



CHIEF PSYCHIATRIST
of Western Australia

‘Ensuring Safe and High Quality Mental Health Care’

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

01 July 2018 – 30 June 2019



Statement of Compliance

HON ROGER COOK MLA

DEPUTY PREMIER;

MINISTER FOR HEALTH; MENTAL HEALTH

In accordance with section 533 and 534 of the *Mental Health Act 2014*, I hereby submit for your information and presentation to Parliament, the Annual Report of the Chief Psychiatrist for the financial year ended 30 June 2019.

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



Dr Nathan Gibson
CHIEF PSYCHIATRIST
ACCOUNTABLE AUTHORITY

10 September 2019

Declaration of Financial Accountability

In accordance with section 61(3) of the *Financial Management Act 2006*, I declare that the Annual Report of the Mental Health Commission includes a report for the financial year ended 30 June 2019 information prescribed by the Treasurer's instructions, in respect of the Office of the Chief Psychiatrist, an affiliated body of the Mental Health Commission.

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



Les Bechelli

**CHIEF FINANCE OFFICER
ACCOUNTABLE AUTHORITY**

10 September 2019

Acknowledgements

Acknowledgement of Country

The Chief Psychiatrist of Western Australia acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia.

We acknowledge the wisdom of Aboriginal Elders past and present and pay respect to Aboriginal communities of today.

Acknowledgement of Lived Experience

The Chief Psychiatrist of Western Australia acknowledges all people with lived experience of mental illness and the people who care for and support them.

He acknowledges that the voice and insight of people with lived experience is essential in the development of safe high quality mental health services.

Disclosures and Legal Compliance

Record Keeping

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

Board and Committee Remuneration

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

Consumer and Carer representatives providing their expertise and perspective on a range of Office of the Chief Psychiatrist Committees and Working Parties have been financially remunerated in accordance with the current policy for Consumer and Carer participation.

Legal and Government policy requirements and financial disclosures

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

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

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

Conflicts of Interest with Senior Officers

In accordance with section 31(1) of the *Public Sector Management Act 1994*, the Office of the Chief Psychiatrist fully complied with the public sector standards in respect of any conflicts of interest.

Compliance with Public Sector Standards and Ethical Codes

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

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

Occupational Safety, Health, and Injury Management

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

‘Ensuring Safe and High Quality Mental Health Care’



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Foreword



It was the year of reviews. With all of these reviews, are mental health services meeting their standards?

With all of the reviews that occur in mental health settings, a number of questions reasonably and naturally get asked:

- Why do these reviews often repeatedly find the same issues arising, review after review- why don't they just get them fixed once and for all?
- Do all of these reviews mean the system is completely broken?

2018-19 has seen the commencement, culmination or ongoing impact of key reviews. The WA Sustainable Health Review (SHR) Report was published in April 2019. Mental health was, importantly and correctly, given very significant priority in the SHR. The focus is on community, transparent public reporting, better integrated services and connected mental health/alcohol and drug care. The Department of Health working group following the Safety and Quality Review, led by Prof Hugo Mascie-Taylor in 2017, finished earlier in 2019. The Mental Health Clinical Governance Review, with the Panel chaired by Dr Martin Chapman, will likely have handed its report to the Minister for Mental Health by the time this Annual Report is published. In WA, it is not that long ago that Professor Bryant Stokes delivered his review into mental health in 2012. The Auditor General in WA has recently released Access to State Managed Adult Mental Health Services, with very salient recommendations.

Nationally, we have seen the ongoing focus from the Royal Commission into Institutional Child Sexual Abuse, and the commencement of the Royal Commission into Aged Care, driven by the important Oakden Report from South Australia, the latter relating specifically to mental health services. We await the report on mental health from the Productivity Commission. From other jurisdictions, we anticipate the inevitable significant recommendations from the Victorian Royal Commission into Mental Health.

Independent reviews are important, as they offer external objectivity, and a chance for a range of voices, particularly those who are often unheard, to be heard. It is also an absolutely essential part of a regular quality and safety loop to get robust feedback from sensible analyses of system performance. They offer a chance to reset.

What about the same issues being identified repeatedly within subsequent reviews - why do they keep reappearing? Many similar system problem issues appear in most jurisdictions around Australia. Similar issues are found in the United Kingdom, New Zealand, and around the world. This is the point of significant frustration for many. If it was simple, it would have been fixed by now, but there is no doubt we can do things smarter.

Is the system broken? This throwaway line is often used. The system is complex and complicated. It reflects the complexity of mental illness - and to think it can be easily simplified perhaps disrespects the individual in distress - **the person who, with their family, must always be at the centre of our attention.** However, the system at times is clumsy. The system certainly does not always put the person or their family at the centre - this is a constant challenge. Mental health is not mechanical, it is not purely transactional - it will frequently face issues of uncertainty in human interaction that cannot be reduced to simple treatment or care algorithms. The system is not always as kind as we believe it should be.

The system, within realistic resource limitations, does need to continue to adapt to best meet the current and future needs of the WA community. But the system is made up of thousands of dedicated and skilled staff - clinical and non-clinical, leaders and coal-face workers - who are changing thousands of lives for the better every day. This is an incredibly rich bedrock on which to continue to build better care. The system is not broken, but - as multiple reviews demonstrate- the system is clearly under stress.

There is a view proposed at times that “inexpensive community care” can replace “expensive hospital care”. This view is excessively simplistic and dangerous. Hospital beds, both acute and rehabilitation, and a range of community care are needed. Good community mental health care is a sensible balance between clinical and a range of psychosocial services. Providing adequate person-centred treatment and care in the community is not cheap. To meet expected standards of care, a recovery-focussed mental health service structure includes robust community acute and rehabilitation clinical services.

Useful ways forward? The development of a system-wide Mental Health Quality Improvement Program in WA would go a long way to ensuring that continuous improvement happens at scale and becomes part of the standard way of working. Restoring a strong clinical voice in the WA mental health system is an important challenge for the Clinical Governance Review.

It is a necessity and a pleasure to acknowledge the work of the staff in the Office of the Chief Psychiatrist (OCP). The OCP has a group of talented and vastly experienced individuals who are working here because they want to see the best mental health care provided to the people of WA. They understand the value and vision of the Chief Psychiatrist role. I believe this Annual Report will highlight the commitment and work ethic of the OCP Staff, and show the value of the role of the Chief Psychiatrist to the WA community.

I trust this Annual Report will provide the Minister, Parliament and the WA community an explicit and transparent understanding of the activities of the Chief Psychiatrist across 2018-19, and, going forward, the key issues critical to the standards of care within mental health services.



Dr Nathan Gibson
CHIEF PSYCHIATRIST

Executive summary

“The Chief Psychiatrist is an independent statutory officer who holds powers and duties as prescribed by the Mental Health Act 2014 (MHA 2014) reporting to Parliament through the Minister for Mental Health.”

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

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

While the Chief Psychiatrist does not run mental health services, he has a unique oversight perspective of the mental health system. This provides an important opportunity to understand both the system and the individual issues affecting the quality and safety of patient care, the wellbeing of the people working in the sector, and the problems in the interface with a range of other agencies.

The Chief Psychiatrist has a very clearly defined role within the mental health law- a regulatory oversight role. In addition, the Chief Psychiatrist plays an active role in negotiating directly with services to get good outcomes for patients and carers- this is done by working constructively with leaders and clinicians at the coalface to get good standards. It may superficially be seen that these two roles are in conflict with each other- both regulation and practical engagement. But engagement with and enhancement of clinical leadership have been shown to significantly improve patient outcomes. This duality in the Chief Psychiatrist’s role is critical for good outcomes in mental health for the people of Western Australia.

The majority of mental health service contacts work well for the individuals and families that use them. WA has highly-trained, skilled and professional mental health clinicians and caring support staff. Despite this, even with quality care, there may be bad outcomes in mental health settings. Care can and does go wrong at times. When there is a bad outcome, it can be devastating, not only for individuals but for families and we also see the broader ripple effect across communities.

Services have an important role to remediate when things go wrong, and to learn and develop their service in the light of bad outcomes. Dealing with complaints is a critical part of routine care.

Currently, the process for reviewing when things go wrong in health services is called a Root Cause Analysis (RCA). RCAs are designed to look for system problems and find better ways of working- they are not about finding or apportioning blame. The Chief Psychiatrist is finding that some RCAs done by mental health services are not taking a detailed look at the root causes of incidents, and so their value to service improvement appears to be variable, and at times low.

Notable Issues to Highlight

WA achieved the lowest seclusion rates in Australia in acute mental health units.

The release of the 2017-18 Australian Institute of Health and Welfare restraint and seclusion national data (the most recent comparative data available) showed that, in acute mental health units, WA had the lowest rate of seclusion (4.3 events per 1000 bed days), the lowest average seclusion duration (2.2 hours) and the second lowest restraint rate (5.1 events per 1000 bed days) in Australia. To make this clearer: one in 34 admissions to an acute mental health unit experienced seclusion.

Why is this critically important? Individuals who are admitted to mental health units have very high rates of prior (historical) personal trauma (physical, sexual, emotional). Restrictive practice such as seclusion and restraint, while seeking to keep a person safe, is inherently traumatising- we need to do everything possible to prevent further trauma while someone is in hospital. The framework for this is called Trauma-Informed Practice.

Reducing restrictive practice has been the high priority of the Chief Psychiatrist for several years. These current figures are a credit to the staff of the Office of the Chief Psychiatrist but are most attributable to the clinicians and staff at mental health services who have been committed to making hospitals safer and more therapeutic spaces.

Services must be vigilant. A warning: there is already evidence that the seclusion rates in WA for 2018-19 have shown increases in 2017-18, although these recent rates in WA have yet to be compared across Australia.

Sexual safety in mental health services must be a key focus

Historically, repeated research has shown that sexual harassment and incidents of sexual assault were not uncommon in mental health units across the world. Much has been done to make mental health units safer places, including in WA. In WA, the Chief Psychiatrist monitors allegations of sexual assault in mental health units. The Chief Psychiatrist has committed to developing Sexual Safety Guidelines for mental health units. These were to be released in the first half of 2019. They will now be released in the second half of 2019, to ensure appropriate further consultation with stakeholders. This will be an important document, and will place significant onus on mental health services to ensure sexual safety, particularly for female patients, but for patients of all genders.

Electroconvulsive Therapy (ECT) services Approved

All existing 10 ECT services were reassessed and met the standards for reapproval by the Chief Psychiatrist in November 2018. An additional service was also Approved, such that there are now 11 Approved ECT Services in WA. ECT remains an important and established treatment option, particularly for people with very severe depression.

Areas of Significant Focus

Forensic Mental Health Services are facing extremely significant challenges in Western Australia

The Inspector of Custodial Services reported in 2018 that ~60% of all MHA 2014 referral forms for prisoners in WA were never enacted, and ~30% of prisoners on these forms didn't get to a psychiatric hospital. Forensic mental health beds have been reduced in recent years. Forensic mental health services in WA are still actively deteriorating in the context that access to care and standards of mental health care for prisoners are not consistently being met.

Clinical acute and rehabilitation community mental health services are required to be a significant focus going forward

The Chief Psychiatrist is experiencing an ongoing escalation in local concern from clinicians, patients and carers regarding the capacity for clinical acute and rehabilitation community mental health services to meet standards of care. There are significantly increasing referrals to specialist clinical community mental health services.

Intellectual disability, autism and other neurodevelopmental disabilities interfacing with mental illness requires better coordination.

With the National Disability Insurance Scheme (NDIS) in an ongoing developmental phase, the Chief Psychiatrist has become aware there are individuals with complex co-occurring mental illness and intellectual disability/neurodevelopmental disability (such as autism) for whom care is becoming more fragmented. For standards to be improved, WA will need to work more specifically towards a coordinated process for this group.

Physical health care in mental health

High physical morbidity and early mortality rates for individuals with severe and enduring mental illness remains a national challenge.

Challenging behaviours and people with severe enduring mental illness and complex needs

Review processes by the Office of the Chief Psychiatrist have identified that the current systemic structure does not necessarily address well the needs of individuals with severe enduring mental illness and complex needs and challenging behaviours.

System Facilitation

In 2018-19, the Chief Psychiatrist played a significant role in directly facilitating positive outcomes for a range of patients where interagency or cross-sector coordination had broken down. The issue of clinical governance is the subject of review in WA by the Mental Health Clinical Governance Review.

Regular Activities of the Office of the Chief Psychiatrist

Active tracking of incidents, events; and reviews

The Monitoring Team at the Office of the Chief Psychiatrist have undertaken a large body of work in 2018-19. Not only has there been timely tracking of thousands of data submissions regarding MHA 2014 notifiable incidents (which are frequently explored further by the Chief Psychiatrist), but there has also been significant active follow-up in the context of other reporting aspects of the MHA 2014. The Chief Psychiatrist is now publicly reporting six-monthly seclusion and restraint data at a service level. The quality and consistency of the data received by the OCP has significantly improved, following the work by the Monitoring Team.

The North and East Metropolitan health Service Clinical Reviews were completed, and the development of a framework for Private Psychiatric Hostel reviews was begun. There were a number of other reviews undertaken, including within the private sector. The Chief Psychiatrist review into mental health services in Kalgoorlie, led, in conjunction with the Mental Health Advocacy Service review to significant changes to service delivery in the Goldfields.

Educating, advising and credentialing

The OCP trained and retrained 172 Authorised Mental Health Practitioners (AMHPs). Currently there are 490 AMHPs in WA. The Education Team facilitated 57 education sessions during 2018-19 covering critical area such as capacity, reducing smoking, Risk Assessment for AMHPs, Graduate nurse training , Mental State Examination for AMHPs, seclusion and restraint information session to nurses and also medical practitioners and information sessions on the MHA2014 for universities, private hospitals, GPs, mental health teams. For the reporting period 540 clinicians rang the Chief Psychiatrist's Clinicians' Helpdesk and were assisted with complex clinical, ethical and legislative interface questions. 12 informal service visits were undertaken to get feedback on standards of care from patients, carers and clinicians, in addition to the Chief Psychiatrist's Review Program.

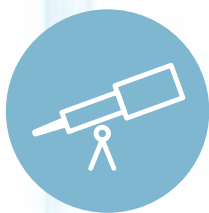
11 ECT services, as noted, were assessed and approved to conduct ECT. Updating the WA Chief Psychiatrist's ECT Guidelines is almost complete, as is the update of the Chief Psychiatrist's Authorised Hospital Standards.

Research and strategy

The Research and Strategy Team within the OCP have undertaken significant work during 2018-19: undertaking reviews, providing advice for the State Coroner, presenting on system design and improvement nationally, and providing advice to the Chief Psychiatrist. A key activity by the team was to push to increase the consistency and profile of quality improvement across mental health services in WA, as a key evidence-based strategy to improve care. The team commenced reviewing the homicides in 2018 that occurred in the context of alleged offenders who had been in contact with mental health services. The team's review into challenging behaviours and severe mental illness undertook significant consultation and reviewed best practice, and this important report will be completed in the second half of 2019.

Who we are

As leaders, we know that in supporting our workforce, shaping the culture of our Office, setting clear direction and in monitoring its progress, we can and must influence the quality of care provided to consumers and carers of mental health services.



Our Vision

‘Mental Health Care to the highest standard.’



Our Mission

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

Our Values



Leadership



Integrity



Respect

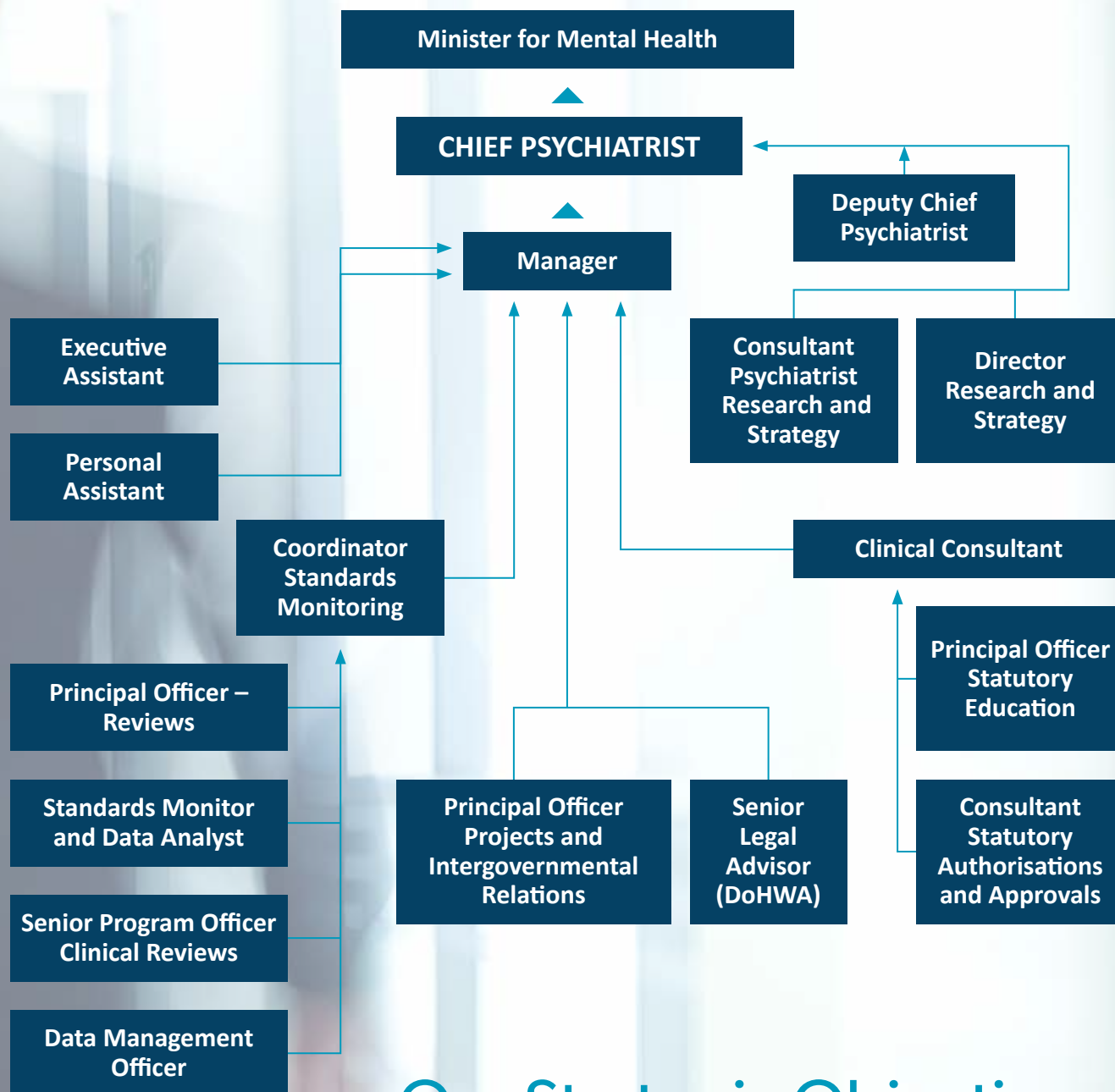


Accountability



Commitment

Our Organisational Structure



Our Strategic Objectives

- Striving for a culture of excellence in our workplace that reflects our values
- Building and enabling transformative leadership both internally and externally
- Build on our strong external partnerships

What helps us ensure high quality mental health care?

Safe, high quality mental health services protect the human rights of our consumers and lead to positive therapeutic outcomes to enable them to enjoy the highest standard of physical and mental health. Our drivers to ensure safe high quality mental health care are described below.

The Mental Health Act 2014

The Chief Psychiatrist plays a significant role in supporting clinicians in the interpretation and the appropriate application of the provisions of the Act. The ways in which we do this is expanded upon further in this report.

The Chief Psychiatrist has contributed to the ongoing development and refinement of a series of proposed amendments in collaboration with the Mental Health Commission who are *'the principal agency assisting the Minister for Mental Health in the administration of the Act.'*

The Charter of Mental Health Care Principles

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

The Charter of Mental Health Care Principles is rights-based, intended to influence the interconnected factors that guide the provision of care, and seeks to incorporate the six principles of recovery oriented mental health practice.

Any person performing a function under this Act must have regard to the principles and make every effort to comply with them.

The Chief Psychiatrist's Standards for Clinical Care

The *Mental Health Act 2014* requires the Chief Psychiatrist to be responsible for overseeing the treatment and care to a range of users of mental health services.

The Act requires the Chief Psychiatrist to discharge that responsibility by publishing a set of standards for the treatment and care provided to persons with a mental illness, as well as responsibility for overseeing compliance with those standards.

The National Standards for Mental Health Services

These Standards apply across the broad range of mental health services. The expectation that the Standards will be incorporated across mental health services formalises the intent of these standards.

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

The National Safety and Quality Health Service Standards

Developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC), in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers, the primary aim of the Standards are to protect the public from harm and to improve the quality of health service provision.

They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

As a member of the national Mental Health Reference Group for ACSQHC, the Chief Psychiatrist brings the national interface to WA.

Criminal Law (Mentally Impaired Accused) Act 1996

The Criminal Law (Mentally Impaired Accused) Act 1996, is an Act relating to the criminal proceedings that involve a person with a mental illness charged with an offence and for whose treatment and care the Chief Psychiatrist has oversight responsibility when they are detained at an authorised hospital.

Review of key attributes of high-performing person-centered healthcare organisations – Report from the Australian Commission on Safety and Quality in Health Care (2018)

This report identifies the key attributes of high-performing person-centered healthcare organisations and proposes a framework to guide health services towards better, person-centered care across a range of settings, systems and hospital types.

The Chief Psychiatrist is an avid advocate of person-centered mental health care and welcomes this report and its findings. The proposed framework has and will continue to influence the Chief Psychiatrist in taking a more person-centered approach to the discharge of his conferred statutory functions and in the broader aspects of his role.

Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (Dec 2017)

This review by Dr Murray Wright, Chief Psychiatrist of NSW, highlighted significant deficits in culture, and is an important reference for reducing trauma and restrictive practice in WA health (not just WA mental health) settings. Reducing trauma and restrictive practice is central to the work of the Chief Psychiatrist, and critical for achieving standards of care.

The Fifth National Mental Health and Suicide Prevention Plan

The Fifth National Mental Health and Suicide Prevention Plan was published in August 2017.

The Plan seeks to establish a national approach for collaborative government action to improve the provision of robustly integrated mental health and related services in Australia. The aim of the Plan is to improve the lives of people living with a mental illness, the lives of their families, carers and communities.

As the Deputy Chair of the national Safety and Quality Partnerships Standing Group, who are responsible for oversight of many of the safety and quality aspects of this Plan, the Chief Psychiatrist has a central role in influencing how the plan is progressed at jurisdictional level.

In his pursuit of safe, high quality care, the Chief Psychiatrist is informed by the five questions that the Care Quality Commission (UK) routinely ask all care services:

1 Are they? **SAFE?**

Consumers are protected from abuse and avoidable harm.

2 Are they? **EFFECTIVE?**

Consumer care, treatment and support achieves good outcomes, helps them maintain quality of life and is based on the best available evidence.

3 Are they? **CARING?**

Staff involve and treat consumers with compassion, kindness, dignity and respect.

4 Are they? **RESPONSIVE?**

Services are organized so that they meet consumer needs.

5 Are they? **WELL-LED?**

Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Our work

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

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

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

Office of the Chief Psychiatrist

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

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

Monitoring and Evaluation Role

Clinicians and service providers are, by statute, required to report to the Chief Psychiatrist on a range of notifiable incidents, including where there may be a negative outcome. They are also required to track certain processes and treatments (e.g. Electroconvulsive Therapy (ECT), segregation of children from adult inpatients, off-label prescribing to children who are involuntary patients, and emergency psychiatric treatment, among others). The Chief Psychiatrist is increasingly aware of the importance of data and its use in effective decision making for clinicians, and therefore advocates the necessity of establishing an ethical framework around data use and disclosure by his Office.

A Review System

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

From time to time the Chief Psychiatrist undertakes a Targeted Review into a particular individuals or groups of cases, under exceptional circumstances.

An Authorisation and Approval System

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

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

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

A Support System

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

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

Engaging constructively with clinicians around quality improvement is a critically important strategy, with quality assurance and regulation, in improving standards.

Expert Advice

Staff of the Office of the Chief Psychiatrist are often called on to provide a range of expert advice on policy initiatives, reports produced and their associated findings, assist in reviews conducted by other organisations or comment on proposed mental health sector related initiatives.

A Guiding System

Under the MHA 2014 the Chief psychiatrist has responsibility for publishing standards and guidelines for mental health services to assist them in the provision of high quality mental health care.

A Research and Strategy Role

For the latter part of this reporting period the Chief Psychiatrist welcomed two additional senior staff redeployed from the Department of Health WA to the Office of the Chief Psychiatrist. This has provided the Chief Psychiatrist with critical capacity to audit and conduct research on contemporary mental health standards issues and examine strategies for their translation into clinical practice.

An Inter-jurisdictional Role

The Chief Psychiatrist is well positioned to interface with agencies both intra and interstate on a number of safety and quality initiatives nationally.

This Office already reports on de-identified aggregate data and advises on a range of significantly important mental health initiatives at State and National level.

Our Support for staff in the Office

Secondments in and out of the Office

We are able to offer secondments to and from the Office and are supportive of our staff taking up secondment opportunities outside of our Office. We regard secondment opportunities as enhancing the skills and abilities of our people who go on secondment, and exposing and highlighting what we do, to build the capacity of people seconded into our Office.

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

Pressures and Demands

The public and parliament have a reasonable expectation that public sector agencies will manage demands efficiently; there are always more demands than resources.

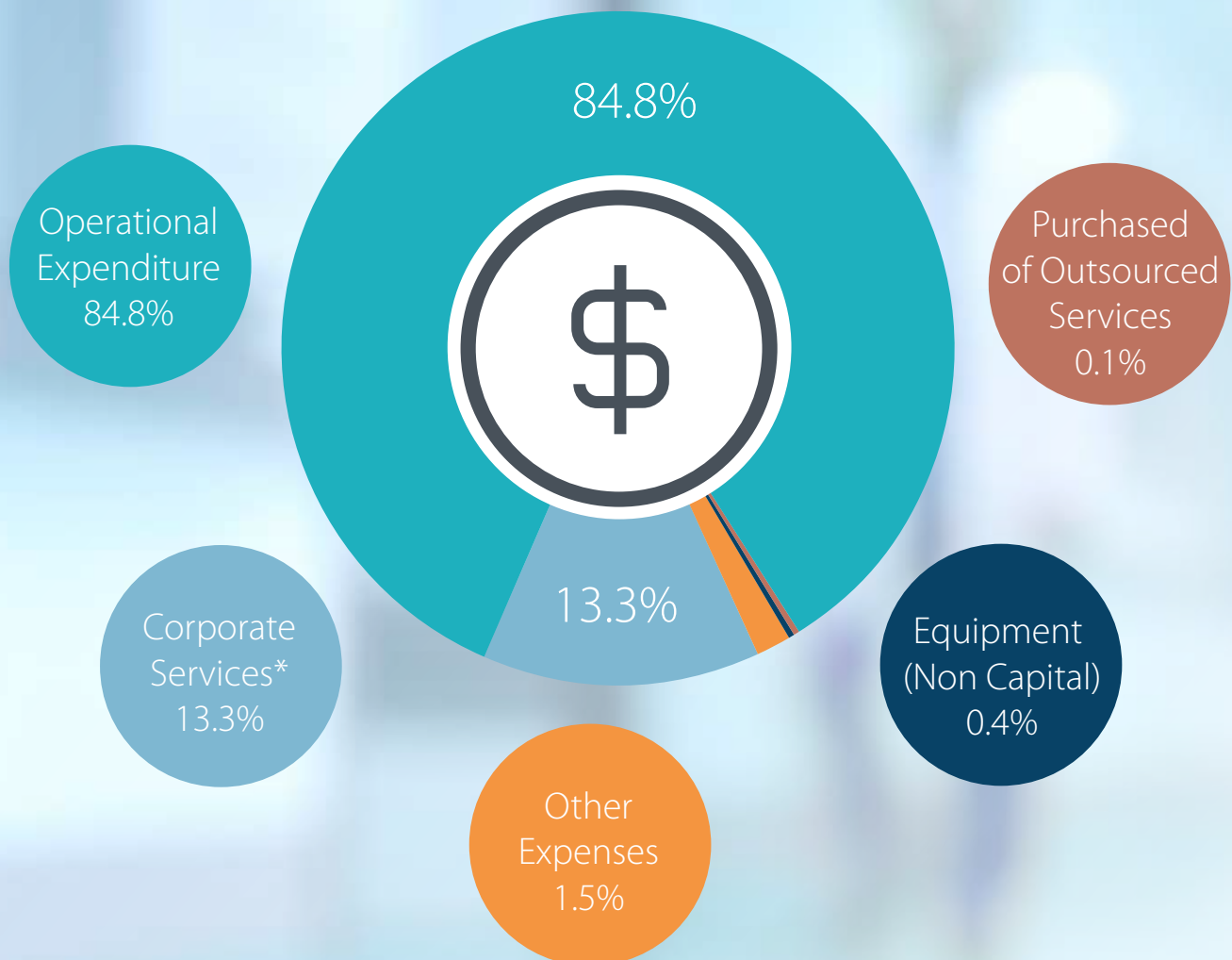
The proposed introduction of the Criminal Law (Mental Impairment) Bill 2019 during the 2019-20 financial year will significantly impact this Office.

The recommendations of the Mental Health Clinical Governance Review whilst unknown at the time of compiling this report, will out of necessity, have an impact on the functions of this Office in terms of providing more rigorous governance oversight for the mental health sector.

Professional Development

The Office has supported its staff in attending a range of professional development opportunities, both at a cost and on a cost neutral basis, to ensure we are abreast of contemporary practice in mental health treatment and care and as a means of enhancing our knowledge and skills. We have also taken the opportunity to showcase the work of this Office by presenting at various State and National conferences.

How we spend our money



*Corporate Services - provided by the Mental Health Commission as *Resources provided free of charge* by separate appropriation and not part of the overall OCP budget.

Our principal collaborators

We are constantly working towards our stakeholder engagement to facilitate their recognition of the duality of the role of the Chief Psychiatrist as both a partner and a statutory agent under the *Mental Health Act 2014*.



Our key strategic objective is to build on our strong external partnerships to facilitate safe, high quality mental health care. We do this through, valuing the voice and expertise of people with lived experience of mental illness and by more meaningful coproduction, co-design and participation at all levels of our work. We proactively engage with clinicians, service providers and community managed services to continuously improve within a statutory framework and to ensure our work adds value. We seek out opportunities to review and reaffirm our stakeholder relationships to assess effectiveness and determine areas for improvement.

Our contribution to statewide and national initiatives

Apart from the routine work of this Office;



State-wide - we have

Contributed

and provided advice to the *Department of Health Western Australia on the Mental Health Clinical Governance Review*

Continued

our commitment to the education of the participants in the State-wide Mental Health Graduate Program and Post Graduate Registrars in Psychiatry program

Participated

Participated in the consumer led initiative for a social media broadcast on *Australian Mental Health Recovery Principles*

Contributed

to the development of the Department of Health WA's strategy for the roll out of the MyHealth Record for Mental Health Service Providers

Provided

mental health expertise to reviews of prisons conducted by the Inspector of Custodial Services

Participated

and advised in the High Value Health Care Collaborative Workshop

Participated

in the WA Suicide Prevention Network Spring Forum

Participated

and provided expert advice to the Stimulant Assessment Panel in respect of stimulant prescribing

Participated

in the Australian Rotary Health WA Forum – *Lift the Lid: Young Minds Matter*

Participated

in the Australian Rotary Health WA Forum – *Lift the Lid: Young Minds Matter*

Continued

our membership and contribution to the Mental Health Network Executive Advisory Group through attendance at their regular meetings and forums

Presented

the keynote opening address at the *Body Image Awareness Week*, Eating Disorders Sector in WA

Participated

and advised on the WA Psychotropic Drug Committee



Advised

on the Department of Health WA's Child Death Review Stakeholder Discussion Group



Participated

and contributed to the Forum on Homelessness and Health



Continued

our participation and contribution to the WA Clinical Senate Quarterly meetings



Participated

and provided advice to the Western Australian Therapeutics Advisory Group (WATAG)



Participated

in the *Reform of the Criminal Law (Mentally Impaired Accused) Act 1996* in collaboration with the WA Department of Justice



Participated

and contributed to the Safety and Quality Leadership Reform Group at the Department of Health WA



Participated

in the seminar *Fostering Health Relationships with the Bench* at The Law Society of Western Australia



Submission

to the *Parliamentary Select Committee into alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community* and attendance at hearing to give evidence in support of submission



Participated

in the WA Suicide Prevention Network Spring Forum



Liaised

with the Office of the Auditor General on the *OAG's Mental Health Audit – Data Analysis*



Contributed

to the DoHWA's *Roundtable Voluntary Assisted Dying Legislation Consultation*



Actively

engaged with the *Royal Commission into Institutional Responses to Child Sexual Abuse: Independent Oversight Working Group* via the Department of Premier and Cabinet in respect of the roll out of the Child Safe Standards and associated reporting mechanisms.



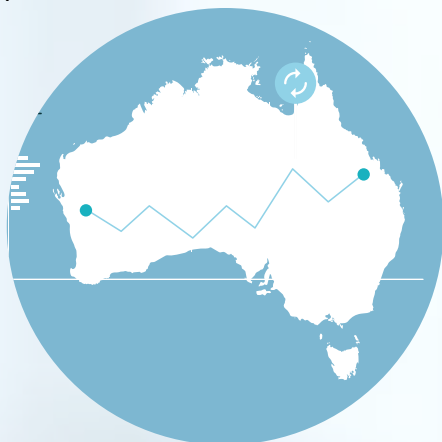
Submission

to the *Joint Standing Committee on the Commissioner for Children and Young People* and attendance at hearing to give evidence in support of submission



Our contribution to statewide and national initiatives

Apart from the routine work of this Office;



Nationally - we have

Consulted

on the *WA National Law Consultation Forum for Health Practitioner Regulation*

Continued

our participation and contribution to the National Health and Medical Research Council's Alcohol Working Committee

Consulted

frequently on Western Australian feedback to a range of initiatives for the Australian Health Ministers Advisory Council (AHMAC)

Chaired

National Restrictive Practice Sub-group (Under SQPSC)

Continued

our involvement and participation in the National Safety and Quality Partnerships Standing Committee (SQPSC), where the Chief Psychiatrist is the jurisdictional representative and Deputy Chair

Consulted

on and provided advice to representatives from the Commonwealth Department of Home Affairs and International Health and Medical Services staff on the application of the *Mental Health Act 2014* to detainees in Immigration Detention Centres in WA

Provided

advice on the *'Inter-Governmental Agreement (IGA) on Ratification and Implementation of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)* and met with the Commonwealth Ombudsman in respect of OPCAT monitoring in mental health inpatient units.

Consulted

and provided expert advice to the Australian Council on Healthcare Standards on the assessment requirements of WA's Public Mental Health Facilities that are accredited under the National Safety and Quality Health Service Standards

Chaired

The Chief Psychiatrist is the Chair – Committee for Examinations, for the Royal and New Zealand College of Psychiatrists

Participated

and contributed to the *Australian Human Rights Commissioner's: OPCAT Implementation Roundtable*

Our view of the Mental Health System for the next year

Guiding the Office of the Chief Psychiatrist forward in 2019-20

In his Foreword to this Report the Chief Psychiatrist has recognised the plethora of inter and intra State reviews and Royal Commissions and their relevance to the mental health sector here in WA.

The Chief Psychiatrist is the only independent agency with a governance and regulatory framework for the mental health Sector in WA. A pivotal focus for this Office in 2019-20 will be the findings and recommendations of the *Review of the Clinical Governance of Public Mental Health Services in Western Australia* and the potential impacts for this Office.

This Office has worked collaboratively with the Mental Health Commission, the Department of Justice and Department of Treasury in scoping the potential impacts of the introduction of the Criminal Law (Mental Impairment) Bill 2019 in respect of the Chief Psychiatrist's statutory responsibilities and will continue to monitor the progress of the Bill in its passage through Parliament.

The Chief Psychiatrist is also looking to establish a more rigorous process in respect of data stewardship and custodianship for all incoming and outgoing data in respect of this Office.

A Snapshot of Western Australia's Public and Private Mental Health Services

In Western Australia (WA), mental health services include public, private, and publically contracted private providers (PPP). The largest sector is the public mental health sector, which provides mental health services across both metropolitan and regional WA. Public mental health services are divided into five Health Service Providers (HSPs), of which four are responsible for services within the Perth metropolitan area. These include North Metropolitan Health Service (NMHS); South Metropolitan Health Service (SMHS); East Metropolitan Health Service (EMHS); and Child and Adolescent Health Services (CAHS). The fifth HSP is the WA Country Health Service (WACHS), which provides mental health services for adults, and children and adolescents across regional Western Australia. In addition, there are three publically contracted private providers (PPP) of mental health services in metropolitan Perth; the Joondalup Health Campus (Ramsay Health Care), the Ursula Frayne Unit, at St John of God Hospital, Mount Lawley and St John of God Midland Public Hospital and a number of private providers of mental health services. Patient activity data for these services are included in this section of the report.

Consumers of mental health services often transition from community mental health services to specialised mental health inpatient services¹ and during this period, their legal status may vary depending on how unwell they are, from voluntary to involuntary and from involuntary to voluntary mental health status. The Snapshot data were provided by data collection departments of the WA Department of Health, *Mental Health Information Data Collection* (MIND), the *Hospital Morbidity Data Collection* (HMDC), and the Emergency Department Data Collection (EDDC). Data sourced from these data collections are subject to data cleansing (for quality), data linkage and clinical coding processes which takes a few months. Therefore, data for the 2018-19 financial year were not available for all variables at the time of reporting so for some variables calendar year are reported (January – December 2018).

For the 2018 calendar year, 62,006 individuals received care from a specialised inpatient and/or community mental health service(s). The majority of these individuals were adults aged between 18 to 64 years (82%), 8% were children <18 years and 11% were 65 years of age or older. Fourteen percent of consumers accessed both specialised inpatient and community mental health services during the 2018 calendar year.



62,006 people received mental health care during the 2018 calendar year, for which the Chief Psychiatrist oversees standards of clinical care

1 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>

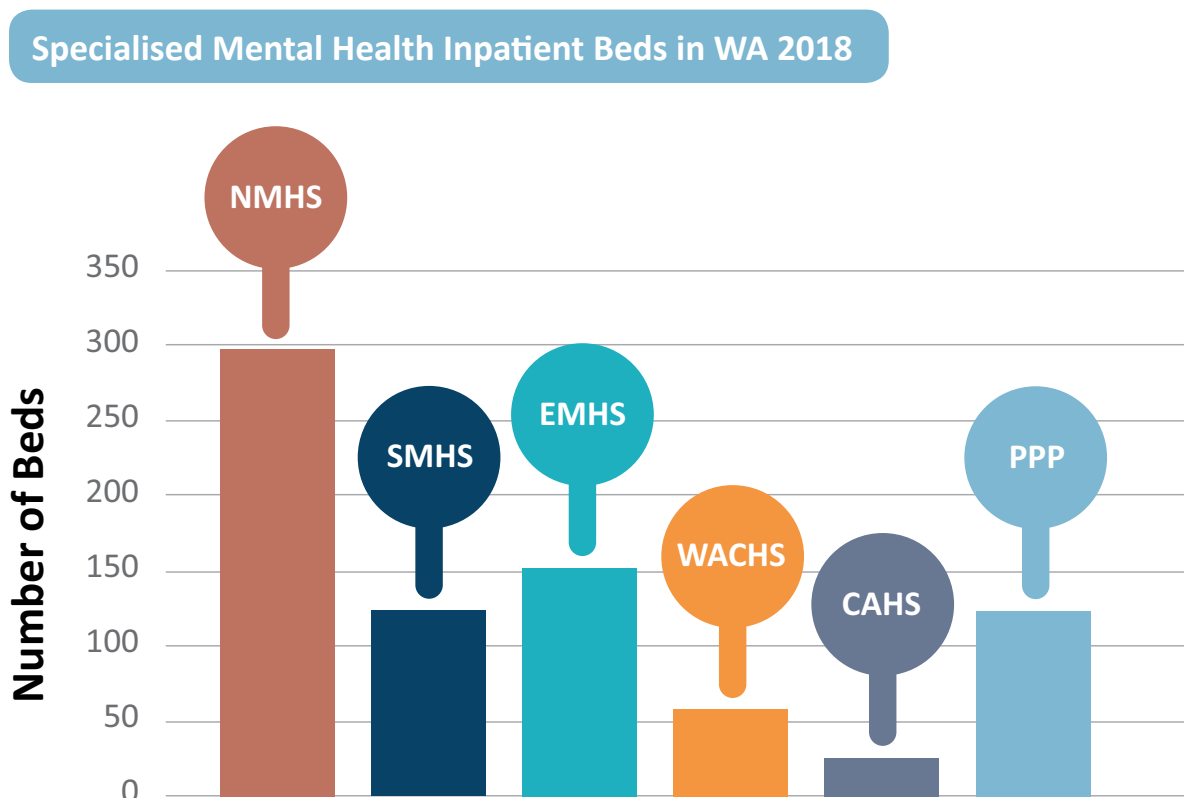
Inpatient Mental Health Services

There were 20,600 separations from public and private specialised mental health inpatient services involving 11,535 individuals in the 2018 calendar year. Of these, 8,609 individuals were treated as a public mental health patient² and 2,926 individuals treated as a private patient. Some consumers had more than one stay as an inpatient and overall, there were 14,722 mental health inpatient separations (discharges) from public and 5,878 from private specialised mental health inpatient services.

Inpatients in a public mental health service can have a mental health status of either voluntary or involuntary during their admission and some patients can have both a voluntary and involuntary status within one admission. There were 2,321 inpatients with an involuntary mental health status at some point during their admitted episode of care involving 3,297 separations.³

On average in 2018 there were 780 available specialised mental health inpatient beds, inclusive of Hospital in the Home (HITH) beds, which was a small (3%) increase from 2017. Inpatient bed data are only available for public and public private partnership mental health services. The highest proportion of mental health inpatient beds were located in NMHS (38%), with 20% located in EMHS with 16% in SMHS and 16% located in Public-Private Partnership hospitals (Figure 1).

Figure 1: Number of specialised mental health inpatient beds for Health Service Provider in Western Australia during the 2018 calendar year



*NMHS – North Metro Health Service; SMHS – South Metro Health Service; EMHS – East Metro Health Service; WACHS – WA Country Health Service; CAHS – Child and Adolescent Health Service; PPP – Public-Private Partnerships

Source: BedState, Department of Health WA Note: Beddays not provided for private hospitals Community Mental Health Services

2 Public mental health patient includes those admitted as public patients in PPP.

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

Community Mental Health Services

There were 61,838 voluntary patients treated by community mental health services who received a total of 963,850 service contacts with specialised community mental health clinicians in the 2018 calendar year. The majority (70%) of community mental health patients were aged 18-64 years, 20% were aged <18 years, and 10% were 65 years or older.

There were 679 patients on a Community Treatment Order, with a total of 850 Orders notified to the Mental Health Advocacy Service in the 2018-19 financial year.⁴ The majority of Community Treatment Orders (94%) involved adults aged 18 to 64 years of age, with 2% involving children <18 years and 4% related to adults aged 65 years or older. A Community Treatment Order is an order under the MHA 2014, which enables a patient to receive treatment as an involuntary patient in the community. Some patients may transition from a voluntary status to being on a Community Treatment Order (and vice versa) within a single community episode of care.

Emergency Department Mental Health Presentations

During the 2018-19 financial year, there were 61,520 mental health presentations to an Emergency Department (ED) during the reporting period, accounting for 5.7% of the total number of ED presentations (n=1,084,326).

The median length of a mental health presentation for an ED episode of care increased with age cohort from 118 minutes for children <18 years of age to 218 minutes for people 65 years of age and older. The majority of mental health presentations (56%) were discharged under their own care upon completion of the ED presentation, 18% of patients were admitted to an inpatient unit, 14% were admitted to an ED observation ward and 6% transferred to another hospital for admission (Table 1). A small proportion of patients (3%) did not wait to be examined by a medical officer and 3% left the ED at their own risk.



**In the 2018
calendar year**

61,838

**community
patients had**

963,850

**contacts with
specialised
community
mental health
services**

⁴ Community Treatment Order data are provided by the Mental Health Advocacy Service.

Table 1: Outcome for Emergency Department Mental Health Presentations 2018-19 Financial Year

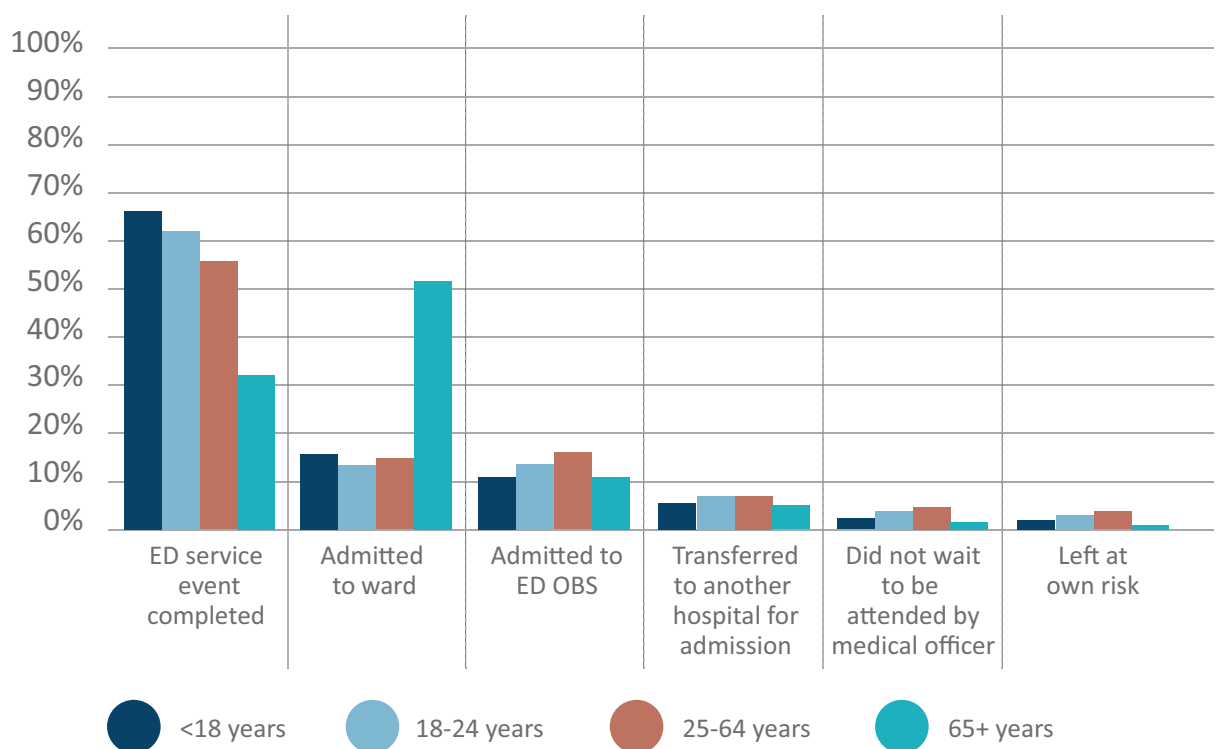
Outcome	Number	%
ED service event completed; departed under own care	34,117	56
Admitted to ward/other admitted patient unit	11,162	18
Admitted to ED Observation Ward	8,607	14
Transferred to another hospital for admission	3,789	6
Did not wait to be attended by medical officer	1,731	3
Left at own risk	1,746	3
Total	61,152	100

Table 1: ED episode end status for mental health presentations for 2018-19 financial year

Source: Emergency Department Data Collections

Figure 2: ED Mental Health Attendances Outcome by Age Group

ED Mental Health Attendances



*Refer to Table 1 for full description of Outcome

The outcome for mental health attendances to ED by age group is shown in Figure 2. The proportion of people discharged from ED was highest for children <18 years of age (66%) with the percentage decreasing with increasing age with around one-third (34%) of people 65 years and older being discharged from ED. In contrast, half (50%) of people aged 65 years and older were admitted to hospital compared with around 13% to 15% of people in the 18 to 64 year age group categories. There was little variation in the proportion of people admitted to an ED observation ward, ranging from 11% for each of the youngest (<18 year olds) and oldest (65+ years) cohorts with the highest being highest being 13% for 18-24 year olds and 16% for people aged 25-64 years.

Areas of significant focus relating to standards of clinical care

During the course of the year a number of important issues relating to standards of clinical care have become evident on the basis of our clinical reviews, site visits, notifiable incidents and contacts with services, consumers, families and carers. This is not an exhaustive list of the challenges facing mental health service delivery across the state - longstanding issues around rural and remote healthcare, suicide, Aboriginal health and wellbeing are but a handful of the established issues in strong focus at a state level- but this section reflects prominent, contemporary, and in some cases escalating issues presenting to the Chief Psychiatrist, which have important impact on standards of mental health care in WA. It is important to consider this section in the context of the broad mental health system in WA, which is generally of high standard, and the improvements that have occurred.

Significant improvements

As a context, there have been many excellent service improvements across 2018-19 that will positively impact standards of clinical care, including the development of an updated mental health patient flow policy and framework, the expansion of alcohol and other drug services, the opening of community beds, the development of multiple mental health observation areas near emergency departments, planning for new mental health inpatient services both metropolitan and regional, telehealth expansion, significant mental health improvements at Kalgoorlie Regional Hospital, and the increased training focus on personality disorders, among others.

It is relevant to note the quality improvement activities that run within health services, and the background of the sheer quantity of mental health service provision that occurs across WA.

The redrafting of the Criminal Law Mentally Impaired Bill is a much-awaited improvement

in mental health rights for a vulnerable group. The Sustainable Health Review prioritised mental health and has presented extensive recommendations, which are being enacted by WA Health and the Mental Health Commission. The Clinical Governance Review is seeking to improve governance in mental health.

The areas the Chief Psychiatrist has identified as needing specific forward focus are outlined below.

Forensic Mental Health Services

The Inspector of Custodial Services reported in November 2018 that ~60% of all MHA 2014 referral forms for prisoners in WA were never enacted, and ~30% of prisoners on these forms didn't get to a psychiatric hospital for timely care: these are individuals with the most severe mental illnesses not getting access to care. Ongoing figures (in 2019) since that 2018 report identify access for prisoners to forensic mental health beds at the Frankland Centre continues to reduce further. The Chief Psychiatrist is responsible for prisoners referred under the MHA 2014, but not responsible for the mental health of prisoners more broadly. The Chief Psychiatrist has received multiple and ongoing reports of severely psychotic prisoners being managed in isolation cells due to lack of access to hospital facilities. Forensic mental health beds in WA have been reduced in actual number in recent years, with women and youth remaining specifically disadvantaged groups.

The significant collaborative work done by WA Health, the Department of Justice and the Mental Health Commission in this space to remediate these issues is acknowledged. Notwithstanding this and skilled staff, forensic mental health service provision in WA is still deteriorating in the context that access to care and standards of mental health care for prisoners are not consistently being met.

Specialist clinical acute and rehabilitation community mental health services

The Chief Psychiatrist is experiencing an ongoing escalation in local concern from clinicians, patients and carers regarding the capacity for clinical acute and rehabilitation community mental health services to meet standards of care. The Productivity Commission's RoGS 2019 data shows significant increases in new admissions to all Mental Health Services over recent years, but the granularity does not capture the significant increases in referrals to specialist clinical acute and rehabilitation community mental health services in WA, nor how many referrals are declined or diverted to primary care. The Auditor General's Report showed that between 2013 and 2017 there was a 17% increase in the number of people accessing mental health community services but a 6% decrease in the total number of hours of care provided. In recent years in WA there has been significant, important and effective investment in community mental health resources primarily for support, social integration and accommodation, but less system development of specialist clinical acute and rehabilitation community mental health services.

Data from clinical acute and rehabilitation community mental health services over recent years has shown significant increases in referrals, significant increases in admission to community clinics, and significant increases in the numbers of individuals not admitted but diverted to other services .

Notwithstanding the clear dedication of clinical staff, the Chief Psychiatrist has noted that specialist clinical acute and rehabilitation community mental health services have not been consistently increased or remodelled to care for the increasing numbers of referrals. This is the business of the Chief Psychiatrist as it is having an impact on standards of care. This issue requires a clearer systemic planning response.

Intellectual disability, autism and other neurodevelopmental disabilities interfacing with mental illness

Reports to the Chief Psychiatrist of fragmented care for individuals with intellectual disability or autism and co-occurring mental illness are relatively common. Work done in New South Wales has identified that although individuals with intellectual disability make up approximately 1% of the population, they utilise approximately 12% of mental health costs- thus, approximately 1/8 of the mental health budget in NSW is potentially required to provide service for individuals with intellectual disability. It is reasonable to consider that many other Australian jurisdictions would reflect the NSW experience. This highlights the significance (and, notably, the well-known higher rates) of mental health issues for this particular cohort and the complexity of the interface. The National Disability Insurance Scheme (NDIS) is a useful and contemporary approach. But with the advent of the NDIS changes, the Chief Psychiatrist has become aware there are individuals with complex co-occurring mental illness and intellectual disability/ neurodevelopmental disability (such as autism) for whom care is becoming more fragmented at this point in the NDIS development.

Currently in WA there is no specialised clinical coordinating structure for individuals with co-occurring intellectual disability or neurodevelopmental disabilities and mental illness- current mental health service structure often does not address the needs of this group. For standards to be improved, WA will need to work more specifically towards a coordinated process for this group.

Physical health care in mental health

High levels of physical illness and early death rates for individuals with severe and enduring mental illness due to cardiovascular and other diseases remains a national challenge, and a national focus under the 5th National Mental Health and Suicide Prevention Plan. The Chief Psychiatrist has tracked physical monitoring

in clinical reviews across services in WA, and supported the development of increased public awareness of physical health issues through strategies such as the use of the M3Q patient-driven medication questionnaire. Use of high dose and polypharmacy (multidrug) medication prescribing has remained a key safety and quality focus for the Chief Psychiatrist as Chair of the WA Psychotropic Drug Committee, and a statewide antipsychotic prescribing audit is currently underway.

The issue of the physical health/mental health interface will require greater integration particularly with primary care- with integration as a key mental health recommendation in the Sustainable Health Review.

Challenging behaviour and severe, enduring mental illness with complex needs

Recent review processes by the Office of the Chief Psychiatrist have identified that the current clinical models and structures in mental health services do not necessarily address well the needs of individuals with severe, enduring mental illness (particularly psychoses interfacing with substance abuse) and complex needs with challenging behaviours, who may fall into the justice system. It is foreseeable that the majority of specialist clinical mental health services will have a small but significant cohort of these individuals. This group are over-represented in those that have poor outcomes in mental health. This is not an easy issue but remains a key responsibility, primarily for mental health services, but through interface with alcohol and drug services and other sectors.

There has been recent important hospital-based as well as specific alcohol and other drug service developments, but there requires a focus explicitly on mental health service modelling and development for this cohort.

System facilitation and care coordination

The Auditor General identified that the Department of Health and the Mental Health

Commission need to use data more effectively together to manage service delivery and reform. Equally, the Department of Health and the Health Service Providers need to do more to operationally coordinate the care of complex individuals who use multiple services- currently the Chief Psychiatrist is frequently being asked by patients, families and clinicians to coordinate care where services have withdrawn or provided inadequate care, or have not shown capacity to work collaboratively with other services.

In 2018-19, the Chief Psychiatrist played a significant role in directly facilitating positive clinical outcomes for a range of patients where intra-agency, interagency or cross-sector coordination had broken down. This is an important systemic function in a complex and complicated system. It is a core function for the Chief Psychiatrist to alert services to issues of concern; however this significant level of direct service delivery coordination is not ordinarily the role of a separate, independent oversight agency- it must operationally be the responsibility for the service providers or system manager to ensure coordination of care. Coordination of care is a basic clinical and health service function- note that health services mostly do provide this coordination, but there remain significant gaps.

Notwithstanding the issue of a patient or carer's relevant personal responsibility and self-agency: where patients use multiple services, or whose presentations are complex, where diagnoses are unclear or disputed among practitioners, where service roles may be blurred, where ideal service models may not be yet available, or where there is no current established pathway for joined-up care, or where patients are clearly and repeatedly falling through the gaps, health services have a responsibility to proactively engage other agencies and facilitate coordination of care until an appropriate outcome is achieved- the patient and carer must be at the centre of care. The issue of clinical governance is the subject of review in WA by the Mental Health Clinical Governance Review Panel.

Our activities



Clinical, Statutory Authorisations and Education Program

The delivery of safe high quality mental health care throughout Western Australia continues to drive the work of the Clinical, Statutory Education and Authorisation Team (CSEAT).

CSEAT comprises of a Clinical Consultant, Principal Officer - Statutory Education and the Consultant - Statutory Authorisations and Approvals. These three arms of CSEAT work cohesively and collaboratively to promote safe quality mental health care.

CSEAT's focus is to improve the safety and quality of mental health care delivered throughout Western Australia by:

- Providing clinical support and engagement across the State
- Providing education and training on the MHA 2014 and the functions of the Chief Psychiatrist
- Authorising and approving mental health related services in line with the statutory requirements of the MHA 2014
- Listening to and working with consumers and personal support persons regarding issues of mental health care

In 2018-2019, CSEAT achieved the following:

- In partnership with consumers, carers/personal support persons and clinicians at the coal face reviewed and approved Western Australia's mental health services for the performance of Electroconvulsive Therapy.
- Developed a process to ensure that the Chief Psychiatrist's Authorised Mental Health Practitioners (AMHPs) Education Operational and Delivery Plan meets relevant standards, takes a more person centred approach and conforms with the principles for contemporary mental health care.
- Revised and value added to the Competency Assessments for AMHP training.
- Commenced the development of a *Inpatient Treatment and Care and MHA 2014* Train the Trainer education program for clinicians working in inpatient mental health services
- Developed and introduced Mental State Examination (MSE) and Risk Assessment courses for AMHPs.
- Introduced podcasts to the suite of Chief Psychiatrist's online training resources
- Worked collaboratively with the Mental Health Commission to streamline the process of gazettal for prescribed psychiatrists.
- Proactively engaged with external stakeholders and hosted a range of events with local guest presenters about issues of importance to the mental health sector.
- At the invitation of the Inspector of Custodial Services, participated in a review of a prison inspection providing mental health clinical expertise.
- Promoted and advocated for the importance of the role of the peer support workers to health service executives.

- Used information obtained through the Clinical Helpdesk as an active feedback loop to drive education and training content.

The review of the Chief Psychiatrist's Standards for Authorisation of Hospitals and the Standards and Guidelines for Electroconvulsive Therapy is almost complete and will be published in the next reporting period.

Listening to and working with Consumers and Personal Support Persons

In keeping with our Strategic Objective of 'valuing the voice and expertise of people with lived experience' the Chief Psychiatrist proactively engages with consumers and personal support persons when visiting mental health services. Listening to and acting on issues raised by consumers and personal support persons is crucial to the development and maintenance of safe high quality mental health care.

Consumers and personal support persons also contact our Office for a variety of reasons but primarily to either ask for advice about their rights under the MHA 2014 or to raise concerns about the delivery of mental health treatment and care. It is important that issues raised are dealt with in a timely manner and callers are provided with advice on their rights and/or on the process for lodging a complaint with the treating service in the first instance or to the Health and Disability Services Complaints Office (HaDSCO).

For this reporting period, CSEAT engaged with and assisted 93 consumers and personal support persons. The calls were primarily seeking advice or intervention by the Office of the Chief Psychiatrist. Of that number, consumers relied on the expertise of this Office on 45 occasions, personal support persons on 39 occasions and either a member of the community or carer advocate on 9 occasions in the reporting period.

Figure 3: Patient and Personal Support Person calls

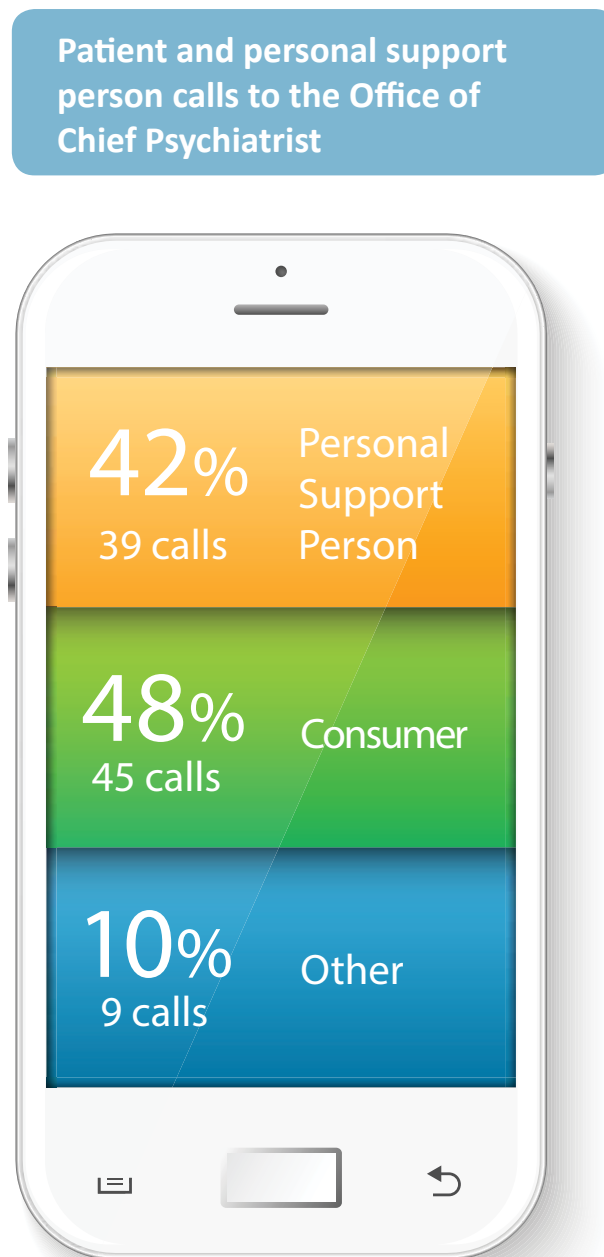


Table 2: How we manage calls to our service

Management of consumer and personal support person contacts

Number	32	3	3	33
Action taken by OCP	Referred to the Mental Health Service providing treatment and care	Referred to the Mental Health Advocacy Service	Referred to the Health and Disability Service Complaints Office	Referred to multiple agencies

Number	4	3	14	1
Action taken by OCP	Department of Health	General Practitioner	Other action taken	Not Specified

Chief Psychiatrists Visits

For the reporting period the Chief Psychiatrist visited ten mental health services and two residential services to meet with staff, consumers and personal support persons. These visits are part of the Chief Psychiatrist's strategic intent to engage proactively with clinicians, consumers, carers and service providers to ensure our work adds value and a forum for people to raise questions and issues around standards of care.

Table 3: Chief Psychiatrist Visits to Mental Health Services

Authorised Units	Community Mental Health Services	Residential Services
1. Leschen Unit, Armadale Hospital	1. Peel Mental Health	1. Albany Halfway House
2. East Metropolitan Youth Unit, Bentley Hospital	2. Lower West Adult Community Mental Health Services	2. Drug and Alcohol Youth Service
3. MHU, Kalgoorlie Hospital	3. Osborne Park Adult Mental Health Service	
4. Mill Street Centre, Bentley Hospital		
5. Mimidi Park, Rockingham General Hospital		
6. Ward 5A, Perth Children's Hospital		
7. Ursula Frayne Unit, St John of God Mount Lawley		

Site visits were well received and overall the feedback from consumers was complimentary of the care and treatment they received. They spoke highly of staff, were happy with the interactions they had and felt they were genuinely invested in supporting their recovery. One was particularly complimentary about the respect of personal space from staff:

‘Staff ask before they come in my room – this is respectful’

Consumers were also appreciative when community case managers were able to in-reach into the mental health units to maintain continuity of care for when they are discharged back home.

‘My case manager visits, allows me to continue my program whilst here’

Across services a range of topics were raised during these site visits by consumers, personal support persons and staff. Some common themes were:

- Peer support workforce has not yet been embedded in all mental health services.
- The challenges for consumers in navigating the National Disability Insurance Scheme process.
- Services displaying posters about the Chief Psychiatrist’s Standards for Clinical Care would raise awareness and accountability.
- Carers advocated for more care between discharge from inpatient units and the commencement of support services.
- A need for greater involvement of families and carers in the development of discharge plans from inpatient mental health services.
- Challenges of obtaining and maintaining an appropriate nursing staff skill mix on inpatient units.
- Safety of staff when nursing forensic patients on non-forensic units, where the environment is not conducive to the type of care such high-risk patients require.
- Difficulties with access to inpatient beds due to severe shortages, resulting in long delays in waiting times for patients in Emergency Department and other settings.
- Challenges with complying with the MHA 2014 timeframe requirements for providing a report to the Mental Health Tribunal for involuntarily detained children and adolescents.
- Long term needs of patients who present with co-morbid addiction to illicit substances, intellectuality disability and a forensic history.

The above concerns were conveyed to the relevant health service executives and assisted by:

- Securing funding for the purchase of resources for a comfort room, sound proofing and lighting.
- Greater access for staff training in restrictive practices
- Highlighting the need for greater collaboration and understanding between agencies involved in providing care to consumers.

Clinical Support and Engagement

The Chief Psychiatrist acknowledges that clinicians are responsible for the delivery of safe, high quality mental health care to consumers throughout Western Australia.

He also acknowledges the invaluable role of mental health clinicians and sees them as the drivers of positive workplace culture, systemic change and experts in their chosen field.

The clinical expertise of the CSEAT enables us to support clinicians to deliver and maintain safe quality mental health treatment and care through:

- Providing a clinical helpdesk that is a resource for clinicians across the mental health sector and responds to phone or email enquiries
- Providing information and advice on the application of the provisions of the *Mental Health Act 2014* in a clinical setting
- Authorising and approving mental health services in line with the *Mental Health Act 2014* requirements including:
 - The training, gazetting and monitoring of Authorised Mental Health Practitioners (AMHPs)
 - Authorisation of hospitals to receive and detain persons requiring mental health inpatient treatment and care
 - Approving mental health services to perform Electroconvulsive Therapy (ECT)
 - Prescribing psychiatrists to enable them to apply the provisions of the *Mental Health Act 2014*
 - Facilitating further opinions for consumers seeking an independent view of their treatment and care
- Providing education and training relevant to the functions of this Office

Clinical Helpdesk

The Clinical Helpdesk has a unique role within the mental health sector, supporting clinicians via phone or email which enables clinicians to seek assistance in:

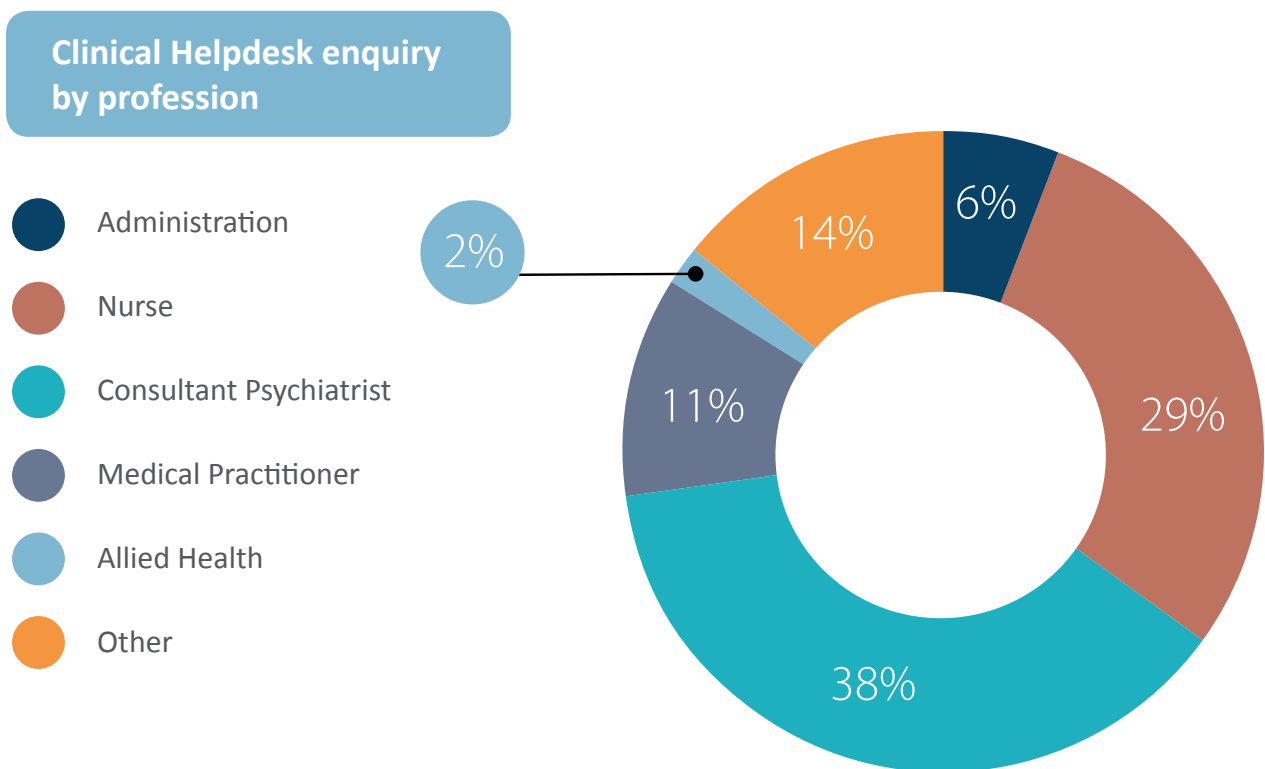
- Understanding and applying the provisions of the *Mental Health Act 2014* to the specific clinical situation they are managing
- Obtaining advice across a range of complex clinical and ethical treatment and care dilemmas.

Clinical Helpdesk Calls

The number of calls to the clinical helpdesk is consistent with the last reporting period and averaged 45 contacts per month. The majority continue to be seeking advice on the practical application of the MHA 2014, especially for clinicians new to WA. However, callers are also seeking an interpretation of the application of the provisions of the MHA 2014 in complex clinical and ethical situations, as the acuity and complexity of people who present with a mental illness increases. Such queries are reliant on a sound legal interpretation of the intent of the law, and highlights the need for this Office to have urgent and immediate access to its own legal counsel.

The majority of contacts to the Clinical Helpdesk continue to be from Consultant Psychiatrists and mental health nurses for this reporting period which is consistent with the responses to the Helpdesk survey.

Figure 4: Clinical Helpdesk Enquiries – Professional Breakdown



The vast majority of calls to the Helpdesk were regarding various aspects of Community Treatment Orders (approximately 30% of all calls). Other enquiries were many and varied. Some of the more common ones included:

- Referral Orders
- Transport Orders
- Inpatient Treatment Orders
- Consent
- Capacity
- Grant of leave
- Apprehension and Return Orders
- Emergency ECT

Enquires to the helpdesk continue to inform CSEAT and assist in the development of new education and training programs offered.

A recently conducted survey of clinicians and health workers who contacted the clinical helpdesk for this reporting period found:

- the helpdesk easy or very easy to contact
- preferred to phone the helpdesk rather than email
- the clinicians staffing the helpdesk approachable
- advice was provided timely in a timely manner
- the advice provided was of high quality

All respondents indicated they would use the helpdesk again and the survey findings are provided on the next page.

Chief Psychiatrist Clinical Helpdesk 2018/19 survey results

The majority of clinicians who contacted the Helpdesk were nursing staff and consultant psychiatrists indicating staff commitment to ensuring that they are providing quality care whilst remaining compliant with the legislative framework of the MHA 2014.

The Helpdesk was utilised predominantly by clinicians working in the major Health Service Providers from across the State.

Figure 5: Professional disciplines of those responding to the survey

Please indicate your current profession

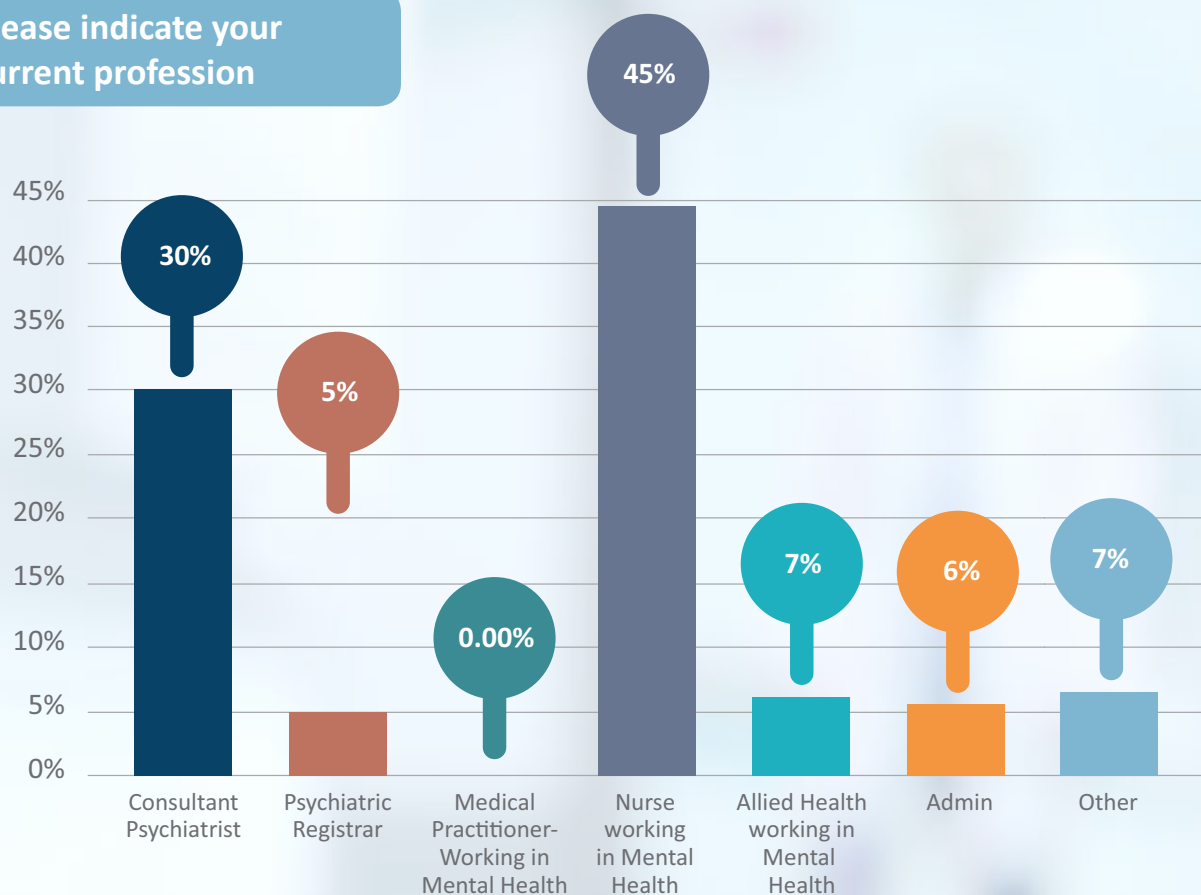
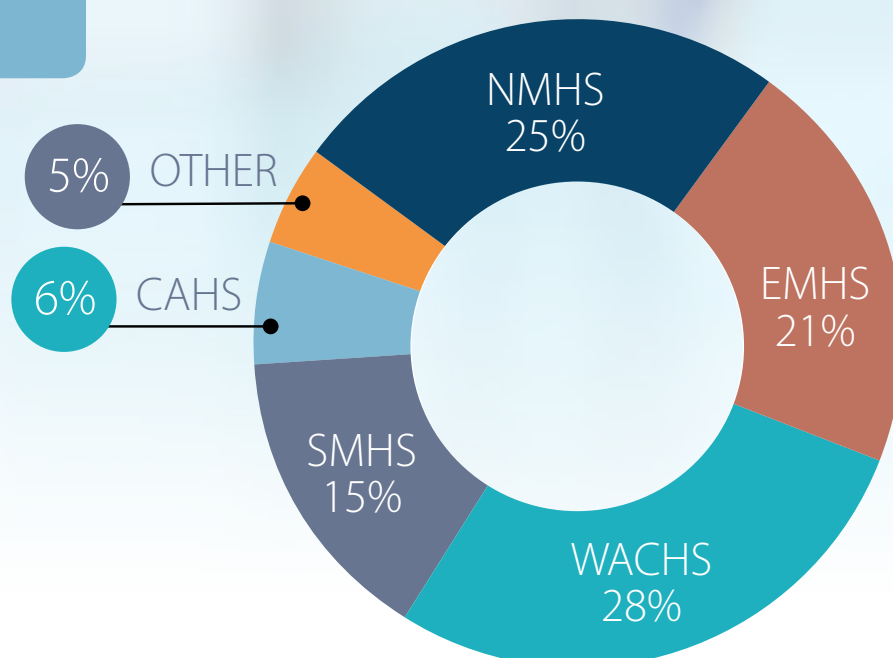


Figure 6: Location across the State of respondents to the survey

Which service do you work for?



CAHS: Child and Adolescent Health Service,
NMHS: North Metropolitan Health Services,
SMHS: South Metropolitan Health Services,
WACHS: WA Country Health Service, EMHS:
East Metropolitan Health Service

Figure 7: Respondents'Contact with the Clinical Helpdesk

The majority of survey respondents contacted the Helpdesk 2 – 5 times during the last year.

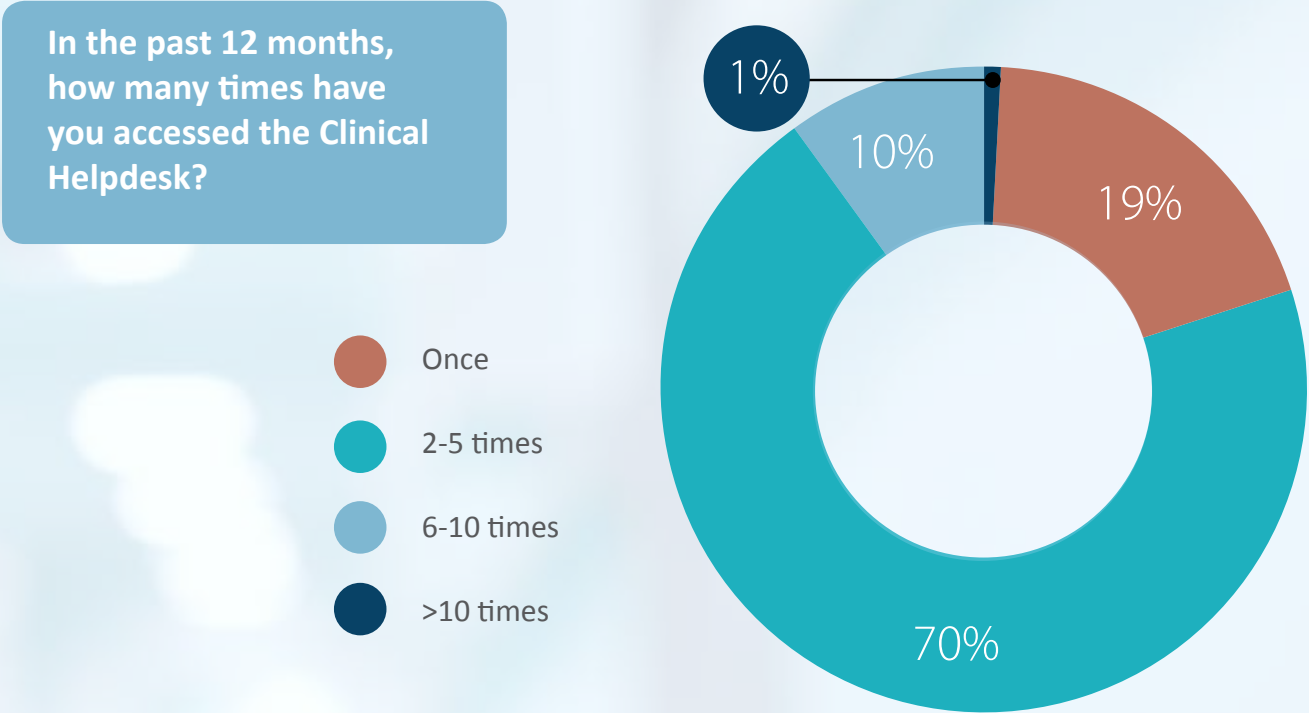


Figure 8: Clinical Helpdesk Responsiveness

The Helpdesk response time indicated an 8% improvement compared to last year.

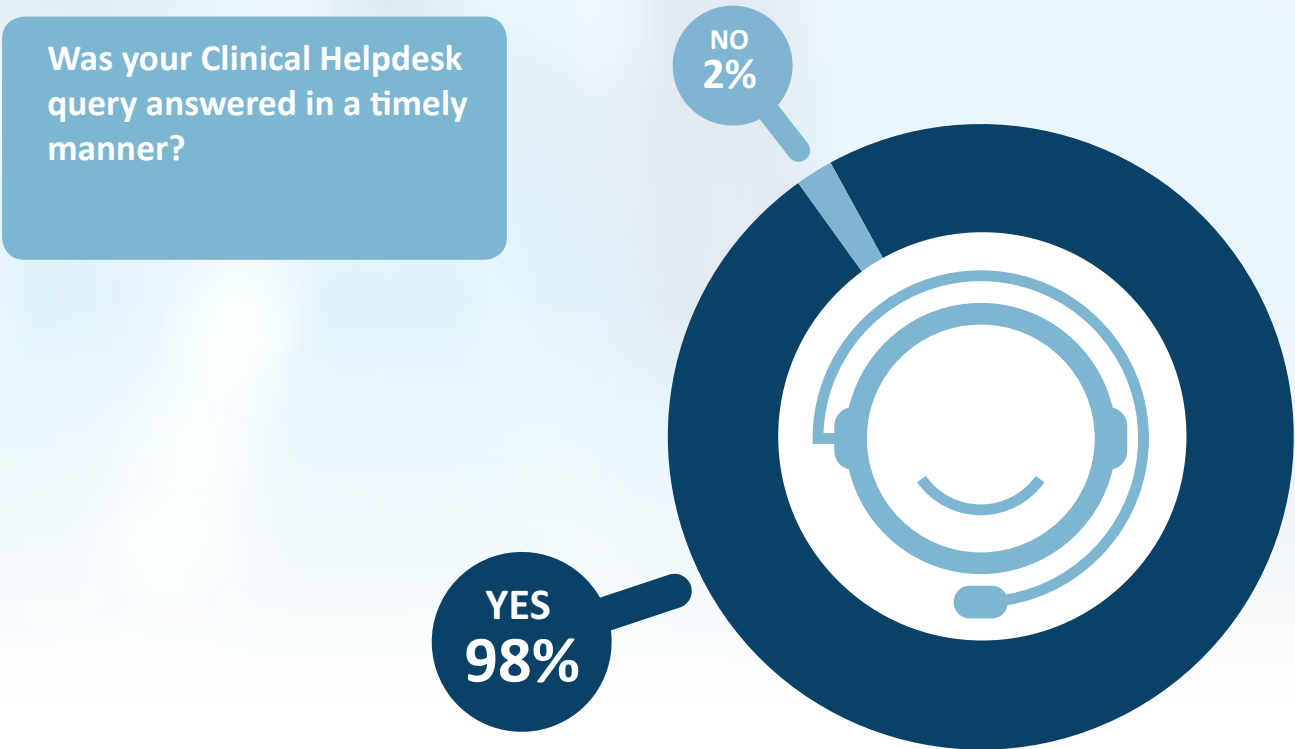


Figure 9: Clinical Helpdesk Helpfulness

97% of respondents found both the advice provided to be helpful or very helpful and the Helpdesk clinician to be approachable or very approachable.

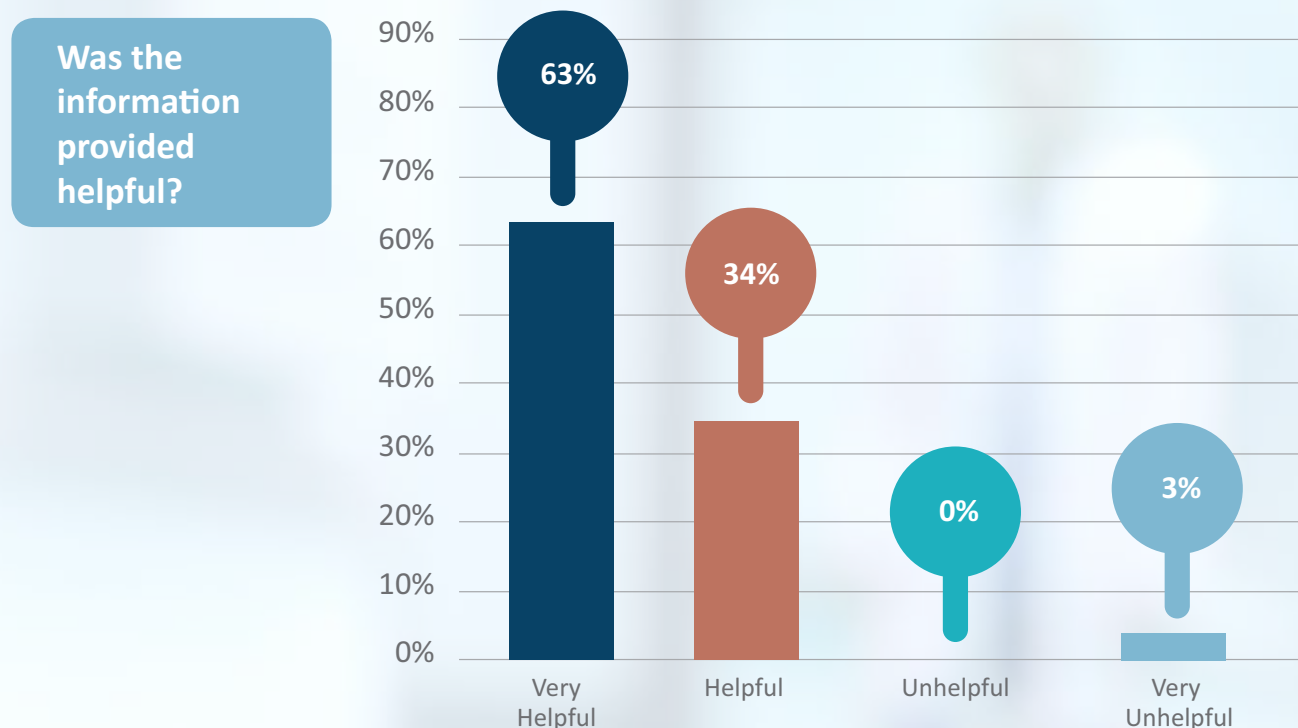
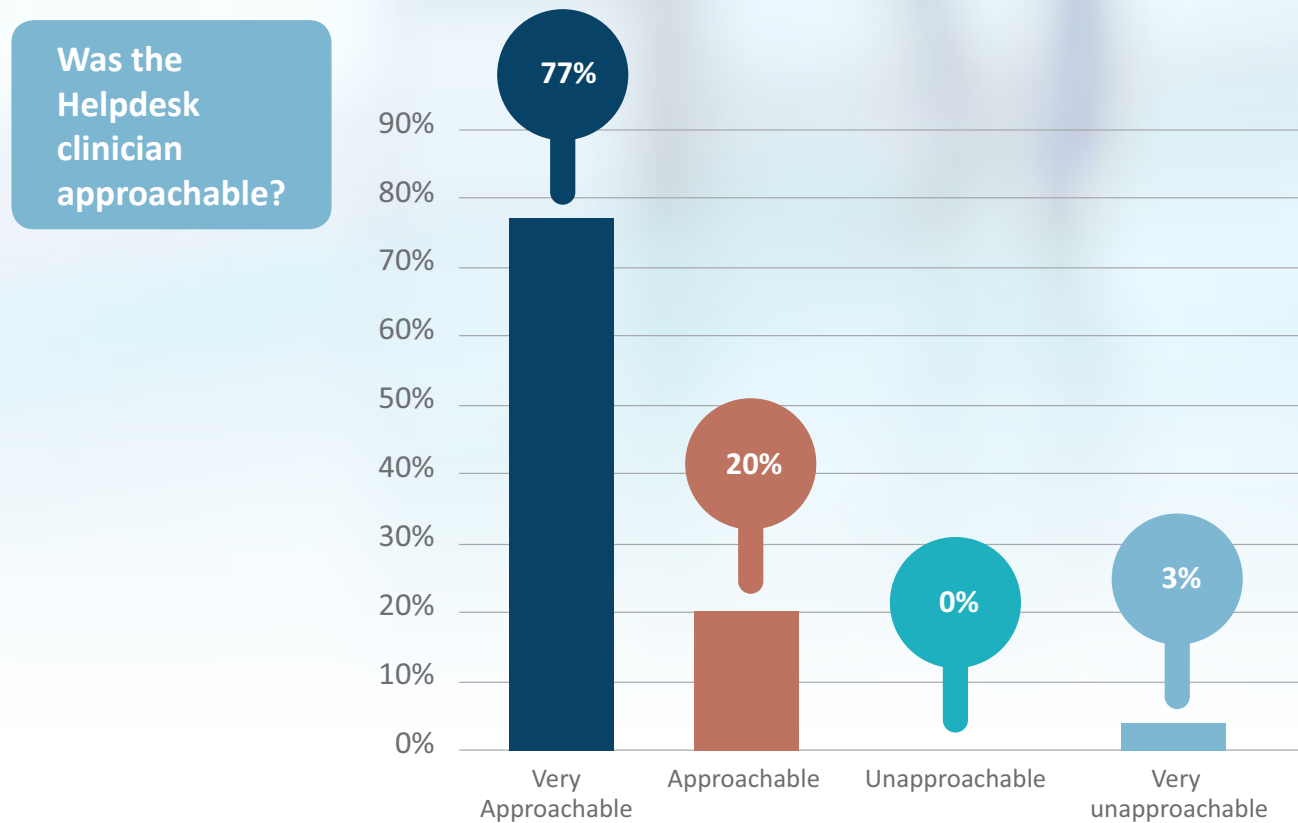


Figure 10: Clinical Helpdesk Approachability



Some quotes from survey respondents included:

"An excellent resource and support for complex patients"

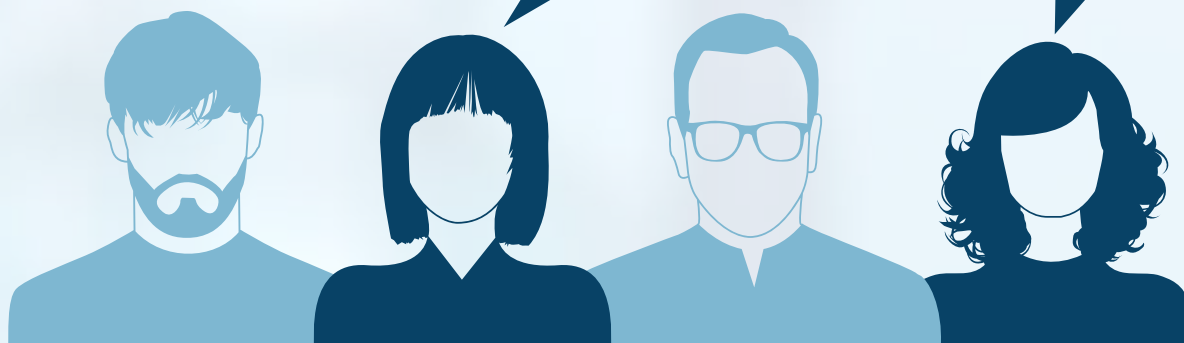
"Great resource, very helpful staff who call you back if they need to clarify options"

"It is very helpful to be able to clarify issues of the law that are so important but can be tricky in their application in the field. Very reassuring to be able to get quality advice"

"The clinical helpdesk has consistently helped resolve MHA 2014 issues in a timely manner. This is especially helpful working in a remote area"

"Have called the helpdesk when in acute care setting and information provided was clear and concise"

"The Helpdesk is essential as sometimes the Act can be complex and requires specialist support"



Statutory Authorisations and Approvals

The Chief Psychiatrist discharges his statutory responsibility for mental health treatment and care through the development, publication and monitoring of standards for clinical care and statutory guidelines. In addition to the *Chief Psychiatrist Standards for Clinical Care*, the Chief Psychiatrist provides standards for the authorisation of hospitals (to receive and involuntarily detain consumers), approves mental health services that provide Electroconvulsive Therapy (ECT) and authorises mental health practitioners to administer defined functions under the MHA 2014.

Authorised Mental Health Practitioners

Authorised Mental Health Practitioners (AMHPs) are an integral part of the mental health system in Western Australia (WA); ensuring access to timely, comprehensive and high quality mental health assessments. The Chief Psychiatrist is responsible for authorising mental health clinicians with the appropriate qualifications, training and experience to perform the functions of an AMHP. We are responsible for monitoring AMHPs in their role and function and maintaining a register of those who are authorised and revoked.

During this reporting period there were:

- 548 clinicians authorised to perform the functions of an AMHP.

Of which there were:

- 334 in the metropolitan area
- 110 throughout regional WA
- 10 within Corrective Services both public and private
- 8 in non-government agencies and
- 86 had their authorisation revoked

Registered Nurses and allied health professionals are eligible to perform the role of an AMHP.

The vast majority of AMHPs in Western Australia are Registered Nurses; this is consistent with the mental health workforce of which nurses comprise the largest number in Western Australia.

Of the total number (548) AMHPs for the reporting, there were by professional breakdown:

- 469 Nurses
- 50 Social workers
- 19 Occupational Therapists
- 10 Psychologists

Authorised Mental Health Practitioner Authorisations and Revocations

A clinician seeking to become an AMHP must satisfy the Chief Psychiatrist that they have the requisite qualifications and experience, appropriate to performing the role. In addition, they are required to attend specific training approved and provided by our Office.

For the reporting period, we ran two initial AMHP training courses for 42 clinicians seeking to become AMHPs. All participants successfully met the stated requirements and were gazetted as AMHPs by the Chief Psychiatrist.

To ensure currency of contemporary practice and knowledge in the role, AMHPs must attend a refresher course at least once every two years. For the reporting period, the Principal Officer Statutory Education ran 10 AMHP refresher courses; 6 for metropolitan AMHPs and 4 for regional and remote AMHPs (via video conferencing) training a total of 130 clinicians.

How we monitor Authorised Mental Health Practitioners

CSEAT monitors AMHPs to ensure they meet the annual requirements to continue to perform the role and function.

The Chief Psychiatrist expects AMHPs to have a working knowledge of section 539 of the *Mental Health Act 2014*, and to comply with the Mental Health Regulations 2015 (Regulation 17) which specifies the requirements for AMHPs to retain currency in their role. These requirements are to

- participate in regular clinical supervision and
- complete AMHP related professional development activity

The Chief Psychiatrist has tightened the rigour around the governance regarding AMHPs in recent years to ensure the continued integrity of the program. Our AMHP monitoring has two components:

- a self-report measure requiring compliance with the conditions of Regulation 17 of the *Mental Health Act Regulations 2015* and;
- a random audit of approximately 10% of AMHPs requiring them to provide evidence of compliance with the conditions of Regulation 17.

It is the responsibility of the AMHP to ensure they complete ongoing training in regard to their AMHP practice and arrange clinical supervision that is relevant to their role as an AMHP. Clinical supervision is a shared responsibility of the AMHP and their health service.

In July 2018 AMHPs were asked to self-report their clinical supervision and continued professional development (CPD) for the reporting period 1 July 2017 to 30 June 2018.

On completion of the self-report, a random audit of 38 (6.5%) AMHPs was conducted. They were asked to provide evidence of their compliance with the requirements of Regulation 17 with particular regard to undertaking clinical supervision and engaging in (CPD) activities.

Of the 38 AMHPs selected for auditing:

- 27 were compliant
- 10 were revoked
- 1 was on leave

For the reporting period, 86 mental health practitioners had their status revoked. AMHPs revoked as a result of the annual self-report and random audit are discussed below.

There were a variety of reasons for the revocations:

- 11 failed to comply with the self-report survey advising their compliance with Regulation 17 of the Mental Health Regulations 2015
- 10 failed to comply with the random audit of AMHPs by providing evidence of Clinical Supervision and Continued Professional Development approved by the Chief Psychiatrist, (Regulation 17 of the Mental Health Regulations 2015)
- 5 were no longer employed by a health service organisation or organisations with governance approved by the Chief Psychiatrist
- 20 were working in a role that no longer requires AMHP gazettal
- 2 went on leave of 12 months or more
- 34 voluntarily requested revocation
- 4 AMHPs who had left the workforce and did not notified the OCP

Monitoring our administrative processes for AMHPs

Following a rigorous review of current processes we identified some gaps in the administration of AMHPs, and developed strategies to ensure such gaps no longer impeded an AMHP from carrying out their role and function.



The AMHP program is regularly reviewed and updated as part of a continuous improvement initiative. This ensures the AMHP program has integrity, is robust and accountable.

Prescribed Psychiatrist

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

- A Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), or
- A psychiatrist with specific 'Specialist' or 'Limited' registration with the Australian Health Practitioners Regulation Agency (AHPRA), or
- Psychiatrists who have been prescribed by the Mental Health Act Regulations 2015 to administer the provisions of the MHA 2014.

A psychiatrist with 'Provisional', 'General' or any other registration type, may only administer the Act following vetting by the Chief Psychiatrist and recommendation by him for gazettal as a psychiatrist authorised to apply the provisions of the MHA 2014.

However for this reporting period the Chief Psychiatrist received no applications for psychiatrists prescribed to administer the MHA 2014.

Authorisation of Mental Health Facilities

An Authorised Hospital is one that can receive persons referred under the MAH 2014 admit involuntary patients (ref. s542 MHA 2014). Generally, it is a specific ward or area of a specified hospital that is authorised, for example a mental health inpatient facility within a hospital.

The Chief Psychiatrist is responsible for making recommendation to the Governor of Western Australia, seeking an order to authorise or de-authorise a mental health inpatient facility in Western Australia.

During this reporting period, we worked closely with the East Metropolitan Youth Unit (EyMU) to amend the authorisation order to incorporate the re-design of an already authorised footprint. We worked collaboratively with the service, providing advice and expertise to ensure compliance with the Standards for the Authorisation of Hospitals and a smooth transition of patients to and from the unit. The unit was successfully authorised on the 28 December 2018.

The Chief Psychiatrist website provides a Register of the Hospitals Authorised under the MHA 2014.

Planned Mental Health Facilities Consultation

It is imperative that health service providers planning new mental health services liaise with the Office of the Chief Psychiatrist in advance to discuss planning of new authorised infrastructure at various stages, particularly with the design, planning and fit out to ensure that they meet the Chief Psychiatrist's authorisation standards.

Services should ensure the modelling, design and physical environment supports safety for all patients, particularly vulnerable cohorts - women, children, youth and adolescents. It is important for new units to incorporate a capacity for gender specific bedrooms within the plan.

Services we have consulted with regarding planned mental health facilities are:

Royal Perth Hospital

The proposed Mental Health Emergency Centre (MHEC) will be located next to the Emergency Department. The purpose-built area will have 8 treatment cubicles made up of 6 beds and 2 seated areas to allow observation and treatment of patients who present with a mental health condition.

The Chief Psychiatrist met onsite with the Executive Team and Project Managers to view the proposed plan and we continue to work closely with the project team in terms of providing a safe environment that is therapeutic, reduces trauma and is conducive to the safety of consumers. The fit out is progressing and is due to be operational in October 2019.

Joondalup Health Campus

In July 2018 the Chief Psychiatrist was invited to be a member of the User Group for the proposed mental health unit at Joondalup Health Campus.

Geraldton Regional Hospital

The development of a mental health inpatient unit on the Geraldton Hospital site will provide the region with the capacity to enable consumers to access inpatient care closer to home and maintain connection with their families.

The proposed Midwest Integrated Mental Health Service (IMHS) is planned to consist of 12 beds and a 4 bed Mental Health Short Stay Unit (MHSSU) co-located in the Emergency Department.

The Midwest service has been proactive in liaising with the Chief Psychiatrist in the design and development phase of planning the new services.

St John Of God - Midland Hospital

Late in 2018 it was announced a Mental Health Emergency Centre would be developed at St John of God Midland Public Hospital that will treat patients with drug, alcohol, acute mental health and behavioural issues. In December 2018 the Chief Psychiatrist was invited to meet with the Project Management Team to discuss the preliminary concept and plans. The anticipated completion date for the project is June 2020.

Involvement with Upgrades to Mental Health Inpatient Units

Fremantle Courtyards Refurbishment

The service commenced a refurbishment project to improve the aesthetics of their inpatient courtyard areas. The Chief Psychiatrist has been actively participating in providing advice and suggestions to ensure the courtyards are welcoming and conducive to ensuring a therapeutic environment for patients.

The refurbishment met the Chief Psychiatrists requirements and in November 2018 both courtyards were open and fit for purpose.

Fiona Stanley Mental Health Unit

In October 2018 the Chief Psychiatrist provided consultation on the pending installation of shade sails, a basketball backboard and hoops and the upgrade of the anti-climbing cones.

Given the approaching summer the Chief Psychiatrist recommended the shade to be addressed as a priority as there was concern for those patients who are receiving medication and are more susceptible to the effects of heat and sunlight. Shades areas also provide patients with the opportunity for respite from the ward environment.

Next step Kewdale - funding

The service provided by Drug and Alcohol Youth Service (DAYS) Residential Rehabilitation Unit is integral to the mental wellbeing of youth with addictions to illicit substances.

Whilst DAYS Residential Rehabilitation Unit (RRU) is not a mental health service for the purposes of the *Mental Health Act 2014*, the Chief Psychiatrist was invited to view the unit and provide advice that would inform proposed works with regard to the need and timing of upgrades.

The Chief Psychiatrist was able to highlight areas of concern, which included the upgrades of anti-ligature fittings. The service was also encouraged to investigate the instalment of anti-ligature doors to ensuites.

Kalgoorlie Mental Health Unit

In September 2018 the Chief Psychiatrist and Deputy Chief Psychiatrist travelled to the Kalgoorlie Mental Health Unit to inspect the unit and meet with staff following a notifiable incident and concerns expressed by WACHS and the Mental Health Advocacy Service about the challenges the unit faced in managing patients safely. The Chief Psychiatrist and Deputy Chief Psychiatrist visited the mental health unit and other parts of the hospital. The Chief Psychiatrist worked with WACHS and MHAS and made recommendations to WACHS about measures needed to ensure the hospital was able to provide safe care in line with authorisation and clinical standards. WACHS has committed resources and redevelopment capacity to the improvements required.

Further Opinions

The Mental Health Act 2014, section 182, relevantly provides for an involuntary patient and mentally impaired accused (MIA) in an authorised hospital to request a further opinion if dissatisfied with their treatment.

An involuntary patient or MIA or their personal support person, may request a further opinion on behalf of a consumer. Such requests are usually made via the mental health service providing treatment and care.

The MHA 2014 also provides for requests for further opinions to be made to the Chief Psychiatrist who then facilitates the provision of one by ensuring that it is provided in a timely manner, is objectively independent and reviews any decision by a psychiatrist to refuse a consumer a further opinion.

Involuntary patients and MIA may seek a further opinion from:

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

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

For the reporting period 2018-2019 we received eight (8) requests to facilitate a further opinion, of which five (5) did not progress (request withdrawn or consumer became voluntary) and three were completed.

For the reporting period the Chief Psychiatrist also received one (1) Refusal to Provide a Further Opinion. The Chief Psychiatrist contacted the clinician and was satisfied that there were appropriate grounds to decline the request and that the refusal was justified in the best interests of the patient.

Statutory Education and Training

The Chief Psychiatrist has a statutory responsibility to ensure that all AMHPs gazetted by him are in receipt of appropriate training and have access to high quality educational content.

The Principal Officer Statutory Education develops and delivers the legislative training requirements for and on behalf of Chief Psychiatrist. Primarily the training provided is to AMHPs and comprises of:

- AMHP Initial training
- AMHP refresher training
- AMHP Mental State Examination and Risk Assessment training
- Open Discussion Session for WACHS AMHPs
- Attendance and support at AMHP Peer Supervision sessions

It was recognised that AMHPs have a significant role to play in regard to performing assessments on people experiencing mental illness and an advanced course on the Mental State Examination and Risk Assessment would benefit them in their role. A pilot program was run in September 2018 and following positive evaluations it was decided to add this program to the other sessions we offer to AMHPs.

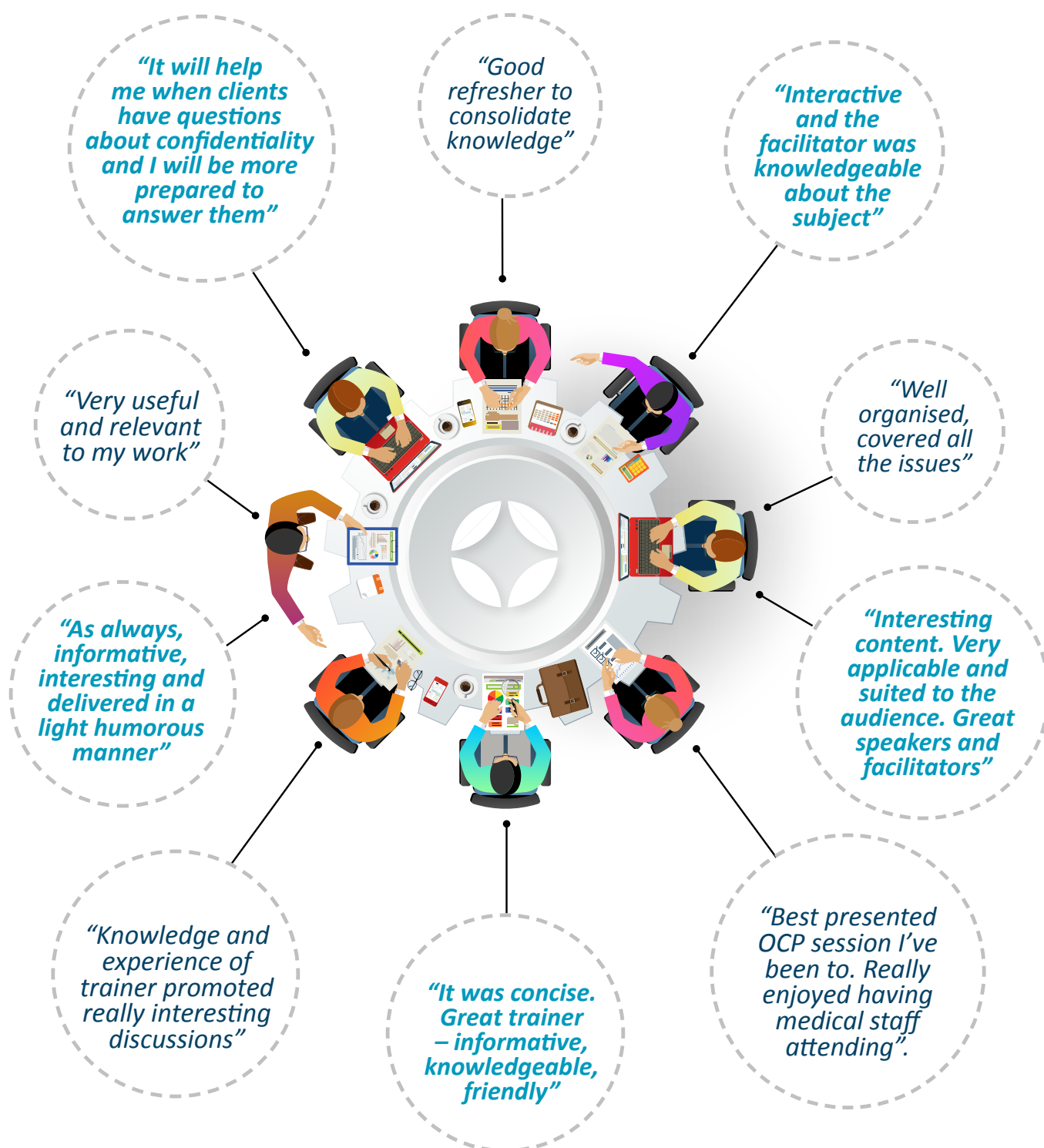
However, the Chief Psychiatrist recognises the invaluable role of education in the delivery of safe quality mental health care and therefore supports the development and delivery of a broad range of educational sessions, some of which are informed by the queries we receive via the Clinical Helpdesk.

In addition to the AMHP courses, we also developed and delivered education sessions on:

- Community Treatment Orders
- Inpatient Care under the MHA 2014
- Capacity as provided for in the MHA 2014
- Confidentiality (as applied to a person's personal health information).

We also provided education and information on request to universities, general and mental health services, private hospitals, Alcohol and Drug services, hostels and Non-Government Organisations (NGOs). For example we provided education on seclusion and restraint in Authorised Hospitals, inpatient issues for medical staff, information for Child and Adolescent Psychiatrists, and Question & Answer sessions at mental health services.

All our courses are highly valued and positively received by attendees. Positive comments from training included:



Overview of training delivered in 2018/2019:

Figure 11: Total AMHP Training Attendees

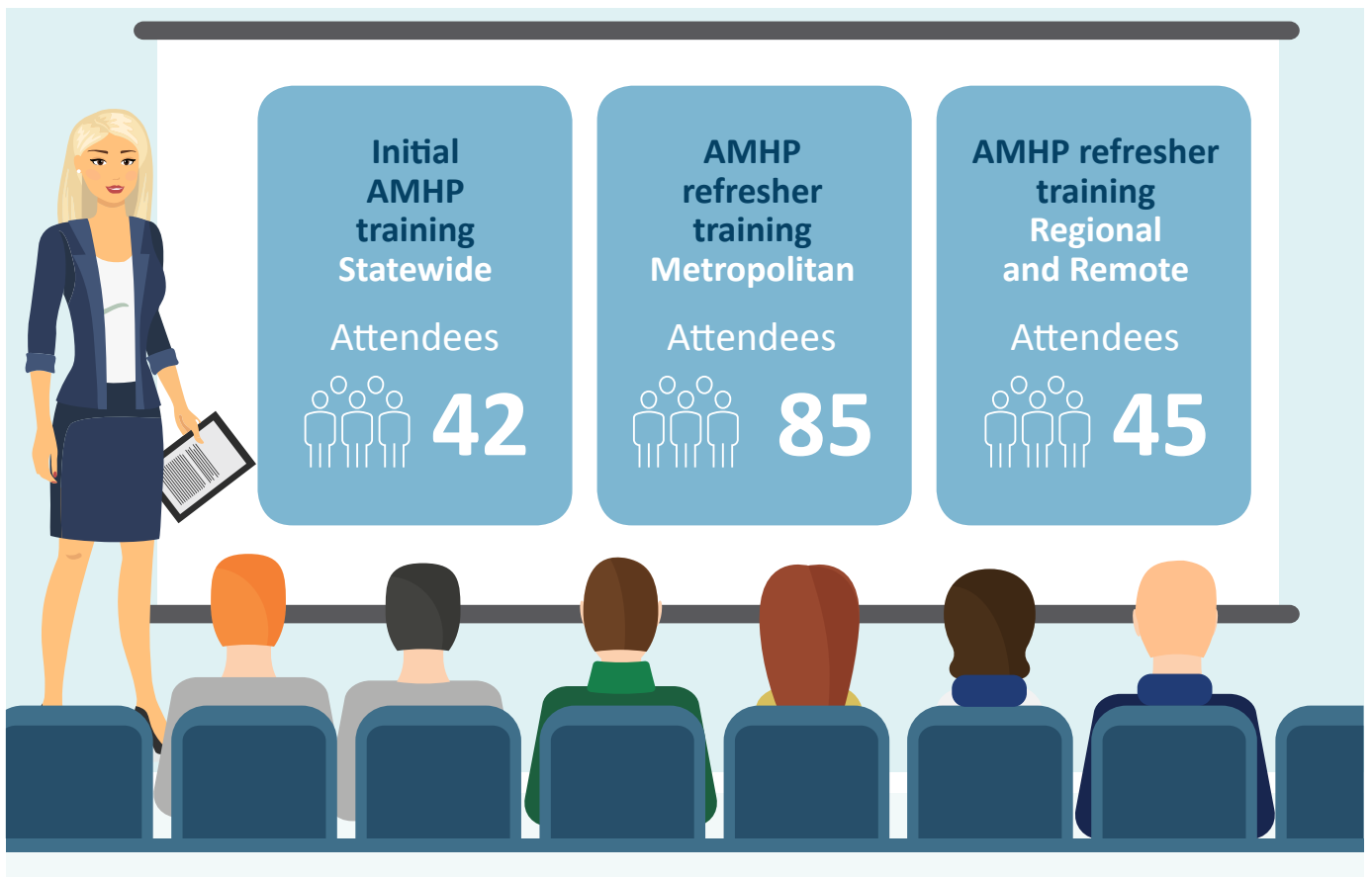


Table 3: Training Opportunities provided

Topic	Number of Presentations Conducted	Region	Number of Attendees
Authorised Mental Health Practitioner (AMHP) Training			
Initial AMHP training	2	Statewide	42
AMHP refresher training	6	Metropolitan	85
	4	WACHS	45
Other Training			
Community Treatment Orders	3	Metropolitan	52
	3	WACHS	91
Confidentiality - A legal and clinical perspective	3	Metropolitan	52
	2	WACHS	23
Capacity	2	Metropolitan	65
Graduate nurse training	2	Statewide & Metropolitan	48
Open Discussion Session for WACHS AMHPs	2	WACHS	32
Mental State Examination for AMHPs	5	Metropolitan	98
	1	WACHS	38
Risk Assessment for AMHPs	3	Metropolitan	59
	1	WACHS	35
Other MHA 2014 training and education to Health services universities, private hospitals, GPs, mental health teams	17	Metropolitan	254
Forum Presentations			
Smoking: WA's Worst Serial Killer	1	Metropolitan	42

Promoting and Disseminating Research and Innovative Practice

In addition to the above initiatives the Office of the Chief Psychiatrist organises seminars with invited speakers to help disseminate innovative practice and research to mental health services.

In addition staff from the Office of the Chief Psychiatrist have published papers and presented at conferences to promote evidence based high quality mental health care.

Treating Western Australia's Worst Serial Killer

Dr Mathew Coleman, Consultant Psychiatrist, Great Southern Mental Health Service, Western Australia (WA) Country Health Service, Albany, WA, and; Clinical Senior Lecturer, The Rural Clinical School of Western Australia and University of Western Australia, Nedlands, WA, Australia

In January 2019, the Chief Psychiatrist hosted a presentation by Dr Mathew Coleman on the findings from the specialist smoking cessation clinic (Smokers' Clinic) recently trialled in the Great Southern.(1) The aim of the study was to develop an evidence-based smoking cessation intervention for mental health patients, delivered by trained junior medical staff.

Dr Coleman highlighted that people with a mental illness are two times more likely to smoke than people who do not have a mental illness. People with mental illness smoke more heavily, are more dependent on cigarettes, have more difficulty quitting, and are more likely to die from a smoking-related cause than smokers without mental illness.(2) In spite of these statistics, psychiatrists are less likely than general practitioners to advise their patients to quit smoking.(3)

The Smokers' Clinic was available to Albany psychiatric inpatients, community patients and staff and involved 6-8 sessions, with referrals made by mental health staff or self-referral. Patients were assessed using the Brain Mind Research Institute assessment protocol.(4) Pharmacotherapies including NRT, varenicline, bupropion as well as others, were offered to referred patients and staff, in addition to behavioural interventions and a weekly 30-minute follow-up (in person and by telephone) for 6–8 weeks. RMOs received an initial one-hour session of education and ongoing weekly supervision by an addiction psychiatrist regarding tobacco smoking, nicotine dependence and treatment options.

The trial indicated that the Smokers' Clinic is a potentially effective evidence-based clinical model to assist patients to achieve abstinence; although the small number of patients in the pilot program limits the interpretation of the results. Abstinence was achieved by 34% of study patients, with women three times more likely to be successful than males. The results indicated that patient with serious mental illness were more likely to be successful than those with high-prevalence mental health disorders. Importantly, the program improved the knowledge and confidence of medical officers to recognise and manage nicotine dependence.

The Smokers' Clinic is continuing in Albany and is being implemented in other mental health services in Western Australia with evaluation of the program continuing. Following the presentation at the Office of the Chief Psychiatrist, Dr Coleman presented at Graylands Hospital and received multiple requests for education around nicotine dependence and having smoke free authorised mental health units.

The presentation was well attended with 35 attendees and 9 Video Conference sites. The majority of attendees (95%) reported increased knowledge about smoking care and nicotine replacement, with 77% reporting increased confidence in managing nicotine dependence and providing smoking care.

References

1. Davis A, Ngo H, Coleman M. *An evaluation of a pilot specialist smoking cessation clinic in a mental health setting. Australas Psychiatry.* 2018;1039856218816372.
2. Williams JM, Steinberg ML, Griffiths KG, Cooperman N. *Smokers with behavioral health comorbidity should be designated a tobacco use disparity group. Am J Public Health.* 2013;103(9):1549-55.
3. Doran CM, Valenti L, Robinson M, Britt H, Mattick RP. *Smoking status of Australian general practice patients and their attempts to quit. Addict Behav.* 2006;31(5):758-66.
4. Bittoun R. *Nicotine Addiction and Smoking Cessation 3-day Training Course. NSW, Australia: The University of Sydney; 2014.*

Chief Psychiatrist Guidelines Development

Development of guidelines for the sexual safety of consumers of mental health services in Western Australia

People accessing mental health services have a right to feel and to be safe. Unfortunately this is not always the case. Reviews, research and reports from many jurisdictions over many years have highlighted that people accessing mental health services do not always feel sexually safe and sometimes experience sexual assault or harassment

Sexual safety refers to being and feeling psychologically and physically safe, including being free of, and feeling safe from, behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe. It is crucial for mental health services to avoid traumatising, re-traumatising or compounding previous trauma and to foster a culture where people feel and are sexually safe.

The Chief Psychiatrist identified the need for guidelines for mental health services to assist services in this regard.

We convened an expert reference group to advise on the development of the Sexual Safety guidelines. The reference group included people with expertise in: consumer lived experience; carers lived experience; adult, child and adolescent, youth and older adult services and forensic services, inpatient and community; Aboriginal mental health; gender diversity; police; private psychiatric hospitals; responding to sexual assault; mental health advocacy; and policy and planning. From the reference group, a steering group was established to meet regularly and guide the development of the sexual safety guidelines.

We conducted a review of the approach taken in services within WA, jurisdictions across Australia and internationally, and did a literature search to identify key papers and recent publications of relevance to the sexual safety of consumers of mental health services.

A draft of the guidelines has been developed and will be circulated for wider consultation in the first quarter of the 2019-20 financial year, with the aim to finalise the guidelines by the end of the calendar year.

The intent of the guidelines is to place an emphasis on actively promoting sexual safety within mental health services and preventing sexual safety incidents.

This first section of the Guidelines will address the overall principles that apply when considering sexual safety. The second section will be devoted to the universal approaches to sexual safety. That is the measures that all services can adopt with everyone to promote sexual safety, such as the culture of the service including trauma informed and gender sensitive care; the role of leadership and governance; empowering and supporting consumers and staff to promote safety and healthy sexual expression; and the safety of the physical environment. The third section will be dedicated to more targeted approaches. That is identifying people who may be at particular risk of being sexually unsafe and adopting strategies to maximize their safety. The final section will provide guidance on how to manage a situation where sexual safety has been breached.

ECT guidelines

The Chief Psychiatrist Guidelines for the use of Electroconvulsive Therapy are currently being reviewed.

Our Standards Monitoring and Evaluation Program



Our Standards Monitoring and Evaluation Program

The Standards Monitoring and Evaluation program (Monitoring and Evaluation) aims to ensure that mental health services provide safe, high quality care. This is achieved through (i) monitoring and evaluation of compliance with standards and reporting of psychiatric treatments and interventions as stipulated under the Act; (ii) monitoring and evaluation of notifiable incidents; and (iii) routine and ad hoc clinical reviews of mental health services. Over the 2018-2019 financial year, the Monitoring Team has collaborated closely with colleagues, mental health services and clinicians, and other key stakeholders through a range of strategies to ensure standards of treatment and care are met.

The Monitoring Team has worked closely with members of the Clinical, Statutory Authorisations and Education team, identifying trends and other issues to inform the education program and collaborating in education and training clinicians around reporting under the Act.

A validation process for seclusion and restraint events reported to the Chief Psychiatrist is conducted in conjunction with mental health services. This process reduces reporting errors and ensures high quality verified data are available for state and national reporting.

To ensure high quality care is provided to residents of private psychiatric hostels, the Monitoring team has consulted with key stakeholders, the Mental Health Commission and the Licensing and Accreditation Regulatory Unit (LARU) at the Department of Health WA. LARU have a statutory remit to oversee the *Standards for the Arrangements for Management, Staffing and Equipment – Private Psychiatric Hostels*, under the Private Hospitals and Health Services Act 1927.

In undertaking the clinical reviews of mental health services, the Clinical Review team has worked closely with Health Service Providers, mental health services, clinicians, consumer and carer representatives and the Mental Health Data Collection team in the Department of Health. This collaboration has been essential to ensure a timely and efficient review process.

Standards Monitoring and Evaluation Program achievements in 2018-2019:

- Clinical reviews of all public mental health services were completed by June 2018. In the 2018-2019 financial year, analysis and reporting was completed for North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), and East Metropolitan Health Service (EMHS).
- The report of findings from the Chief Psychiatrist's independent Clinical Governance Review of City East Mental Health Service was presented to the Chief Executive of EMHS.
- Consumers and Carers were recruited and trained in undertaking clinical reviews of the standards of care delivered in mental health services.
- A survey of clinician awareness, knowledge and understanding of the Chief Psychiatrist's Standards for Clinical Care was completed.
- Monitoring and Evaluation Team members worked with the Statutory Education Team to provide training on reporting seclusion and restraint events under the Act.
- Worked with mental health services to validate the seclusion and restraint notifications to the Chief Psychiatrist and to reduce reporting errors.
- The two-year review of the *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist* was undertaken following consultation with mental health services and other key stakeholders.
- Mental health services were notified that seclusion and restraint data will be published on the Chief Psychiatrist website commencing with 2018-19 first quarter data.
- Improved reporting of the prescription of off-label pharmaceuticals to children and youth less than 18 years of age was achieved through communication and collaboration with mental health services.
- Meetings were held with private psychiatric hostel licensees and managers, the Mental Health Commission and the LARU with the aim of improving strategic governance processes and improving standards of care at private psychiatric hostels.



**"I feel grateful to be given this
opportunity to have a voice... Can you
please tell the OCP that we are doing our
best for these people and their families"
Mental Health Staff**

Chief Psychiatrist's Clinical Monitoring Program

The Mental Health Act 2014 (s.515) prescribes the Chief Psychiatrist with the responsibility to monitor the treatment and care of mental health patients within Western Australia. With this legislative requirement, the Chief Psychiatrist carries out monitoring of all mental health services within the State.

The Chief Psychiatrist's Clinical Monitoring Program is responsible for evaluating the standards and consistency of mental health services' clinical governance practices and procedures. This is done by conducting reviews of mental health services.



Clinical Monitoring Reviews

Routine monitoring of public mental health services against the Chief Psychiatrist's Standards.



Targeted Reviews

Reviews of a service and/or clinical case to investigate a specific concern or allegation.



Thematic Reviews

Reviews of a particular area or 'theme' across multiple mental health services.

The Clinical Monitoring Program is staffed by a Principal Officer – Reviews and a Program Officer. The 2018-2019 financial year has been a year of consolidation for the Clinical Monitoring Program. The Clinical Monitoring program has analysed data collected during the reviews of South Metropolitan Health Service and North Metropolitan Health Service in 2017, and data from the review of East Metropolitan Health Service in 2018 (totalling 58 health services in all). Reports have been provided to all three Health Service Providers. In addition, the Clinical Monitoring Program undertook a targeted governance review of a community clinic and an in-depth targeted review of a clinical case at a private mental health service.

Between 2016 and 2019, all public mental health services have undergone a Clinical Standards and Service Review providing the Chief Psychiatrist with an overview of the standards of mental health service delivery across Western Australia. The overarching findings will direct the priorities of the monitoring program going forward to ensure that key areas for service delivery improvement remain a focus.

Under the Mental Health Act 2014, the Chief Psychiatrist is also has responsibility for monitoring the standards of psychiatric care provided for mental health consumers resident in a private psychiatric hostel and consumers receiving psychiatric care at a private mental health service or through a Non-Government Organisation (NGO). Planning has commenced to extend the existing program to monitor these services.

Chief Psychiatrist's Standards for Clinical Care

In November 2015, the Chief Psychiatrist's Standards for Clinical Care (CP Standards) were published as per the requirements of the Act (s.547). As intended, a review of these standards was commenced during the 2017-18 financial year and the Chief Psychiatrist undertook the first round of consultation. The CP Standards have been revised based on the feedback and are undergoing further consultation before they are published.

Awareness and Implementation of the Chief Psychiatrist's Standards for Clinical Care


An important aspect of monitoring compliance is having an understanding of how widely the standards are known and utilised. For three years now, the Chief Psychiatrist has conducted surveys to understand mental health clinicians' knowledge and awareness of the Chief Psychiatrist's Standards for Clinical Care (CP Standards). The 2019 survey was expanded to include consumers, carers, and general and primary health providers in addition to mental health clinicians.

A key finding of the July 2017 survey was that more communication about the CP Standards was warranted. In response to this finding, an action plan to improve communication was developed and implemented. The 2018 results indicated that AMHPs had a good level of awareness, however, more work was needed to educate other mental health clinicians. A possible explanation for this finding is that the CP Standards are covered in AMHP training.

The 2019 survey found that a good level of awareness has been achieved amongst mental health staff, with 96% of mental health staff (99% amongst AMHPs) reporting they are aware of the CP Standards. Amongst respondents who were not mental health clinicians, less than half (42%) reported they were aware of the CP Standards.

In addition to feedback about awareness of the standards, the survey collected data about respondents' opinions of the standards, which will be utilised as part of the process of review. Results show that despite 46% of staff who were aware of the CP Standards reporting that they need more education and training, 93% reported that they understood the CP Standards and 92% agreed that they use them to guide their practice.

Feedback about the content of the standards revealed that 93% of respondents agree that the CP Standards are about the most important aspects of mental health care. Going forward, a key suggestion is to improve understanding of how the CP Standards fit with other standards that are relevant to mental health services, such as the National Standards for Mental Health Services and the National Safety and Quality Health Service Standards.



"The standards are an integral part of my practice, they form the framework on which I hang my practice."

"There are a lot of standards to be applied to MH Services. It would be good if there was one set."

"Standards of Clinical Practice are essential to guide clinical practice."

Our Clinical Monitoring Reviews

In 2016 the Chief Psychiatrist implemented a new clinical monitoring program. All public mental health services have now been reviewed and planning has commenced to conduct reviews of private psychiatric hospitals and private psychiatric hostels.

Comprehensive Clinical Record Review

The focus of the Comprehensive Clinical Record Review is to assess the quality of clinical care as evidenced within the written clinical record. The review is based on the Chief Psychiatrist's Standards for Clinical Care.

Staff Feedback

Feedback is collected from staff working within the mental health service via face-to-face interviews and through a staff survey. Staff working in the service are grouped by discipline and level of experience, then randomly selected from within each group and invited to give an interview. Any other staff who request an interview are also given the opportunity to provide feedback. Survey questions are based on the United Kingdom's National Health Service (NHS) Staff Survey - <https://www.nhsstaffsurveys.com/Home/>

Consumer and Carer Feedback

Multiple formats are made available to provide consumers and carers with options for their preferred method to provide feedback; face-to-face interviews, phone interviews, online and paper based surveys. Face-to-face feedback is collected by consumers and carer reviewers.

Trained Independent Reviewers

Senior clinicians along with consumers and carers with experience in consultation roles are appointed as reviewers. To ensure an independent perspective on service delivery, clinicians are not permitted to review any service where they have worked within the last three years; consumers and carers are not permitted to review any service where they (or the person they care for) currently receives mental health care or where they have engaged in consultation / representation activities within the past six months. Prior to each review, the Office of the Chief Psychiatrist provides the reviewers with thorough training. The Office of the Chief Psychiatrist has commissioned the Western Australian Association for Mental Health to provide all consumer and carer reviewers with training in de-escalation skills, to improve safety when conducting interviews. The Office of the Chief Psychiatrist provides training to all reviewers regarding the requirements of the Chief Psychiatrist's Standards for Clinical Care along with procedures for conducting the review.

Clinical Review of WA Country Health Service

The WA Country Health Service (WACHS) was reviewed between May–July 2016. The review identified five areas of notable practice and made seven recommendations for service improvement (see OCP Annual Report 2016-17 p43). The Chief Psychiatrist has received progress reports; progress has been made on all recommendations and one recommendation has been closed. A further progress report was due in May 2019 and this will be followed up in the 2019-20 financial year.

Clinical Review of Child and Adolescent Health Service

The Chief Psychiatrist reviewed Child and Adolescent Health Service (CAHS) Mental Health Services in May 2017. The review identified five areas of notable practice and made seven recommendations for service improvement (see OCP Annual Report 2017-18 p63). The Chief Psychiatrist received a progress report regarding the recommendations in February 2019 and a further progress report is expected in August 2019.





Clinical Review of South Metropolitan Health Service

The Chief Psychiatrist reviewed South Metropolitan Health Service (SMHS) Mental Health Services in May/June 2017. The review identified five areas of notable practice and made eight recommendations for improvement (see OCP Annual Report 2017-18 p63). In May 2019, the Chief Psychiatrist received a report outlining progress towards achieving the recommendations; a further progress report is expected in the 2019-20 financial year.

Clinical Review of North Metropolitan Health Service

The Chief Psychiatrist's review of North Metropolitan Health Service (NMHS) took place in November-December 2017. A team of thirty-one senior clinicians and two carers visited twenty-nine NMHS mental health services. A total of 218 clinical records were reviewed. Interviews were conducted with 113 staff and 36 consumers and carers. There were 146 respondents to the staff survey. Due to competing priorities within the Clinical Monitoring team, completion of the report of findings was delayed. The team were required to undertake two targeted reviews (see below) which had to be prioritised over completion of the NMHS data analysis and reporting.

The review identified four areas of notable practice:

-  **Mental health assessment**
-  **Risk assessment on admission**
-  **Communication at transfer of care**
-  **Completion of care plans**



Analysis and
reporting of NMHS
Review completed

A total of eleven recommendations for improvement were made across the areas of involvement of personal support people, involvement of consumers in care planning, risk assessment and management plans, medication safety, physical health care and implementation of the Chief Psychiatrist's Standards for Clinical Care. Action plans and reports of progress against the recommendations are due to be submitted by the service over the coming 12-month period.

Clinical Review of East Metropolitan Health Service

The Chief Psychiatrist's review of East Metropolitan Health Service (EMHS) took place in April-May 2017. A team of 16 senior clinicians, four consumers and two carers visited seven EMHS mental health services. The team interviewed 110 staff and 74 consumers and carers. A total of 198 clinical records were reviewed. The review received 184 responses to the staff survey and 94 responses to the consumer and carer surveys.

The review identified four areas of notable practice:

- ❖ **Mental health assessment**
- ❖ **Assessment of patient risk to self and others**
- ❖ **Inpatient physical health examinations within 12 hours**
- ❖ **Medication and treating team information at transfer of care**



Analysis and
reporting of EMHS
Review completed

A total of eight recommendations for improvement have been made across the areas of involvement of personal support people, involvement of consumers in care planning, physical health care in community setting and implementation of the Chief Psychiatrist's Standards for Clinical Care. Action plans and reports of progress against the recommendations are due to be submitted by the service over the coming 12-month period.

Our Reviews of Private Psychiatric Hostels

In February 2019, the Office of the Chief Psychiatrist employed a Principal Officer, Psychiatric Hostel Reviews for a six month project to develop the hostel monitoring program. The objective of this project was to design how the Chief Psychiatrist will meet the statutory responsibility for oversight of the quality treatment and care provided to over 700 residents across Western Australia, as required under the Mental Health Act 2014 (s.515).

Other agencies also have responsibility for monitoring aspects of service provision in private psychiatric hostels:

- ❖ **Mental Health Commission (MHC)**
Responsible for commissioning services and service quality monitoring.
- ❖ **Licencing and Accreditation Regulatory Unit (LARU)**
Responsible for licencing of the service and monitoring of the environment and facilities.
- ❖ **Mental Health Advocacy Service (MHAS)**
Responsible for consumer advocacy and investigation of reports from residents.

The OCP is working in partnership with these agencies to design a streamlined monitoring process which aims to avoid duplication.

A key goal of this project has been to develop a monitoring tool in consultation with mental health clinicians, hostel owners, consumers, carers, and culturally diverse and Aboriginal consultation groups, using co-design principles. Consultation with these groups was undertaken through targeted forums, face to face meetings, email submissions, hostel visits and phone consultations.

The first pilot review is scheduled to occur early in the 2019-20 financial year. Further consultation is planned before the design of these reviews is finalised.

Our Targeted Reviews

Targeted reviews occur when the Chief Psychiatrist has a sufficient concern about a particular aspect of psychiatric treatment and care to warrant an in-depth understanding of the issue. Targeted reviews may investigate the standards of psychiatric treatment and care provided to an individual patient or group of patients.

The reviews are undertaken in such a way as to encourage those involved in providing treatment and care to learn from and reflect on their practice as well as to identify system hazards or vulnerabilities so action can be taken to make improvements to the standards of psychiatric care being provided.

Targeted Review of City East Community Mental Health Service

In June 2017, the Chief Psychiatrist received an anonymous letter which raised concerns regarding alleged breaches of standards of practice, clinical governance issues and human resource management within the City East Continuing Care Team (CCT). The Chief Psychiatrist wrote to the Chief Executive EMHS, forwarding a copy of the letter. In response to these concerns, the Acting Chief Executive EMHS commissioned an external review, which was conducted by the WA Centre for Mental Health Policy Research, a department of WA Health. A recommendation of that review was that an independent evaluation be undertaken by the Chief Psychiatrist in six months' time.

The Chief Psychiatrist's Clinical Governance Review of City East Community Mental Health Service was completed in May 2018. A total of 103 clinical records were reviewed. Interviews were conducted with 36 staff and there were 21 respondents to the staff survey. A total of 15 consumers and carers provided feedback. The review made twelve recommendations in the areas of partnering with consumers and carers, governance, leadership and culture, clinical performance and effectiveness and patient safety and quality systems. An action plan was received from EMHS in April 2019 and the first progress report is due during the first half of the 2019-20 financial year.

Targeted Case Reviews

Where the Chief Psychiatrist has sufficient concern about the treatment and care of an individual or group of individuals, he may direct the completion of an in-depth case review. This may be undertaken by the Clinical Monitoring team, or, in circumstances which are particularly complex and sensitive, the review may be completed by the Research and Strategy team.

The confidential nature of patient information in a case review means that detailed findings are rarely made publicly available. Where the outcomes from a case review can highlight systemic issues of sufficient concern, further investigation may be undertaken through a thematic review.

At the request of the Chief Psychiatrist, one case review was completed by the Clinical Monitoring Program during the reporting period.

Looking Forward

A key area of work for the Clinical Monitoring Team in 2019 – 2020 is to refine the Clinical Standards and Service Reviews, including a review of the audit tools, reviewer training program, processes for conducting site visits and follow-up of the implementation of review recommendations. This will involve consultation with mental health clinicians, managers and health service executives, as well as consumers and carers, with the goal of ensuring continuous improvement in monitoring and meaningful contribution to improving the standards of clinical care provided in WA mental health services.

Work will also commence on developing a monitoring program for private mental health services. This is a new area of work for the Chief Psychiatrist under the MHA, and will involve extensive collaboration with the private sector to develop a meaningful monitoring program that ensures statutory requirements are met, while contributing useful information to assist each service to meet their other quality improvement responsibilities.

Goals for 2019-20

- Commence reviews of private psychiatric hostels
.....
- Undertake consultation with HSPs regarding clinical monitoring reviews with the aim of refining the clinical review process and methodolog
.....
- Commence consultation and planning for reviews of private services
.....
- Provide state-wide benchmarking reports to HSPs
.....

Our Statutory Monitoring

The Chief Psychiatrist continues to build on the established reporting and quality assurance mechanisms that, in collaboration with health service providers ensure safe high quality care.

Mental health services in Western Australia report on the following:	
Electroconvulsive therapy (s. 201)	Segregation of children from adult inpatients (s. 303)
Emergency ECT (s.201)	Off-label prescription provided to children who are involuntary patients (s. 304)
Restrictive practices (s. 224; s. 240)	Approving involuntary inpatient treatment orders in a general hospital (s. 61)
Notifiable incidents (s. 526; s. 254)	Emergency psychiatric treatment (s. 204)
Psychosurgery (s. 209)	Urgent non-psychiatric treatment for involuntary and MIA patients (s. 242)
Treatment decisions that differ to the Advance Health Directive of an involuntary patient (s. 179)	

The Monitoring Team in the Office of the Chief Psychiatrist monitors 'Notifiable Incidents' as stipulated in the Act. At the discretion of the Chief Psychiatrist, individual cases may be investigated. Any specific concerns the Chief Psychiatrist may have are followed up directly with the Mental Health Service and recommendations made as required.

The following section presents data for the 2018-19 financial year.

Electroconvulsive Therapy

Under the Act, ECT can only be administered in approved ECT services 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 (MIA) patient and on any children between 14 and 18 years of age.

The Act s.201 stipulates that the person in charge of the Mental Health Service must report at the beginning of each month on any course of ECT, which was completed or discontinued in the previous month. A course of ECT is taken to have been completed during a month, if the last

treatment in the course was performed during that month, whether or not any of the other ECT treatments in the course were performed during the month. A course of ECT is taken to have been discontinued during a month if;

(a) one or more of the treatments in the course have been performed, whether or not during the month; and

(b) the decision not to perform any more of the treatments in the course was made (for whatever reason) during the month.

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

The Act requires ECT services to report to the Chief Psychiatrist details about the ECT course. A range of parameters are collected including details about the number of treatments within the course, the mental health status of the patient (voluntary, involuntary, referred, mentally impaired accused (MIA)), the number of children receiving ECT, and information about any serious adverse event that occurred during or after any of those courses.

The Chief Psychiatrist and ECT clinicians have raised concerns that the Act requires data on serious adverse events without also collecting data on the benefits of ECT. The Chief Psychiatrist is consulting with ECT clinicians regarding collecting data on patient outcomes following ECT in order to obtain data to evaluate the risks and benefits of ECT. The aim would be for each ECT service to assess patient outcomes following ECT using clinical and cognitive measures recommended by the Clinical Alliance and Research in ECT (CARE) Network, a large network of national and international hospitals which collects a common set of clinical data with an aim to improve ECT clinical practice. The three aims of the CARE project are to improve clinical

services, facilitate auditing and benchmarking, and to facilitate research.

The CARE Network supplies participating hospitals with carefully developed standardised forms and a database for collecting data for audit, benchmarking, and for research. Each hospital keeps its own records, there is no central repository.

A number of ECT services in WA already collect data on patient outcomes using the measures recommended by the Care Network. Reporting patient outcomes to the Chief Psychiatrist would provide a complete picture of the impact of ECT on patient mental health and wellbeing and provide WA the unique opportunity to monitor and evaluate the risks and benefits of ECT using state-wide data. This would benefit both mental health consumers and ECT clinicians.

The Chief Psychiatrist will continue to consult with ECT clinicians through the Section of Electroconvulsive Therapy and Neuro-stimulation WA (SENWA) forum during the 2019-2020 financial year. The aim is to obtain agreement from ECT clinicians regarding the collection of outcome measures and reporting of these to the Chief Psychiatrist through the mandatory reporting process.

Electroconvulsive Therapy and approved suites

The *Mental Health Act 2014* requires the Chief Psychiatrist approve all services that perform Electroconvulsive Therapy (ECT) in Western Australia.

In November 2018 the Chief Psychiatrist concluded the review of one new and ten existing approved ECT suites in Western Australia. The review team consisted of the Chief Psychiatrist, the Deputy Chief Psychiatrist, the Consultant – Statutory Authorisations and Approvals and a consumer representative.

Eleven Mental Health Services approved for the performance of ECT are:

- Albany Health Campus
- Armadale Hospital
- Bentley Hospital
- Fremantle Hospital
- Hollywood Clinic
- Joondalup Health Campus
- The Marian Centre
- Perth Clinic
- Rockingham General Hospital
- Sir Charles Gairdner Hospital
- St. John of God Midland Public Hospital

Chief Psychiatrist's Electroconvulsive Therapy Standards and Guidelines

The work on the review of the Chief Psychiatrist's Standards and Guidelines for Electroconvulsive Therapy nears completion and the new guidelines are expected to be finalised in the next reporting period.

ECT Statistics

Table 4: ECT courses and treatments completed in the 2018-19 financial year

Age	Status	Number of ECT Courses Completed in 2017-18	ECT Treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
Patients over 18	Voluntary	668	5636	816	0	6452
	Involuntary / Referred ^a	44	404	50	28	482
	Mixed ^b	26	359	86	25	470
Total		738	6399	952	53	7404

Table 4: ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2018 – 30 June 2019).

Note: The data are representative of those who completed their course of ECT between 01 July 2018 and 30 June 2019. It is important to note that the starting date for some of the courses may have commenced prior to the beginning of the reporting period 1 July 2018. Persons having not completed their course of ECT are not included in Table 4. ^aMentally Impaired Accused are included in this category; ^bPatients who had both an involuntary and a voluntary status in the same course.

Persons over 18

For the reporting period 1 July 2018 – 30 June 2019 there were 738 completed ECT courses reported to the Chief Psychiatrist (Table 4). Of the 738 courses, 668 (90.5%) were for patients with a voluntary status, 44 (6%) were for involuntary or referred status, and 26 (3.5%) were for Mixed (both voluntary and involuntary) status.

There were 7404 ECT treatments involving adults over the age of 18 years completed in the 2018-19 financial year, of which 6399 (86%) were acute treatments, 952 (13%) were maintenance and 53 (1%) consisted of emergency treatments.

Of all ECT courses received by patients over 18, 29% were treated in ECT services located within a public hospital, 11% in a publically contracted private hospital and 60% in ECT services within a private hospital.

Persons under 18

Due to the small number of patients who received ECT under the age of 18 the data for the number of courses and status for these patients are not reported.



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.

ECT is a very effective evidence-based treatment for serious mood disorders, including major depression and mania, catatonic states and occasionally with schizophrenia or other neuropsychiatric disorders.

Serious Adverse Events

Persons over 18

Of 738 ECT courses, an adverse event during one or more treatments was reported for 8% of these courses. Of the courses which had an adverse event during a treatment, the majority of adverse events (61%) involved the patient having a headache, 8% involved an anaesthetic complication, 15% the patient had a memory deficit, and 16% consisted of an adverse event categorized as 'Other' (Figure 12). Fewer than 5 courses (0.7%) contained more than one type of adverse event.


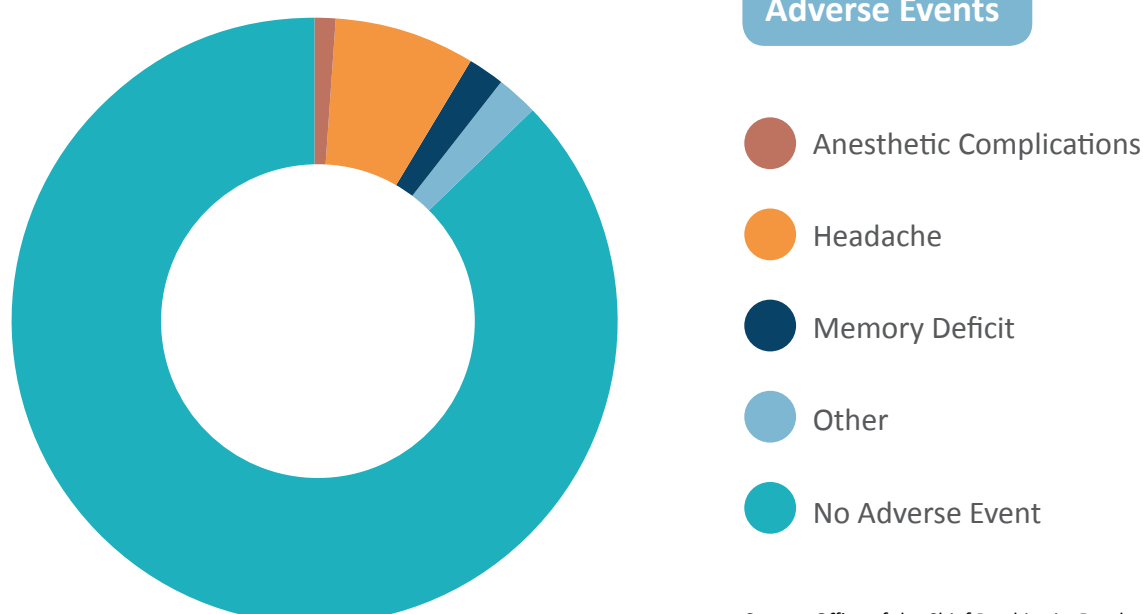
Persons under 18

There were no reported adverse events for ECT courses for patients under 18 years of age.

Emergency ECT Approved by the Chief Psychiatrist for this financial year

There were 68 Emergency ECT treatments authorised by the Chief Psychiatrist or his delegate, for the reporting period. Of these ECT treatments, 81% were completed before 30 June 2019.

Figure 12: Number of ECT courses that contained an ECT treatment associated adverse events



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

Adverse Events

- Anesthetic Complications
- Headache
- Memory Deficit
- Other
- No Adverse Event

Source: Office of the Chief Psychiatrist Database

Restrictive Practices

Restrictive Practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with mental health or disability issues. Restrictive Practices should only be used when there is no less restrictive way of providing treatment or preventing injury or damage to people and resources. This section reports on the restrictive practices of seclusion and restraint events occurring in WA authorised mental health units.

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.

Patients requiring multiple events of seclusion and/or restraint during their period of care are patients who have particularly challenging behaviours and consideration needs to be given to the severity of the mental illnesses being experienced by the patients that may have resulted in multiple events and longer periods of seclusion and/or restraint. The Chief Psychiatrist and mental health staff are committed to implementing evidence-based state-wide best practice clinical/therapeutic interventions with the aim of reducing the use of seclusion and restraint.

Work continues at the national level to gain a consistent approach to defining and reducing restrictive practices across jurisdictions (e.g. the Restrictive Practices Working Group, sub-group of the Safety and Quality Partnerships Standing Committee), of which the Chief Psychiatrist is a member.

Reporting of Restrictive Practices

The Chief Psychiatrist is responsible under the Act to monitor and report restraint and seclusion events occurring within authorised mental health units in WA, both at the State and National level.

A system of monitoring and evaluating restrictive practice events and their rates has been established in the Office of the Chief Psychiatrist (OCP) to ensure the reporting of seclusion and restraint events is accurate and complete. Staff in the OCP undertakes a process of validating the data received against the data collected by mental health services. The system involves mental health services using the Chief Psychiatrist Approved Forms for reporting seclusion (Forms 11A-11G) and/or restraint (Forms 10A-10I); the Approved Forms are available on the Chief Psychiatrist website www.chiefpsychiatrist.wa.gov.au.

In all cases of seclusion and restraint, the appropriate Approved Forms must be completed to authorise the event, inform a psychiatrist of the event, record patient observations and record details of examination of the patient within six hours of completion of the event. In addition, Approved Forms must be completed to extend or revoke authorisations' for seclusion and/or restraint events. The completed Approved Forms must be sent to the Chief Psychiatrist where OCP staff review the Approved Forms, collate the data, monitor compliance with the Act, and liaise with mental health services to validate the data. Restrictive practice events are closely monitored and where concerns are identified, the Chief Psychiatrist and/or his staff engage directly with the services regarding the issues.

In keeping with the goals for 2018/19 the Chief Psychiatrist published seclusion and restraint data at the mental health service level for the first time in 2018-19. These data will be published biannually and not quarterly as stipulated in the Annual Report 2017-18.

It is anticipated that the publication of seclusion and restraint data on the Chief Psychiatrist's website will help to promote openness and transparency around the use of restrictive practices by mental health services in Western Australia.

It is important to note that the variability in the rates of seclusion and restraint between hospitals may be due to a variety of factors such as the acuity of the patient population. Small numbers of acutely unwell patients with challenging behaviours can have a disproportionate effect on the rates of seclusion and restraint at a service. The Chief Psychiatrist consults with the relevant mental health services about their practices and strategies for reducing the use of restrictive practices in these complex cases and is confident that the services are providing high quality care. The Chief Psychiatrist endorses ongoing education sessions for all mental health clinicians working in authorised mental health services to ensure compliance with completion of Approved Forms.

Seclusion

The Chief Psychiatrist is committed to reducing and where possible eliminating the use of seclusion in mental health services across WA. Significant initiatives have been made in mental health services to reduce and eliminate the use of seclusion.

Seclusion may be used to prevent a person from physically injuring themselves or others, or persistently causing serious damage to property. 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.

The Mental Health Act 2014 relevantly provides for the conditions under which Seclusion may be used. 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 other 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. It is the Chief Psychiatrist's expectation that medical practitioners attend the patient as soon as practicable after the patient was placed in seclusion, rather than towards the end of the duration of the order.

A post-seclusion physical examination must occur within six hours of the person being released from seclusion. It is our expectation that the post-seclusion examination occurs as soon as practicable.



'Seclusion is the confinement of a person who is being provided with treatment or care at an authorised hospital, by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave.'

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

Mental Health Act 2014

Each seclusion event must be reported using the Chief Psychiatrist Approved Forms, as stipulated in the Act and available at: <https://www.chiefpsychiatrist.wa.gov.au/legislation/forms-mha-2014/>.

During the 2018-19 financial year, there were 11,752 separations (discharges), for 7,363 individuals. Of these, 365 individuals (5%) were secluded involving a total of 1,552 seclusion events Table 5. The majority of seclusion events (n=1,352 (87%)) involved patients aged 18-64 years.

Table 5: Number of seclusions reported to the Office of the Chief Psychiatrist

Age Group	Separations	Individuals Separated	Individuals Secluded	Seclusion Events
Patients under 18 years of age	1,135	643	44	156
Patients aged 18–64 years	9,473	6,089	315	1352
Patients aged 65 years and older	1,144	657	6	44
Total	11,752	7,363	365	1,552

Seclusion Events - Total Population (All Ages)

Duration of Seclusion Events

Of the 1,552 seclusion events reported, 22% lasted less than 60 minutes, 53% lasted between 60 and 120 minutes, and 25% lasted more than 120 minutes (Table 6). The median duration for seclusion ranged from 37 minutes for events lasting less than 60 minutes through to 231 minutes for events lasting more than 120 minutes.

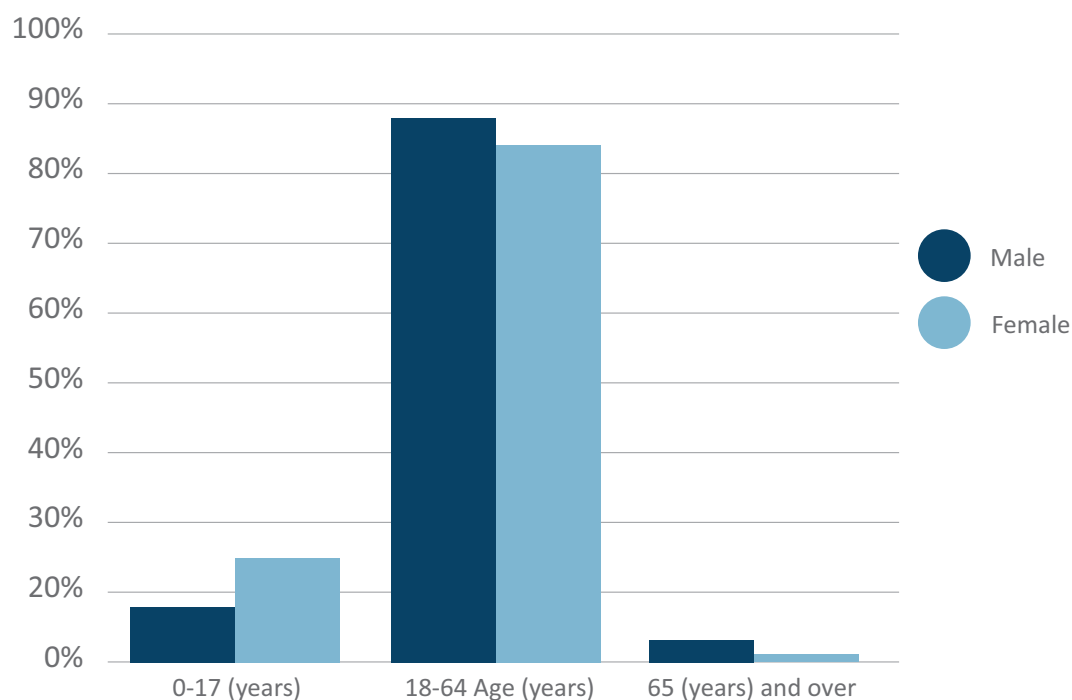
Table 6: Duration of seclusion events in authorised Mental Health units – Total population

Length category	Individuals*	Events	Median Duration in minutes
Less than 60 minutes	143	335	37
60 to 120 minutes	249	820	105
More than 120 minutes	130	397	231

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

Of the 365 individuals secluded, the majority (65%) were male patients and 35% female patient. Of the 1,552 seclusion events reported, male patients were involved in 68% and female patients in 32% of events. Of the 1,059 seclusion events involving a male patient 88% were aged 18-64 years, 8% involved children <17 years and 4% involved people 65 years or older (Figure 13). Of the 493 seclusion events involving a female patient, 15% involved young women aged <17 years, which was almost double that of seclusion events involving males aged <17 years (8%).

Figure 13: Proportion of Seclusion Events by Gender and Age Group



Source: Office of the Chief Psychiatrist Database

Seclusion Events – Patients under 18 Years

Duration of Seclusion Events

There were 44 patients aged less than 18 years who were secluded, accounting for 156 seclusion events. The majority of patients <18 years (80%) were secluded less than 5 times, and 20% were secluded more than 5 times.

Of the 156 seclusion events reported for patients less than 18 years old, 44% lasted less than 60 minutes, 46% lasted between 60 and 120 minutes, and 10% lasted more than 120 minutes (Table 8). The median duration of seclusion for each category (Table 8) was less than for the overall duration shown for the total population in Table 7.

Table 8: Duration of seclusion for patients under 18 years

Length category	Individuals*	Events	Median Duration in minutes
Less than 60 minutes	30	68	33
60 to 120 minutes	27	72	89
More than 120 minutes	13	16	153

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

Seclusion Events – Patients 18 – 64 Years

Duration of Seclusion Events

Of the 315 patients aged 18–64 years who were secluded, 84% were secluded less than 5 times, 10% between 5 to 10 times, and 6% were secluded more than 10 times. Of the 1,352 seclusion events reported for patients aged 18–64 years, 20% lasted less than 60 minutes, 53% lasted between 60 and 120 minutes, and 27% lasted more than 120 minutes (Table 9). The median duration of seclusion was similar to the pattern observed for the total population in Table 7.

Table 9: Duration of seclusion for patients aged 18–64

Length category	Individuals*	Events	Median Duration in minutes
Less than 60 minutes	111	264	40
60 to 120 minutes	217	728	105
More than 120 minutes	115	360	230

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

Seclusion Events – Patients 65 Years and Over

There were 44 seclusion events reported for 6 patients aged over 65 years. Due to the small number of patients secluded, further statistics are not reported in order to prevent identification of individuals.

National Key Performance Indicators for Seclusion Events

The Australian Institute for Health and Welfare (AIHW) reports annually on national and state/territory yearly seclusion rates in acute mental health facilities. The Chief Psychiatrist is responsible for collating WA data on seclusion and for reporting these data to the AIHW for inclusion in the national restrictive practices dataset. The AIHW comparative data for 2017–18 showed WA with a seclusion rate of 4.3 per 1,000 bed-days, the lowest rate in Australia, and the average duration of an episode of seclusion was 2.2 hours, the second lowest in Australia. To make this clear one in 34 admissions to an acute mental health inpatient unit experienced seclusion.

The rate of seclusion events within WA authorised mental health inpatient units during the 2018–19 financial year was 6.8 per 1,000 bed-days. The rate of seclusion was lowest in older adult mental health services at 0.2 per 1,000 bed-days and the rate of seclusion events in adult mental health services was 7.6 per 1,000 bed-days. The rate of seclusion events was highest for child and adolescent mental health services (21.2 per 1,000 bed-days) and forensics services (18.4 per 1000 bed-days).

The rate of seclusion in the 2018-19 financial year is markedly increased from the rate of 4.3 per 1,000 bed-days in the 2017-18 financial year. It is important to note that a small number of patients with challenging behaviours have contributed to this increase. Overall, 6 patients had 30 or more seclusion events each; equating to 609 seclusion events in total and accounting for 39% of all seclusion events. The Chief Psychiatrist closely monitors these cases and this may involve the Chief Psychiatrist and his staff engaging directly with the services to ensure the treatment and care being provided to the patient are appropriate and meet the Chief Psychiatrist's standards, and to ensure clinicians are being supported.

Restraint

Bodily restraint can be used to prevent the person from (i) physically injuring themselves or others, (ii) persistently causing damage to property, or (iii) to provide the person with treatment when the use of restraint is unlikely to pose a significant risk to the person's physical health. The Act contains specific principles relating to the use of bodily restraint, including what degree of force is acceptable and that the person being restrained, must be treated with dignity and respect.

Restraint may be initially authorised for a maximum of 30 minutes, and a mental health practitioner or nurse must be in physical attendance with the person at all time, 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 authorised. If the person is restrained for longer than 6 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 our expectation that the post-restraint examination occurs as soon as practicable.

Under the Act, restraint events must be reported to the Chief Psychiatrist through the Chief Psychiatrist Approved Forms (<https://www.chiefpsychiatrist.wa.gov.au/legislation/forms-mha-2014/>), with the exception of restraints occurring to escort a patient to seclusion. All mental health services continue to maintain their own restraint register for their internal reporting requirements to enable cross-checking and validation of the number of restraint events notified to us.

For the 2018-19 financial year there were 11,752 separations (discharges), involving 7,363 individuals. Of these, 415 patients (6%) were restrained involving a total of 1,333 events of restraint (Table 10).



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

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

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

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

Mental Health Act 2014

Table 10: Number of restraint events reported to the Office of the Chief Psychiatrist

Age Group	Separations	Individuals	Individuals Restrained	Restraint Events
Patients under 18 years of age	1,135	643	61	249
Patients aged 18-64 years	9,473	6,089	318	984
Patients aged 65 years and older	1,144	657	37	100
Total	11,752	7,389	416	1,333

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

Restraint Events – Total Population (All Ages)

Duration of Restraint Events

Of the 415 patients who were restrained, 88% were restrained less than 5 times, 8% were restrained between 5 and 10 times, and 4% were restrained more than 10 times. Of the 1,333 restraint events reported, 68% lasted less than 5 minutes, 17% lasted between 5 and 10 minutes, and 15% lasted more than 10 minutes (Table 11). The median duration of restraint ranged from 2 minutes for restraints lasting less than 5 minutes to 21 minutes for restraints lasting more than 10 minutes.

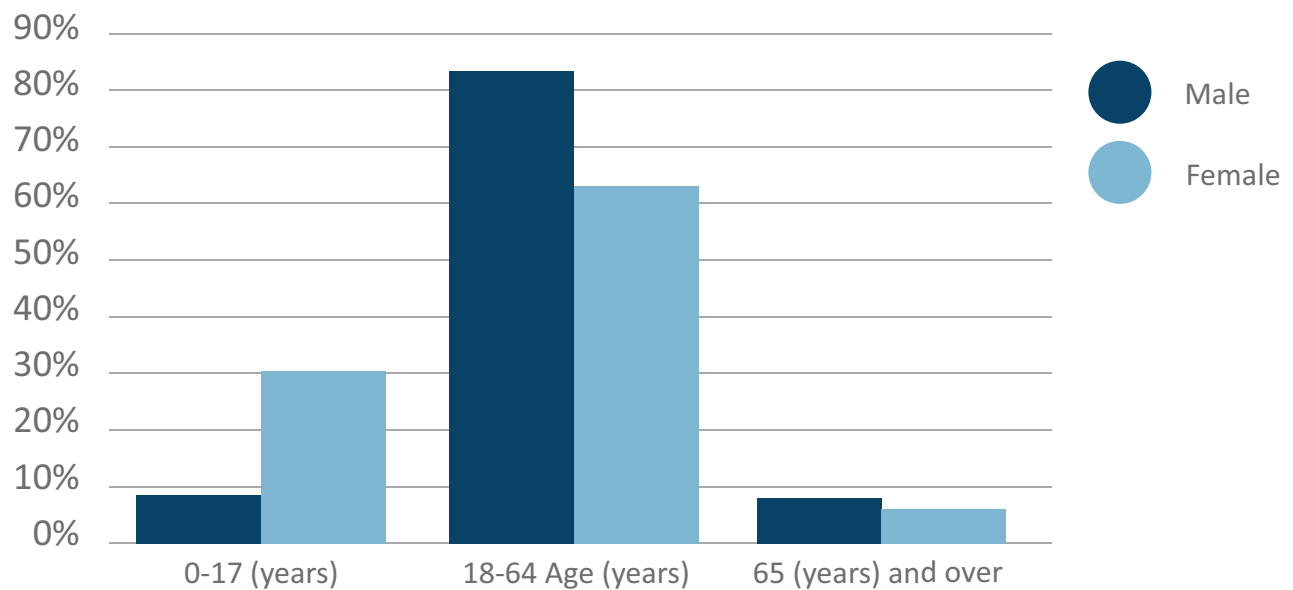
Table 11: Duration of restraint events in authorised Mental Health units – Total Population

Length category	Individuals*	Events	Median Duration in minutes
Less than 5 minutes	312	914	2
5 to 10 minutes	143	224	6
More than 10 minutes	89	195	21

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

Of the 415 individuals restrained the majority were male (53%) and 47% were female patients. There were 710 restraint events involving a male patient and of these, 83% involved a male patient aged 18-64 years, 9% involved males <17 years and 8% involved males 65 years or older (Figure 14). Of the 623 restraint events involving a female patient, 30% involved young women aged <17 years, which was over three-times the proportion of restraint events involving young males aged <17 years (9%). Just under two-thirds (63%) of females restrained were aged 18-64 years and 7% were 65 years or older.

Figure 14: Events of Restraint by Gender and Age Group



Source: Office of the Chief Psychiatrist Database

Physical or Mechanical Restraint across all age groups

The majority (99%) of restraints involved the patient being physically restrained (n=1,324) with 9 events involving mechanical restraint of the patient. Due to the small number of restraints involving mechanical restraint of the patient, no further details can be provided in order to prevent the patient identification.

Restraint Events – Patients under 18 Years

Duration of Restraint Events

Of the 61 patients less than 18 years of age who were restrained, 52 were restrained less than 5 times and 9 patients were restrained more than 5 times. Of the 249 restraint events involving patients aged less than 18 years, 44% lasted less than 5 minutes, 23% lasted between 5 and 10 minutes, and 33% lasted more than 10 minutes. The median duration ranged from 2 minutes for restraint events lasting less than 5 minutes to 30 minutes for restraint events lasting more than 10 minutes (Table 12).

Table 12: Duration of restraint events for patients under 18 years

Length category	Individuals*	Events	Median Duration in minutes
Less than 5 minutes	43	109	2
5 to 10 minutes	32	58	7
More than 10 minutes	20	82	30

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

Restraint Events – Patients 18 – 64 Years

Duration of Restraint Events

Of the 318 patients aged 18 to 64 years who were restrained, 283 were restrained less than 5 times, 25 patients between 5 and 10 times, and 10 patients were restrained more than 10 times. Of the 984 restraint events reported, 74% lasted less than 5 minutes, 16% lasted between 5 and 10 minutes, and 10% lasted more than 10 minutes. The median duration ranged from 2 minutes for restraints lasting less than 5 minutes to 17 minutes for restraints lasting more than 10 minutes (Table 13).

Table 13: Duration of restraint events for patients aged 18–64 years of age

Length category	Individuals*	Events	Median Duration in minutes
Less than 5 minutes	241	726	2
5 to 10 minutes	101	154	6
More than 10 minutes	62	104	17

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

Restraint Events – Patients Over 65 Years

Duration of Restraint Events

Of the 37 patients aged over 65 years who were restrained, the majority (84%) were restrained less than 5 times and 16% of patients restrained more than 5 times. Of the 100 restraint events reported, 79% lasted less than 5 minutes, 12% lasted between 5 and 10 minutes, and 9% lasted more than 10 minutes. The median duration of restraint was shorter than for the total population (Table 11) ranging from one minute for restraints lasting less than 5 minutes to 15 minutes for restraints lasting more than 10 minutes (Table 14).

Table 14: Duration of restraint events for patients over 65 years

Length category	Individuals*	Events	Median Duration in minutes
Less than 5 minutes	29	79	1
5 to 10 minutes	10	12	6
More than 10 minutes	7	9	15

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

National Key Performance Indicators for Restraint Events

The Australian Institute for Health and Welfare (AIHW) reports annually on national and state/territory yearly restraint rates in acute mental health facilities. As for seclusion events, the Chief Psychiatrist is responsible for collating WA data on restraints and reporting these data to the AIHW for inclusion in the national restrictive practices dataset. The AIHW comparative data for 2017-18 showed WA with a restraint rate of 5.1 per 1,000 bed-days, the second lowest rate in Australia.

The rate of restraint events within WA authorised mental health inpatient units during the 2018-19 financial year was 5.8 per 1,000 bed-days. The rate of restraint was lowest in older adult mental health services at 1.4 per 1,000 bed-days and the rate of restraint events in adult mental health services was 5.7 per 1,000 bed-days. The rate of restraint events was highest for child and adolescent mental health services (28.7 per 1,000 bed-days) and forensics services (17.6 per 1000 bed-days).

Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist

The Mental Health Act 2014 (the Act) requires mental health services (s.526) to report deaths and other notifiable incidents (s.254(1); s.525) of mental health patients (s.524) to the Chief Psychiatrist as soon as practicable, ideally within 48 hours of the event. Reporting to the Chief Psychiatrist is required in addition to all other reporting requirements that services are required to undertake, including both internal management structures within the service and reporting to external government agencies.

Notifiable incidents must be reported either via the *Datix Clinical Incident Management System* (Datix CIMS) or by completing the OCP⁵ *Notifiable Incident Reporting Form* available on the Chief Psychiatrist website. Notifiable incidents must be reported as soon as practicable to the Chief Psychiatrist, ideally within 48 hours of the event occurring. Each notifiable incident relating to a mental health patient is reviewed to determine whether the incident fits within the Chief Psychiatrist's statutory remit and coded accordingly.

The *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist*, (the Notifiable Incident Policy), outlines the reporting process for notifiable incidents to be reported to the Chief Psychiatrist. Separate Notifiable Incident Policies have been developed for public hospitals and community health services, private hospitals and Non-Government Organisations (NGOs), and Private Psychiatric Hostels, due to the different requirements for notifications each of these agencies are required to undertake.

Review of the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist

Each of the three Notifiable Incident Policies 2015 was due for review as soon as practicable, two years after commencement of the Act. The Notifiable Incident Policies 2015 were internally reviewed and discussed by senior OCP staff before being released for stakeholder consultation in 2018- 2019. The feedback received was reviewed and incorporated in each of the Notifiable Incident Policies 2015, as relevant, along with feedback that had been provided by services since the launch of the Policy in 2015 and during consultation in 2018-19. Following consultation with key stakeholders, the Notifiable Incident Policies were updated during the 2018-19 financial year and are located on the Chief Psychiatrist website www.chiefpsychiatrist.wa.gov.au. Key changes to the Notifiable Incident Policies 2018 are discussed within the relevant notifiable incident section below.

Public Mental Health Services

The Department of Health Operational Directive (OD_058815) for the Notifiable Incident Policy for public mental health services was rescinded as the Office of the Chief Psychiatrist is now an independent statutory office and the Notifiable Incident Policy 2018 was distributed directly to Health Service Providers.

⁵ Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.

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

Private Mental Health Services and Non-Government Organisations

Legal advice obtained in the 2018-19 financial year advised that Non-Government Organisations that employ mental health clinicians to provide mental health services meet the definition of a mental health service and therefore, have a statutory requirement to report notifiable incidents to the Chief Psychiatrist. All relevant Non-Government Organisations were advised in writing on 10 January 2019 that as of 1 February 2019, they were expected to comply with the Notifiable Incident Policy for private hospitals and NGOs. The updated Notifiable Incident Policy for Private Mental Health Services now includes advice for relevant Non-Government Organisations to report notifiable incidents to the Chief Psychiatrist.

Private Psychiatric Hostels

Private psychiatric hostels are included in the definition of a mental health service under s.252 and s.507 of the MHA 2014. The MHA 2014 refers to the Hospitals and Services Act 1927 for definitions of private psychiatric hostels and their residents. Under the Hospitals and Services Act 1927 (Part 1; 2(1)), private psychiatric hostel means private premises in which 3 or more persons reside and are treated or cared for who are socially dependent because of mental illness and are not members of the family of the proprietor of the premises. Under the Hospitals and Services Act 1927 (Section 26P), resident, in relation to a private psychiatric hostel, means a person who is (a) socially dependent because of mental illness; and (b) who is residing and being cared for or treated in the hostel.

Staff in the Office of the Chief Psychiatrist works with staff from the three other government agencies that also have a remit to monitor notifiable incidents in Private Psychiatric Hostels; the Mental Health Commission, the Department of Health Licensing and Regulatory Unit, and the Mental Health Advocacy Service. These agencies work closely to ensure that licensees of the hostels comply with their legislative requirements to provide high standards of care to their residents and that all notifiable incidents are reported as required by legislation or contractual requirements.

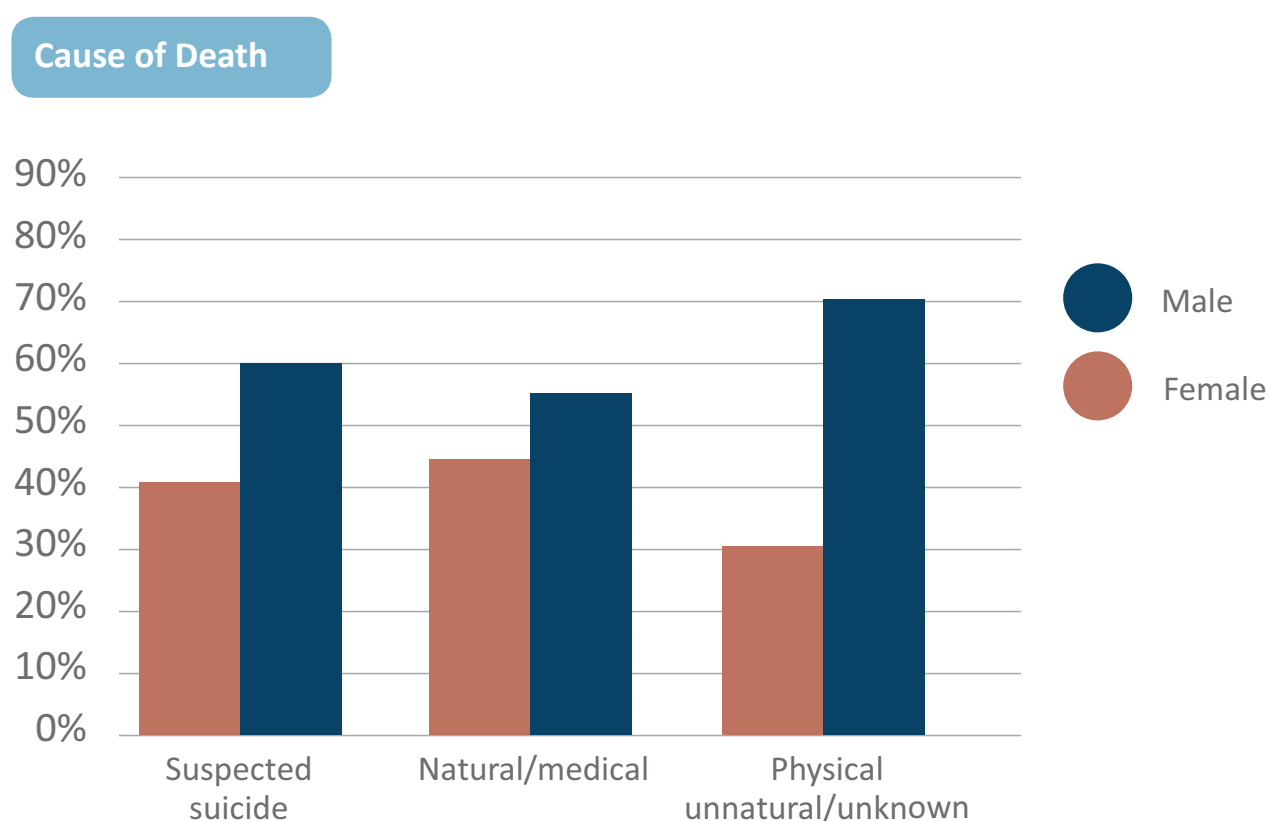
Notifiable incidents reported to the Chief Psychiatrist 2018-19

Deaths

Any deaths of active patients receiving mental health care who are in the care of a health service, and any deaths that occur within 28 days of discharge or deactivation of a patient from a health service, must be reported to the Chief Psychiatrist, even if the health service becomes aware of the death after the 28 day period. One of the changes to the Notifiable Incident Policies included reducing the time for reporting deaths of discharged or deactivated patients from three months to 28 days. As this change occurred during the 2018-19 financial year, a small number of deaths reported to the Chief Psychiatrist occurred more than 28 days and within three months following discharge of the patient.

The Chief Psychiatrist received 208 notifications from mental health services regarding deaths of patients during the 2018-19 financial year, of which 43% were reported to be due to natural causes, 23% were suspected to be suicide, 7% were reported to be due to physical/unnatural causes and for 28% the cause was unknown at the time of reporting. A higher proportion of the deaths reported involved men (61%) than women (39%) and this was consistent across each of the causes of death (Figure 15).

Figure 15: Cause of deaths reported by Gender



* Physical/unnatural deaths included but were not limited to, deaths due to homicide, falls, motor vehicle accidents, and unintentional drug overdose.
Source: Office of the Chief Psychiatrist Database and Datix CIMS

Almost two thirds (65%) of deaths due to natural causes involved a person aged 65 years or older. The majority of deaths due to unnatural or unknown causes were reported for adults aged 25-64 years (78%).

Of the 45 notifications of suspected suicide incidents, the majority (89%) of suspected suicides notified to the Chief Psychiatrist related to adults aged 25 years of age and older, with 11% involving adolescents less than 25 years of age. Just over half (51%) of suspected suicides involved an active mental health consumer, 27% of these individuals had been assessed in an Emergency Department prior to their death and 22% involved a patient who had been discharged or deactivated from a mental health service within three months of their death.

Other Notifiable Incidents

There were 4,205 notifiable incidents reported for 1,464 patients, with a median of three incidents reported per patient. In a small proportion of events (2.6%), two types of incidents were reported and in 9% of events two or more patients were involved. The majority of incidents involved an involuntary patient (65%), 5% involved a patient who was referred under the Mental Health Act for assessment and 30% involved a voluntary patient. Over half (61%) of incidents involved a male patient.

The most frequently reported primary incident was aggressive behaviour/assault, which was the primary incident for 76% of notifications. The second most frequently reported primary incident related to involuntary/referred patients being absent without leave (AWOL) accounting for 10% of notifications and 4% of notifications related to a missing, high-risk voluntary patient. A small proportion of notifications related to the attempted absconding of a patient (1.4%), 7% to an attempted suicide, and 2% reported an incident of a sexual nature such as sexual contact, assault, harassment or indecent act. The remaining 0.03% of notifiable incidents reported were serious medication errors, unreasonable use of force by a staff member or allegation of murder/homicide comprised 0.03% of events.

A secondary incident was reported for 2.6% of patients (n=108) with the most frequently reported incidents being aggressive behaviour/assault (n=44), an incident of a sexual nature (as above) (n=35) and attempted absconding (n=13).

Other Notifiable incidents required to be reported to the Chief Psychiatrist

- Assault and/or aggression
- Sexual contact and/or allegation of sexual assault
- Non suicidal self-injury/harm
- Attempted suicide
- Absent without leave (AWOL)
- Missing person
- Serious medication error
- Unlawful sexual contact suspected between a patient/other person and a staff member
- Unreasonable use of force by a staff member

The majority of notifiable incidents (88%) were reported through Datix CIMS with the remaining 12% reported through the Chief Psychiatrist's Notifiable Incident Form, which is primarily used for reporting by mental health services outside the public health system, such as Non-Government Organisations, and Private Psychiatric Hostels. In the public mental health services the severity of the incident is coded for all events where health care was determined to have contributed to, or caused, the incident. Of the 3,717 incidents (88%) reported through Datix CIMS, the patient outcome indicated that there was either minimal or no harm for the majority of patients, (87%), 2% resulted in moderate harm, and 0.7% resulted in serious harm/death. All incidents resulting in serious harm or death are investigated by the service. The remaining 10% of incidents were not given a severity code indicating that a clinical review of the incident had found that the health care provided to the patient had not contributed to, or caused, the incident.

The Chief Psychiatrist reviews all serious clinical incidents and where indicated, follows-up directly with the relevant service and/or may undertake a targeted review of the incident.

Aggression and/or Assault involving a Patient

There were 3,214 primary notifications of aggression and/or assault notifications reported in the 2018-19 financial year, relating to 2,999 incidents (some services notified separately for both parties involved (n=215 (6.7%)). The 3,214 notifications involved 959 patients and accounted for 75% of all notifiable incidents reported to the Chief Psychiatrist. Two-thirds (66%) of aggression/assault incidents involved male patients and 34% involved female patients. More than one patient was involved in the event in 11% of aggression/assault incidents.

The median number of aggression and/or assault incidents was four per person. Over half (60%) of the 959 patients involved in aggression and/or assault had one notification, 15% had two events reported, 9% had three

events reported, and 16% of patients had four or more notifications of aggression and/or assault. Of particular concern was the small number of patients who had a large number of aggressive and assault events notified. Five per cent of patients had nine or more notifications of aggression and/or assault and 16 patients had 20 or more notifications.

The aggression and/or assault incidents reported to the Chief Psychiatrist were classified by the type of behaviour being exhibited (e.g. assault, destruction of property, refusal of treatment) and who the patient was



Aggression and/or Assault (patient to any other person(s)) includes physical or threatening behaviour towards other patients or residents, members of staff or visitors and includes destruction of property. It also includes incidents where a patient or resident of a psychiatric hostel is a victim of aggression. Aggression and/or assault can occur within an inpatient setting (including on hospital grounds and Emergency Departments), at a community mental health service or during staff assessment of the client at their home or other place, or at a private psychiatric hostel.

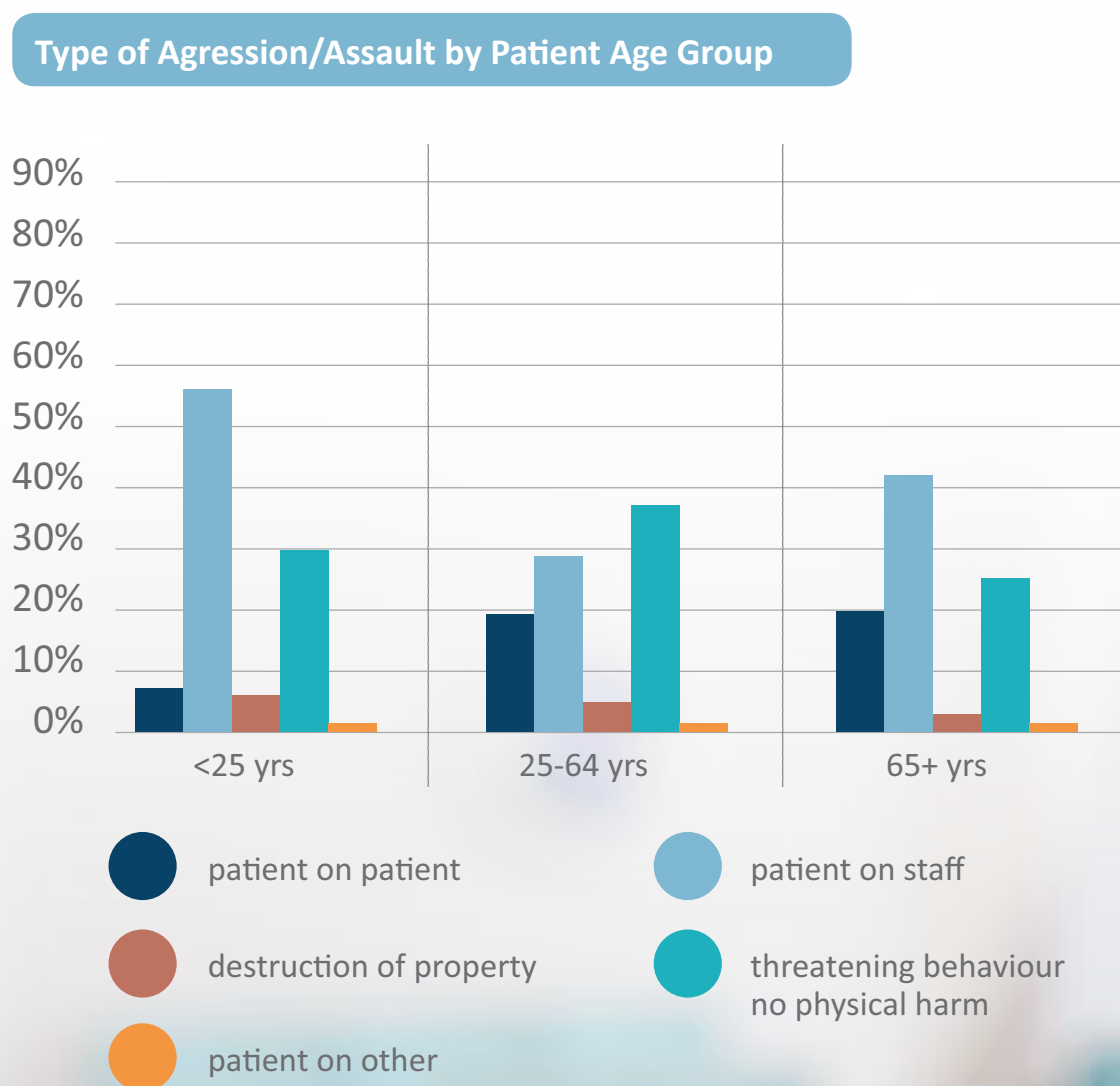
directing the aggression and/or assault toward (e.g. another patient, staff, other person). The most frequently reported primary type of aggressive behaviour involved the patient being aggressive towards, or assaulting a staff member (41%) or behaving in a threatening manner towards staff and/or other patients, but without causing physical harm 32%, equating to 73% of all aggression and/or assault incidents. Aggressive behaviour/assault by a patient to another patient was reported in 14% of notifications and destruction of property in 5%. A small proportion of notifications reported aggression and/or assault by the patient towards other person, such as a visitor (0.8%), refusal of treatment (1%) or towards themselves (0.4%).

The majority 85% of notifications for aggression and/or assault events involved either patients <25 years of age (42%) or an adult aged 25-64 years (43%), with 15% involving patients 65 years and older. Over half (54%) of notifications involving young people <25 years involved the patient assaulting a staff member compared with 29% of events involving 25-64 year olds and 42% of events involving people aged 65 years or older (Figure 16). The second most frequently occurring aggression and/or assault event for each age group involved threatening behaviour without resulting in physical harm; 37% of incidents involving an adult aged 25-64 years, 30% of events involving youth <25 years of age and 25% of incidents involving patients aged 65 years or older. Notifications involving aggression and/or assault by a patient towards another patient were highest for adults 25-64 years (19%) and adults 65 years or older (20%).



Any deliberate self-inflicted bodily injury with the intention of ending one's life must 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. The classification of 'attempted suicide' is a clinical judgment made at the time of the incident.

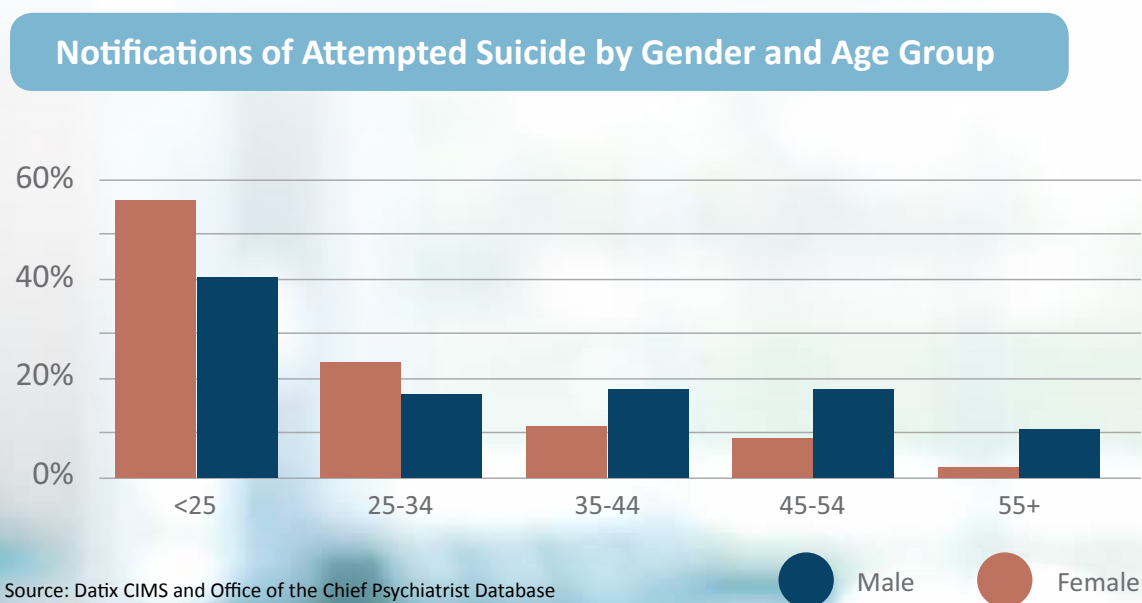
Figure 16: Primary types of aggression/assault incidents by patient age group



Attempted suicide

There were 304 notifications of attempted suicide to the Chief Psychiatrist during the 2018-19 financial year, involving 211 individuals. Approximately one-third (30%) of patients attempting suicide had multiple suicide attempts; 17% had two attempts, 6% had three attempts and 7% of individuals had four or more suicide attempts notified. Around three-quarters (74%) of notifications involved an inpatient, 18% involved a patient of a Community Mental Health Service, and 9% involved a person attending and Emergency Department. The majority of suicide attempts involved females (73%) with over half (53%) involving young women aged less than 25 years, 25% were aged 25-34 years and 22% were aged 35 years or older (Figure 17). For males, the highest proportion of attempted suicides occurred in adolescents <25 years of age (41%), 15% were aged 25-34 years and 44% were aged 35 years or older.

Figure 17: Notifications of attempted suicide by gender and age group



Any deliberate self-inflicted bodily injury with the intention of ending one's life must 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. The classification of 'attempted suicide' is a clinical judgment made at the time of the incident.

Absent Without Leave (AWOL) Involuntary and Referred Patients

There were 398 notifications of an involuntary patient or a patient referred for assessment under the MHA 2014 being AWOL, relating to 299 patients. The majority of AWOL patients (75%) had one event, 16% had two events, and 9% of patients had between three and six AWOL events reported. The majority of AWOL patients (92%) were involuntary at the time they went AWOL and 8% were patients who had been referred for assessment. In addition, there were 70 notifications of attempted absconding.

Over half of AWOL patients were male (63%) and 37% were female. The distribution of AWOL events by gender and age group is shown in Figure 17. The majority of AWOL patients were aged less than 45 years and the gender distribution was similar across each of the age groups.

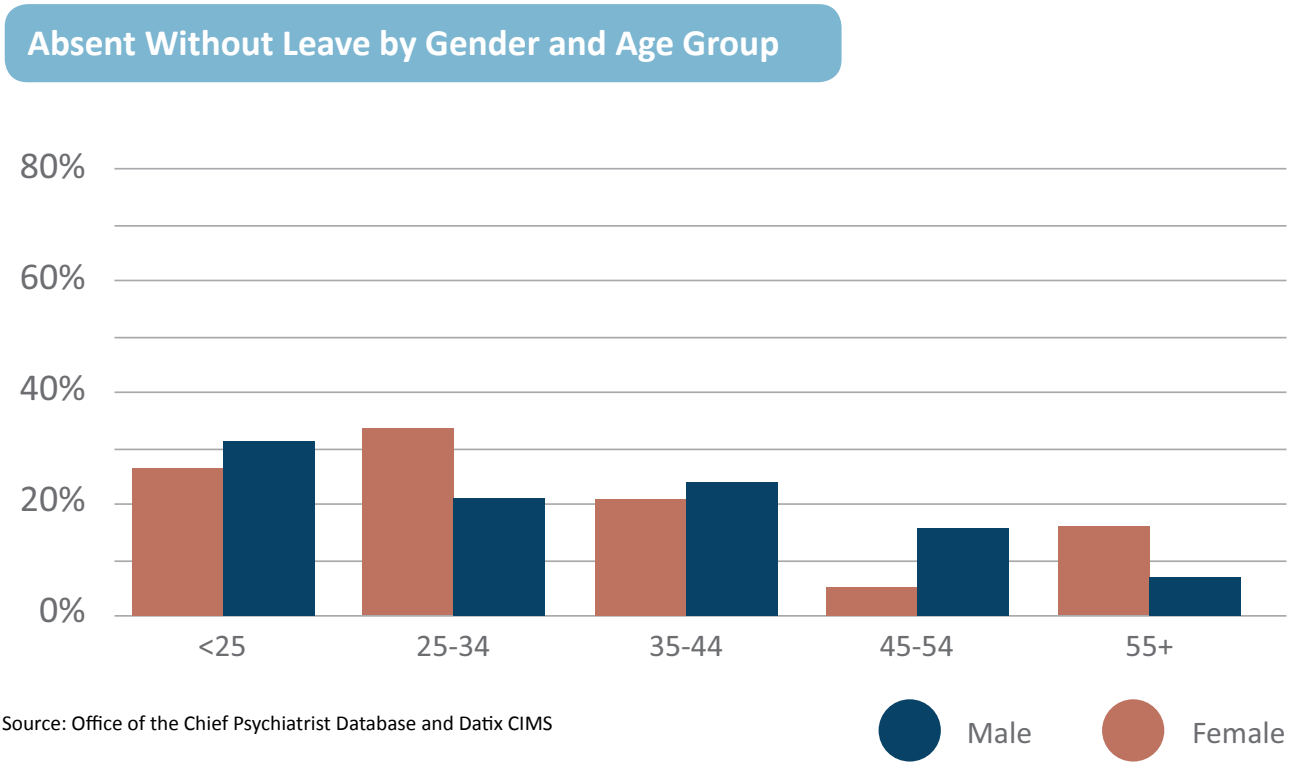
Police were notified by the mental health service that the patient was AWOL in for 56% of incidents. Around half (51%) of patients who were reported AWOL were located on the same day, 22% within 24 hours, and 17% were located within two to four days. The average (mean) length of time a patient was AWOL was 7 days. Almost all (98%) of AWOL patients had been located by the end of the 2018-19 financial year. The Chief Psychiatrist was notified that fewer than five patients experienced serious harm while they were AWOL.



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:

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

Figure 18: Absent Without Leave Involuntary and Referred Patients by Age Group

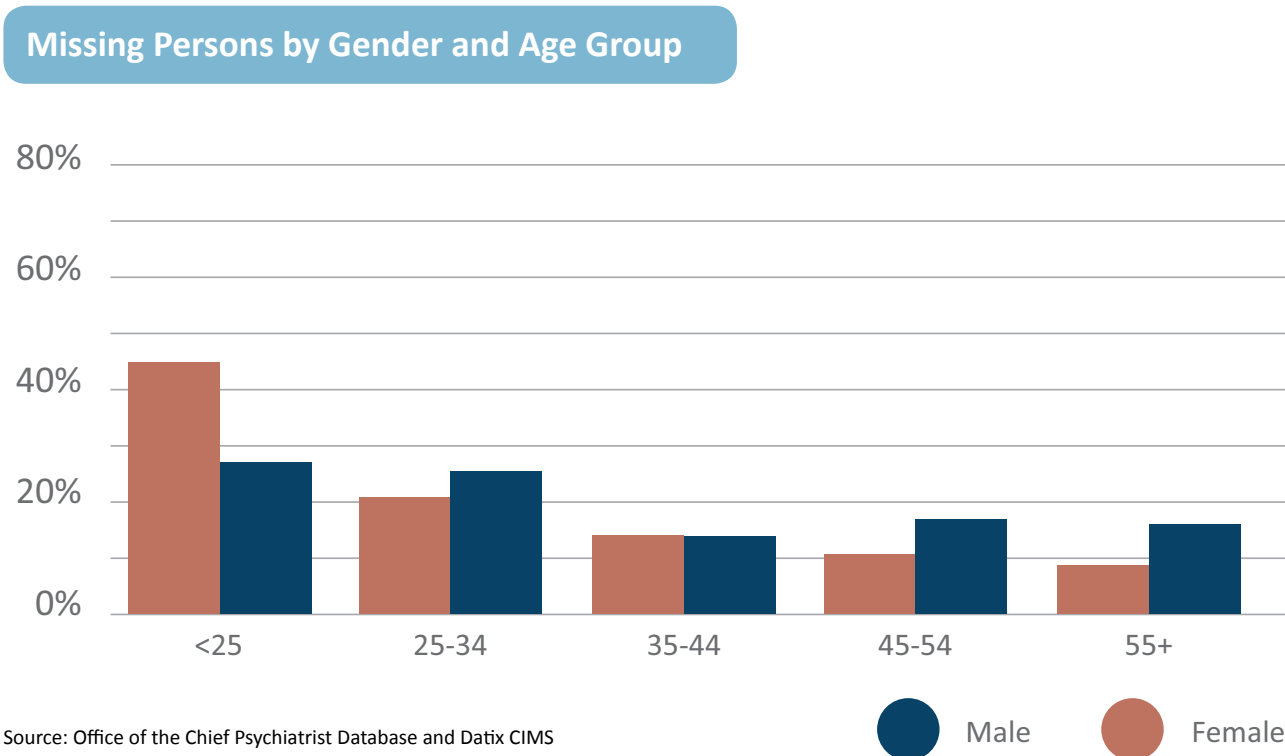


Missing Persons – Voluntary Patients of Mental Health Services at High Risk

There were 174 notifications of voluntary patients reported as missing from a mental health service, involving to 163 individuals, of whom 56% were female and 44% male. A higher proportion of females (44%) than males (27%) aged <25 years were reported as a missing person. Conversely, a higher proportion of males aged 25-34 years (26%) and aged 45-54 years (17%) were reported as a missing person than females of the same age, 21% and 11% respectively (Figure 19). The majority of patients (94%) had one notification informing the Chief Psychiatrist that they were a missing person and 6% had between two and four events reported.

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

Figure 19: Missing Person by gender and patient age group



Serious Medication Error

During the reporting period there were five incidents pertaining to serious medication errors reported to the Chief Psychiatrist in the 2018-19 financial year. The small number of incidents prevents publication of any further details of these events.

Allegations of Unreasonable Use of Force by Staff

For the reporting period, there were six allegations of unreasonable use of force on a patient by a staff member of a mental health service reported to the Chief Psychiatrist. The small number of incidents prevents publication of any further details of these events.

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



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

The Chief Psychiatrist followed up directly with each health service provider involved, to obtain and review the investigation reports.

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

All allegations of sexual assault reported to the Chief Psychiatrist are investigated by the mental health service providing notification of the allegation and the incident may also be investigated by the Chief Psychiatrist.

There were 57 notifications of sexual contact/assault reported during the 2018-19 financial year relating to 48 incidents (some services notified separately for both parties involved). Following investigation by the mental health service, one quarter (25%) of the allegations reported were found to be unsubstantiated or delusional. Over half (54%) of the 48 notifications related to an allegation of assault, 29% were reported as mutual sexual contact between patients and 17% were classified as inappropriate behaviour.

The majority of the 57 notifications received involved a female (61%) and 39% involved a male. Of the notifications involving a female 39% were <24 years of age and for notifications involving a male over half (60%) were <24 years of age. The majority of notifications related to involuntary or referred patients (54%) and 46% of incidents involved voluntary patients.

Allegations of unlawful sexual contact between a staff member of a mental health service or a private psychiatric hostel and a patient/resident, or unlawful sexual contact that is alleged to have occurred between the patient within a hospital setting and another person that is not a patient or staff member of a mental health service, must be reported to the Chief Psychiatrist. For the reporting period, there were <5 allegations of unlawful sexual contact by a staff member toward a patient of a mental health service. The Chief Psychiatrist followed up directly with each health service

provider involved, to obtain and review the investigation reports.⁶

Homicides

The Chief Psychiatrist commenced collecting data on homicides allegedly committed by a mental health patient in the 2018-19 financial year. Six notifications of homicide allegedly committed by a person who was a mental health patient were received during the 2018-19 financial year.



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

6 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.

Private Psychiatric Hostel Notifiable Incidents Reported to the Chief Psychiatrist 2018-19

The Private Psychiatric Hostel Notifiable Incidents reported to the Chief Psychiatrist are included in the overall statistics reported in the previous section. The following data consist only of notifiable incidents involving residents of a Private Psychiatric Hostel.

There were 47 notifiable incidents reported to the Chief Psychiatrist for the 2018-19 financial year of which 28% were incidents of aggression, 32% for a missing person, 21% attempted suicide and 12% related to an allegation of sexual assault.



Incidents of Sexual Contact and/or Allegations of Sexual Assault (patient to any other person(s)) that occurred within an inpatient setting (including EDs and hospital grounds), community mental health service (this includes incidents occurring during staff assessment of the client at their home or other place) or at a private psychiatric hostel, must be reported to the Chief Psychiatrist. 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 traumatize patients who may have experienced sexual assault in the past. However, consensual sexual activity is permitted within private psychiatric hostels. Inappropriate sexual behaviour includes behaviour that is sexual in nature but not directly involving other patients or staff (e.g., removing clothing, disinhibited sexual behaviour).

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' ⁶

Other Statutory Reporting

Admission of a Child to an Adult Inpatient Mental Health Unit

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

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

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

There were 8 notifications to the Chief Psychiatrist of a child <18 years of age, being admitted to a mental health service. The average (mean) age of children admitted to an adult inpatient unit was 17 years of age. Two-thirds (62%) of the children were segregated from the adults in the ward and all were assigned a 1:1 special. The majority of notifications were from regional hospitals.

A validation process of compliance with reporting was undertaken in consultation with staff in the Mental Health Data Collection in the Department of Health, to determine whether all required notifications had been received in the 2018-19 financial year. The data indicated that under reporting was occurring in some mental health services. The Chief Psychiatrist wrote to Chief Executive Officers advising them of the

lack of compliance with reporting as required under the Act s.303 and requesting that clinicians were reminded of their responsibility to comply with reporting. Increased reporting has been noted since this correspondence.



Validation process to assess compliance with reporting undertaken

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

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

The use of off-label treatments provided to a child who is an involuntary patient must be reported to the Chief Psychiatrist, including the type of off-label treatments provided and the reason for the decision. For the reporting period, there were 16 notifications about children who were involuntary patients and received off-label treatments, which is less than the number of notifications received in the 2017-18 financial year. All notifications were from mental health services in the metropolitan area. The average (mean) age of involuntary children provided with an off-label treatment was 17 years of age.

Under-reporting of off-label treatment was identified in the 2017-18 financial year and mental health services were reminded in

writing of their statutory requirement to report off-label treatment to the Chief Psychiatrist. However, the number of notifications received in the 2018-19 financial year is likely to represent continued under-reporting.

In May and June 2019, the Monitoring Team met with pharmacists from the Perth Children's Hospital and Fiona Stanley Hospital to discuss the issues around mandatory reporting of off-label treatment to children <18 years of age who are involuntary patients. The pharmacists highlighted the important issue of prescribing practices across child and adolescent psychiatry as well as primary health and the need to remind prescribers of the mandatory requirements for reporting off-label treatment to the Chief Psychiatrist. The Chief Psychiatrist is committed to working with health services to increase reporting compliance and will continue to monitor reporting compliance.



Emergency Psychiatric Treatment

Under s.204 of the Act the medical practitioner who provided Emergency Psychiatric Treatment (EPT) must give the Chief Psychiatrist a copy of the record of the treatment provided on the approved form 9A. EPT does not include the use of ECT, psychosurgery or prohibited treatments (including deep-sleep therapy, insulin coma therapy and insulin sub-coma therapy). A medical practitioner may provide a person with EPT without informed consent.

There were 138 cases of EPT reported to the Chief Psychiatrist, of which 49% were female and 51% male patients. The majority of patients receiving EPT were adults aged between 25 and 64 years (48.5%), with 9% aged 65 years or older. Just over one-quarter (27.5%) of patients were aged 18-24

years and 15% were <18 years of age. The types of treatment provided to the patient included the patient receiving medication alone (87%) or the patient receiving medication in conjunction with the patient being secluded and/or restrained (13%). The majority of notifications were from metropolitan hospitals (91%), with 9% from WA Country Health Services.

Urgent Non-Psychiatric Treatment Reporting Requirements

Under s.242 of the Act the person in charge of the Authorised Hospital must report the provision of Urgent Non-Psychiatric treatment to the Chief Psychiatrist through submission of the approved form.

There were <5 episodes of urgent non-psychiatric treatment reported and all were treated in the metro hospitals. The small number of notifications prevents further examination of these data.

Urgent Non-Psychiatric Treatment Reporting Requirements

Under section 242 of the Act the person in charge of the Authorised Hospital must report the provision of Urgent Non-Psychiatric treatment to the Chief Psychiatrist through submission of the approved form 9B, 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.

Approving Involuntary Treatment Orders within a General Hospital

Under s.61(2)(b) of the Act, the Chief Psychiatrist or delegate, must provide consent for a patient to be detained on an involuntary treatment order within a general hospital setting (approved form 6B). The treating psychiatrist must report to the Chief Psychiatrist, at the end of each consecutive 7-day period for the duration of the order using the approved 6B attachment form.

The Chief Psychiatrist or delegate authorised 150 involuntary treatment orders in a General Hospital setting during the 2018-19 financial year. Of the 150 orders, 45% involved a general hospital admission of 7 days or less, 23% comprised a general hospital admission between 8 to 14 days and 32% a general hospital admission of more than 14 days. Of the 150 orders there were 130 patients of which 18% were for patients under the age of 18 years.

Of the 130 patients, 51% (n = 66) were in general hospital for 7 days or less, 23% (n = 30) were in general hospital for between 8 to 14 days and 35% (n = 46) were in a general hospital for more than 14 days. A small number of patients (n = 11) were admitted to a general hospital on more than one occasion.

When the patient stays more than seven days in a general hospital, the mental health clinicians must submit a weekly report to the Chief Psychiatrist using the 6B Attachment form. For orders that were valid for more than 7 days, the Chief Psychiatrist received 63% of the required approved 6B attachment forms. More specifically the Chief Psychiatrist received 47% of the required 6B attachments for patients that were in a general hospital for 8 – 14 days and 66% of the required attachments for patients that were in a general hospital for more than 14 days. When these are overdue, Chief Psychiatrist staff follow-up with the mental health clinicians with the aim of ensuring compliance with reporting under the Act.

The Office of the Chief Psychiatrist collaborates with the Mental Health Advocacy Service to validate 6B Inpatient Treatment Orders notified to the Chief Psychiatrist. This established validation process aids cross checking of Inpatient Treatment Orders, Expiry and Revocation and overcomes many limitations in the reporting system and improves the overall validity of the notification of orders.

Our Research and Strategy Program

The Research and Strategy Program was established in 2017. The overall objective of the program is to support the delivery of safe, high quality treatment and care by undertaking research, reviews and investigations in a way which supports evidence informed decisions, supports the endeavours of clinicians and services to continuously improve the quality of services and builds the capacity of the mental health sector.

The Program has the following three core components:

Research and Sector Development

- Delivering a strategic research program;
- Disseminating findings from research, reviews and investigations; and
- Translating knowledge from international and national advances in mental health to the Western Australian context.

Reviews and Investigations

- Undertaking system-wide, service level and individual reviews and investigating issues of a complex and sensitive clinical nature to inform future service development and quality improvement; and
- Providing high level clinical advice to the Chief Psychiatrist.

Stakeholder Engagement

- Partnering with mental health clinicians in key areas of the work program to enhance services and build sector capacity; and
- Engaging stakeholders across mental health and health services, non-government agencies and the university research sector to address complex inter-sectoral issues.

Research and Sector Development

Strengthening Quality Improvement (QI) and Innovation

The Office of the Chief Psychiatrist is leading a significant reform initiative, in collaboration with key partners, to build a system-wide QI program for mental health in WA. While there are a number of individual QI projects being implemented within mental health services in WA; there is no systemic approach to building a culture of improvement with the required investment in building organisational capacity and infrastructure required to reach sustainability. There is growing international momentum to adopt improvement science methods to underpin QI as a sustainable way of addressing complex quality issues in mental health care. Within Australia, following on from the findings of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities, a QI approach is being actively pursued in NSW.

In 2018 we published a discussion paper entitled Mental Health Quality and Safety in WA: Building the Foundations for Improvement which argues the case for developing a QI program for mental health across the State. The paper was presented at a number of key groups including the Mental Health Quality and Safety in WA Committee, the Co-Leadership Safety and Quality Mental Health Steering Group and the Mental Health Network Executive Advisory Group. As part of the discussions the following stages were presented as being essential to building a system-level sustainable QI program. The focus at this point in time has been on the first stage.

Stage 1: Building a coalition of key stakeholder organisations

The support of Health Service Providers, the Department of Health as system manager, the Mental Health Commission and consumer and carer organisations is essential to co-designing and establishing a system-wide mental health QI program.

Stage 2: Engaging a partner organisation

Virtually all organisations that have successfully launched system-wide QI improvement programs have highlighted the importance of engaging an experienced external partner organisation.

Stage 3: Building workforce and organisational capacity and capability

This stage involves the introduction of training programs for staff and consumers and carers in improvement science and methodology and the use of QI tools. It also involves establishing the infrastructure, including the establishment of QI teams and QI coaches and ensuring that the information systems are fit for purpose.

Long-Term Treatment Outcomes in Early Psychosis Specialist Services

The aim of the research is to investigate whether people treated in specialist Early Intervention in Psychosis (EIP) services have better short and long-term outcomes when compared with those who receive standard treatment.

The first phase of the study, funded by the WA Mental Health Commission, was led by Dr Smith and Adjunct Associate Professor Theresa Williams in their previous roles within the WA Centre for Mental Health Policy Research. The research is being conducted in partnership with the Division of Psychiatry and the School of Population and Global Health at the University of Western Australia and the Centre for Clinical Research, North Metropolitan Health Service. Professor Flavie Waters, in her role at the Centre for Clinical Research, has taken on the role of Co-ordinating Principal Investigator with Dr Smith and Theresa Williams continuing as investigators within the research team.

To date the project has:

- Identified the study cohort from the two EIP services.
- Undertaken a preliminary analysis of data from the two EIP service cohorts.
- Selected a matched comparison control group.

Linked the EIP cases and standard treatment controls to the Hospital Morbidity Data Collection, the Mortality Data Collection, the Emergency Department Data Collection and the Mental Health Information System.

The final phase of the study will involve analysing this linked data base to better understand the long term outcomes of treatment and care provided in specialist EIP services.

Reviews and Investigations

Targeted Case Review

After receiving a request from the Office of the State Coroner, the Chief Psychiatrist requested that an in-depth case review be conducted by the Senior Psychiatrist, Research and Strategy, into the treatment and care of an individual. The review report has been provided to the Coroner.

Review into the Treatment and Care of People with Severe Mental Illness and Challenging Behaviours

The Chief Psychiatrist has become increasingly concerned about the standard of care being provided to people with a serious mental illness and challenging behaviour. These individuals have multiple complex needs and, without appropriate care, are at high risk of becoming homeless, facing criminal charges or ending up in prison. They are some of the most vulnerable people in our community.

Clinicians have highlighted the difficulties they face, despite their best efforts, in meeting the complex needs of these individuals within the current service system. Families, in telling their stories and advocating for better services for their loved ones, have highlighted the high personal cost of inadequate care. The human cost to the individual consumers is often hidden to the wider community but is immense. Both clinicians and families have expressed their frustration with the current service system. They have identified service gaps, fragmented services or parts of the service system that are not well structured to meet the needs of these individuals and their families.

As a consequence, the Chief Psychiatrist has instigated a formal targeted review into the treatment and care of people who have a serious mental illness with complex needs and challenging behaviour. The Research and Strategy team within the Office of the Chief Psychiatrist have been tasked with undertaking the review to investigate the issues and, in partnership with key stakeholders, develop options to enhance future clinical services. Specifically, it aims to gain a deeper understand of the challenges and to shape the solutions by:

- Identifying the characteristics of this group of consumers.
- Exploring the barriers and enablers to providing high quality treatment and care.
- Estimating the number of consumers in this cohort.
- Mapping the current range of service types, configurations and models of care.
- Gaining an understanding of the consumer journey through the mental health service system to identify service use and the adequacy of the service response.
- Identifying 'best practice' models from other jurisdictions
- Developing options for future service development
- Disseminating the findings widely to inform and encourage debate on future directions.

The scope of the Review extends to all metropolitan adult mental health services, both inpatient and community.

To date the Review has:

- Undertaken an extensive consultation process with key stakeholders.
- Examined a wide range of material from previous reviews and investigations conducted by the Office of the Chief Psychiatrist.
- Carried out a literature search and examined models of care from other jurisdictions including interviews with clinical leads of innovative services in Queensland and Victoria.
- Examined the medical records of a small number of consumers with complex needs and challenging behaviours who had received treatment from multiple mental health services across the metropolitan area in order to better understand the patient journey and the adequacy of the service response.
- Surveyed each of the metropolitan Health Service Providers to identify the availability of specialist mental health services, both community and inpatient (acute and sub-acute), which are primarily dedicated to providing treatment for consumers with complex needs and challenging behaviours.

A draft report is currently being developed and on completion will be distributed and discussed with key stakeholders to gain their feedback prior to a final report being released.

Review into homicides allegedly committed by people who have had contact with, or were being treated by, WA mental health services during 2018

In 2018, there were 9 homicides allegedly committed by 7 people who had had contact with, or were being treated by, WA mental health services. This is an increase compared with a total of 9 deaths in the preceding 3 years (3 in 2015, 4 in 2016 and 2 in 2017). The Chief Psychiatrist was concerned about this increase and initiated a preliminary review into the treatment and care of the 7 individuals who allegedly committed the homicides in 2018.

The Review aims to:

- clarify possible factors which may be associated with this apparent spike in homicides by persons with a history of mental illness
- identify some of the common themes which, if addressed, will lead to improvements in the safety and quality of care.

The reviewers have examined Root Cause Analyses and other documentation completed by the Health Service Providers. A report is in the process of being completed which will inform the Chief Psychiatrist's decision as to what, if any, further action should be taken.

Peer Reviewed Journal Publication

Williams T, Smith G (2019) Laying new foundations for 21st century community mental health services: An Australian perspective, International Journal of Mental Health Nursing

Summary

While there has been a significant increase in investment in community mental health in Australia since the advent of the National Mental Health Strategy in the early 1990's, there has been little guidance on service design and delivery. This has led to a growing diversity of approaches and concern about the adequacy of care with repeated calls for a system overhaul. Consumers and carers have very largely been absent from decision-making about service design and development which has led to a system primarily designed by healthcare professionals. However, with the emergence of recovery as a core principle in mental health, it is time for consumers and carers to be centrally engaged in co-designing services with service providers.

This raises the question of whether dominant service delivery models – such as the growth of specialist teams/services, the changing balance between profession specific and generic case management roles in multidisciplinary teams and the separation of inpatient from community care – will prevail. Contentious issues in these three service delivery areas are outlined to stimulate debate and highlight the pressing need for national guidance on the configuration of community mental health services. Building on the lessons learned from the first National Mental Health Strategy, we outline a proposal for a co-designed National Framework for Community Mental Health Services to guide the delivery of care in a way which satisfies the aspirations of consumers, carers and mental health professionals alike.

Conference Presentations

You Can Lead a Horse to Water...Meeting the Challenge of Implementation

Paper presented by Adjunct Associate Professor Theresa Williams and Dr Smith at the International Forum on Quality and Safety in Healthcare held in Melbourne in September 2018.

Summary

Implementation research could be significantly improved by a more systematic approach to the use of causal theory that can provide practical guidance on how to promote behavioural change. This presentation:

- Analyses a series of studies highlighting strategies that have been used in implementing practice change; and
- Examines their effectiveness, through the 'lens' of motivational theory, which has the potential to reshape thinking about what health care organisations can do to promote clinical practice change.

Implementing Reform: What Works and What Doesn't?

Paper presented by Dr Smith at the The MHS annual conference held in Adelaide in August 2018.

Summary

The challenges of implementing clinical practice change at the organisational level are well documented. Many of the standard approaches such as clinical practice guidelines, policy directives and training have had limited impact on collective behaviour change. Evidence suggests that the implementation 'gap' can be attributed largely to two critical factors: a view of organizational culture that does not adequately reflect its complexity and diversity and a limited understanding of what motivates individuals and groups to change their practices. This presentation provides a brief analysis of selected studies from a literature review highlighting strategies that have been used in the implementation of practice change, focusing particularly on their effectiveness and the lessons that can be learned from them. It then looks at implementation through the 'lens' of a motivational theory with the aim of providing a potential explanatory mechanism for understanding the success or failure of various approaches. What is critical is not the 'what' - the individual strategy or group of strategies or the implementation framework, but rather the 'how' – the creation of an autonomy-supportive workplace environment that fosters staff engagement. This presentation describes a practical approach to supporting effective clinical practice change.

From Passive 'Receivers' to Active 'Co-Creators': Empowering Staff to Improve the Quality and Safety of Care

Paper presented by Dr Smith at the annual conference of the Royal Australian and New Zealand College of Psychiatrists held in Cairns in May 2019.

Summary

The challenges of implementing changes in clinical practice are well document with a recent observation that the drive for improved quality has 'frozen in time'. Despite widespread acknowledgement of the importance of engagement of front-line staff in the change process, the prevailing quality improvement strategies have largely been top-down with increasing control and standardisation. Dealing with this stagnation has proved remarkably difficult – so we need to tackle it in a new way. The presentation uses Self-Determination Theory (SDT), a widely researched and empirically validated theory of human need fulfilment and motivation, to provide a clearer understanding of why the implementation of change in clinical settings succeeds or fails. Selected examples of implementation studies, derived from a narrative review of the literature, are analysed using the lens of SDT to provide practical guidance on how to promote behavioural change within workplaces/organizations. Evidence suggests that the critical determinant in staff buy-in to practice change is not in the nature of the specific interventional tool(s), but in the degree to which the process is experienced by staff as meeting their psychological needs for autonomy, competence and relatedness. Recognition needs to be given to the critical importance of engagement of front-line staff in the co-creating and shaping of clinical practice change as a means of generating a sense of buy-in and ownership.

Our Projects and Intergovernmental Relations Program

The Projects and Intergovernmental Relations program serves as the liaison between the Chief Psychiatrist and other government agencies at state and federal level.

Co-Leadership Committee for Safety and Quality

The Chief Psychiatrist is a member of the Co Leadership Committee for Safety and Quality and participates as a rotating chair. The Co Leadership also comprises of representatives from the Mental Health Commission, Health Service Providers, Mental Health Advocacy Service, consumer and carer groups, State-wide Aboriginal Service and Primary Health Care Services.

The committee's main purpose is to:

- Strengthen collaboration partnerships and communication between agencies to ensure effective responses to Safety and Quality issues and reduce duplication.
- Provide a coordinating function for the governance of Safety and Quality by facilitating a shared understanding across mental health services.
- Build on the existing standards for accreditation and licencing.

Data

One area of focus in this past 12 months has been on tracking the many pieces of data that are collected in the realm of safety and quality to ensure that there are appropriate actions taken. The committee set up a data sub-committee who tracked, mapped and presented this data to the committee. What unfolded was that there were several other agencies also progressing in this area. The Department of Health –Patient Safety & Clinical Quality Excellence are developing the mental health tranche of a dashboard. The Mental Health Data Collection-data integrity have further refined their MIND dashboard and early meetings with the reviewers conducting the Clinical Review of Safety and Quality in Mental Health Services indicated that they will be mapping the safety and quality committees and the data.

In light of these developments the committee will strategically re-align with the recommendations from the review and view data in real-time from the dashboards.

State-wide Towards the Elimination of Restrictive Practices (TERP)

A further proposal to create a subcommittee that would establish a State-wide Towards the Elimination of Restrictive Practices (TERP) was accepted by the committee with the intention of assisting services in their pursuits of eliminating restrictive practices by;

- Providing a conduit to national information from the Safety Quality Partnership Standing Committee (SQPSC) on national and interstate Initiatives.
- Creating and fostering a consistent State-wide culture and approach that is supported by clinical and administrative leaders.
 - Providing a platform across the state for the cross-pollination of successful interventions.
 - Acknowledging the difficulties of the isolation and remoteness of rural clinical areas by providing a support and a sense of belonging.

Interagency Transport

The coordination of services such as police, ambulance and health service providers to safely transport patients both within the state and within the metropolitan area remains a priority for the Chief Psychiatrist. The Interagency Transport Forum has the Chief Psychiatrist as a member and has consistently ensured that the following principles are adhered to whilst transporting patients:

- That all staff have training in mental health ‘consumer engagement’
- That current training requirement meet the legislative requirements of the MHA, 2014
- That all staff involved in transporting consumers meet the Chief Psychiatrist ‘Standards for Clinical Care’
- That transport officers have training in the prevention and management of aggression.

Department of Health Coronial Review Committee

The Chief Psychiatrist is a member (ex officio) of the Coronial Review Committee. Many of the coronial investigations involved people who were suffering from a serious mental disorder. During the reporting period the need for postvention in rural areas was identified. The committee have acted on the Chief Psychiatrist’s input to ensure this service is instituted and continues to monitor the progress.

Memberships, Working Groups and Committees

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

- Australian Commission on Safety and Quality in Health Care Mental Health Reference Group
- Clinical Senate
- Co-Leadership Mental Health Safety and Quality Steering Group
- Coronial Review Committee
- Chief Psychiatrist Electroconvulsive Therapy Working Party
- Health Expert Advisory Group (national)
- Justice Health Project Oversight Committee
- Mental Health Network
- Peak Incident Review Committee
- Psychiatric Hostels Advisory Committee
- Reducing Adverse Medication Events in Mental Health Working Party (SQPSC subgroup)
- Restrictive Practice Subgroup (subgroup to SQPSC)
- Royal Australian & New Zealand College of Psychiatrists Committee for Examinations
- Royal Australian & New Zealand College of Psychiatrists Professional Practice Committee (PPC)
- Royal Australian & New Zealand College of Psychiatrists Evidence Based Practice Committee (EBPC)
- Royal Australian & New Zealand College of Psychiatrists Practice Policy and Partnership Committee
- Safety and Quality Partnership Sub-Committee (SQPSC)
- State Datix Committee
- Stimulants Assessment Panel (WA Health)
- WA Psychotropic Drug Committee
- WA Primary Health Alliance Steering Committee - Statewide Integrated Master Plan for Primary Mental Health, AoD and Suicide Prevention
- WA Therapeutics Advisory Group
- Member – World Psychiatric Association Working Group: Review of guidance on Relationships of psychiatrists, health care organisations and psychiatric associations with the Pharmaceutical industry.
- Adjunct Clinical Associate Professor, University of Western Australia School of Medicine
- Adjunct Associate Professor, University of Western Australia School of Medicine – Department of Psychiatry
- Journal reviewers: Australasian Psychiatry, ANZ Journal of Psychiatry, International Journal for Quality in Health Care, BMJ, BMJ Open, Journal of Pharmacoepidemiology and Drug Safety, Public Health Research and Practice

Glossary of terms used

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

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