior clinical reviewers. Post-training feedback again highlighted the reviewers' satisfaction with the training content and their confidence to conduct the review.

SMHS Reviewer Training Feedback

The content of the training program was appropriate given the tasks that OCP undertakes during a review.



Having completed the training course I feel that I have acquired the necessary skills to carry out the site visit.



Mental Health Service	Sites Visited	No. Records Reviewed
Fiona Stanley Mental Health Unit	Fiona Stanley Inpatient Unit	21
	Youth Community Assessment and Treatment Team	17
Fremantle Mental Health Service	Fremantle Inpatient Mental Health	6
	Fremantle Community Mental Health	18
Peel, Rockingham & Kwinana Mental Health Service	Mimidi Park Inpatient Mental Health	20
	Rockingham / Kwinana Adult Community Mental Health	13
	Peel Adult Community Mental Health	19
TOTAL		117

Table 10: Mental Health Services and sites visited as part of our Clinical Standards and Service Review of SMHS

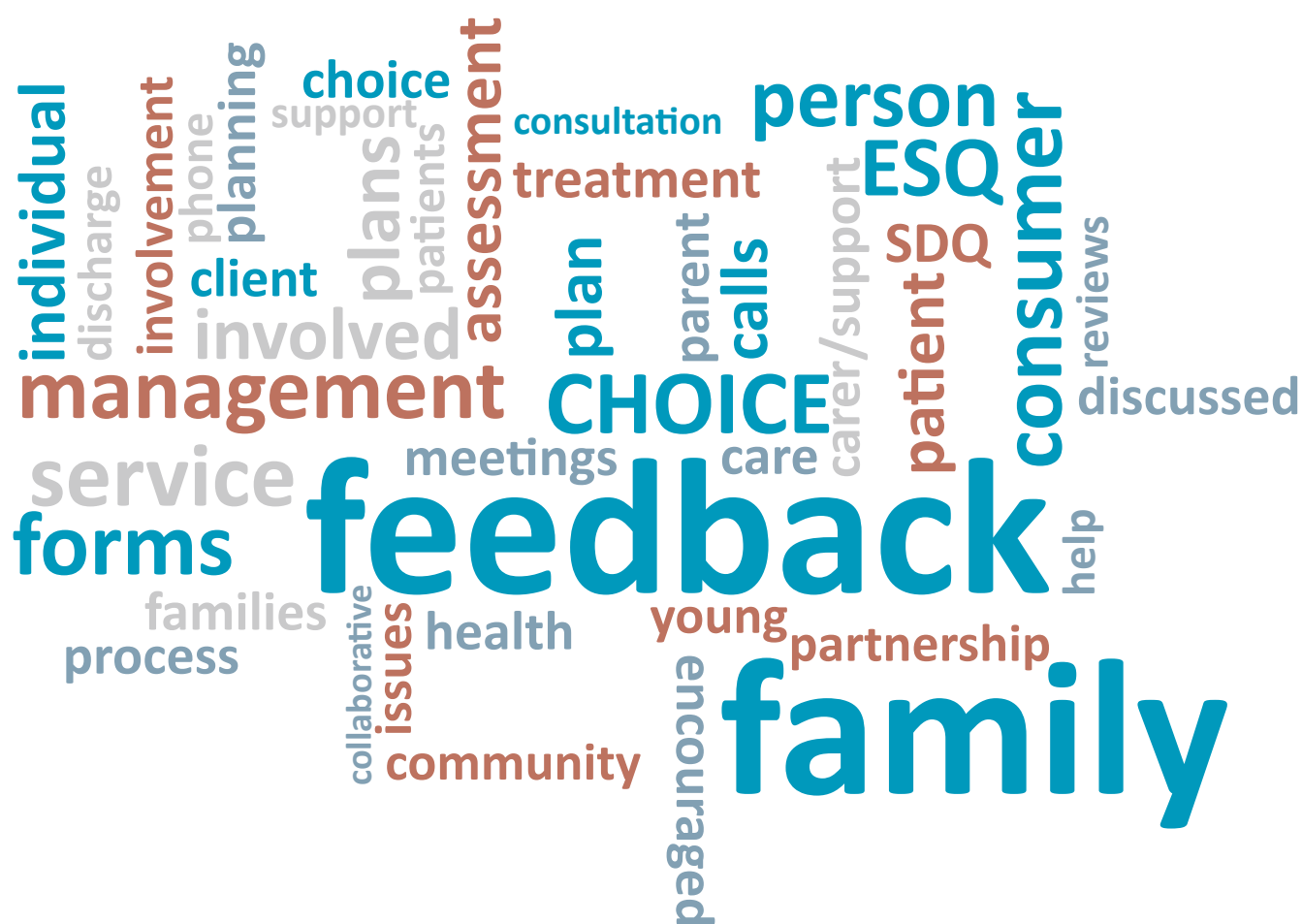
Planned Clinical Reviews for 2017/18

There are two remaining services to be reviewed within the planned two-year timeframe; North Metropolitan Health Service and East Metropolitan Health Service. Prior to undertaking these reviews, the Clinical Monitoring team plans to assess the feedback received from previous reviews in order to enhance and revise the clinical audit tool and interview questions.

Responses to CAMHS Clinical Staff Interview Question 1 “Can you provide me with examples of how patients and carers are involved in their own treatment and care?”



“Hearing the perspectives and experiences of different staff attending, facilitators encouraged interaction”



Our Thematic and Targeted Clinical Case Reviews

The Chief Psychiatrist has powers of inspection under the Act and can receive a request from the Minister for Mental Health to make inquiries about any matter connected with the provision of care, treatment or any other service for any person who has a mental illness.

We undertake targeted clinical reviews in order to monitor the standards of mental health care in WA. Targeted reviews occur when the Chief Psychiatrist has a sufficient concern about a particular aspect of psychiatric care and treatment that warrants an in-depth understanding of the issue. Targeted case reviews may investigate the standards of psychiatric care provided to an individual patient or group of patients. Due to the confidential nature of the patient information contained in these reviews they are often not published in the public domain.

Chief Psychiatrist's Thematic Reviews

Historically we have undertaken thematic reviews, looking at specific themes across all services, e.g. physical health care. There were no thematic reviews undertaken during this reporting period. When previously undertaken, the topics for thematic reviews were informed by the outcomes of clinical reviews.

Targeted Case Reviews

We carry out in-depth inquiries into patient care in mental health services. Findings may lead to recommendations that the system can learn from, to improve the care provided to patients in mental health and other services. There were no targeted case reviews conducted during the reporting period.

Our Statutory Monitoring

Since the implementation of the MHA 2014, we have established a number of reporting and quality assurance mechanisms that, in collaboration with services, ensure safe, high quality care.

Mental health services are statutorily required to report the following:

- Electroconvulsive therapy (s. 201)
- Emergency ECT approved by the Chief Psychiatrist
- Restrictive practices
- Seclusion (section 224)
- Restraint (section 240)
- Notifiable incidents (section 526)
- Psychosurgery (section 209)
- Treatment decisions that differ to the Advance Health Directive of an involuntary patient (section 179)
- Segregation of children from adult inpatients (section 303)
- Off-label prescription provided to children who are involuntary patients (section 304)
- Approving involuntary inpatient treatment orders in a general hospital (section 61)
- Emergency psychiatric treatment (section 204)
- Urgent non-psychiatric treatment for involuntary and MIA patients (section 242).

We monitor 'Notifiable Incidents' pertaining to individual cases and identify trends. At our discretion, we may investigate any case the Chief Psychiatrist may have specific concerns about. In these cases, there is direct inquiry to the service involved and recommendations made as necessary.

The remainder of this section presents data for the 2016-17 financial year pertaining to our statutory responsibilities in regard to monitoring for;

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy (ECT) is the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle-relaxing agent. Notwithstanding some public and historical stigma, ECT is a very effective evidence-based treatment of serious mood disorders, including major depression and mania, catatonic states and occasionally with schizophrenia or other neuropsychiatric disorders.

Under the MHA 2014, ECT can only be administered in ECT suites or operating theatres approved by the Chief Psychiatrist and these are required to follow the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy 2015* and the *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2006*.

The Act contains specific provisions regulating the use of ECT, including obtaining informed consent from voluntary patients and the circumstances in which a patient can provide informed consent. A medical practitioner must obtain approval from the Mental Health Tribunal in order to perform ECT on an involuntary or Mentally Impaired Accused patient.

The person in charge of the Mental Health Service must report at the beginning of each month on any course of ECT, which was completed or discontinued in the previous month. A course of ECT is taken to have been completed during a month, if the last treatment in the course was performed during that month, whether or not any of the other ECT treatments in the course were performed during the month. A course of ECT is taken to have been discontinued during a month if;

- (a) one or more of the treatments in the course have been performed, whether or not during the month; and
- (b) the decision not to perform any more of the treatments in the course was made (for whatever reason) during the month.

Maintenance ECT is a course of ECT applied infrequently, for example every two weeks or monthly, and can continue long-term. If a decision to suspend maintenance ECT is made, the treatment is considered to have stopped. Maintenance ECT not applied within a three month period is considered ceased and should be reported.

ECT Statistics

The table below shows the ECT treatments that were reported to and monitored by the Chief Psychiatrist during the 2016-17 financial year.

Age	Status	Number of ECT Courses	ECT Treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
Patients over 18	Voluntary	480	4,185	430	0	4,615
	Involuntary	55	572	64	21	657
	MIA	<5	12	0	0	12
	Mixed	10	121	18	7	146
	Subtotal	±	4,890	512	28	5,430
Patients under 18	Voluntary	0	0	0	0	0
	Involuntary	<5	24	0	0	24
	MIA	0	0	0	0	0
	Mixed	<5	5	0	0	5
	Subtotal	±	29	0	0	29
Total		±	4,919	512	28	5,459

Table 11: ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2016 – 30 June 2017).

Note: The data are representative of those who completed their course of ECT between 01 July 2016 and 30 June 2017. It is important to note that the starting date for some of the courses may have commenced prior to the beginning of the reporting period 1 July 2016. Persons having not completed their course of ECT are not included in Table 11.

±Where the number in a cell is <5, the total number of individuals cannot be provided in order to prevent potential identification of patients.

For the reporting period 1 July 2016 – 30 June 2017, there were 5,459 ECT treatments completed of which 4,919 (90%) were acute treatments, 512 (9%) were maintenance and 28 (<1%) consisted of emergency treatments.

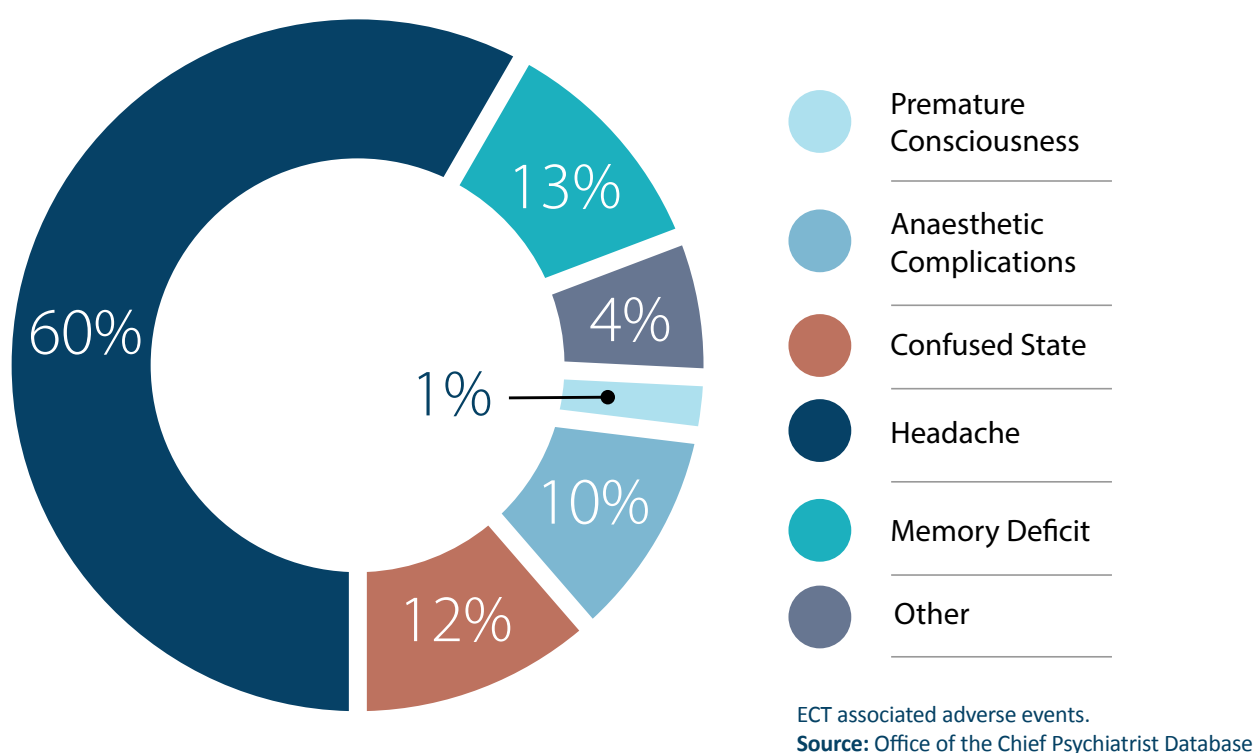
Patients over 18 years of age received a total of 5,430 ECT treatments of which 4,890 (90%) were acute ECT treatments, 512 (9%) maintenance ECT, and 28 (<1%) consisted of emergency ECT. Patients under 18 years of age received less than five courses of ECT with 29 treatments (100%) being acute ECT treatments.

Of all the ECT courses reported to us, 29% were reported by ECT services located within a public hospital, 7% in a publically contracted private hospital and 64% reported by ECT services within a private hospital.

Adverse Events

Within all courses of recorded ECT, 81 reported an adverse event. Among the 81 courses, there were 769 ECT treatments and 207 (27%) adverse events recorded. Adverse events occurred in less than 5% of all ECT treatments for the reporting period. The type and proportion of adverse events are presented below (please note that there were no muscle tears or vertebral column damage reported to the Chief Psychiatrist).

Types of Adverse Events



Emergency ECT Approved by the Chief Psychiatrist

The Act contains specific provisions for the use of Emergency ECT on involuntary and Mentally Impaired Accused (MIA) patients where ECT is deemed necessary to either 'save the person's life' or 'because there is an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person.' Under these circumstances the medical practitioner must obtain approval from the Chief Psychiatrist, to undertake emergency ECT.

There were 33 Emergency ECT treatments approved by the Chief Psychiatrist or his authorised delegate, for the reporting period. It is important to note, that this number can include courses of ECT treatments completed after 30 June 2017, which will be reported in the next financial year. Therefore, the number will not equate to the number of Emergency ECT treatments in Table 11.

Restrictive Practices

In WA, mental health clinicians in authorised hospitals use seclusion and restraint as a last resort, when either all other methods of de-escalation have been tried or de-escalation cannot be used. The safety and care of the patient, other patients or visitors and staff is important and should not be compromised. Seclusion may be used to prevent a person from physically injuring themselves or others or persistently causing serious damage to property.

Bodily restraint can be used to prevent the person from (i) physically injuring themselves or others, (ii) persistently causing damage to property, or (iii) to provide the person with treatment when the use of restraint is unlikely to pose a significant risk to the person's physical health. Seclusion and restraint should only be used when there is no less restrictive way of providing treatment or preventing injury or damage.

When viewing the data on the rates of seclusion and restraint in authorised hospitals, consideration needs to be given to the severity of the mental illnesses being experienced by the patients that may have resulted in multiple events and longer periods of restraint and/or seclusion. Patients requiring multiple events of seclusion and/or restraint during their period of care are patients who may have particularly challenging behaviours and clinicians may need to implement specific targeted clinical/therapeutic interventions in an effort to reduce the use of restrictive practices.

Further reductions in the rates of seclusion and restraint will be achieved with the continued commitment of mental health staff to implement evidence-based state-wide best practice methods.

We have established a system of monitoring and evaluating restrictive practice events and their rates. The data collected is shared with mental health services on a regular basis to assist services to track their progress in reducing the use of these restrictive practices.

Reporting on restrictive practices includes data on seclusion, physical and mechanical restraint occurring within authorised hospitals. While there is no obligation for mental health services to maintain a register of seclusion and restraint events, we encourage services to maintain such a register.

While other restrictive practices have been raised at a national level (e.g., chemical restraint), Key Performance Indicators for these practices have not been defined and therefore are not currently reported. There is significant work being done at a national level to gain a consistent approach to defining and reducing restrictive practices across jurisdictions (e.g. the Restrictive Practices Working Group, sub-group of the Safety and Quality Partnerships Standing Committee), of which we are a member.

Seclusion

We are committed to reducing the rate of seclusion and where possible eliminating the use of restrictive practices in mental health services across WA. There is considerable interest nationally and internationally to reduce and eliminate the use of seclusion.

Seclusion can only be used within an authorised hospital if the person is at risk of physically injuring themselves or another person, or if they are persistently causing serious damage to property and there is no less restrictive way of preventing injury or damage other than placing them in seclusion. Seclusion purely for the purposes of preventing self-harm should be avoided.

Seclusion can be initially authorised for a maximum of two hours and the person being secluded must be observed every 15 minutes by a nurse or mental health practitioner. Seclusion can be extended for periods of up to two hours, however an examination must be completed by a medical practitioner within two hours from the time the person was secluded, or from their last examination, before it can be extended. It is our expectation that medical practitioners



'Seclusion is the 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.'

'A person is not considered to be secluded merely because the person is alone in a room or area that the person is unable to leave because of frailty, illness or mental or physical disability.'

Mental Health Act 2014

attend the patient as soon as practicable rather than wait for the full duration of the seclusion order. A post-seclusion physical examination must occur within six hours of the person being released from seclusion. It is our expectation that the post-seclusion examination occurs as soon as practicable.

Each seclusion event must be reported to us using the approved forms, as stipulated in the Act.

During the reporting period, there were 11,966 separations (discharges), for 7,511 individuals. Of these, there were 1,008 episodes of seclusion (total number of patients not provided in the interests of preserving patient privacy and confidentiality) table 12.

Age Group	Separations	Individuals	Individuals Secluded*	Seclusion Episodes
Patients under 18 years of age	847	452	28	124
Patients aged 18–65 years	9,996	6,425	326	879
Patients aged 65 years and older	1,123	634	<5	5

Table 12: Number of seclusions reported to the Office of the Chief Psychiatrist

*The subtotals for individuals will not add to the total number of reported seclusions as a person may have been secluded more than once for varying lengths of time.

Seclusion Episodes - Total Population (All Ages)

Duration of Seclusion Episodes

Of the 1,008 episodes reported, 21% lasted less than 60 minutes, 48% lasted between 60 and 120 minutes, and 31% lasted more than 120 minutes (Table 13). The time patients were secluded ranged from 5 minutes to 4185 minutes, with a median duration of 115 minutes.

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 60 minutes	132	209	40
60 to 120 minutes	241	484	105
More than 120 minutes	145	315	230

Table 13: Duration of seclusion events in authorised Mental Health units – Total population

*The subtotals for individuals will not add to the total number of reported seclusions as a person may have been secluded more than once for varying lengths of time.

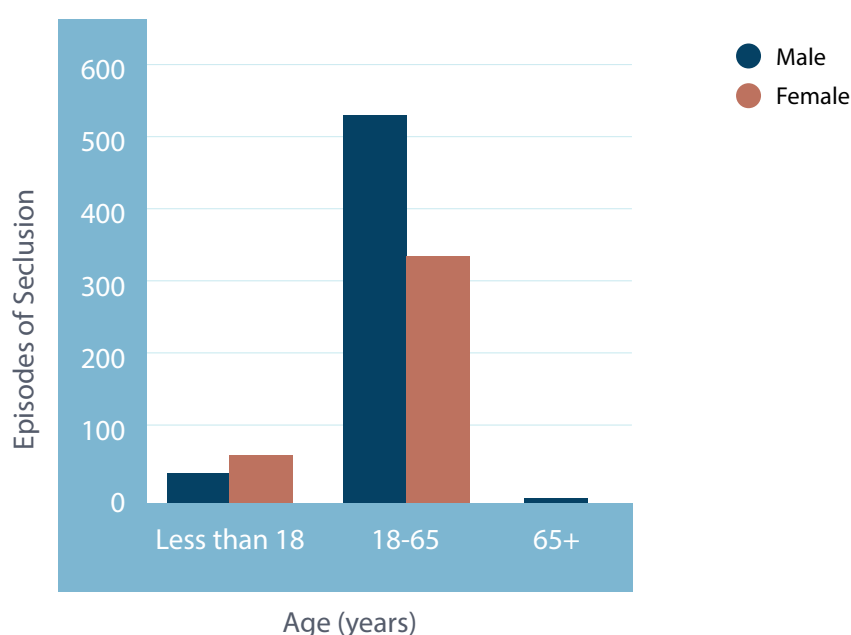
Across all age groups, 61% of those secluded were male, which accounted for 59% of episodes of seclusion reported.

For those under 18 years of age, 61% of those secluded were female, which accounted for 60% of episodes of seclusion for this age group.

For those aged 18-65 years, 62% of those secluded were male, which accounted for 61% of all seclusion episodes reported.

For those aged 65 years and over, only a very small number of patients were secluded to enable any meaningful understanding of the data.

Seclusion episodes by Gender and Age Group



Source: Office of the Chief Psychiatrist Database

Seclusion Episodes – Patients under 18 Years

Duration of Seclusion Episodes

Of the 28 patients aged under 18 years who were secluded, 19 were secluded less than 5 times, 5 patients between 5-10 times, and less than 5 patients were secluded more than 10 times.

Of the 124 seclusion episodes reported, 43% lasted less than 60 minutes, 43% lasted between 60 and 120 minutes, and 14% lasted more than 120 minutes (Table 14). The time patients under 18 years were secluded was between 5 minutes and 620 minutes, with a median duration of 70 minutes.

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 60 minutes	22	53	36
60 to 120 minutes	14	53	95
More than 120 minutes	8	18	135

Table 14: Duration of seclusion for patients under 18 years

*The subtotals for individuals in Table 14 will not add to the total number of individuals secluded (Table 12) as some patients were secluded more than once for varying lengths of time.

Seclusion Episodes – Patients 18 – 65 Years

Duration of Seclusion Episodes

Of the 326 patients aged 18–65 years who were secluded, 275 patients were secluded less than 5 times, 39 patients between 5-10 times, and 12 were secluded more than 10 times. Of the 879 seclusion episodes reported to us, 17.5% lasted less than 60 minutes, 49% lasted between 60 and 120 minutes, and 33.5% lasted more than 120 minutes (Table 15). The time patients were secluded ranged from 5 minutes to 4185 minutes, with a median duration of 117 minutes.

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 60 minutes	108	154	40
60 to 120 minutes	227	430	105
More than 120 minutes	135	295	230

Table 15: Duration of seclusion for patients aged 18–65

*The subtotals for individuals will not add to the total number of reported seclusions as a person may have been secluded more than once for varying lengths of time.

Seclusion Episodes – Patients over 65 Years

Due to the small number of patients aged over 65 years of age, detailed statistics are not reported in order to prevent potential identification of individuals.

National Key Performance Indicators for Seclusion Episodes

The AIHW reports on national and state/territory yearly seclusion rates within authorised and non-authorised hospitals. During the current reporting period the overall rate of seclusion within authorised mental health inpatient units in WA was 5.1 episodes per 1,000 bed-days. The rate of seclusion was lowest for older adult services (0.1 episodes per 1,000 bed-days) and adult mental health services (5.3 episodes per 1,000 bed-days), and highest within child and adolescent (14.7 per 1,000 bed-days) and forensics services (15.2 episodes per 1,000 bed-days).

Restraint

The Act contains specific principles relating to the use of bodily restraint, including what degree of force is acceptable and that the person being restrained, must be treated with dignity and respect.

Restraint may be initially authorised for a maximum of 30 minutes, and a mental health practitioner or nurse must be in physical attendance with the person at all times, and file a record of the observations made on the approved Form. Restraint can be extended for periods of up to 30 minutes; however, an

examination by a medical practitioner must occur within 30 minutes before an extension can be made. If the person is restrained for longer than 6 hours, a psychiatrist must examine them. A post-restraint physical examination must occur within six hours of the person being released from the restraint. It is our expectation that the post-restraint examination occurs as soon as practicable.

Under the Act, mental health services are required to provide us with copies of the approved Forms, which need to be completed for each restraint event, with the exception being, when the restraint is undertaken to escort a patient to seclusion. In order to ensure a smooth transition, we have requested that each service continue to maintain their own restraint register to enable cross-checking and validation of the number of restraint events notified to us.

For the reporting period there were 11,966 separations, involving 7,511 individuals. Of these, 416 patients were restrained with 951 episodes of restraint (Table 16).

Age Group	Separations	Individuals	Individuals Restrained*	Restraint Episodes
Patients under 18 years of age	847	452	48	172
Patients aged 18-65	9,996	6,425	325	692
Patients aged 65 years and older	1,123	634	44	87

Table 16: Number of restraints reported to the Office of the Chief Psychiatrist

*The subtotals for individuals will not sum to the total number of reported restraint episodes as a person may have been restrained more than once for varying lengths of time.

Restraint Episodes – Total Population (All Ages)

Duration of Restraint Episodes

Of the 416 patients who were restrained, 378 were restrained less than 5 times, 26 patients between 5-10 times, and 12 patients were restrained more than 10 times. Of the 951 episodes reported, 58% lasted less than 5 minutes, 25% lasted between 5 and 10 minutes, and 17% lasted more than 10 minutes (Table 17). The time patients were restrained ranged from less than 1 minute to 270 minutes, with a median duration of 3 minutes.

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 5 minutes	296	549	2
5 to 10 minutes	173	243	6
More than 10 minutes	90	159	19

Table 17: Duration of restraint events in authorised Mental Health units – Total Population

*The subtotals of individuals will not add to the total number of reported restraints as a person may have been restrained more than once for varying lengths of time.



‘Bodily restraint is defined as the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.’

‘Bodily restraint does not include the appropriate use of medical or surgical appliance in the treatment of a physical illness or injury or the appropriate use of furniture that restricts a person’s capacity to get off the furniture.’

‘Physical restraint is the restraint of a person by the application of bodily force to the person’s body to restrict the person’s movement.’

‘Mechanical restraint is the restraint of a person by the application of a device to a person’s body to restrict the person’s movement. It also does not include restraint by a police officer acting in the course of duty or a person exercising a power under section 172(2) of the Act.’

Mental Health Act 2014

Across all ages, an equal proportion of male and female patients experienced an episode of restraint. However, females accounted for 55% of all restraint episodes.

For those patients under 18 years of age, 62.5% of those restrained were female, which accounted for 66% of restraint episodes for this age group.

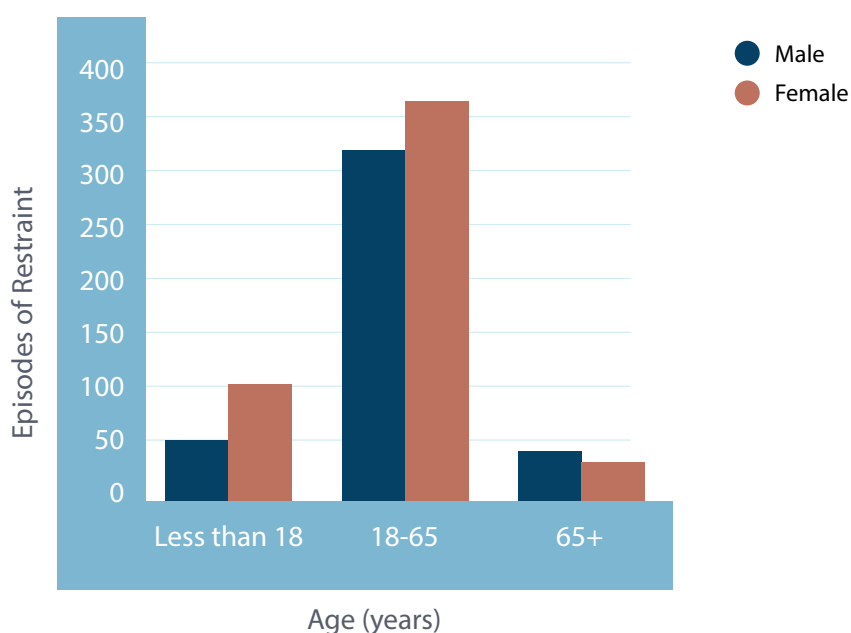
For those patients aged 18-65 years, 52% of those restrained were male, however, 53% of restraint episodes applied to females.

For those patients aged over 65 years and over who had a reported episode of restraint, 52% were male, which accounted for just over half i.e. 54% of all restraint episodes for this age group.

Physical or Mechanical Restraint across all age groups

Across all age groups, the majority of restraints were physical (n = 941) with the remainder mechanical (n = 10).

Restraint episodes by Gender and Age Group



Source: Office of the Chief Psychiatrist Database

Restraint Episodes – Patients under 18 Years

Duration of Restraint Episodes

Of the 48 patients under 18 years of age who were restrained, 38 were restrained less than 5 times, 5 patients between 5-10 times, and 5 patients were restrained more than 10 times. Of the 172 episodes reported, 46% lasted less than 5 minutes, 30% lasted between 5 and 10 minutes, and 24% lasted more than 10 minutes. The time patients were restrained ranged from less than 1 minute to 68 minutes, with a median duration of 5 minutes (Table 18).

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 5 minutes	30	79	2
5 to 10 minutes	28	52	7
More than 10 minutes	24	41	19

Table 18: Duration of restraint for patients under 18 years

*The subtotals of individuals will not add to the total number of reported restraints as a person may have been restrained more than once for varying lengths of time.

Physical or Mechanical

All reports of restraint to the Chief Psychiatrist for patients under 18 years of age utilised physical restraint techniques, with no reports of mechanical restraint.

Restraint Episodes – Patients 18 – 65 Years

Duration of Restraint Episodes

Of the 325 patients aged 18 to 65 years who were restrained, 300 were restrained less than 5 times, 19 patients between 5-10 times, and 6 patients were restrained more than 10 times. Of the 692 restraint episodes reported, 59% lasted less than 5 minutes, 25% lasted between 5-10 minutes, and 16% lasted more than 10 minutes. The time patients were restrained ranged from less than 1 minute to 270 minutes, with a median duration of 3 minutes (Table 19).

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 5 minutes	231	408	2
5 to 10 minutes	131	174	5
More than 10 minutes	59	110	17

Table 19: Duration of restraint for patients aged 18–65 years of age

*The subtotals of individuals will not add to the total number of reported restraints as a person may have been restrained more than once for varying lengths of time.

Physical or Mechanical

The majority of restraints episodes were physical (n = 682), with the remainder mechanical (n = 10).

Restraint Episodes – Patients Over 65 Years

Duration of Restraint Episodes

Of the 44 patients aged over 65 years who were restrained, 41 were restrained less than 5 times, with less than 5 patients between 5-10 times, and less than 5 patients restrained more than 10 times. Of the 87 episodes reported, 71% lasted less than 5 minutes, 20% lasted between 5 and 10 minutes, and 9% lasted more than 10 minutes. The time patients were restrained ranged from less than 1 minute to 60 minutes, with a median duration of 2 minutes (Table 20).

Length category	Individuals*	Episodes	Median Duration in minutes
Less than 5 minutes	36	62	2
5 to 10 minutes	14	17	7
More than 10 minutes	7	8	20

Table 20: Duration of restraint for patients over 65 years

*The subtotals of individuals will not add to the total number of reported restraints as a person may have been restrained more than once for varying lengths of time.

National Key Performance Indicators for Restraint episodes

Rates of restraint are difficult to benchmark nationally, due to variations in reporting between the states and territories. Significant progress has been made towards a national reporting framework for restraint events across all jurisdictions. The Australian Institute of Health and Welfare and the Safety and Quality Partnerships Standing Committee, have led the initiative to begin national reporting and jurisdictional comparative restraint rates, where possible.

With the implementation of the Act, reporting requirements in WA have been standardised, enabling the accuracy of future benchmarking at state level.

During the reporting period the rate of restraint within authorised mental health inpatient units in WA for all age groups was 4.8 episodes per 1,000 bed-days. The rate of restraint varied across services, with the lowest rate of episodes observed in Older Person services (2.4 per 1,000 bed-days) and Adult services (4.3 per 1,000 bed-days), and the highest rate within Child and Adolescent services (23.6 per 1,000 bed-days). Forensics services had a rate of 7.8 episodes per 1,000 bed-days.



Notifiable incidents reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017

Deaths and other notifiable incidents that involve patients receiving care from mental health services throughout WA must be reported to the Chief Psychiatrist.

As set out in the *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist*, notifiable incidents must be reported, within 48 hours of the event or as soon as practicable, either via the *Datix Clinical Incident Management System* (Datix CIMS) or by completing the OCP¹¹ *Notifiable Incident Reporting Form* available on our website.

The mental health status of the person(s) involved in an incident must be reported at the time of the incident. Incidents reported through Datix CIMS, require the notifying person to assign a *Severity Assessment Code* (SAC) of 1, 2 or 3 based on the actual or potential consequences associated with the clinical incident.

The SAC rating is used to determine the appropriate level of investigation, action and escalation required. In Datix CIMS the notifying person enters the SAC rating that they assess as best reflecting the level of harm that has, or could have, occurred to the patient as a result of the incident.

Following notification of a clinical incident, senior staff at the hospital and/or health service concerned, review the incident and confirm the SAC rating, which may differ from the original SAC rating allocated by the notifying person. Time lags may exist in the confirmation of a SAC rating for an incident recorded in Datix CIMS.

All incidents reported through Datix CIMS undergo an investigation by a senior staff member. The minimum level of investigation required by the Datix CIMS Policy is dependent on the SAC rating. Incidents assigned a SAC1 rating require a Root Cause Analysis (RCA) or similar investigation appropriate to the incident.

Through this process, potential causative and contributing factors are identified so that the service can develop and implement recommendations to prevent similar incidents from occurring in the future.

We individually assess incidents reported in Datix CIMS, to determine whether they fall within our statutory remit and are coded accordingly.



SAC1: includes all 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. In WA SAC1 includes the eight nationally endorsed sentinel event categories

SAC2: includes all incidents/ near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition or illness

SAC3: includes all incidents/ near misses where minimal or no harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.

WA Health Clinical Incident Management (CIM) Policy 2015.2.

11 OCP=Office of the Chief Psychiatrist

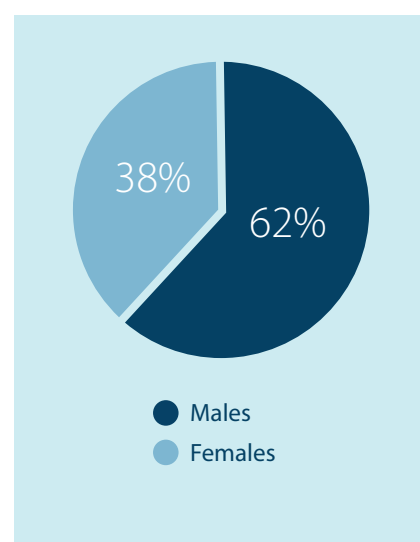
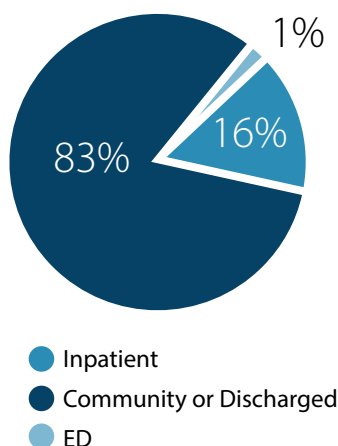
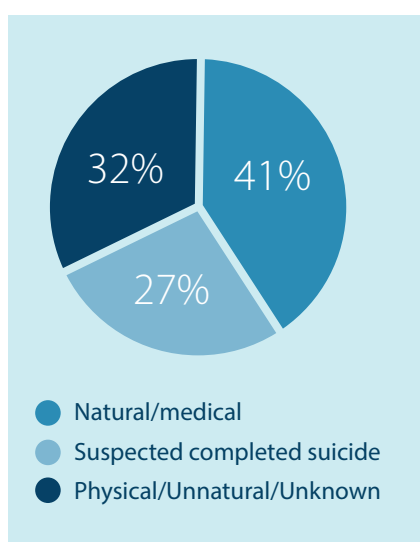
Deaths

Any deaths of active patients receiving mental health care who are in the care of a health service, and any deaths that may implicate or involve a mental health service or other health services, must be reported to us. This includes all deaths occurring within 3 months of a mental health patient's discharge or deactivation.



193 deaths of patients in mental health services

were reported to the Chief Psychiatrist in 2016-2017 financial year



Characteristics of deaths for patients of mental health services reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017. The cases of suspected suicide reported only include people who were in contact with a mental health service. The majority of suicides in WA occur in people who have not had contact with mental health services.

*Physical Unnatural deaths refer to motor vehicle accidents, falls etc.

These attributions of cause of death are likely, however the WA Coroner may alter a cause of death following Coronal review.

For the reporting period, the deaths of 193 patients of mental health services were reported to us through either Datix CIMS (n = 88) or the OCP Notifiable Incident Reporting Form (n = 105).

The majority of these deaths were either for active community patients or patients who had been discharged from a mental health service within 3 months of their death, followed by inpatients in an authorised or general hospital, and then patients who died in an ED. Of the 193 deaths, 38% (n = 74) were female and 62% (n = 119) were male patients.

- 41% (n = 79) of all deaths reported were attributable to natural or specific medical causes.
- 27% (n = 52) of all deaths reported were attributable to suspected and completed suicide.
- 32% (n = 62) of all deaths reported were attributable to 'physical unnatural' or 'unknown' causes. Physical unnatural deaths included but are not limited to, deaths due to homicide, falls, motor vehicle accidents, and unintentional drug overdose.

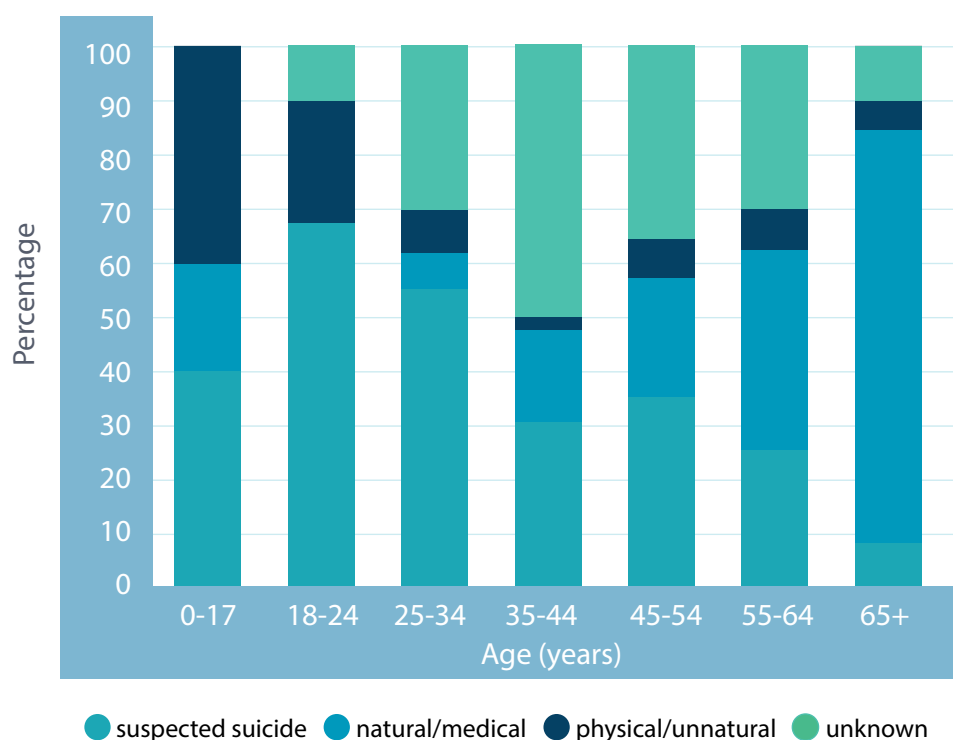
Of the deaths reported to us, 54% had a SAC rating confirmed, with 86% of these classified as a SAC1 incident. For all incidents assigned a SAC rating, a clinical investigation had been completed for 78% of cases.

The proportion of suspected suicides reported to us was greatest for those who were 0 – 34 years of age. Suspected suicide accounted for 40% of the reported deaths in those aged 17 years or younger, and 58% of the deaths in those aged 18 to 34 years. Of the 128 deaths reported for patients aged 45 years or older, 17% were suspected suicides. The majority of deaths (65%) occurring in patients aged 55 years and over were attributed to natural or specific medical causes.

	Suicide n= 52	Natural/ medical n= 79	Physical Unnatural* n= 15	Unknown n= 47	Total n= 193
Male	64%	55%	73%	64%	62%
Female	36%	45%	27%	36%	38%
Rated at SAC1	85%	16%	53%	53%	47%

Table 21: Suspected causes of deaths of patients of mental health services reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017

Source: Datix CIMS and Office of the Chief Psychiatrist Database



Deaths of patients of mental health services by category of death and age group reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017

Source: Datix CIMS and Office of the Chief Psychiatrist Database

Other Notifiable Incidents

Other notifiable incidents that must be reported to us include:

1. Attempted Suicide
2. Non Suicidal Self-Injury
3. Assault and/or Aggression
4. Unreasonable use of force by a staff member
5. Sexual Contact and/or Allegation of Sexual Assault
6. Unlawful sexual contact
7. Absent Without Leave (AWOL)
8. Missing Person
9. Serious medication error.

For the reporting period, there were 3,581 other notifiable incidents spread equally between males and females at 50% that were reported for 1,466 patients (Table 22). Of these incidents, 94% (n = 3,375) described a single incident type while for 6% (n = 206) a secondary incident also occurred. The most common secondary incidents reported related to assault/aggressive behaviour (n = 78), non-suicidal self-injury (n = 48), attempted absconding (n = 21), absconding (n = 20), sexual contact/alleged sexual assault (n = 16) and attempted suicide (n = 15).

Mental health status						
Incident type	Involuntary		Voluntary		Referred*	
	number	%	number	%	number	%
Assault/aggressive behaviour	1,349	65	616	30	99	5
Sexual contact/alleged Sexual Assault	56	64	29	33	<5	<5
Non-suicidal self-injury	136	32	265	62	29	6
Attempted suicide	68	22	219	72	19	6
Absconding – leaving hospital without permission**	293	89	0	0	36	11
Absconding – did not return from granted leave**	70	100	0	0	0	0
Missing person±	0	0	184	100	0	0
Attempted absconding	48	61	25	32	6	7
Serious medication error	<5	27	11	73	0	0
Unlawful sexual contact by staff	0	0	<5	100	0	0
Unreasonable use of force by staff	<5	100	0	0	0	0
ECT error	<5	100	0	0	0	0
Other SAC1 incidents	<5	25	9	75	0	0
Total	2,031	57	1,359	38	191	5

Table 22: Other Primary Notifiable Incidents reported to us between 1 July 2016 and 30 June 2017

Source: Datix CIMS and Office of the Chief Psychiatrist Database

Where the number in a cell is <5, the numbers and percentages have not been provided in order to prevent potential identification of patients.

*Referred relates to people who have been referred under the MHA 2014 for assessment by a psychiatrist; not yet involuntary.

**Involuntary/referred patients only

The majority of the incidents reported to us were through Datix CIMS (n = 3,086), with the remainder reported through the OCP Notifiable Incident Reporting Form (n = 495). 59% of patients were involved in one incident, 38% were involved in 2 to 5 incidents, 2% between 6 to 10 incidents and 1% between 10 to 71 incidents.

Of the 3,581 incidents, those that were confirmed as SAC1 rating was 9%, a SAC2 rating was 26% and a SAC3 rating was 55%, while the remaining 10% did not have an assigned SAC rating at the time of reporting.

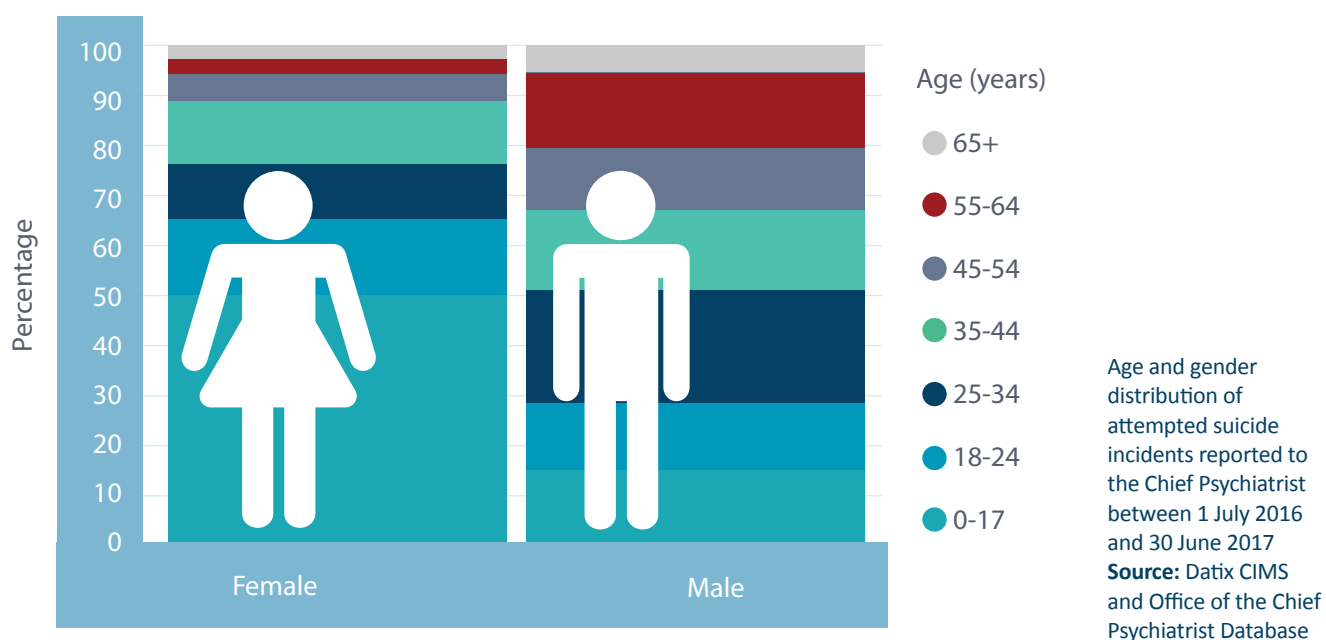
For incidents with a SAC1 rating, a clinical investigation was completed in 82% of cases for the reporting period.

Attempted suicide

Any deliberate self-inflicted bodily injury with the intention of ending one's life must be reported to us. This does not include suicidal ideations, which have not been acted upon. It does include incidents which are considered a near miss where an 'incident may have, but did not cause harm, either by chance or through timely intervention.'¹² This includes, but is not limited to, self-poisoning, overdose, jumping from a height and hanging. These incidents can occur whilst the patient is receiving inpatient or community care or within an ED. The classification of 'attempted suicide' is a clinical judgment made at the time of the incident.

For the reporting period, 321 reports to us were classified as an attempted suicide. Of these, 74% were female and 26% male. 12% were reported as a SAC1, 30% as SAC2, 50% as SAC3 and 8% had no SAC rating assigned at the time of reporting.

Almost half of the females who attempted suicide 48% were aged 17 years or younger, whilst for males a high proportion, 39% were aged between 25 to 44 years.



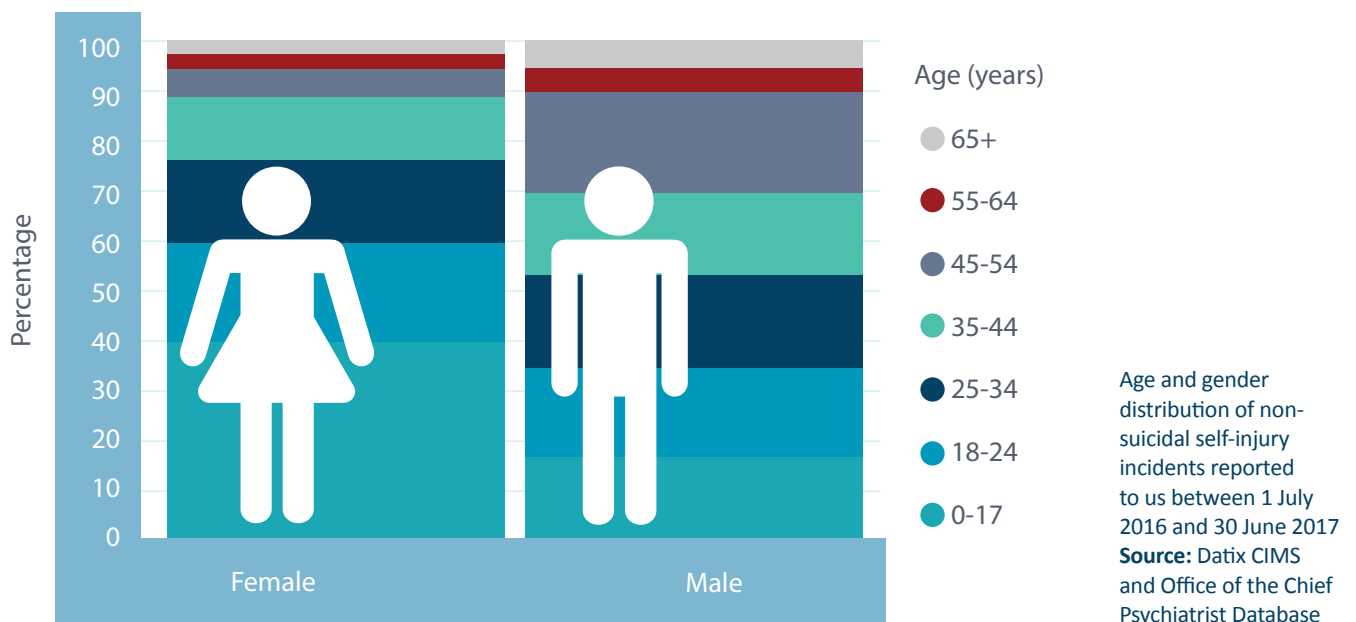
12 Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.

Non-Suicidal Self-Injury

Any deliberate self-inflicted bodily injury where there is no evident intention to die must be reported to us. The absence of suicidal intent is reported by the patient or can be inferred by frequent use of methods that the patient knows by experience, not to have lethal potential.

Non-suicidal self-injury represents a maladaptive coping mechanism to regulate overwhelming emotions and to endure life. This includes but is not limited to self-poisoning, overdose, and cutting.¹³ These incidents can occur whilst the patient is receiving inpatient or community care or within an ED.

For the reporting period, there were 475 reports of non-suicidal self-injury for 273 patients. Of these, 79% were female and 21% male. The proportion of non-suicidal self-injury behaviours in females, generally decreased as age increased, with the most common age group being those aged 17 years or younger (40%). There was less variability for males, with similar rates of non-suicidal self-injury for those between the 0-54 years of age, before markedly declining among older patients.



13 Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.

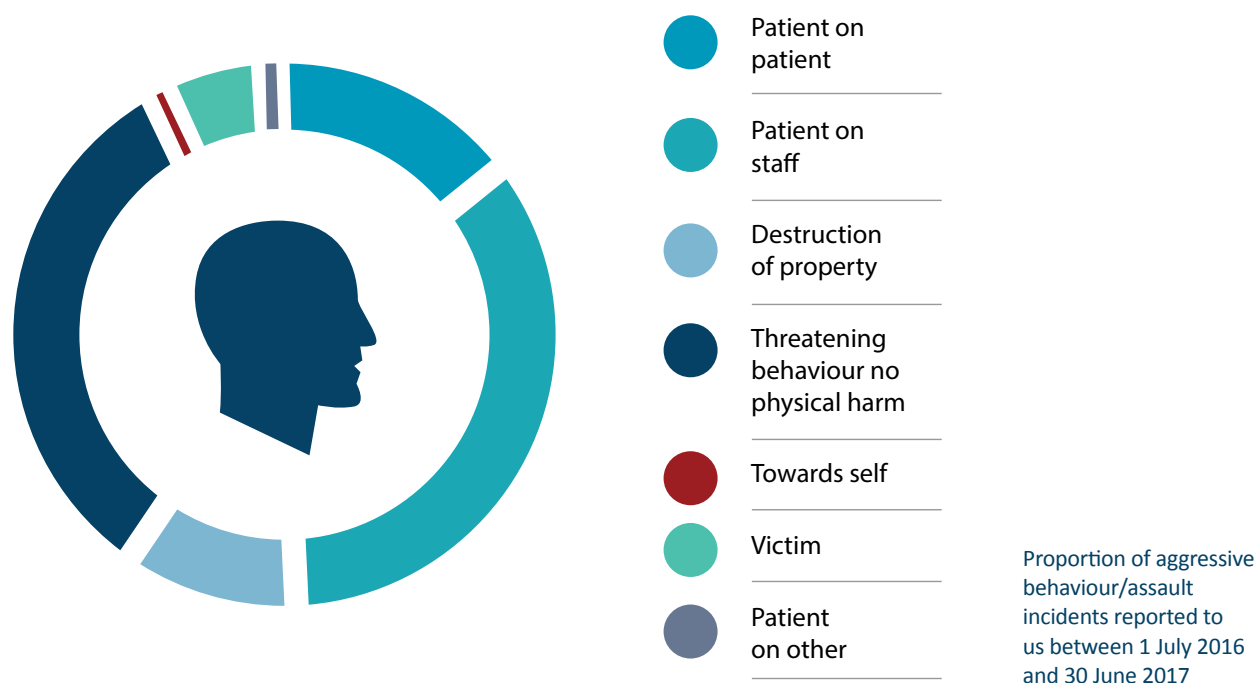
Aggressive Behaviour and/or Assault by a Patient

Aggression and/or Assault (patient to any other person(s)) includes incidents towards other patients or residents, members of staff or visitors. It also includes self-injurious behaviour that is not an apparent self-harming incident, or where a patient or resident is a victim of aggression or where aggression resulted in destruction of property. Aggression and/or assault can occur within an inpatient setting (including EDs and on hospital grounds), in community mental health services (this includes incidents occurring during staff assessment of the client at their home or other places) or at a private psychiatric hostel.

For the reporting period, there were a total of 2,139 reports to us where the incident pertained to aggressive behaviour/assault involving 1,419 patients. This equates to 57% of all notifiable incidents reported to us. Of these, 42% involved a female patient and 58% male patients.

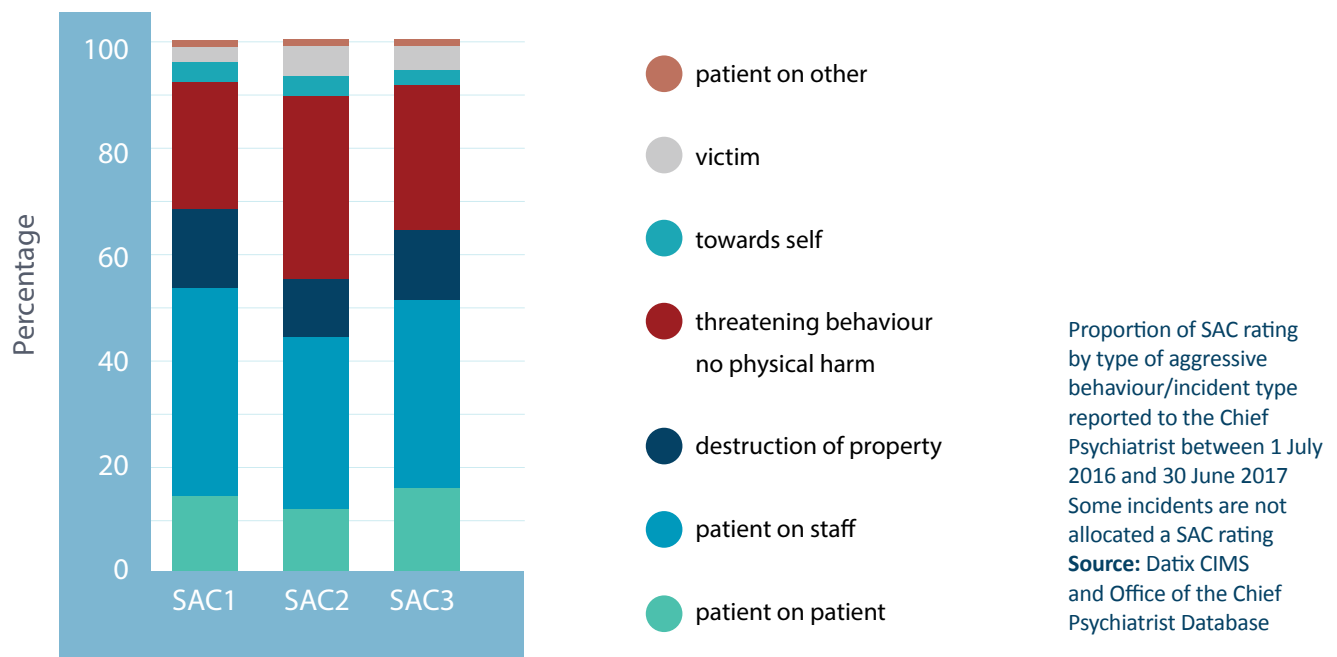
The majority of aggressive behaviour/assault incidents reported to us were classified as patient on staff 34% and threatening behaviour with no physical harm 32%, equating to 66% of all aggressive behaviour/assault incidents. Other notifications of aggressive behaviour/assault reported included patient to patient assault (15%), destruction of property (11%), as a victim of assault or aggression (6%), aggressive behaviour towards themselves (1%), and patient towards other (includes visitors) (1%).

Proportion of aggressive behaviour/assault incidents



5% of aggressive incidents were recorded as a SAC1 rating, 28% as a SAC2 rating and 64% as a SAC3 rating, while 3% of incidents did not have a SAC rating assigned at the time of reporting.

Of the most commonly reported SAC1 incidents for aggressive behaviour/assault, 39% (n=41) were classified as patient on staff, 23% (n=25) as threatening behaviour with no physical harm, 16% (n=17) as destruction of property and 14% (n=14) as patient on patient.



Allegations of Unreasonable Use of Force by Staff

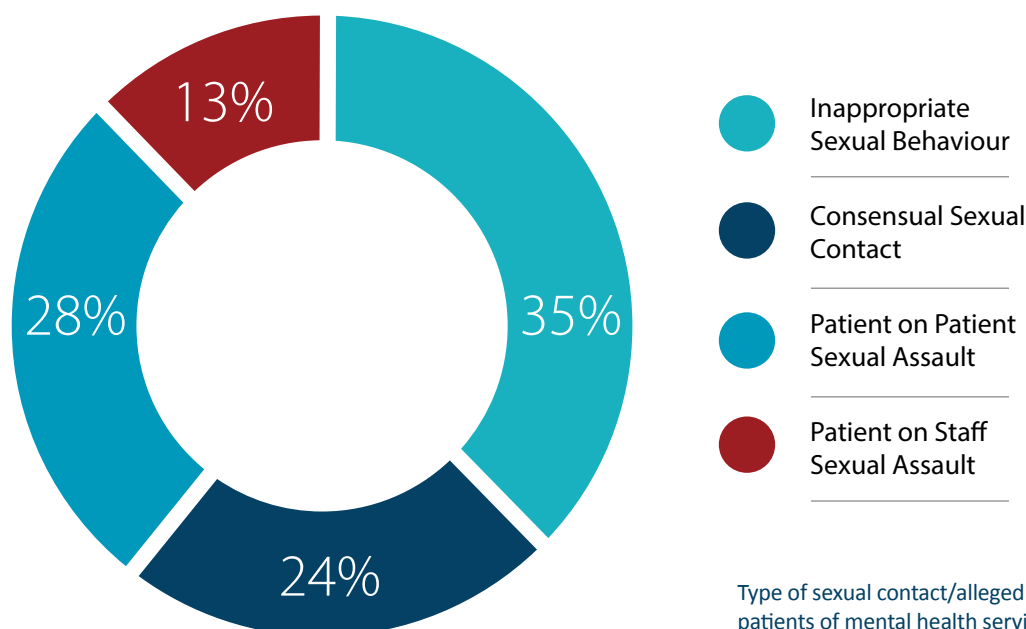
Allegations of unreasonable use of force, pertaining to a patient subjected to such use of force by a staff member of a mental health service (includes staff of a private psychiatric hostel), must be reported to us.

For the reporting period, there were <5 allegations of unreasonable use of force on a patient by a staff member of a mental health service reported to us.

All incidents reported to us are investigated by the notifying mental health service. To ensure the continued safety of patients and residents, the Chief Psychiatrist has powers to investigate further as required.

Sexual Contact/Alleged Sexual Assault by a Patient of a Mental Health Service

Incidents of Sexual Contact and/or Allegations of Sexual Assault (patient to any other person(s)) that occurred within an inpatient setting (including EDs and hospital grounds), community mental health service (this includes incidents occurring during staff assessment of the client at their home or other place) or at a private psychiatric hostel, must be reported to the Chief Psychiatrist. The figure below shows a breakdown of the types of incident reported.



Type of sexual contact/alleged sexual assault for patients of mental health services reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017

Any sexual activity/behaviour (including sexual touching) that occurs between people aged over 16 years, where mutual consent has been granted by those involved and they are considered to have capacity to provide consent, is not defined as sexual assault.

Sexual contact is prohibited on inpatient wards as it has the potential to further traumatise patients who may have experienced sexual assault in the past. Some patients may be vulnerable to being coerced into participating in sexual activity. Consensual sexual activity is permitted within private psychiatric hostels. For the reporting period, there were 25 incidents of prohibited consensual sexual contact on an inpatient ward, involving a male and a female patient.

Inappropriate sexual behaviour is included in this category and includes behaviour that is sexual in nature but not directly involving other patients or staff (e.g., removing clothing, disinhibited sexual behaviour). During the reporting period, there were 36 cases of inappropriate behavior involving 22 females (61%) and 14 males (39%).

Sexual assault is defined as;

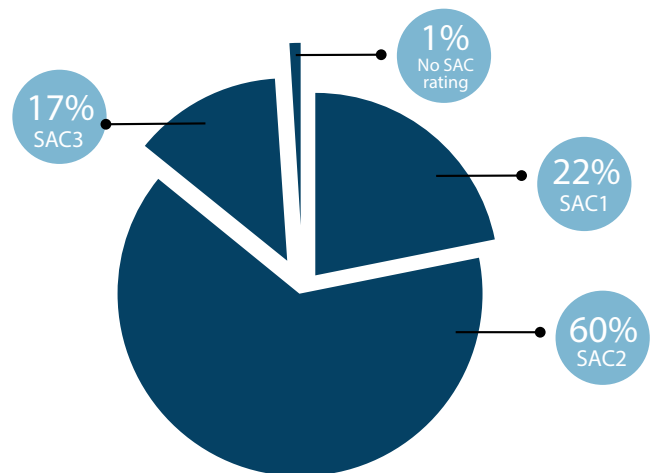
‘any unwanted sexual behaviour/activity or act that is threatening, violent, forced, coercive or exploitative and to which the person has not given or was not able to give consent’¹⁴

For the reporting period, there were 42 incidents of alleged sexual assault reported to us.

There were 13 reports of alleged sexual assaults on members of staff, with the majority committed by involuntary male patients.

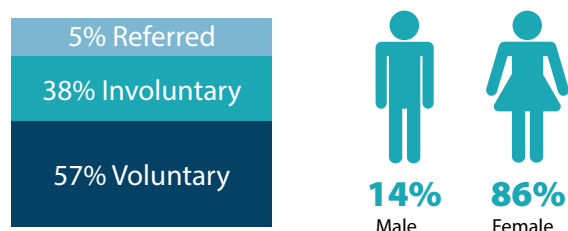
There were 29 reports of alleged sexual assault on patients by fellow patients. The majority of victims were females involving male perpetrators. More than half were voluntary patients, followed by involuntary, and a small proportion were referred patients at the time of the incident. The majority of perpetrators were male involving female victims. Patient status was evenly split between voluntary and involuntary at the time of the incident.

Over half of the incidents of sexual contact/alleged sexual assault were assigned a SAC3 rating, almost one quarter a SAC2 rating and fewer than 5 were assigned a SAC1 rating. A small proportion did not have a SAC rating assigned for the reporting period.



SAC ratings for sexual contact/alleged sexual assaults involving patients of mental health services reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017
Source: Datix CIMS and Office of the Chief Psychiatrist Database

Victims of Alleged Sexual Assault



Perpetrators of Alleged Sexual Assault



Characteristics of sexual assaults for patients of mental health services reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017 **Source:** Datix CIMS and Office of the Chief Psychiatrist Database

All allegations of sexual assault reported to the Chief Psychiatrist are investigated by the mental health service who provided notification of the allegation. To ensure the continued safety of patients and residents, we reserve the right to investigate further as required.

14 Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.

Allegations of Unlawful Sexual Contact

Incidents of unlawful sexual contact reasonably suspected to have occurred between a patient and a staff member of a mental health service (includes staff members of a private psychiatric hostel) or another person within a hospital (including EDs) that is not a patient of a mental health service, must be reported to us.

For the reporting period, there were <5 allegations of unlawful sexual contact by a staff member toward a patient of a mental health service. All allegations of unlawful sexual contact reported to the Chief Psychiatrist are investigated by the notifying mental health service. To ensure the continued safety of patients and residents, we reserve the right to investigate further as required.

Absent Without Leave (AWOL) Involuntary and Referred Patients

Under section. 97 of the Act, AWOL relates to involuntary inpatients, involuntary community patients subject to an order to attend, patients on an order for assessment, and referred patients that meet the following criteria:

- i. any forensic patient who leaves the hospital or other place where the person is detained without being granted leave of absence
- ii. any detained involuntary patient or patient referred for examination who leaves from an authorised hospital, a general hospital, including emergency departments, or other place without being granted leave of absence
- iii. the failure of an involuntary patient to return from a period of authorised leave following expiry of leave or on cancellation
- iv. any patient referred for examination who leaves from an authorised hospital, general hospital, including emergency departments, or other place
- v. any involuntary community patient who leaves the place where they are detained subject to an order to attend.

We must be informed of the date the person returns or is located, the outcome and whether there were any adverse events whilst the patient was AWOL.

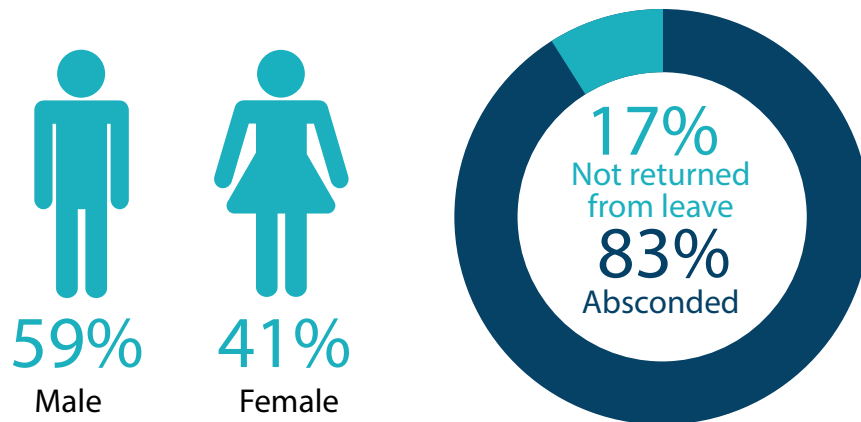
For the reporting period, 415 incidents were reported as AWOL, pertaining to 329 patients. At the time of reporting, there were <5 patients who were currently AWOL.

The majority of AWOL patients were male, and most incidents related to patients leaving the hospital or place of detention, without permission (i.e. absconding); whilst a small proportion of involuntary patients did not return from a grant of leave. Of the 329 patients who left without permission, the majority were reported as being involuntary with the remainder being referred patients.

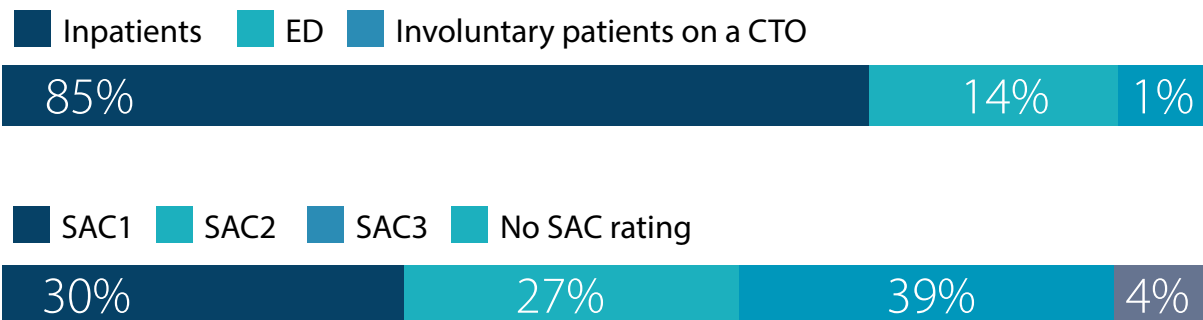
The greatest proportion of patients who went AWOL were inpatients, a smaller proportion absconded whilst being detained in an ED and the remainder were involuntary patients on a community treatment order subject to an order to attend.

Over one third of all reported AWOLs were deemed 'low risk' and therefore the incidents were reported as a SAC3. Just over one quarter of AWOLs were reported as a SAC2 and just under a third were reported as a SAC1. The average (median) length of time a patient was AWOL was 2 days.

Characteristics of AWOL Incidents



Mental health status at time of AWOL



Characteristics of AWOL incidents for patients of mental health services reported to the Chief Psychiatrist between 1 July 2016 and 30 June 2017

Source: Datix CIMS and Office of the Chief Psychiatrist Database

Most patients reported to be AWOL (85%) were returned to the ward and 5% were located by the mental health service or the police but did not return. A further 4% were not located and discharged. The remainder were either located and subsequently discharged from the service or had re-presented to other services.

An adverse outcome was reported for 26 (6%) of the 415 incidents reported as AWOL; these outcomes included self-harm, falls and intoxication leading to hospitalisation. There were <5 deaths of AWOL patients reported during the 2016-17 financial year.

Missing person – Voluntary Patients of Mental Health Services at High Risk



Any voluntary patient of a mental health service who is at high risk of harm and is missing from a mental health service, general hospital, or emergency department without the agreement of or authorisation by staff must be reported to us as a 'Missing person'.

For the reporting period, a total of 14 voluntary patients who were considered to be high risk of harm to themselves or others were reported as missing persons from a hospital or an ED. The majority of these patients were reported to have been returned to the mental health service, with <5 not found and discharged from the service.

Serious Medication Errors

During the reporting period there were 15 incidents pertaining to serious medication errors (of which 5 were SAC1s), with approximately 75% of events involving voluntary patients. None of these incidents resulted in the death of the patient.



An error in any medication prescribed for, or administered or supplied to, the person that has had, or is likely to have, an adverse effect on the person. Adverse effect means to need medical intervention, review or has or is likely to have caused death.

Other Statutory Reporting to the Chief Psychiatrist

Psychosurgery

Under section 209 of the Act, all provisions of psychosurgery must be reported to us. Psychosurgery is not used in WA for the treatment of psychiatric disorders and mental illness; however, treatments such as deep brain stimulation (which can be classified as psychosurgery) are more commonly used for the treatment of physical conditions, including some neurological conditions.

For the reporting period there were no persons reported to us who had received psychosurgery as treatment for their mental illness.

Treatment Decisions Different to Advance Health Directive of Involuntary Patients

Section 179(2)(c) of the Act requires that if a medical practitioner makes a decision about a patient's treatment that is different to their advance health directive then they must report this decision to us, using the requisite form available on our website.

There were no reported instances where the treatment decision of an involuntary patient differed to their Advanced Health Directive.

Children who are admitted to Adult Inpatient Units

Under section 303 of the Act a mental health service that does not generally admit children needs to be satisfied prior to admitting a child that they are able to:

- provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual belief; and
- the treatment, care and support can be provided to the child in a part of the mental health service that is separate from any part of the mental health service in which adults

are provided with treatment and care if, having regard to the child's age and maturity, it would be appropriate to do so.

Under the Act, the person in charge of the mental health service must report to us why they are satisfied that the above criteria have been fulfilled using the requisite form available on our website.

For the reporting period, there were 11 instances reported to us where a child was admitted to a mental health service, which does not generally admit children and therefore needed to be segregated from adult patients. The average age (mean) of children admitted to an adult inpatient unit was 16.5 years of age.

The primary reasons for admission to an adult ward were; adolescent patients in the metropolitan area waiting for transfer to an available bed in an adolescent mental health unit, followed by a lack of adolescent mental health units in regional areas and <5 adolescent patients waiting for Royal Flying Doctor Service transfer from regional areas to a metropolitan adolescent mental health unit.

Off-label Treatment Provided to a Child who is an Involuntary Patient

Under section 304 of the Act, off-label treatment pertains to the provision of a registered therapeutic good for purposes other than in accordance with the approved product information, and is administered to a child who is an involuntary patient. In the public mental health service sector, off-label treatments are only rarely used.

All use of off-label treatments provided to a child who is an involuntary patient, must be reported to the Chief Psychiatrist, including the type of off-label treatments provided and the reason for the decision.

To ensure safe psychiatric treatment is administered to children, we have advised all psychiatrists particularly child and adolescent psychiatrists, about the statutory reporting requirements when prescribing off-label treatments to children.

For the reporting period, there were 7 reports about children who were involuntary patients, and received off-label treatments. This may be an under-representation of the true number of off-label treatments, particularly where treatment was initiated by a private psychiatrist, GP, or paediatrician, prior to the child's involuntary status. The Chief Psychiatrist is currently liaising with relevant service providers to ensure clinicians fully understand and comply with this statutory requirement.

Approving Involuntary Treatment Orders within a General Hospital

Under section.61(2)(b) of the Act, the Chief Psychiatrist or delegate, must provide consent for a patient to be detained on an involuntary treatment order within a general hospital setting. The treating psychiatrist must report to us, at the end of each consecutive 7-day period for the duration of the order.

For the reporting period, 87 patients were subject to an involuntary order in a General Hospital setting, 10 of who were under the age of 18 years. The Chief Psychiatrist authorised 97 involuntary treatment orders in a General Hospital setting. Of the 97 orders, 14% were for patients under the age of 18 years of age.

Of the 97 orders, 29% (n = 28) were valid for less than 7 days, 20% (n = 19) were valid for between 7 to 14 days and 51% (n = 50) were valid for 15 days or more.

Emergency Psychiatric Treatment

Under section 202(2) of the Act, EPT does not include the use of ECT, psychosurgery or prohibited treatments (including deep-sleep therapy, insulin coma therapy and insulin sub-



Emergency psychiatric treatment (EPT) involves treatment determined to be necessary to save a person's life or prevent the person from endangering themselves or others.

coma therapy). A medical practitioner may provide a person with EPT without informed consent.

We must be provided with a copy of the approved Form (section 204), as soon as practicable, containing the information outlined in Appendix A of this report.

For the reporting period, there were 176 episodes of EPT reported to us. Outside of mental health service settings, clinicians often use the doctrine of necessity rather than using EPT to provide treatment to patients.

Urgent Non-Psychiatric Treatment for Involuntary Inpatients and Mentally Impaired Accused (in Authorised Hospitals)

Under section 242 of the Act the provision of urgent non-psychiatric treatment must be reported as soon as practicable to us by completing the approved Form containing information outlined in Appendix B.

For the reporting period, there were 23 episodes of urgent non-psychiatric treatment reported to us.

Other initiatives to ensure safe, high quality care

Root Cause Analysis Reviews for SAC1 events

Our SAC1 Root Cause Analysis (RCA) review initiative in collaboration with the Patient Safety Surveillance Unit (PSSU) at the Department of Health, comprehensively investigates SAC1 incidents for compliance with the *Chief Psychiatrist's Standards for Clinical Care* and the *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist*.

Elements of an incident reviewed include: completeness and content of discharge summaries, referrals, risk assessments, and management plans. This financial year, we reviewed 17 incidents with a SAC1 classification. Of these 17 incidents, 11 required no further investigation, 4 resulted in a request for further information from the reporting service, 1 service delivery improvement recommendation, and 1 request was made for the patient's medical record to enable an in-depth review.

A common theme among the reviews found most RCAs completed by mental health services primarily identified patient factors e.g. mental health diagnosis, family history, social factors that contributed to the clinical incident without a comparative analysis of systemic factors.

Our commitment to residents of Private Psychiatrist Hostels

We continue to work collaboratively with the Licensing and Regulatory Unit (LARU) at the Department of Health and the Mental Health Commission (MHC), to ensure safe, high quality care to residents of private psychiatric hostels by consulting across agencies concerning reporting compliance for notifiable incidents.

We are also consulting on the optimal approach for conducting quality evaluations in private psychiatric hostels to ensure appropriate governance and support.

For Prolonged Restrictive Practice Events

Reducing the use of restrictive practices is a priority action area for the Chief Psychiatrist, recognising that seclusion and restraint are a serious infringement of an individual's rights, and can cause psychological trauma and physical injury to consumers and health-care staff.

Seclusion and restraint events are monitored for identifiable trends or prolonged events. In the case of a prolonged event, the Chief Psychiatrist has set a time limit for the duration of both seclusion and restraint.

If the duration of an episode of seclusion or restraint has extended beyond this time-limit (i.e. 6 hours or more for a Seclusion episode and 1 hour or more for a Restraint episode), a letter is sent to the Head of the Clinical Service requesting information on:

- Why the patient was in seclusion or restrained beyond the set time-limit
- When was a Consultant Psychiatrist intervention or review undertaken
- Was the case reviewed by the responsible mental health service
- What debriefing occurred with the patient and their family
- A management plan addressing strategies to further limit and prevent the need for seclusion and/or restraint

When receiving information about seclusion or restraint episodes, we analyse the approved forms to ensure compliance with the Act, as well as identifying any discrepancies or errors. All identified errors are summarised and sent to services each month, with detailed information about errors. Services are requested to initiate strategies to improve compliance with the Act.

Notable Practice to reduce restrictive practices

Recent initiatives implemented by the Chief Psychiatrist and some health service providers to reduce the use of restrictive practices include:

- Facilitating the *Towards Elimination of Restrictive Practice 11th National Forum*, in order to maintain an agenda of continuous reduction in the use of restrictive practices within mental health services.

The forum was a co-sponsored initiative between the Chief Psychiatrist (the lead agency), the Mental Health Commission (MHC WA), Department of Health (DoHWA), Western Australian Association for Mental Health (WAAMH), the National Mental Health Commission and the Australian Government Department of Health.

The forum was a space to share best practice and come together to work collaboratively towards eliminating restrictive practices throughout Australia.

Ensuring safe, high quality care for patients of mental health services – Goals for 2017-18

- Finalise the Clinical Review of the South Metropolitan Health Service
- Conduct Clinical Reviews of the North Metropolitan Health Service and East Metropolitan Health Service
- Undertake a benchmarking exercise using data gathered from clinical reviews
- Review recommendations and identify topics for thematic reviews
- Undertake a scoping exercise regarding clinician awareness of the *Chief Psychiatrist's Standards for Clinical Care*
- Publishing seclusion and restraint data on our website, and holding bi-monthly forums where health service providers can meet to discuss the data and share any strategies or initiatives that reduce the use of restrictive practices
- Providing timely aggregate-level data reports to health services concerning trends in relation to notifiable incidents
- Putting in place a more robust monitoring mechanism for the prescription of off-label treatments to children and young people under 18 years of age
- Conducting data linkage projects to examine issues such as the association between the standard of psychiatric care provided by mental health services and patient outcomes
- Continue to work closely with key stakeholders to provide appropriate and strategic governance structures that ensure safe, high quality care for residents of private psychiatric hostels.

Working Groups and Committees

We are involved in a range of committees and working groups with key stakeholders across the health sector. These include but are not restricted to the following;

- Clozapine Steering Committee
- Coronial Review Committee
- Chief Psychiatrist Standards and Guidelines Working Group
- Chief Psychiatrist Electroconvulsive Therapy Working Party
- Mental Health Network
- National Restrictive Practice Working Group
- National Reducing Adverse Medication Events in Mental Health Working Party
- National Safety and Quality Partnership Sub-Committee
- Peak Incident Review Committee
- Prioritising *National Standards for Mental Health Services* Working Group
- Private Mental Health Regulations Reference Committee
- Royal Australian & New Zealand College of Psychiatrists Committee for Examinations
- Stimulants Assessment Panel
- State Datix Committee

Appendices

Appendix A: Emergency Psychiatric Treatment Reporting Requirements

Under section 204 of the Act the medical practitioner who provided EPT must give the Chief Psychiatrist a copy of the record of the treatment provided on the approved form containing the following information:

- The name of the person provided with the treatment;
- The name and qualification of the practitioner who provided the treatment;
- The names of any other people involved in providing the treatment;
- The date, time and place the treatment was provided;
- Particulars of the circumstances in which the treatment was provided;
- Particulars of the treatment provided.

Appendix B: Urgent Non-Psychiatric Treatment Reporting Requirements

Under section 242 of the Act the person in charge of the Authorised Hospital must report the provision of Urgent Non-Psychiatric treatment to the Chief Psychiatrist through submission of the approved form containing the following information:

- The name of the person provided with the treatment;
- The name and qualification of the practitioner who provided the treatment;
- The names of any other people involved in providing the treatment;
- The date, time and place the treatment was provided;
- Particulars of the circumstances in which the treatment was provided;
- Particulars of the treatment provided.

Glossary of terms used

Abbreviation	
AMHP	Authorised Mental Health Practitioner
AIHW	Australian Institute of Health and Welfare
AHPRA	Australian Health Practitioner Regulation Agency
AWOL	Absent without leave
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CIMS	Datix Clinical Incident Management System
CSEAT	Clinical, Statutory Education and Authorisations Team
DoHWA	Department of Health Western Australia
Dr	Doctor
ECT	Electroconvulsive Therapy
EMAHS	East Metropolitan Health Service
ED	Emergency Department
EDDC	Emergency Department Data Collection
ED OBS	Emergency Department Observation Ward
EPT	Emergency Psychiatric Treatment
HaDSCO	Health and Disability Services Commission
HMDS	Hospital Morbidity Data System
Hon.	Honourable
LARU	Licensing and Regulatory Unit
MHAS	Mental Health Advocacy Service
MHA 2014	Mental Health Act 2014
MHC	Mental Health Commission
MHT	Mental Health Tribunal
MIA	Mentally Impaired Accused
MIND	Mental Health Information Data Collection
OCP	Office of the Chief Psychiatrist
PCH	Perth Children Hospital
SAC	Severity Assessment Code

References

Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards (September 2012)*. Sydney. ACSQHC, 2012.

Chief Psychiatrist's Standards for Clinical Care www.chiefpsychiatrist.wa.gov.au

Chief Psychiatrist's Guidelines www.chiefpsychiatrist.wa.gov.au

Department of Health, Western Australia, *Clinical Incident Management Policy*. (2015). Perth: Patient Safety Surveillance Unit.

Department of Health, Western Australia, *Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist*. (2015). Perth: Office of the Chief Psychiatrist.

Western Australia Mental Health Act 2014

National Principles for Communicating about Restrictive Practices with Consumers and Carers,

Safety and Quality Partnership Standing Committee (May 2017), Mental Health Drug and Alcohol Principle Committee

National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services, Safety and Quality Partnership Standing Committee (May 2017), Mental Health Drug and Alcohol Principle Committee

National Standards for Mental Health Services 2010 © Commonwealth of Australia 2010.

Review of Safety and Quality in the WA health system – A strategy for continuous improvement, Professor Hugo Mascie-Taylor (2017)

Review of the admissions or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia, Department of Health, Western Australia; Mental Health Commission. Stokes, B. (2012).

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