GOVERNMENT OF
WESTERN AUSTRALIA

Chief Psychiatrist
of Western Australia

ENSURING SAFE
AND HIGH-QUALITY
MENTAL HEALTH CARE

Annual Report of the Chief Psychiatrist of Western Australia

1 JULY 2021 – 30 JUNE 2022

Produced by the Office of the Chief Psychiatrist, Western Australia

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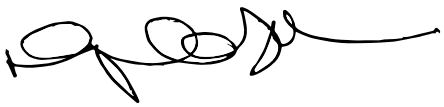
Statement of compliance

The Hon Amber-Jade Sanderson BA MLA

Minister for Health and Mental Health

In accordance with sections 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 of Western Australia for the financial year ended 30 June 2022.



Dr Nathan Gibson

Chief Psychiatrist

Monday 12 September 2022

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 of Western Australia includes a report for the financial year ended 30 June 2022 of information prescribed by the Treasurer's instruction 951 Related and Affiliated Bodies, in respect of the Office of the Chief Psychiatrist, which is 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.

Cameron Patterson
Chief Finance Officer
Monday 12 September 2022

Disclosures and legal compliance

Record keeping

The Chief Psychiatrist has complied with the statutory record keeping practices under the *State Records Act 2000* and with the standards and policies of the State Records Office of Western Australia and the Chief Psychiatrist's Record Keeping Plan.

The Chief Psychiatrist's Record Keeping Plan has been endorsed by the State Records Office for a further period of three years from April 2022.

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 Instructions, there has been no remuneration for Board members.

Consumer and Carer representatives providing their expertise and perspective on a range of 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

Treasurer's instruction 903(12) requires 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 financing 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 such a direction. The Minister must cause the text of a direction to be laid before each House of Parliament.

The Minister issued no such directives to the Chief Psychiatrist, and nor did the Chief Psychiatrist request a direction from the Minister for the reporting period.

Conflicts of interest

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 Commissioner's Instruction No. 7: Code of Ethics.

Staff of the Office of the Chief Psychiatrist, who are employees of the Mental Health Commission, complied with the Mental Health Commission's Code of Conduct, and demonstrated 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 were provided with a comprehensive induction and orientation and one member of staff was the nominated Occupational Safety and Health Officer.

Acknowledgement of Country

The Chief Psychiatrist of Western Australia acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia, and acknowledges the traditional owners of the lands upon which the Office sits – **nidja Wadjuk Noongar boodja nookook nyininy.**

We acknowledge the wisdom of Aboriginal Elders past, present and emerging 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.

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Moorditj

Noongar word for strong

From the Chief Psychiatrist

The community of Western Australia has faced some of its greatest trials this year. Equally, mental health services have faced the test of increasing referrals, workforce shortages and heightening community expectation. As Chief Psychiatrist, I acknowledge the massive challenges for staff – both clinical and non-clinical, in the face of these unrelenting pressures. It is truly a testament to their professionalism that we continue to maintain high standards throughout our mental health services.

The Noongar word for strong is moorditj. Our mental health staff are moorditj and I thank them for caring for the mental health of our most vulnerable people with such commitment and dedication. It is through these mental health staff that the Chief Psychiatrist can work to improve services and health outcomes. We also have a responsibility to be open to active changes in how the Office of the Chief Psychiatrist (OCP) engages with Aboriginal peoples and hears the wisdom of Elders.

In 2021-22, the OCP has been a key driver in major pieces of work including the Infant, Child and Adolescent Taskforce, the Graylands Reconfiguration and Forensic Taskforce and the Mental Health Community Roadmap.

It is encouraging to see the State Government planning mental health services for children and adolescents, prisoners, and rehabilitation services for people with very complex, severe and enduring mental illness. The further development of community mental health services, both clinical and non-clinical, will be critical for the sustainability of standards.

The next few years are likely to continue to be challenging, as sustainable service developments are further implemented. It's important that we assist the community to understand why these changes will take time. We must hear, respect and work with the voice of the consumer and carer during this time.

I thank the staff of the Office of the Chief Psychiatrist. They are a highly skilled and incredibly hard-working group. Each and every one of my staff remains committed to seeing timely and tangible improvements for consumers, carers, care-workers and clinicians, through all of the different ways we drive standards of mental health care.

Dr Nathan Gibson

Chief Psychiatrist

Executive summary

The Chief Psychiatrist's mission is to ensure that all Western Australians receive the highest standard of mental health care.

The 2021-22 financial year was significantly impacted by the COVID-19 pandemic, which required a change to the usual activities of the OCP, particularly during the second half of the year, as community transmission took off in Western Australia. Standards of care took on a slightly different emphasis, as the Office advocated for assertive approaches to vaccination for mental health consumers, worked with the Mental Health Commission and Department of Health to ensure that robust supports were in place for vulnerable people living in psychiatric hostels, and produced guidance for clinical services needing to incorporate infection control considerations into their usual processes for providing care.

While some of our usual reviews and visits have had to be postponed in recent months, we were able to successfully complete a large number of important service reviews this year. The team carried out in-depth reviews of a number of psychiatric hostels, and formally reviewed all of the State's electroconvulsive therapy (ECT) services through a rigorous authorisation process. Comprehensive work to re-authorise mental inpatient units is also well underway. The OCP's expertise in the safe and therapeutic design of mental health units is valued in the sector, and we have been involved in the planning process for a number of new inpatient units and redesign of current facilities this year.

An increase in budget has meant the OCP has been able to expand the work we have been able to commence this year and recruit to key roles. We are able to provide more in-depth analysis of the information we receive through our statutory reporting processes. This has allowed a more detailed focus on important areas of quality and safety such as restrictive practices in inpatient units, children requiring inpatient care, sexual safety in mental health services and Aboriginal people in inpatient mental health settings. A new Community of Practice for clinicians across the sector has been established, providing an opportunity for clinicians to get together (virtually) and to support each other and share good practice. This has been well received.

Our capacity to provide clinical advice and help services to translate the requirements of the *Mental Health Act 2014* (MHA 2014) has also been enhanced.

During 2021-22, the OCP concluded structural reform aimed at making the Office more efficient and sustainable, enhancing the leadership capabilities internally.

Research has been an important focus this year. The OCP partnered with the University of Western Australia (UWA) on a research project that will help us to better understand the patient journey for consumers and highlight service gaps and opportunities to improve outcomes. Work also began on a project with Curtin University and the Mental Health Advocacy Service to improve the OCP's capacity to work in authentic partnership with Aboriginal Elders to improve mental health care.

As we work with the sector, we are acutely aware of the challenges that this year has brought in terms of increasing demand and exceptionally challenging workforce shortages. The difficulties that the community has faced, and that clinicians and service providers have experienced in maintaining continuity of service, have been profound. We have endeavoured to support their efforts and add value wherever we can. At the system level, we have engaged in the work to develop achievable workforce strategies for the years ahead.

We have been pleased to contribute to the work of the Infant, Child and Adolescent Taskforce, which stemmed from the Chief Psychiatrist's review of the tragic death of Kate Savage, and welcome the State Government's commitment to this work. We continue to have a focus on the needs of prisoners experiencing mental illness who are unable to access inpatient care, and of people with severe and complex mental illness including those with intellectual disability and neurodiversity. We held a Forensic Forum in 2021, and have been involved in the work of the Graylands Reconfiguration and Forensic Taskforce, advocating for an exciting, contemporary integrated model as the future of the current Graylands site.

The work of the OCP has been wide-reaching and productive this year despite the challenges of the COVID pandemic. We have provided strong statutory oversight. Our achievements in 2021-22 have provided important direction and drive for services to improve the standards of mental health treatment and care for Western Australians.

Key achievements

Monitored treatment and care of approximately 77,000 patients in a range of mental health services across WA, including:

58
public mental health inpatient units

3
publicly contracted private providers of mental health services

55
clinical community mental health services (CMHS)

25
clinical community mental health services with specialised models of care

16
non-government organisations providing clinical mental health care

6
Step Up Step Down mental health facilities

4
private psychiatric hospitals

32
private psychiatric hostels

Monitored standards for treatment and care in areas such as:

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

Provided expert advice on **8 legislative reform projects.**

Established the **Community of Practice – connecting more than 155 clinicians** over four sessions to share ideas regarding COVID and beyond.

Conducted reviews into areas such as ECT services, authorised hospitals, private psychiatric hostels and notifiable incidents.

Partnered with University of Western Australia to research the patient journey and identify gaps in the mental health system.

Provided expert representation on **25 Statewide** and **13 National mental health committees**.

Held Forensic Forum in 2021 – to explore pathways for WA prisoners in need of acute mental health treatment and care.

Contributed to **14 Consultations** including the Mental Health Commission Community Roadmap and the Statutory Review of the *Mental Health Act 2014*.

Initiated a project with Curtin University to enhance authentic engagement with Noongar Elders and the broader Aboriginal community.

Strengthened program to promote and enhance sexual safety for consumers of mental health services.

Published COVID-19 guidance documents for mental health services

Held 70 training sessions on the MHA 2014 to 882 mental health clinicians and nursing graduates.

Who we are

The Chief Psychiatrist is an independent statutory officer who holds powers and duties as prescribed by the *Mental Health Act 2014* (MHA 2014) and reports to Parliament through the Minister for Mental Health. This means that the Chief Psychiatrist is an independent regulator who monitors the standards of care provided by a wide range of mental health services to around 77,000 people across the state each year.

The work required to carry out this role is considerable and broad in its scope and is carried out by the staff of the Office of the Chief Psychiatrist (OCP).

While the OCP does not run mental health services, through its work the OCP has a unique perspective of the areas of the mental health sector. It takes a proactive approach to support the mental health sector to improve health outcomes for consumers of mental health services in accordance with its vision, mission and values.

The Chief Psychiatrist is required by the MHA 2014 to prepare an annual report for the Minister for Mental Health at the end of each financial year.

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.

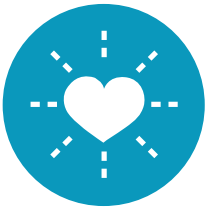
Our strategic objectives

- Striving for a culture of excellence in our workplace that reflects our values.
- Building and enabling transformative leadership both internally and externally.
- Building on our strong external partnerships to facilitate safe high-quality mental health care.

Our values

LEADERSHIP

INTEGRITY



RESPECT

ACCOUNTABILITY

COMMITMENT

Structure of the Office

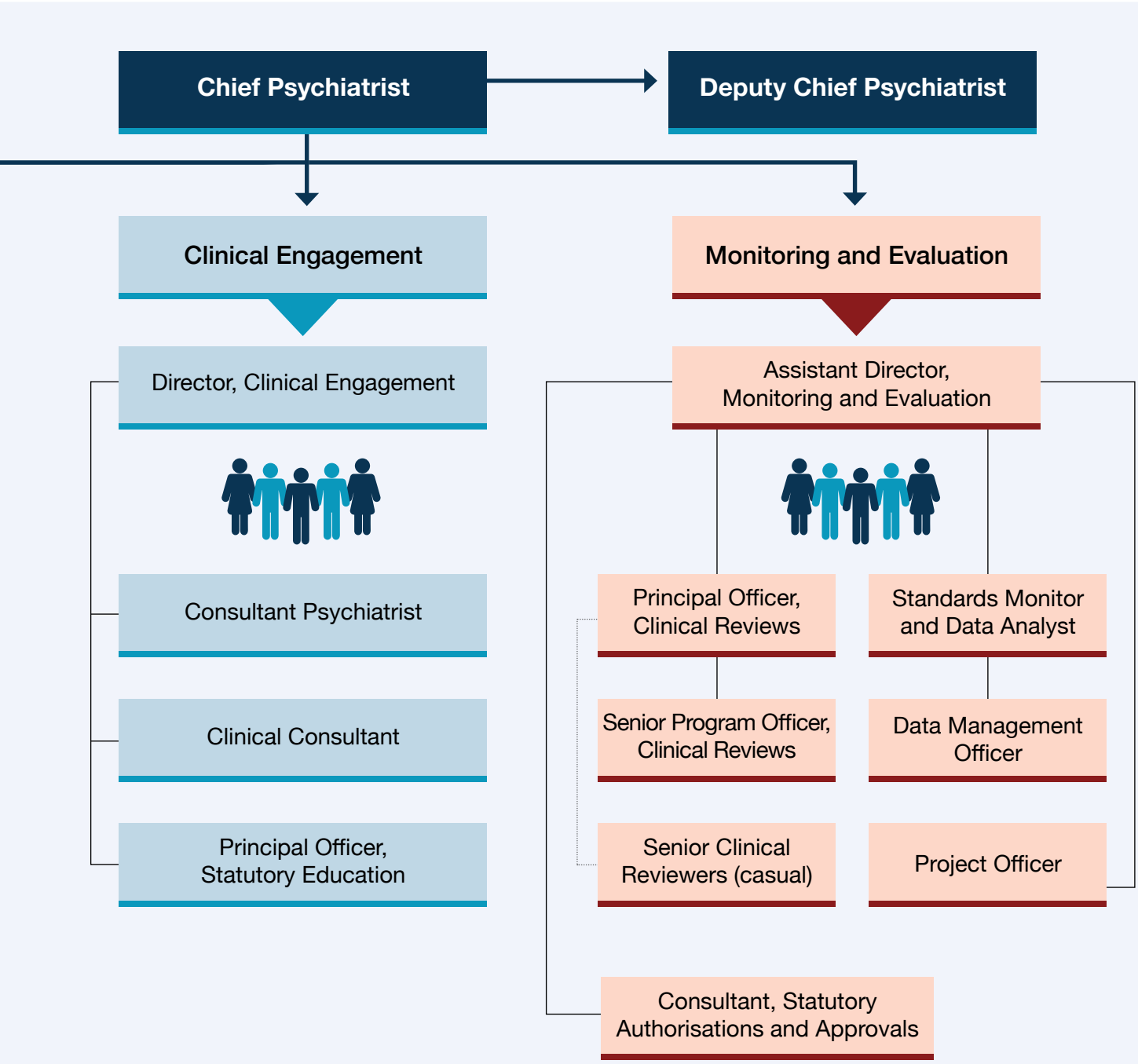
The Office of the Chief Psychiatrist has increased its capacity to manage workload pressures due to a higher demand for mental health treatment and care and to manage the expansion in mental health services both public and private across the State.

A review of the organisational structure has allowed a more streamlined approach to functions in the Office that are better able to support the discharge of the Chief Psychiatrist's statutory responsibilities.

The Chief Psychiatrist is supported by 20 staff.

Executive Governance Team:

- Chief Psychiatrist
- Deputy Chief Psychiatrist
- Director of Governance
- Director of Clinical Engagement
- Assistant Director of Monitoring and Evaluation



Office of the Chief Psychiatrist organisational structure

The Office of the Chief Psychiatrist is structured broadly into three streams:

Governance

The Governance Stream provides strategic leadership and management support to the Chief Psychiatrist. Key roles include:

- directing the operations of the OCP through the development and implementation of proactive strategies to support best practice in mental health policy, frameworks and systems
- ensuring governance systems and operational processes are in place and resources are allocated to deliver on the Chief Psychiatrist's role and function in respect of systemic improvement and statutory responsibilities under the MHA 2014 and other relevant legislation
- developing and maintaining key stakeholder relationships on behalf of the OCP.
- acting as the interface between the Chief Psychiatrist, the Office and the wider mental health sector across Western Australia and other Government and non-government agencies both at inter- and intra- state level
- governing the internal workings of the Office in respect of its obligations under the various legislative requirements, e.g. *WA Financial Management Act*, *Health Services Act, Freedom of Information Act*, MHA 2014, Public Sector Management Act, OSH and Equal Opportunities legislation
- providing high-level legal advice to the Chief Psychiatrist and the Office
- acting as the liaison between the Chief Psychiatrist and the State Solicitors Office
- managing all budgetary and fiscal responsibilities for the Office
- overseeing the provision of administrative and executive support to the Chief Psychiatrist and staff of the Office of the Chief Psychiatrist.

Monitoring and Evaluation

The Monitoring and Evaluation Stream implements programs and strategies to assist the Chief Psychiatrist to discharge statutory responsibilities for the treatment and care of mental health patients and the monitoring of standards of care delivered across Western Australia (MHA 2014 s.515).

The Monitoring and Evaluation Stream comprises three integrated teams responsible for data monitoring and evaluation, clinical reviews and authorisations of mental health services. These teams are comprised of highly skilled staff with clinical, policy and data monitoring expertise. Their roles and responsibilities include:

- conducting independent clinical reviews, and targeted reviews of specific contentious issues, by evaluating psychiatric treatment and care provided in mental health services against established standards
- monitoring and evaluating statutory notifications to the Chief Psychiatrist and the compilation of state and national mental health care performance reports
- implementing the Chief Psychiatrist's governance and legislative responsibility to authorise hospitals for the admission of involuntary patients and approving mental health services to perform electroconvulsive therapy

- developing policies, standards and guidelines to assist clinical services to meet their reporting and clinical responsibilities under the MHA 2014
- providing data, including trends, to mental health services and key stakeholders on areas of risk and gaps in standards of care to promote continuous safety and quality improvement
- collaborating with academics to develop a research program to examine the relationship between the standards of mental health care, service delivery and patient outcomes
- working with mental health clinicians and external stakeholders to translate evidence-based information and support good practice to provide:
  - expertise, knowledge and advice to improve standards of psychiatric care, service delivery and clinical policy
  - education and advice to clinicians to ensure mental health services meet their MHA 2014 statutory reporting requirements
  - best practice design elements for mental health wards and outdoor spaces in authorised public and private hospitals across WA
  - online forums that promote best practice, knowledge sharing and problem-solving between mental health services.

Clinical Engagement

The Clinical Engagement Stream has a focus on the Chief Psychiatrist's role of working in partnership with services to enhance the safety and quality of mental health treatment and care. The clinical expertise of staff in this stream supports the key priorities of the Chief Psychiatrist by proactively identifying unmet needs, gaps in services and identifying strategic solutions; supporting and promoting innovation and contemporary practice; and enhancing the capability of the mental health workforce. Key functions include:

- supporting services to implement initiatives to continuously improve the delivery of treatment and care
- undertaking targeted or commissioned reviews into complex issues
- providing guidance on complex clinical and ethical treatment and care issues
- delivering education programs
- monitoring and authorising mental health clinicians to perform the functions of an Authorised Mental Health Practitioner.

Professional development

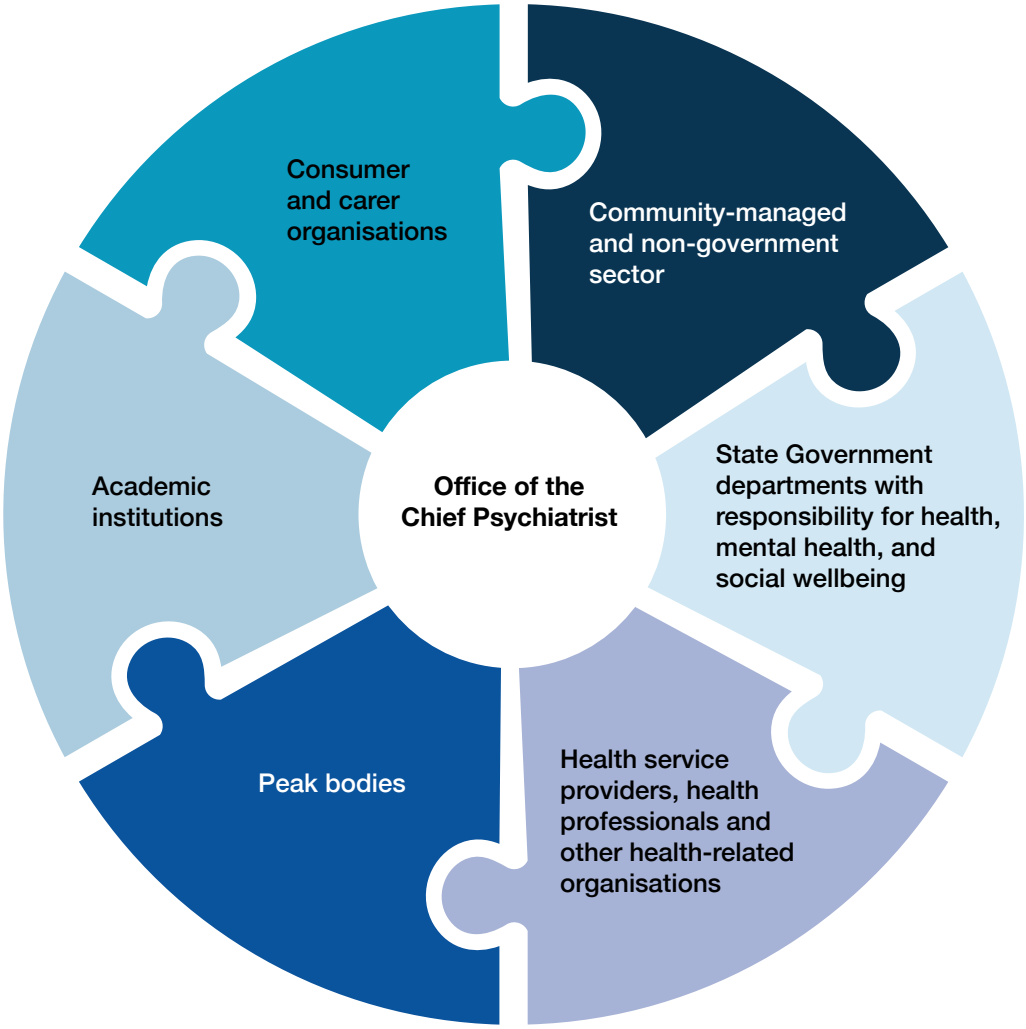
The Chief Psychiatrist encourages a continuous learning environment for staff and supports attendance at a range of professional development events, both on a cost and cost-neutral basis.

As a means to better equip our staff in engaging with Aboriginal people, the Chief Psychiatrist has partnered with Curtin University's Looking Forward Project for the next two years to enhance staff capacity to work with Aboriginal people around co-design.

Who we work with

Our stakeholder engagement strategy seeks to maximise the value of our interface to ensure that all Western Australians receive the highest standard of mental health treatment and care.

We engage closely with:

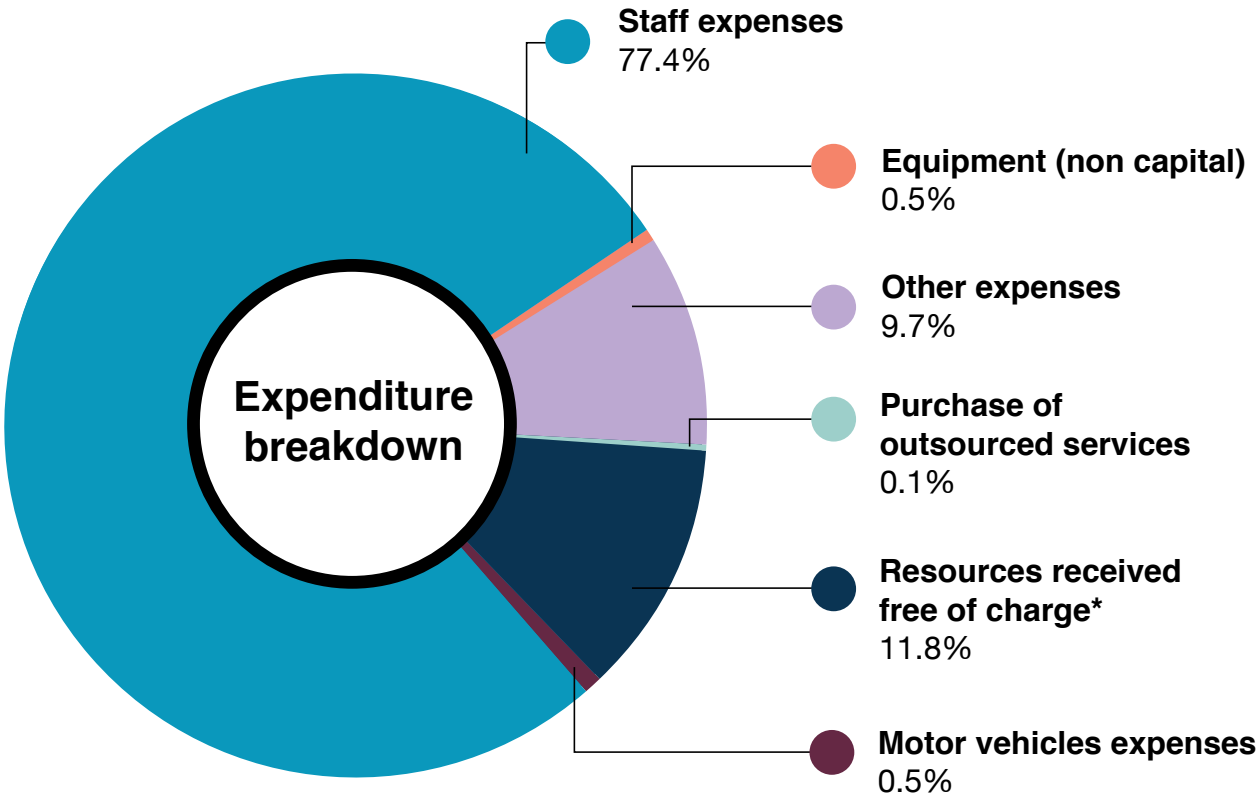


Our key strategic objective is to build on our strong external partnerships to facilitate safe, high-quality mental health care. We do this by valuing the voice and expertise of people with lived experience, supporting meaningful co-production and co-design, and ensuring participation at all levels of our work.

We proactively engage with clinicians, service providers and the community services sector to continuously improve and to ensure our work adds value. We actively seek opportunities to review, reaffirm and build on our stakeholder relationships in keeping with the aspirations of our Strategic Plan 2018-23.

How we spend our money

An overview of expenditure for the Office for 2021-22 is represented in percentages in the diagram below:



*Corporate Services provided by the Mental Health Commission as *Resources provided free of charge* by separate appropriation and not part of the overall Chief Psychiatrist's budget.

OCP internal response to COVID-19

Like other organisations, the OCP has had to adapt to higher levels of staff absence, and adopt hybrid working models, embedding flexibility into our core service delivery. However, despite this, our staff have shown the ability to rapidly pivot, adapt and identify new and innovative ways of continuing to oversee standards of care, and have shown great resilience and commitment throughout.

To ensure the safety of OCP and mental health service staff, and to allow services capacity to focus on COVID-19 in Western Australia, the OCP changed focus to strategies that worked effectively in a COVID context. These focussed on oversighting service preparation and implementation of prioritised physical and mental health care in the COVID environment.

Planning for future reviews will consider infection control requirements to ensure the safety of consumers and staff. The Chief Psychiatrist will continue to work with services to identify effective alternate monitoring processes, and will continue to be very visible, present and engaged with service leaders, clinicians, consumers and carers across the sector.

Mental health sector snapshot

Mental health services in Western Australia

The vast majority of specialist clinical mental health care occurs in the community.

Clinical Rehabilitation Services (CRS)

CRS provide long-term inpatient and community care to people with complex needs; provide intensive support; and help people work towards personal recovery goals whilst also providing clinical care.

Consultation Liaison Services (C-L)

C-L services are for people who are in hospital for their physical health. When a person experiences a deterioration in his or her mental health, a C-L team completes an assessment and will help whether it's the first time, or if the person has had mental health issues before. The C-L team supports the treating team and makes sure the person gets the mental health care he or she needs.

Safe Haven Cafés

Safe Haven Cafés are an alternative to the Emergency Department. Care can include early intervention, distress management and problem-solving. People can receive support from both clinical staff and peer workers.

Specialised Mental Health Emergency Units (MHOA and MHEC)

Some emergency departments in WA hospitals contain specialised mental health emergency units, such as mental health observation areas (MHOA) or mental health emergency centres (MHEC). These services provide treatment and care in a mental health emergency, when the care required necessitates a timeframe of more than 4 but less than 72 hours.

Inpatient Mental Health Services

Inpatient mental health services provide treatment and care to patients in hospital. Most inpatient services provide 'acute care', which means urgent care. Acute mental health issues start suddenly or get worse quickly. Acute care is generally available for a short time, often approximately 10 days. There are limited options available for longer-term inpatient mental health care.

Private Psychiatric Hostels (PPH)

A Private Psychiatric Hostel is a home where people can live when they need support because of their mental health. PPHs are run by non-clinical mental health staff. Clinical mental health care is provided to hostel residents by CMHS and General Practitioners (GPs).

Emergency Departments

Emergency Departments provide assessment and treatment in a mental health emergency.

Telehealth and Telephone Mental Health Services

Telehealth and telephone mental health services are hotlines people can contact in a mental health emergency. Clinicians assess people over the phone and, if necessary, refer a person to a local mental health service, usually a CMHS. This includes the Mental Health Emergency Response Line (MHERL), Rurallink and the 'Here For You' helpline. The WACHS Mental Health Emergency Telehealth Service (MHETS) provides emergency mental health care via telehealth to people in rural and remote EDs, hospitals, nursing posts and some Aboriginal Medical Services. CAMHS Crisis Connect is a phone and telehealth service for children and their families experiencing a mental health crisis in the metropolitan area.

Hospital in the Home (HiTH)

HiTH provides the same level of care to a patient as they would receive in a hospital, in their own home. The clinical team visits at least daily. There are child and adolescent, youth, adult and older adult HiTH services.

Non-Government Organisations (NGO) and Community Managed Organisations (CMO)

NGO and CMO services provide psychosocial support to people with mental health issues. There are a large variety of NGO and CMO services. Some provide general support, while others are designed to support people with a specific issue. The Chief Psychiatrist only has remit over these services if they provide clinical treatment and care.

Step-Up Step-Down Services (SUSD)

Step-up step-down services are short-term live-in services. They are designed for people who need a bit more time after discharge from hospital to recover, or for people experiencing a deterioration in their mental health in the community.

Clinical Community Mental Health Services (CMHS)

CMHS provide clinical treatment and care in the community. CMHS assess needs and initiate mental health treatment; help keep people well, through ongoing care; and help people receive care from a General Practitioner. There are child and adolescent, and adult and older adult CMHS, along with a number of other specialist services, eg. Aboriginal Mental Health Services, Mental Health Co-Response.

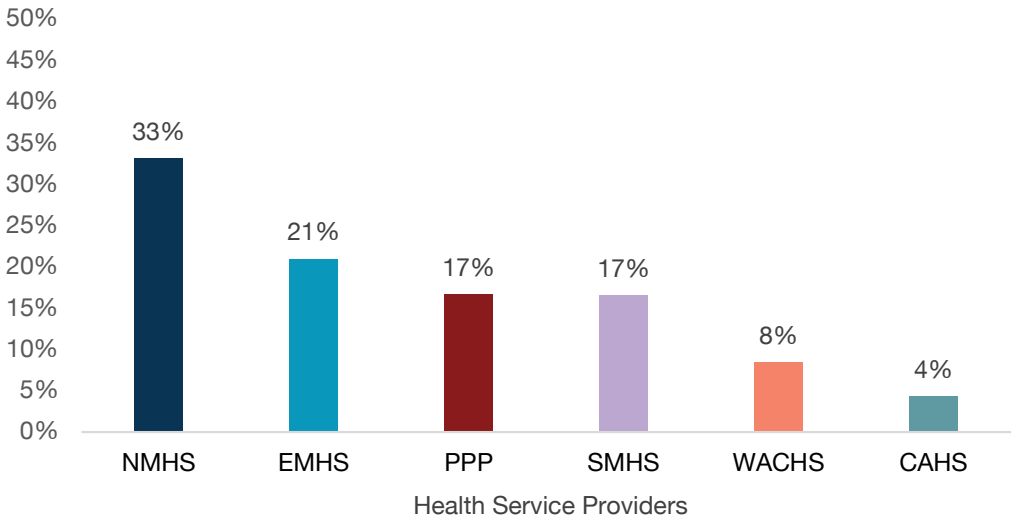
In the 2021 calendar year, 66,483 individuals received public sector specialist inpatient and/or community mental health care. Just over two-thirds (68%) of these specialised mental health services were provided to adults aged 18-64 years, 22% were provided to children less than 18 years of age and 11% to adults 65+ years of age. Of these, 8,803 people received both inpatient and specialist clinical community mental health services during 2021, equating to 13% of all consumers. The majority (81%) of these were 18-64 years of age, 10% 65+ years and 9% were children under 18 years.

Inpatient mental health services

Public hospitals providing inpatient mental health services

There was an average of 812 available beds in the 2021 calendar year, 64 of these are Hospital in the Home (HiTH) beds provided by the North Metropolitan Health Service and South Metropolitan Health Service. An average of 748 inpatient beds were available across WA, with 92% available in the Perth metropolitan and 8% in WACHS regions (Figure 1).

Figure 1: Location of mental health beds in Western Australia (by Health Service Provider). 748 average beds in 2021



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

There were 8,885 people with one or more inpatient admission to a specialised public inpatient mental health service (acute and non-acute wards), for a total of 14,903 separations in 2021. The majority (81%) were adults 18-64 years, 12% were 65 years or older and 9% were children under 18 years of age. One quarter (25%) of inpatients had an involuntary mental health status at some stage during their admission and 75% had a voluntary mental health status, equating to 3,213 and 11,690 separations respectively. Of the 8,885 people who accessed inpatient mental health treatment and care in 2021, 874 (10%) were recorded as Aboriginal.

In the 2021 calendar year, there were 793 children under 18 years of age who accessed acute specialised mental health inpatient wards, involving 1,353 separations. Of the 1,353 separations, 440 (33%) were from Perth Children's Hospital, 913 (67%) related to separations from youth wards which admit children and adolescents 16-24 years and adult wards which admit adults 18 years of age and older. Under the MHA 2014 s.303, these 913 separations of young people less than 18 years from mental health wards admitting adults are required to be reported to the Chief Psychiatrist. For more information, please refer to the Statutory Reporting section of this report.

Note: These figures include inpatients in public mental health services and inpatients classified as a 'public' patient in a public/private mental health service.

Private hospitals providing inpatient mental health services

There are four private hospitals providing mental health services in WA and three publicly contracted private providers that admit some private patients. During the 2021 calendar year, 3,068 private inpatients in total were discharged from these services, involving 5,846 separations. The majority of patients were adults 18-64 years (89%), 8% were adults 65+ years and 4% were under 18 years of age.

Authorised mental health facilities

Under the MHA 2014, authorised hospitals are hospitals that have mental health facilities where people can receive involuntary inpatient treatment and care.

Currently in WA there are 17 health campuses with authorised mental health facilities:

Child and Adolescent Health Service

- Perth Children's Hospital

East Metropolitan Health Service

- Armadale Hospital and Health Service
- Bentley Hospital and Health Service
- Royal Perth Hospital

North Metropolitan Health Service

- Graylands/Selby Health Campus
- Sir Charles Gairdner Hospital

Women's and Newborn Health Service (North Metropolitan Health Service)

- King Edward Memorial Hospital

South Metropolitan Health Service

- Fiona Stanley Hospital
- Fremantle Hospital and Health Services
- Rockingham General Hospital

WA Country Health Service

- Albany Hospital, WACHS Great Southern
- Broome Hospital, WACHS Kimberley
- Bunbury Hospital, WACHS South West
- Kalgoorlie Regional Hospital, WACHS Goldfields

Private Hospitals Providing a Public Service

- Joondalup Health Campus, North Metropolitan Health Service
- St John of God Midland Public Hospital, East Metropolitan Health Service
- St John of God Mt Lawley Hospital, East Metropolitan Health Service

Clinical Community Mental Health Services

The number of people receiving mental health care from CMHS in the 2021 calendar year was 66,401, involving 1,034,794 service contacts. Just over two-thirds of individuals receiving services in the community (68%) were aged 18-64 years, 22% were under 18 years of age and 11% were 65 years or older.

Of the 63,534 people receiving care through a CMHS in the 2021-22 FY, 883 did so on an involuntary basis through a Community Treatment Order (CTO). The majority of people receiving involuntary care in the community (89%) were aged 18-64 years, 4% were under 18 years and 6% were 65 years or older.

Emergency Departments

In the 2021-22 financial year (FY), 5.6% of attendances at an Emergency Department (ED) were for a mental health issue, totalling 62,843 presentations, and 1.7% of ED attendances were for an alcohol and other drug (AOD) issue, equating to 18,661 presentations. The trends in mental health and AOD presentations to ED have been relatively stable over time ranging from 5.4% for mental health attendances in 2016-17 peaking at 6.1% in 2019-2020. The percentage for AOD presentations ranged from 1.8% in 2016-17 to 2% in 2019-2020.

A higher proportion of people presenting to ED for an AOD issue were aged 25-64 years (70.1%) compared with 57.2% of mental health presentations (Table 1). In contrast, a higher proportion of mental health ED presentations involved young people less than 18 years (15.5%) and older adults 65+ years (10.8%) than AOD presentations (9% and 4.3% respectively). For adolescents 18-24 years, the proportions were similar for mental health (16.5%) and AOD (16.6%).

Table 1: Mental health and alcohol and other drug ED presentations by age group

Age Group	less than 18	18-24	25-64	65+	Total
	n (%)	n (%)	n (%)	n (%)	n
Mental Health	9,732 (15.5)	10,386 (16.5)	35,917 (57.2)	6,807 (10.8)	62,842
AOD	1,675 (9.0)	3,106 (16.6)	13,086 (70.1)	794 (4.3)	18,661

Length of episodes

The length of episodes for ED mental health and AOD presentations are reported as minimum (10th percentile) and maximum (90th percentile) and showed similar patterns across all age groups. The length of stay (LOS) for young people less than18 years presenting for mental health issues was 243 minutes (10th 86; 90th 884) and 244 minutes (10th 75; 90th 835) for AOD presentations. The median LOS increased with each age group. People 65 years and older had the longest LOS for both mental health of 345 minutes (10th 114; 90th 1076) and AOD presentations 322 minutes (10th 103; 90th 877).

ED outcomes

The majority of people presenting to the ED with either a mental health (54.7%) or an AOD (52.5%) issue departed under their own care (Table2). A higher proportion of people presenting for an AOD issue (23.9%) were admitted to an ED Observation Unit than for a mental health presentation (13.4%). Conversely, a higher proportion of people presenting for mental health issues were either admitted to hospital (19.7%) or transferred to another hospital (4.1%) than people with an AOD presentation (10.6% and 2.1% respectively). A similar proportion of mental health and AOD patients did not wait to be attended to by a medical officer or left at their own risk (7.8% and 10.5% respectively).

Table 2: ED Outcomes mental health and AOD presentations

Presenting Diagnosis	Departed ED under own care	Admitted to ED Observation Unit	Admitted to hospital	Transferred to another hospital for admission	Left at own risk or did not wait to be seen by medical officer
	%	%	%	%	%
Mental Health	54.7	13.4	19.7	4.1	7.8
AOD	52.5	23.9	10.6	2.1	10.5

ED outcomes by age groups

The ED discharge outcomes varied by age for mental health (Figure 2) and AOD (Figure 3) presentations. Key age-related features for discharge outcomes include:

- The majority of children less than18 years departed under their own care for both mental health (69%) and AOD (61%) presentations and for youth 18-24 years it was 59% and 57% respectively.
- Half (50%) of people 65+ years presenting for mental health issues were admitted to hospital compared with 21% of people 65+ years presenting for AOD issues.
- Across all age groups, a higher proportion of AOD presentations were admitted to an ED Observation Unit than people presenting for mental health issues, most notably for 25-64 years (AOD 25%; MH 6%) and 65+years (AOD 29%; MH 10%).
- In each age group a higher proportion of people presenting for AOD issues left at their own risk or did not wait to be attended by a medical officer than people presenting for mental health issues, most notably for 25-64 years (AOD 10%; MH 4%) and 65+ years (AOD 6%; MH 3%).

Figure 2: Mental health ED outcomes by age group 2021-2022 FY

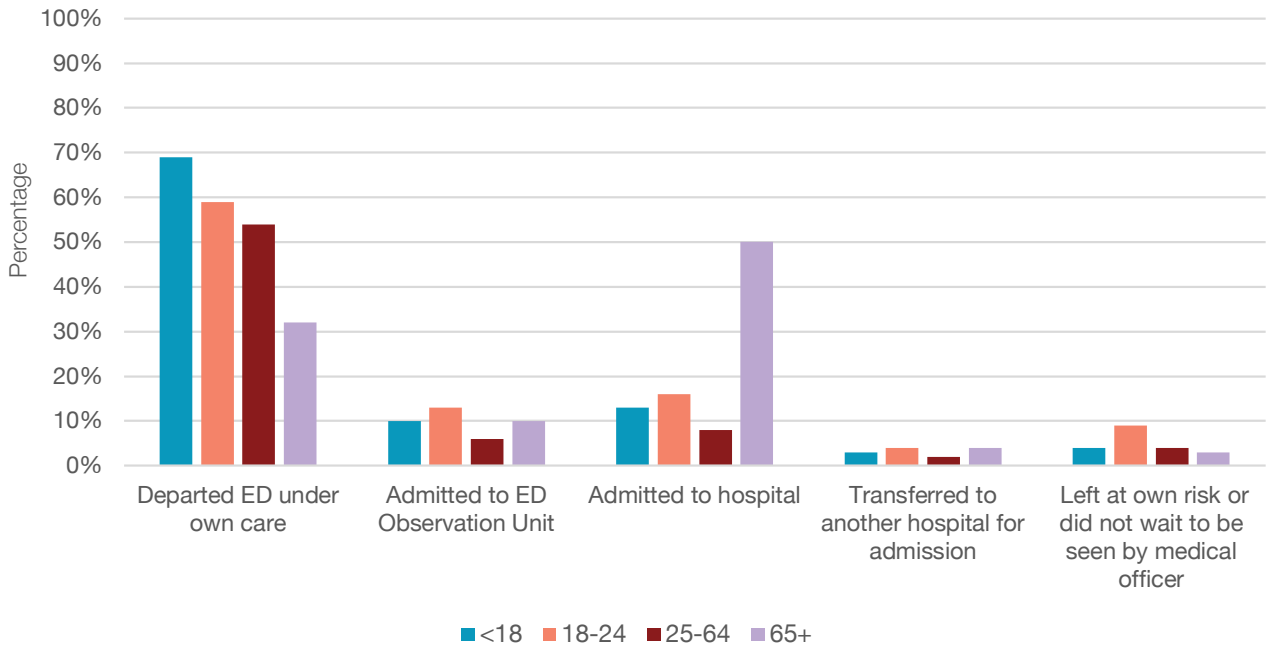
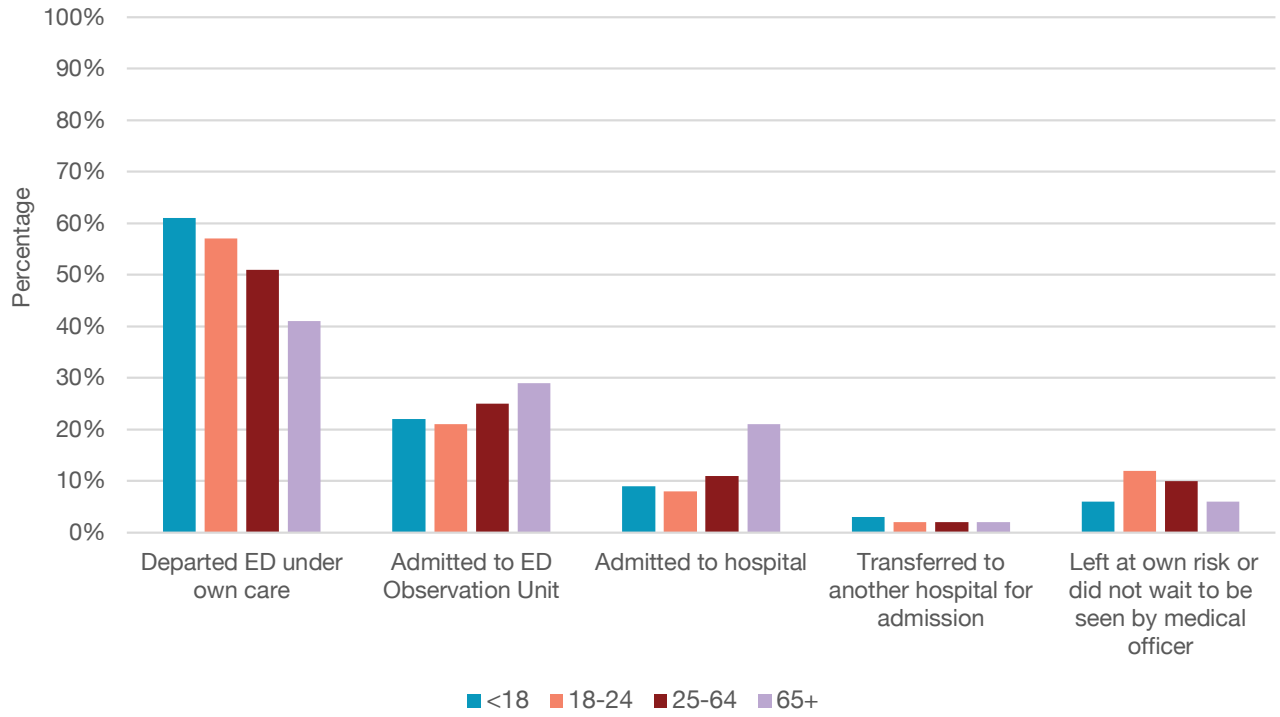


Figure 3: Alcohol and other drug ED outcomes by age group 2021-2022 FY



Community-based Step-Up Step-Down Services

Community-based mental health step-up/ step-down services provide short-term residential support to people following discharge from hospital, and additional support for people experiencing a deterioration in their mental health. These services provide psychosocial and clinical support services with the aim of promoting recovery and rehabilitation.

The Mental Health Commission has service agreements with three Non-Government Organisations providing six step-up/step-down services and a total of 68 beds: Albany (6 beds), Bunbury (10 beds), Geraldton (10 beds), Joondalup (22 beds), Kalgoorlie (10 beds), Rockingham (10 beds). In the 2021 calendar year there were 679 admissions across all step-up/step-down services; an increase from 572 admissions in the 2020 calendar year.

Private psychiatric hostels

There are 32 private psychiatric hostels in WA. The 2022 Psychiatric Hostels Snapshot conducted on 14 January 2022 found there were 622 residents living in a private psychiatric hostel on the day of the snapshot. For further information, please see the 'Clinical Monitoring of Private Psychiatric Hostels' section of this report.

Mental Health Commission alcohol and other drug services

The Mental Health Commission provides inpatient and outpatient/community based AOD services. The next Step inpatient unit provided treatment to 582 inpatients in the 2021-22 FY. For the majority of inpatients, the primary drug of concern was alcohol (83%) with 17% of inpatients identifying other drugs including opioids (6%), cannabinoids (4%) and benzodiazepines (4%). The primary drug for the remaining 3% included amphetamines, methamphetamines, or other drug types.

The community alcohol and other drug services (CADS), including East Perth and DAYS (Drug and Alcohol Youth Service), saw 1,491 clients in the 2021-22 FY. Just under half of CADS clients reported alcohol as the primary drug (47%) followed by opioids (41%) and cannabinoids (5%). The primary drug for the remaining 7% included benzodiazepines (3%), methamphetamine (3%) and less than 1% for each of amphetamines and other drug types.

Mental Health Commission-funded non-government organisations providing prevention, treatment and support services

The Mental Health Commission provides a range of mental health and alcohol and other drug (AOD) services in the community through contracted Non-Government Organisations (NGOs). There were a total 121 NGO organisations funded by the MHC in the 2021 calendar year. Of these, 83 were funded to deliver mental health services only, 25 to deliver AOD services and 13 to deliver both mental health and AOD services. Of these, 16 NGOs provide mental health clinical services and are required to adhere to the Chief Psychiatrist's Standards for Clinical Care and to report notifiable incidents to the Chief Psychiatrist.

Safe Haven Cafés

There are two Safe Haven Cafés in WA: the Dabakan Ngowoort Koorliny Mia located at Royal Perth Hospital and Safe Place: Dawanga boothalenga-woorr nganjileg-gerring, located at Kununurra Hospital. Safe Haven Cafés are peer-run facilities providing psychosocial support for individuals in a crisis. In many cases, these services assist people before or after they attend an ED.

There is ongoing work needed to understand the role of Safe Haven Cafés in ED diversion.

Dabakan Ngowoort Koorliny Mia at Royal Perth Hospital

Dabakan Ngowoort Koorliny Mia opened in April 2021 and received 28 people in the first three months. In the 2021-22 financial year 920 clients used this service, of which 81% were repeat clients and 46% were rough sleepers.

Clients gave a variety of reasons for attending Dabakan and many gave more than one reason. The majority of people (72%) cited social interaction as the reason for attending, 12.8% attended as an alternative to ED, including 2.6% presenting after hours when no other services other than ED were available and 3.6% attended after presenting to ED. A small proportion of clients reported having mental health issues (2.3%), 0.8% had alcohol and other drug issues (AOD) and 0.8% were experiencing domestic violence.

Clients reported a range of positive impacts from attending this service including that it provided a safe space that was accessible and inclusive (54%) de-escalation of distress (22%), positive interaction with peer workers (7%), received information about mental health services (8%) and referral to appropriate services (1%).

A client satisfaction survey conducted with 96 (10.4%) of clients found a high satisfaction with the service giving the service a rating of 4.94/5.0.

Safe Place: Dawanga boothalenga-woorr nganjileg-gerring at Kununurra Hospital

In the 2021-22 financial year 550 clients used this service, of which 87% were Aboriginal, 73% were female and 43% returned more than once. The majority of clients (66%) were aged between 25 and 50 years, 22% were aged between 16 and 24 years, and 12% were over 50 years of age.

Clients were referred from a number of sources, with over half (56%) self-referred, 25% referred from the emergency department, 15% referred by family or friends and 2% referred by other services. Less than five clients were referred by the mental health team. Data on the outcome for clients was reported for 45% of clients and of these, the majority (55%) were provided with information about other services, 33% had an interaction with a Peer Worker and 12% were referred to appropriate services.

New facilities opened in 2021-22

In the reporting period the Chief Psychiatrist received one application for the Authorisation of a new mental health facility.

East Metropolitan Health Service, Mental Health Royal Perth, Dabakarn Mental Health Unit
12 beds (secure)

On 6 May 2022 the Dabakarn, Mental Health Unit (MHU) at Royal Perth Hospital was Gazetted (No 62, 2022) as an Authorised Hospital. The MHU consists of 12 beds to be used by high acuity mental health consumers with complex mental health needs and challenging behaviours. The MHU will provide 24-hour, 7 day a week, mental health inpatient care and treatment for adult consumers aged between 18 and 65 years who are experiencing acute mental health illness.

During the reporting period the Consultant, Statutory Authorisation and Approvals worked closely with the project team on the development of the MHU. There has been a significant change in the way mental health units are designed and although the Dabakarn Mental Health Unit was a refurbishment of an existing ward at Royal Perth Hospital, the project team used evidence-based research and contemporary internal design. The planning has sought to maximise the therapeutic environment in an older building with a restricted footprint.

As well as a therapeutic environment the project team was mindful in ensuring the unit was culturally appropriate. By incorporating Aboriginal themes, artwork and design throughout the unit a culturally rich built environment has been created.

The design is gender sensitive and provides a secure consumer pod for female and vulnerable patients. All bedrooms are single bedrooms with modern ensuites. An important design feature of the unit is access to light and fresh air, with large doors in the communal spaces opening on to a well-designed courtyard.

Dabakarn takes its name from the Wadjuk Noongar language, meaning 'slowly, slowly'.

Working with the sector

Working with the sector

COVID-19

Community transmission of COVID-19 following the opening of the State and international borders in early 2022 has significantly impacted mental health service provision and the work of the OCP, as well as the wider community.

COVID-19 vaccinations for mental health consumers

In 2021, as the COVID-19 vaccination program rolled out, the OCP became concerned about vaccination rates in consumers of mental health services; a group more likely to have significant medical problems that can complicate COVID-19 infection, and who are not always able to engage with public health messaging or attend primary care. We advocated with the Department of Health and other stakeholders for this group to be considered as a hard-to-reach population for the purposes of targeted vaccination provision. Early in the reporting period, the Chief Psychiatrist wrote to all Health Service Provider Chief Executive Officers to highlight the issue and request information about their approaches to vaccinating their community mental health and inpatient consumers.

Through our work with mental health services, the Office identified a team that had launched a very successful way of helping consumers access vaccination, in partnership with their local public health team. Proactively engaging consumers and families in discussion about vaccination, and then holding vaccination clinics at the community mental health team base allowed people who might have otherwise missed out to protect themselves against COVID-19. In order to share this good practice example, the Office hosted a well-attended webinar to showcase the work of this team and help share strategies. This initial webinar led to the establishment by the Office of a Community of Practice, which was initially started to allow services to share their experiences and learnings of managing COVID-19 in the mental health setting. Subsequently, the focus of the Community of Practice was broadened to include topics beyond COVID-19, and has been well received by the sector (see Community of Practice section).

Guidance for the mental health sector

Mental health services work within the legislative framework of the MHA 2014. Since 2020 services have been subject to the Mental Health Infection Control Directions (MHICD), which are issued under the *Public Health Act 2016*, and which require clinicians to use specified infection control measures when carrying out various actions under the MHA 2014. In early 2022, it became apparent that the MHICD were out of date. The Office was instrumental in advocating for an updated version to reflect the Government's public advice at the time, and Direction No. 4 was issued in March 2022.

During this period, the OCP received numerous queries from the mental health sector regarding the practical implications of managing clients and services given the complex interface

between the MHA 2014 and the *Public Health Act 2016* under which the Mental Health Infection Control Directions were issued. Whilst providing rapid responses to individual enquirers, in February 2022 the OCP also published and widely circulated the OCP's COVID-19 Frequently Asked Questions for Mental Health Services to provide guidance across the wider sector. This was followed by a subsequent version published in mid-March 2022 in response to additional inquiries and the rapidly evolving situation.

To further support and guide mental health services, the OCP developed a Good Practice Guide: Providing mental health care when there is community transmission of COVID-19. This guide contains practical considerations relevant to mental health consumers, along with specific advice tailored for the WA system. Since it was published on the Chief Psychiatrist's website in March 2022, it has been accessed over 900 times. Based on feedback, the guide was well received by the sector, for example, one clinician stated:

"Well done for writing a common sense document, with realistic instructions. I could see myself using this checklist for my own and my family's care."

COVID-19 safe mental health wards

As the pandemic continues to impact services, they are constantly innovating to ensure patients testing positive to COVID receive a high standard of treatment and care within a safe environment. The Chief Psychiatrist continues to provide advice on safety and suitability and it remains a priority for the OCP that Standards of Care continue to be met and services ensure that wards:

- are suitable
- are appropriate for the intended cohort
- are therapeutic

Private psychiatric hostels

The experiences of residential care facilities in other jurisdictions during community transmission of COVID-19 highlighted the need for a coordinated approach to supporting Private Psychiatric Hostels in WA. Private Psychiatric Hostels in WA are non-clinical services and many provide care in physical environments which are not conducive to adherence to isolation protocols. The OCP worked closely with the Mental Health Commission (MHC), the Department of Health's Licensing and Accreditation Regulatory Unit (LARU) and the Mental Health Advocacy Service (MHAS) to design systems to support Private Psychiatric Hostels prior to the onset of the COVID-19 wave of early 2022. The result of these efforts was the implementation of a phone line called the Contact Point, which was operated by the MHC. Information from the Contact Point was relayed to relevant agencies, including the OCP, to ensure oversight of emerging issues while reducing the regulatory burden for hostels.

Community of Practice

Ensuring safe and high standards of care in a rapidly changing environment is contingent on committed, collaborative, well-informed and responsive staff. The Chief Psychiatrist is invested in providing opportunities to engage, support, connect, and inform clinical staff across the sector.

In March 2022, the OCP introduced the Community of Practice in response to the increased COVID-19 community transmission and consequent clinical challenges. The sessions have now been broadened to include other topics, which complement existing OCP training initiatives in supporting best-practice and continuous improvement in mental health services.

The purpose of the Community of Practice is to provide a forum for services and practitioners to:

- share learning, ideas, and practice-based evidence in adapting to changing demands
- respond effectively through collaboration
- share State, national and local guidelines and strategies
- sustain high-quality mental health care across the system and State.

The sessions are short (30 minutes), informal and online, to minimise the impost on clinical time and to allow access by clinicians across the State. From Warburton to Kalgoorlie, Peel and across the metropolitan area, attendees have returned to multiple sessions. External collaborators such as the Mental Health Advocacy Service and the Department of Justice have joined sessions of interest for collaborative, cross-sector learning.

There have been a total of 157 attendances so far to Community of Practice over four sessions in 2022.

The four sessions held in the first half of 2022 are listed below. Summaries of the sessions are available on the Chief Psychiatrist's website.

- **Inpatient Care in COVID-19**
  23 March 2022 (28 attendees)
- **Coping with Staff Shortages in Community Mental Health Services**
  21 April 2022 (45 attendees)
- ***Mental Health Act 2014*** **(MHA 2014) Questions & Answers**
  26 May 2022 (40 attendees)
- **Wungen Kartup – Overview, Accessing us and our Cultural Approach**
  30 June 2022 (44 attendees)

The open and honest sharing from participants about their practice-based solutions, innovations, and hard work has inspired and informed colleagues. Clinicians have questioned together what is possible, what is right, have shown determination and have heard that many challenges are shared.

The feedback and comments below about the Community of Practice demonstrate the transformative impact of reflective practice and having a space for the diverse voices of clinicians working at all levels across health services and the State.

"I want to acknowledge the staff; it is the staff who change the culture. It's important to be acknowledged by the leadership, but it makes a difference when you are surrounded by a team."

— Acting Team Leader

"Absolutely blown away by (the service's effective workforce response) in this time of adversity."

— Clinical Nurse Specialist

"A lot of the mob down here are Noongar, but there are a lot of people who are off country in Perth, and it can be hard. If you're already struggling and going through things, it can be more difficult. When people are on country and surrounded by their family and their mob, we get better outcomes."

— Aboriginal Mental Health Worker

"The idea of the forum to allow a range of service providers to share experience and network is to be encouraged and I thank the OCP for leading on this."

— Program Manager

Mental health workforce

The mental health workforce in WA is under pressure to meet increasing demand for services. Growing the workforce is key to meeting this demand and ensuring the delivery of safe, high-quality treatment and care. Along with other jurisdictions in Australia, WA is facing critical mental health workforce shortages both in inpatient and community services. As new services are developed over the next two to three years, the need to build on and retain the existing workforce will become one of the most pressing issues facing the mental health sector. Rural and remote services continually experience particular challenges in attracting and retaining staff.

The Chief Psychiatrist has identified workforce as a significant risk for standards of mental health treatment and care in WA in coming years. While there are workforce shortages across mental health clinical services, two reviews undertaken in the previous year by the Chief Psychiatrist specifically addressed the need for an expanded workforce to deliver services for children and adolescents and to provide rehabilitation and recovery services for people with severe, enduring mental illness and complex needs.

Work is underway at a system level on workforce issues. The Infant, Child and Adolescent Taskforce, which arose from the Chief Psychiatrist's review into the death of Kate Savage, has started the process of implementing recommendations including expanding and diversifying the workforce. The Department of Health is leading the development of a WA Mental Health Workforce Action Plan which aims to build a sustainable workforce by addressing the issues of supply, retention, staff wellbeing, training and capability.

Clinical monitoring of private psychiatric hostels

The MHA 2014 (section 515) makes the Chief Psychiatrist responsible for monitoring the treatment and care of patients of mental health services in Western Australia. Section 507 of the MHA 2014 provides that a mental health service includes a private psychiatric hostel, meaning that the Chief Psychiatrist's responsibilities extend to mental health patients residing within those facilities.

The Chief Psychiatrist's monitoring of private psychiatric hostels includes all facilities operating under a private psychiatric hostel licence granted by LARU. A private psychiatric hostel, as defined in the *Private Hospitals and Health Services Act 1927* (PHHSA 1927), is a *"private premises in which 3 or more persons who — (a) are socially dependent because of mental illness; and (b) are not members of the family of the proprietor of the premises, reside and are treated or cared for."* The Chief Psychiatrist works closely with the other agencies who also have a role in the oversight of private psychiatric hostels: LARU, MHAS and the MHC.

The Chief Psychiatrist uses three methods to monitor private psychiatric hostels:

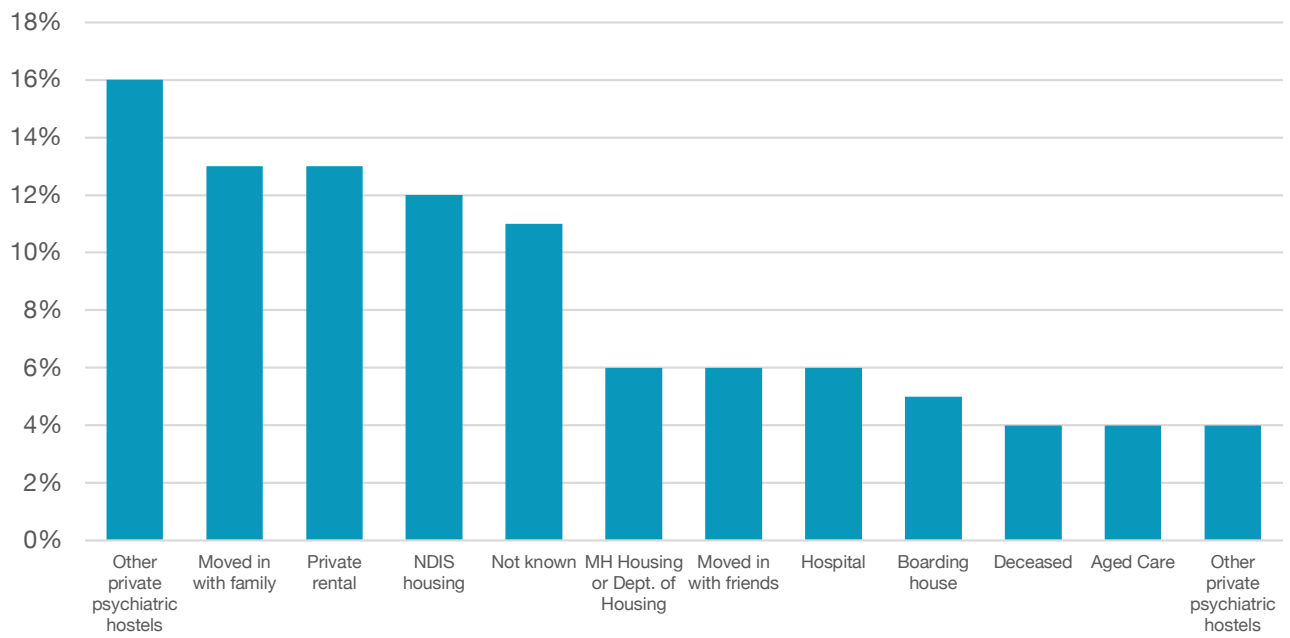
- Chief Psychiatrist's Annual Private Psychiatric Hostel Snapshot (the Snapshot)
- Reviews of the Treatment and Care Provided to Residents of Private Psychiatric Hostels (Hostel Reviews)
- Monitoring Notifiable Incidents reported by hostels (see Notifiable Incidents).

Snapshot

The Snapshot commenced in its current form in 2020. The data are published on the Chief Psychiatrist's website. The 2022 Snapshot included all 32 hostels and their 622 residents. Most residents live in hostels for the short-to-medium term; on the census date (14 January 2022), 55% of residents had been living in the hostel for four years or less. Of all hostel residents, 64% receive mental health treatment and care from a public CMHS and 98% have a GP.

In 2022, the Chief Psychiatrist used the Snapshot to look more closely at what happens when residents leave a Private Psychiatric Hostel. It was found that 60% of people who left had lived in the hostel for less than two years. Of the possible exit locations, 16% moved into another Private Psychiatric Hostel, 13% moved in with family and 13% moved to private rental accommodation (Figure 4). In 2023, the Chief Psychiatrist will add a question to the Snapshot to collect more information about the reasons that residents move on.

Figure 4: Where residents go when they leave the hostel



Hostel reviews

The Chief Psychiatrist's reviews of the treatment and care provided to residents of private psychiatric hostels, which commenced in 2019, examine the relationship between clinical services and private psychiatric hostels and how it impacts on the care that residents receive. The review program continued to experience some delays related to COVID-19 during the 2021-22 financial year. However, the State's largest provider of Private Psychiatric Hostel care, St Bart's with 110 beds, was successfully reviewed.

The Chief Psychiatrist monitors the implementation of recommendations it makes to hostels and other agencies interfacing with care provision through this review process. The OCP routinely provides phone support to organisations undergoing an implementation process but can provide more intensive support when a need is identified. We provided clinical support to one organisation implementing recommendations during the 2021-22 financial year.

During this period, the following organisations have implemented all recommendations:

- Devenish Lodge
- Life Without Barriers Ngatti House
- Mental Health Commission
- WA Country Health Service

The following organisations continue their process of implementation:

- Albany Halfway House Albany Community Supported Residential Units (CSRU)
- East Metropolitan Health Service
- North Metropolitan Health Service
- Pu-Fam (Guildford Care Facility) – St Jude's Hostel
- Southern Cross Care Community Options
- South Metropolitan Health Service
- St Bart's

Legal

The OCP is taking positive steps to assist mental health clinicians to correctly and appropriately apply the provisions of the MHA 2014.

Our General Counsel provides assistance within the OCP to help identify legal and policy issues that arise in situations faced by mental health clinicians on a daily basis whilst providing treatment and care to people under the MHA 2014. The Chief Psychiatrist believes this valuable service leads to increasingly high standards of mental health treatment and care and ultimately leads to better outcomes for mental health consumers and for the community more broadly.

Our General Counsel is also actively involved in assisting the Chief Psychiatrist to bring justice and fairness to consumers of mental health services, by reviewing the laws and policies that apply to or impact them in some way and by recommending change where appropriate. In 2021-22, our General Counsel represented the Chief Psychiatrist on a number of legislative reform project committees, and made submissions on behalf of the Chief Psychiatrist on a number of additional law reform projects.

The legislative reforms projects on which the General Counsel represented the Chief Psychiatrist, and provided expert opinion and guidance were:

- the Mental Health Commission's statutory review of the MHA 2014
- the Department of Justice's Criminal Law (Mental Impairment) Reform Project
- the National Mutual Recognition of Mental Health Orders Legislation Project.

The law reform projects on which our General Counsel made submissions on behalf of the Chief Psychiatrist were:

- Victoria's *Mental Health and Wellbeing Act*: update and engagement paper
- the Mental Health Commission's statutory review of the MHA 2014
- Western Australia's Parliamentary Commissioner Amendment (Reportable Conduct) Bill 2021
- the statutory review of Part 9E of the *Guardianship and Administration Act 1990 (WA)*
- the review by the Department of Health of the *Private Hospitals and Health Services Act 1927* and the Private Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997.

Clinical consultant

The OCP's Clinical Consultant engages directly with the mental health sector and provides timely support by responding to helpdesk enquiries from clinicians, consumers, carers, families, and other community members.

The Clinical Consultant role provides a key support to the clinical sector to maximise compliance with the MHA 2014. After a period of vacancy, the role has again been in place since February 2022.

Of all multidisciplinary clinician enquiries received by the Clinical Consultant, the majority (42%) over the past 12 months have come from Consultant Psychiatrists and relate to the clinical translation and application of the MHA 2014. This year there have also been a high number of queries relating to COVID-19, and the interface between the MHA 2014, Standards of Care, and infection control requirements.

Training in the MHA 2014

The Chief Psychiatrist has a statutory responsibility to ensure that Authorised Mental Health Practitioners (AMHPs) are provided with the appropriate and ongoing training to ensure they maintain a contemporary knowledge of the MHA 2014 relating to their functions and responsibilities.

This training program is delivered by the Principal Officer Statutory Education who holds both statutory education and AMHP portfolios. In recognition of the stresses on the mental health system over the last six months, the Statutory Educator has:

- increased the number of training sessions to provide more flexibility and availability for existing AMHPs
- provided an increased presence at AMHP peer supervision sessions across the State to provide advice and support
- responded to the increased requests from mental health services to train new AMHPs by providing additional 2-day initial AMHP training programs, including two in regional WA.

However, since the commencement of the MHA 2014, the responsibility to provide ongoing MHA 2014 training to clinical staff lies with Health Service Providers (HSPs). The Chief Psychiatrist does not hold statutory responsibility for the operational aspects of MHA 2014 training, but is clear that appropriate training and updating with contemporary resources is critical for compliance with the legislation and maintenance of standards of care and rights.

The Chief Psychiatrist's Guidelines (h) advise that:

- mental health services are to provide adequate training and information for their staff to allow them to conduct functions under the MHA 2014
- clinicians who perform functions under the MHA 2014 have a responsibility to ensure that they are familiar with and comply with the MHA 2014
- clinicians must undertake appropriate education or information sessions including e-learning and face-to-face education.

The Chief Psychiatrist's Authorised Hospital Standards (standard 5.7) require the health service to demonstrate that it has a policy that ensures that relevant MHA 2014 training is provided to all staff at entry and as a yearly refresher.

Feedback from mental health service clinical staff suggests that services variously rely on staff completing the Mental Health Commission's e-learning modules as a one-off activity; clinical staff conducting their own informal ad-hoc information sessions; or regular/irregular training sessions delivered by either a psychiatrist, staff development or senior clinician. Only a couple of services advise that they schedule formal face-to-face training. Concerningly, some clinical staff advise that they have never been provided with any MHA 2014 training at either HSP or service level.

All medical practitioners can complete Form 1A Referral Orders, Detention Orders and Transport Orders. However most medical practitioners across the heath system work in non-mental

health settings (e.g. general hospitals, private hospitals and general or private practice). The oversight of MHA 2014 knowledge among this broad cohort of doctors remains a challenge because many doctors rarely use the MHA 2014, or are not targeted for ongoing professional development around the legislation.

Because the MHA 2014 is a particularly complex piece of legislation, it is imperative that clinical staff who perform functions under the legislation remain up to date in their knowledge around translation. It is established that where professional development is not routinely undertaken in any clinical setting, there can be drift in practice.

The Chief Psychiatrist has noticed some inconsistency in application of the MHA 2014 since its commencement which is, in part, linked to deficits in appropriate professional development for clinical staff. The Chief Psychiatrist has previously written to the HSP Chief Executives regarding this concern.

A redevelopment of the e-learning packages to ensure contemporary MHA 2014 translational information is a priority.

The current review of the MHA 2014 needs to consider what active steps need to be taken to ensure both improved training and resources are developed in a timely way and that there is a more active and tracked process to ensure that clinicians who are using the MHA 2014 are adequately trained.

Authorisations

The OCP works closely with mental health services and external stakeholders to provide advice and improve knowledge of contemporary mental health ward design and best practice design elements. Over recent years there have been many learnings; mental health spaces are no longer designed as places of containment but are instead designed to be places of wellness. They are homelike - or better – hotel-like and provide opportunities for rehabilitation and empowerment.

In 2021-22 the OCP's Consultant Statutory Authorisations and Approvals was invited to be a member of the WACHS Acute Psychiatric Unit Redevelopment Project Working Group. The group's membership comprises staff from all regions and aims to share knowledge and learnings for a consistent approach to the planning and development within regional mental health units.

Physical built environment

Designing, building and refurbishing a mental health unit requires specialist knowledge. What might be considered aesthetically pleasing with respect to furnishings and layout may not always be safe and suitable in the mental health setting. For example, inappropriate selection of fixtures and fittings may create potential hazards for patients and staff. Whilst all services undertook some form of minor upgrades to infrastructure to enhance the physical environment and patient experience during the financial year, not all minor works were made known to the Chief Psychiatrist.

The Chief Psychiatrist's Standards for Authorisation of Hospitals under the MHA 2014 (Standards for Authorisation) require services undertaking major renovations, and or refurbishments, to consult with the Chief Psychiatrist prior to commencing any works. Over recent years this process has worked exceptionally well and led to effective collaboration and consultation with all stakeholders including architects. This collaboration has resulted in contemporary designs for mental health facilities, an example of which is the newly opened Dabakarn Mental Health Unit located at Royal Perth Hospital.

The Chief Psychiatrist continues to work with services to ensure mental health facilities are therapeutic and are safe and suitable.

The Standards for Authorisation (section 1.27 – section 1.32) set out the requirements for services to provide suitable and safe outdoor areas. Site visits undertaken by OCP staff have observed outdoor areas that do not meet the Standards for Authorisation and are uninviting to patients.

There is a vast amount of research demonstrating that the built environment should promote wellness, provide access to fresh air, natural light and nature as these are considered therapeutic and assist in patient recovery. Given the positive influence the outdoor environment can have on the patient recovery process, it is disappointing that many services are not meeting the required standards. Going forward, services

must ensure these areas are maintained to a high standard and there is an ongoing budget specific to their mental health units.

Good design principles for mental health facilities include:

- the design of nursing stations to encourage greater interaction between staff and patients
- comfort and sensory rooms as a key component of trauma-informed care
- contemporary design for arrival areas that promote environments that are non-confrontational, provide for de-escalation, and offer the patient a calm atmosphere.

Having regard for these focus areas it is pleasing to note that in 2021-22 there was significant upgrading and development of mental health facilities including physical environments and outdoor spaces.

Guidance for SAC1 mental health clinical incident investigations

Severity Assessment Code (SAC) 1 clinical incidents are clinical incidents that have or could have (near miss) caused serious harm or death that is attributable to health care provision (or lack thereof) rather than the patient's underlying condition or illness.

All SAC1 clinical incidents must be investigated using a rigorous methodology, usually by a Root Cause Analysis (RCA). The aim of investigating these incidents is to identify system problems and find better ways of working. It is not about finding or apportioning blame.

In the 2018-19 Annual Report, the Chief Psychiatrist noted concerns about the poor standard of some of the SAC1 mental health clinical incident investigations. Some RCAs undertaken by mental health services were not taking a detailed look at the root causes of incidents, and so their value to service improvement appeared to be variable, and at times low.

The Chief Psychiatrist's concerns led to a collaboration between the OCP's data monitoring team and staff in the Department of Health Patient Safety and Surveillance Unit, to develop a guideline to assist mental health staff undertaking SAC1 clinical incident investigations relating to mental health care. Following broad consultation with mental health services, the final document was endorsed by the Chief Psychiatrist and the Department of Health. The Guidance for SAC1 Mental Health Clinical Incident Investigations was published in June 2022.

This Guideline should be used in conjunction with the Chief Psychiatrist's Standards for Clinical Care and the Department of Health Clinical Incident Mandatory Policy, the Clinical Incident Management Guideline and Toolkit, available on the Department of Health website.

Restrictive practices reporting

The State and Federal Governments have committed to work towards eliminating restrictive practice in mental health units. The Chief Psychiatrist is committed to working towards expanding that remit and addressing restrictive practice in broader mental health settings.

The reporting of restrictive practices under the MHA 2014 is complex, requiring the use of a minimum of four forms per restraint or seclusion event, with many events requiring up to nine different restraint and seven different seclusion forms. Multiples of these forms may be required for prolonged events. The current forms are paper-based, and notifications are handwritten. This generates a significant workload for staff in both the OCP and authorised mental health services who manually transcribe the relevant data for monitoring and reporting purposes. In the 2021-22 financial year, the Chief Psychiatrist received notification of 2,406 restraint and seclusion events, requiring a minimum of 9,624 paper forms to be written by clinicians and transcribed by both the OCP and authorised mental health services.

In order to streamline this statutory reporting requirement, the OCP has developed new electronic restraint and seclusion forms. The electronic forms have been developed in Microsoft Excel to be identical to the existing paper forms, as required by the MHA 2014. The Excel forms contain features which will streamline reporting and data management, whilst reducing errors in statutory compliance and reporting inaccuracies.

The new forms are being trialled in a small number of authorised mental health services in 2022 to test the functionality of these electronic forms in the inpatient setting. OCP staff will train and support staff and address any issues with the Excel forms that may arise. It is anticipated that they will be implemented across all authorised mental health services in the 2022-23 financial year.

The rates of restrictive practices within Western Australia continue to be significantly lower than the national average, however WA's rates of seclusion and restraint have plateaued. It is critically important, as an indicator of the quality and consumer focus of mental health services, that we continue to work towards bringing those rates down even further. Restrictive practices with mental health patients occurring in other non-mental health settings (such as emergency departments and general hospital wards) are an area of concern. Both the Royal Australian and New Zealand College of Psychiatrists and the Australasian College of Emergency Medicine have committed to working towards reducing restrictive practice in emergency departments across Australia.

The OCP will work with HSPs around targeted strategies to embed trauma-informed care and continue to work towards eliminating restrictive practices in all health settings.

Access and service improvement: a better patient journey

Access and service improvement: a better patient journey

The voice of those with lived experience, and the wisdom of Aboriginal Elders and communities, must be embedded in the development and function of mental health services.

Child and adolescent mental health

In August 2020, the Minister for Mental Health requested that the Chief Psychiatrist undertake a review into the treatment of Ms Kate Savage, a 13-year-old girl who tragically died whilst under the care of Child and Adolescent Mental Health Services (CAMHS). The Review was also tasked with considering the adequacy of current services to respond to young people with complex needs and high-risk behaviour.

The report on the Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services found that community CAMHS was under considerable pressure and no longer able to keep up with the substantial increase in referrals which had occurred over the previous five years. It also found that the management of adolescents with complex needs and high-risk behaviours had progressively come to dominate CAMHS, significantly reducing the capacity to treat younger children.

The Review made a number of recommendations to try to address what it saw as the more urgent matters but, in the limited time available, was unable tackle the broad rebuilding program that was considered necessary. One of the key recommendations, therefore, was the establishment of a Ministerial Taskforce, led by an independent chair, to bring together experts in children's and young people's mental health, families and young people and other key stakeholders to: (a) oversee the immediate staged implementation of the Review recommendations; and (b) develop a whole of system approach for Perth metropolitan and WA country specialist public child and adolescent mental health services.

The Taskforce, which was chaired by Ms Robyn Kruk and commenced operation in March 2021, delivered its final report on 15 March 2022. It proposed an Infant, Child and Adolescent (ICA) Mental Health Strategy and Roadmap to build a system in which the mental health of all infants, children and adolescents is identified, supported, and treated early in life and early in illness with the aim of ensuring that all WA children, families and carers have timely, enduring and equal access to integrated and high-quality public mental health care. The State Government has endorsed all 32 ICA Taskforce recommendations.

The Chief Psychiatrist, and the OCP, provided significant advice in the Taskforce process.

The Chief Psychiatrist fully supports the framework set out in the ICA Taskforce report. Given the scale and complexity of the recommended reforms, and particularly the proposed increase in the public ICA clinical workforce, the implementation will need to be staged. A Ministerial Oversight Committee has been set up together with an ICA Taskforce Implementation Steering Committee to ensure that the ICA mental health system reforms are implemented effectively and efficiently, in an integrated manner.

Community mental health services

The vast majority of specialist mental health care occurs in the community.

Effective, assertive community mental health care that supports recovery, partners with other providers, and holistically responds to people's needs can reduce the pressure on Emergency Departments and inpatient beds, and is preferred by consumers.

However, we are acutely aware of the ongoing issues faced by the sector: consumers report being unable to access care when they need it and experiencing care that can feel disjointed, inflexible, and not always compassionate or culturally safe. Services are struggling to meet increasing demand, workforce shortages impact continuity and frequency of care and add to the pressure on dedicated staff, yet precious clinical time is diverted to administrative tasks. The Auditor General's 2019 report, Access to State Managed Mental Health Services, told us that ED was the entry point for almost half of people needing care. The impact of COVID-19 on both demand and workforce means that this situation has not improved in the last few years. The situation is even more challenging for people who live in rural and remote areas where distance often adds to the complexity of accessing care.

At the same time, the pandemic has driven innovation, for example in the use of telehealth and digital mental health care. We are probably yet to fully consider what we have learnt and how we can adapt mental health services for the future. The voice of those with lived experience and their loved ones, and the wisdom of Aboriginal Elders and communities, needs to be embedded in the design of services because a diversity of perspectives is needed. The coming years will require us to harness creative and contemporary solutions.

One inspiring example of innovation in maintaining a service and improving culture in the face of staff shortfalls was the subject of an OCP Community of Practice session in April 2022 – Coping with staff shortages in community mental health services.

The Chief Psychiatrist welcomed the work of the Mental Health Commission's Community Treatment and Emergency Roadmap this year, and looks forward to seeing positive outcomes to the work.

Data linkage project with the University of Western Australia

A data-linkage project has been commenced to examine the relationship between the standards of psychiatric care, mental health service delivery and patient outcomes. The project is a collaboration between the OCP and the School of Population and Global Health at the University of Western Australia.

The Auditor General's 2019 report, Access to State Managed Mental Health Services identified gaps in mental health service delivery that impact on the patient journey. Over the period of the study (2013-2017) there was a decrease in the availability of inpatient services resulting in a reduced capacity to admit people requiring urgent care. In addition, the funding for community treatment services had not increased to meet demand. However, the AG did not examine how these shortages impacted the standards of psychiatric care and ultimately, the effect on patient outcomes.

The project will examine the interaction between multiple organisational, environmental and patient factors that determine the quality of psychiatric care, mental health services and patient outcomes. The project outcomes will inform service delivery policy and guidelines to improve the standards of mental health care and deliver services more effectively.

Rehabilitation and recovery: vulnerable groups and their complex needs

Rehabilitation and recovery: vulnerable groups and their complex needs

Graylands Reconfiguration and Forensic Taskforce (GRaFT)

The Chief Psychiatrist's Review Building rehabilitation and recovery services for people with severe enduring mental illness and complex needs, which was released in 2020, found that current mental health system was not working effectively for this group of consumers and their families/carers. It recommended investment in the development of a coordinated network of inpatient, residential and community rehabilitation and recovery services, including Specialist Neurodevelopmental Services for the treatment and care of people with co-occurring mental illness and intellectual, cognitive and developmental disability.

In May 2021, the Chief Psychiatrist met with the Chair of GRaFT to promote the development of a Secure Extended Care Unit (SECU) and high acuity Community Care Unit (CCU) beds on the Graylands site. The Chief Psychiatrist expressed a firm view that forensic inpatient services should be retained on the Graylands site rather than being collocated with correctional facilities or established as a stand-alone service. It was pointed out that there is a significant overlap between the clinical profiles and needs of people who use forensic and rehabilitation beds.

In a subsequent submission to GRaFT during 2021-22, it was proposed that the whole of the Graylands site should be retained for the staged development of a Collaborative Centre for Mental Health and Wellbeing, bringing together people with lived experience expertise, experts in clinical and non-clinical care, researchers and educators to provide a base for Statewide mental health services and a 'hub' for research, knowledge dissemination, training and professional development.

The Centre would support and partner with a broad 'network' of clinical, non-clinical and private mental health services, consumer and carer organisations, tertiary organisations and peak bodies to 'heal the divide' that has developed within the sector and support dissemination of exemplary practice across the service system.

It was envisaged that the Collaborative Centre would be developed in stages to provide a range of inpatient and community services for all age groups, with initial priority given to filling the gaps in Statewide services including forensic services (youth and adult); inpatient rehabilitation services; services for people with comorbid mental health and alcohol and drug problems and people with comorbid neurodevelopmental condition; Trauma Informed Care; and services for people with personality disorders (youth and adult).

The proposal has been discussed with, and received keen interest and support from, a wide range of stakeholders.

Forensic mental health: people with mental illness who are involved with the criminal justice system

Forensic mental health services within Western Australia continue to lag behind other jurisdictions. Access to acute mental health beds for people in prisons remains extremely limited, meaning that prisoners are often simply unable to access the care and treatment they need when acutely mentally unwell. This reporting period showed deterioration in access compared with the previous reporting period. This remains an area of significant concern and the Chief Psychiatrist has continued advocating for improved standards of treatment and care for forensic mental health patients.

On 30 September 2021, the Chief Psychiatrist brought together key stakeholders from the Department of Justice, Department of Health, the Mental Health Commission and Health Service Providers to deliver a 'Symposium on Clinical Pathways for Forensic Mental Health Consumers' (Forensic Forum) to discuss constructive pathways for WA prisoners in need of acute inpatient mental health treatment and care.

Invited experts presented on a range of topics relevant to the forensic mental health sector. A hypothetical based on case studies was held during the symposium to facilitate a discussion on how pathways to care for this cohort of patients may be better coordinated to ensure safe high-quality treatment and care.

Representatives from the Office of the Chief Psychiatrist continue to collaborate with key stakeholders on the development of a model of care for forensic mental health services through regular meetings, focus groups and workshops. The Forensic Model of Care Working group is a sub-group of the Graylands Reconfiguration and Forensic Taskforce (GRaFT) which oversees the planning and development of contemporary services to meet the mental health needs of Western Australians.

The OCP has collaborated with the Office of Inspector of Custodial Services (OICS) by assisting in a prison review. Representatives of the Chief Psychiatrist have also visited Banksia Hill and the Bindi Bindi Mental Health Unit at Bandyup Prison.

Criminal Law (Mental Impairment) Bill

The Department of Justice has actively sought to collaborate with the Chief Psychiatrist on the reform of the *Criminal Law (Mentally Impaired Accused) Act 1996*. With support from the Department of Justice, representatives from the Office of the Chief Psychiatrist have continued to be actively engaged in providing advice and applying their knowledge and expertise to progress reform through the Criminal Law Mental Impairment (CLMI) Bill.

Residents of private psychiatric hostels

Residents of private psychiatric hostels are a vulnerable group with complex needs.

A strong theme identified through the Chief Psychiatrist's monitoring of Private Psychiatric Hostels is that while many organisations work very hard to provide high-quality care to their residents, the current system structure means that private psychiatric hostels are not designed to provide care to the people with the most complex needs.

The reviews conducted by the OCP to date have consistently observed that individuals who have greater complexity and functional impairment appear to be funnelled to residential services that have lower funding and fewer resources to deal with their recovery and rehabilitation needs. Most services that offer a residential recovery programme are designed primarily to cater for consumers who have more functional independence on entry. This paradoxical system design means that the hostel residents who need more support are receiving less care.

The Chief Psychiatrist will continue the reviews of Private Psychiatric Hostels in to the 2022-23 financial year.

Aboriginal mental health

Aboriginal mental health

The Chief Psychiatrist has actively pursued an agenda to better position the OCP in advancing the standards of treatment and care for Aboriginal people.

Addressing cultural security, the need for truth and equity, and how mental health care can be developed with, not for, Aboriginal people, is a crucial part of the day-to-day work across the sector.

Ensuring that the voices and views of Aboriginal people are central is essential for better access to services for Aboriginal people, for ensuring that services offered are culturally safe, and for improving standards of mental health care.

The Chief Psychiatrist and the Deputy Chief Psychiatrist were in attendance at the Allawah Burdiyas Call to Action Community Conference at which they were presented with a message stick to symbolise their responsibility for overseeing the standards of mental health treatment and care provided to Aboriginal people.

Aunty Sandra Wilkes presents a boorna wangkiny (message stick) to Dr Nathan Gibson, Chief Psychiatrist on 31 May 2022.

Boorna Wangkiny – a direct message regarding the Chief Psychiatrist's responsibility to oversee significantly improved and culturally secure standards of care for Aboriginal patients within WA mental health services.

To build on this responsibility, the OCP has joined with the Faculty of Health Sciences at Curtin University. The project will assist the staff of the OCP to build authentic engagement with Aboriginal people in order to provide true collaborative and effective care, through the expertise of Aboriginal Elders and young people. It aims to improve the confidence, capability and competence of non-Aboriginal staff to work in authentic partnership with Aboriginal people across policy issues.

Wungen Kartup Specialist Aboriginal Mental Health Service joined the OCP's Community of Practice during Reconciliation Week 2022; the week's theme being 'Be Brave. Make Change'. Clinicians heard about Wungen Kartup's approach to helping Aboriginal people build trust and rapport with services through yarning and taking time to get to know each other. The importance of building up cultural strength and how to support and connect with Aboriginal people and their specific community when on and off Country whilst accessing in mental health services was shared. A summary of the session is available on the Chief Psychiatrist's website. The OCP is committed to enabling future discussions with Aboriginal people to support high-quality therapeutic relationships, better experiences of care and to reduce restrictive practices.

Sexual safety in mental health services

Sexual safety in mental health services

The release of the Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services in Western Australia in 2020 required Health Service Providers to look at practical measures to ensure patients are physically and psychologically safe, and these have been well received by the sector.

Every person who uses a mental health service has the right to feel and be safe throughout their journey; however, we know that both nationally and internationally this has not always been the case. Many people using services have an experience of trauma in their lives, and all mental health services, particularly those providing residential or inpatient care, need to be designed and run in a way that actively minimises the risk of traumatising, re-traumatising or compounding past trauma for their users. This requires attention to the structural design of the buildings, the policies in place and a culture where safety is at the heart of service provision.

Some services have, as part of a refurbishment, reconfigured ward areas to provide safe and suitable gender-specific environments for vulnerable patients. Solutions have included the use of swing doors to create same gender areas with separate lounge and outdoors areas. New build mental health facilities must provide safe and suitable areas for vulnerable patients.

Work has continued to embed the guidelines into all of the OCP's functions and interactions with services. The OCP successfully applied for a McCusker intern from UWA; and many thanks are due to our intern, who developed the project plan to allow this work to commence during her placement with us.

This work means that:

- Clinicians are more aware of the requirement to report all alleged sexual behaviour incidents, which has improved reporting to the Chief Psychiatrist. The data are reported in the Notifiable Incidents section.
- Where any concerns or areas requiring improvement have been identified from incidents, we have followed up and liaised with the service to ensure that we provide support to them in understanding their requirements.
- Our reviews of services include in-depth consideration of the sexual safety of consumers in that setting.
- Authorised mental health practitioners are made aware of the Sexual Safety Guidelines as part of their training.
- Advice is given about new builds and or refurbishment of inpatient units, and authorisation/reauthorisation of units includes contemporary evidence-based information about best practice approaches to sexual safety.
- External stakeholders such as designers and architects are educated to ensure safe and suitable areas form part of the design brief and ongoing functionality.

In addition the OCP has provided specific reports and data on request to support services wishing to understand their own performance in this area. Members of the team have been able to collaborate with Health Service Provider working groups looking at sexual safety on authorised units, to support the process and contribute to their action plans.

The Chief Psychiatrist notes Recommendation 13 of the Royal Commission into Victoria's Mental Health System which relates to sexual safety and requires new inpatient units to be built with a layout that enables gender-based separation, and existing units to be reviewed and retrofitted if necessary to meet a sexual safety standard. At a national level, mental health inpatient services specifically for women are starting to emerge. This is a key consideration for Western Australia, with a number of new units currently in the design or build phase.

Authorisations and approvals

Authorisations and approvals

Several mental health services reported as new builds in the Chief Psychiatrist's Annual Report 2020-21 remain in development or in the final stages of planning. The OCP has been active in providing advice throughout the process of these new builds and other unit refurbishments.

Planned new unit bed numbers	
South Metropolitan Health Service, Mental Health Fremantle Hospital V Block	40 beds (adult and older adult open and secure)
WA Country Health Service Geraldton Health Campus	12 beds (8 open – 4 secure)
Private Hospitals Providing a Public Service Joondalup Health Campus	121 beds (adult, older adult and youth open and secure)

Refurbishments are occurring in the following inpatient mental health units:

- Albany Health Campus
- Bentley Hospital
- Broome Hospital
- Bunbury Hospital
- Graylands Hospital
- Kalgoorlie Health Campus
- St John of God Mt Lawley, Ursula Frayne Unit

Review of the authorisation of mental health facilities

The purpose of the review is to ensure authorised hospitals in Western Australia continue to comply with the Chief Psychiatrist's Authorised Hospital Standards under the MHA 2014. The first stage of the review commenced in July 2020 with a service self-assessment and the formal visits were the second stage of this process. In August 2021 the Chief Psychiatrist and review delegates commenced the first visits to services as part of the ongoing review of the authorisation of mental health facilities.

Services that have been formally reviewed in the reporting period include:

- St John of God Hospital, Mount Lawley – Ursula Frayne Unit
- Graylands Hospital
- Albany Health Campus
- Armadale Hospital
- Kalgoorlie Hospital
- Rockingham General Hospital
- Bunbury Hospital
- Sir Charles Gairdner Hospital

The Chief Psychiatrist continues to support the authorisation of all of these services under the MHA 2014.

Services approved to provide ECT

The MHA 2014 requires all services that perform electroconvulsive therapy (ECT) in WA to be reviewed and approved by the Chief Psychiatrist every three years (s.544).

The Chief Psychiatrist received no applications from additional services seeking approval to be gazetted to perform ECT during 2021-22.

In the reporting period 2021-22 the Chief Psychiatrist formally reviewed all 11 existing ECT services. The review examined the ECT service's compliance with the Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy (2015) and the Chief Psychiatrist Guidelines for the use of Electroconvulsive Therapy (2006).

The Chief Psychiatrist has approved these services under the MHA 2014 to provide ECT:

Private hospitals

- Hollywood Clinic
- The Marian Centre
- Perth Clinic

Publicly contracted private hospitals

- Joondalup Health Campus
- St. John of God Midland Public Hospital

Public hospitals

- Albany Health Campus
- Armadale Hospital
- Bentley Hospital
- Fremantle Hospital
- Rockingham General Hospital
- Sir Charles Gairdner Hospital

Work continues to progress a review of the Chief Psychiatrist's ECT Guidelines.

Further opinions

Since the commencement of the MHA 2014, access to further opinions has been challenging and they continue to be difficult to facilitate in a timely fashion.

For the reporting period 2021-22 the Chief Psychiatrist received eight requests for a further opinion. As reported in 2020-21 Annual Report, completion rates for further opinions are low due to requests being withdrawn (for example when the patient becomes voluntary), or when the requestor seeks a further opinion from an external or private psychiatrist.

In June 2021 the Department of Health rescinded the Operational Directive for further opinions. To simplify the process for clinicians, the Consultant, Statutory Authorisations and Approvals collaborated with the Mental Health Unit on the request and reporting template. The goal was to reduce the administration and duplication of information. Feedback from clinicians highlighted some potential improvements and additions, which have now been added.

The Chief Psychiatrist continues to be concerned that there is no formal tracking process for requests for further opinions that do not come through the OCP. There is no consistent approach to providing timely further opinions across HSPs. There remains a systemic risk that patients may not always be able to access the further opinions they request in a reasonable timeframe.

Chief Psychiatrist's visits to mental health services

The Chief Psychiatrist and team visit services throughout the year to meet with staff and consumers, and view the physical environment. During the first half of the year a number of face to face visits occurred, including those required for the reviews of approved ECT services and authorisation visits. However, due to the COVID-19 pandemic, the Chief Psychiatrist also met online with services to discuss issues relating to standards of treatment and care.

Consumer and Carer Advisory Groups

When visiting services the Chief Psychiatrist invites Consumer and Carer Advisory Groups (CCAGs) to meet. For this reporting period delegates of the Chief Psychiatrist met with several CCAGs.

Matters that have been raised by CCAGs includes:

- expanding availability of Psychiatric Liaison Nurses
- expansion of Peer Support workforce
- improved liaison with General Practice
- enhanced involvement of families and carers in discharge planning
- timely discharge summaries
- improved consistency of physical health care checks and treatment within mental health services
- addressing challenges for mental health care within Emergency Departments
- enhanced rehabilitation and youth services
- Greater availability of barbeques and social activities in inpatient units
- increased availability of in-reach community services
- greater availability of psychology and counselling services.

The Chief Psychiatrist has heard and represented these issues to the HSPs.

Statutory reporting

Statutory reporting

Data are provided for each incident type for the population as a whole during the 2021-22 financial year. A separate section follows to break down the incidence in the Aboriginal patients. Please note the Aboriginal consumer data are captured over a different reporting period – the 2021 calendar year - so is not directly comparable to the whole of population data which covers from July 2021 – 30 June 2022 (see section Statutory Reporting – Aboriginal patients).

Restrictive practices

The Western Australian Government has historically committed to work towards elimination of restrictive practices within mental health settings.

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's 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 Western Australia. The Chief Psychiatrist expects that in line with the state and national commitment to work towards eliminating the use of restrictive practice in mental health services, that restraint and seclusion data are made readily available by health services to facilitate evaluation of reduction strategies.

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 of rates of restrictive practices at a service.

The Chief Psychiatrist monitors the use of restraint and seclusion on an ongoing basis and seeks further details when a patient is secluded for a prolonged period or held in a prone restraint position for a prolonged period. In the 2021-22 financial year, the Chief Psychiatrist sent 11 pieces of correspondence regarding instances of restraint and seclusion that did not fall into the Chief Psychiatrist's guidelines for clinical practice, due to the use of prolonged prone restraint, and prolonged seclusion. These correspondences were to ensure that adequate review of incidents has taken place, and that services have undertaken planning to prevent further need for seclusion and restraint.

Seclusion

Of the 6,861 people who accessed care and treatment in an Authorised Hospital in the 2021-22 financial year, 5% (357)* had a seclusion event at some point during their stay.

**Please note that some individuals have been counted twice in the sections below due to having a seclusion event both before and after turning 18 years of age.*

Children aged less than 18 years

The Chief Psychiatrist received notification of 163 seclusion events involving 45 children and youth under 18 years of age, almost two thirds of whom were female (62%). Of the 163 seclusion events reported, 39% were less than 60 minutes, 46% between 60 and 120 minutes and 15% lasted more than 120 minutes. The median duration for each of these categories was 36.5 minutes, 85 minutes, and 228 minutes, respectively.

Adults aged 18-64 years

The Chief Psychiatrist received notification of 1,129 seclusion events involving 310 adults 18-64 years of age, two-thirds of whom were males (66%). Of the seclusion events reported, 17% were less than 60 minutes, over half (56%) had a duration of between 60 and120 minutes, and 26% lasted more than 120 minutes. The median duration for each of these categories was 41 minutes, 105 minutes, and 229 minutes, respectively.

Adults aged 65 years and older

The Chief Psychiatrist received notification of seven seclusion events involving less than five adults 65 years of age and over. Due to the small number of patients secluded, further statistics are not reported to prevent identification of individuals.

Restraint

Of the 6,861 people who accessed care and treatment in an Authorised Hospital in the 2021-22 financial year, 6% (429)* had a restraint event at some point during their stay. Of the 1,107 restraints reported 99% comprised physical restraints with 1% involving mechanical restraint. All mechanical restraints involved patients aged 18-64 years.

**Please note that some individuals have been counted twice in the sections below due to having a restraint event both before and after turning 18 years of age.*

Children aged less than 18 years

There were 188 restraint events involving 57 children and youth under 18 years of age, approximately two thirds of whom were females (63%). The majority (62%) of restraint events were for less than five minutes, with a median duration of three minutes. Restraint events lasting 5 to 10 minutes comprised 25% of all events and 13% lasted more than 10 minutes.

Adults aged 18-64 years

There were 854 restraint events involving 342 adults 18 - 64 years of age, with an even split between males (50%) and females (50%). The majority (67%) of restraint events were less than five minutes, with a median duration of three minutes. Restraint events lasting 5 to 10 minutes comprised 21% of all events and 12% lasted more than 10 minutes.

Adults aged 65 years and older

There were 65 restraint events involving 33 adults over 64 years of age, the majority of whom were males (58%). Three-quarters (74%) of restraint events lasted less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 17% of all events and 9% lasted more than 10 minutes.

Use of prolonged prone restraint

Placing patients in the prone restraint position entails a significant risk of harm, and as such emphasis is placed upon eliminating the use of prone restraint. If prone restraint is used, its use is limited to three consecutive minutes by a number of jurisdictions globally. The Chief Psychiatrist's Standards for Clinical Care direct staff and management of Authorised Hospitals to

"Avoid the use of prone restraint where possible to minimise the risk of respiratory compromise."

A number of deaths in other Australian jurisdictions prompted closer examination of the use of prone restraints in Western Australia, and closer monitoring by the Chief Psychiatrist. Of the 1,107 restraints that occurred in the 2021-22 financial year, 638 (58%) of those involved the use of the prone position. Of the 638 prone restraints, 54 (8%) involved the use of prone for more than three consecutive minutes.

Australian Institute for Health and Welfare national reporting 2021-22

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.

Over the past 5 years, WA has consistently been one of the leaders in the reduction of the use of restrictive practices in Australia.

Seclusion

The overall WA rate of seclusion for the 2021-22 FY was 5.6 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 3). The rate of seclusion in WA for adults 18-64 years of age was 6.9 per 1,000 bed days. The rate of seclusion for children and adolescents below 18 years of age was 15.8 per 1000 bed days in the 2021-22 FY. Older adult mental health services had the lowest rate of seclusion at less than 0.1 per 1,000 bed days and Forensics had a rate of 6.2 per 1,000 bed days.

Restraint

The overall rate of restraint for the 2021-22 FY was 4.8 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 3). The WA restraint rates were 5.6 per 1,000 bed days for adults 18-64 years of age, 1.2 per 1,000 bed days for older adults 65 years and older, and 6.8 per 1,000 bed days for forensics. The rate of restraint for children and adolescents below 18 years of age was 9.2 per 1,000 bed days in the 2021-22 FY.

Table 3: Overall national and Western Australian rates of seclusion and physical restraint

	Seclusion per 100 bed days		Restraint per 100 bed days	
	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	8.1	5.0	11.0	4.8
2020-21	7.3	4.2	11.6	4.3
2021-22	*	5.6	*	4.8

*Not available at the time of publication

Notifiable incidents

The Chief Psychiatrist receives notifiable incident reports in line with section 526 of the MHA 2014. The OCP staff review all notifications and use a risk management approach to escalate some notifications for review by the Chief Psychiatrist. If there are areas of concern, the Chief Psychiatrist may refer the incident to the Health Service Provider or the Department of Health for more information; request an investigation by the service; or may decide to undertake an investigation, such as a targeted review.

Public mental health services report notifiable clinical incidents to the Chief Psychiatrist through the Department of Health's Datix Clinical Incident Management System (Datix CIMS). Mental health services outside the public health system, such as non-government organisations (NGOs) and private psychiatric hostels, do not have access to Datix CIMS, so they report using the Chief Psychiatrist's Notifiable Incident Form. The majority of notifiable incidents (82.5%) were reported through Datix CIMS, with the remaining 17.5% reported through the Chief Psychiatrist's Notifiable Incident Form. For clinical incidents reported through Datix CIMS, the severity of the incident was coded for all events where health care was determined to have contributed to, or caused, the incident.

The Deputy Chief Psychiatrist reviews all serious notifiable incidents and, where indicated, follows up directly with the relevant service, provides advice as required, and/or undertakes a targeted review of the incident. There were 472 serious incidents that were flagged for

follow-up by the Deputy Chief Psychiatrist and 35% of these were flagged for further follow up with the mental health service. The follow-up ranged from requesting an investigation report, treatment information or mandatory information such as risk assessment and management plans or sending the service the Chief Psychiatrist's Sexual Safety Guidelines.

Notifiable incidents required to be reported to the Chief Psychiatrist include:

- death
- assault and/or aggression
- alleged sexual behaviour
- attempted suicide
- absent without leave (AWOL)
- missing person
- serious medication error
- unreasonable use of force by a staff member
- alleged homicides.

Notifiable incidents reported to the Chief Psychiatrist in the 2021-22 financial year may contain more than one incident category and, therefore, the notifications are coded as primary and secondary notifiable incident notifications.

Primary incidents

There were 3,291 notifiable incidents reported for 1513 patients, with a median of one incident reported per patient. One-third of patients (32%) had two or more incidents reported. The majority of incidents involved an involuntary patient (59%), 37% involved a voluntary patient and 4% involved a person who was referred under the MHA 2014 for assessment, or who was not under the MHA 2014. More than half (56%) of incidents involved a male patient.

The most frequently reported primary incident, involving 68% of all notifications, was aggressive behaviour/assault. The next most frequently reported primary incidents were attempted suicides and patients absent without leave (AWOL), each accounting for 9% of all notifications. Incidents involving a missing high-risk voluntary patient are also reported to the Chief Psychiatrist, equating to 4.5% of notifications received. A small proportion of notifications were related to deaths (6%) and 3% related to allegations of sexual behaviour, such as sexual contact, assault, harassment or an indecent act. The remaining 0.5% of notifiable incidents reported included serious medication errors, or allegations of murder/homicide.

Secondary incidents

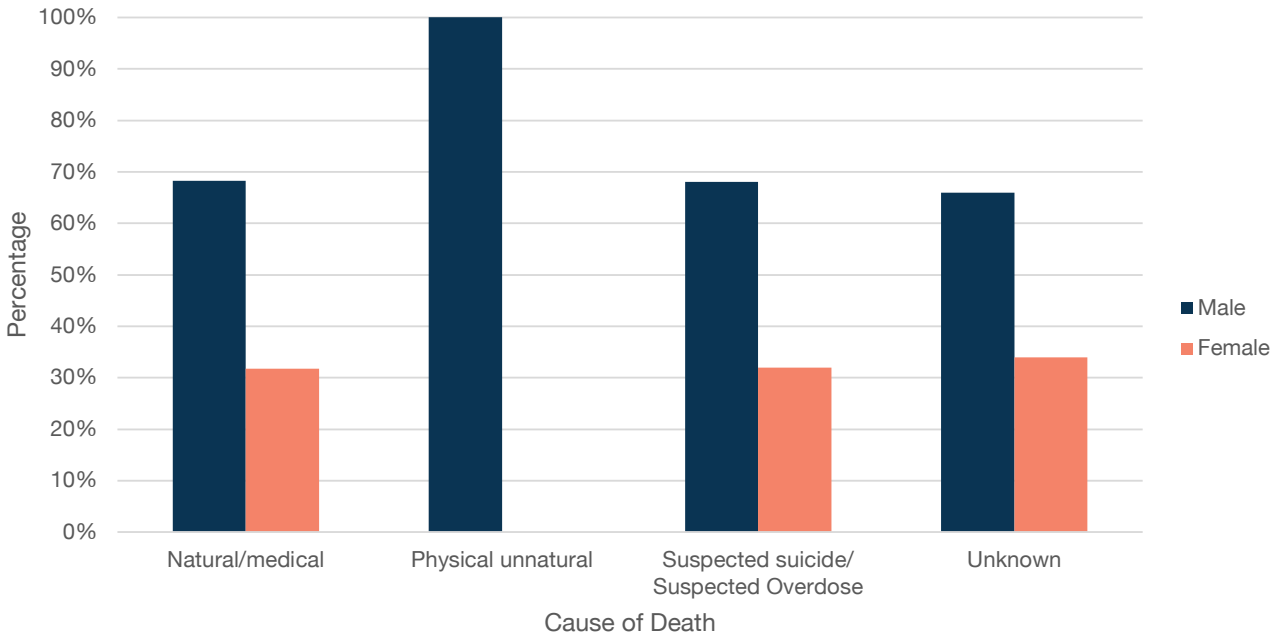
There were 127 secondary notifiable incidents reported for 107 patients. One-third of secondary incidents reported were aggressive behaviour/assault, and alleged sexual behaviour (both 33%). Attempted suicide comprised 14% of incidents, AWOL of involuntary/referred patients 12%, missing high-risk voluntary person 5.5%, with the remaining 2.5% comprising death or unreasonable use of force by a staff member.

Death

Deaths of patients actively receiving mental health care and any deaths that occur within 28 days of discharge or deactivation of a patient from a health service must be reported to the Chief Psychiatrist by the person in charge of the mental health service, even if he or she becomes aware of the death after the 28-day period (in accordance with MHA 2014 section 52 and the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist).

The Chief Psychiatrist received 193 notifications from mental health services regarding deaths of patients during the 2021-22 financial year, of which 44% were reported to be due to natural causes, 35% were suspected to be suicide or suspected accidental overdose, 3% were reported to be due to physical/unnatural causes and for 18% the cause was unknown at the time of reporting. A higher proportion of the deaths reported involved men (68%) than women (32%) and this was consistent across each of the causes of death (Figure 5).

Figure 5: Cause of death of mental health patients reported by gender

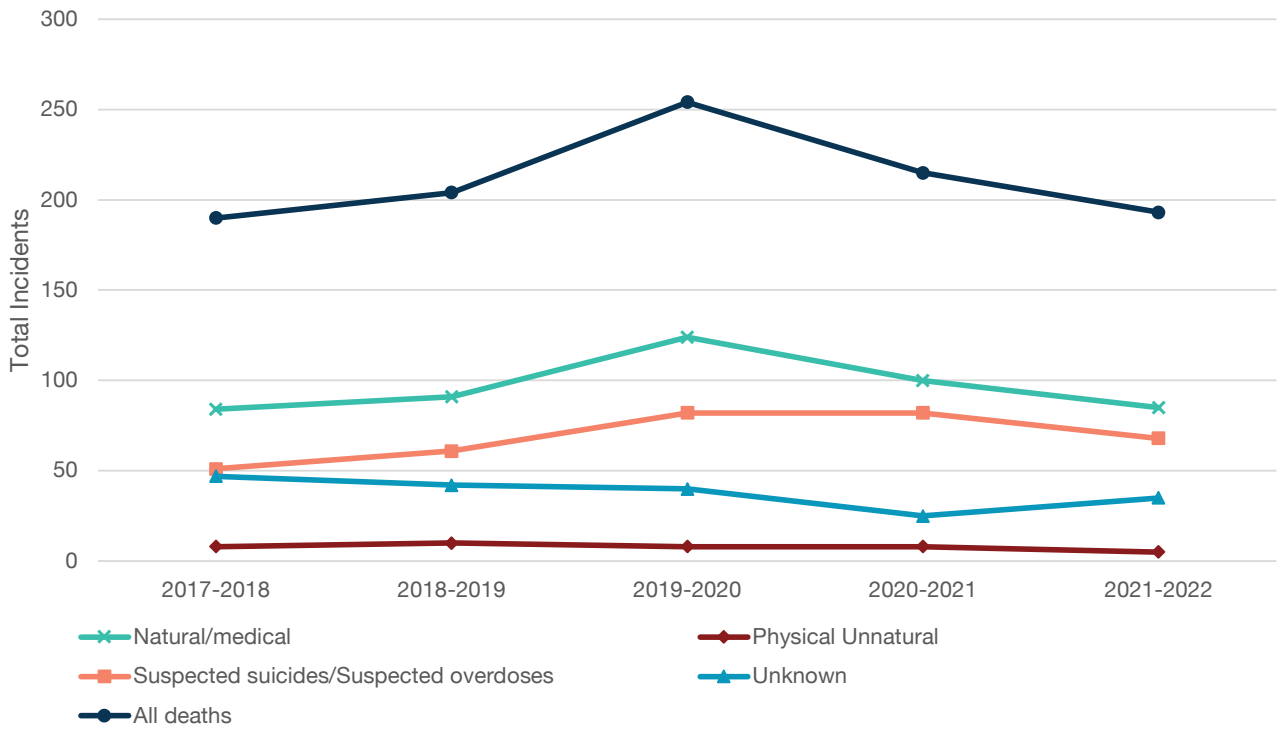


Physical/unnatural deaths included, but were not limited to, deaths due to falls, motor vehicle accidents, and drowning. Source: Office of the Chief Psychiatrist database and Datix CIMS.

All of the deaths due to natural causes, physical/unnatural and unknown involved a person aged 18 years or older. Of the 68 notifications of suspected suicide incidents, the majority related to adults 18 years of age and older, with less than five involving patients less than 18 years of age.

Death notifications to the Chief Psychiatrist increased between 2017-18 (n=190) and 2019-20 (n=254) before decreasing by 15% in 2020-21 (n=215) and a further 10% reduction 2021-22 (n=193) (Figure 6). The increase in death notifications during the 2019-20 financial year was due to an increase in natural/medical deaths and suspected suicides/suspected overdoses.

Figure 6: Trends in death notifications of mental health patients



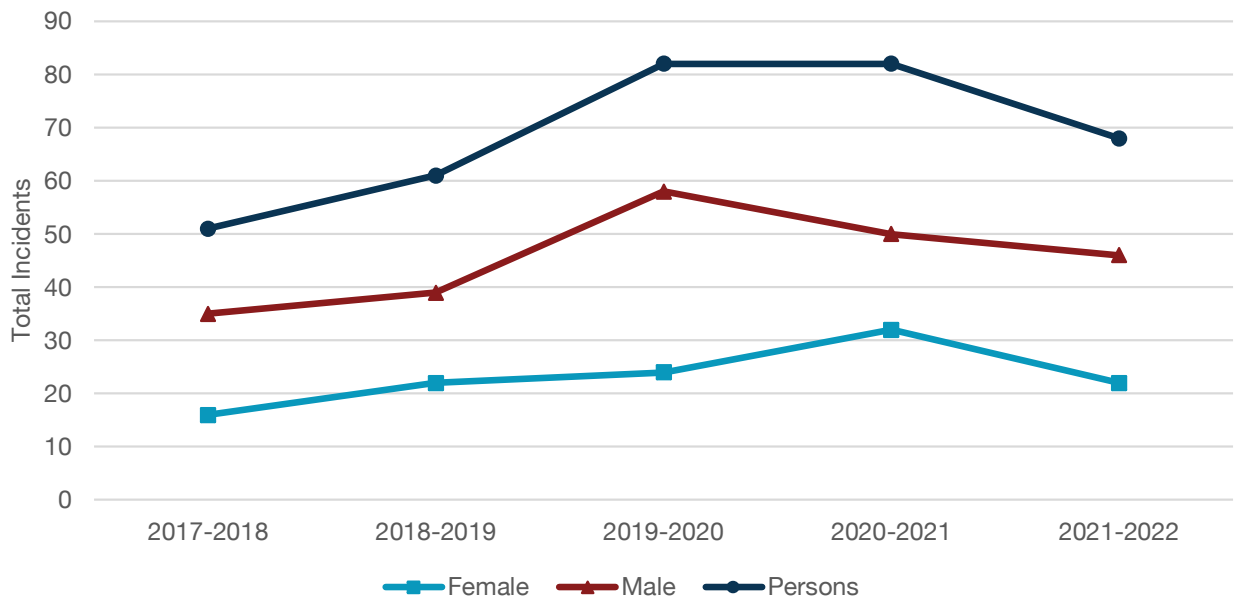
Trends in suspected suicide

The Chief Psychiatrist received 68 notifications of death by suspected suicide[1] in 2021-22 financial year. This was a 17% reduction of notifications received compared with the previous two financial years, where 82 suspected suicides were reported respectively in 2019-20 and 2020-21. A small number of death notifications initially reported in previous financial years where cause of death was unknown were reclassified to suspected suicides following further information in the investigation report.

All incidents reported as suspected suicides are reviewed by the Deputy Chief Psychiatrist and where required, services are contacted to obtain further information or to request the investigation review outcome when completed.

Over two thirds (68%) of suspected suicides in the 2021-22 financial year involved a male. This is consistent with previous years, with males comprising more than 60% of notifications. There was a steady increase in notifications of suspected suicides for females until 2020-21 (n=32), this number then reduced in 2021-22 (n=22) (Figure 7).

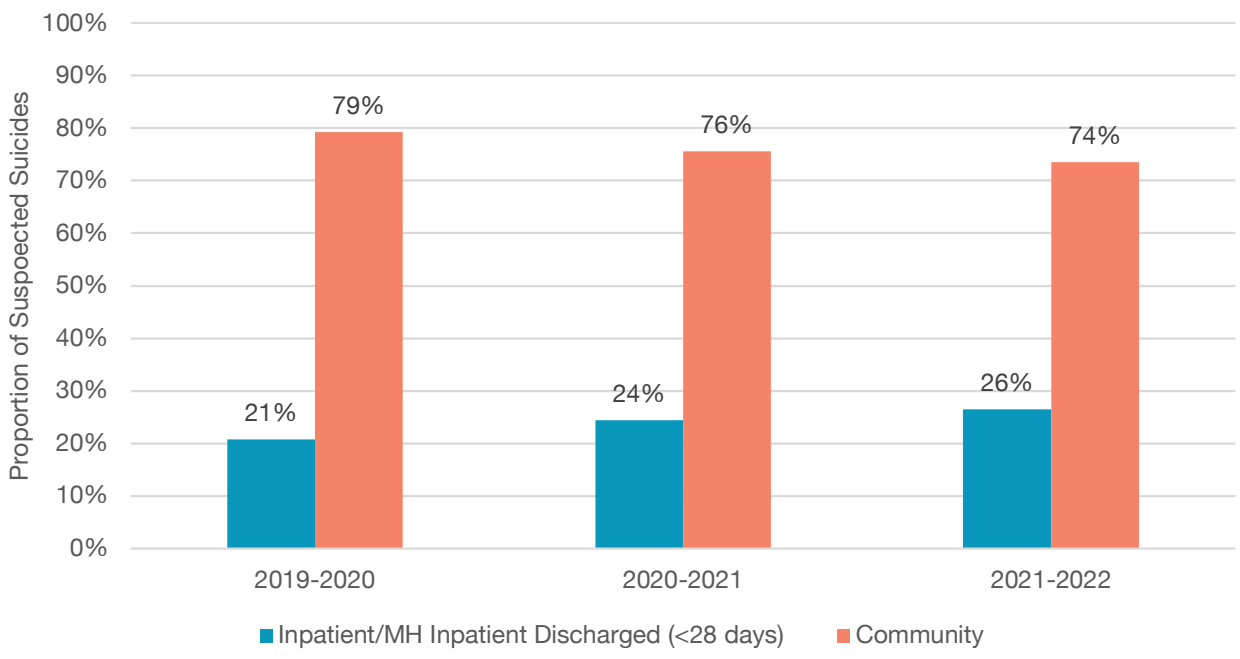
Figure 7: Trends in the number of suspected suicides notified to the Chief Psychiatrist



[1] This section includes deaths involving suspected overdose which made up 4% (n=8) of total death notifications in 2021-2022.

The majority of suspected suicides notified to the Chief Psychiatrist during the 2021-22 financial year took place in the community setting, not within an inpatient ward or emergency department. There have been less than five suspected suicides which occurred on an inpatient ward reported in previous financial years. Notifications of suspected suicides involving an inpatient or patient who had been discharged from a mental health inpatient admission prior to their death increased from 21% in 2019-20 to 24% in 2020-21 and 26% in 2021-22 (Figure 8). The notifications to the Chief Psychiatrist are only reported as deaths within 28 days after discharge following confirmation of the date of discharge and the categories are correct to the best of our knowledge.

Figure 8: Suspected Suicide of patients discharged less than 28 days from a mental health inpatient admission



Attempted suicide

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

The Chief Psychiatrist received 326 notifications of attempted suicide involving 250 individuals during the 2021-22 financial year. Of the 250 individuals, the majority (84%) had one reported attempted suicide, 9% had two attempted suicides, and 7% had three or more attempted suicides. One-tenth (10%) of attempted suicides were reported to have resulted in serious harm to the patients. Three out of four (75%) attempted suicides involved voluntary patients and one out of four (25%) involved involuntary patients or patients referred for assessment.

The majority of reported attempted suicides involved females (73%), with just under one-third (32%) of the women aged less than 18 years (Table 4). For males, the highest proportion of attempted suicides occurred for those age 18 years and older (82%).

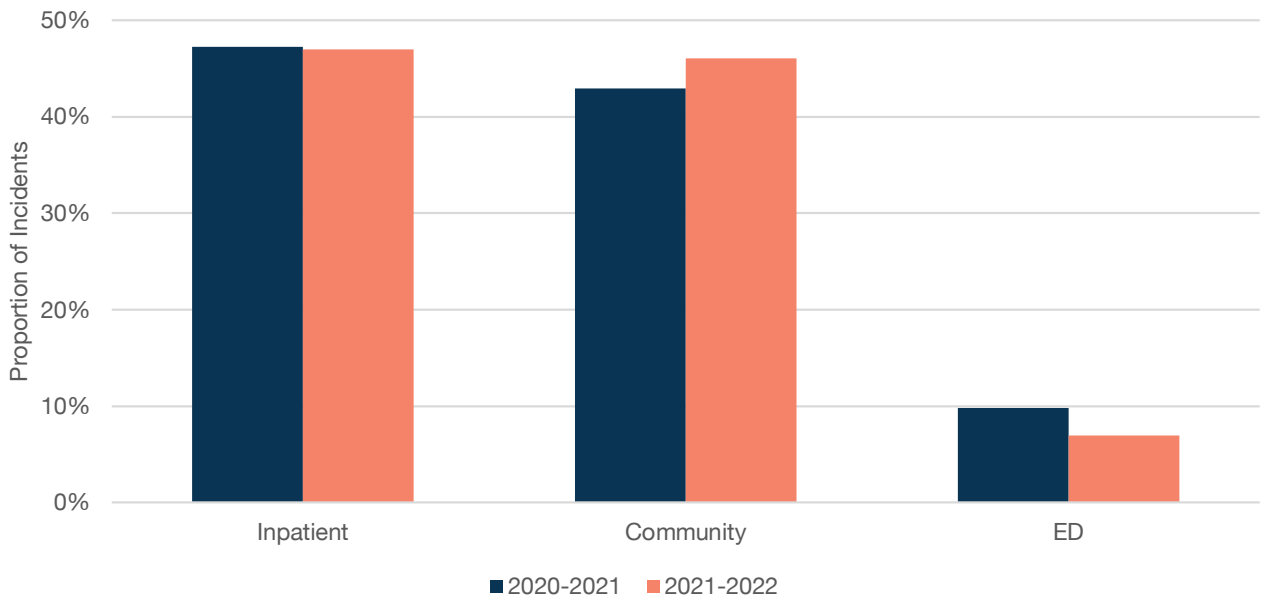
Table 4: Notifications of attempted suicide by gender and age group

Age (Years)	Female	Male	Total Incidents
Under 18	76	16	**92**
18 and over	161	73	**234**
Total Incidents	**237**	**89**	**326**

Notifications of attempted suicides were reported to occur mostly in an inpatient ward (46%) and in the community (47%) e.g. private psychiatric hostels or residential homes, with the remaining incidents occurring when the person was attending an ED (7%). This was consistent with figures reported in the previous financial year (Figure 9).

A review of serious clinical incidents, including attempted suicide, is conducted weekly by the Deputy Chief Psychiatrist and the Monitoring Team. The focus of the incident review is the standards of psychiatric care being provided to the person. For attempted suicides occurring in either an inpatient ward or Emergency Department, the investigation report and other relevant documentation are reviewed to ensure potential risk factors are addressed. Where the structural design of the site is identified as a possible contributing factor, the issue is flagged for review by the Chief Psychiatrist through the authorisation process.

Figure 9: Proportion of incidents by location of the attempted suicide

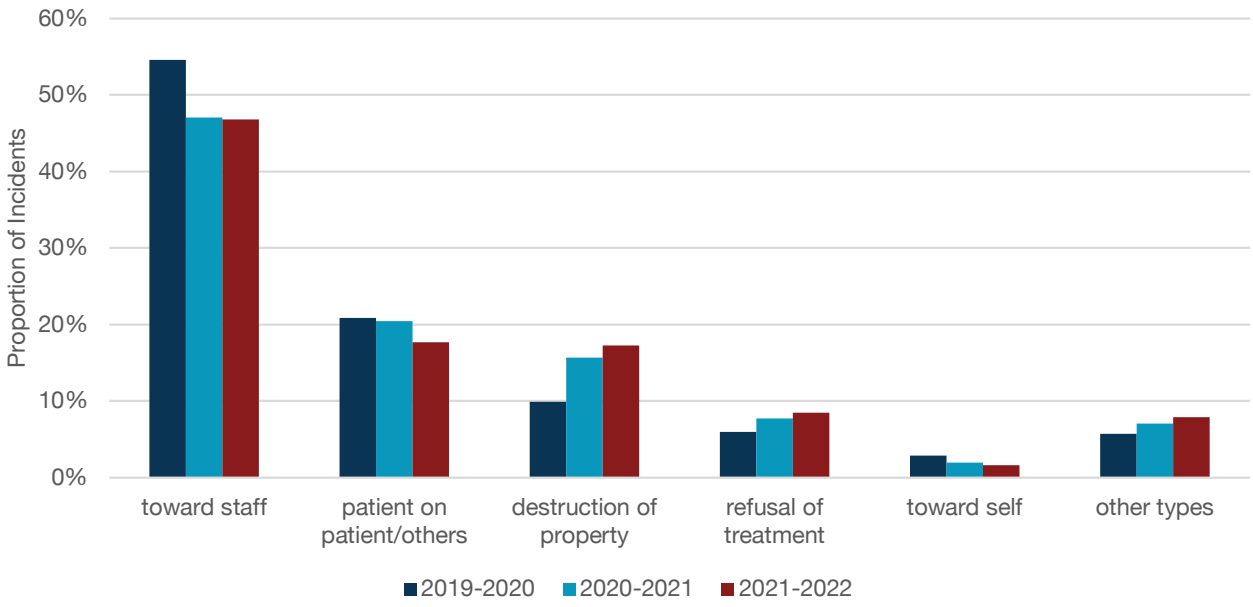


Aggression incidents

There were 2,292 notifications of aggression incidents reported to the Chief Psychiatrist during the 2021-22 financial year, which was similar to the number of events (n=2,308) reported in the 2020-21 financial year. Incidents of aggression may involve more than one type of aggression, such as aggression towards staff and aggression towards another patient in one incident. In addition, some incidents may involve more than one person directly or indirectly.

Around 40% of the 2,292 aggression incidents had more than one type of aggressive behaviour, with a total of 3,201 aggression events reported. The proportion of notifications involving a patient being aggressive towards a staff member (47%) was the same as the previous financial year (Figure 10). There was a small decrease (2%) in the proportion of aggression incidents involving a patient being aggressive towards another patient or other person e.g. visitor (18%). An increasing trend in notifications was noted for aggression incidents involving destruction of property (from 10% in 2019-20 to 17% in 2021-22) and refusal of treatment (from 6% in 2019-20 to 9% in 2021-22) (Figure 10).

Figure 10: Proportion of incidents by aggression behaviour category



During the 2021-22 financial year, over two-thirds (72%) of reported aggression incidents involved an inpatient who was involuntary or referred. The majority (94%) of aggression incidents occurred on inpatient wards and 6% occurred at a community mental health clinic, private psychiatric hostel or ED.

More than half (59%) of the 2,291 aggression incidents involved males and the majority (85%) of aggression incidents involved patients aged 18 years and over (Table 5).

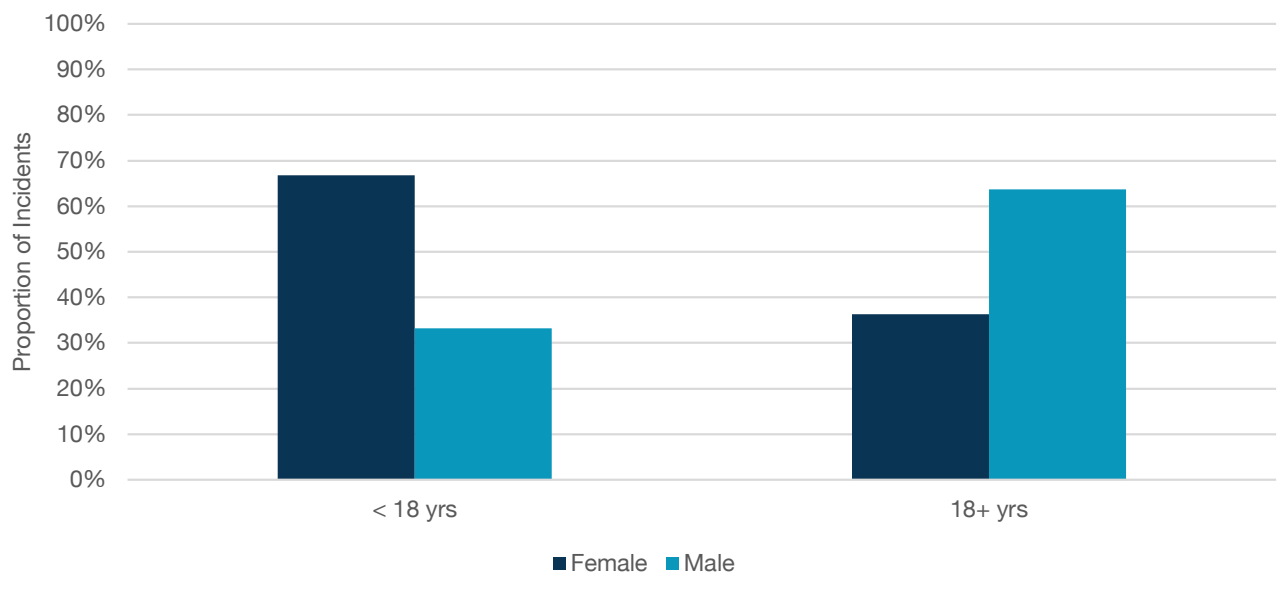
For children and adolescents under 18 years, two-thirds (67%) of aggression incidents involved females whereas for mental health patients aged 18 years and over, close to two-thirds (64%) of aggression incidents involved males (Figure 11).

Table 5: Notifications of aggression incidents by age group and gender

Age (Years)	Female	Male	Total Incidents
Under 18	234	117	**351**
18 and Over	705	1,235	**1,940**
Total Incidents	**939**	**1,352**	**2,291**

One incident was reported where the age was not specified, n=1

Figure 11: Proportion of incidents by aggression by age group and gender

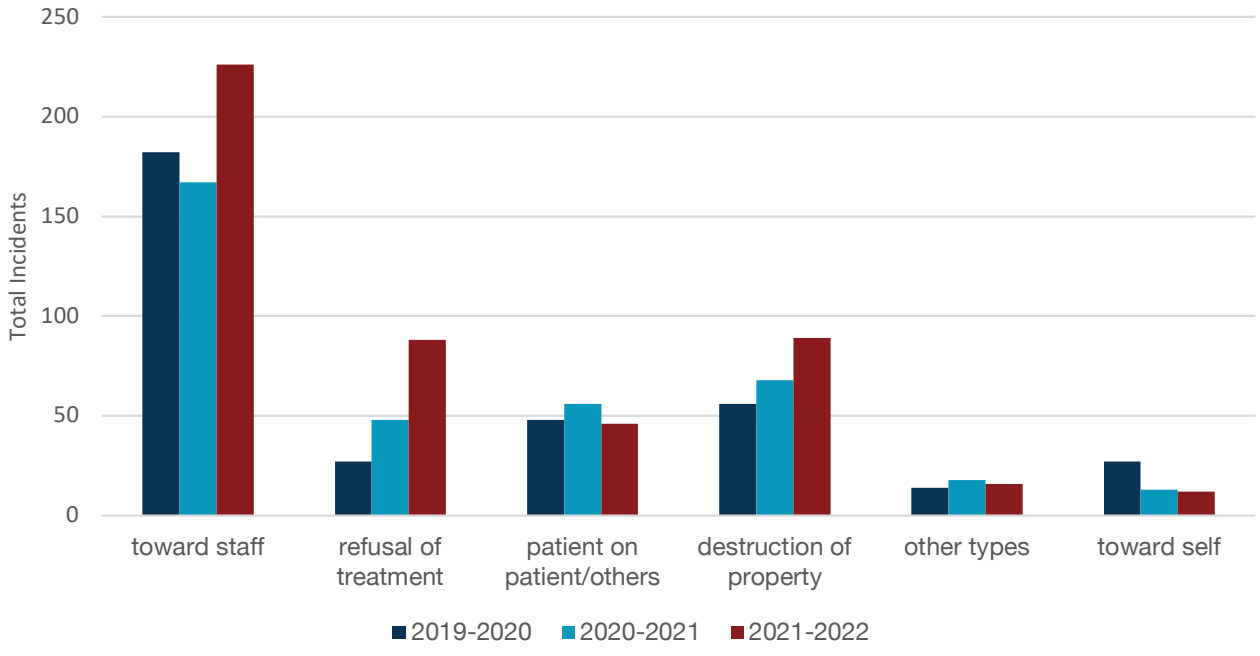


For children and adolescents under 18 years, there were 351 aggression incidents reported to the Chief Psychiatrist for the 2021-22 financial year, which is a 30% increase in notifications compared with the previous financial year. This increase reflects an increase in aggression towards staff, refusal of treatment, and destruction of property (Figure 12). Over the past three financial years, there has been a three-fold increase in refusal of treatment from 27 to 88 notifications and a 59% increase in destruction of property from 56 to 89 notifications.

For children and adolescents under 18 years, half (52%) of the patients had one aggression incident, 26% had two or three incidents, 12% had between four and 10 incidents, and 10% had more than 10 incidents reported in the 2021-22 financial year.

For mental health patients aged 18 years and over, just under two-thirds (62%) of patients had one aggression incident reported, 22% had two or three incidents, 13% had between four and10 incidents, and 3% had greater than 10 incidents reported in the 2021-22 financial year.

Figure 12: Total incidents by aggression behaviour type (under 18 years)



Alleged sexual behaviour incidents

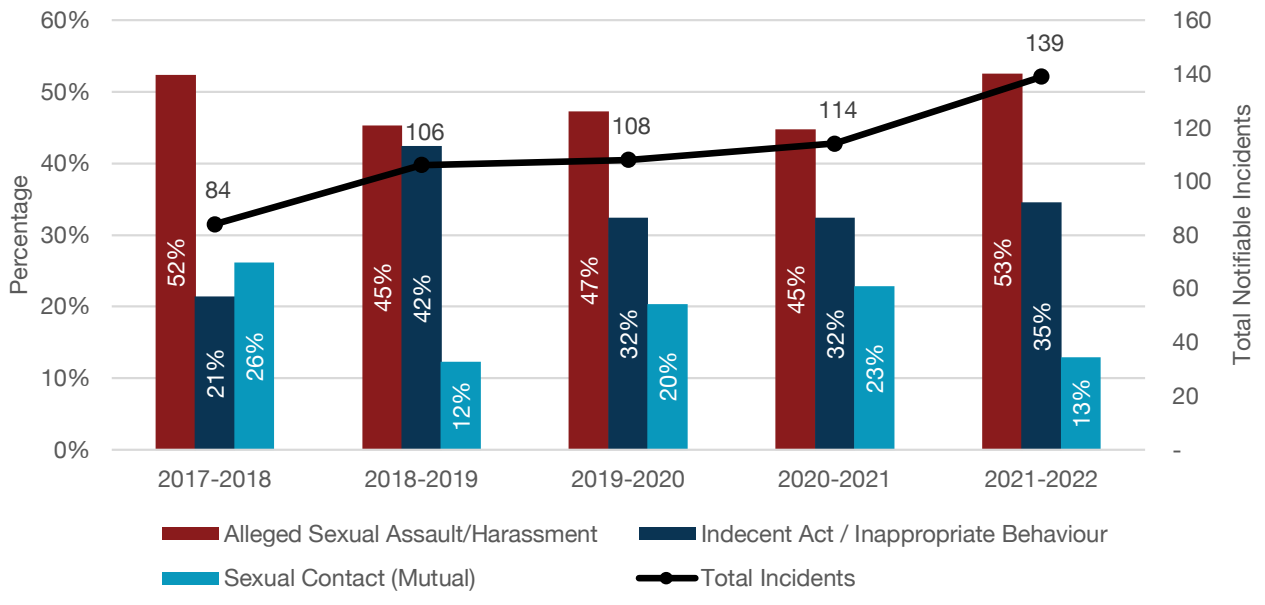
A total of 139 alleged sexual behaviour incidents were notified to the Chief Psychiatrist in the 2021–22 financial year (Figure 13), which was a 22% increase from the previous financial year. Of the total notifiable incidents reported for alleged sexual behaviour in 2021-22, 53% were alleged sexual assault/harassment, 35% were indecent act/inappropriate behaviour and 13% were reported as consensual sexual contact (prohibited in inpatient wards). The majority (88%) of alleged sexual assault/harassment incidents reported occurred in an inpatient setting, 10% occurred at a Private Psychiatric Hostel (Hostel), and less than five[2] occurred at a community mental health clinic or an ED.

Of the alleged sexual behaviour incidents reported in 2021-22, nearly half (47%) reported in the inpatient setting were allegations of sexual assault/harassment, whereas the majority (94%) reported by Hostels were allegations of sexual assault/harassment.

It is important to note that the Chief Psychiatrist's Sexual Safety Guidelines were released in December 2020. It is expected that effective roll-out of the guidelines would lead to an initial increase in reporting of alleged sexual behaviour incidents. The Chief Psychiatrist is seeking for staff to appropriately report sexual behaviours where alleged assault is suspected: hence, we anticipate an increase specifically in reports of alleged sexual assault/harassment.

Of all allegations of sexual assault/harassment incidents that were notified to the Chief Psychiatrist in 2021-22, 81% were substantiated, 14% were determined not to have occurred,

Figure 13: Types of alleged sexual behaviour and trends in total incidents notified to the Chief Psychiatrist



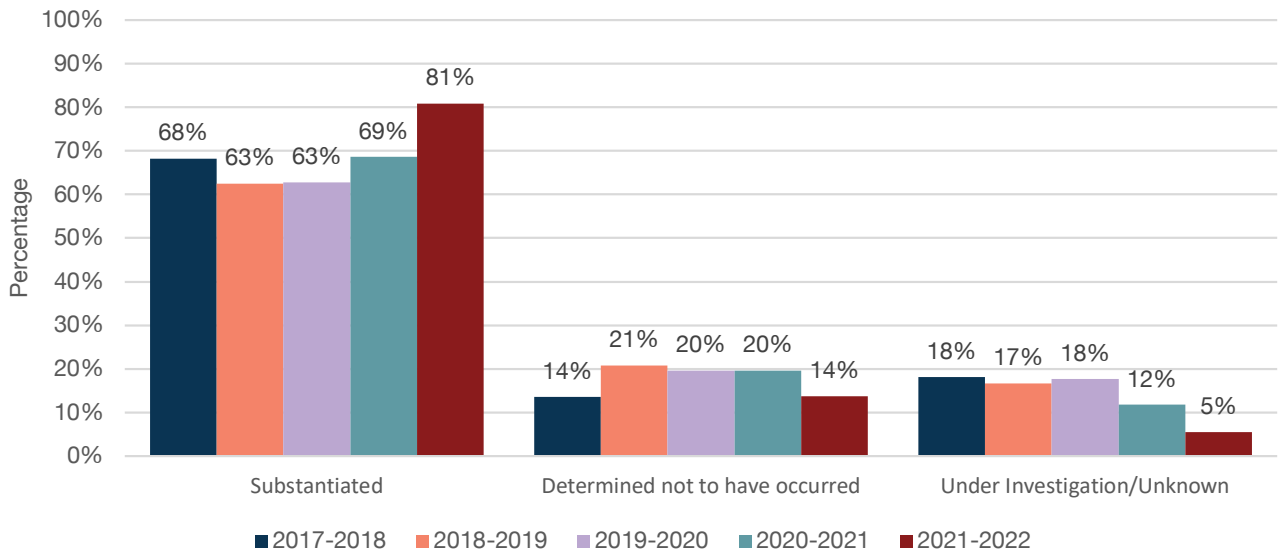
[2] Where less than five patients are involved in an incident, further details cannot be provided to prevent patient identification.

and 5% were still under investigation/outcome unknown as at 1 July 2022 (Figure 14).

The Office of the Chief Psychiatrist has increased its focus on monitoring and investigating alleged sexual behaviour incidents. In 2021-22 over half (53%) of alleged sexual behaviour incidents reported were flagged to the Deputy Chief Psychiatrist for review and where required, these were followed-up by contacting services to obtain further information and offer support to staff in implementing sexual safety measures. When an alleged sexual behaviour incident is reported a copy of the Sexual Safety Guidelines is emailed to the service as a resource to support staff in managing the incident and to ensure continued awareness of the Guidelines.

The increase in alleged sexual behaviour incidents notified to the Chief Psychiatrist since 2020-21 may be related to the improved reporting by services since the publication of *Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services in Western Australia*. Since their release in December 2020, there has been an increase in notifications of alleged sexual behaviour incidents from 108 in 2019-20 to 139 in 2021-22.

Figure 14: Investigation outcome of alleged sexual assault/harassment incidents



Absent Without Leave (AWOL) – involuntary and referred patients

Under section 97 of the MHA 2014, AWOL relates to a person leaving or not returning to a hospital or another place, where the person is being detained under the MHA 2014, without having been granted leave.

There were 304 notifications involving 210 involuntary patients or patients referred for assessment under the MHA 2014 reported as AWOL during the 2021-22 financial year (Table 6). The majority of AWOL patients (76%) had one event; 15% had two events; and 9% of patients had three or more AWOL events reported. The majority of AWOL notifications (94%) involved patients who were involuntary at the time they went AWOL and 6% were patients who had been referred for assessment. Just under two-thirds of AWOL patients were male (61%) and the majority (94%) of AWOL events involved patients that were 18 years of age or older.

In around half (53%) of AWOL notifications, the patients were located on the same day, 29% a day later, and 16% were located two to five days later, with the remaining 3% located between six and 26 days later. Almost all (98%) of AWOL patients had been located by the end of the 2021-22 financial year and less than five[2] patients experienced serious harm while they were AWOL.

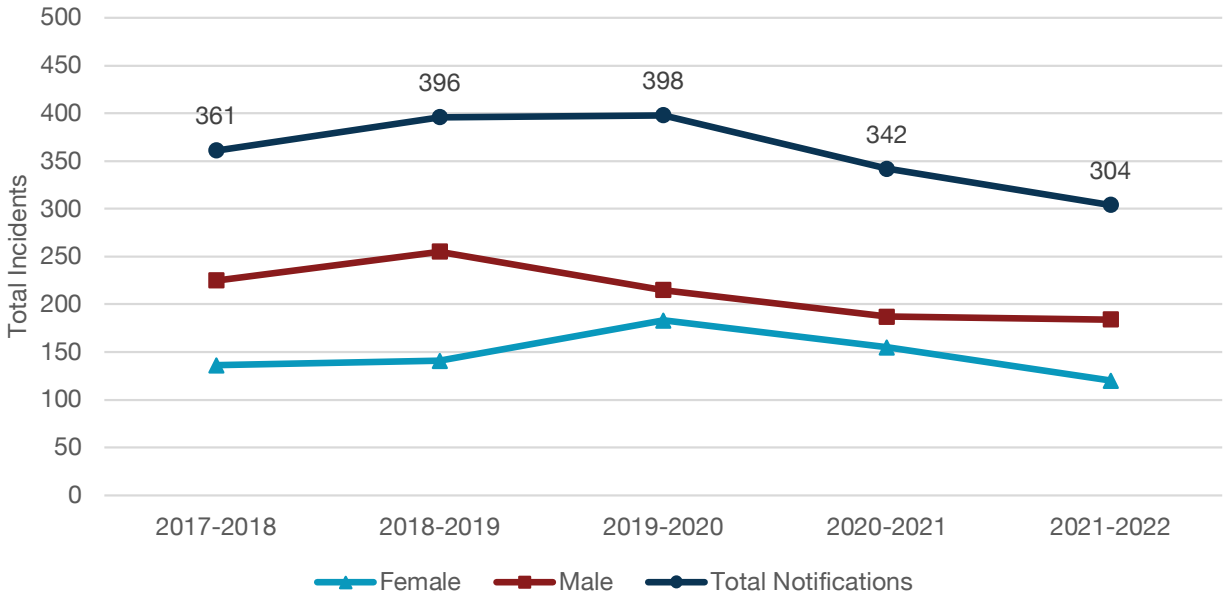
Table 6: Notifications of absent without leave involuntary and referred patients by age group and gender

Age (Years)	Female	Male	Total Incidents
Under 18	12	5	**17**
18 and Over	108	179	**287**
Total Incidents	**120**	**184**	**304**

[2] Where less than five patients are involved in an incident, further details cannot be provided to prevent patient identification.

Notifications for AWOL incidents increased from 2017-18 (n=361) to 2018-19 (n=396) and 2019-20 (n=398) before decreasing by 14% in 2020-21 (n=342) and a further 11% reduction in 2021-22 (n=304) (Figure 15).

Figure 15: Trends for AWOL notifications[3]



Missing persons – voluntary patients at high risk

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

There were 158 notifications of voluntary patients reported as missing from a mental health service, involving 132 individuals, of whom 59% were male and 41% were female (Table 7). The percentages are similar to the percentages for male and female adults 18 years and over. In contrast, for children and adolescents under 18 years, a higher proportion of notifications involved a female (57%) than a male (43%) patient.

The majority of patients (88%) had one missing person notification and 12% had between two and eight events reported. Less than five incident reports resulted in serious harm to patients following the missing person notification.

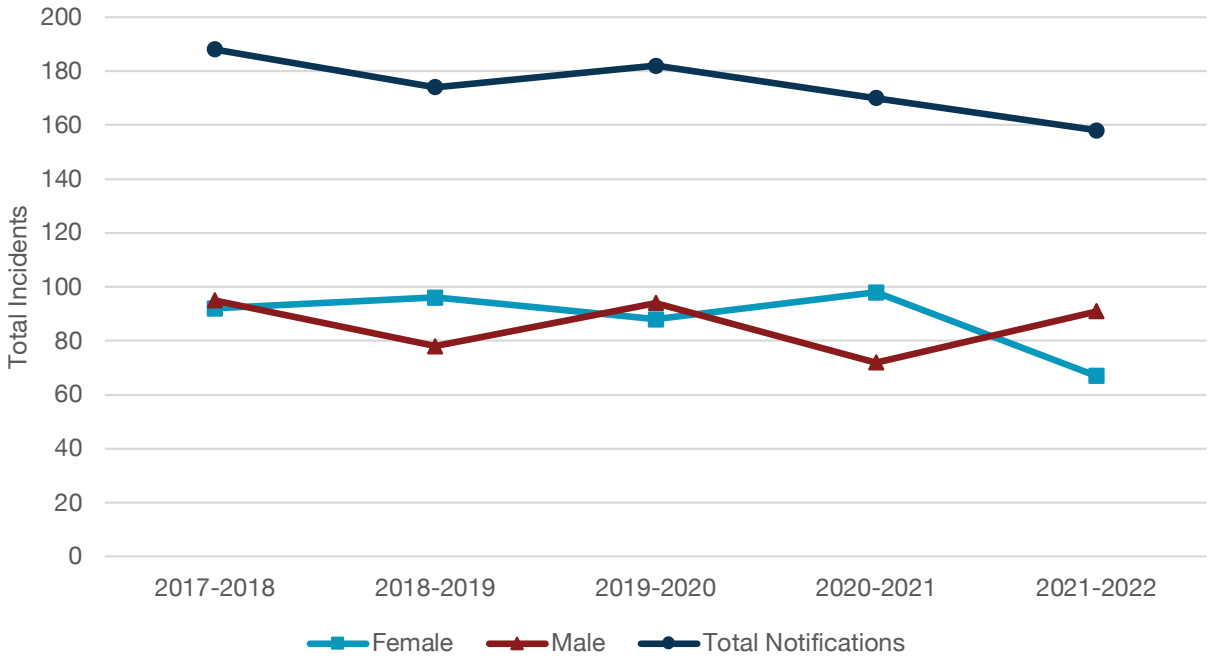
[3] Some data difference in previous financial years due to data validation and late notifications received after the data were published.

Table 7: Notifications of missing person by gender and patient age group

Age (Years)	Female	Male	Total Incidents
Under 18	12	9	**21**
18 and Over	55	82	**137**
Total Incidents	**67**	**91**	**158**

Total notifications for missing persons decreased from 2017-18 (n=188) to 2018-19 (n=174) before increasing slightly in 2019-20 (n=182) and further decreasing in 2020-21 (n=170) and 2021-22 (n=158) (Figure 16). Notifications for female and male patients fluctuated over the last five financial years.

Figure 16: Trends for missing person notifications[3]



[3] Some data difference in previous financial years due to data validation and late notifications received after the data were published.

Serious medication error

A serious medication error is an error in any medication prescribed for, or administered or supplied to, a person where it has, or is likely to have, an adverse effect on the person. Adverse effect means an effect that has led to the need for medical intervention or review or has caused or is likely to cause death.

There were less than five serious medication errors with major adverse effects reported to the Chief Psychiatrist during the 2021-22 financial year, of which all incidents were reviewed by the Deputy Chief Psychiatrist.

Allegations of unreasonable use of force by staff

Allegations of unreasonable use of force by a staff member of a mental health service (including staff of psychiatric hostels) must be reported to the Chief Psychiatrist.

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

For the reporting period, there were less than five allegations of unreasonable use of force on a patient by a staff member of a mental health service reported to the Chief Psychiatrist. Each incident was reviewed and, where required, was flagged to the Chief Psychiatrist and investigated further to ensure an appropriate response was actioned by the service.

Alleged homicides

Less than five notifications of homicide allegedly committed by a person who was a mental health patient were received during the 2021-22 financial year. The number of notifications was similar to the 2020-21 financial year.

Aboriginal patients

Data on Aboriginality are not reliably reported through the reporting system. Information on Aboriginal status is collected in administrative data, but these data are not reliably coded on administrative health and mental health datasets, and as such may be an under-estimation of the number of Aboriginal people accessing mental health services. Administrative data received from the Department of Health showed that of the 8885 people who accessed public and/or public private partnership inpatient mental health services in the 2021 calendar year, 874 (10%) were recorded as Aboriginal.

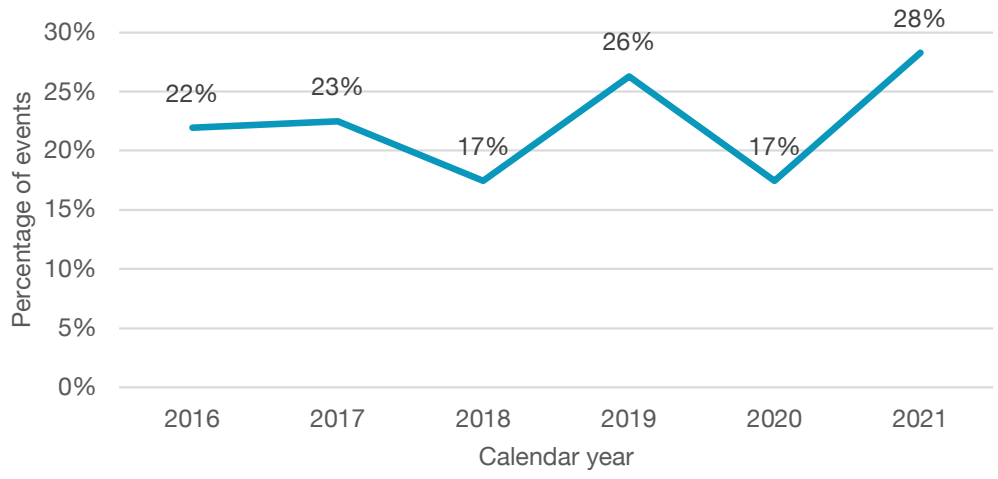
To ensure accurate ascertainment of Aboriginal status, the Information and System Performance Directorate in the Department of Health linked the Chief Psychiatrist's restrictive practices data with its comprehensive flag for Aboriginal status for 2021. It is important to note the over-representation of Aboriginal patients in these figures. This highlights the importance of access to an Aboriginal mental health staff member to support Aboriginal patients and ensure the standards of culturally-safe models of care provided.

Restrictive practices

Use of seclusion

In the calendar year 2021, there were 313 seclusion events involving an Aboriginal patient, equating to 28% of the total 1,106 seclusion events. This is the highest proportion of seclusion events involving an Aboriginal patient since 2016 when the Chief Psychiatrist began collecting these data (Figure 17).

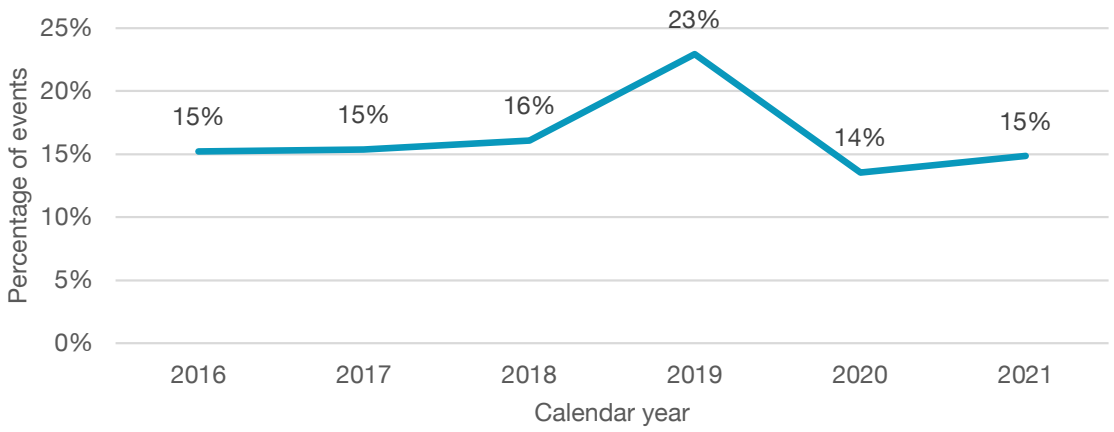
Figure 17: Trends in the percentage of seclusion events involving an Aboriginal patient since 2016



Use of restraint

In the calendar year 2021, there were 143 restraint events involving an Aboriginal patient, equating to 15% of the total 1,108 restraint events. The proportion of restraint events involving an Aboriginal patient has remained relatively stable between 14% and 16%, with the exception of 2019 when the proportion increased to 23% (Figure 18). Of the 446 individuals restrained in the 2021 calendar year, 73 (16%) were Aboriginal.

Figure 18: Trends in the percentage of restraint events involving an Aboriginal patient since 2016



Notifiable incidents

Primary incidents

Of the 3,348 primary notifiable incidents reported for 1,576 patients during the 2021 calendar year, 623 (19%) incidents were reported for 276 (18%) Aboriginal patients. Over half (58%) of the notifications involved a male Aboriginal patient and 87% of notifications involved adults 18 years and over. Of the 623 primary incidents involving an Aboriginal patient the type of incident reported included:

- aggressive behaviour/assault – 73% of notifications
- absent without leave, involuntary/ referred patients – 13% of notifications
- missing, high-risk voluntary patients – 5.5% of notifications
- deaths – 3% of notifications
- attempted suicides – 3.5% of notifications
- alleged sexual behaviour – 2% of notifications.

Secondary incidents

There were 122 secondary notifiable incidents reported for 105 patients for the 2021 calendar year. Of the 122 notifications, 31 (25%) of the notifications were reported for 25 (24%) Aboriginal patients. The most frequently reported secondary incidents were incidents of a sexual nature (52%), aggressive behaviour/assault (29%); and AWOL, attempted suicide and missing person comprised 19% of notifications.

Death notifications

The Chief Psychiatrist received 207 notifications in the 2021 calendar year advising of the death of a mental health patient. Of the 207 death notifications, 20 (10%) related to an Aboriginal patient. Out of the 207 deaths, Aboriginal patients comprised 7% of deaths that were due to natural/medical or unknown causes, and 15% that were due to suspected suicides/ suspected overdose. Out of the 20 Aboriginal patients, 45% of the deaths were due to natural/medical or unknown causes, and 55% were due to a suspected suicide or suspected overdose. All the suspected suicides involving an Aboriginal patient related to adults aged 18 years or older.

Aggression incidents

There were 2315 notifications of incidents relating to aggression, involving 935 patients. Of these, 466 (20%) were reported for 184 (20%) Aboriginal mental health patients. Incidents relating to aggression may involve more than one type of aggressive behaviour. For the 466 incidents involving an Aboriginal patient, there were 663 aggression events reported. Of these, 40% involved aggression towards staff, 14% involved assaults on staff, 10% involved aggression towards other patients, 7% involved assault of another patient, 15% involved aggression towards property, and 5% involved destruction of property. The low numbers of the remaining 9% of aggressive incidents prevents further information being provided.

Alleged sexual behaviour incidents

There were 147 notifications of incidents of alleged sexual behaviours reported for 121 mental health patients. Of the 147 notifications, 29 (20%) were reported for 23 (19%) Aboriginal patients, of which less than 5 were under 18 years of age. Of the 29 notifications, 52% involved a male (as either the perpetrator or victim).

Attempted suicide

The Chief Psychiatrist was notified of 319 attempted suicides involving 262 individuals. Of these, 22 (7%) incidents involved 17 (6%) Aboriginal mental health patients. The majority (71%) of Aboriginal patients were 18 years of age or older, and 86% of the attempted suicides involved a female.

Absent without leave (AWOL)

There were 313 AWOL notifications of an involuntary patient or a patient referred for assessment under the MHA 2014, relating to 220 patients. Of the 313 notifications, 83 (27%) involved 58 (26%) Aboriginal patients, of which 62% were male.

Missing persons

There were 164 notifications relating to 130 voluntary patients reported as missing from a mental health service, with 34 (21%) notifications involving 26 (20%) Aboriginal patients. The majority (62%) of missing Aboriginal patients were male.

Summary and trends over time

All notifiable incidents for Aboriginal patients are outlined in Table 8 and trends in the proportion of notifiable incidents for Aboriginal patients from 2017-2021 are outlined in Table 9.

Table 8: Notifiable incidents reported to the Chief Psychiatrist during the 2021 year – by Aboriginal status*

Type of Incident	All Notifications N	Aboriginal %	All Individuals N	Aboriginal %
Aggression	2,315	20	935	20
Alleged Sexual Behaviour	147	20	121	19
Attempted Suicide	319	7	262	6
AWOL	313	27	220	26
Death	207	10	207	10
Missing Person	164	21	130	20

*Includes both primary and secondary notifiable incidents

Table 9: Trends in the proportion of incidents reported to the Chief Psychiatrist per calendar year from 2017-2021 for Aboriginal patients

Type of Incident*	2017 %	2018 %	2019 %	2020 %	2021 %
Aggressive	66	64	70	65	71
Alleged Sexual Behaviour	2	5	4	2	4.5
Attempted suicide	2	3	3	4	3.5
AWOL	18	15	15	18	13
Death	2	3	3	5	3
Missing Person	9	9	6	7	5
Total	**100**	**100**	**100**	**100**	**100**

*Due to small numbers, some types of incidents are not presented in the table above.

Electroconvulsive therapy

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

The provision of ECT in WA is strictly regulated under sections 194 to 199 of the MHA 2014. The MHA 2014 prohibits ECT being given to children under 14 years of age and requires approval from the Mental Health Tribunal before it can be provided to a patient on an involuntary treatment order; children 14 to 17 years of age; or a person classified as a mentally impaired accused. Where emergency ECT is required to be performed on an adult involuntary patient or a person who is a mentally impaired accused, approval from the Chief Psychiatrist or their delegate must be obtained prior to the ECT being performed. Voluntary patients must provide informed consent prior to receiving ECT.

The Chief Psychiatrist approved emergency ECT on seven occasions during the 2021-22 financial year. All seven were at public hospitals. The Chief Psychiatrist maintains a register of health services that have been approved as meeting the standards to perform ECT. All ECT services were re-authorised in the 2021-22 financial year, and details are provided in the 'Services approved to provide ECT' section.

Mandatory reporting of ECT data to the Chief Psychiatrist

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

For the reporting period 2021–22, there were 789 completed ECT courses involving adults 18 years and above and reported to the Chief Psychiatrist, compared with 783 courses in the 2020-21 financial year (Table 10). There were less than five ECT courses reported for patients under 18 years of age. Of the 789 courses, 725 (92%) were for patients with a voluntary status, 45 (6%) were for involuntary or referred status, and 19 (2%) were for mixed status (both voluntary and involuntary) (Figure 19).

There were 8,434 ECT treatments completed in the 2021-22 financial year, of which 7,017 (83.2%) were acute treatments, 1,397 (16.6%) were maintenance treatments and 20 (0.2%) consisted of emergency treatments (Figure 20).

In the 2021-22 financial year, there were 13 emergency ECT treatments authorised by the Chief Psychiatrist or delegate. Because some of these emergency ECT treatments were part of an ongoing course of ECT that was not

completed in the 2021-22 reporting period, they are not reflected in Table 10. These emergency ECT treatments will be reported in the financial year in which the ECT course is completed. Similarly, Table 10 includes some emergency ECT treatments authorised in the previous financial year.

Table 10: ECT courses and treatments completed in the 2021-22 financial year.

Age	Status	Number of ECT courses completed in 2021-22	ECT treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment\	Total
All patients[a]	Voluntary	725	6,055	1,144	0	7,199
	Involuntary / Referred[b]	45	634	31	10	675
	Mixed[c]	19	328	222	10	560
	Total	**789**	**7,017**	**1,397**	**20**	**8,434**

[a] patients under 18 not reported separately due to small number;
[b] Mentally Impaired Accused are included in this category;
[c] Patients who had both an involuntary and a voluntary status in the same course.
Source: Office of the Chief Psychiatrist Database

Both the number of completed ECT courses, and the number of completed ECT treatments have increased over the last three years, with the biggest increase between the 2019-20 and 2020-21 financial years.

Figure 19: Total ECT courses by status

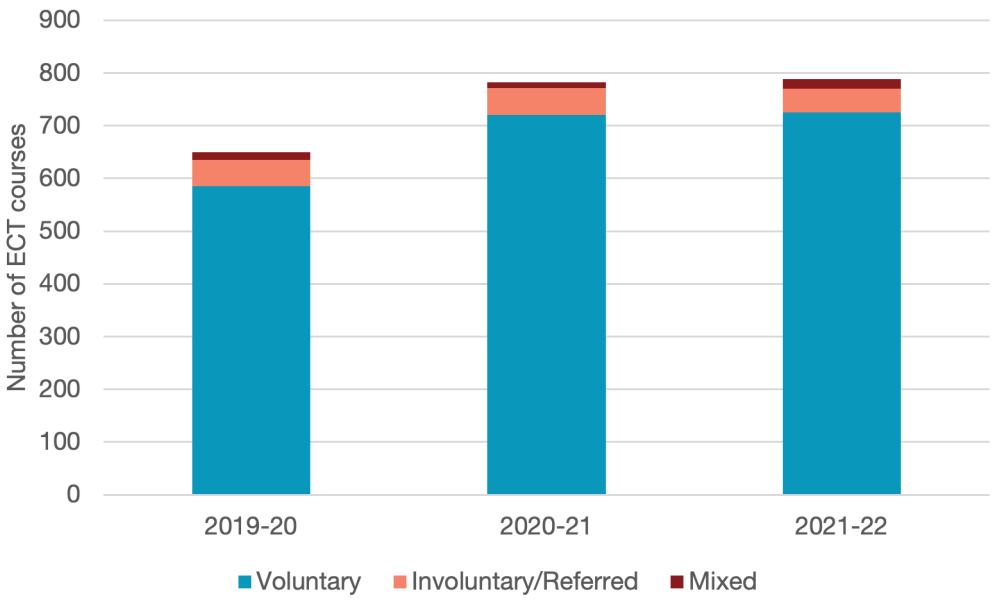
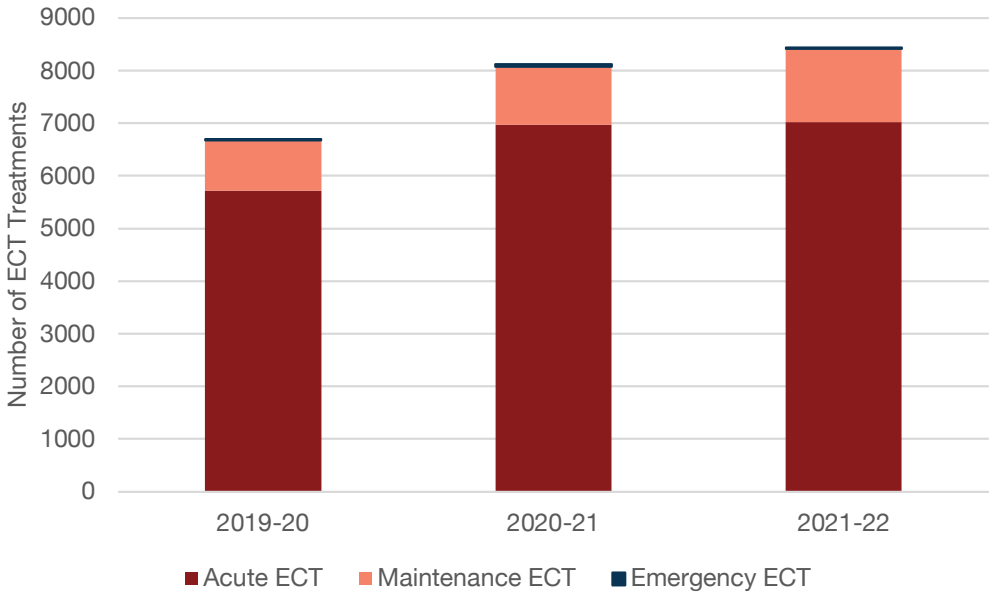


Figure 20: Type of ECT treatment by year



The majority of all ECT courses (62%) were provided in a private hospital, 29% were provided in a public hospital and 9% were provided in a publicly contracted private hospital.

Serious adverse events

Under the MHA 2014, a serious adverse event in relation to ECT means premature consciousness during a treatment; anaesthetic complications (for example, cardiac arrhythmia) during recovery from a treatment; an acute and persistent confused state during recovery from a treatment; muscle tears or vertebral column damage; severe and persistent headaches; persistent memory deficit.

The majority (89%) of the 789 ECT courses of ECT reported during 2021-22 did not have any serious adverse events reported. An adverse event during one or more treatments was reported for 11% (n=91) of these courses. This is a small decrease from 13% (n=103) of 783 ECT courses in 2020-21.

Involuntary treatment orders in a general hospital

Under section 61(2)(b) of the MHA 2014, the Chief Psychiatrist (or delegate) must provide consent for a patient to be detained on an involuntary treatment order in a general hospital setting. The treating psychiatrist must report to the Chief Psychiatrist at the end of each consecutive seven-day period for the duration of the order.

The Chief Psychiatrist authorised 254 involuntary treatment orders in a general hospital setting during the 2021-22 financial year.

Of the 254 orders, 48% (121) were for patients in a general hospital for seven days or less, 27% (69) were in general hospital for between eight to 14 days and 25% (64) were in a general hospital for more than 14 days. A small number of patients (35) were admitted to a general hospital on more than one occasion.

If a patient stays more than seven days in a general hospital, the mental health clinicians must submit a report to the Chief Psychiatrist using the 6B attachment form. For inpatient treatment orders that were valid for more than seven days, the Chief Psychiatrist received 44% of the required 6B attachment forms. When these are overdue, OCP 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 and improves the overall validity of the notification of orders.

Emergency psychiatric treatment

Under section 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 EPT provided. 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 205 cases of EPT reported to the Chief Psychiatrist, of which 58% were female and 42% male patients. The majority of notifications were from metropolitan hospitals (83%), with 17% from the WA Country Health Services. Of the patients who received EPT, 43% were adults aged between 25 and 64 years, 13% were 18-24 years, 38% were under 18 years of age and 6% were 65 years or older.

The types of EPT provided to the patients included medication alone (29%), or medication in conjunction with the patient being secluded and/or restrained (71%). Compared with the 2020-21 financial year, less EPT involving seclusion and restraint was reported this financial year. The method of administration of EPT was also reported; 76% of EPT was administered via intra-muscular injection, 12% was administered orally and the other methods reported were sublingual, intravenous, other or not specified (12%). The most commonly reported medications were Olanzapine (24%), Midazolam (23%), Droperidol (19%), Clonazepam (11%), Lorazepam (9%), and Haloperidol (4%), which together account for 91% of all administered medications.

Urgent non-psychiatric treatment

Under section 242 of the MHA 2014, the person in charge of an authorised hospital must report to the Chief Psychiatrist using an approved form if urgent non-psychiatric treatment is provided to a patient who is:

- *an involuntary patient who is under an inpatient treatment order*
- *a mentally impaired accused required under the Criminal Law (Mentally Impaired Accused) Act to be detained at an authorised hospital.*

Urgent treatment means treatment urgently needed by a patient to:

- *save the patient's life*
- *prevent serious damage to the patient's health*
- *prevent the patient from suffering or continuing to suffer significant pain or distress.*

This financial year, there were less than five episodes of urgent non-psychiatric treatment reported. The small number of notifications prevents further examination of these data.

Admission of a child to an adult mental health unit

Under section 303 of the MHA 2014, a mental health service that does not generally admit children needs to be satisfied prior to admitting a child that:

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

Under the MHA 2014, the person in charge of the mental health service must report to the Chief Psychiatrist why he/she is satisfied that the above criteria have been satisfied.

Whenever a child under 18 years of age is admitted to any mental health service where adults are also admitted, a section 303 report must be completed at the time of admission. This includes when a child is admitted to a youth inpatient mental health service, which admits young people aged 16 to 24 years, and Mental Health Observation Areas. The Chief Psychiatrist and the parent or guardian must receive this report. It must also be filed in the medical record.

The Chief Psychiatrist received 259 notifications of a child under 18 years of age being admitted to an adult mental health service in the 2021-22 financial year compared with 363 notifications in the 2020-21 financial year. Of the 259 notifications received, 187 (72%) of these were for females, and 72 (28%) were for males. Validation of admission data from WA Health identified gaps in reporting from some services in the second half of the financial year, accounting for the apparent decrease. This is being addressed with the services.

In April 2020 the Chief Psychiatrist collaborated with the Mental Health Commission to consult with public and private mental health services with the aim of ensuring awareness of the requirement to report under section 303 and to increase reporting compliance. However, reporting compliance remains low. To address the under-reporting, a monitoring project will be implemented in the 2022-23 financial year to review the section 303 forms received against admission data for youths aged less than 18 years. OCP staff will identify services that have poor reporting compliance and assist them to improve reporting in order to ensure the safety of children and youth admitted to adult mental health services.

Off label prescribing to a child who is involuntary

Under section 304 of the MHA 2014, off-label treatment pertains to the provision of registered therapeutic goods to a child who is an involuntary patient for purposes other than those included in the approved product information. The use of off-label treatments for 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.

In the public mental health service sector, off-label treatments are rarely used. For the reporting period, there were less than five notifications of children who were involuntary patients receiving off-label treatments, which is less than the number of notifications received in the previous financial year. The small number of notifications prevents further examination of these data.

Other activities of the OCP

Other activities of the OCP

Statewide committees

Mental Health Act Statutory Review Steering Group

Criminal Law (Mental Impairment) Reform Inter-agency Implementation Steering Committee

Criminal Law Mentally Impaired Bill Working Group for Mental Health Agencies

DoH Coronial Review Committee

DoH Mental Health Workforce Planning Project – Program Control Group

DoH COVID-19 Mental Health Working Group

DoH Quality Surveillance Group - Mental Health

DoH Mental Health Patient Transport Steering Group

Mental Health Workforce Project Plan - Program Control Group

Mental Health Network Governance & Strategic Alignment Steering Committee

Mental Health Network Executive Advisory Group

WA Therapeutic Advisory Group

WA Psychotropic Medication Group

WA RANZCP Branch Committee

Stimulant Assessment Panel

High Risk Serious Offenders Board

Mental Health Statutory Review Group

Statutory Systems Change Project

Private Hostels Agency Committee (PHAC)

COVID-19 Coordination Centre (Psychiatric Hostels)

Accountability Agencies Senior Officers Group

Geraldton Health Campus Redevelopment User Schematic Design User Group

Fremantle Hospital V Block Mental Health Unit Redevelopment, Project Briefing and Schematic Design

Royal Perth Hospital Dabakarn Mental Health Unit, Schematic Design Development Group

WACHS Acute Psychiatric Unit Redevelopment, Program Control Group

National activities

Chief Psychiatrist's Peer Review

RANZCP Education Committee

RANZCP Committee for Exams

National Safety & Quality Community Mental Health Service Standards Advisory Group

Gayaa Dhuwi (Proud Spirit) Declaration Government Expert Advisory Group

National Mutual Recognition Interjurisdictional Project Steering Committee

OPCAT Community of Practice Meeting

RANZCP Accreditation Committee

RANZCP Corporate Governance Committee

RANZCP Membership Engagement Committee

RANZCP Committee for International Medical Graduate Education

RANZCP Overseas Trained Psychiatrists Committee

RANZCP Gender Equity Steering Group

OCP contribution to consultations

National Safety and Quality Mental Health Standards for Acute and Community Mental Health Services and Mental Health Guide

National Safety and Quality Mental Health Standards for Community Mental Managed Organisations

National Principles for Forensic Mental Health

National digital MH standards

MHC Community Roadmap

Youth mental health initiatives

Emergency Departments (DOH project consultation)

Victoria's *Mental Health and Wellbeing Act*: update and engagement paper

Mental Health Commission's statutory review of the *Mental Health Act 2014*

Western Australia's Parliamentary Commissioner Amendment (Reportable Conduct) Bill 2021

Statutory review of Part 9E of the *Guardianship and Administration Act 1990 (WA)*

DoH review of the *Private Hospitals and Health Services Act 1927* and the Private Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997

Good Care for Mental Health Consumers in Emergency Departments' Workshop

Focus group to inform design and delivery of three new youth community support and accommodation services. On behalf of the MHC, the consultation process was supported by Nous Group and the Youth Affairs Council of WA (YACWA).

Other visits/external engagement

Bindi Bindi Mental Health Unit, Bandyup Prison

Reviewer: Office of the Inspector of Custodial Services review of Hakea Prison

Mental Health Alcohol and Other Drugs Forum: Building Momentum Together

Royal Perth Hospital ED Consultant Salon

Expert Advisory Group membership: Ministerial Taskforce on Infant, Child and Adolescent Mental Health

RAP (Reconciliation Action Plan) Ready: Reconciliation WA

RANZCP WA Branch: Smoking Ceremony and Opening Ceremony for new premises

Appendix

Appendix

Statutory framework and role of the Chief Psychiatrist

The Chief Psychiatrist is an independent statutory officer with responsibility for overseeing the standards of treatment and care provided by mental health services across WA. The Chief Psychiatrist is not a part of the Mental Health Commission or the Department of Health.

The Chief Psychiatrist reports to State Parliament through the Minister for Mental Health and provides advice to the Minister about the provision of mental health services for the State.

The Chief Psychiatrist's role is a key component of the clinical governance system that ensures that the people of WA are provided with safe, high quality mental health treatment and care. The Chief Psychiatrist has both a regulatory and quality-improvement role.

The Chief Psychiatrist's functions and powers are prescribed by the MHA 2014. They are outlined in the following sections:

Oversight of the treatment and care provided to all patients of mental health services (section 515 MHA 2014)

The Chief Psychiatrist is responsible for overseeing the treatment and care of all patients of mental health services, namely all voluntary patients; involuntary patients; patients referred under the MHA 2014 for examination by a psychiatrist; and all mentally impaired accused patients detained in an authorised hospital. This includes oversight of the mental health treatment and care provided by public and private hospitals; community mental health services; private psychiatric hostels; and non-government organisations (NGOs) providing clinical services.

Currently the Chief Psychiatrist oversees the treatment and care provided by 58 public mental health inpatient units; three publicly contracted private providers of mental health services; seven private psychiatric hospitals; 32 private psychiatric hostels; 16 NGOs providing clinical mental health care; six Step Up/Step Down mental health facilities; and 41 alcohol and drug treatment services. This amounts to overseeing the treatment and care of approximately 77,000 patients each year.

Setting standards for treatment and care (sections 515(2) and 547–549 MHA 2014)

The Chief Psychiatrist must discharge his/her responsibility for overseeing the treatment and care provided by mental health services by publishing standards.

The Chief Psychiatrist has mandated the National Standards for Mental Health Services 2010 and has developed the *Chief Psychiatrist's Standards for Clinical Care*, which comprises eight additional standards that address particular issues of relevance to WA or issues requiring additional attention. *The Chief Psychiatrist's Standards for Clinical Care* relate to:

- Aboriginal Practice
- Assessment
- Care Planning
- Consumer and Carer Involvement in Individual Care
- Physical Health Care of Mental Health Consumers
- Risk Assessment and Management
- Seclusion and Bodily Restraint Reduction
- Transfer of Care.

Overseeing compliance with standards of mental health treatment and care (sections 515(2)(b) and 520-523 MHA 2014)

The Chief Psychiatrist must oversee compliance with any standards published, applied, adopted or incorporated. The Chief Psychiatrist does this by conducting clinical reviews of mental health services. This includes audits of case notes and extensive interviews with, and surveys of staff, consumers, carers and other stakeholders. The reviews often generate recommendations on which services must take action and report to the Chief Psychiatrist. Where there is an area of particular concern, the Chief Psychiatrist may conduct a targeted review. Other ways the Chief Psychiatrist monitors standards include monitoring notifiable incidents, authorisations, approvals and carrying out informal visits to services.

Receiving and reviewing notifiable incidents (sections 526-530 MHA 2014)

Under section 525 of the MHA 2014, services must notify the Chief Psychiatrist of any notifiable incident that occurs in the course of providing mental health care to a patient. Notifiable incidents prescribed in the MHA 2014 include the death of a person; an error in medication; unlawful sexual contact; unreasonable use of

force; and any other incident that has or is likely to have an adverse effect on a person receiving treatment or care. The Chief Psychiatrist may investigate any of these incidents. Details of notifiable incidents reported to the Chief Psychiatrist are provided throughout this report.

The Chief Psychiatrist scrutinises notifiable incidents to identify issues around standards of care; and works with services to ensure they learn from incidents to improve the standard and quality of care provided by them.

Monitoring the use of restrictive practices in mental health services in WA (Part 14 Divisions 5 and 6 MHA 2014)

All incidents of seclusion and restraint are reported to the Chief Psychiatrist. The Chief Psychiatrist then publishes, on a quarterly basis, service-level data relating to these incidents as part of a multi-pronged approach to reducing restrictive practices.

Where there are high numbers of restrictive practices, or where individual patients are being secluded or restrained multiple times or for prolonged periods, the Chief Psychiatrist and his/her staff liaise with the service to ensure it is working on strategies to minimise the use of these practices whilst maintaining the safety of all patients and staff.

Authorising, training, and keeping a register of authorised mental health practitioners (sections 539 and 540 MHA 2014 and Regulation 17 *Mental Health Regulations 2015*)

The Chief Psychiatrist places a high value on the role and functions of authorised mental health practitioners (AMHPs).

The Chief Psychiatrist designates a mental health practitioner, who satisfies the relevant criteria, as an AMHP by order published in the Western Australian *Government Gazette*.

The Office of the Chief Psychiatrist trains mental health practitioners to carry out the functions of an AMHP under the MHA 2014, to ensure their practice is at a reasonable standard before they can be designated as an AMHP. The Office provides refresher training; ensures the AMHPs engage in professional development; and provides clinical supervision to them on an annual basis to help them maintain their skills.

The Chief Psychiatrist keeps a register of AMHPs, which is published on the Chief Psychiatrist's website.

Authorising public hospitals to receive and admit involuntary patients (section 542 MHA 2014)

The Chief Psychiatrist is responsible for recommending to the Governor of Western Australia, the authorisation of a public hospital, or part of a public hospital, to receive and admit involuntary patients under the MHA 2014. The Chief Psychiatrist has developed standards that all new units within a public hospital must meet for the purpose of authorisation and has embarked on reviewing the authorisation of existing units: *the Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014 (2019)*. There are currently 19 authorised units (across 16 health campuses) and another four in development that will be seeking authorisation in the future. The Chief Psychiatrist encourages health service providers that are planning a new unit to liaise closely with the Office at an early stage of planning to ensure the unit will meet the authorisation standards. Upon acceptance of the Chief Psychiatrist's recommendation, the Governor authorises the unit by order published in the *Government Gazette*.

The Chief Psychiatrist maintains a register of all authorised mental health inpatient facilities, which is published on the Chief Psychiatrist's website.

Approving mental health services at which electroconvulsive therapy can be performed (section 544 MHA 2014)

Electroconvulsive therapy (ECT) can only be performed at a mental health service that has been approved for that purpose by the Chief Psychiatrist. Currently 11 services are approved.

The Chief Psychiatrist has developed standards for the administration of ECT: the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy 2015*. The Chief Psychiatrist has published guidelines for ECT: *The ECT Guide: The Chief Psychiatrist's Guidelines for the Use of ECT in WA 2006* (these are currently being updated). Services approved for the performance of ECT are re-approved on a tri-annual basis to ensure they meet the Chief Psychiatrist's Standards.

Publishing guidelines (section 547 MHA 2014)

The Chief Psychiatrist must publish guidelines on the following:

a. making decisions about whether a person is in need of an inpatient treatment order or a community treatment order;

b. making decisions under section 26(3)(a) of the MHA 2014 about whether a place that is not an authorised hospital is an appropriate place to conduct an examination;

c. ensuring as far as practicable the independence of psychiatrists from whom further opinions referred to in sections 121(5) and 182(2) of the MHA 2014 are obtained;

d. making decisions under section 183(2) of the MHA 2014 about whether to comply with requests for additional opinions made under section 182 of the MHA 2014;

e. the preparation, review and revision of treatment, support and discharge plans;

f. the performance of ECT;

g. compliance with approved forms;

h. ensuring compliance with the MHA 2014 by mental health services.

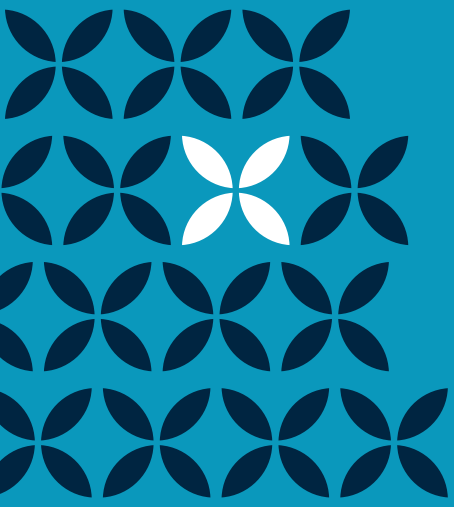
The Chief Psychiatrist may publish other guidelines relating to the treatment and care of persons who have a mental illness.

Other approvals

The Chief Psychiatrist must approve the following prior to them being carried out:

- The administration of emergency ECT to an involuntary patient (section 199 MHA 2014).
- Involuntary detention in a general hospital (section 61(1)(a) MHA 2014).
- Changing the supervising psychiatrist of an involuntary patient on a community treatment order (section 135 MHA 2014).

The Chief Psychiatrist also approves and publishes forms under the MHA 2014 (sections 545 and 546 MHA 2014).



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