



CHIEF PSYCHIATRIST
of Western Australia

Chief Psychiatrist Annual Report

30 November 2015 – 30 June 2016



Statement of Compliance

HON ANDREA MITCHELL MLA
MINISTER FOR MENTAL HEALTH; DISABILITY; CHILD PROTECTION

In accordance with s. 533 of the *Mental Health Act 2014*, I hereby submit for your information the Annual Report of the Chief Psychiatrist for the financial year ended 30 June 2016.

The Annual Report has been prepared in accordance with the provisions of the *Mental Health Act 2014* and in accordance with s. 61 of the *Financial Management Act 2006*.



Dr Nathan Gibson
CHIEF PSYCHIATRIST
ACCOUNTABLE AUTHORITY

20 September 2016

Disclosures and Legal Compliance

Record Keeping

As a newly established independent office, the chief Psychiatrist complied with the statutory record keeping practices in accordance with the *State Records Act 2000* and the standards and policies of the State Records Commission.

In the reporting period the office rolled out the electronic document and records management system known as desktop TRIM and all staff were provided with training. This resulted in an improvement in the filing and timely retrieval of documents.

Board and Committee Remuneration

In Accordance with disclosure under s. 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.

No such directives were issued by the minister with portfolio responsibility for the Office of the Chief Psychiatrist during 30 November 2015 to 30 June 2016.

Conflicts of Interest with Senior Officers

In accordance with s. 31(1) of the *Public Sector Management Act 1994*, the Office of the Chief Psychiatrist (OCP) fully complied with the public sector standards, the Western Australian Code of Ethics. The office will continue to comply with the principles of the WA Health Department Code of Conduct until an OCP specific Code of Conduct is implemented.

Compliance with Public Sector Standards and Ethical Codes

In accordance with s. 31(1) of the *Public Sector Management Act 1994*, the OCP fully complied with the public sector standard, the Western Australian Code of Ethics.

All recruitment was conducting according the *Equal Opportunity Act 1984* and no breach claims were lodged for recruitment in the reporting period.

Occupational Safety, Health and Injury Management

For the reporting period the OCP was compliant with the *Occupational Health and Safety Act 1984*. During the transition to the new offices the staff were provided with:

- Ergonomic assessments
- Free flu injections
- Emergency preparedness training
- Training on compliance with the standards of the new buildings including disability access
- Regular consultations around the conditions of the new working environment.

Contents

Foreword	1
Executive Summary	2
Reform and the <i>Mental Health Act 2014</i>	4
Review of History of the Act	4
Objects of the Act	4
Summary of the Act	4
Rights of the Individual, Families and Carers	5
Charter of Mental Health Care Principles	5
People of Aboriginal or Torres Strait Islander Descent	5
Expanded Role of the Chief Psychiatrist from the <i>Mental Health Act 1996</i>	5
The Role of the Chief Psychiatrist	6
Vision	6
Mission	6
Values	6
Appointment of the Chief Psychiatrist	6
Roles and Responsibilities	6
Office of the Chief Psychiatrist Structure and Governance	7
Accountable Authority	8
Responsible Minister	8
Clinical Leadership and Support	9
WA Mental Health at a Glance	11
Inpatient and Community Mental Health Services	11
Inpatient Mental Health Services	11
Community Mental Health Services	12
Emergency Department Mental Health Presentations	13
Clinical Helpdesk	14
Clinical Education	15
Education to Support the Role and Function of the Chief Psychiatrist under the <i>Mental Health Act 2014</i> and other Legislative Requirements	15
Education for <i>Mental Health Act 2014</i> Implementation	16
The Mental Health Act Education Resources	17
Authorised Mental Health Practitioners (AMHPs) Training Program	18
The AMHP Role	18
AMHP <i>Mental Health Act 2014</i> Preparation	18
Training for Current AMHPs	19
AMHP Forums	19
AMHP Refresher Training	19

Authorisations	20
Authorised Hospitals in Western Australia	20
Service Visits	20
Approved Electroconvulsive (ECT) Sites	21
Authorised Mental Health Practitioners (AMHPs)	22
A Six-Month-Post Review of <i>Mental Health Act 2014</i> Implementation and the AMHP Role	22
Requests for Further Opinion	23
Chief Psychiatrist's Clinical Monitoring Program	24
Chief Psychiatrist's Clinical Standards and Service Review	24
Chief Psychiatrist's Targeted Clinical and Case Reviews	27
Chief Psychiatrist's Statutory Monitoring	29
Electroconvulsive Therapy (ECT)	29
ECT Statistics	30
Emergency ECT Approved by the Chief Psychiatrist	31
Restrictive Practices	31
Seclusion	32
Restraint	35
Notifiable incidents reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016	39
Other Statutory Reporting to the Chief Psychiatrist	48
Psychosurgery	48
Treatment Decisions Different to Advance Health Directive of Involuntary Patients	48
Segregation of Children from Adult Inpatients	49
Off-label Treatment Provided to a Child who is an Involuntary Patient	49
Approving Involuntary Treatment Orders within a General Hospital	49
Emergency Psychiatric Treatment	50
Urgent Non-psychiatric Treatment for Involuntary Inpatients and Mentally Impaired Accused (in Authorised Hospitals)	50
Alignment with National and State Objectives	51
Working Groups and Committees	51
Looking Forward	53
Appendix A: ECT reporting requirements – ECT	54
Appendix B: Reporting requirements – Emergency Psychiatric Treatment	55
Appendix C: Reporting requirements – Urgent Non-Psychiatric Treatment	55
Glossary	56
Abbreviations	56
Terminology	57
References	58

Foreword

Mental illness is the largest single cause of disability in Australia and accounts for 24% of the national burden of non-fatal disease ([Fourth National Mental Health Plan](#)). At a state level, there is undoubted value in having a specific focus on standards in mental health care.

The *Mental Health Act 2014* (Act) mandated the Chief Psychiatrist as an independent statutory entity – separate from both the Department of Health and the Mental Health Commission (MHC), acknowledging a public wish for a heightened independence and separation.

This is the first formal Chief Psychiatrist’s Annual Report as a separate entity. This must be considered in the context that the Chief Psychiatrist and the Office of the Chief Psychiatrist have been providing statutory and independent oversight to mental health services since 1997. I would acknowledge the previous Chief Psychiatrists and their staff who have significantly contributed to standards of mental health care in Western Australia for almost 20 years. I thank the Department of Health who provided fair and fulsome support for the Chief Psychiatrist during that period.

This Annual Report must be viewed through a measured lens. It contains data from the first seven months of the Act, reflecting a system ‘getting used to’ to using the new legislation. Legislation is one aspect and interfaces with existing drivers for safe, quality care – drivers such as clinical standards, consumer/carer values and sector governance.

As Chief Psychiatrist I am extremely proud of the work ethic and performance of all staff in my Office during our transition to becoming an independent statutory entity. The Manager of the Office, Mr Creswell Surrao, undertook the focal leadership role in transition. This transition was done in the context of the concurrent public sector recruitment freeze, major structural change in Health, and the diversion of several staff to assist the implementation of the Act.

There are numerous collaborators in this complex mix that is the mental health service in Western Australia. This is made more challenging given that mental health is inevitably interwoven with multiple social welfare, justice and general health sectors. People – individuals – and their families and social networks are impacted by mental illness. This individual approach must always be considered when looking at statistics and broader public health issues.

I acknowledge the role of the Mental Health Commission as the agency responsible for the *Mental Health Act 2014*. I acknowledge the Area Health Services, now under the new structure, who have provided the vast majority of clinical services and the importance of the statutory agencies associated with the Act. The role of community managed organisations in the sector is now central to the provision of care. The private sector and primary care has been very open thus far to engagement with the Chief Psychiatrist.

As Chief Psychiatrist of Western Australia, I respect the core roles of consumers, carers and clinicians in safe, quality mental health care. I trust this annual report will provide the Minister, Parliament and the public with robust information and assist the leverage of strong standards.

Dr Nathan Gibson
CHIEF PSYCHIATRIST

This page has been left blank intentionally.

Executive Summary

On 30 November 2015, the *Mental Health Act 2014* (the Act) commenced, replacing the *Mental Health Act 1996*. On this date, the Chief Psychiatrist became an independent statutory appointee under the Act, reporting directly to the Minister for Mental Health.

While annual reports usually represent a full year, the Act introduced new reporting requirements for the Chief Psychiatrist as an independent statutory entity commencing from 30 November 2015. Thus, for this inaugural annual report, reporting will occur from 30 November 2015 to 30 June 2016. There will be matters relating to the period prior to 30 November 2015 discussed briefly in this report in order to give appropriate context regarding the establishment of the Chief Psychiatrist as an independent statutory entity, the Act implementation, and changes to function and reporting processes.

The Mental Health Commission is the agency with overall responsibility for the Act, with the Chief Psychiatrist having specified responsibilities within that legislation. In the 12 months prior to the commencement of the Act, the Chief Psychiatrist diverted significant resources to work with the Mental Health Commission, the Department of Health and other statutory agencies to ensure appropriate implementation of the new legislation within clinical services. This has involved a multi-faceted logistical approach encompassing the development of Approved Forms, Chief Psychiatrist Standards and Guidelines, the redevelopment and enhancement of the Authorised Mental Health Practitioner (AMHP) Program, the assessment of all Electroconvulsive Therapy (ECT) services in WA and the comprehensive development and delivery of education to prepare all mental health clinicians, other relevant clinicians and General Practitioners for the change in legislation with considerable focus to the rights of the individuals, families and carers.

Under the Act the Chief Psychiatrist is responsible for overseeing the treatment and care of all involuntary patients, Mentally Impaired Accused (MIA) persons detained in an authorised hospital, persons referred under section 26(2) or (3)(a) or 36(2) and those under an order made under section 55(1)(c) or 61(1)(c), as well as all voluntary patients being provided with treatment and care by a mental health service. Practically speaking, all involuntary patients, voluntary patients within public sector inpatient and community mental health services, inpatients within private psychiatric hospitals and day hospitals fall under the auspice of the Chief Psychiatrist, as do licensed psychiatric hostel residents. This is a significantly expanded role, given the addition of voluntary and private sector patients to the previous legislation.

As a separate agent, the Chief Psychiatrist provides advice to the Minister for Mental Health, and may provide advice to the Director General of Health and the Mental Health Commissioner. In the context of changed broader health legislation in WA (the *Health Services Act 2016*), the Chief Psychiatrist has been required to redefine relationships with Area Health Services, whose Boards now have greater statutory responsibility for standards.

The Chief Psychiatrist performs the role of overseeing mental health services through a standards monitoring process, tracking of mandatory reporting under the Act, service and individual reviews, provision of education to and oversight of AMHPs, as well as maintaining a local and national safety and quality interface to ensure the highest standards of contemporary clinical care.

The Chief Psychiatrist provides a Clinical Helpdesk which is a critical service for clinicians. This role provides practical support to clinicians by senior clinicians in the Office of the Chief Psychiatrist who can advise regarding aspects of treatment and care under the Act. The role provides immediate feedback, or in some cases further investigations or a targeted review can be undertaken.

A major reform upon implementation of the Act identified the Health and Disability Services Complaints Office (HaDSCO) as the statutory complaints mechanism for mental health services. The Chief Psychiatrist does not provide a first-response complaint role for individuals, families or carers, but may assist mental health services and HaDSCO in the resolution of complaints relating to standards of care. The Chief Psychiatrist has the discretion to directly investigate specific situations relating to standards of care. While separate statutory agencies, there is a regular interface with the Mental Health Tribunal and the Mental Health Advocacy Service, as well as engagement with a range of peak and community managed organisations.

The Chief Psychiatrist continues statutory responsibility for the care and treatment of mental health patients and for monitoring the standards of psychiatric care provided to all mental health patients throughout Western Australia through the Clinical Monitoring Program. During and following the implementation of the new legislation, the Clinical Monitoring Program was redeveloped in line with the requirements of the Act and other contemporary guiding documents (such as the Stokes Report, the National Safety and Quality Healthcare Standards and the National Standards for Mental Health Services), and Mental Health Service Reviews recommenced in May 2016.

At the national level, the Chief Psychiatrist is involved with interjurisdictional processes to better define standards, reduce restrictive practices, reduce medication errors and enhance clinical leadership.

The Act has introduced an expanded range of mandatory reporting to the Chief Psychiatrist related to notifiable incidents (including deaths), ECT, and a range of specified issues relating to children in adult facilities, physical care, and other treatment matters. This annual report will provide a summary of this data.

It is acknowledged that mental health clinicians have actively and openly engaged in reporting in the context of the Act. Jurisdictional rates for seclusion have been reported nationally for several years and WA continues to remain below the national average. Restraint rates are not reported nationally given significant differences in definition and reporting processes across jurisdictions. In 2016, the Australian Institute of Health and Welfare (AIHW) is exploring a process for potential commencement of reporting national jurisdictional restraint data. In WA, this inaugural Chief Psychiatrist Annual Report will publish restraint data from authorised hospitals in WA. The lack of national benchmarks for restraint will require public patience while a consistent approach to reporting is developed in the years ahead. Equally, with the changes to reporting practices under the Act, certain collated data will not have previous comparators, and this report must be considered in that context.

Note: The term 'consumer' is used routinely in mental health practice. Because the Act uses the term 'patient', this term will be predominantly used in this report.

Reform and the *Mental Health Act 2014*

Review of History of the Act

The *Mental Health Act 1996*, in replacing the *1962 Mental Health Act*, was a giant step for Western Australia introducing criteria for involuntary status, a Mental Health Review Board who had the power to overturn involuntary status, the Council of Official Visitors replacing the Board of Visitors, Community Treatment Orders which provided for compulsory treatment in the less restrictive environment of the community rather than a hospital and the appointment of Chief Psychiatrist to oversee the care and treatment of patients.

One requirement under the 1996 Act was a review of the legislation after five years. That review by Professor Darcy Holman commenced in 2001 and was completed in 2003. The Holman Review made a number of recommendations and work on drafting a new Act commenced in 2005. There were significant changes in mental health at the time with the Recovery Movement, the emphasis on community care, the reduction of seclusion and restraint, the appointment of a Minister for Mental Health and Mental Health Commissioner. The Mental Health Commission were tasked with developing a new Act and in 2015 a new Act was passed following extensive consultation with all stakeholders.

Objects of the Act

The Objects of the *Mental Health Act 2014* are to ensure that people who have a mental illness are provided with the best possible treatment and care, with the least possible restriction of their freedom, the least interference with their rights and with respect for their dignity. The role carers and families be recognised by involving them in the care and treatment of patients with the aim of minimising the effect of mental illness on family life. Furthermore to ensure the protection of people who have a mental illness and the protection of the community.

Summary of the Act

The statutory authority of the Chief Psychiatrist is significant in ensuring responsiveness, consistency and compliance across the sector. The powers invested in the Chief Psychiatrist impose a governance responsibility over any Mental Health Service and other specified agencies that seek to influence the delivery of mental health treatment and care to the Western Australian community.

The responsibilities of the Chief Psychiatrist under the Act are summarised as follows:

- A significantly area of responsibility of oversight that now includes voluntary patients, referred persons as well as involuntary patients, and private mental health services as well as public mental health services
- Significantly expanded training and education for clinicians who perform functions under the Act and the development of associated training resources
- A significant system of mandatory reporting to the Chief Psychiatrist
- Approving and managing compliance of approved Forms
- Developing, approving and monitoring Clinical Standards and Guidelines
- Overseeing the authorisations and approvals of mental health facilities.

Rights of the Individual, Families and Carers

Patient rights are the cornerstone of the legislation and there are a number of clinical duties which ensure that these rights are upheld. While the Act imposes responsibilities on clinicians, it also removes some liberty and freedom of choice for patients, at times placing patients in situations where they can only exercise their rights through the legislation. It is imperative that attention is given to patient rights. Matters regarding patient rights are scattered throughout the Act which address the rights of patients, carers, family members and personal support persons. Furthermore the Act details the obligations of clinicians to ensure these rights are observed.

Charter of Mental Health Care Principles

The Charter of [Mental Health Care Principles](#) is a schedule to the Act related to patient centred care, the recovery approach and the involvement of carers. It is essentially a set of expectations for patients who receive care and treatment at mental health services. It is intended to influence the interconnected factors that facilitate recovery from mental illness.

People of Aboriginal or Torres Strait Islander Descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers ([Principle 7: Charter of Mental Health Care Principles](#)).

Expanded Role of the Chief Psychiatrist from the *Mental Health Act 1996*

The Act has redefined the role of the Chief Psychiatrist to broaden the focus on system-wide issues and support of mental health clinicians in delivering safe and effective mental health treatment and care. This is achieved through the Chief Psychiatrist providing expert clinical advice and leadership, development of standards for clinical care and clinical guidelines, training and education and specialist information. The Chief Psychiatrist will also analyse data, publish reports about clinical service reviews undertaken, monitor aspects of the provision of mental health services, conduct investigations, and make recommendations to improve the delivery of safe and high quality mental health care.

The Role of the Chief Psychiatrist

Vision

“Psychiatric care to the highest quality”

Mission

“The Chief Psychiatrist aims to ensure that all Western Australians who are receiving psychiatric care are provided with the highest level of treatment in a humane, ethical and fair manner.”

Values

- ✦ Commitment
- ✦ Respect
- ✦ Accountability
- ✦ Integrity
- ✦ Leadership

Appointment of the Chief Psychiatrist

The Office of the Chief Psychiatrist is established by the Governor under s. 508 of the Western Australia *Mental Health Act 2014*. The Chief Psychiatrist is accountable to the Minister for Mental Health for the efficient and effective management of the agency, Office of the Chief Psychiatrist.

The Chief Psychiatrist and his agency, the Office of the Chief Psychiatrist support the Minister for Mental Health in the administration of Western Australia *Mental Health Act 2014* and sets of subsidiary legislation.

The Chief Psychiatrist is supported by the Office of the Chief Psychiatrist (OCP) that consists of a Deputy Chief Psychiatrist, manager, clinical advisors, project officers, data analysts and administrative staff.

Roles and Responsibilities

The Chief Psychiatrist is responsible for the treatment and care of all voluntary patients of mental health services, involuntary patients, Mentally Impaired Accused (MIA) persons detained at an authorised hospital, persons referred under s.26(2) or (3)(a) or 36(2) and those under an order made under s. 55(1)(c) or 61(1)(c) of the Act. This responsibility must be discharged by publishing standards for the treatment and care to be provided by mental health services and overseeing compliance with those standards. The Chief Psychiatrist has the following specific responsibilities, roles and functions under the Act:

- Directions by the Minister – the Chief Psychiatrist must comply with directions issued by the Minister (s. 516).
- Requests for reports – the Chief Psychiatrist must comply with request by the Minister (s. 517) or the CEO of the Health Department (s. 518) for reports on particular matters

- Review of treatment – the treatment decisions for involuntary patients and an MIA made by a psychiatrist may be reviewed, if a notice is provided in writing. This may result in affirming, varying, revoking or substituting the initial treatment decision
- Power of inspection – if concern exists regarding the standards of care or treatment than the Chief Psychiatrist may inspect authorised hospitals and mental health services that are not authorised, interview any relevant person, inspect and make copies of relevant documentation
- Power of Disclosure
- Monitoring of notifiable incidents and compliance with statutory reporting
- Preparation of an annual report.

Office of the Chief Psychiatrist Structure and Governance

The office of the Chief Psychiatrist of Western Australia comprises the Chief Psychiatrist, Deputy Chief Psychiatrist and Manager supported by 10.6 full-time employees (FTE) as shown in the organisational chart on the following page (12.9FTE in total).

The OCP undertakes core activities and functions through two main program areas as outlined below.

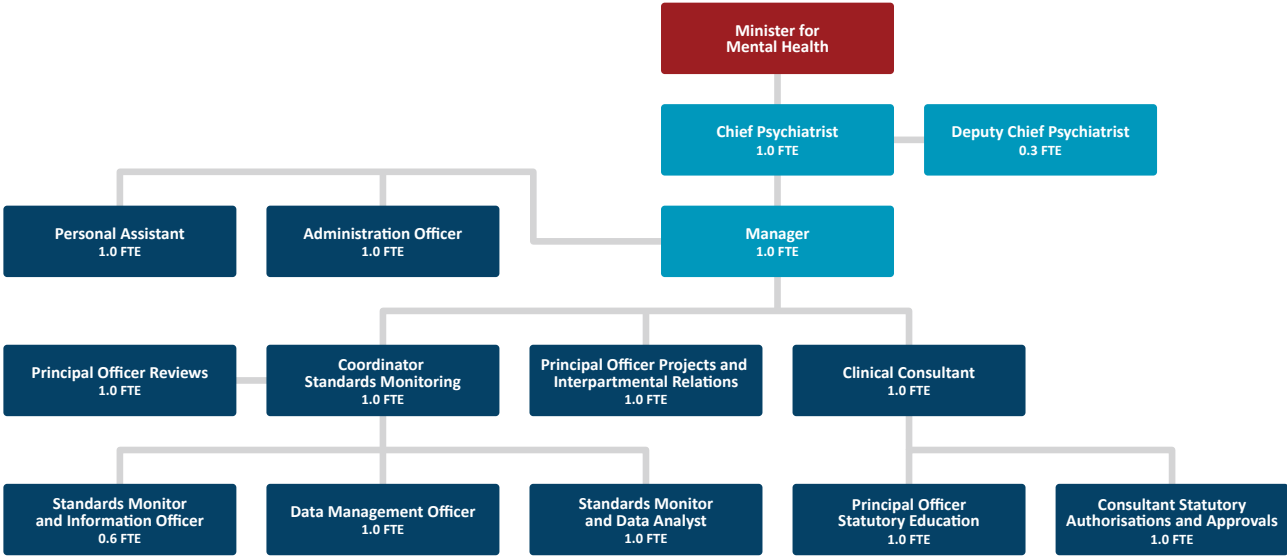
Clinical and statutory advice relating to:

- Ensuring that high quality clinical care is provided by clinicians
- Education and support
- Treatment and further opinion
- Authorisations and Approvals
- Inspections and remedy.

Standards and monitoring:

- Clinical monitoring of standards of psychiatric care
- Thematic reviews of mental health services
- Targeted Reviews of specific incidents and sentinel events
- Considering compliance with the State Coroners’ recommendations
- Monitoring and evaluation of statutory reporting and regulations compliance
- Monitoring and evaluation of notifiable incidents by legislation.

Figure 1: Organisational Structure



*DoHWA provided Legal Support at 0.8FTE. Mental Health Commission provided corporate support.

Accountable Authority

The Chief Psychiatrist, Dr Nathan Gibson, is the accountable authority for the Office of the Chief Psychiatrist.

Responsible Minister

The Chief Psychiatrist is responsible to the Minister for Mental Health, the Hon. Andrea Mitchell MLA.

Professional Development Framework for Staff

The Professional Development Plan (PDP) is the Office of the Chief Psychiatrist's formal annual process to support, develop and assess employees' professional development requirements to ensure the OCP has a skilled, knowledgeable and capable workforce. It applies to all persons whether in paid employment, on contract or undertaking voluntary services for the OCP.

The PDP is based on the principle of a professional approach to role development and performance with issues being dealt with as and when they arise through ongoing feedback and related discussions. The PDP is a fundamental part of good people management practice, in addition to regular informal discussions, providing constructive feedback on an individual's professional development requirements and performance.

The OCP is committed to promoting diversity to ensure the OCP optimises the diverse backgrounds, skills, talents and perspectives of its entire workforce. Throughout the professional development process all employees are treated fairly and equitably in line with the *Equal Opportunity Act 1984*.

Clinical Leadership and Support

Underpinning the activities of the Chief Psychiatrist and Office of the Chief Psychiatrist in supporting clinical practice is the recognition that patients and their carers have a better experience if they receive care and treatment from clinicians who are clinically competent and knowledgeable of the legislative framework within which they operate. Clinicians who feel supported in a challenging area of practice are likely to remain in the workforce for longer periods of time and develop their skills and expertise. They are also more likely to respond positively to feedback and requests for attention to areas noted for practice and system improvement.

During the reporting period the Chief Psychiatrist worked with the mental health sector to address treatment and system issues by; developing Standards, Guidelines, a Clinician's Practice Guide to the *Mental Health Act 2014*, monitoring the outcomes of clinical reviews, audits and investigation; and conducting and contributing to education and training.

In addition to endorsing the following:

- National Standards for Mental Health Services
- National Practice Standards for the Mental Health Workforce
- National Safety and Quality Health Service Standards.

The Chief Psychiatrist developed the following Standards for Clinical Care as required under s. 547 of the Act:

- Aboriginal practice
- Assessment
- Care planning
- Consumer and carer involvement in individual care
- Physical health care of mental health consumers
- Risk assessment and management
- Seclusion and bodily restraint reduction
- Transfer of care.

The Chief Psychiatrist developed the following guidelines as required under s. 547 of the Act;

- a. Making decisions about whether or not a person is in need of an inpatient treatment order or a community treatment order (s. 547(1)(a))
- b. Making decisions under s. 26(3)(a) about whether or not a place that is not an authorised hospital is an appropriate place to conduct an examination.
- c. Ensuring as far as practicable the independence of psychiatrists from whom further opinions referred to in s. 121(5) or 182(2) are obtained.
- d. Making decisions under s. 183(2) about whether or not to comply with requests made under s. 182 for additional opinions.
- e. The preparation, review and revision of treatment, support and discharge plans.
- f. The performance of electroconvulsive therapy (s. 545(1)(f))
- g. Compliance with approved forms.
- h. Ensuring compliance with the *Mental Health Act 2014* by mental health services.

The Chief Psychiatrist Standards and Guidelines are available at www.chiefpsychiatrist.wa.gov.au

WA Mental Health at a Glance

Inpatient and Community Mental Health Services

Mental health status is fluid and therefore an individual may transition between receiving care voluntarily, involuntarily and no longer receiving mental health care and treatment. In this section of the report, information was obtained from the Department of Health central data collections (Mental Health Information System MHIS and Hospital Morbidity Data Collection, HMDC) for the 2015 calendar year. To ensure completeness of the data (which is subject to data quality, data linkage and clinical coding processes) sourced from MHIS and HMDC, only 2015 calendar year figures are reported in this section of this report (unlike the remainder of the report).

Public mental health services are provided throughout metropolitan and regional WA. During 2015 the metropolitan region was divided into three area health regions: North Metropolitan (NMHS); South Metropolitan (SMHS); and Child and Adolescent Health Services (CAHS). Regional WA is covered by WA Country Health Service (WACHS). There are three mental health services under public/private partnership agreements within the metropolitan area – Joondalup Health Campus Mental Health Unit (Ramsay Health Care), St John of God Mount Lawley Hospital Ursula Frayne Unit and, from November 2015, St John of God Midland Public Hospital Mental Health Unit. Public patient activities undertaken by these services are included in this report. There are also private mental health services in WA, however the total number of separations for these services has not been included in this report.

In the 2015 calendar year, 55,948 individuals received care from a mental health service (including public and public private partnership mental health services).

Inpatient Mental Health Services

During the 2015 calendar year there were 13,843 mental health inpatient separations from mental health inpatient services (for public and public/private partnership mental health units, but not including private psychiatric hospitals) for 8,344 individuals in WA. Of those individuals, 6,842 were voluntary at some point during their admitted episode of care, and 2,250 patients were involuntary at some point during their admitted episode of care. It should be noted that some patients have both a voluntary and involuntary status within one admission.

There was an average of 868 available specialised mental health inpatient beds in WA during 2015. The distribution of beds across the area health services is shown in Table 1.

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

Area Health Service	Beds
North Metropolitan Health Service	526
South Metropolitan Health Service	261
WA Country Health Service	61
Child and Adolescent Health Service	20
Total	868

Source: BedState, WA DoH

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>

Community Mental Health Services

During the 2015 calendar year there were 55,436 community mental health patients. Of these, 55,401 voluntary patients received a total of 844,071 service contacts with community mental health services. There were also 689 patients on a Community Treatment Order receiving 27,366 service contacts with public community mental health services. It should be noted that it is not unusual for patients to have both a voluntary status and be on a Community Treatment Order within a single community episode of care.

Note: Data development work is currently underway to incorporate the collection of the *Mental Health Act 2014* Legal Forms in the statewide mental health data collection. As such, figures for involuntary service contacts with specialised community mental health services for 2015 is incomplete.

Emergency Department Mental Health Presentations

Data presented in this part of the report cover the period from the commencement of the Act on 30 November 2015 to 30 June 2016 and were obtained from the Emergency Department Data Collections, Data Integrity Directorate, WA Department of Health. The data include persons presenting to an Emergency Department (ED) (excluding Peel Health Campus), who were coded as a mental health attendance (including drug and alcohol presentations).

There were 33,296 mental health emergency department (ED) presentations during the report period, accounting for 5.9% of the total number of WA ED presentations (n=568,938) during this period. The median length of episode was 207 minutes. The majority of mental health presentations were either admitted (n=10,466 (31%)), or were discharged (n=18,861, (57%)) following their ED presentation and 12% of patients had a range of other outcomes as described in Table 2.

Table 2: ED episode end status for mental health presentations between 30 November 2015 and 30 June 2016.

Episode End Status	Number of mental health ED presentations
Admitted to ward/other admitted patient unit	6,297
Admitted to ED Observation Ward	4,169
Nursing Home	34
Returned to Hospital in the home	16
Discharged after admission	13
ED service event completed; departed under own care	18,861
Transferred to another hospital for admission	1,924
Did not wait to be attended by medical officer	938
Left at own risk	1,019
Died in ED	5
Unknown	20
Total	33,296

Data Source: Emergency Department Data Collections, Data Integrity Directorate.

Clinical Helpdesk

The Clinical Helpdesk is a service provided by clinical staff at the OCP, for clinicians to ask any question or query a process under the *Mental Health Act 2014*. In most cases the clinician can be provided with information immediately in response to a query. The Clinical Helpdesk remains in high demand to assist clinicians in appropriately applying the provisions of the Act and undertaking statutory reporting requirements.

This specialised support service is provided during office hours (8.30–16.30 Monday – Friday) by staff from the Office of the Chief Psychiatrist (OCP). A decision was made to facilitate an additional service to respond to queries raised out-of-hours by the Consultant Psychiatrist on call. This allowed the service to be available for 24-hours a day, 7-days a week; the extended out-of-hours service operated between 30 November 2015 and continued until 31 May 2016. There were approximately 65 telephone queries documented by the out-of-hours service during this six-month period. The Chief Psychiatrist has an expectation that senior clinicians trained in the Act will provide a first line of clinical support to service staff regarding queries about the Act.

There were in excess of 600 queries documented by the Clinical Helpdesk between 30 November 2015 and 30 June 2016. During the month of December 2015 there were in excess of 250 telephone calls received and in January 2016 over 130 calls to the clinical helpdesk. In addition to direct phone calls clinicians also received email queries which were responded to as soon as practicable. The Helpdesk continues to average 5–10 calls per day.

The most significant number of queries received related to the correct use of the Mental Health Act Approved Forms and statutory notifications.

Clinical Education

The Office of the Chief Psychiatrist provides education and training for mental health clinicians, students and other government and non-government agencies. These education and training sessions are in relation to the role of the Chief Psychiatrist and activities of the Office of the Chief Psychiatrist and the *Mental Health Act 2014*. They can be requested by any department or service and are usually conducted at no cost to the department or service requesting them. By conducting education sessions the Office of the Chief Psychiatrist ensures that clinicians and others are informed and educated about lawful procedures and best practice.

Specifically, education and training is provided in three main areas:

- Education to support the role and function of the Chief Psychiatrist under the Act and other legislative requirements
- *Mental Health Act 2014*
- Authorised Mental Health Practitioner Training.

Whilst having full remit to train AMHPs, it is practically impossible for the Chief Psychiatrist to train all other clinicians, mental health or otherwise, regarding the Act. Significant numbers of clinicians (over 200) were trained as trainers prior to the commencement of the Act. It is an absolute expectation that Area Health Services provide their own trainers to orientate and update their staff regarding the *Mental Health Act 2014*. The Chief Psychiatrist will oversee the ongoing standard of education regarding the Act.

Education to Support the Role and Function of the Chief Psychiatrist under the *Mental Health Act 2014* and other Legislative Requirements

Education for University and TAFE Students

It is essential that the future mental health workforce is well informed about the Act. As part of their university education the Chief Psychiatrist and his staff provide an overview of the Act to some tertiary students in the field of Nursing, Psychology and Occupational Therapy.

Prior to the commencement of the Act, all tertiary institutions in WA providing training for clinicians were notified of and provided with access to online *Mental Health Act 2014* training.

In May 2016 sessions were presented to university staff and undergraduate nursing students as follows:

- Murdoch University
- Curtin University.

Postgraduate Nursing Education

As a component of postgraduate education for nurses the Chief Psychiatrist has provided sessions on the legislation to enable new graduates who are entering the workforce to be better prepared in their area of work, which is predominantly inpatient services. There is an expectation that all newly graduated nurses and other clinical staff will undertake the Clinician's e-Learning Package (CeLP) and any face-to-face sessions subsequently organised by their services.

Supplementary Education Sessions

It is essential for the production of high quality and relevant education and training packages that ongoing stakeholder engagement is incorporated to reflect the values of a multifaceted interdisciplinary approach to the provision of mental health services and maintaining clinical standards.

Between April and May 2016 supplementary sessions were provided to clinicians and staff of the [Mental Health START Court](#) and the [Next Step Drug and Alcohol Program](#) to a total of approximately 70 attendees.

Education for *Mental Health Act 2014* Implementation

In 2015, the Chief Psychiatrist was required to assist in the provision of education to all mental health clinicians and other relevant stakeholders for the implementation of the Act.

The Chief Psychiatrist's Education Working Group (CPEWG), chaired by the Chief Psychiatrist had wide representation from clinical services, the Mental Health Commission, the Office of Mental Health (now the Mental Health Unit – Department of Health WA), the Office of the Chief Psychiatrist, the [Statewide Aboriginal Mental Health Service](#), the [Transcultural Mental Health Service](#), consumers and carers and a specialist educational representative. The CPEWG was instrumental in developing and approving an educational strategy and content for the roll out of the *Mental Health Act 2014*. These training resources commenced the implementation phase in September 2015 and continue to be utilised to educate and inform anyone wishing to apply the provisions of the Act.

The development and provision of the training was a joint initiative between the Office of the Chief Psychiatrist, the Mental Health Commission and the Department of Health WA.

The Mental Health Act Education Resources

- The [Clinician's e-Learning Package](#) (CeLP), is a three-hour interactive training delivered online. There is an expectation that all mental health clinicians complete the CeLP. A high percentage of clinicians had completed the on-line program prior to commencement of the Act.
- The [Referrer's e-Learning Package](#) (ReLP), is a 45 minute online package specifically developed for medical practitioners and Authorised Mental Health Practitioners who have the power to refer a person experiencing mental illness for examination by a psychiatrist.
- The Train-the-Trainers program is a two-day course providing detailed information about the Act in a face-to-face delivery mode. Over 200 clinicians undertook this training and were then able to provide training in the Act to colleagues at service level.
- Capacity training for psychiatrists, medical practitioners and AMHPs was provided by a psychiatrist via a Train-the-Trainer program allowing those practitioners to provide capacity training at the local service level.
- Mental Health Act Transition Training for existing Authorised Mental Health Practitioners (AMHPs) was provided over a six month period. This two-hour training provided information on the referral process and the expanded role and functions of AMHPs under the Act.
- A [Clinicians' Practice Guide to The Mental Health Act](#) (Edition 3) is available for download for any clinician authorised to apply the provisions of the Act. The Clinicians' Practice Guide is a publicly available document on the Chief Psychiatrist's website. This comprehensive guide to the legislation also includes the Chief Psychiatrist's Standards and Guidelines and a number of Addenda on important issues for clinicians.

Education and Training did not cease following commencement of the *Mental Health Act 2014*. Ongoing education, online and face-to-face, continues and is part of the Chief Psychiatrist's educational remit to ensure appropriate standards of care.

In addition, there is A Brief Overview of the Act, which is a four-page document which provides basic information on the legislation which can be read by general health clinicians such as GPs. Also, a number of Fact Sheets and brochures for the general public were developed by the Mental Health Commission with the assistance of the Chief Psychiatrist.

The Clinical Consultant and the Principal Officer Statutory Education were pivotal in assisting the Chief Psychiatrist's Standards and Guidelines Working Group, developing the [Chief Psychiatrist's Standards for Clinical Care](#) and a set of eight Statutory Guidelines in regard to a variety of clinical and legal functions to be performed under the legislation.

Programs held by the Chief Psychiatrist and the website of the Chief Psychiatrist are the primary pathways for mental health clinicians working in the public and private sector to be informed, educated and trained in discharging their functions under the Act.

Authorised Mental Health Practitioners (AMHPs) Training Program

The AMHP Role

The Clinicians' Practice Guide to The *Mental Health Act 2014* (Edition 3) (Addendum 8) outlines the role of the AMHPs and requirements for the role which are:

- Appropriate working knowledge of the Act and associated legislation
- Knowledge of the role and functions of the AMHP including experience in assessment procedures for anyone in a state of mental distress
- Sufficient information and training to ensure that the AMHP adopts practices which are clinically and legally safe in carrying out their functions
- Each mental health region, service or AMHP employer is required to support and facilitate supervision of practice and on-going education for all AMHPs operating within the region or service.

AMHP *Mental Health Act 2014* Preparation

In preparation for commencement of the Act the Authorised Mental Health Practitioners Education Round Table (AMHPERT) provided advice to the Chief Psychiatrist on education and training for AMHPs. The advice included the addition of on-line training while maintaining part of the face-to-face training which participants reported as being extremely valuable in their understanding of the Act. Based on the recommendations from AMHPERT the Principal Officer Statutory Education devised an updated education program for the mental health practitioners seeking gazettal as AMHPs.

The development of educational resources are designed to support and advance the statutory role and functions of the OCP as well as support the AMHPs and discipline specific mental health professionals. Effective evaluation processes utilised serve to ensure that education and training packages are contemporary, evidence based and promote best practice.

Training for Current AMHPs

Although the majority of these training sessions occur outside the dates specified by this annual report, this information has not previously been reported. The sessions were facilitated in both the metropolitan and regional areas.

Prior to the 30 November 2015 there were 11 training sessions conducted which included a total of 259 participants.

For the reporting period 30 November 2015 – 30 June 2016 there were 11 training sessions conducted and an overall total of 284 participants trained. Whilst a total of 543 AMHPs were trained overall, some declined to continue in the role and requested revocation of their status.

AMHP Forums

It is anticipated that future AMHP Forums will be facilitated every six months to which all AMHPs will be invited. Topics which are relevant to the AMHP role such as updates on legislative and clinical issues as well guest speakers will be invited to present.

AMHP Refresher Training

On a six-monthly basis current AMHPs will be offered the opportunity to attend refresher training which will assist them to network and to review and update their skills.

New AMHPs

The Office of the Chief Psychiatrist will continue to run full training for clinicians seeking to become AMHPs, with the support of their service.

Authorisations

Authorised Hospitals in Western Australia

Section 542 of the Act invests the Chief Psychiatrist with the responsibility to make recommendations to the Governor to issue an order, published in the Western Australian Government Gazette, authorising a public hospital or part of a public hospital for the reception of persons under the Act and for the admission of involuntary patients.

Previous arrangements under the *Mental Health Act 1996* for authorisation of hospitals continued on proclamation of the Act. All authorised hospitals maintained their authorisation status under the *Mental Health Legislation Amendment Act 2014*.

While under the Act the Chief Psychiatrist is not required to provide a Register, a Register of authorised hospitals continues to be made available on the Chief Psychiatrist’s [website](#).

For the reporting period 30 November 2015 to 30 June 2016 the Chief Psychiatrist did not receive any new applications for the authorisation of a hospital although there has been significant preparation for the authorisation of Perth Children’s Hospital (PCH).

The Chief Psychiatrist’s Standards for the Authorisations of Hospitals 2007 are currently under review. This review commenced on proclamation of the *Mental Health Act 2014*. The Consultant, Statutory Authorisation and Approvals is the responsible officer for overseeing this review. The new standards upon completion will take into consideration the advancements and changes in technology to minimise the risk to patients and staff.

Service Visits

The Chief Psychiatrist and staff of the OCP undertake a regular program of visits to services. There are both formal visits to review clinical standards and environment, as well as informal visits.

The informal visits typically involve meetings with clinicians, clinical leaders, consumers and carers. Informal service visits provide an opportunity to receive feedback and discuss issues of service delivery and coordination of care.

Approved Electroconvulsive (ECT) Sites

Under the Act (s.544) all mental health services that perform ECT must be approved by the Chief Psychiatrist, by order published in the Gazette. This order may specify conditions subject to which ECT can be performed at the mental health service specified in the order. All ECT sites must comply with the [Chief Psychiatrist’s Practice Standards for the Administration of Electroconvulsive Therapy 2015](#) and the standards of the [Department of Health Western Australia’s Licensing and Accreditation Regulatory Unit](#).

In preparation of the commencement of the Act, the Chief Psychiatrist was required to review and approve ECT sites in Western Australia. These are found in Table 3 below.

Fiona Stanley Hospital sought approval after the original 10 ECT sites were approved.

Table 3: Sites approved for ECT by the Chief Psychiatrist

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
Fiona Stanley Hospital	12/02/2016	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

Authorised Mental Health Practitioners (AMHPs)

Section 539 of the Act requires the Chief Psychiatrist by order published in the [Gazette](#), to designate a mental health practitioner as an AMHP if satisfied that the practitioner has the qualifications, training and experience appropriate for performing the functions of an AMHP under the Act.

To be authorised as an AMHP, the Act requires a mental health practitioner to have at least three years' experience in the management of people with a mental illness. The mental health practitioner must be supported in this role and have the approval of the Executive Director / Clinical Lead (Metro Tier 3/WACHS Tier 4). The clinician must also be registered with the [Australian Health Practitioner Regulation Agency](#) (AHPRA) as a Registered Nurse, Psychologist, Occupational Therapist or be eligible for membership of the Australian Association of Social Workers.

Arrangements for AMHPs previously gazetted under the *Mental Health Act 1996* continued on proclamation of the new Act. AMHPs who had completed the mandatory training requirements of the Chief Psychiatrist, were transitioned under the [Consequential Amendments Act](#).

The Chief Psychiatrist is required to maintain a register of Authorised Mental Health Practitioners and make this register publicly available. The first register was published on 30 May 2016 following an audit of the current database. The register is updated upon Gazettal notices either authorising or revoking AMHPs. Gazettal notices are available on the State Law Publisher.

An extensive and rigorous process was undertaken to make the AMHP database contemporary. This process involved audit and correspondence with all AMHPs and services.

As of the 30 June 2016 there were 482 active AMHPs across the State of Western Australia.

A Six-Month-Post Review of *Mental Health Act 2014* Implementation and the AMHP Role

A six-month-post review survey was conducted to explore the influence of implementation of the Act on the AMHP role. A total of 187 AMHPs completed the survey which amounted to a 38.5% response rate. The questions posed and the responses are presented below.

AMHPs can use a variety of Forms, such as Form 1A, Attachment to Form 1A, Form 1B, Forms 3A, 3B, 4A, 4B and Form 5A confirming a CTO. Of all AMHPs 55% (n=100) reported their experience in using the Forms as 'No Change' and 30% (n=55) reported they found the process 'Easy'.

The AMHP can now complete a Detention Order (Form 3A). Completing a Form 3A is a notifiable event and at least one personal support person should be notified that this order has been made. One half of all AMHPs (53%, n=85) reported 'No Change' in the process and just over one quarter (27% n=43) suggested they found the process 'Easy'.

Following the introduction of Transport Officers, 70% of AMHPs (n=110) reported 'No Change' in the process of transferring a referred person, 11.5% of AMHPs (n=18) reported that the process was 'Easy' and 18.5% (n=29) found the process 'Difficult'.

An AMHP can refer a person to a place that is not authorised (Form 1A). Of all AMHPs 70% (n=113) reported 'No Change' to their experience with this referral process, and 20% (n=32) suggested they found this 'Easy'. There were 79% (n=145) who believed the option of any AMHP being able to revoke Form 1A was a good option for management of a referred person.

Of all AMHPs surveyed 86% (n=137) reported that they did not experience any issues with the process required for management of a person on a Community Treatment Order (CTO) requiring referral for assessment by psychiatrist and subsequent inpatient care. Almost three quarters of AMHPs (73.5%, n=132) believe that being able to confirm a CTO is an appropriate duty for an AMHP in the management of a patient in the community.

In summary, there were 66% (n=117) of AMHPs who believed that the new Act led to an increase of duties for AMHPs and 34% (n=60) did not believe there had been any increase. In addition to this, 88.5% (n=138) of AMHPs surveyed stated that they believed that being authorised as an AMHP adds clinical value for the service and 75.5% (n=118) believed it also added value for the patient.

Requests for Further Opinion

Section 182 of the Act provides for further opinions to be requested by a patient (self), a carer or an advocate on behalf of the patient. The requests can be made to the area mental health service the patient is attached to. The Act also provides for requests for further opinions may also be made to the Chief Psychiatrist. The role of the Chief Psychiatrist when a Further Opinion is requested through this Office is to liaise with the patient, carer or advocate and determine the preferred pathway for obtaining a further opinion. 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.

The Department of Health's Operational Directive ([OD: 0637/15](#)) outlines the principles and processes in regard to a patient requesting a further opinion. Specific timeframes have been set by the Chief Psychiatrist and Area Health Chief Executives.

Patients are afforded the following options when requesting a further opinion either through their health service or via the Chief Psychiatrist:

- 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).

Post implementation of the Act has identified some concern in terms of availability of psychiatrists to provide further opinions, particularly when the request is from a different mental health service. It is the view of the Chief Psychiatrist that the Department of Health should consider setting up a formal system of reciprocal further opinion provision across services in order to better meet the needs of patients. It is acknowledged that where psychiatrists are required to travel to undertake a further opinion, that this puts increased pressure on their ability to spend time with their own patients. Where necessary a psychiatrist is able to provide a further opinion via video conferencing. This is particularly helpful in rural and remote areas.

For the reporting period 30 November 2015 to 30 June 2016 the Chief Psychiatrist received six requests to facilitate a further opinion. All requests were received in writing, three from patients and three from the Mental Health Advocacy Service.

The majority of further opinions are primarily facilitated by mental health services directly. There is no current system for collecting total numbers of further opinion requests across the system.

Chief Psychiatrist’s Clinical Monitoring Program

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

- Chief Psychiatrist’s Clinical Standards and Service Reviews
- Chief Psychiatrist’s Targeted Clinical and Case Reviews
- Chief Psychiatrist’s Thematic Reviews.

Within health care, administrative and regulatory duplication is a significant risk. The Chief Psychiatrist’s clinical review process differs from other existing National review processes by a greater degree of vertical inquiry into clinical issues. That is to say, senior clinicians are appointed as reviewers and it is their experience which assists the depth of the review process. Notwithstanding, the Chief Psychiatrist’s audit tools align, where possible, with key National and local documents and standards.

The independence of the Chief Psychiatrist is another critical point of difference in the clinical review process. It is in this way that the Chief Psychiatrist adds value and uses clinical monitoring to assist the maintenance of standards.

While services have a statutory obligation to comply with standards related to the Act, the Chief Psychiatrist may not necessarily have a statutory remit to direct recommendations that might sit outside of these standards. Notwithstanding, the Chief Psychiatrist will actively seek follow up of all recommendations by those services involved.

Chief Psychiatrist’s Clinical Standards and Service Review

The Act (s.515) prescribes the Chief Psychiatrist with the responsibility to monitor the treatment and care of mental health patients within Western Australia, and in 2016 the Chief Psychiatrist implemented a new clinical monitoring program – the Chief Psychiatrist’s Clinical Standards and Service Review.

It is the intention of the Chief Psychiatrist that all mental health services within WA will be reviewed over a two year period, with the reviews consisting of a comprehensive clinical record review and face-to-face staff feedback.

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 assessed:

- Patient and carer/support person engagement
- Mental state assessment
- Physical assessment and ongoing physical management
- Risk assessment and management
- Individual management plans
- 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.

Clinical Review Pilot

A pilot of the clinical review audit tool was conducted between January and March 2016 to test and refine the tool. Seven mental health services were visited with 36 files audited (Table 4). In addition to the audits the reviewers as representatives of the Office of the Chief Psychiatrist were able to gain feedback from the services surrounding clinical documentation post implementation of the Act.

Table 4: Mental health services visited as part of the Chief Psychiatrist’s Clinical Review Pilot

Site	Area Health Service	Setting	Files audited
Graylands	NMHS–MH	Adult Inpatient	7
Bentley	SMHS–MH	Adult Community	5
Bentley	CAMHS	CAMHS Inpatient	4
Osborne OA	NMHS–MH	Older Adult Inpatient	3
Osborne OA	NMHS–MH	Older Adult Community	4
Bunbury	WACHS–MH	Inpatient Unit	5
Inner City	NMHS–MH	Adult Community	8
Total		7 services	36

Clinical Review of WA Country Health Services

The WA Country Health Service 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 (Table 5).

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 outcome of these reviews will be provided to the mental health services and a statewide report will be published.

Table 5: **Mental Health Services and sites visited as part of the Chief Psychiatrist's Clinical Standards and Service Review of WACHS**

Mental Health Service	Sites Visited	No. Records Reviewed
Central West Mental Health Service	Geraldton Community	8
	Carnarvon Community	13
Goldfields Mental Health Service	Kalgoorlie Acute Psychiatric Unit (Inpatient)	9
	Kalgoorlie Community	11
	Esperance Community	10
Great Southern Mental Health Service	Albany Acute Psychiatric Unit (Inpatient)	5
	Albany Community	13
	Katanning Community	9
	Narrogin Community	9
Kimberley Mental Health and Drug Service	Broome Inpatient (Mabu Liyan)	9
	Broome Community	9
	Derby Community	5
	Kununurra Community	8
Pilbara Mental Health and Drug Service	Port Hedland Community	11
	Karratha Community	13
	Carnarvon Community	13
South West Mental Health Service	Bunbury Acute Psychiatric Unit (Inpatient)	11
	Bunbury Community	10
	Margaret River Community	9
	Bridgetown Community	11
	Busselton Community	13
Wheatbelt Mental Health Service	Northam Community	7
Total		216

Chief Psychiatrist’s Targeted Clinical and Case Reviews

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

In order to monitor the standards of mental health care in WA the Chief Psychiatrist and staff in the OCP undertake targeted clinical reviews on various topics. Targeted reviews occur when the Chief Psychiatrist has 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 but are provided either to the Director General of Health or the appropriate Chief Executive for follow up.

Mental Health Presentations to Emergency Departments

A review of mental health presentations to Emergency Departments (EDs) was undertaken by the OCP between February and April 2015, with the report of findings released during this reporting period. The main aims of this review were to examine the:

- ED pathway for mental health patients
- Management of mental health patients in the ED
- Management of Sentinel Events in the ED
- Wait time for mental health patients in the ED.

Data were obtained from three sources for this review, the Emergency Department Data Collection (EDDC), review of clinical records from the ED and interviews with ED staff. The review identified 23 Emergency Departments (nine metropolitan; and 14 rural hospitals) with a significant number of mental health presentations (over 20 per month) where the clinical records would be reviewed. Led by a Senior Clinical Reviewer, the review examined the content of clinical records from Emergency Departments; and conducted interviews with mental health and non-mental health staff working within the Emergency Departments. A statewide report is published on the Chief Psychiatrist’s [website](#) and site specific ED reports were distributed to each of the individual mental health services reviewed.

St John Ambulance Review

The Minister for Health, through the former Acting Director General of the Department of Health, Professor Bryant Stokes, asked the Chief Psychiatrist to undertake a [Review](#) into the deaths of five people who worked as Paramedics or Volunteers with St John Ambulance WA. The deaths of these five people occurred between 21 December 2013 and 30 March 2015. The purpose of this Review was to consider the factors that may have contributed to the deaths of these people and, particularly, whether their role as a Paramedic or Volunteer may have played a part in their deaths. There were seven recommendations which arose from this review and the [findings](#) published in March 2016.

This report is noted because, even though it was undertaken while the Chief Psychiatrist sat within the Department of Health, it was released after 30 November 2015. This report remains a Department of Health report.

Targeted Case Reviews

The Chief Psychiatrist often carries out in-depth inquiries into patient care in mental health services. Findings may lead to recommendations which the system can learn from and improve the care provided to patients in mental health and from other services.

There were two target case reviews conducted by the Chief Psychiatrist during the reporting period. Confidentiality restricts further detail to be provided in this annual report.

Chief Psychiatrist's Thematic Reviews

Historically the Chief Psychiatrist has undertaken thematic reviews, looking at specific themes across all services, eg. physical health care. There were no thematic reviews undertaken during this reporting period, but it is anticipated that certain themes may emerge during the broader monitoring processes.

Chief Psychiatrist's Statutory Monitoring

On 30 November 2015 the Chief Psychiatrist became an independent statutory body under the Act. The implementation of the Act introduced new reporting requirements to the Chief Psychiatrist.

The Act requires mental health services to report to the Chief Psychiatrist on the following items:

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

The Chief Psychiatrist monitors for trends or notifications which potentially may sit outside of the range of normal standards. In these cases there is direct inquiry to the service involved and intervention where required.

As this is the inaugural annual report of the Chief Psychiatrist under the Act, this report will not make any comparison to previous years as reporting mechanisms and requirements may have changed.

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 has been found to be very effective in the treatment of serious mood disorders including major depression and mania, catatonic states and occasionally with schizophrenia or other neuropsychiatric disorders. Under the Act, 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 (s. 192(2)(a)).

ECT Statistics

Table 6 shows the ECT treatments that were reported to and monitored by the Chief Psychiatrist.

Table 6: ECT statistics reported to the Chief Psychiatrist during reporting period (30 November 2015 – 30 June 2016)

	Patients over 18 years (n)				Patients under 18 (n)
	Voluntary*	Involuntary	MIA	Total	
Number of ECT courses ECT	243	29	<5	±	0
ECT Treatments:	2513	369	20	2902	0
- Acute ECT Treatments	2182	273	12	2467	0
- Maintenance ECT Treatments	323	84	8	415	0
- Emergency ECT Treatments	8	12	0	20	0
Serious Adverse Events	16	<5	0	±	0

Note: The data are representative of those who completed their course of ECT between 30 November 2015 and 30 June 2016. It is important to note that the starting date for some of these courses may have commenced prior to 30 November 2015. Persons having not completed their course of ECT are not included in Table 6.

*During the course of the ECT treatment, a small number of patients (n= <5) were both a voluntary and an involuntary patient in the statistics above. These individuals have been coded as voluntary. ±Where the number in a cell is <5, the total number of individuals cannot be provided in order to prevent potential identification of patients.

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 (s.201(3)). A course of ECT is taken to have been completed during a month if the last treatment in the course was performed during the month, whether or not any of the other treatments in the course were performed during the month (s. 201(4)). 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 (s.201(5)).

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 in the past three months is considered ceased and should be reported.

Of the courses of ECT that were administered between 30 November 2015 and 30 June 2016, 243 were for voluntary patients, 29 were for involuntary patients, and <5 were for MIA (Table 6). No patients under 18 years of age received ECT. Patients over 18 years of age received a total of 2,902 ECT treatments of which 85% (n=2,467) were acute ECT treatments, 14% (n=415) maintenance ECT, and 0.7% (n=20) emergency ECT. Over half (60%) of the emergency ECT treatments were given to involuntary patients and 40% were given to voluntary patients. Of the ECT courses reported to the Chief Psychiatrist, 37% were reported by ECT services located within either a public or public private partnership hospital and 63% were reported by ECT services located within a private hospital.

Emergency ECT Approved by the Chief Psychiatrist

The Act contains specific provisions for the use of Emergency ECT on involuntary and MIA patients where the 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' (s. 199(2)(a)). Under these circumstances the medical practitioner must obtain approval from the Chief Psychiatrist, or one of the Chief Psychiatrist's Delegates, to undertake emergency ECT (s. 199(2)(c)).

There were 21 Emergency ECT treatments approved by the Chief Psychiatrist or his Delegates from commencement of the Act on 30 November 2015 to 30 June 2016. It is important to note that this number can include courses of ECT treatments completed after 30 June 2016 which will be reported in the next financial year. Therefore the number will not equate to the number of Emergency ECT treatments in Table 6.

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 physically injuring themselves or other, persistently causing damage to property, or provide the person with treatment and 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 (*Mental Health Act 2014 ss 215, 232*). 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 which 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 seclusion and restraint.

Further reductions in the rates of seclusion and restraint will be achieved with the continued commitment of mental health staff to the implementation of evidence based state-wide best practice methods. A system of monitoring and evaluating seclusion and restraint events and their rates has been established by the OCP and the information collected is reported to mental health services on a regular basis. This will assist mental health services to track their progress in reducing the use of these restrictive practices.

Reporting on restrictive practices includes reporting on seclusion, physical and mechanical restraint occurring within authorised hospitals – of note, there is no statutory requirement for the Chief Psychiatrist to capture restrictive practices that occur within the general health setting. While there is not an obligation on mental health services to maintain a register of seclusion and restraint events the Chief Psychiatrists encourages services to maintain such a register. While other restrictive practices have been raised at a national level e.g. chemical restraint, the Key Performance Indicators for these have not been defined and therefore are not reported at this point. However, there is significant work being done at the national level to gain a consistent approach to defining and reducing restrictive practices across jurisdictions for example the Restrictive Practices Working Group, sub-group of the Safety and Quality Partnerships Standing Committee, of which the Chief Psychiatrist is a member.

Seclusion

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 (MHA14- 212). 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.

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. There is considerable interest nationally and internationally to reduce and eliminate the use of seclusion.

Under s. 212–225 of the Act 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 the Chief Psychiatrist's expectation that medical practitioners 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 the Chief Psychiatrist's expectation that the post-seclusion examination occurs as soon as practicable.

Each seclusion event must be reported to the Chief Psychiatrist through approved forms, as stipulated in the Act.

During the reporting period (30 November 2015 to 30 June 2016):

- In total, there were 6706 separations. Of these, 219 patients were secluded
- For patients aged 18–65 years, there were 5,670 separations involving 4,102 individuals. Of these, 191 patients (4.7%) had a total of 501 seclusion episodes (Table 7).
- For patients under 18 years, there were 343 separations involving 231 individuals. Of these, 20 patients (8.9%) had a total of 40 seclusion episodes (Table 7).
- For patients aged 65 years and older, there were 692 separations involving 402 individuals. Of these, 8 patients (2%) had a total of 15 seclusion episodes (Table 7).

Table 7: Number of seclusions reported to the OCP

Age Group	Separations	Individuals Secluded	Seclusion Episodes	Authorised units
Patients aged 18–65 years old	5,670	191	501	15
Patients under 18 years old	343	20	40	4
Patients 65 years and older	692	8	15	3

* The sub-totals for individuals will not add to the total number of reported seclusions as a single person may have been secluded multiple times for varying lengths of time.

Duration of Seclusion Events 30 November 2015 and 30 June 2016 – total population

The median duration of seclusion events across all age groups was 111 minutes and the time of seclusion ranged from four minutes to 900 minutes. Of all reported cases 55% of seclusion events lasted between 60 and 120 minutes, 28% of events were over 120 minutes and 16% were less than 60 minutes (Table 8).

Table 8: Duration of seclusion events in authorised Mental Health units – total population

Length category	Individuals*	Episodes	Average Duration (median)
Less than 60 minutes	63	91	33 (34)
60 to 120 minutes	162	307	98 (105)
More than 120 minutes	80	158	261 (235)

* The sub-totals for individuals will not add to the total number of reported seclusions as a single person may have been secluded multiple times for varying lengths of time.

Duration of Seclusion Events – Patients 18–65 years

Of the 191 patients aged 18–65 years who were secluded, 169 were secluded less than 5 times, 14 between 5 and 10 times, and 8 were secluded more than 10 times. Of the 501 seclusion episodes reported to the Chief Psychiatrist, 57% lasted between 60 and 120 minutes, 30% of episodes lasted more than 120 minutes and 13% lasted less than 60 minutes (Table 9). The overall median length of seclusion was 115 minutes. The majority of seclusions for adults involved males (64%) and 36% involved females.

Table 9: Duration of seclusion for patients aged 18–65

Length category	Individuals*	Episodes	Average Duration (median)
Less than 60 minutes	48	67	33 (34)
60 to 120 minutes	148	284	99 (105)
More than 120 minutes	74	150	256 (235)

* The sub-totals for individuals will not add to the total number of reported seclusions as a single person may have been secluded multiple times for varying lengths of time.

Duration of Seclusion Events – Patients under 18 years

With regards to the duration of a seclusion event, 10 patients were secluded for less than 60 minutes, 11 patients between 60 and 120 minutes, and less than five for more than 120 minutes. The range of time patients under 18 years were secluded was between five minutes and 730 minutes with the median length of seclusion 61.5 minutes. In contrast to seclusions involving patients aged 18–65 years, the majority of seclusions of patients under 18 years involved females (75%) and 25% involved males.

Table 10: Duration of seclusion for patients under 18 years

Length category	Individuals* (n)	Episodes (n)	Average Duration (median)
Less than 60 minutes	10	18	33 (27)
60 to 120 minutes	11	17	81 (79)
More than 120 minutes	<5**	5	423 (480)

*The sub-totals for individuals in Table 10 will not add to the total number of individuals secluded (Table 9) as some patients were secluded multiple times for varying lengths of time.
**Where the number of individuals is <5, the exact number is not reported to prevent potential identification of individuals.

Duration of Seclusion Events – Patients 65 years and older

The duration of seclusion events is not reported for patients aged 65 years and older due to the small numbers who were secluded. This is to prevent potential identification of individuals.

National KPIs

The Australian Institute for Health and Welfare (AIHW) reports on yearly seclusion data from both the states/territories and nationally. During the reporting period (30 November 2015 – 30 June 2016) the overall rate of seclusion in WA was 4.9 per 1,000 beddays. The rate of seclusion was lowest for older adult services (0.5 per 1,000 beddays) and adult mental health services (5.4 per 1,000 beddays) followed by 10.8 per 1,000 beddays for forensic services and highest for child and adolescent services at 12.4 per 1,000 beddays.

The national rate of seclusion events has shown a steady decrease since 2010–11, from 11.8 in 2010–2011 to 7.8 in 2014–2015. This represents a reduction of 10% since 2011.

Restraint

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 (MHA14 s. 227). 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 whilst 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. 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. 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.

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 (s. 232).

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 six hours they must be examined by a psychiatrist. A post restraint physical examination must occur within six hours of the person being released from the restraint. It is the Chief Psychiatrist’s expectation that the post restraint examination occurs as soon as practicable.

Under the Act mental health services are required to provide the Chief Psychiatrist with copies of the approved Forms which need to be completed on each occasion of restraint, with the exception being when the restraint was undertaken to escort a patient to seclusion. In order to ensure a smooth transition the Chief Psychiatrist requested that each service continue to maintain their own restraint register to enable cross-checking/validation of the number of restraint events notified to the OCP.

During the reporting period (30 November 2015 to 30 June 2016) (Table 11):

- In total, there were 6706 separations and 474 episodes of restraint
- For patients aged 18 to 65 years, there were 5,670 separations involving 4,102 individuals. Of these, 184 patients (4.5%) had a total of 336 restraint episodes.
- For patients under 18 years, there were 343 separations involving 231 individuals. Of these, 31 patients (13.4%) had a total of 81 restraint episodes.
- For patients aged 65 years and older, there were 692 separations involving 402 individuals. Of these, 25 patients (6.2%) had a total of 57 restraint episodes.

Table 11: Number of restraints reported to the OCP

Age Group	Separations	Individuals Secluded	Seclusion Episodes	Authorised units
Patients under 18 years of age	343	31	81	8
Patients aged 18–65 years	5,670	184	336	14
Patients aged 65 years and older	692	25	57	7

Of the 31 patients under 18 years of age who were restrained, the majority (81%) were restrained less than 5 times and 19% were restrained between 5 and 10 times. No patient was restrained more than 10 times.

Duration of Restraint Events 30 November 2015 and 30 June 2016 – total population

The median duration of a restraint event for all patients was four minutes and the time of restraint ranged from less than one minute to 67 minutes. Of all reported events, 51% had duration of less than five minutes, 29% were between five and 10 minutes and 20% of restraint events were longer than 10 minutes (Table 12).

Table 12: Duration of restraint events in authorised Mental Health units – total population

Length category	Individuals	Episodes	Average Duration (median)
Less than 5 minutes	147	242	2 (2)
5 to 10 minutes	102	136	7 (7)
More than 10 minutes	64	96	21 (16.5)

Duration of Restraint Events – Patients 18–65 years

Of the 184 patients aged 18 to 65 years who were restrained, 95% were restrained fewer than 5 times and <5 patients were restrained more than 10 times, with the remainder of patients restrained between 5 and 10 times. The largest proportion of restraints (46%) were for <5 minutes, 34% between 5 and 10 minutes, and 19% for more than 10 minutes (Table 13). Restraint times ranged from <1 minute to 67 minutes, with a median time of 4 minutes. Approximately half (48%) of restraints involved females and just over half (52%) involved males.

Table 13: Duration of restraint for patients aged 18–65 years of age

Length category	Individuals*	Episodes	Average Duration (median)
Less than 5 minutes	109	173	2 (2)
5 to 10 minutes	80	97	7 (7)
More than 10 minutes	46	66	20 (15)

* The sub-totals of individuals will not add to the total number of reported restraints as a single person may have been restrained multiple times for varying lengths of time.

Duration of Restraint Events – Patients under 18 years

Just over one-third (36%) of restraints were for <5 minutes, 34% between 5 and 10 minutes, and 30% were for more than 10 minutes. Restraint times ranged from <1 minute to 50 minutes, with a median time of 6 minutes. The majority of patients under 18 years of age who were restrained were female (small numbers prevent exact numbers/percentages being presented).

Table 14: Duration of restraint for patients under 18 years

Length category	Individuals*	Episodes	Average Duration (median)
Less than 5 minutes	16	32	2 (2)
5 to 10 minutes	15	25	8 (8)
More than 10 minutes	13	24	22 (19.5)

* The sub-totals of individuals will not add to the total number of reported restraints as a single person may have been restrained multiple times for varying lengths of time.

Child and adolescent service strategies for prevention and management of aggression in WA, whilst seeking to reduce all restrictive practices, specifically seek to prioritise reduction of seclusion above restraint, whereas strategies used by adult services tend to seek equal reduction of seclusion and restraint. All reports of restraint to the Chief Psychiatrist for patients aged less than 18 years of age used physical restraint techniques, with no reports of mechanical restraint being used.

Duration of Restraint Events – Patients over 65 years

Just under two-thirds (65%) of restraints were for < 5 minutes, 20% between 5 and 10 minutes, and 15% were for more than 10 minutes. Restraint times ranged from <1 minute to 40 minutes, with a median time of 2 minutes. The majority of patients 65 years and older who were restrained were male (small numbers prevent exact numbers/percentages being presented).

Table 15: Duration of restraint for patients under 18 years

Length category	Individuals*	Episodes	Average Duration (median)
Less than 5 minutes	22	37	2 (2)
5 to 10 minutes	7	14	7 (6)
More than 10 minutes	5	6	23 (20)

* The sub-totals of individuals will not add to the total number of reported restraints as a single person may have been restrained multiple times for varying lengths of time.

National KPIs

The rates of restraint are difficult to nationally benchmark due to differences in reporting criteria and processes across the states and territories. With the implementation of the Act, reporting requirements in WA have been streamlined and therefore data for any future benchmarking will be accurate, but will not necessarily compensate for different restraint definitions or data collection methods across jurisdictions. Furthermore, there is work at a national level by the Australian Institute of Health and Welfare and the Safety and Quality Partnerships Standing Committee to begin reporting national and jurisdictional comparative restraint rates, where possible.

During the reporting period (30 November 2015 – 30 June 2016) the rate of restraint in WA for all age groups was 4.1 per 1,000 beddays. The rate of restraint varied across services with the lowest rates observed in Forensic services (2.0 per 1,000 beddays) and Older Person services (2.3 per 1,000 beddays), and higher rates in Adult services (4.0 per 1,000 beddays) and Child and Adolescent services (28.5 per 1,000 beddays). In almost all cases, the patients were physically restrained with less than five mechanical restraint events reported to the Chief Psychiatrist.

Notifiable incidents reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016

Deaths and other notifiable incidents that involve patients receiving care from mental health services throughout WA are required to be reported to the Chief Psychiatrist (s.526(2)). As set out in the Policy for Reporting Notifiable Incidents to the Chief Psychiatrist, notifiable incidents must be reported to the Chief Psychiatrist, ideally within 48 hours of the event, either via the electronic Datix Clinical Incident Management System (Datix CIMS) or completion of the [Chief Psychiatrist Notifiable Incidents reporting Form](#).

The mental health status of the person(s) involved in the incident is reported by the notifier at the time of the incident. Incidents reported through Datix CIMS require the notifier to assign a Severity Assessment Code (SAC) of 1, 2 or 3 based on assessment of the actual or potential consequences associated with the clinical incident as set out in the [WA Health Clinical Incident Management \(CIM\) Policy 2015.2](#). The SAC rating is used to determine the appropriate level of analysis, action and escalation. In Datix CIMS the notifier 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 into the Datix CIMS senior staff at the hospital/ health service concerned review the incident and confirm the SAC rating, which may differ from the SAC rating allocated by the notifier. Time lags may exist in the confirmation of SAC ratings for incident records in Datix CIMS.

- **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.

All incidents reported through Datix CIMS undergo an investigation by a senior staff member. The minimum level of investigation required by the CIM Policy is dependent on the SAC rating, with SAC1 incidents requiring a Root Cause Analysis (RCA) or similar investigation methodology appropriate to the incident. Through this process potential causative and contributing factors can be identified so that the service can develop and implement recommendations to prevent similar incidents from occurring in the future.

Incidents reported through Datix CIMS are individually assessed by the OCP to determine whether they fall within the Chief Psychiatrist's reporting policy and are coded accordingly. Given the recent transition to the electronic Datix CIMS reporting process, data in this report is not compared with that in previous year's reports produced by the OCP.

Deaths

Any death of a mental health patient while under the care of a mental health service or other health service and any death that may implicate or involve mental health or other health services needs to be reported to the Chief Psychiatrist. All deaths, that mental health services become aware of, occurring within three months of a person being discharged or deactivated from mental health services also needs to be reported.

During the reporting period, the deaths of 105 mental health patients were reported to the Chief Psychiatrist (Table 16; Figure 2) through either Datix CIMS (n = 51) or the OCP notification form (n = 54). Of these deaths 13% (n = 14) were an inpatient in an authorised or general hospital and 87% (n = 91) were either active community patients or had been discharged from a mental health service within 3 months prior to their death. Of these deaths, 37% (n = 39) were female and 63% (n = 66) were male patients. Natural/medical causes were attributed to 50% (n = 52) of reported deaths, 32% (n = 34) were a suspected completed suicide and 18% (n = 19) were categorised as ‘physical unnatural or unknown’. 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 the Chief Psychiatrist 54% had a SAC rating confirmed, with 91% of these were classified as SAC1. Of those with an assigned SAC, the clinical investigation had been completed at the time of writing this report for 71% of cases.

Table 16: Suspected causes of deaths of mental health patients reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016

	Suicide n= 34	Natural/ medical n= 52	Physical Unnatural* n= <5	Unknown n= 16	Total n= 105
Male	68%	60%	<5	62%	63%
Female	32%	40%	<5	37%	37%
Rated at SAC1	90%	14%	<5	69%	50%

Source: Office of the Chief Psychiatrist and Datix CIMS

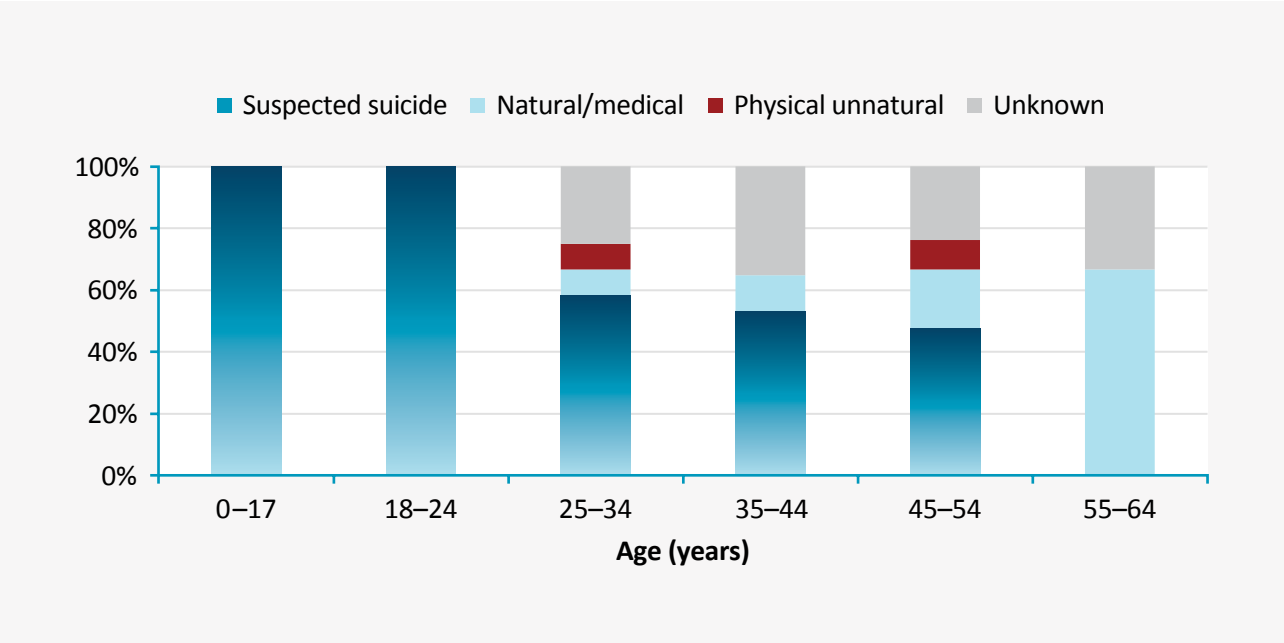
The reported cases of suspected suicide only include people who were in contact with a mental health service. The majority of suicides in WA occur in people who have not had contact with mental health services.

*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.

The proportion of suspected suicides reported to the Chief Psychiatrist was greatest in the younger age groups (Figure 2). All deaths in those aged 24 years or younger were classified as a suspected suicide and just over half (58%) of the deaths in those aged 25 to 44 years. A greater proportion of deaths occurring in patients aged 55 years or over were attributed to natural/medical causes. There were 43 deaths reported for patients aged 65 years or older of which <5 were suspected suicides.

Figure 2: Deaths of mental health patients by category of death and age group reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016



Source: Office of the Chief Psychiatrist and Datix CIMS

*The data for 65+ years are not presented in Figure 2 as there were < 5 suspected suicides, all other deaths in this age group were classified as natural/medical.

Other Notifiable Incidents

Other notifiable incidents that need to be reported to the Chief Psychiatrist include:

- 1. Attempted Suicide
- 2. Non Suicidal Self-Injury/Harm
- 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.

During the reporting period there were 2,019 other notifiable incidents (51% female and 49% male) reported for 880 patients to the Chief Psychiatrist (Table 17). Of these reported incidents most (93%) described a single incident type while for 6.5% (n = 131) a secondary incident occurred along with the primary incident reported. The most common secondary incident was related to assault/aggressive behaviour (n = 42), non-suicidal self-injury/harm (n = 33), attempted absconding (n = 20), attempted suicide (n = 20), and sexual contact/alleged sexual assault (n = 16). The majority of the incidents were reported to the Chief Psychiatrist through Datix CIMS (n = 1,803), with the remainder reported through the Chief Psychiatrist’s notifiable incident reporting form (n = 216). Sixty three percent of patients were involved in one incident, 30% were involved in between 2 and 5 incidents, 5% between 6 and 10 incidents and 2% were involved in greater than 10 incidents (maximum 44 incidents). Of the 2,019 incidents 5% were confirmed as a SAC1, 28% as a SAC2, 59% SAC3 and the remaining 8% did not have an assigned SAC rating at the time of reporting. A clinical investigation had been completed for 75% of those incidents with a SAC1 rating at the time of writing this report.

Table 17: Other Primary Notifiable Incidents reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016

Incident type	Mental health status					
	Involuntary		Voluntary		Referred*	
	number	%	number	%	number	%
Assault/aggressive behaviour	736	62	408	35	36	3
Sexual contact/alleged Sexual Assault	27	±	21	±	<5	±
Non-suicidal self injury/harm	46	19	189	77	11	4
Attempted suicide	44	18	177	71	28	11
Absconding – leaving hospital without permission**	186	91	0	0	18	9
Absconding – did not return from granted leave	24	100	0	0	0	0
Missing person±	0	0	6	100	0	0
Attempted absconding	29	69	7	17	6	14
Serious medication error	0	0	<5	100	0	0
Unlawful sexual contact by staff	0	0	<5	100	0	0
Unreasonable use of force by staff	<5	50	<5	50	0	0
Other SAC1 incidents	<5	33	<5	77	0	0
Total	1,095	54	824	41	100	5

Source: Office of the Chief Psychiatrist and Datix CIMS

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

**Involuntary/referred patients only

±Voluntary patients who were at high risk (SAC1 only) ±Where the number in a cell is

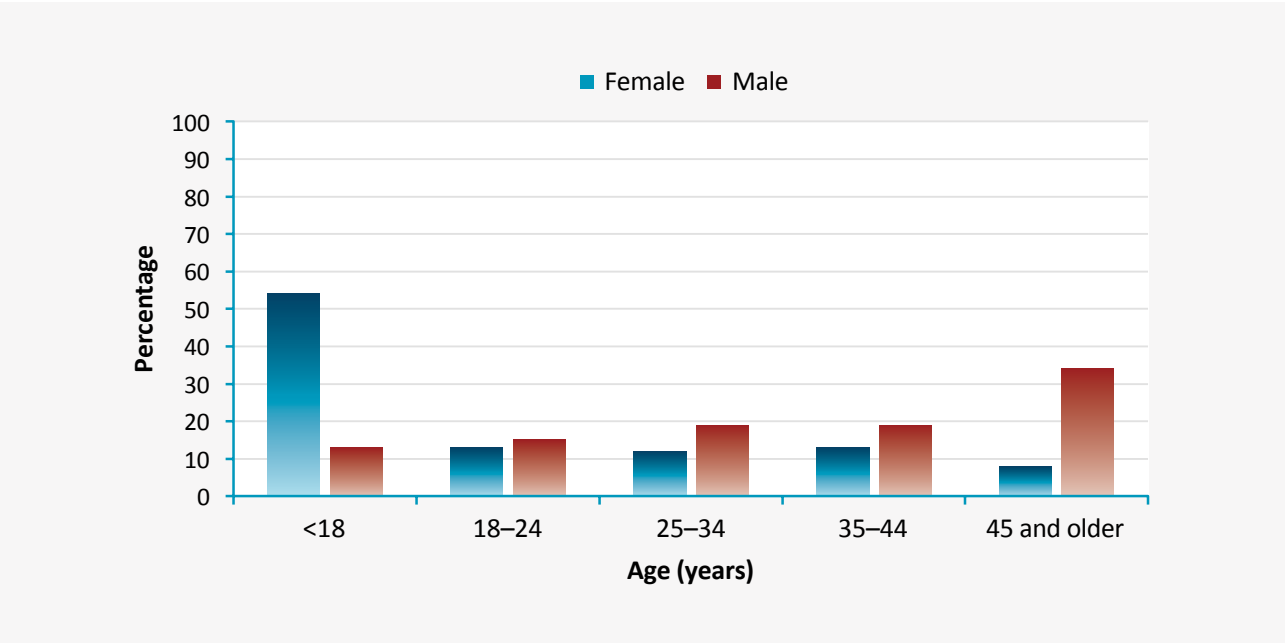
<5, the numbers and percentages have not been provided in order to prevent potential identification of patients.

Attempted suicide

Any deliberate self-inflicted bodily injury with the intention of ending one’s life needs to be reported to the Chief Psychiatrist. 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.’ 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. ¹

The classification of attempted suicide is a clinical judgement made at the time of the incident. During the reporting period, 269 reports to the Chief Psychiatrist were classified as an attempted suicide. Of these, 83% were female and 17% male. Nine percent were reported as a SAC1, 30% as SAC2, 54% as SAC3 and 7% had no SAC rating assigned at the time of reporting. The greatest proportion of females who attempted suicide (54%) were aged less than 18 years (Figure 3) whilst for males a greater proportion were aged 45 years and older (34%).

Figure 3: Age and gender distribution of attempted suicide incidents reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016



Source: Office of the Chief Psychiatrist and Datix CIMS

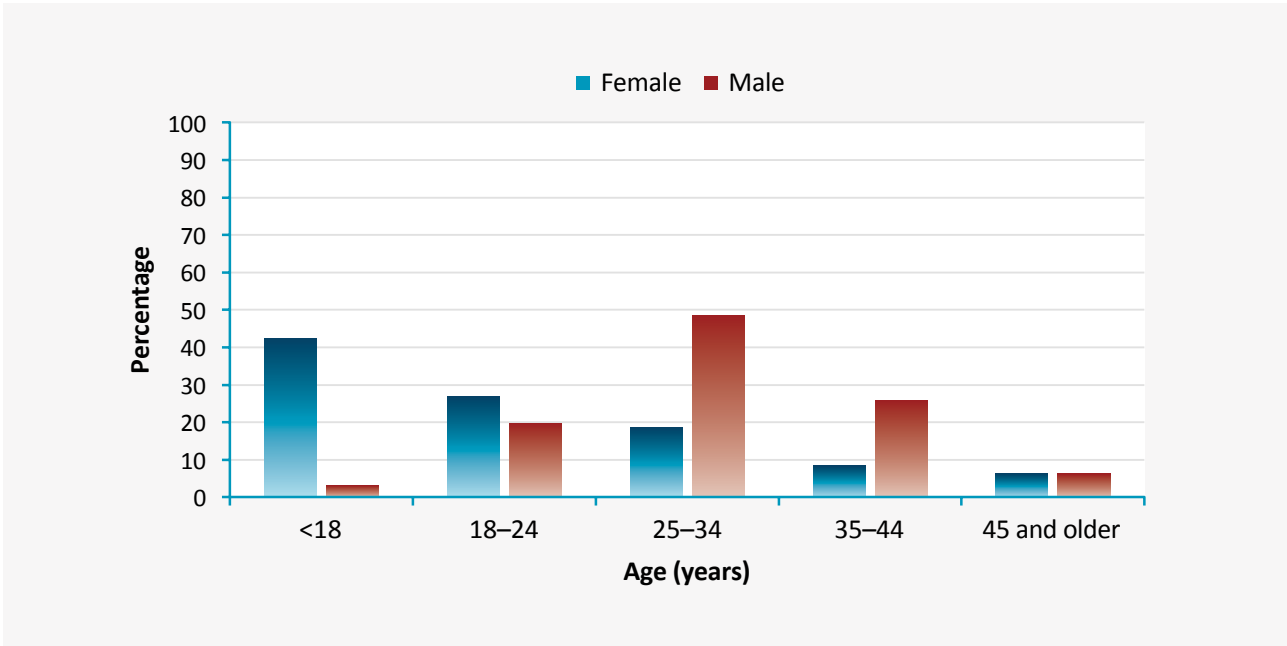
1 Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist. Reference is: Department of Health, Western Australia. Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist. (2015). Perth: Office of the Chief Psychiatrist.

Non-Suicidal Self-Injury/Harm

Any deliberate self-inflicted bodily injury where there is no evident intention to die must be reported to the Chief Psychiatrist. The absence of suicidal intent is either 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/harm 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. These incidents can occur whilst the patient is receiving inpatient or community care or within an ED.

During the reporting period, there were 280 reports of non-suicidal self-injury/harm to the Chief Psychiatrist involving 153 patients. Of these, 87% were female and 13% male. The proportion of females undertaking non-suicidal self-injury/harm behaviours decreased as age increased, with the most common age group being those aged less than 18 years (41%) (Figure 4). This pattern was not present for males, with the greatest number of males with reported non-suicidal self-injury/harm being aged 25–34 years.

Figure 4: Age and gender distribution of non-suicidal self-injury/harm incidents reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016



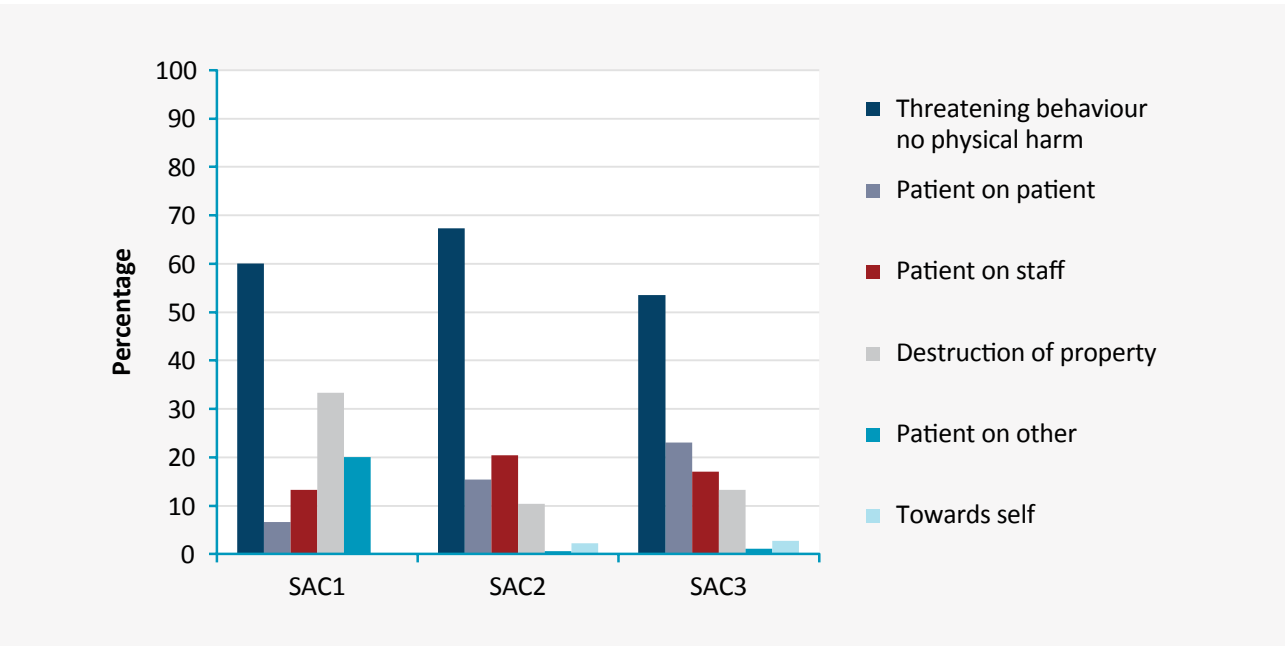
Source: Office of the Chief Psychiatrist and Datix CIMS

Aggressive Behaviour and/or Assault by a Patient

Aggression and/or Assault (patient to any other person(s)) that occurred within an inpatient setting (including emergency department and hospital grounds), on community mental health service premises (this includes incidents occurring during staff assessment of the client at their home or other premises) or at a private psychiatric hostel.

During the reporting period, there were a total of 1,221 reports to the Chief Psychiatrist where the incident involved aggressive behaviour involving 476 patients. This equated to 58% of all notifiable incidents reported to the Chief Psychiatrist. A SAC 1 rating was recorded for 1% of aggressive incidents, a SAC 2 for 29%, a SAC 3 for 64% and a SAC rating was allocated for 5% at the time of reporting. Over half (58%) of these incidents involved threatening behaviour which did not result in physical harm to other (Figure 5). Other types of aggressive behaviour/assault reported included patient to patient assault (22%), patient assault of a staff member (17%), patient to other (includes visitors) (1%), destruction of property (12%) and aggressive behaviour towards themselves (2%) (Note: some incidents involved more than one type of aggressive behaviour/assault).

Figure 5: Aggressive behaviour and/or Assault by a patient reported to the Chief Psychiatrist between 30 November 2015 and 30 June 2016



Source: Office of the Chief Psychiatrist and Datix CIMS

Percentages will not add to 100% as a single incident may involve multiple aggressive behaviour types

Allegations of Unreasonable Use of Force by Staff

The patient is harmed by suspected unreasonable use of force by a staff member of a mental health service (includes staff members of a private psychiatric hostel).

During 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 the Chief Psychiatrist.

All allegations of unreasonable use of force by a staff member reported to the Chief Psychiatrist are investigated by the mental health service who notified the allegation. The Chief Psychiatrist reserves the right to investigate further as required.

Sexual Contact/Alleged Sexual Assault by a Mental Health Patient

Sexual Contact and/or Allegation of Sexual Assault (patient to any other person(s)) that occurred within an inpatient setting (including emergency departments and hospital grounds), community mental health service premises (this includes incidents occurring during staff assessment of the client at their home or other premises) or at a private psychiatric hostel.

Definition: 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’. 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 and some patients may be vulnerable to being coerced into participating in sexual behaviour.

During the reporting period, there were 65 incidents related to sexual contact/alleged sexual assault reported to the Chief Psychiatrist. The majority of these reports related to involuntary patients (63%), 35% to voluntary patients and 2% to referred patients. Fewer than five incidents were reported as a SAC1, 26% were SAC 2, 54% were SAC3 and 19% did not have a SAC rating allocated at the time of reporting.

All allegations of sexual assault reported to the Chief Psychiatrist are investigated by the mental health service who notified the allegation.

Allegations of Unlawful Sexual Contact

Unlawful sexual contact reasonably suspected to have occurred with the patient by a staff member of a mental health service (includes staff members of a private psychiatric hostel) or another person within a hospital (including emergency departments) that is not a mental health patient.

There were <5 allegations of unlawful sexual contact by a staff member toward a mental health patient. All allegations of unlawful sexual contact reported to the Chief Psychiatrist are investigated by the mental health service who notified the allegation.

Absent Without Leave (AWOL) Involuntary and Referred Patients

Under the Act s. 97 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 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 a 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.

The Chief Psychiatrist must be informed of the date the person returns or is located, the outcome and whether there were any adverse events whilst AWOL.

During the reporting period, a total of 228 incidents were reported as being AWOL to the Chief Psychiatrist, involving 204 patients. At the time of writing this report, there were no outstanding AWOL patients.

Two thirds of AWOL patients were male (67%) and a third were females (33%). Most incidents related to patients leaving the hospital or place of detainment without permission (89.5%), whilst a small proportion (10.5%) of involuntary patients did not return from granted leave. Of the 204 patients who left without permission, 91% were reported as being involuntary at the time and 18% were referred patients.

The greatest proportion (79%) of patients who went AWOL were inpatients at the time, a smaller proportion (19%) absconded whilst being detained in an ED and the remainder were involuntary patients on a community treatment order subject to an order to attend. Just under half (46%) of all reported AWOLs were deemed ‘low risk’ and therefore the incident were reported as a SAC3. Just over a quarter of AWOLs (27%) were reported as a SAC2 and just under a quarter (24%) were reported as a SAC1. No SAC was available for 8 incidents at the time of reporting. The average length of time AWOL was 1 day, ranging from 0 to 36 days.

Most patients reported to be AWOL (90%) were returned to the ward and 6% were discharged whilst AWOL. The remainder were either located and subsequently discharged from the service or re-presented to services. An adverse outcome was reported for 7 of the 228 (3%) incidents reported as AWOL; these outcomes included self-harm, falls and intoxication leading to hospitalisation. There were no deaths of AWOL patients reported during this reporting period.

Missing person – Voluntary Mental Health Patients at High Risk

Definition: Any voluntary mental health patient 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 needs to be reported to the Chief Psychiatrist as a 'Missing person'.

During the reporting period, a total of 6 voluntary patients who were considered to be high risk of harm to themselves or others were reported as missing persons from hospital or ED. All of these patients were reported to have been returned to the mental health service.

Serious Medication Error

Definition: 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 (Act s 525(b)) Adverse effect means to need medical intervention, review or has or is likely to have caused death. Only incidents classified as a SAC1 have been included in this report.

During the reporting period, there were <5 incidents related to serious medication errors reported to the Chief Psychiatrist. None of these incidents resulted in the death of the patient.

Other Statutory Reporting to the Chief Psychiatrist

Psychosurgery

Under s. 209 of the Act all provisions of psychosurgery need to be reported to the Chief Psychiatrist. 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.

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

Treatment Decisions Different to Advance Health Directive of Involuntary Patients

According to s. 179(2)(c) of the Act 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 the Chief Psychiatrist (s. 179(3)), using the Chief Psychiatrist's form.

During the reporting period there were no instances reported to the Chief Psychiatrist where the treatment decision of an involuntary patient differed to their Advanced Health Directive.

Segregation of Children from Adult Inpatients

Under s.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 the Chief Psychiatrist why they are satisfied the that above two criteria have been fulfilled (s. 303(3)), using the Chief Psychiatrist's form.

During the reporting period there were five instances reported to the Chief Psychiatrist 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.

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

Under s.304 of the Act off-label treatment involves the provision of a registered therapeutic good for purposes other than in accordance with the approved product information for the registered therapeutic good to a child who is an involuntary patient. All use of off-label treatment provided to a child who is an involuntary patient must be reported to the Chief Psychiatrist, including the type of off-label treatment provided and the reason for the decision (s. 304(3)).

During the reporting period there were six involuntary children reported to the Chief Psychiatrist who had received off-label treatment.

Approving Involuntary Treatment Orders within a General Hospital

Under the Act s. 61(2)(b) the Chief Psychiatrist, or one of the Chief Psychiatrist's Delegates, must provide consent for a patient to be detained on an involuntary treatment order within a general hospital. The treating psychiatrist must report regularly, at the end of each successive 7-day period, to the Chief Psychiatrist for the duration that the person is detained.

During the reporting period there were 39 patients with a combined total of 47 authorised consents for an involuntary treatment order in a general hospital, of which 15% (n = 7) were for 6 patients under the age of 18. Of these 47 authorised consents, 36% (n = 17) lasted less than 7 days, 30% (n = 14) lasted between 7 to 14 days and 34% (n = 16) lasted for 15 days or more.

Emergency Psychiatric Treatment

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. Under s.202(2) of the Act EPT does not include the use of ECT, psychosurgery or prohibited treatments (including deep sleep, coma, and insulin sub-coma therapy). A medical practitioner may provide a person with EPT without informed consent being given to the provision of treatment (s.203).

The Chief Psychiatrist must be provided with a copy of the approved Form (s. 204), as soon as practicable, containing the information outlined in Appendix B.

During the reporting period there were 128 reported episodes of EPT to the Chief Psychiatrist. Outside of mental health settings, clinicians often use the doctrine of necessity rather than formally using EPT.

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

Urgent non-psychiatric treatment is treatment needed to save a patient’s life; prevent serious damage to the patient’s health or prevent the patient from suffering or continuing to suffer significant pain or distress. The provision of urgent non-psychiatric treatment needs to be reported as soon as practicable to the Chief Psychiatrist (s. 242(3)) via completion of the approved Form that contains information outlined in Appendix C.

During the reporting period there were 22 episodes of urgent non-psychiatric treatment reported to the Chief Psychiatrist.

Alignment with National and State Objectives

The OCP’s key activities and functions are aligned with the principles and standards outlined in the following documents:

- [Mental Health Act 2014](#)
- [National Standards for Mental Health Services 2010](#)
- [Mental Health, Alcohol and Other Drug Services Plan 2015–2025](#)
- [The Roadmap for National Mental Health Reform 2012–2022 \(COAG\)](#)
- [Carers Recognition Act 2004](#)
- [Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia-Professor B Stokes July 2012 \(“Stokes Review”\)](#)
- Historical review processes such as the [Chief Psychiatrist’s Clinical and Thematic Reviews](#)

Working Groups and Committees

The OCP is involved in a range of national and state-wide committees, working groups and panels across the Department of Health and other government / non-government agencies. These include but are not restricted to the following.

National Representation and Consultation

- Australian Council for Safety and Quality in Health Care (ACSQHC) Mental Health Reference Group
- National Health and Medical Research Council (NHMRC) Alcohol Working Group
- Safety and Quality Partnerships Standing Committee (SQPSC)
- Restrictive Practices Working Group (Sub-group of SQPSC above)
- Restrictive Practice Data Working Group (Sub-Group of SQPSC above)
- Reducing Adverse Medication Events in Mental Health Working Party (Sub-Group of SQPSC above)
- Royal Australian and New Zealand College of Psychiatrists Binational Committee for Examinations.

Western Australian Representation and Consultation

- Authorised Mental Health Practitioners Education Round Table
- Coronal Review Committee
- Coronal Recommendations Working Group
- Chief Psychiatrist Standards and Guidelines Working Group
- Chief Psychiatrist Approved Forms Working Group
- Chief Psychiatrist Education Working Group
- Chief Psychiatrist Clinical Advisory Round Table
- Chief Psychiatrist Steering Committee
- Change Management and Relocation Team
- Disability Justice Project Expert Panel
- Dual Disability Competency Framework and training advisory group
- *Mental Health Act 2014* Policy Review Committee
- Mental Health Bill Implementation Reference Group
- Mental Health Inter Hospital Patient Transfer Service Reference Group
- Mental Health Bill Implementation Group
- Mental Health Bill Education Steering Committee
- Mental Health Leadership Group
- Mental Health Bill Operational Rollout Group
- Mental Health Executive Directors Forum
- Mental Health Network
- Mental Health System-wide Clinical Policy Group
- Parliamentary Standing Committee
(the Chief Psychiatrist appeared before the Delegated Legislation Committee)
- Project Control Group Datix CIMS Complaints Working Group
- Project Control Group Consumer Feedback Module
- Project Control Group Transition
- PSOLIS Working Group
- Peak Incident Review Committee
- Reduction of Adverse Medication Events in Mental Health Working Party
- Research Advisory Council
- Royal Australian and New Zealand College of Psychiatrists
- Southern Integrated Research Organisation Research Advisory Council
- Stimulants Assessment Panel
- Stokes Implementation Partnership Group
- State Datix Committee
- WA Mental Health, WA Police, Ambulance and Royal Flying Doctor Service Forum.

Looking Forward

There are several focus areas for the Chief Psychiatrist going forward:

- The Chief Psychiatrist is seeking to better use the mandatory reporting and Clinical Review data in a timely feedback loop to services and clinicians.
- Enhancing clinical leadership and strengthening the role of the consumer and carer in mental health care remain long-term commitments.
- Reducing restrictive practices and enhancing the quality use of medicines remain key unchanged foci.
- There is ongoing work for services to embed their own Act training and updating, based on standardised training maintained by the Office of the Chief Psychiatrist.
- The development of mental health standards of care within services is a crucial and ongoing process and the responsibility of every clinician and health leader.

Western Australia comes from a strong base but the structural changes within health services will require sustained focus on maintaining standards, particularly around communication and continuity of care.

Appendix A: ECT reporting requirements – ECT

Under the Act mental health services need to provide monthly statistics on the use of ECT. These statistics must include:

- The number of people in respect of whom a course of ECT therapy at the mental; health service was completed or discontinued during the month
- The number of those people who were children
- The number of those people who were voluntary patients
- The number of those voluntary patients who were children
- The number of those people who were involuntary patients
- The number of those involuntary patients who were children
- The number of those people who were MIA detained at an authorised hospital
- The number of those MIA who were children
- The number of treatments with ECT in each of those courses
- The number of those courses that were courses of Emergency ECT
- Details of any serious adverse event that occurred, or is suspected of having occurred, during or after any of those courses.

Serious adverse events include:

- Premature consciousness during a treatment
- Anaesthetic complications (for example, cardiac arrhythmia) during recovery from a treatment
- An acute and persistent confused state during recovery from a treatment
- Muscle tears or vertebral column damage
- Severe and persistent headaches
- Persistent memory deficit.

Appendix B: Reporting requirements – Emergency Psychiatric Treatment

Under the Act the medical practitioner who provided EPT treatment must provide the Chief Psychiatrist with a copy of an 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 C: Reporting requirements – Urgent Non-Psychiatric Treatment

Under 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

Abbreviations

Act	<i>Mental Health Act 2014</i>
AMHP	Authorised Mental Health Practitioner
AMHPERT	Authorised Mental health Practitioners Education Round Table
AWOL	Absent without leave
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Services
CeLP	Clinician’s e-Learning Package
CP	Chief Psychiatrist
CPEWG	Chief Psychiatrist Education Working Group
DATIX CIMS	DATIX Clinical Incident Management System
Dr	Doctor
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDDC	Emergency Department Data Collection
EMHS	East Metropolitan Health Service
EPT	Emergency Psychiatric Treatment
FTEs	Full time Employees
HaDSCO	Health and Disability Services Commission
HMDC	Hospital Morbidity Data Collection
HMDS	Hospital Morbidity Data System
Hon	Honourable
MHC	Mental Health Commission
MHRB	Mental Health Review Board
MIA	Mentally Impaired Accused
NMHS	North Metropolitan Health Service
OCP	Office of the Chief Psychiatrist
PCH	Perth Children Hospital
RCA	Root Cause Analysis
ReLP	Referrers e-Learning Package
SAC	Severity Assessment Code
SMHS	South Metropolitan Health Service
START Court	Specialist Treatment and Referral Team
WACHS	Western Australia Country Health Service

Terminology

Beddays

A bedday in Western Australia is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Separations

Separation is the term used to refer to the process by which an admitted patient completes an episode of care by being discharged, dying, transferring to another hospital or changing the type of care (for example, moving from acute care to rehabilitation care).

Source: AIHW

Service Contact

Community mental health care service contacts can be conducted either with an individual or in a group session. Service contacts can be face-to-face, via telephone or video link, or using other forms of direct communication. They can be conducted either in the presence of the patient, or with a third party, such as a carer or family member, and/or other professional or mental health worker.

Source: AIHW

Certain applications still use the term ‘occasion of service’ rather than ‘service contact’.

References

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.

National Mental Health Working Group. (2005). *National safety priorities in mental health: a national plan for reducing harm*, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia, Canberra.

Stokes, B. (2012). *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.

Western Australia, *Mental Health Act 1996*, No. 68

Western Australia, *Mental Health Act 2014*.

This document can be made available in alternative formats on request for a person with disability.

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.