CHIEF PSYCHIATRIST
of Western Australia

'Ensuring Safe and High Quality Mental Health Care'

Annual Report of the Chief Psychiatrist of Western Australia

01 July 2019 – 30 June 2020

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 2020.

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

Dr Nathan Gibson
CHIEF PSYCHIATRIST
ACCOUNTABLE AUTHORITY

8 September 2020

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 2020 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

8 September 2020

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.

We acknowledge 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, the Office of the Chief Psychiatrist does not have a Board.

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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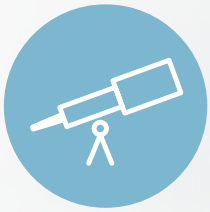
Foreword

As an independent oversight agent enshrined within the Mental Health Act 2014, the Chief Psychiatrist is required to produce an Annual Report. The Chief Psychiatrist acknowledges the dedicated work of the staff of the Office of the Chief Psychiatrist. The Chief Psychiatrist has prepared this Annual Report to assist planners and staff across the mental health sector to facilitate better care for consumers of mental health services and their families and supports. In that light, this report is commended to the Minister for Mental Health.

Dr Nathan Gibson MBBS FRANZCP
CHIEF PSYCHIATRIST

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

Statutory Framework and Role of the Chief Psychiatrist

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 several functions and strategies, including:

A Reporting System

Clinicians and service providers are, by statute, required to report to the Chief Psychiatrist on a range of notifiable incidents, including where there may be a negative outcome. They are also required to track certain processes and treatments (e.g. Electroconvulsive Therapy), 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 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 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

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

Events impacting on the activities of the Office of the Chief Psychiatrist

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

Just like the rest of the world, the Office of the Chief Psychiatrist was not set up to respond to the COVID-19 pandemic, in terms of meeting our statutory obligations. The activities of the Office were subject to a reliance on staff working remotely, and we had to rethink our ability to carry out functions like clinical reviews, provision of face:face training and Chief Psychiatrist visits to mental health services, whilst balancing our other responsibilities to ensure safe, high quality mental health care in unprecedented conditions for our generation.

The Chief Psychiatrist, in recognition of the impact of COVID-19 on the mental health sector, strongly supported the secondment of the Deputy Chief Psychiatrist to the position of Clinical Lead – Mental Health Workstream, COVID-19 Clinical Services and Operational Response Program at the Department of Health.

The Office continues to experience the reverberations of SARS-CoV-2, as we navigate the current phase of restrictions for this public health emergency.

Retirements, Resignations, Separations and Secondments

The Office experienced one retirement, one resignation and one separation from our Office and provided two secondment-out opportunities for staff.

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.

A significant amount of time, effort and resources went into working constructively with the Department of Justice and Mental Health Commission in developing a budget submission for the introduction of a new Criminal Law (Mental Impairment) Bill 2019, in terms of its impact on the statutory remit of the Chief Psychiatrist and his Office. Whilst on hold due to COVID-19, we anticipate this work will ramp up during the forthcoming financial year following the State election.

The Review of the Clinical Governance of Public Mental Health Services provided some key findings and observed patterns adversely affecting a more robust approach to governance initiatives within public mental health services. Significantly, the observation of 'unclear leadership, an apparent lack of integration between clinical and nonclinical systems, duplication of monitoring of performance' have all combined to manifest in a 'lack of clarity in roles, responsibility and accountability resulting in a system with limited support for quality and innovation'. The ten recommendations made have been met with varying degrees of endorsement from across all sectors. The Chief Psychiatrist has welcomed recommendation 6.2 Responsibility for monitoring the services delivered to assist people with mental health issues and agreed this should reside with the Office of the Chief Psychiatrist. However, a stringent limitation is the finite resources of the Office which will mean a slow implementation of this recommendation. The pathway provided by the Review i.e. 'expand the role of the Office of the Chief Psychiatrist from areas currently managed by the Mental Health Commission and transfer the responsibility and resources' is unlikely to be considered under the current prevailing economic conditions. Broadly, the findings of the Review of the Clinical Governance of Public Mental Health Services, were consistent with the findings of the LeCG report Functional Review of Roles and Responsibilities for Mental Health Program in WA – February 2009.

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 capitalized on opportunities to showcase the work of this Office through attendance and representation at various conferences and seminars.

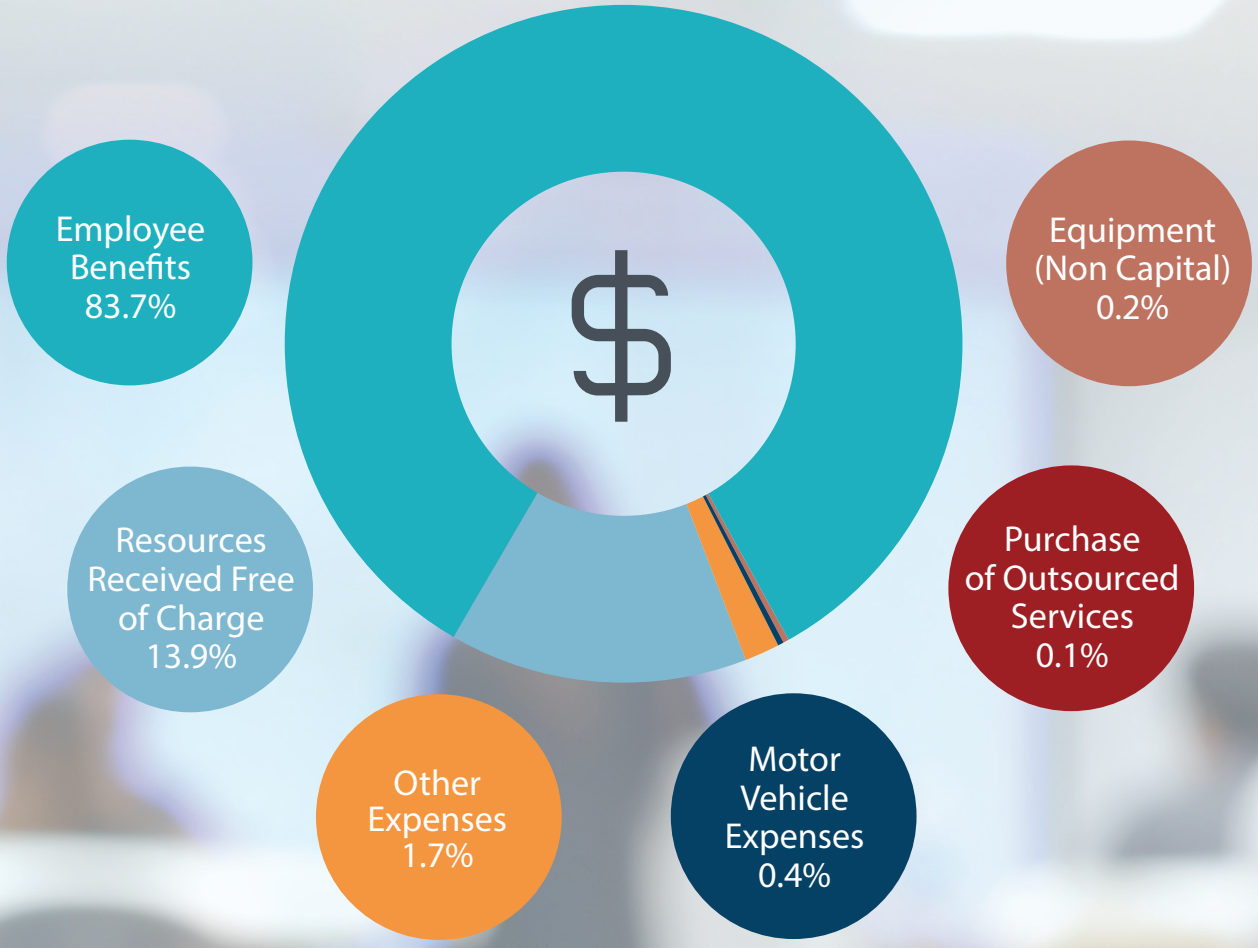
Who we work with

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 MHA 2014.

We engage closely with;

Our key strategic objective is to build on our strong external partnerships to facilitate safe high-quality mental health care. We have done 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 services sector to continuously improve to ensure our work adds value. We actively seek opportunities to review and reaffirm our stakeholder relationships in keeping with the aspirations of our Strategic Plan 2018-23.

How we spend our Money



Areas of significant focus relating to standards of clinical care

COVID-19 clearly dominated thinking and practice in 2020. There was reduced capacity for the Chief Psychiatrist's review process, but rigorous oversight of services continued in different ways. The most significant challenges to high quality mental health in Western Australia were not simply due to COVID-19, but were a mix of issues that have, in-essence, often been long-standing challenges. This is not an exhaustive list of the difficult matters 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.

The astute reader will note the similarity of issues with the preceding years Annual Report. 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.

COVID-19

COVID-19 saw a significant and timely response from the WA mental health sector. The State response to the COVID-19 crisis is well described in a range of departmental Annual Reports. It is important for the Chief Psychiatrist to focus on those issues relating to standards of care. The Chief Psychiatrist was actively involved in a range of state-level COVID-19 planning processes. The OCP developed a formal office plan regarding internal safe work practice during COVID-19.

COVID-19 impact on Chief Psychiatrist functions

The Deputy Chief Psychiatrist, Dr Sophie Davison, was seconded to the Department of Health to act as the Mental Health COVID-19 Clinical Lead for WA. The majority of OCP staff worked from home at the height of the COVID-19 restrictions. The Chief Psychiatrist continued to track sentinel events and provide active oversight on this matter. Active planning for the Review of Hostels continued. There was reduced direct visiting with mental health services, consumers and carers temporarily between March and June 2020. The Clinical Helpdesk continued as usual during the COVID-19 restriction period.

Alternate means of engagement

The Chief Psychiatrist noted the increase in telephonic and audiovisual clinical contacts and the reduction in direct face to face clinical contacts during the COVID-19 restrictions period. These data were tracked by the Department of Health. Standards regarding telephonic and audiovisual care (in the context of digital care) are being pursued by the Australian Commission for Safety and Quality in Health Care. When these are finalised later in 2020, there will be a requirement to consider WA's needs for the further development of standards, guidelines and protocols regarding non-face to face clinical contact.

Psychiatric Hostels

As with the aged care sector, residents of private psychiatric hostels are a group at seriously increased risk during a COVID-19 epidemic, given the generally older age of the residents, their frequent physical comorbidities and potentially reduced capacity to fully engage with public health strategies. The Chief Psychiatrist was and remains proactive in tracking the disaster planning processes for psychiatric hostels during the COVID-19 pandemic.

Significant improvements

WA has a high quality and well-resourced mental health system relative to most around the world, and there has been consistent development of this structure and network throughout 2019-20.

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

The pending **Criminal Law Mentally Impaired Bill** is highly anticipated. The **Sustainable Health Review**, having prioritised mental health remains a key driver for system improvement, which are being enacted by WA Health and the Mental Health Commission. The Clinical Governance Review has led to the welcome creation of the **Chief Medical Officer Mental Health**- a long-overdue clinical voice within the state mental health commissioning body. The establishment of the **Mental Health Executive Council** (MHEC) to bring the public sector mental health services together- the effectiveness of this governance change sits with Chief Executives of the Health Service Providers. The creation of the **Community Mental Health, Alcohol and Other Drug Council** (CMC) gives an importantly enhanced voice to the broader mental health sector. It will be important for the MHEC and the CMC to work together to reduce the inherent tension between clinical and non-clinical service development that still exists in Western Australia. More consistent collaboration between these components of the sector will provide better outcomes for individuals and their families.

The development of **Step Up-Step Down** services and the Mental Health Commission's focus on enhancing accommodation for individuals with mental illness is a key component to enhancing care. The announcement of **older adult beds** for individuals with neurological disorders and behavioural disturbance is a significant milestone for WA. The planning for **Community Care Units** to complement the range of community based residential services is also an important new step.

2019-20 has seen significant assertive planning steps for a range of priority issues.

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.

The significant assertive and collaborative work done by WA Health, the Department of Justice and the Mental Health Commission in this space to remediate these issues is acknowledged. Options to better support the mental health of prisoners within prison are being developed. More forensic mental health beds outside of prison are being developed. It will be some years before these

new services are actualised. Notwithstanding this, and skilled staff, forensic mental health service provision in WA is still deteriorating in the context that, for prisoners, there is insufficient access to care and standards of mental health care are not consistently being met. It is not uncommon for significantly mentally unwell prisoners and remandees to be discharged from hospital back to prison due to unavailability of beds.

The introduction of the new much-anticipated and well-crafted Criminal Law Mentally Impaired Bill will mean that individuals on Hospital Orders and Custody Orders will potentially, within the next 12-24 months, consistently use all the beds within the 30-bed Frankland Centre leaving no mental health beds available for the use of the remaining 7000 prisoners in Western Australia.

Despite long-term planning commitments, 2019-20 saw a worsening of this situation from the previous year.

Specialist clinical acute and rehabilitation community mental health services

There has been inconsistent use of language regarding community mental health across Australia. The majority of clinical mental health care in Western Australia occurs in the community. Hospitals represent the minority of clinical occasions of service in the mental health, although they are major and expensive events. Quality, evidence-based community mental health care is delivered to people in their own homes by a respectful, balanced and assertively collaborative mix of specialist clinical community mental health services, primary care and community-managed organisations providing for the correct balance of clinical and psychosocial care appropriate for each individual.

There remains a deficit of specialist clinical acute and rehabilitation community mental health services in Western Australia. 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. In addition, WA has the lowest average time spent by community mental health clinicians with community mental health patients of any state in Australia- we spend less time with community patients. 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 the Auditor General's Report into Adult Community Mental Health Services demonstrates there has been less system development of specialist clinical acute and rehabilitation community mental health 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.

Specialist clinical residential rehabilitation services remain a deficit in WA (Secure Extended Care Units, or equivalent and less restrictive options such as Community Care Units), but there has been an important step in the announcement of Community Care Unit development in WA. Going forward, this is another critical piece in the broader jigsaw of services. Thus, this matter is actively being addressed in planning.

Community mental health requires a balanced specialist clinical, primary care and psychosocial approach.

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 cohort and the complexity of the interface. The National Disability Insurance Scheme (NDIS) is a useful and contemporary approach. However, 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.

This matter remained unaddressed from the previous Chief Psychiatrist's Annual Report.

Physical health care in mental health

The issue of the physical health/mental health interface will require greater integration, particularly primary care integration is a key mental health recommendation in the Sustainable Health Review. There are a range of good quality improvement processes occurring at service level, but there is still not a consistent sector-wide approach.

Challenging behaviour and substance-induced psychosis

The Chief Psychiatrist's Challenging Behaviour Review finalisation has been delayed by COVID-19. It will be finished in 2020. The draft was circulated and placed on the Chief Psychiatrist's website for feedback. The issue of individuals with challenging behaviours and complex presentations remains an unresolved issue for mental health services, with not clear changes to service approach since 2018-19.

Restrictive Practice

Western Australia continues to lead Australia in the elimination of restrictive practice in mental health settings with low restraint and seclusion rates. However, an extremely disturbing trend began to emerge during 2019-20 in WA mental health units across several Health Service Providers- the increased use of prone restraint, with inconsistent monitoring of physiological parameters during prone restraint. Prone restraint increases the risk of death during restraint. The during 2019-20 Chief Psychiatrist wrote to all Chief Executives regarding this matter, seeking greater local oversight and a focus on eliminating prone restraint.

WA continues to perform well working towards eliminating restrictive practice but the increase in poorly monitored prone restraint is unacceptable.

Governance

In 2019-20, the Chief Psychiatrist continued to play 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 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 outcomes of the Clinical Governance Review have not directly addressed this matter of complex cross-agency operational coordination. It is a residual issue to be considered by the MHEC.

Sexual Safety

COVID-19 delayed the finalisation of the Chief Psychiatrist's Sexual Safety Guidelines. Every patient in a mental health inpatient unit has the right to feel sexually safe. Every family member has the right to know their loved one is sexually safe within a mental health inpatient unit. The Chief Psychiatrist will release this important document in late 2020.

Chief Psychiatrist's statutory oversight of the treatment and care of consumers of mental health services

The Chief Psychiatrist is responsible for overseeing the treatment and care of all patients of mental health services. This includes all voluntary patients, all involuntary patients, all patients referred under the *Mental Health Act 2014* for examination and all mentally impaired accused detained in an authorised hospital, and the treatment and care provided by public and private psychiatric hospitals, public community mental health services, private psychiatric hostels and non-government organisations providing clinical mental health services.

Setting Standards for Treatment and Care

The Chief Psychiatrist must discharge his responsibility for oversight of the treatment and care provided by mental health services by publishing Standards (s.515 MHA 2014) and Guidelines.

The Chief Psychiatrist has mandated the National Standards for Mental Health Services 2010 and developed 8 additional standards of clinical care that address particular issues of relevance to Western Australia or where particular attention needs to be focussed.

Standards for the Authorisation of Hospitals under the Mental Health Act 2014

547. Publication of guidelines and standards

(1) The Chief Psychiatrist must publish Guidelines for each of these purposes

(b) making decisions under section 26(3)(a) about whether or not a place that is not an authorised hospital is an appropriate place to conduct an examination;

The Chief Psychiatrist released the Standards for Authorisation of Hospitals under the *Mental Health Act 2014* in October 2019. The revised Standards apply to all mental health facilities especially those seeking authorisation under the MHA 2014.

The Authorisation Standards require services to work collaboratively with the Chief Psychiatrist from the initial planning stages, to discuss modelling and technological advancements across the design of the facility and in respect of the Chief Psychiatrist's Authorisation Standards and Standards for Clinical Care, that support and enhance contemporary clinical practice.

The Standards provide a pathway for design and planning and to guide architects in ensuring the requirements of an acute mental health inpatient unit are understood. There has been a plethora of research into the design concepts of mental health facilities in recent years and serve as drivers for safety, security and high-quality care, by providing areas that are private, promote sexual safety and preserve consumers' privacy and dignity in short, emphasises a person-centred approach to individualised care. Services must also ensure the design/refit of the unit provides gender specific areas, accommodates gender diversity, and provides a safe environment for those who are more vulnerable and at higher risk. There is a greater focus on access to appropriate outdoor spaces that are well planned and maintained post authorisation.

In keeping with contemporary thinking, the Standards have a significant focus on eliminating the use of restrictive practices. There is an expectation that new facilities seeking authorisation will commit to a culture which emphasises reduction of restrictive practices and focuses instead on de-escalation and a trauma-informed approach to care. The Chief Psychiatrist has advised services he is open to models that facilitate alternatives to seclusion and use of seclusion rooms, such as comfort rooms as contemplated by the Child and Adolescent Mental Health Services or the Safe Wards initiative.

Taking an alternative view into new design concepts for mental health facilities has been challenging, as the traditional custodial view remains within the broader health environment. However, services that are in the initial planning stage for new mental health facilities have worked hard to incorporate these principles whilst being challenged in terms of cost and economic viability.

Authorised Hospitals

541. Authorised hospital: meaning

An authorised hospital is -

(a) a public hospital, or part of a public hospital, in respect of which an order is in force under section 542; or

(b) a private hospital the licence of which is endorsed under the Hospitals and Health Services Act 1927 section 26 D A(2).

Currently there are 17 authorised facilities in Western Australia. The Chief Psychiatrist maintains a register of Authorised Hospitals in Western Australia. The register can be viewed on the Chief Psychiatrist's website:

https://www.chiefpsychiatrist.wa.gov.au/authorisations/authorised-hospitals-2/authorised-hospitals/

Although the Chief Psychiatrist did not receive any applications for the authorisation of a facility in this reporting period, the office has been actively collaborating and advising services that are planning new facilities. Staff from the Office have at the invitation of the Health Service for example, travelled to Geraldton on several occasions to meet with the Redevelopment Team, consulting and advising on the design concept for the new facility. These meetings included consumer and carer representatives, architects, design teams and clinical staff. The strong commitment to design a contemporary and modern mental health unit; one that promotes safety; reduces restrictive practices; provide trauma informed care and has a healthy proactive culture that promotes best practice is commendable.

The Chief Psychiatrist held discussions with the following services who have sought information about the requirements for Authorisation in terms of redevelopment and remodelling of an existing mental health facility.

- Fremantle Hospital - Remodelling of a ward to facilitate an improved standard of care
- Joondalup Health Campus – Extension to the existing mental health inpatient service to better service the local community
- Royal Perth Hospital - Remodelling of a ward to meet the needs of the inner-city community
- Broome Hospital – Contemplation of improved facilities to ensure safe high-quality care

We continue to liaise closely with services on matters that affect Standards of Authorisation, through visits to the following facilities;

- Perth Children Hospital (Ward 5) – to ensure a safe secure environment that positively impacts the consumer experience
- Ursula Frayne Unit – environmental scan identifying areas for upgrades to improve the standard of care
- Fremantle Hospital – inspection to inform on improvements that will result in an improved standard of care
- Fiona Stanley Hospital – inspection to inform on improvements that will result in a positive therapeutic environment

Specialised Inpatient and Community Mental Health Services

For the 2019 calendar year, 69,392 individuals received care from specialised inpatient and/or community mental health services , which include public and publicly contracted private providers. Most of these consumers were adults (70%) with 20% aged <18 years and 10% aged 65 years or older. A small proportion of these consumers (15%) accessed both specialised inpatient and community mental health services.

Inpatient mental health services

In the 2019 calendar year 10,517 people accessed inpatient mental health services, involving 16,501 separations. Inpatients 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. Inpatients can have a mental health status of either voluntary or involuntary during their admission with some patients having both a voluntary and involuntary status within one episode of care. Three-quarters (75%) of people have a voluntary legal status during their admitted episode of care equating to 7,926 people and 12,879 separations. There were 2,591 inpatients with an involuntary mental health status at some point during their admission, involving 3,622 separations.

Over the 2019 financial year, there were 781 specialised mental health inpatient beds, including Hospital in the Home (HITH) beds. Just over one-third (36%) of the inpatient beds were in North Metro Health Service, 21% in East Metro, 16.8% in South Metro and 16.7% in the publicly contracted private providers. The WA Country Health Service (WACHS) has 7.6% and Perth Children's Hospital has 2% of beds.

Community mental health services

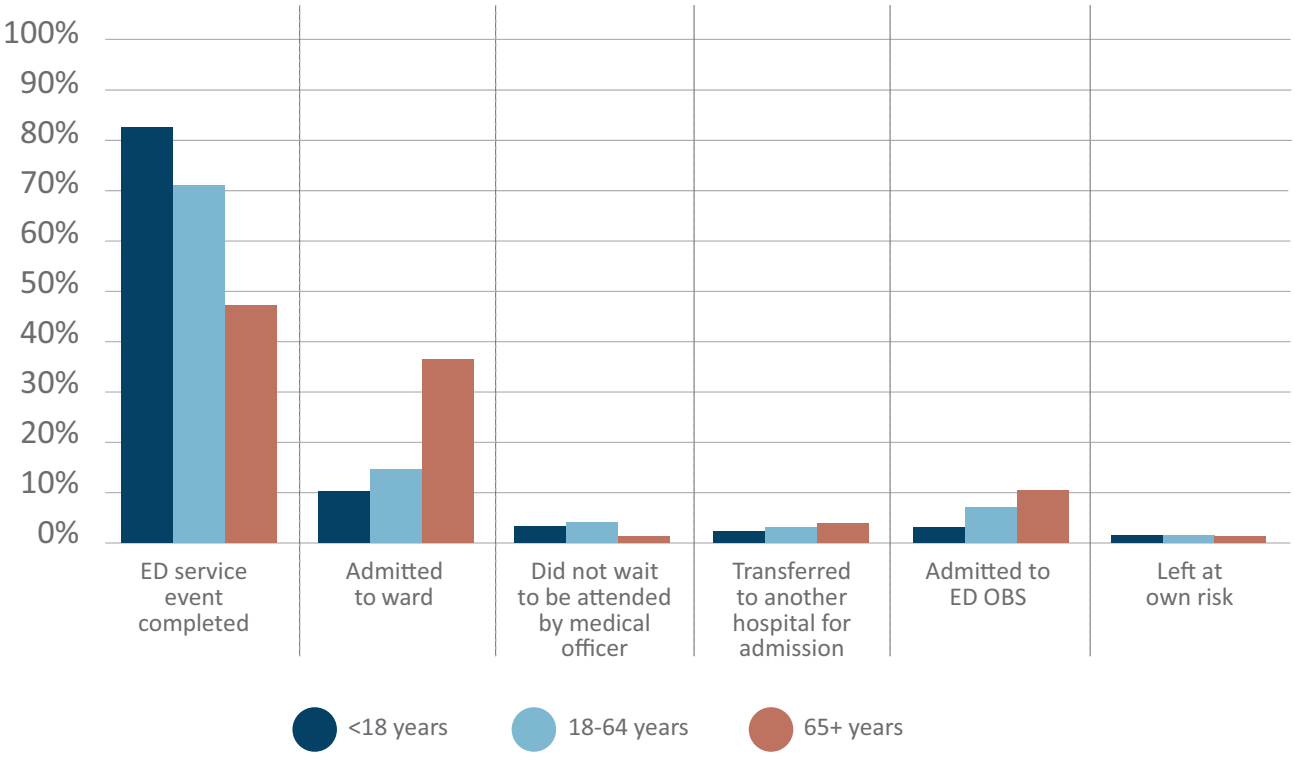
Community mental health services provided mental health care to 65,365 people involving 1,020,246 service contacts with specialised community mental health clinicians in the 2019 calendar year. This is an increase since 2018 of 6% in the number of consumers and the number of service contacts. The majority of consumers accessing community mental health services received treatment as a voluntary patient (98.6%). There were 709 consumers treated on a Community Treatment Order (CTO) with a total of 839 CTOs recorded for the 2019-20 financial year. A CTO is a legal order enabling an involuntary patient to receive treatment in the community. Some consumers may transition from a voluntary status to being on a CTO (and vice versa) within a single community episode of care.

Emergency Department Mental Health Presentations

Mental health presentations comprised 5.9% of the total number of Emergency Department (ED) presentations, equating to 62,762 attendances. Around three quarters (77%) of mental health ED presentations involved adults aged 18-64 years of age, with 13% involving people <18 years of age and 10% involving people 65 years and older. The median length of a mental health presentation for an ED episode of care increased with increasing age, ranging from 115 minutes for children and youth <18 years of age, 140 minutes for people <24 years to 18-24 years of age to 215 minutes for people aged 65 years and older.

Over half (56%) of people presenting to ED for a mental health issue departed under their own care, with 20% of people admitted to an inpatient unit, 6% transferred to another hospital for admission, and 12% admitted to an ED observation unit. A small proportion of people either did not wait to be attended by a medical officer 3% or left at their own risk 3%. The outcome of mental health presentations to the ED varied by age group (Figure 1). The proportion of people admitted to a ward or other inpatient unit increased with age from 9.6% for people <18 years to 36.5% for people 65 years and older. In contrast, over 83% of people <18 years of age and 71% of people 18-64 years of age were discharged under their own care compared with 47% of people aged 65 years or older.

Figure 1: Emergency Department Attendances Outcome by Age Group



Source: Emergency Department Data Collections

Private Hospitals Providing Mental Health Services

There are seven private hospitals providing mental health services, of which three are publicly contracted private providers which admit both public and private patients.

Private Psychiatric Hostels

There are 723 private psychiatric hostel (hostels) beds in Western Australia providing long-term accommodation for people with a psychiatric illness. Overall, 64% of residents of private psychiatric hostels are active with a Community Mental Health Service, 43% are active with NDIS services. In preparation for a review of the standards of clinical care being provided to hostel residents, the Chief Psychiatrist conducted a snapshot of 67% of the residents of private psychiatric hostels in November 2019; the results are provided on page 66.

Non-Government Organisations

In 2018 the Chief Psychiatrist received legal advice that Non-Government Organisations providing clinical mental health services come under the remit of the Chief Psychiatrist. There are sixteen Non-Government Organisations providing mental health clinical services, which are required to adhere to the Chief Psychiatrist's Standards for Clinical Care and to report notifiable incidents to the Chief Psychiatrist.

Statutory Reporting

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.

Electroconvulsive Therapy (ECT)

544. Chief Psychiatrist to approve mental health services

(1) The Chief Psychiatrist may, by order published in the Gazette, approve a mental health service as a mental health service at which electroconvulsive therapy can be performed.

(2) The order may specify any conditions subject to which electroconvulsive therapy can be performed at the mental health service specified in the order.

(3) The Chief Psychiatrist may, by order published in the Gazette, amend or revoke an order published under subsection (1)

Electroconvulsive therapy is the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anesthesia 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.

The provision of Electroconvulsive Therapy (ECT) in Western Australia is strictly regulated under the MHA 2014 Part 14, Division 1 sections 194 to 199. The Act prohibits ECT being given to children under 14 years of age and requires approval from the Mental Health Tribunal before ECT is provided to a patient on an involuntary treatment order, children 14 to <18 years of age, or persons classified as Mentally Impaired Accused. Where Emergency ECT is required to be performed on an adult involuntary patient of a person who is mentally impaired accused, approval from the Chief Psychiatrist must be obtained prior to the ECT being performed. Voluntary patients must provide informed consent prior to receiving ECT.

The Chief Psychiatrist has approved eleven Mental Health Services to perform ECT. These include three private hospitals (Hollywood Clinic, The Marian Centre, and Perth Clinic); two publicly contracted private hospitals (Joondalup Health Campus and St John of God Midland Public Hospital) and six public hospitals (Albany Health Campus, Armadale Hospital, Bentley Hospital, Fremantle Hospital, Rockingham General Hospital and Sir Charles Gairdner Hospital). The Chief Psychiatrist maintains a register of health services who have been approved as meeting the standards to perform ECT.

All approved suites will be reviewed in the 2021-22 financial year to ensure compliance with the Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy (2015). The Review for ECT services will coincide with formal visits pertaining to the Review of Authorisation of Authorised Hospitals.

Mandatory reporting ECT data to the Chief Psychiatrist

Mental Health Services are required under the MHA 2014 s.201, to report on any course of ECT which was completed or discontinued in the previous month to the Chief Psychiatrist. The MHA 2014 requires the person in charge of the mental health service to report details about the number of treatments within the course, the mental health status of the patient (voluntary, involuntary, referred, mentally impaired accused) and information about any serious adverse event that occurred during or after the completion of the course.

For the reporting period 1 July 2019 – 30 June 2020 there were 650 completed ECT courses reported to the Chief Psychiatrist involving adults over the age of 18 years, compared with 738 courses in the 2018-19 financial year (Table 1). There were no courses reported for patients under 18 years of age. Of the 650 courses, 585 (90%) were for patients with a voluntary status, 50 (8%) were for involuntary or referred status, and 15 (2%) were for mixed status (both voluntary and involuntary).

There were 6703 ECT treatments completed in the 2019-20 financial year, of which 5719 (85.5%) were acute treatments, 959 (14%) were maintenance and 25 (0.5%) consisted of emergency treatments (Table 1).

In the 2019-20 financial year there were 56 Emergency ECT treatments authorised by the Chief Psychiatrist or his delegate. Some of these Emergency ECT treatments are part of course of ECT, which were not completed during the 2019-20 reporting period and are therefore are not reflected in Table 1. These Emergency ECT treatments will be reported in the financial year when the ECT course is completed. The number of Emergency ECT treatments given in ECT courses that were completed during 2019-20 are shown in Table 1. These include some emergency ECT treatments authorised in previous financial years.

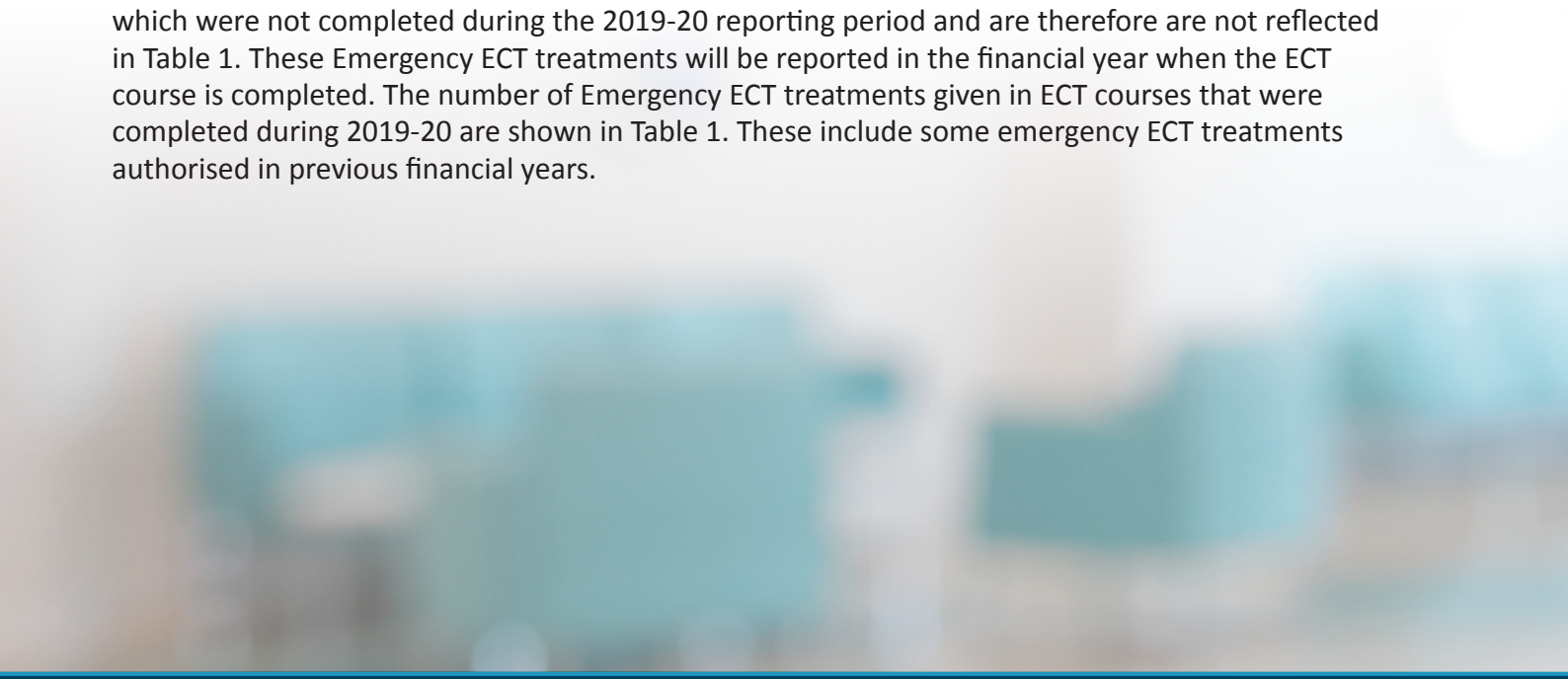


Table 1: ECT courses and treatments completed in the 2019-20 financial year.

Age	Status	Number of ETC Courses Completed in 2017-18	ECT Treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
Patients over 18	Voluntary	585	4890	875	0	5765
	Involuntary / Referred[a]	50	592	7	17	616
	Mixed[b]	15	237	77	8	322
	Total	**650**	**5719**	**959**	**25**	**6703**

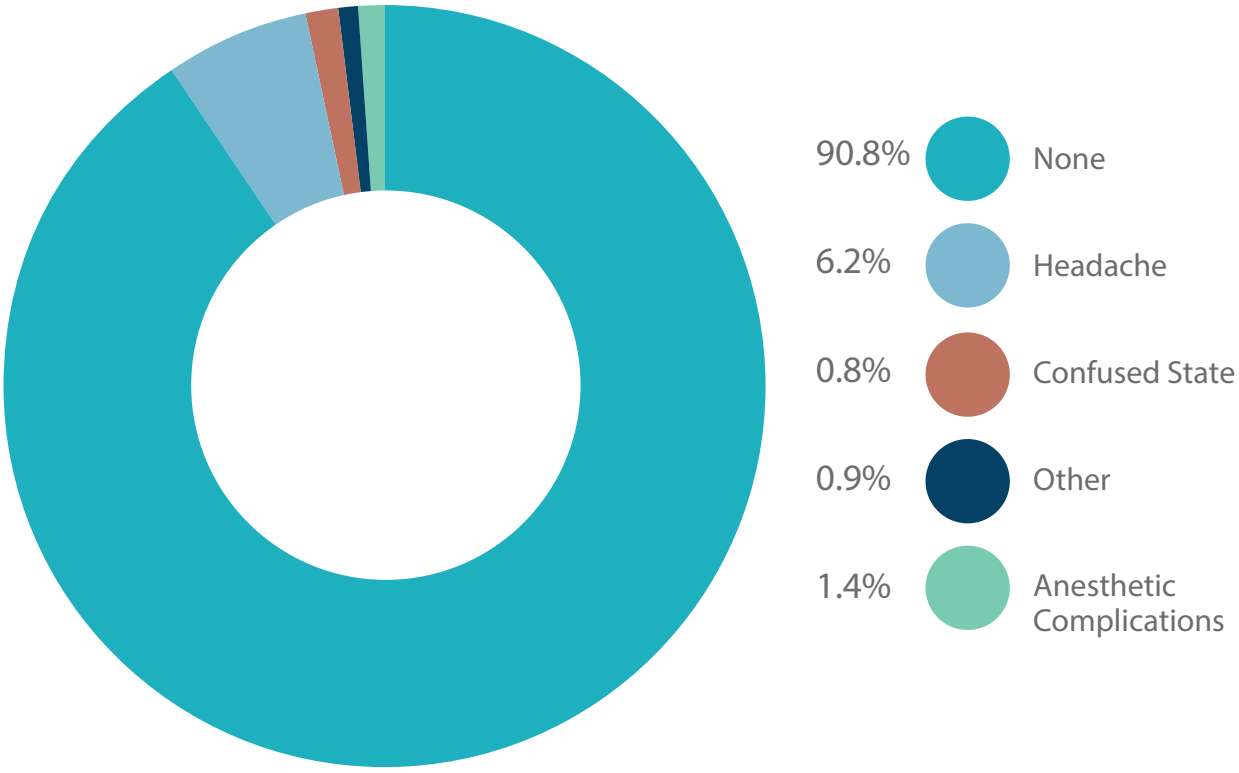
Table 1: ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2019 – 30 June 2020).
Note: The data are representative of the ECT courses completed of between 01 July 2019 and 30 June 2020. It is important to note that the starting date for some of the courses may have commenced prior to the beginning of the reporting period 1 July 2019. Data relating to ECT courses that were not completed in 2019-20 are not included in Table 4 and will be reported in the financial year that the course is completed. [a]Mentally Impaired Accused are included in this category; [b]Patients who had both an involuntary and a voluntary status in the same course.
Source: Office of the Chief Psychiatrist Database

The majority of all ECT courses (63%) were provided to patients 18 years of age and older in a private hospital, 30% were provided in a public hospital and 7% were provided in a publicly contracted private hospital.

Serious Adverse Events

The majority (91%) of the 650 ECT courses did not have any serious adverse event reported. An adverse event during one or more treatments was reported for 9% (n=60) of these courses (Figure 2). Of the courses which had an adverse event during a treatment, two-thirds (67%) involved the patient having a headache only, 15% involved an aesthetic complication only, 8% consisted of a confused state only, and 9% consisted of an adverse event categorized as 'Other', which includes a combination, memory deficit and other unspecified adverse events.

Figure 2: Proportion of ECT Courses that had an ECT associated serious adverse event



Note: *Other includes: Combination, memory deficit and other unspecified adverse events;
There were no cases of premature consciousness or muscle tears of the vertebral column reported in the 2019-20 financial year.

ECT Standards and Guidelines

The Chief Psychiatrist continues to review the current set of standards and guidelines. This initiative has been impacted by the secondment of our Deputy Chief Psychiatrist to the Department of Health's COVID-19 state-wide response.

What's happening (ECT Care Network) at a national level

Work is being done to establish a national network of ECT hospitals to enable improved collaborative approach to data collection and research, with the aim of identifying the safest and most effective approaches to ECT. The network is providing new knowledge of the benefits and risks of ECT and is identifying areas for improving ECT clinical practice, which may further improve patient outcomes.

Restrictive Practices

Restrictive Practices are 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.

Eliminating restrictive practice

Reducing and where possible eliminating the use of restrictive practices in mental health services is a key priority for the Chief Psychiatrist. The use of restrictive practices is strictly governed by the Mental Health Act 2014; sections 230-239 for restraint, and sections 214-223 for seclusion. In Western Australia, restrictive practices can be used within an authorised mental health service however; they are only used as a last resort, when all other methods of de-escalation have been tried or where de-escalation cannot be used.

Seclusion and restraint may be used to prevent a person from physically injuring themselves or others, or persistently causing serious damage to property. In addition, restraint may be used to provide a person with treatment.

Under the MHA 2014, the Chief Psychiatrist is responsible for monitoring and reporting seclusion and restraint. Mental Health Services use the Chief Psychiatrist Approved Forms for reporting all seclusion and restraint events to the Chief Psychiatrist (*https://www.chiefpsychiatrist.wa.gov.au*).

The MHA 2014 strictly governs the processes around the use of restrictive practices including their authorisation, notification of relevant medical officers including psychiatrists, routine observations of the patient, examination(s) of the patient, and examination by a psychiatrist both during and post-restraint. The reporting process is well-regulated and staff in the Office of the Chief Psychiatrist (OCP) routinely monitor reporting compliance with the MHA 2014 and undertakes a robust validation process to ensure high quality data are available for state and national reporting.

The rigorous reporting and monitoring regimes have several benefits for both patients and staff:

- Ensures that all patients being secluded or restrained receive consistently high standards of care during and after these events;
- Patients with repeated high-risk behaviours requiring seclusion and/or restraint are identified and monitored
- Trends in seclusion and restraint events are monitored and increases identified early enabling mental health services to assess their progress towards eliminating the use of seclusion and restraint;

- The Chief Psychiatrist is made aware of concerning trends early enabling him to consult with mental health services about their practices and strategies for reducing the use of restrictive practices in these complex cases, thereby ensuring that both the patient and the staff receive appropriate care and support.

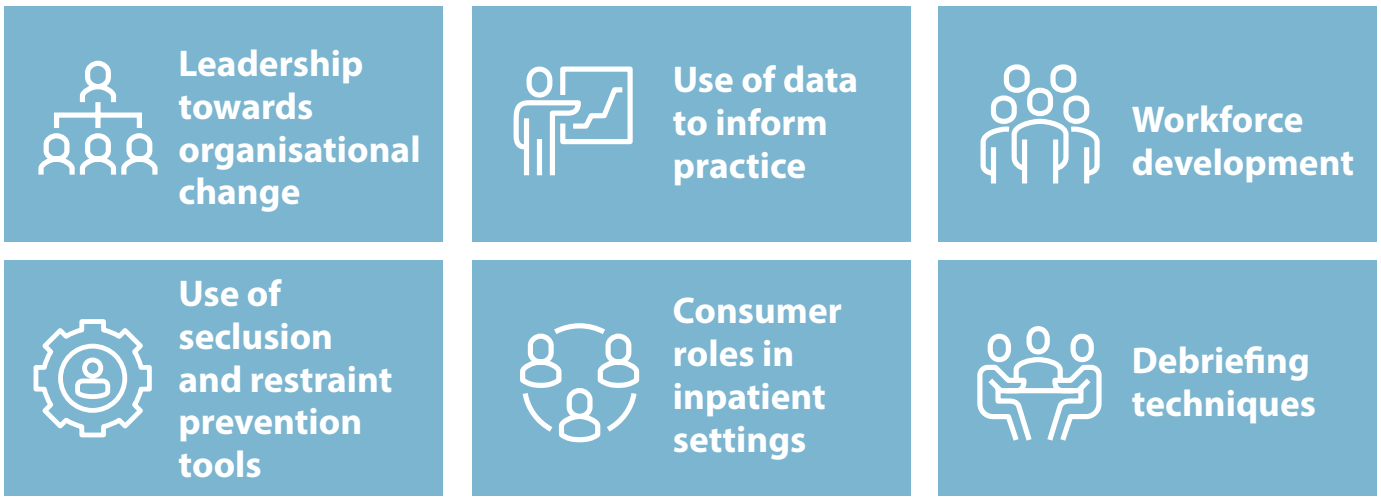
Prevention Strategies

The elimination of the use of seclusion and restraint will require mental health services to implement up-stream strategies including those based on trauma-informed care. Many mental health consumers have a history of trauma and abuse such as physical, sexual and emotional abuse, domestic violence and family alcohol and other drug misuse. These experiences can lead to mental health problems and impact on a person's behaviours or responses, including aggressive behaviours, which often result in a person being secluded and/or restrained.

The Chief Psychiatrist strongly endorses the use of trauma-informed care in mental health services. Trauma-informed care is based on the understanding that a high proportion of mental health consumers have experienced trauma and that this may be a factor in how they respond to stressful situations, how they regulate their emotions and have a negative impact on their relationships with others. Key factors of trauma-informed care include understanding a person's personal experiences of trauma and risk for and history of violence, the use of de-escalation strategies, and debriefing of both patients and staff following a seclusion or restraint event.

It is essential that Health Service Providers prioritise the development of a plan to reduce the use of seclusion and restraint in mental health services. Six core strategies have been identified that when implemented together contribute to reducing the use of seclusion and restraint in mental health services and should be used to guide performance improvement strategies (Figure 3). These strategies identify the need for leadership and organisational change, data-informed policy, procedures and practices, clinicians trained in trauma-informed care and consumer input.

Figure 3: Six core strategies to help reduce restrictive practice



Reference: Huckshorn, K.A. (2004) 'Reducing seclusion restraint in mental health use setting: Core strategies for prevention', Journal of Psychosocial Nursing and Mental Health Services 42(9): 22-33.

Precursors to seclusion and restraint for adults 18 years and older

One of the main precursors to the use of restraint practices is patient aggression and/or assault, including aggression to other patients, mental health staff, self, or other persons such as visitors to the service. There are four categories of aggression/assault reported to the Chief Psychiatrist; physical assault, aggressive behaviour resulting in damage to property, threatening behaviour (where the patient can go through with their threat) and patient refusal of treatment. During the 2019-2020 financial year, 2,067 incidents of aggression and/or assault involving adults 18 years and older were reported to the Chief Psychiatrist, comprising almost half (48%) of all notifiable incidents reported to the Chief Psychiatrist for this age group, during the financial year.

Of the total aggression/assault incidents, over half (51%) involved a patient being aggressive to a staff member and 22% involved a patient being aggressive towards another patient or other person, such as visitors. A smaller proportion of these incidents related to destruction of property (9%) and refusal of treatment (6%), aggression to self (3%) and 9% involved other types of aggression. A small proportion of incidents (12%) involved two or more patients.

Males were involved in a higher proportion of aggressive incidents (64%) than females (36%). Over half of patients (60%) were involved in one or two aggressive events, 15% in either three or four events, 20% in 5-19 events and 5% were involved in 20 or more events over the course of the 2019-20 financial year.

Examining the type of aggressive incidents by the number of events, a consistent pattern can be seen for both females (Table 2) and males (Table 3). The proportion of events involving patient aggression towards staff members increased with the number of events a patient was involved in during their admission. When a patient was involved in one or two aggressive events patient aggression towards a staff member contributed to just under half of all aggressive events (44% for females and 47% for males). When a patient was involved in twenty or more aggressive events the proportion involving patient aggression towards a staff member increased to 93% for females and 77% for males. In contrast, the proportion of events involving a patient being aggressive to another patient decreased when a patient had three or more aggressive events during their admission for both females and males. When a female patient had twenty or more aggressive incidents reported, none of these incidents involved aggression towards another patient, compared with 12% for male in this category (Table 2; Table 3).

Table 2: Aggression/Assault Type: Female Adults 18 Years and Older

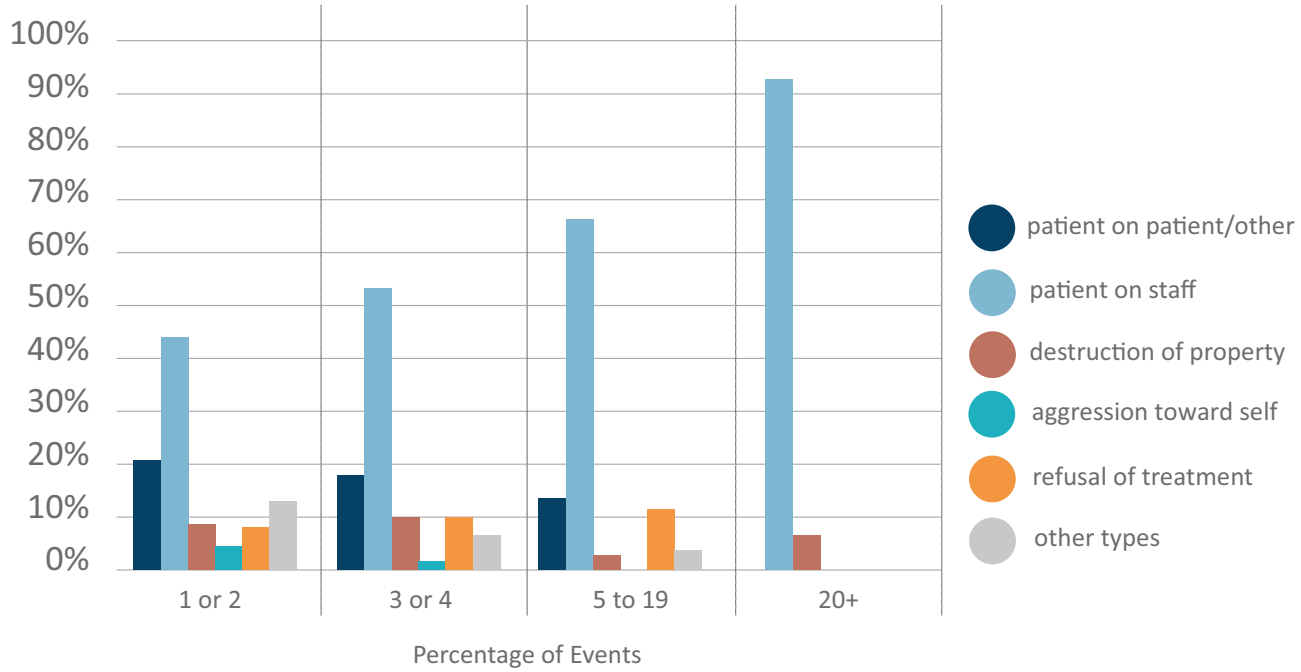
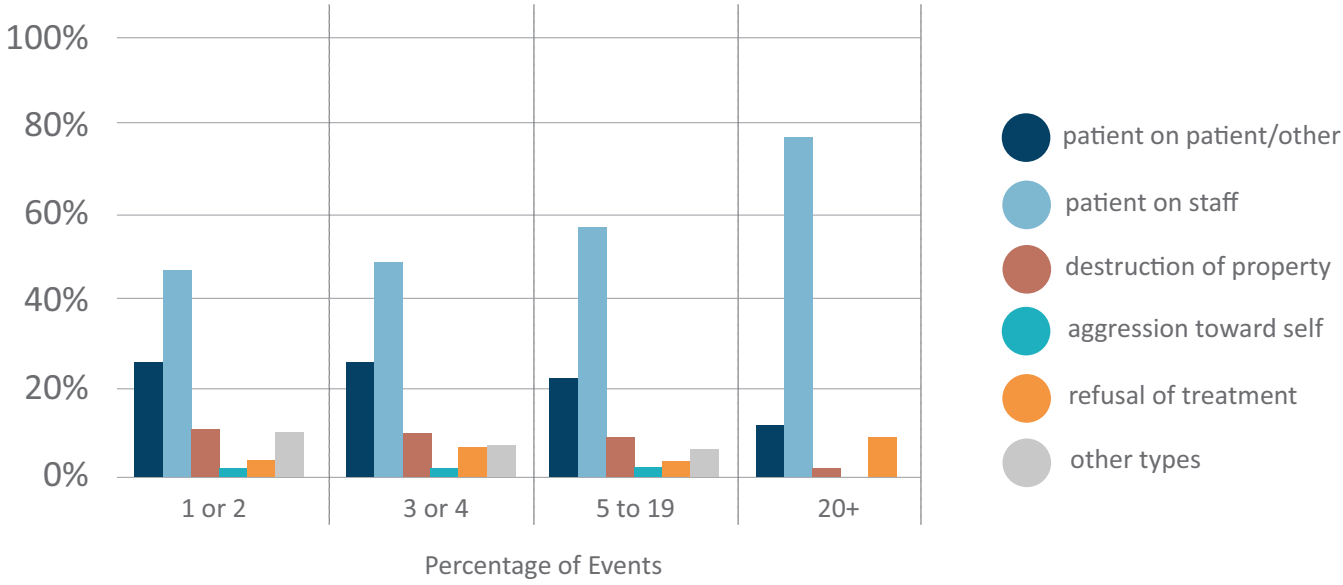


Table 3: Aggression/Assault Type: Males 18 Years and Older



Reporting rates of restrictive practices

The Chief Psychiatrist reports the rates of seclusion and restraint and compliance with the MHA 2014 biannually on the Chief Psychiatrist website. The data are reported separately for each mental health service with the aim of promoting openness and transparency around the use of restrictive practices by mental health services in WA.

It is important to note that the variability in the rates of seclusion and restraint between hospitals may be due to the acuity of the patient population, amongst other factors. Small numbers of acutely unwell patients with challenging behaviours can have a disproportionate effect on rates of restrictive practices at a service.

Seclusion

Adults aged 18-64 years

The Chief Psychiatrist received notification of 1021 seclusion events involving 318 adults 18 - 64 years of age during the 2019-2020 financial year, the majority of whom were males (64%). Over half of all seclusion events (59%) had a duration of between 60-120 minutes, 14% less than 60 minutes and 27% more than 120 minutes. The median duration for each of these categories were 40 minutes, 105 minutes, and 230 minutes, respectively.

Adults aged 65 years and older

The Chief Psychiatrist received notification of 15 seclusion events involving 7 adults 65 years of age and over during the 2019-2020 financial year. Due to the small number of patients secluded, further statistics are not reported to prevent identification of individuals.

'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

'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

Restraint

Adults aged 18-64 years

During the 2019-20 financial year, there were 822 restraint events involving 358 adults 18 - 64 years of age, the majority of whom were males (53%). Two-thirds (67%) of restraint events were less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 22% of all events and 11% lasted more than 10 minutes.

All mechanical restraints involved patients aged 18 – 64 years, and comprised 1% of all restraint events.

Adults aged 65 years and older

During the 2019-20 financial year, there were 82 restraint events involving 40 adults over 64 years of age, the majority of whom were males (52.5%). Over three-quarters (77%) of restraint events lasted less than five minutes, with a median duration of two minutes. Restraint events over 5 minutes comprised 23% of all events.

Australian Institute for Health and Welfare National Reporting 2019-2020

The Australian Institute for Health and Welfare (AIHW) reports the rates of restrictive practices annually for each state and territory. The Chief Psychiatrist is responsible for reporting WA seclusion and restraint data to the AIHW for inclusion in the national restrictive practices' dataset. WA is a leader in the reduction of the use of restrictive practices in Australia.

Seclusion

The rate of seclusion for the 2019-20 financial year is 5.0 per 1,000 bed days including child and adolescent, older adult and forensic services. The rate of seclusion in Western Australia for adults 18-64 years of age was 6.1 per 1,000 bed days lower than the rate of 6.8 per 1,000 bed days in 2018-2019 financial year. Older adult mental health services had the lowest rate of seclusion at <0.1 per 1,000 bed days and Forensics had a rate of 10.2 per 1,000 bed days for adult mental health services.

Restraint

The rate of restraint is 4.8 per 1,000 bed days including child and adolescent, older adult and forensic services. The WA restraint rate for 2019 - 2020 was 5.2 per 1,000 bed days for adults 18-64 years of age, 1.4 per 1,000 bed days for older adults 65 years and older, and 9.9 per 1,000 bed days for forensics.

Table 4: Overall National and Western Australian Rates of Seclusion and Physical Restraint

	Seclusion per 1,000 beddays		Restraint per 1,000 beds	
	National	WA	National	WA
2017 - 18	6.9	4.3	6.3	5.1
2018 - 19	7.3	6.8	7.3	5.8
2019 - 20	*	5.0	*	4.8

*Not available at time of publication

The Chief Psychiatrist represents WA on the national Safety and Quality Partnership Standing Committee (SQPSC) and was a member of the Restrictive Practices Sub-Committee. The Sub-Committee was convened to ensure that the elimination of restrictive practices is embedded in the broader safety and quality strategy across all jurisdictions. A recent review indicated that the Sub-Committee has achieved this goal and as such, the Sub-Committee was recently disbanded.

The commitment to eliminating the use of restricted practices is continuing at the national level. The intent of the SQPSC and the AIHW is for all states and territories to continue to report seclusion and restraint data and these data will then be reported nationally by the AIHW. A review of the national safety and quality priorities formulated in 2005 has been undertaken recently and the elimination of restrictive practices remains as a priority and continues to be very much part of the safety and quality discussion.

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 authorised 168 involuntary treatment orders in a General Hospital setting during the 2019-20 financial year. Of the 168 orders, 58.4% involved a general hospital admission of 7 days or less, 22% comprised a general hospital admission between 8 to 14 days and 19.6% a general hospital admission of more than 14 days. Of the 168 orders there were 128 patients of which 19.4% of orders were for patients under the age of 18 years. A small number of patients (n = 23) 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 60.5% of the required approved 6B attachment forms. More specifically the Chief Psychiatrist received 65% of the required 6B attachments for patients that were in a general hospital for 8 – 14 days and 59% 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 MHA 2014.

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 thereby improving the overall validity of the notification of orders.

Notifiable Incidents

The MHA 2014 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 occuring. 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 OCP Notifiable Incident Reporting Form available on the Chief Psychiatrist website. 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.

Sexual Safety of People Accessing Mental Health Services

The sexual safety of people accessing mental health services is a priority issue for the Chief Psychiatrist. Mental health inpatient wards in WA admit both males and females, which raises sexual safety issues. Although sexual harassment and sexual assault is reported by both male and female patients, most of the alleged incidents reported to the Chief Psychiatrist involve a male perpetrator targeting a female. Ensuring a safe environment is essential to avoid traumatising people or retraumatising people who have previously experienced sexual abuse trauma. As such, sexual activity is not allowed in the inpatient setting and this includes consensual sexual activity.

Under the MHA 2014 s.254 mental health services are required to report to the Chief Psychiatrist allegations of unlawful sexual contact involving a staff member of a mental health service and allegations of sexual contact that occur on the premises of a mental health service. Monitoring and evaluation of these notifiable incidents are undertaken by staff in the Office of the Chief Psychiatrist.

The Chief Psychiatrist identified the need to provide guidance to mental health staff on promoting sexual safety within their service and importantly, preventing sexual harassment and sexual assault incidents occurring in the mental health service setting.

An Expert Reference Group chaired by the Deputy Chief Psychiatrist was established to develop a Sexual Safety Guideline aimed at informing services of procedures and processes that they can implement to address the specific sexual safety needs of their service, consumers and setting. A draft of the guidelines was developed and circulated for wider consultation in the 2019-20 financial year. The guidelines are due to be released in the next financial year.

Sexual Incidents Notified to the Chief Psychiatrist

Mental health services are required to report sexual contact and allegations of sexual assault and harassment reported by patients within an inpatient setting (including emergency departments and hospital grounds), community mental health service premises, or private psychiatric hostel. These include incidents involving the patient with any other person(s) and include incidents involving the patient and a staff member alleged to have occurred during clinical assessment of the patient at their home or other premises. All allegations of a sexual incident are required to be investigated by the mental health service.

Sexual incidents notified to the Chief Psychiatrist are classified into four categories:

- sexual contact involving people over 16 years of age who have mutually consented
- allegation of indecent act/inappropriate behaviour
- allegation of sexual harassment
- allegation of sexual assault

There were 112 notifications of sexual incidents reported to the Chief Psychiatrist during the 2019-20 financial year, equating to 3% of all notifiable incidents reported. Over half (59%) of the incidents involved a patient who was either involuntary or referred under the MHA 2014 and 41% involved a voluntary patient. Just under one-third (30%) of incidents related to an indecent act or inappropriate behaviour, 28% related to allegations of sexual assault, 23% related to sexual harassment and 19% involved mutual sexual contact.

In the majority of the 31 allegations of sexual assault the victim was a female, with fewer than five notifications alleged to have involved a male victim (small numbers prevent exact percentages being published). Conversely, most of the alleged perpetrators were male (81%). Over one-third of allegations (39%) were substantiated, 26% were determined not to have occurred, and the investigation for the remaining 35% had not been finalised by the end of the 2019-20 financial year.

Fewer than five notifications of alleged sexual incidents had the highest Severity Assessment Code (SAC) rating of 'SAC1'.

All allegations of sexual assault reported to the Chief Psychiatrist are investigated by the mental health service providing the notification and the incident may also be investigated by the Chief Psychiatrist. Staff in the Office of the Chief Psychiatrist followed-up with the relevant service for further information on 8% of the notifications and the Chief Psychiatrist met with mental health services to discuss circumstances in a small number (fewer than five) of the sexual incidents notified. In each of these incidents, the Chief Psychiatrist was satisfied that the services were putting measures in place to improve the sexual safety of inpatients in their service.

Development of the Chief Psychiatrist's Sexual Safety Guidelines

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. A large proportion of mental health consumers have experienced sexual abuse during their lifetime. 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 Expert Reference Group convened to advise on the development the Chief Psychiatrist's Sexual Safety Guideline 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.

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

A review was conducted to identify the approach to sexual safety 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.

The Guidelines address the overall principles that apply when considering sexual safety and provides information on universal approaches to sexual safety. Universal approaches include 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. Targeted approaches to promoting

sexual safety are also discussed. These include identifying people who may be at risk of being sexually unsafe and adopting strategies to maximise their safety. Guidance is also provided on how to manage a situation where sexual safety has been breached including medical, forensic and police considerations.

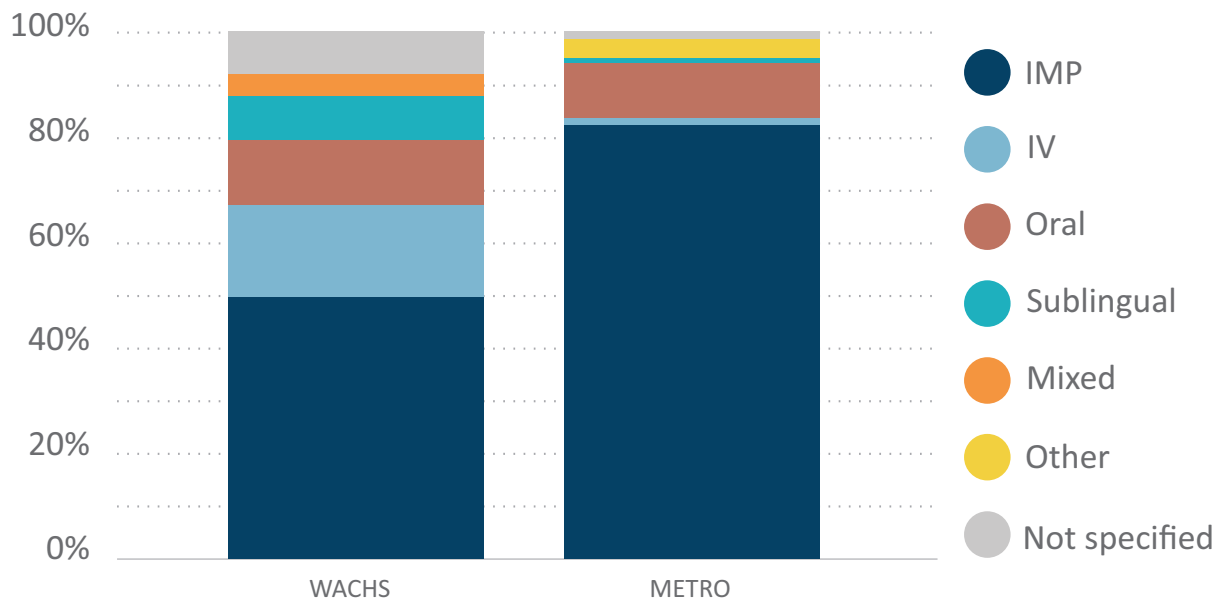
The Chief Psychiatrist's Sexual Safety Guidelines will be key to supporting mental health consumers and staff to develop and implement policies and procedures that prioritise sexual safety within the mental health setting.

Emergency Psychiatric Treatment

Under s.204 of the MHA 2014 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 198 cases of EPT reported to the Chief Psychiatrist, of which 59% were female and 41% male patients. The majority of notifications were from metropolitan hospitals (88%), with 12% from WA Country Health Services. Of the patients receiving EPT, 41% were adults aged between 25 and 64 years, 5% were 65 years year or older 26% were 18-24 years and 28% were <18 years of age. The types of treatment provided to the patient included the patient receiving medication alone (48%) or the patient receiving medication in conjunction with the patient being secluded and/or restrained (52%). Compared with the 2018-19 financial year, more seclusion and restraint was utilised this financial year in conjunction with the provision of EPT. The method of administration of EPT was also reported; 78% of EPT was administered via intra-muscular injection, 12% administered orally and the other methods reported were sublingual, mixed, other or not specified (10%). Regional facilities utilised intra-muscular injection half of the time with a range of other options used, whereas metro facilities generally used intra-muscular injection to administer emergency psychiatric treatment (Table 5). The most commonly reported medications were Midazolam, Clonazepam, Droperidol, Haloperidol, Lorazepam, and Olanzapine accounting for 87% of administered medications. The method of administration for these treatments was most commonly via intra-muscular injection, ranging from 63% of the time for Lorazepam to 96% of the time for Haloperidol.

Table 5: Method of Administration for Emergency Psychiatric Treatment by Region



Urgent Non-Psychiatric Treatment

Under s.242 of the MHA 2014 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. Similar to the previous financial year, there were <5 episodes of urgent non-psychiatric treatment reported, and all occurred in a metro hospital. The small number of notifications prevents further examination of these data.

Notifications of Deaths of Mental Health Consumers

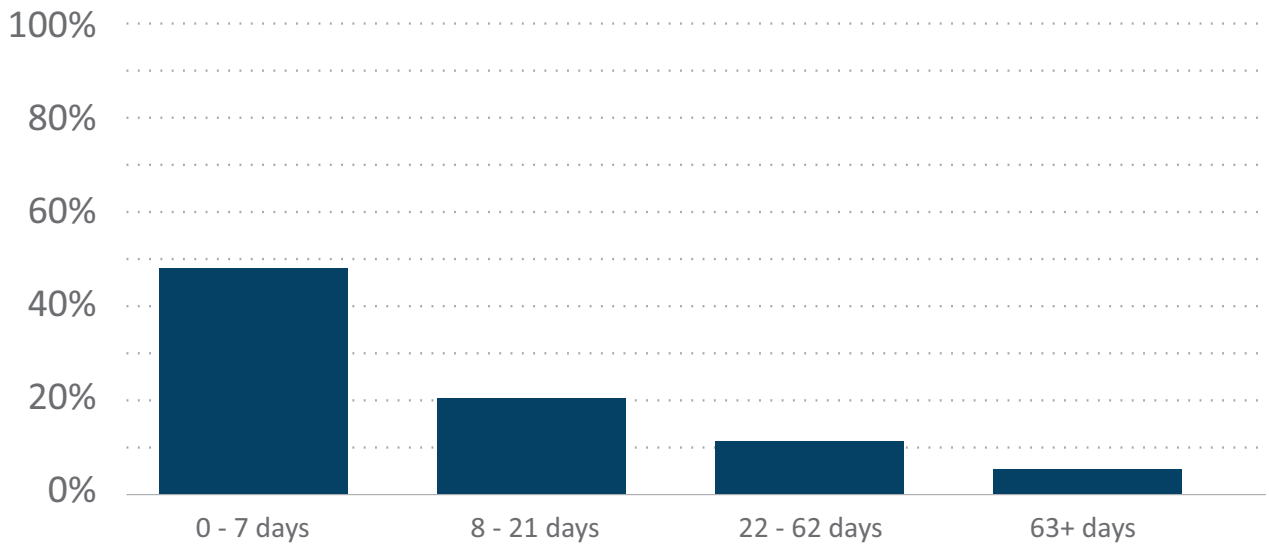
The MHA 2014 stipulates that deaths of people who are mental health consumers, wherever the death has occurred, must be reported to the Chief Psychiatrist. This includes deaths of active patients and any deaths of mental health consumers that occur within 28 days of discharge or deactivation from a health service. This includes deaths that the mental health service has become aware of after the 28-day period.

The Chief Psychiatrist received 271 notifications in the 2019-2020 financial year advising of the death of a mental health patient. Just under half (48%) of deaths were due to natural causes, 29% were a suspected suicide, 3% were due to a physical/unnatural cause and for 20% the cause of death was unknown at the time of reporting.

The majority of deaths reported involved a male patient (59%) with males involved in around two-thirds (67%) of suspected suicides and 70% of deaths where the cause was unknown. Most death notifications involved an adult aged 25-64 years (59%) and this age group accounted for 84% of suspected suicides and 87% of the deaths of unknown cause. Deaths of young people less than 25 years of age comprised 7% of all deaths and 34% of deaths involved people 65 years and older.

The most recent date that the mental health service had been in contact with the patient or had attempted to contact the patient prior to their death is shown in Figure 4. Data were available for 86% of patients who died within the 2019-2020 financial year. Almost half (48%) of all patients who had died had been in contact with the mental health service within the week prior to their death 20%, within two to three weeks 12%, and 5% of deaths the most recent contact was more than two months prior to the death. The most recent contact date was not able to be verified for 15% of deaths notified. The proportions for suspected suicides and unnatural/physical deaths were similar to the overall percentages reported in Figure 4.

Figure 4: Days since most recent /attempted contact by Mental Health Service



Note: Date not reported for 15% of all deaths and 8% of suspected suicide deaths. These data were obtained from the death notification and/or PSOLIS.

Notifications of Persons Absent Without Leave and Missing

There were 386 notifications of patients 18 years and older being Absent Without Leave (AWOL), involving 279 involuntary or referred patients. Of these 279 patients, 72% had one AWOL event, 13% absconded twice, 5.5% absconded three times and 9.5% absconded four or more times. Most patients who absconded were male (54%) and between the ages of 25 and 64 years (79%).

The majority (92%) of patients were returned to hospital, 6% were located but not returned to the hospital and 2% of AWOL patients were not located. Police were notified for 19% of AWOL events. Just under half (44%) of AWOL patients returned to the ward on the day they went AWOL, 28% the next day and 10% two days after going AWOL. A further 14% of patients had been located between 3 and 14 days of going AWOL; equating to 99% of patients located within two weeks of going AWOL. A small proportion of patients (3%) had used alcohol or other drugs while AWOL.

Mental health services are also required to notify the Chief Psychiatrist of any voluntary psychiatric patient at high risk of harm who is missing from a mental health service, general hospital or emergency department, without the agreement of, or authorisation by, staff.

In the 2019-20 financial year, 155 high-risk voluntary patients were reported missing, of which 85% were located. The majority of missing people were male (53%) and police were notified of 26% of

incidents. Over three-quarters (83%) of missing patients were located within one day, 10% within two days, 2% within three or four days and 5% between five days and two weeks of the patient reported missing.

Notifications of Attempted Suicide

The Chief Psychiatrist was notified of 232 attempted suicides involving 190 adults aged 18 years and older. The majority of adults (82%) had one attempted suicide, 10% two attempts and 9% had three or more attempts. Sixty per cent of cases involved a female patient, of which 32% were aged 18-24 years and 64% aged 25-64 years compared with 28% and 60% (respectively) for males. For people 65 years and older the proportion of males attempting suicide was higher (12%) than for females (4%). Suicide attempts were most commonly reported by inpatient units (62%) and community services (32%), with 6% occurring within an Emergency Department. A small proportion (12%) were classified as a SAC1, which is the highest severity assessment classification score.

Serious Medication Error

There were seven notifications relating to a serious medication error (SAC1) reported to the Chief Psychiatrist. The small number of incidents prevents publication of further details.

Allegations of Unreasonable Use of Force by Staff

The Chief Psychiatrist was notified of fewer than five allegations of a staff member using unreasonable force on a patient. The small number of incidents prevents publication of further details.

Alleged Homicides

No incidents of alleged homicides were reported to the Chief Psychiatrist in the 2019-2020 financial year.

Notifiable Incidents Reported by Private Psychiatric Hostels

Private Psychiatric Hostels are included as a mental health service under the MHA 2014 section 507 and are required to report notifiable incidents to the Chief Psychiatrist. The data for residents of Private Psychiatric Hostels are reported separately in this section however, their data are also included in the total data reported.

There were 99 notifiable incidents reported to the Chief Psychiatrist by Private Psychiatric Hostels in the 2019-20 financial year. The notifiable incidents included missing persons (39%), aggressive behaviour (34%) and attempted suicide (16%). There were fewer than five people involved in each of the following incidents, which combined comprised 11% of notifications reported: allegations of sexual harassment/assault, deaths, and serious medication errors. Just under three-quarters (72%) of incidents reported involved males. In particular, men were involved in 80% of aggressive incidents and 80% of notifications of a missing person.

Children and Youth less than 18 years of age

The Chief Psychiatrist oversees the standards of psychiatric care provided to children and youth in Western Australia through a range of measures. These include monitoring and evaluating notifiable incidents, the use of restrictive practices (seclusion and restraint) in authorised mental health services, clinical reviews of services, and the safety of children and youth admitted to mental health services that also admit adults. The Chief Psychiatrist and his staff represent the interests of children and youth receiving mental health services through participation on committees and working groups.

There were 13,799 children and youth less than 18 years of age accessing specialised inpatient and/or community mental health services in the 2019-2020 financial year, equating to 20% of all people accessing these services. Of these, 801 children and youth were admitted to a mental health inpatient ward, accounting for 1,476 hospital separations. Just under half (44%) of children/youth were admitted to Perth Children's Hospital and 56% were admitted to either a youth or an adult mental health ward. Most of the children and youth (90.5%) were admitted as a voluntary patient.

Notifiable Incidents reported to the Chief Psychiatrist in respect of children and adolescents

The Chief Psychiatrist received 431 notifiable incidents involving 123 children and youth less than 18 years of age, of which over half (56%) were involved in one incident, 23% in 2-3 incidents, 6% were involved in 4-5 and 15% were involved in 6 or more incidents. Over two-thirds (68%) of incidents involved females and over one-third (36%) occurred between midday and 6pm. Involuntary and referred patients were involved in 28% of notifiable incidents reported.

Aggressive events comprised the most frequently reported incidents (68%). Over half of aggressive events (58%) involved the patient being aggressive and/or threatening towards staff and 14% of aggressive events involved the patient being aggressive and/or threatening towards another patient or other person, 16% involved the destruction of property or threating to destroy property, 6% involved the patient refusing treatment and 6% involved aggression toward self. The other frequently reported incidents involved patients attempting suicide (17%) or leaving the ward without permission (10%), either AWOL or missing person. A small proportion (2.6%) of incidents involved allegations of inappropriate sexual behaviour; the small number of incidents prevent further details being provided.

Deaths of young people less than 25 years of age were reported for 19 young people, equating to 7% of all deaths. Of these, 68% were a suspected suicide or classified as a physical/unnatural death. The mental health service had been in contact or attempted to contact 58% of these young people within two months prior to their death.

Restrictive Practices

Seclusion and bodily restraint can only be used within an authorised hospital, primarily when a 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 and/or restraint.

The Chief Psychiatrist is committed to reducing and where possible eliminating the use of restrictive practices in mental health services across WA. Under the Mental Health Act 2014, all seclusion and restraint events, including details about the event, are required to be reported to the Chief Psychiatrist. This enables detailed monitoring and evaluation of all seclusion and restraint events and compliance with the Mental Health Act 2014 and early identification of complex cases and increases in the rate of these events.

As evidenced in the above notifiable incidents, many children and youth have particularly challenging behaviours during their inpatient stay and these factors precede seclusion and/or restraint events. Consideration needs to be given to the severity of the mental illnesses being experienced by the patient that may have resulted in multiple events with longer periods in seclusion and/or restraint. Where concerns are identified through monitoring and evaluation, the Chief Psychiatrist and staff consult 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.

Seclusion

The Chief Psychiatrist received notification of 102 seclusion events involving 46 children and youth under 18 years of age during the 2019-2020 financial year, just over half of whom were male (52%). Of the 102 seclusion events reported, 40% were less than 60 minutes, 53% between 60 and 120 minutes and 7% lasted more than 120 minutes. The median duration for each of these categories was 41 minutes, 78 minutes, and 141 minutes, respectively.

Restraint

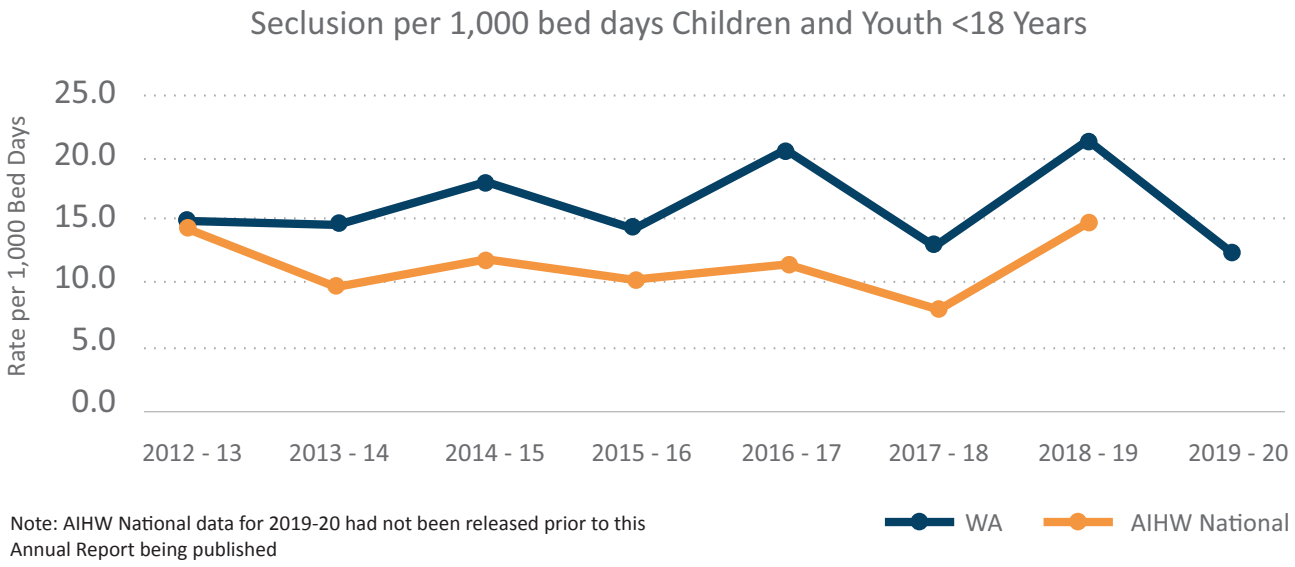
During the 2019-20 financial year, there were 173 restraint events involving 61 children and youth under 18 years of age, the majority of whom were females (67%). Over half (54%) of restraint events were for less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 23% of all events and 23% lasted more than 10 minutes.

State and National Key Performance Indicators

The rate of seclusion and restraint are reported on the Chief Psychiatrist's website for WA and for each authorised mental health service, bi-annually. The Chief Psychiatrist also reports WA data for restrictive practices to the Australian Institute for Health and Welfare (AIHW) for inclusion in the annual national restrictive practice dataset.

The 2019-2020 WA rate of seclusion for children and youth less than 18 years of age was 12.3 per 1,000 bed days, dropping from 21.2 per 1,000 bed days in the 2018-19 financial year (Figure 5). The 2019-20 rate of seclusion is the lowest rate of seclusion reported by WA since the 2012-13 financial year. The WA rate of seclusion for children and youth less than 18 years of age has been consistently higher than the national rate over the past eight financial years, since the 2013-14 financial year.

Figure 5: Rate of Seclusion per 1,000 bed days: Western Australia and AIHW National Data

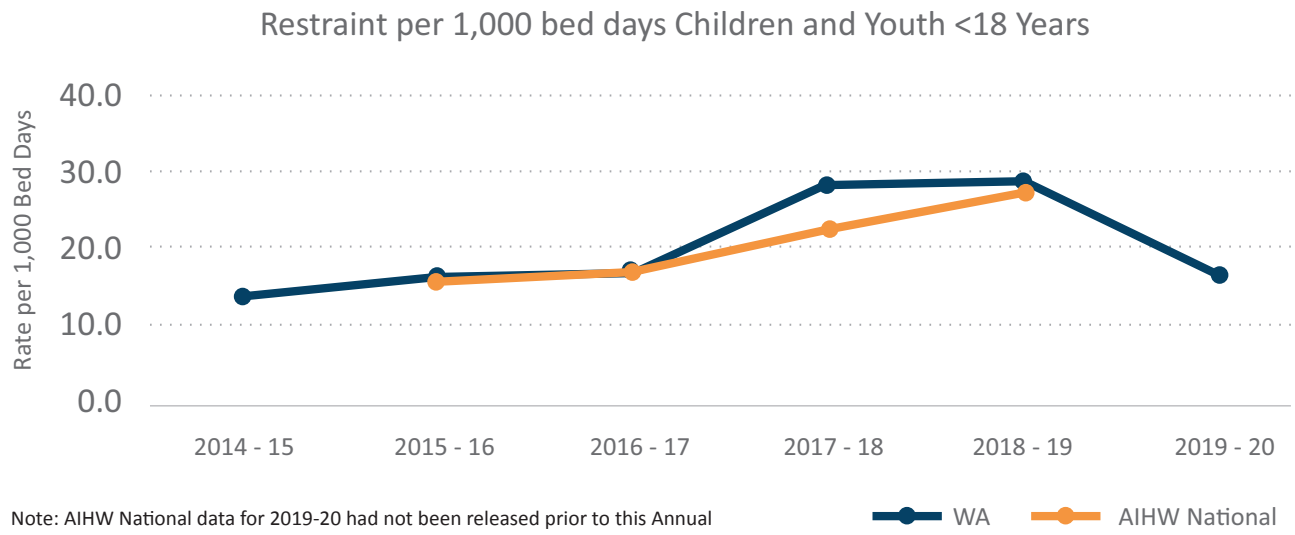


Note: AIHW National data for 2019-20 had not been released prior to this Annual Report being published

The WA rate of restraint for children and youth <18 years of age in the 2019-2020 financial year was 16.2 per 1,000 bed days, dropping from 28.7 per 1,000 bed days in the 2018-19 financial year (Figure 6). This is a similar pattern to the reduction that occurred in the rate of seclusion. National reporting of restraint commenced in 2015-16 and since then, the WA rate of restraint has aligned closely with the national rate.

The reductions in the rates of seclusion and restraint for children and youth <18 years of age in this financial year are significant achievements. This success demonstrates the commitment Child and Adolescent Mental Health Services (CAMHS) has made to reduce the use of restrictive practices in their services.

Figure 6: Rate of Restraint per 1,000 bed days



Note: AIHW National data for 2019-20 had not been released prior to this Annual Report being published. National reporting of restraint events commenced in the 2015-16 financial year.

Keeping Children and Youth Safe in the Inpatient Setting

Admission of a Child less than 18 years to an Adult Inpatient Mental Health Unit

The MHA 2014 S.303 requires mental health services that do not generally admit children need 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 is appropriate to do so.

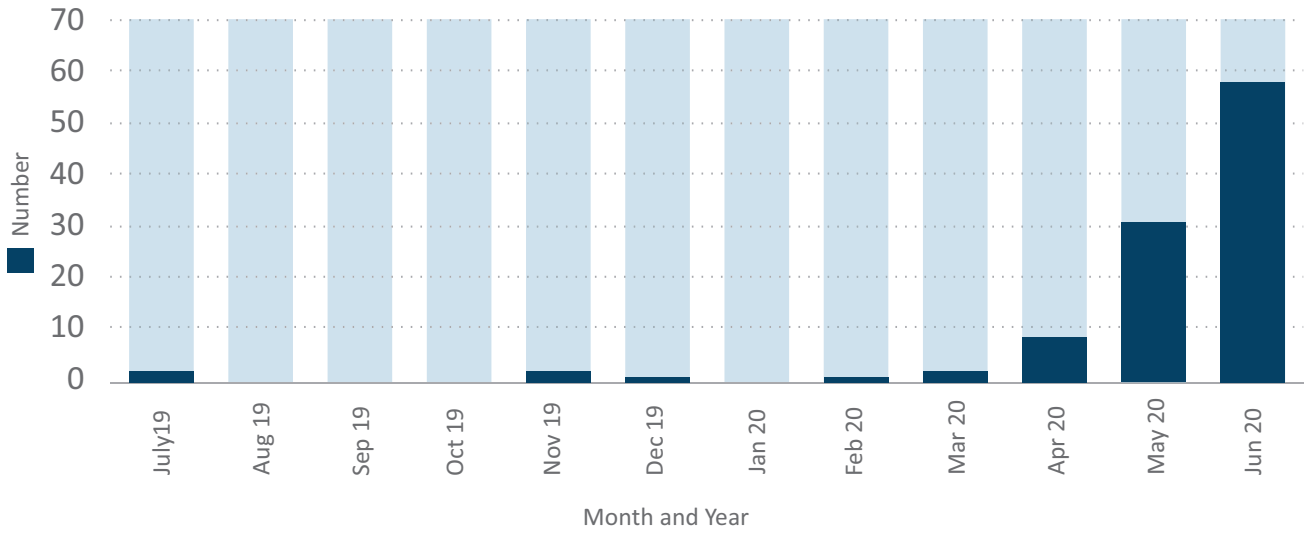
Under the MHA 2014, the person in charge of the mental health service must report to the Chief Psychiatrist why they are satisfied that the above criteria have been fulfilled using the requisite Approved Form. Since the MHA 2014 came into effect in 2015, a range of new mental services have been developed, including inpatient services catering specifically for youth (children and young people aged 16 to 24 years) as well as the development of Mental Health Observation Areas (MHOAs), which may admit children under 18 years of age. The development of these inpatient services led to the Mental Health Commission and the Chief Psychiatrist seeking expert advice on the understanding of s.303 in relation to these new inpatient services.

The expert advice indicated that s.303 will apply whenever any mental health service admits a child, if that mental health service also admits adults, irrespective of whether the child is admitted as a voluntary or involuntary inpatient. This includes children under 18 years of age admitted to a youth inpatient mental health service and those admitted to a MHOA.

The MHC and the OCP held a series of meetings in April-May with key stakeholders from public and private mental health services to advise them of the new interpretation of s.303 and the implications for their services. This information was confirmed in a letter to the Chief Executives with an information sheet outlining reporting requirements and responsibilities under the Act. The information sheet was distributed to mental health services and is available on the Chief Psychiatrist's website.

This change in the application of s.303 has resulted in a substantial increase in the number of notifications received by the Chief Psychiatrist. The Chief Psychiatrist received 107 notifications of a child <18 years of age (Figure 7) being admitted to a mental health service in the 2019-20 financial year compared with 8 notifications in the 2018-19 financial year. During the 2019 calendar year there were 834 separations (discharges) from acute specialised mental health inpatient wards, excluding admissions to Perth Children's Hospital, for children less than 18 years. It is anticipated that there will be a continued increase in the number of s.303 notifications to the Chief Psychiatrist over the next financial year. There will be ongoing monitoring of the trends in s.303 notifications by the Chief Psychiatrist, who will continue to work with mental health services to ensure compliance with s.303 and the safety of children and youth admitted to adult mental health services.

Figure 7: MHA 2014 s.303 Notifications to the Chief Psychiatrist 2019-20 Financial Year



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

Under s.304 of the MHA 2014, 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 13 notifications about children who were involuntary patients and received off-label treatments, which is less than the number of notifications received in the previous financial year. Most notifications were from mental health services in the metropolitan area. The average (mean) age of involuntary children provided with an off-label treatment was 16 years.

Working across governmental agencies

The Chief Psychiatrist and staff provided input into the Ombudsman's Fatality Review of Certain Child Deaths.

Further Opinions

182. Further opinion may be requested

(1) This section applies in relation to any of these people —

(a) the patient, whether or not the patient has the capacity to give informed consent to the treatment being provided to him or her were that consent required;

(b) if the patient does not have that capacity — the person who is authorised by law to give that consent on the patient's behalf were that consent required;

(c) if the patient has a nominated person — the nominated person;

(d) if the person has a carer — the carer;

(e) if the person has a close family member — the close family member.

(2) A person to whom this section applies who is dissatisfied with the treatment being provided to the patient may request orally or in writing the patient's psychiatrist or the Chief Psychiatrist to obtain the opinion (a further opinion) of a psychiatrist who is not the patient's psychiatrist about whether it is appropriate to provide the treatment to the patient.

In 2019-2020 the Chief Psychiatrist received eight requests to assist in facilitating a Further Opinion for a consumer.

Completed Further Opinions rates are very low with < 5 being completed. Of the 8 requests received several did not progress. The reasons for this are outlined below

- request withdrawn
- patient became voluntary
- patient opted for a private psychiatrist

The Chief Psychiatrist does not have access to the data regarding the Key Performance Indicators for services providing Further Opinions. However, the Chief Psychiatrist is aware of difficulties experienced by services when a further opinion is requested outside of the patient's usual treating service and is considerate of these time delays in accessing a further opinion.

The Office of the Chief Psychiatrist continues to provide support and advice on the facilitation of Furth Opinions.

Which Psychiatrists can administer the Mental Health Act 2014 (MHA 2014) as psychiatrists?

There are two aspects to administering the Mental Health Act 2014 as a psychiatrist:

1) training and

2) definition of a psychiatrist as per section 4 of the Mental Health Act 2014

For the reporting period one request for an amendment to regulation 4A of the Mental Health Regulations 2015 were received.

System Improvement

The Chief Psychiatrist has strongly advocated for a number of key initiatives to improve the Western Australian mental health sector and directly impacting the consumer experience. He was pleased to note that the driving principles of the *WA State Priorities – Mental Health, Alcohol and Other Drugs 2020-24* were to 'prioritise investment on the areas and services of greatest need' and 'use an evidence-based approach to both determine and deliver these priorities'. In keeping with the above the Chief Psychiatrist has played a key role in advocating for the following initiatives for system improvement.

Specialised Clinical Community Mental Health Services

The Chief Psychiatrist recognises the need for well-resourced specialised clinical community mental health services. His view was strongly supported by the Western Australian Auditor General's Report – 'Access to State-Managed Adult Mental Health Services – Aug 2019' which concluded that 'an efficient and effective State-funded mental health care system should help people to stay in the least intensive care setting required to manage their condition, while providing access to more intensive care when needed'. The Auditor went on to report that more people were accessing specialised clinical community mental health services, but that the overall capacity had not been increased resulting in people receiving less care for e.g. between 2013 – 2017 there was a 17% increase in the number of people accessing specialised clinical community mental health services and for the same period there was a 6% decrease in the total hours of care provided by the services. As a result of the Auditor General's findings the Mental Health Commission engaged Klynveld Peat Marwick Goerdeler (KPMG) to conduct a snapshot evaluation of 'Non-admitted mental health services evaluation' – May 2020. Their report indicated that feedback from service providers indicated that services are seeing increasing numbers of consumers but were providing less care or less frequent care per consumer due to increasing demand for services coupled with a lack of alternative treatment options and discharge support options.

In providing feedback to the snapshot evaluation, the Chief Psychiatrist identified a number of themes running through the report which he broadly structured under the following headings:

- Service Capacity and Demand
- Service Components and;
- Data collection and usage

directing consideration toward broader investment into specialised clinical community mental health services rather than the narrow view taken in the evaluation report, whilst acknowledging the limitations experienced by the evaluators.

Physical health of Mental Health Consumers

The disparity in physical health outcomes for people with mental health issues is well recognised as a key issue facing the mental health system. Improving the physical health of people living with mental illness and reducing early mortality has been identified as a priority area in the Fifth National Mental Health and Suicide Prevention Plan 2017. An analysis of Western Australian data found that people living with mental health conditions die earlier than the average Australian and this life expectancy gap is not explained by suicide; 77.7% of these premature deaths were caused by chronic physical health conditions.[3] Fragmentation of health systems has been identified as a key factor which hampers progress in this area.[1,2]

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1. Chief Psychiatrist of Western Australia Chief Psychiatrist's Standards for Clinical Care 2015 Available from *https://www.chiefpsychiatrist.wa.gov.au/standards-guidelines/chief-psychiatrists-standards-for-clinical-care/*
2. Commonwealth of Australia The Fifth National Mental Health and Suicide Prevention Plan 2017 Available from *http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf*
3. Lawrence D, K Hancock and S Kisely. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population-based registers: BMJ; 2013. Available from: *https://www.bmj.com/content/346/bmj.f2539*.

During 2019-20, the Chief Psychiatrist participated in the National Symposium on Coexisting Mental and Physical Health conditions. The purpose was to bring together key stakeholders to identify evidence-based interventions and policy solutions.

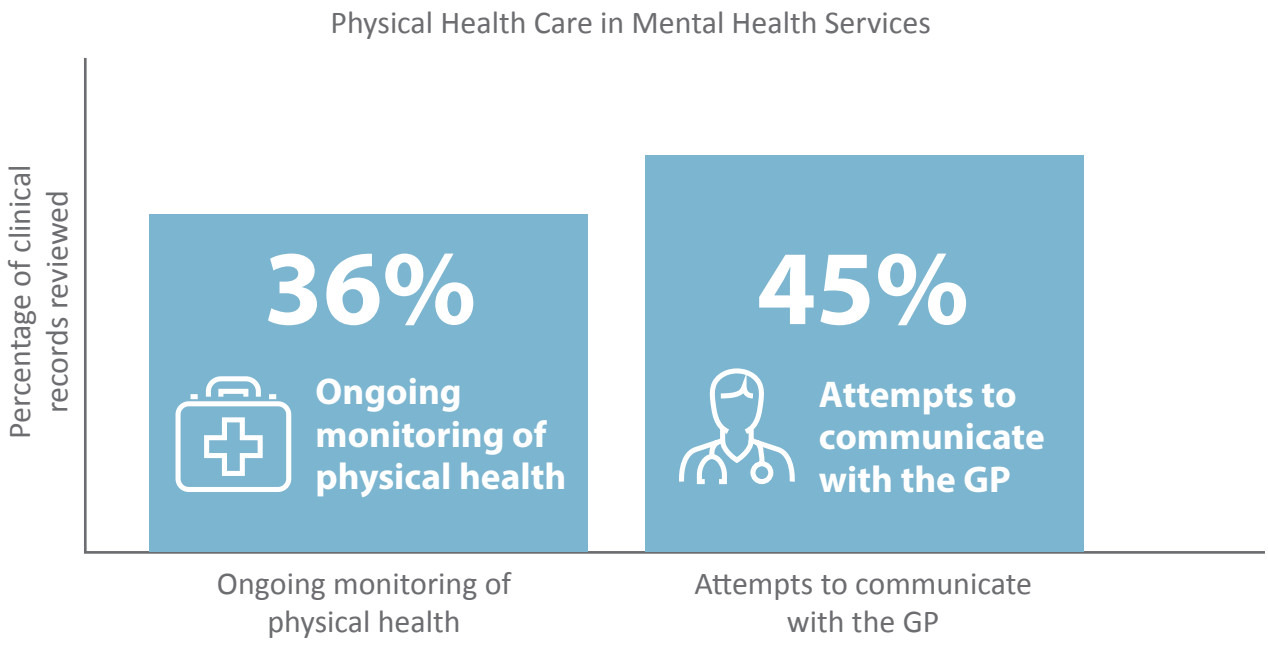
In Western Australia, the Mental Health Act 2014 requires all people admitted to an inpatient mental health service to be offered a physical health examination within 12 hours of admission.

The purpose of this examination is to identify whether treatment for physical health is needed and to alert the service to facilitate access. The Chief Psychiatrist's Standards for Clinical Care require mental health services to support consumers to improve their physical health and to facilitate equity in access to physical health care. To achieve these aims, mental health services should focus on two goals:

- Reducing fragmentation through ongoing communication with physical health services
- Ongoing screening of consumers' physical health

During the first round of clinical monitoring reviews, the Chief Psychiatrist examined indicators relating to physical health care of mental health consumers. Reviewers looked for evidence of ongoing monitoring of physical health. For consumers with an identified general practitioner, reviewers also looked for evidence of attempts to communicate with the general practitioner. The results showed just over a third (36%) had evidence of ongoing monitoring of their physical health and fewer than half (45%) of medical records had evidence of communication with the patient's GP (Figure 8). Thirteen recommendations relating to improvements in physical health care were issued to mental health services. To date, two recommendations have been closed and follow-up is continuing with services regarding outstanding recommendations.

Figure 8: Physical health indicators from clinical reviews



Standards of Care for Aboriginal and Torres Strait Islander Consumers

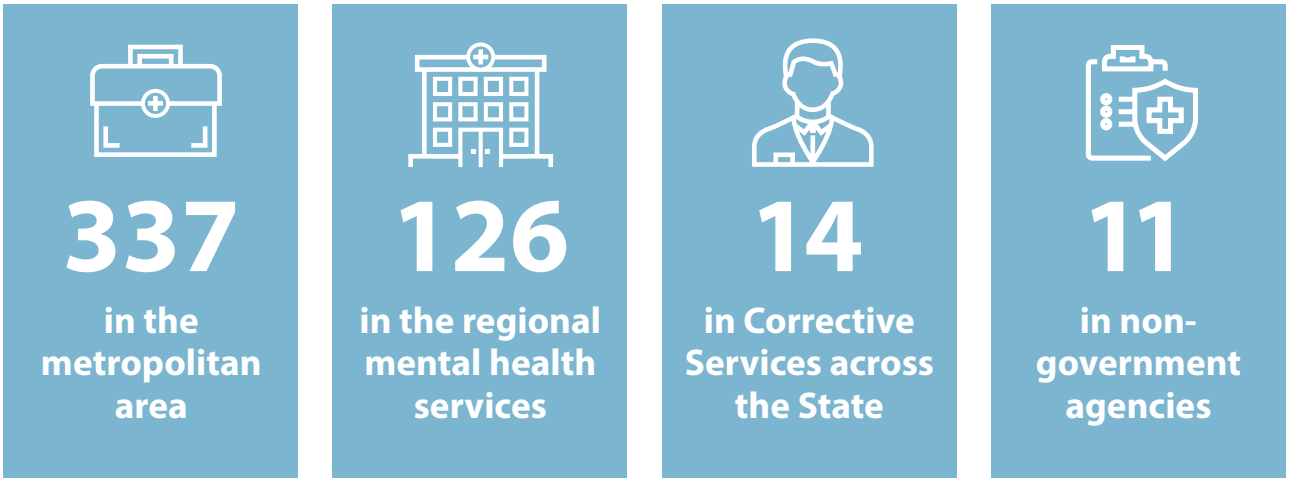
Aboriginal and Torres Strait Islander people are more likely than other Australians to experience need for mental health services and yet generally, have less access to services.[1] The MHA 2014 and the Chief Psychiatrist's Standards for Clinical Care[2] outline specific requirements for all mental health services when providing psychiatric care to Aboriginal People.

Data around the standards of care provided to Aboriginal people were collected during the Chief Psychiatrist's Clinical Monitoring Reviews. However, due to the sampling method used, insufficient numbers of clinical records belonging to Aboriginal people were reviewed, limiting the ability to draw firm conclusions. To overcome this limitation, the standards of psychiatric care provided to Aboriginal consumers have been identified as a key area for a thematic review. The primary aims of the thematic review will be to examine how closely services adhere to the requirements of the MHA 2014 and the Chief Psychiatrist's Standard for Clinical Care of Aboriginal people.

Consultation for the review commenced in 2019. Meetings have been undertaken with key stakeholder groups to identify issues for the review and start to develop the specific data collection processes required. Consultation will continue during 2020 – 21, in preparation of a future review. No date has been set at this stage; the timeframe is impacted by the need to complete baseline reviews under the MHA 2014 (see Clinical Reviews).

Authorised Mental Health Practitioners & Training

Authorised Mental Health Practitioners (AMHPs) are senior mental health practitioners and are recognised as an integral part of mental health services. As at 30 June 2020 there were 488 clinicians authorised to perform the functions of an AMHP in WA and were located across the State as follows:



1. Commonwealth of Australia The Fifth National Mental Health and Suicide Prevention Plan 2017 Available from *http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf*
2. Chief Psychiatrist of Western Australia Chief Psychiatrist's Standards for Clinical Care 2015 Available from *https://www.chiefpsychiatrist.wa.gov.au/standards-guidelines/chief-psychiatrists-standards-for-clinical-care/*

The Chief Psychiatrist may designate a mental health practitioner as an authorised mental health practitioner (AMHP) if satisfied that the practitioner has the qualifications, training and experience appropriate for performing the functions of an AMHP.

In addition, a clinician seeking to become an AMHP is required to attend a two-day initial training course provided by our Office.

On behalf of the Chief Psychiatrist the Principal Officer Statutory Education develops and delivers the legislative training requirements to AMHPs and other cohorts in the mental health sector.

During the reporting period, we ran two initial AMHP courses for 40 mental health practitioners who successfully met the requirements and were gazetted as AMHPs by the Chief Psychiatrist.

The Chief Psychiatrist also has a statutory responsibility to ensure that all AMHPs gazetted by him are provided with appropriate ongoing education and training to maintain contemporary practice in and knowledge of their AMHP role.

COVID-19 State of Emergency requirements impacted our ability to deliver the training program in full as it was suspended from mid-March until the end of May 2020.

The following training was delivered to AMHPs across the State:

AMHP Training sessions	Number of sessions	Number of Attendees
AMHP Initial training	2	40
AMHP Refresher training	9	163
AMHP Mental State & Risk Assessment	6	95
AMHP Peer Supervision attendance & support	3	21
AMHP MHA 2014 Open question forums	2	36
Total	**22**	**355**

The Chief Psychiatrist continues to recognise the role of education in the delivery of quality mental health care and supports the delivery of a range of educational sessions to the broader mental health sector on request including to universities, general and mental health services, Alcohol and Drug services and other organisations.

The following training sessions were provided to the above cohort:

AMHP Training sessions	Number of sessions	Number of Attendees
Community Treatment Orders	6	105
MHA 2014 Inpatient Care & Treatment train the trainer course	3	35
Confidentiality in the mental health clinical setting	2	34
MHA 2014 for Graduate Nurses	2	35
Brief overview of the MHA 2014	2	22
Restrictive Practices	1	3
MHA 2014 Open question forums	1	14
Total	**17**	**248**

The training programs are reviewed regularly to ensure that the information remains contemporary and encompasses trending issues raised via the Clinical Helpdesk and feedback from course attendees.

Clinical Helpdesk

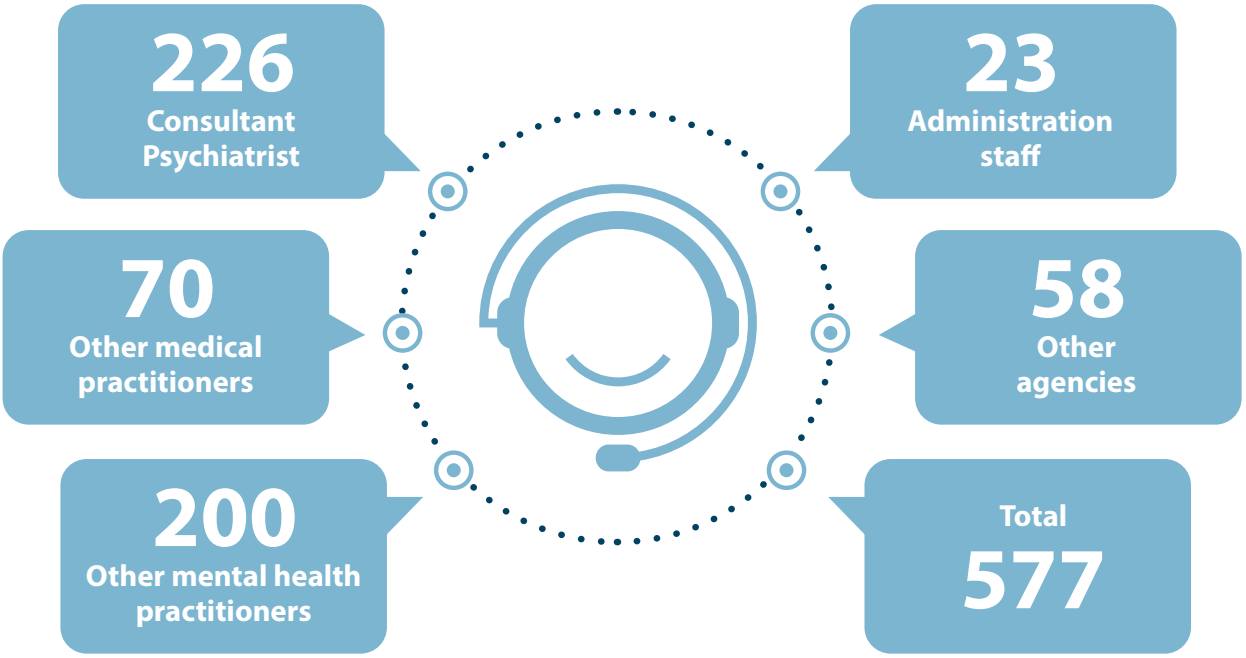
The Clinical Helpdesk continues to be an in-demand service with an average of 50 contacts a month from mental health clinicians seeking advice on the practical application of the MHA 2014 provisions in the context of clinical practice and to seek guidance on a range of complex clinical, ethical and policy matters.

The majority of contacts are by phone and the most common themes of the calls to the Clinical Helpdesk have been:

- Community Treatment Orders which remain an area of ongoing complexity
- Referral Orders
- Reception and detention for examination
- Inpatient Treatment Orders in the General Hospitals
- Inpatient Treatment Orders in Authorised Hospitals
- Capacity and whether the MHA 2014 or the provisions of the Guardianship and Administration Act 1990 were more appropriate
- Emergency ECT provisions
- Grant of Leave Orders
- Transfer Orders
- Apprehension and Detention Orders
- Transport Orders
- Confidentiality
- Seclusion and Restraint
- Restriction of Communication
- Nominated person

Most of the contacts to the Clinical Helpdesk were from consultant psychiatrists, other medical practitioners and mental health practitioners which demonstrates a commitment by clinicians to ensuring that the rights of people subject to provisions of the MHA 2014 are being appropriately observed.

The breakdown by profession is as follows:



Review of the Authorisation of Mental Health Facilities

The Chief Psychiatrist has commenced a review of the authorisation of all mental health facilities that were previously authorised under the Mental Health Act 1996 and incorporated into the MHA 2014.

The purpose of the Review is to ensure the requirements of the Standards for Authorisation can be met to ensure safe high-quality care and promote an environment that is welcoming; therapeutic and one that is consumer centered and consistent with the Chief Psychiatrist's for Standards for Clinical Care.

Due to the impact of COVID-19 and accompanying restrictions, on the 25 June 2020 the Chief Psychiatrist held an online information workshop for services with authorised facilities. The workshop was to inform services of the Review, the reason for it, what it would involve and the expectations of the Chief Psychiatrist.

Clinical Reviews

The MHA 2014 prescribes the Chief Psychiatrist with the responsibility for publishing standards for the treatment and care to be provided by mental health services to mental health consumers and for monitoring the standards of psychiatric care provided throughout the state of Western Australia - MHA s.515 (2). To meet these responsibilities, the Chief Psychiatrist has implemented a Clinical Monitoring Program whereby all mental health services within WA are systematically reviewed against the Chief Psychiatrist's Standards.

- Clinical Monitoring Reviews
  - Routine monitoring of mental health services against the Chief Psychiatrist's Standards for Clinical Care
- Targeted Reviews
  - Reviews of a service and/or clinical case to investigate a specific concern or allegation.
- Thematic Reviews
- Reviews of an aspect of care or 'theme' across multiple mental health services Evaluation of Clinical Monitoring Reviews

Following completion of the first reviews of all public mental health services under the MHA 2014, the Chief Psychiatrist undertook an evaluation of this method for monitoring compliance with the Chief Psychiatrist's Standards for Clinical Care. Staff in the OCP undertook extensive consultation with the services which had been reviewed, members of the OCP's reviewer pool who had participated in the process, people with lived experience of mental illness, and the WA Health Mental Health Unit. Videoconferencing was used to seek feedback from mental health staff and people with lived experience located outside the metropolitan area.

The evaluation considered the suitability of indicators for monitoring adherence to standards, the methods for collecting and analysing data, and providing feedback to services. The processes used in WA were benchmarked against processes undertaken by the Chief Psychiatrist of South Australia and the Chief Psychiatrist of Queensland with the aim of better understanding the monitoring processes undertaken in those jurisdictions, to allow for comparisons in terms of resource utilisation and methodology.

The evaluation identified strengths of the review process, along with areas for improvement.

Strengths	Areas for improvement
Independent	Length of time to finalise report of findings
Comprehensive	Duplication of processes at the service level, which can contribute to audit fatigue
Reviewers have relevant clinical experience	Consideration of service context
Services are involved in the review	Small sample size
Focus on patient care	Too broad a focus
Minimal impact on service delivery	Recommendations too general
Services receive both positive and constructive feedback	Limited opportunity for front-line clinical staff to have ongoing engagement with the process
Consumers and carers are involved in the review process	The focus of the review was more on monitoring under the MHA 2014, rather than continuous improvement

Key feedback from clinicians and service managers was that conducting reviews at Health Service Provider (HSP) level meant that recommendations were perceived as too general. In some cases, individual services formed the impression that the recommendations were based on the performance of other parts of the HSP and were therefore not relevant. Additionally, communication from the Chief Psychiatrist relating to actions arising from the recommendations was addressed to the HSP executive and did not always reach individual services. There was strong support for thematic reviews which focus on a key area, rather than general reviews which monitor compliance across all standards.

Feedback from people with lived experience focused on the need to monitor whether clinicians did "all the things that a competent clinician would do"; when this was explored, key aspects identified were strongly aligned with the Chief Psychiatrist's Standards for Clinical Care. There was also a focus on monitoring whether a "human connection" was made, that is, whether consumers feel understood by mental health services.

The benchmarking process identified some differences between the types of reviews and methodology used by different jurisdictions. These differences must be considered in the context of differences in legislation and structure of the health departments in each state. Key feedback from South Australia was that combining announced visits with unannounced visits can provide useful information. Suggestions from Queensland focused on the importance of having a set of performance indicators, with clear, routine methods for collecting data, along with utilisation of the Chief Psychiatrist's team as a resource to support front-line staff with quality improvement.

The information from this review process will be used to make improvements to the way future reviews will be conducted. Changes will include the way data are collected and compiled and the way in which recommendations are made to services. Baseline reviews of all mental health services under the Chief Psychiatrist's remit are currently being conducted and the information from these will be used to identify key areas for a program of thematic reviews. Resourcing for the Chief Psychiatrist's Clinical Reviews was designed around the Chief Psychiatrist's remit under the Mental Health Act 1996, which included public clinical mental health services only. With the Chief Psychiatrist's expanded remit under the MHA 2014 S.515, the frequency that each service can be reviewed is limited. Baseline reviews are yet to be completed for:

- Private psychiatric hostels
- Private hospitals
- Step-up-step-down facilities
- Non-Government mental health services providing clinical mental health services

Clinical Monitoring Reviews of Private Psychiatric Hostels

Under section 507 of the MHA 2014, the definition of a "mental health service" includes private psychiatric hostels. In 2019, the Chief Psychiatrist commenced planning for a program of Clinical Monitoring Reviews of private psychiatric hostels.

Private psychiatric hostels are also subject to monitoring processes by other government agencies. The aim of the Chief Psychiatrist's process is not to duplicate existing monitoring processes, but to predominantly focus on the standards of clinical care provided to residents of private psychiatric hostels, which are not included in the monitoring conducted by other agencies. The standards of clinical care required by the Chief Psychiatrist help to underpin good mental health outcomes for residents. The review will focus on:

1. The clinical care provided by mental health services to residents within hostels, and how the hostel staff support, and are supported to do that.
2. The relationships between mental health services and hostels and how that impacts on residents and the care that they receive.

To design the monitoring process, the OCP undertook consultation with key stakeholders, including representatives from the licensed psychiatric hostels, clinical mental health staff, consumers and carers. The reviews will be conducted by trained, independent reviewers, who are senior mental health clinicians with experience in working with residents of psychiatric hostels. The process will involve interviewing residents and their families, staff of both hostels and relevant clinical mental health services, along with other stakeholders. A review of residents' records and any formal documented agreements between hostels and clinical mental health services will also be undertaken.

Reviews were scheduled to commence in the first half of 2020, however, were put on hold when the Clinical Monitoring Program was suspended due to COVID-19. With the lessening of restrictions, the Clinical Monitoring Program has recommenced, and the first hostel review is scheduled to commence in September 2020. A COVID-19-safe plan for clinical reviews has been designed to align with the phases of the WA Government's COVID-19 coronavirus: WA roadmap. This will allow reviews to be modified, rather than cancelled, should the phase of restrictions change again.

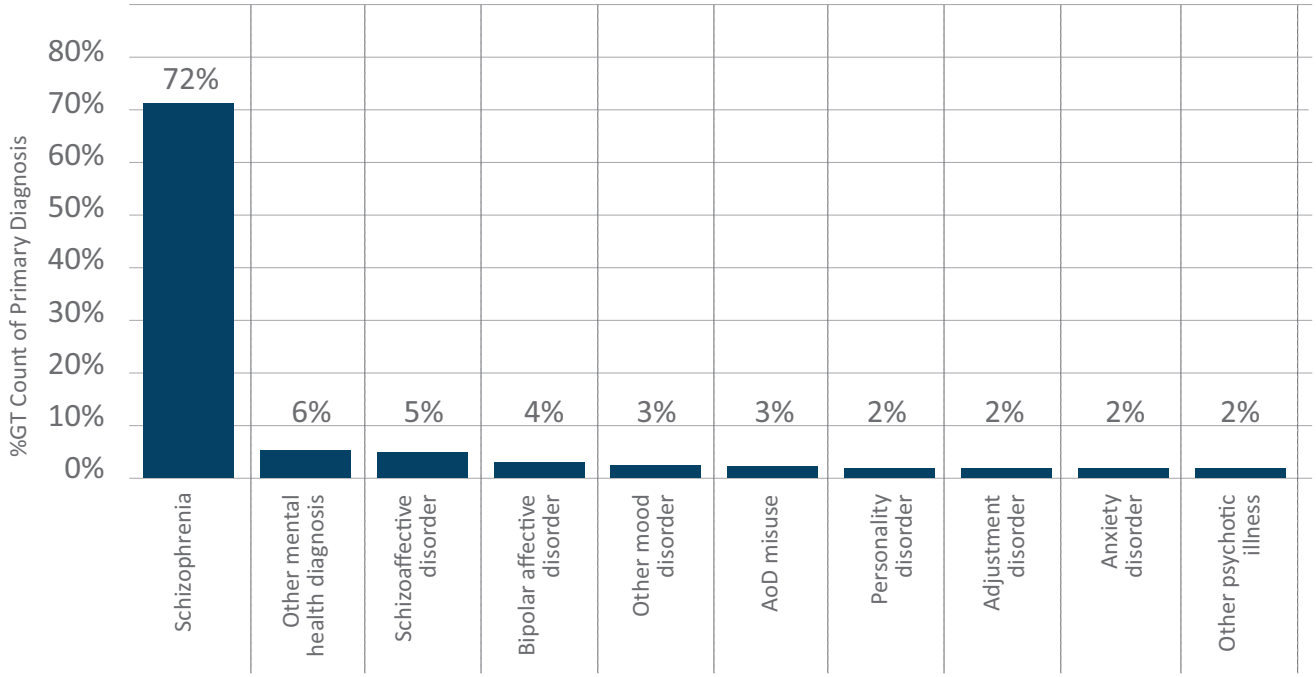
The Chief Psychiatrist's Reviews of Private Psychiatric Hostels will obtain important information about coordination of care for residents and identify strategies for improvement.

Private Psychiatric Hostel Dashboard

The Chief Psychiatrist's Private Psychiatric Hostel Dashboard is a snapshot of the residents and the clinical care they receive. A new process for collecting and updating the information has improved data accuracy and enables review of more detailed information about the mental health needs and service use of private psychiatric hostel residents, compared with the previous process. A report of the findings of the snapshot will be published on the website of the Chief Psychiatrist and updated annually.

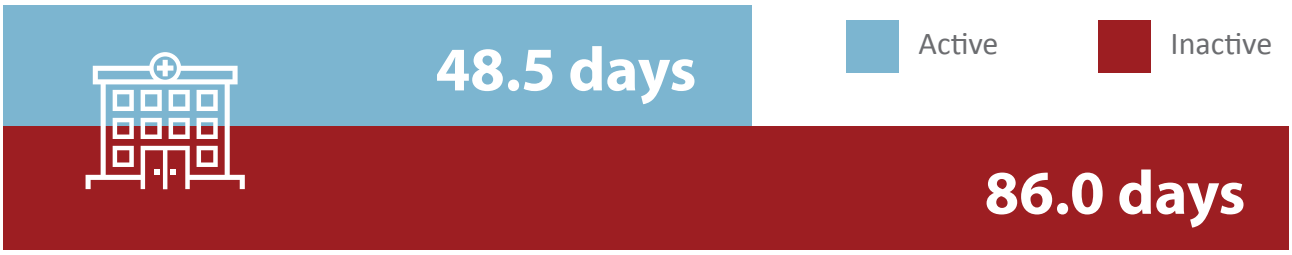
The most recent snapshot data found that the most common psychiatric diagnosis of people who reside in private psychiatric hostels is schizophrenia, similar to the findings from two years ago. (Figure 9).

Figure 9: Primary psychiatric diagnoses of residents of private psychiatric hostels



When admissions to inpatient services over a 12-month period were considered (Figure 8), hostel residents who were active with an HSP-provided specialist clinical mental health service had a median of 48.5 days in hospital, while those who were not had a median of 86 days spent in hospital.

Figure 10: Total days an individual spent in hospital over the last 12 months (median)



Residents with the most complex mental health needs

Data obtained and analysed for the Private Psychiatric Hostel Dashboard revealed that of residents of private psychiatric hostels with the most complex mental health needs*, 16% had their application for National Disability Insurance Scheme services declined (Figure 11) and 27% are not active with a community mental health service. In the 12-month period which was reviewed, this group also had more presentations to the emergency department (Figure 12) than the average for residents of Private Psychiatric Hostels and more admissions to inpatient mental health services (Figure 13).

Figure 11: NDIS Status

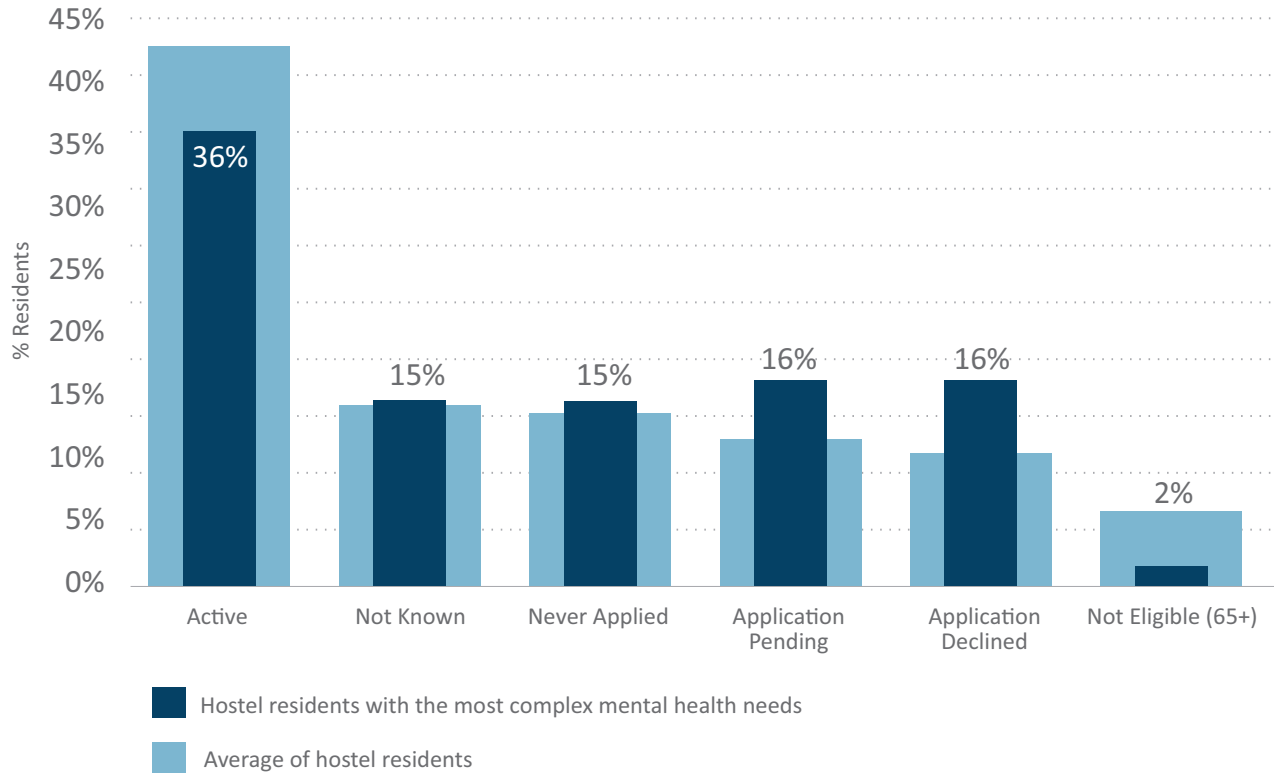


Figure 12: Emergency Department Presentations in the last 12 months

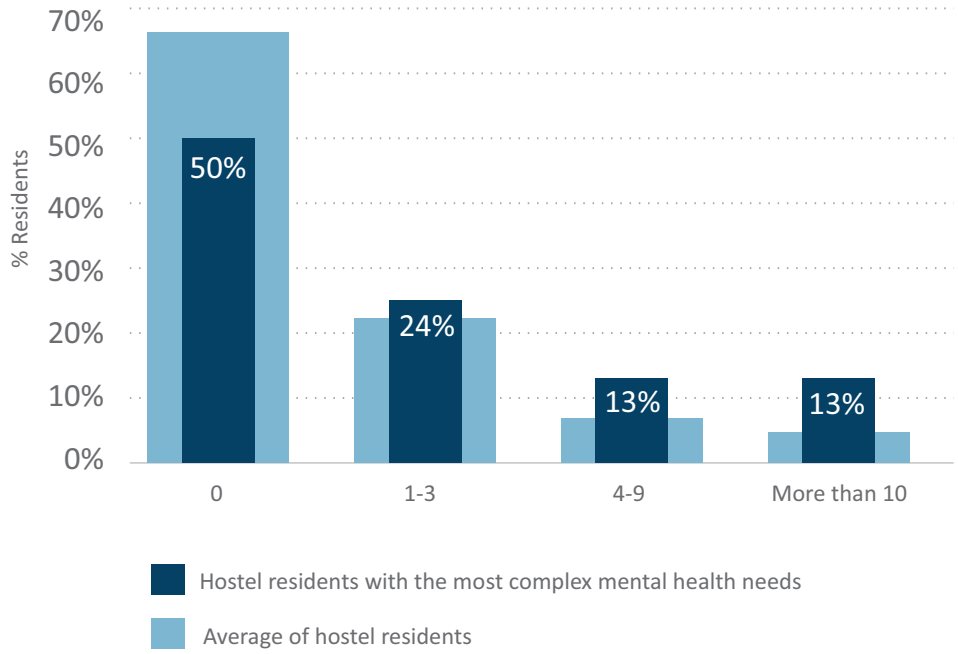
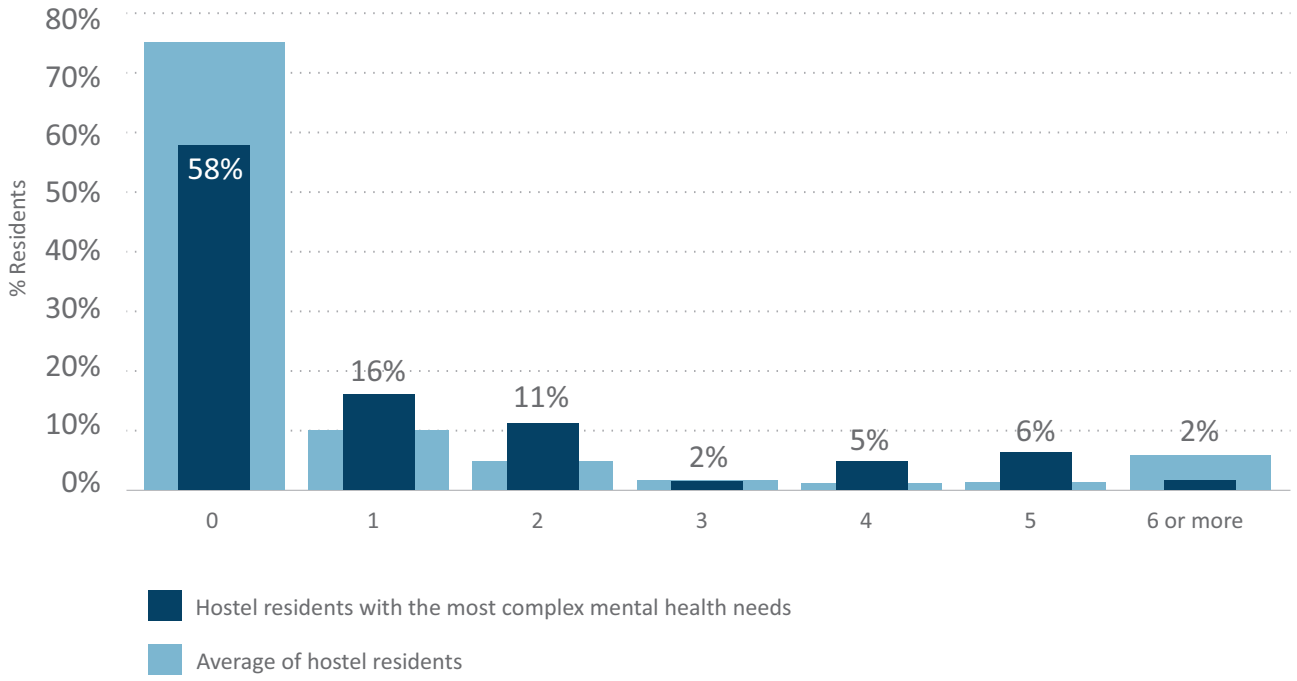


Figure 13: Inpatient Admissions in the last 12 months



*For this analysis, 'most complex needs' was defined as more than one standard deviation above the population average on the Health of the Nation Outcome Scale (HoNOS), a national outcome measure, when it was last assessed.

Targeted Reviews

Targeted Reviews are undertaken when the Chief Psychiatrist becomes sufficiently concerned about the standards of psychiatric treatment and care being delivered to a patient or group of patients, to warrant an in-depth understanding of the issues. Reviews are undertaken with a focus on system hazards or vulnerabilities, so action can be taken to improve the standards of care for future service delivery.

In the 2018-19 Annual Report the OCP reported on a targeted review of clinical governance, which had been undertaken at City East Community Mental Health Service. A 12-month follow-up review was completed in March 2020. The review found that there had been significant improvements across the organisation, with six of the twelve recommendations made by the Chief Psychiatrist now closed. A progress report on the remaining recommendations is due in the 2020–21 financial year.

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, mental health services in Western Australia. This was an increase compared with a total of 9 deaths in the preceding 3 years. As a consequence, the Chief Psychiatrist initiated a preliminary review into the treatment and care of the 7 individuals who allegedly committed these homicides in 2018.

The Review aimed 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 examined the investigations into the treatment and care of the individuals who allegedly committed the homicides as well as other documentation provided by the relevant health services. The Chief Psychiatrist then determined that there would be limited value in undertaking further investigation as the Review findings were very clear.

The Review report has been provided to key stakeholders. There may be value in releasing the Review findings publicly, however, it is important to note that the report has been careful not to undermine any pending court processes and has not identified any individuals or organisations. Discussions are being held with each of the relevant organisations in relation to the findings.

Complex Cases and Agency Facilitation

The Office is routinely contacted regarding complex and ethically challenging clinical cases, where there is a need for rigourous care coordination and interagency collaboration. For this reporting period we attended <5 case conferences in respect of clinically complex cases and <5 agency facilitation cases to ensure oversight of the treatment and care of residents of private psychiatric hostels.

Review into the Treatment and Care of People with Severe, Enduring Mental Illness and Challenging Behaviour

The Chief Psychiatrist has become increasingly concerned about the standard of care being provided to people with a severe, enduring mental illness, complex needs and challenging behaviour. Clinicians and families have raised issues about the current service system. They have identified significant service gaps, fragmented services and a service system which is largely not meeting 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 this cohort. The Review will investigate the issues and, in partnership with key stakeholders, develop options to enhance future clinical services. It is intended to be a catalyst for change – to stimulate debate, to build a broad consensus for a way forward and importantly, to galvanise action aimed at improving treatment and care.

As part of the review process, there has been extensive consultation with clinicians from a broad range of public mental health services, including community, inpatient, forensic and specialist aboriginal services. A workshop was conducted with key stakeholders to identify significant issues, gain a greater understanding of the complexity of the challenges and investigate options. Discussions were held with a key mental health carer community managed organisation and the peak body representing consumers in Western Australia.

Late in 2019 the draft Review report was widely distributed to key stakeholders for comment and feedback. A number of written submissions were received which were largely supportive of the proposed direction and the report is currently being finalised to reflect feedback from the submissions. It is anticipated that the Review will be publicly released this year.

Visits to Mental Health Services

521. Visits to mental health services

(1) The Chief Psychiatrist may visit —

(a) an authorised hospital whenever the Chief Psychiatrist considers it appropriate to do so; and

(b) a mental health service that is not an authorised hospital whenever the Chief Psychiatrist reasonably suspects that proper standards of treatment and care have not been, or are not being, maintained by the mental health service.

The Chief Psychiatrist visited 10 mental health services in the 2019-2020 reporting period 6 of which were in the metropolitan area and 4 in regional areas. Staff are given the opportunity to meet with the Chief Psychiatrist and ask questions about matters relating to standards of care and issues pertaining to administering the Mental Health Act 2014. Consumers and Carers also meet with the Chief Psychiatrist to discuss any concerns they have regarding their care. The Chief Psychiatrist feeds back this information to services and provides recommendations that relate to standards of care and service improvement.

We visited the Albany Health Campus, Mental Health Inpatient Unit during the Rural and Remote Mental Health Conference held there in October 2019. The Chief Psychiatrist met with available staff for a discussion on standards of care and was provided with a tour of the unit.

In December 2019 Dr Sophie Davison – Deputy chief Psychiatrist visited Bunbury Health Campus, Mental Health Inpatient Unit. Dr Davison met with staff at the mental health service, including staff from Margaret River and Busselton via video link. She also met with the members from the Consumer Advisory Group and Carers Advisory Group. It was noted Bunbury have a very active consumer and carer advisory group who are actively engaged in promoting quality care.

In February 2020 the Chief Psychiatrist and the Consultant, Statutory Authorisations and Approvals visited Port Hedland Health Campus and met clinicians and staff from Community Mental Health Services. Dr Gibson also met with Aboriginal Elders and local NGO's at a community forum. The meeting highlighted the significant issues for aboriginal people in regional areas, particular the access to accommodation for the homeless, access to drug and alcohol rehabilitation along with the limited access to NGO services. It was noted during the visit there needed to be greater collaboration between services including NGOs to ensure resources are maximised.

Staff reported on the benefits of the Emergency Telehealth Service and how this is enabling clinicians' time to reflect on practice and provide quality services. I understand from the discussion with staff it has eased some of the pressures experienced in assessing patients – particularly over weekends.

On route to Karratha Dr Gibson took the opportunity to meet with several staff from the Child Adolescent Mental Health Service (CAMHS) and staff from the Department of Child Protection. We heard of the complex cases the team are dealing with and difficulties within the community. The region lacks wraparound services and there is no forum for NGO's to meet and share information about services. There is a need for greater collaboration between the NGO sector in order to develop services that complement each other and that do not overlap.

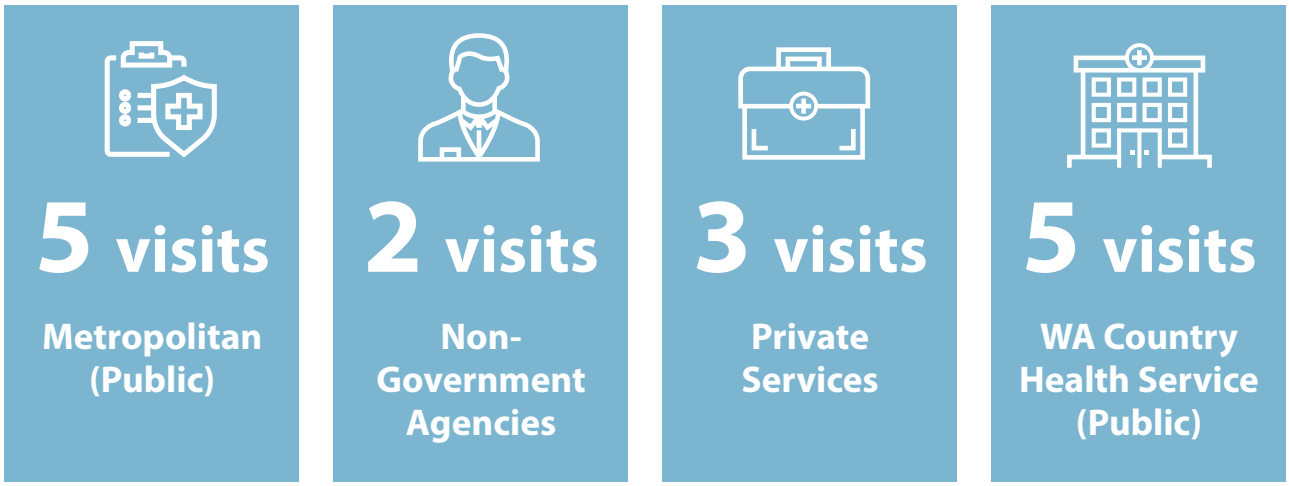
As a result of the COViD-19 pandemic visits to mental health services were cancelled.

On 28 May 2020 Dr Gibson, the Clinical Consultant and Consultant Statutory Authorisations and Approvals was invited to Hollywood Private Hospital to view the recent upgrades to the Mental Health Unit and ECT suite. The redevelopment and refurbishment is very much welcomed and increases bed capacity for the State.

The Chief Psychiatrist also visited a number of Non-Government Organisations (NGOs).

- During Homelessness Week in August 2019 the Chief Psychiatrist, the Deputy Chief Psychiatrist and several staff members were invited by the Salvation Army Beacon Centre to meet and discuss common issues. Although the Chief Psychiatrist has no statutory responsibility for the service provided by Beacon, the purpose of the visit was to tour the facility and hear about the service Beacon provides.
- Similarly visits to Next Step and Drug and Alcohol Youth Service (DAYS) were to view the facilities in terms of safety and suitability and make recommendations.
- Whilst in the Pilbara region (February 2020) we met with staff from Mawarnkarra Health Service and discussed the challenges faced by the service along with the complex cases and high levels of co-morbidities among the patients.

Mental Health Services Nunber of Visits



Security Guards

In June 2020 the Chief Psychiatrist wrote to all Health Service Providers with Authorised mental health inpatient services seeking information on the use and functions of security guards within their respective services.

The Chief Psychiatrist is committed to ensuring inpatient services are homely, therapeutic and are not custodial, which maybe implied with the presence of security guards within the ward environment.

Most security staff form part of the general hospital. Although not all wards have permanent security guards, most services indicated the function of security guards is to provide a safe environment for both patients and staff. Services also indicated security staff utilised when required and are involved in the management of patients with significant aggressive and violent behaviours.

Most services use security staff for 1:1 (sometimes 4:1) specials. Reasoning includes clinical staffing levels and level of aggression that place staff and other patients at risk of harm.

Although the information received from services did not include the levels of training security guards, some services indicated all security staff received the same training as clinical caregivers in the management and prevention of aggression.

Advancing the Knowledge

The Chief Psychiatrist is committed to influencing the delivery of mental health treatment and care and use his sphere of influence on the National stage and across the mental health sector in Western Australia

Promoting Quality Improvement (QI)

In 2018/19 the Office of the Chief Psychiatrist published a discussion paper Mental Health Quality and Safety in WA: Building the Foundations for Improvement which promoted the development of a Quality Insurance (QI) program for mental health, at scale, across all mental health services in WA. 2019/2020 has seen the Office of the Chief Psychiatrist participate with the Clinical Excellence Division, Department of Health, in a number of activities to further the development of a mental health QI program, including (a) a proposal for its inclusion as a topic for debate at the Clinical Senate for its 2020 program; and (b) development of a business case for a project aimed at embedding system-wide quality improvement (QI) within public mental health services to provide a long-term approach to building high quality and safe services for mental health patients in Western Australia (WA).

At a national level, the Office of the Chief Psychiatrist was invited to participate in a Mental Health Service Improvement Collaboration Forum in Brisbane, which was attended by representatives from all States and Territories and New Zealand. It was proposed that the Forum should focus initially on building QI capability across the jurisdictions, later moving on to establish a 'QI Collaborative' to work on a set of agreed safety and quality priorities.

Coroner's recommendation in relation to communication with families/carers

Following an inquest into the death by suicide of a mental health consumer in September 2019, the Coroner recommended that the Office of the Chief Psychiatrist consider issuing guidance specifically aimed at the problem in communication between staff and families/carers that arises in circumstances in which a consumer, who is voluntary and deemed to have capacity, refuses to consent to having their family/carer involved in their care.

Since there are already a number of guidelines around that very effectively address this issue, the problem is not one of a lack of guidelines but rather of limited uptake into clinical practice. It was decided that the best approach would be to engage the mental health clinical leads from the Health Service Providers in a series of meetings to determine how services were currently dealing with this issue (including any promising initiatives they already had in place) and getting them involved in finding a sustainable way forward.

The initial meeting had to be delayed for several months due to the pressure on services resulting from the COVID-19 crisis. In the interim, a brief discussion paper was circulated with data from the Chief Psychiatrist's reviews of public mental health services, suggesting that one of the sources of this problem may lie with the approach taken by some staff in seeking to obtain consent. Relying on a single, early, blanket request for consent to involve family/carers in the consumer's treatment and care is not sufficient and a more nuanced approach is required.

At the first meeting it was proposed that the Office of the Chief Psychiatrist look at developing some clear principles to guide practice. A number of key areas for action were identified including education/training and skills development, leadership and embedding carers in services. A key issue for subsequent meetings will be getting HSPs to identify strategies for how each of them can take the matter further within their services.

Privacy and Responsible Information Sharing Legislation for the WA public sector

Staff represented the Office and contributed to a series of meetings and workshops in respect to the Proposed Privacy and Responsible Information Sharing Framework for the WA Public Sector with due regard to confidentiality and privacy led by the Department of Premier and Cabinet.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

We have contributed to the Western Australian response to the Restrictive Practices Issues Paper – which are a key area of inquiry for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Keeping Children Safe: Proposed approach to the Independent oversight of child-related work in Western Australia

We have contributed to a series of workshops and meetings leading to the development of a Discussion Paper by the Independent Oversight Working Group in respect of progressing the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse led by the Department of Premier and Cabinet for Western Australia.

Perth Gayaa Dhuwi (Proud Spirit) Declaration and Indigenous Governance Framework

The Chief Psychiatrist participated in a workshop on strategies for the implementation of the Gayaa Dhuwi Declaration and Indigenous Governance Workshop.

Mental Health Act 2014 Proposed amendments

Staff of the Office collaborated closely with staff from the Mental Health Commission in the development of proposed amendments to the Mental Health Act 2014.

A Safe Place – Accommodation Strategy

Staff of the Office participated in and contributed to the Mental Health Commission's accommodation strategy to develop solutions specific to the forensic cohort of consumers for the short and medium term.

National Symposium on the Comorbid Mental and Physical Health Conditions

Staff of the Office participated in the national symposium to develop strategies for improving the physical health of consumers of mental health services held in Canberra.

Restrictions for Regions: The value of eliminating Restrictive Practices in Regional settings

The Chief Psychiatrist presented at the 2019 WA Rural and Remote Mental Health Conference in Albany on the value of eliminating restrictive practices in our regional authorised mental health inpatient units.

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;

NATIONAL

- Australian Commission on Safety and Quality in Health Care - Mental Health Reference Group
- Australian Commission on Safety and Quality in Health Care – Hospital-Acquired Complications Curation Clinical Advisory Group (ACSQHC HACs CCAG)
- Australian Health Ministers' Advisory Council - National Mutual Recognition Project Interjurisdictional Project Steering Committee
- National Safety Priorities in Mental Health Prioritisation Workshop
- Health Expert Advisory Group (National)
- 5th National Mental Health Plan Action 26 National Mutual Recognition Project Interjurisdictional Steering Committee
- Suicide Prevention Working Group
- National Safety and Quality Partnership Sub-Committee (SQPSC)
- Restrictive Practice Subgroup (subgroup to SQPSC)
- Reducing Adverse Medication Events in Mental Health Working Party (SQPSC subgroup)
- Gayaa Dhuwi (Proud Spirit) Declaration and Indigenous Governance Framework implementation workshop
- Senior Psychiatrists Peer Review Meeting
- Royal Australian & New Zealand College of Psychiatrists Education Committee
- Royal Australian & New Zealand College of Psychiatrists Committee for Examinations
- Royal Australian & New Zealand College of Psychiatrists Practice Policy and Partnership
- Royal Australian & New Zealand College of Psychiatrists Professional Practice Committee (PPC)
- Royal Australian & New Zealand College of Psychiatrists Evidence Based Medicine Committee (EBPC)
- National Health and Medical Research Committee - Alcohol Working Committee

STATE

- Royal Australian & New Zealand College of Psychiatrists WA Branch Chair Forum
- Member, Clinical Senate – Department of Health Western Australia
- Co-Leadership Mental Health Safety and Quality Steering Group – Mental Health Commission
- Coronial Review Committee – Department of Health Western Australia
- Royal Commission into Institutional Responses to Child Sexual Abuse - Independent Oversight Working Group - Department of Premier and Cabinet WA
- Mental Health Network Executive Advisory Group – Mental Health Commission
- Peak Incident Review Committee – Department of Health Western Australia
- Psychiatric Hostels Advisory Committee – Department of Health WA
- State Datix Clinical Incident Management System Committee – Department of Health WA
- Stimulants Assessment Panel – Department of Health WA
- WA Psychotropic Drug Committee – Department of Health WA
- WA Primary Health Alliance Steering Committee - Statewide Integrated Master Plan for Primary Mental Health, Alcohol and other Drugs and Suicide Prevention – WA Primary Health Alliance
- WA Psychotropic Drug Committee (WAPDC) – Department of Health WA
- WA Therapeutics Advisory Group – Department of Health WA
- Mental Health Interagency Forum – Department of Health WA

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

- WA Recovery Stakeholder Engagement: COVID-19 Pandemic – Mental Health; Alcohol and Other Drugs Ministerial Roundtable
- Royal Australian & New Zealand College of Psychiatrists COVID-19 Education Steering Group
- COVID-19 Sector Forum - Session 1 - Supported Accommodation Services

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 Complaints Office
HMDS	Hospital Morbidity Data System
Hon.	Honourable
HSP	Health Service Provider
KPMG	Klynveld Peat Marwick Goerdeler
LARU	Licensing and Accreditation Regulatory Unit
MHAS	Mental Health Advocacy Service
MHA 2014	Mental Health Act 2014
MHC	Mental Health Commission
MHOA	Mental Health Observation Area
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's Hospital
SAC	Severity Assessment Code
SMHS	South Metropolitan Health Service
WACHS	WA Country Health Service

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