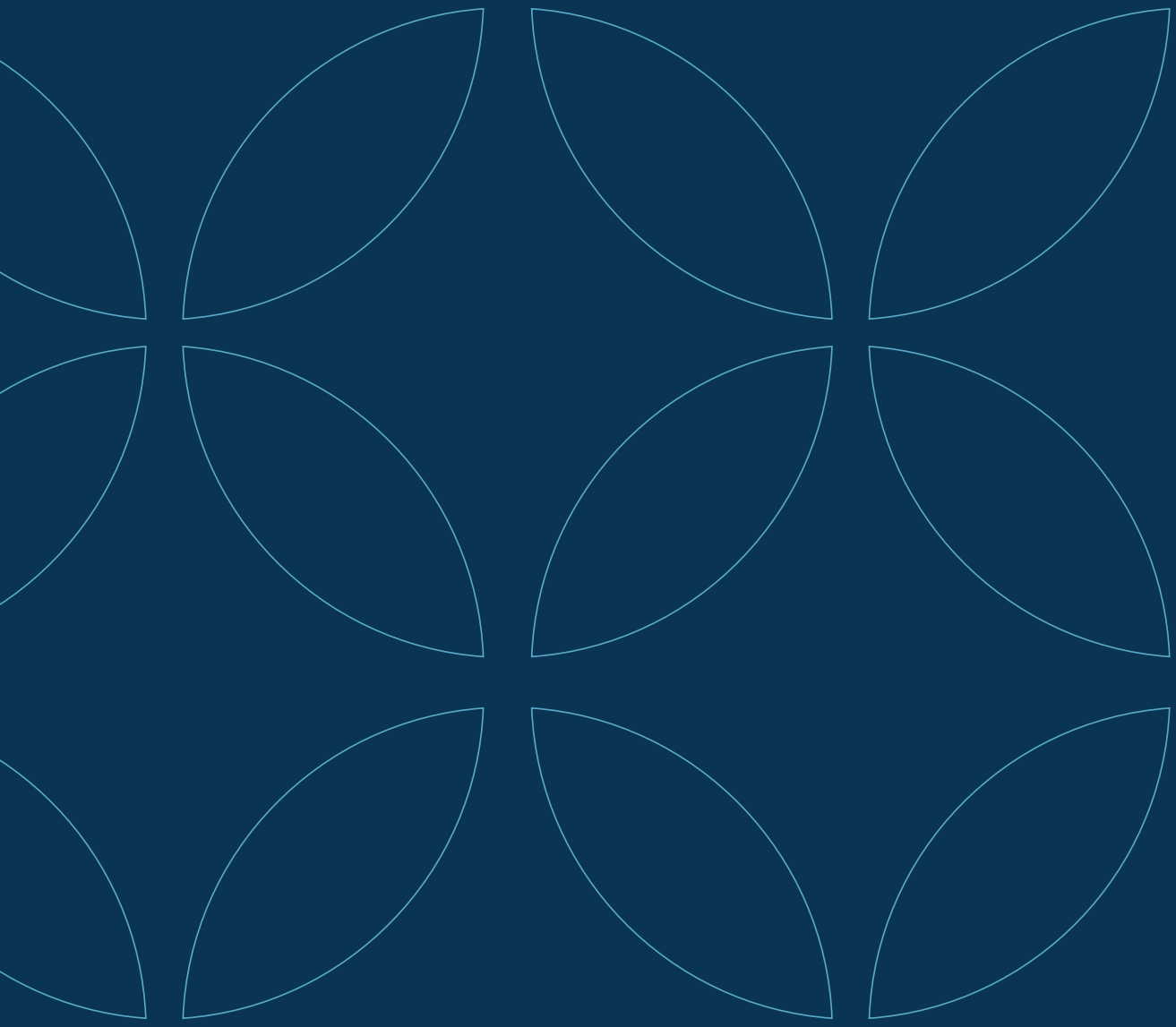
GOVERNMENT OF
WESTERN AUSTRALIA

Chief Psychiatrist
of Western Australia

ENSURING SAFE AND HIGH-QUALITY MENTAL HEALTH CARE

Annual Report of the Chief Psychiatrist of Western Australia

1 JULY 2022 – 30 JUNE 2023



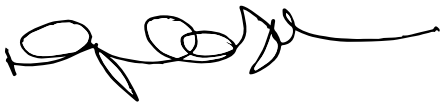
Produced by the Office of the Chief Psychiatrist, Western Australia

Statement of compliance

Hon Amber-Jade Sanderson MLA

Minister for Health; 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 2023.



Dr Nathan Gibson

Chief Psychiatrist

15 September 2023

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 2023 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

15 September 2023

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 *Work Health and Safety Act 2020*. All new staff to the Office were provided with a comprehensive induction and orientation and one member of staff was the nominated Work Health and Safety Representative.

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 of the Chief Psychiatrist sits – **nidja Wadjuk Noongar boodja noonook 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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Kaatadjiny Walbraaniny Danjoo

Learning to heal together

From the Chief Psychiatrist

Kaatadjiny walbraaniny danjoo is the Noongar phrase for learning to heal together. The gaps in mental health standards of care, and social and emotional wellbeing for Aboriginal peoples are a critical challenge for WA mental health services and the whole of government. We can only truly reduce these gaps by authentic engagement with Aboriginal Elders, young people and the community. Mental health services, clinicians and carers that can authentically engage, and work effectively and respectfully with and for, Aboriginal peoples will automatically and consequently be providing excellent mental health care for all consumers and carers across WA. It's not one or the other. The core values and the shared value of relational engagement are consistent.

The current focus on a more effective governance framework for WA mental health services is very welcome, with the aim to improve access and standards of treatment and care. State planning priorities that are based on rigorous analysis of future need, that are achievable, and that are founded on contemporary and evidence-based practice, are central to high quality standards of care. The implementation processes around both the Infant, Child and Adolescent Taskforce and the Graylands Reconfiguration and Forensic Taskforce will see better services and better outcomes for disadvantaged groups in our community.

Mental health is a complex and complicated system and there is no easy or perfect solution. We are taking steps to ensure contemporary models of care are clarified within services. My key messages this year return to the crux of quality care. What has been increasingly important, remains important. We need strong and explicit clinical and lived experience leadership at service and system levels – with time to lead.

The vital skill in mental health is the ability to communicate and engage - this is not a "soft" skill, but the hard, technical, evidence-based skill in mental health. This changes outcomes. This must be remembered in every environment where mental health assessment, treatment and care is happening. Across all parts of WA we need explicit, ongoing support for our excellent clinicians and staff who are involved in providing treatment and care to individuals and families suffering from the impacts of mental illness. They must be enabled to develop and be mentored to maintain compassion and continue to build their skills. This has a high impact effect on improving standards.

I unreservedly thank my staff, the staff of the Office of the Chief Psychiatrist, who remain dedicated, highly skilled and focussed on effective accountability. They make a difference.

Dr Nathan Gibson

Chief Psychiatrist

Executive summary

Executive summary

The Office of the Chief Psychiatrist has continued to strive for mental health care to the highest standard for the people of Western Australia.

The 2022-23 reporting year has been challenging for the sector, with most mental health services identifying workforce shortages as their most acute and pressing problem. This is a national and international issue for health care, as services, states, territories and countries compete for skilled clinical staff. The impact of this shortage on access to mental health care across both private and public sectors is affecting the community, and is widely felt.

Throughout the year, the Office of the Chief Psychiatrist (OCP) staff continued to train all of Western Australia's Authorised Mental Health Practitioners, and contributed to a number of local and national workforce consultations and plans. We advocated for, and supported, the extension of psychiatry training in the state, to allow rural WA to 'grow its own' psychiatrists to serve the community. The Chief Psychiatrist was pleased to see the Royal Australian and New Zealand College of Psychiatrists (RANZCP) develop the WA Rural Psychiatry Training Program, with the inaugural cohort starting in 2023 – this will enhance the future rural workforce.

Additionally, in response to requests from Health Service Providers to assist with significant shortages in the psychiatry workforce, the first cohort of 14 Prescribed Medical Practitioners (PMPs) had their names added to the *Mental Health Regulations 2015* in June 2023, following the development of a new Standard under the *Mental Health Act 2014* (MHA 2014) to allow suitable senior, experienced medical practitioners to carry out additional functions under the MHA 2014. This new process was subject to broad consultation, and involves a rigorous selection process and completion of a training program. We welcome our new PMPs, who have significant training and expertise in the use of the MHA 2014, and will help services ensure that consumers have timely access to psychiatrists. The OCP continues to credential this group, maintain standards and support their work through regular peer supervision. A second program will be rolled out for a new cohort in August 2023.

Also this year, the OCP made up for lost time by expediting a series of important reviews and visits to services that were postponed during the previous year due to COVID-19. Using revised methodology, the team has now completed reviews of the majority of the state's psychiatric hostels, which provide accommodation and supports for some of our most vulnerable consumers. This important piece of work will be completed by September 2023, and has identified several common themes and issues, to be summarised in an overall report, which will be available by the end of 2023. Throughout this reporting period, the Chief Psychiatrist continued to undertake regular targeted assessments and reviews where concerns were raised about standards of care. For example, a targeted review of s. 303 of the MHA 2014, which relates to children who are admitted to inpatient units where adults are also admitted, has been completed. The OCP continues to track the progress of the implementation of recommendations made from these reviews. Our program to review the authorisation of WA's inpatient mental health units has progressed this year, and we have carried out a number of formal and informal visits to services, including without notice visits.

One of our proudest achievements this year was commencing a journey to embed cultural safety within the work of the OCP to improve the standards of mental health care experienced by Aboriginal people in Western Australia. This project is called Kaatadjiny Walbraaniny Danjoo – Learning to Heal Together.

We are so grateful for the generosity of the wise Noongar Elders and young people who have agreed to partner with us and guide us as we walk this path together. We are committed to meaningful, long-term change.

Another focus for the OCP has been MHA 2014 compliance. Concerns about omissions in some of the MHA 2014 reporting to the Chief Psychiatrist under s.303, as well as other areas of potential non-compliance identified through our oversight activities, led to engagement with the Director General of Health, CEOs of the Health Service Providers, other accountability agencies, consumers, carers, clinicians and Aboriginal representatives to determine how best to improve compliance. This resulted in the commencement of a project to improve MHA 2014 proficiency and reduce errors, which will continue into next year.

The Chief Psychiatrist's Community of Practice went from strength to strength this year, with around 200 participants attending a session on medico-legal aspects of duty of care and restraint in mental health and emergency. We continue to feature a wide range of themes, with valuable engagement from presenters and participants.

Restrictive practices and the use of detention and restraint in non-authorised settings, such as emergency departments, have remained a focus. The OCP partnered with the Department of Health's Mental Health Unit to host a well-attended forum on working towards elimination of restrictive practice, in February 2023. We are now engaged in the development of a Statement of Intent on the elimination of restrictive practices for Western Australia, and further strategic work. Following the judicial outcome of a case concerning one of Western Australia's tertiary hospitals, the Chief Psychiatrist committed to developing a guideline and training content to support clinicians working in non-authorised settings to manage legal and clinical frameworks for the care of people who present with disturbed behaviour or who are at high risk of harm. This work is well underway.

The OCP has also continued to provide statutory oversight and engage with a wide range of stakeholders across the lived experience, statutory, community and service delivery sectors. We have continued to formally assess inpatient mental health units and ECT services against the Chief Psychiatrist's Authorised Hospital Standards. We have also supported services developing new mental health units by considering international best practice principles for hospital design, and providing expert feedback about models of care. Other core roles included offering education, support and expert advice to clinicians in translation of the MHA 2014, and contributing to the review of the MHA 2014. Significant work has also gone into planning for the incoming Criminal Law Mentally Impaired (CLMI) legislation, and delivering a new and updated strategic plan for the OCP.

The Chief Psychiatrist has continued to focus on these high priority issues for standards of care in mental health services in WA:

- sexual safety within mental health services
- the development of forensic mental health services
- the development of services for individuals with co-occurring neurodevelopmental issues
- the development of appropriate rehabilitative pathways for individuals with severe and enduring mental illness.

Above all, the Office of the Chief Psychiatrist has continued to strive for mental health care to the highest standard for the people of Western Australia.

Key achievements

Monitored treatment and care of approximately 62,000 patients in a range of mental health services across WA, including:

58
public mental health inpatient units

55
clinical community mental health services (CMHS)

35
private psychiatric hostels

3
publicly contracted private providers of mental health services

25
clinical community mental health services with specialised models of care

5
private psychiatric hospitals

16
non-government organisations providing clinical mental health care

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

Welcomed **14 Prescribed Medical Practitioners** – a new role for WA initatied by the OCP to help alleviate pressure on the system.

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

Advised on upgrades, refurbishment, design and development of **7 mental health inpatient facilities.**

Provided expert advice on **6 legislative reform projects.**

Provided expert representation on **25 Statewide and 2 National mental health committees**

Presented **8 Community of Practice sessions – connecting more than 700 clinicians** to support best-practice and continuous improvement in mental health services.

Reviewed standards of care provided to residents of psychiatric hostels across 7 licensees, 16 hostels, and 11 community mental health services.

Delivered 98 MHA 2014 training sessions to 1,080 mental health clinicians, Authorised Mental Health Practitioners, nursing graduates and other clinicians working in the public and private mental health sector.

Assisted 423 clinicians with clinical enquiries and **115 consumers** and carers through the Clinical Helpdesk.

Conducted reviews into areas such as ECT services, authorised hospitals, notifiable incidents, and the treatment and care provided to children and adolescents admitted to adult wards.

Trained 96 new Authorised Mental Health Practitioners.

Who we are

The Office of the Chief Psychiatrist (OCP) comprises staff with a wide range of knowledge, skills and abilities who support the Chief Psychiatrist in meeting statutory responsibilities and setting standards for safe, high-quality mental health treatment and care for all Western Australians. We do this by proactively monitoring, engaging and assisting the mental health sector's work to improve health outcomes for consumers of mental health.

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 purpose

We support better mental health care, so people can live their best lives.

Our strategic objectives

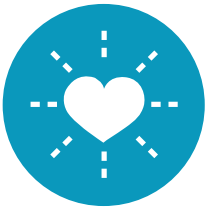
- Striving for a culture of excellence in our workplace that reflects our values.
- Building and enabling transformative leadership both internally and externally.
- Building on our strong external partnerships to facilitate safe, high-quality mental health care.

Our vision and strategic objectives support and define our future, where we are heading and how we will get there.

Our values

LEADERSHIP

INTEGRITY



RESPECT

ACCOUNTABILITY

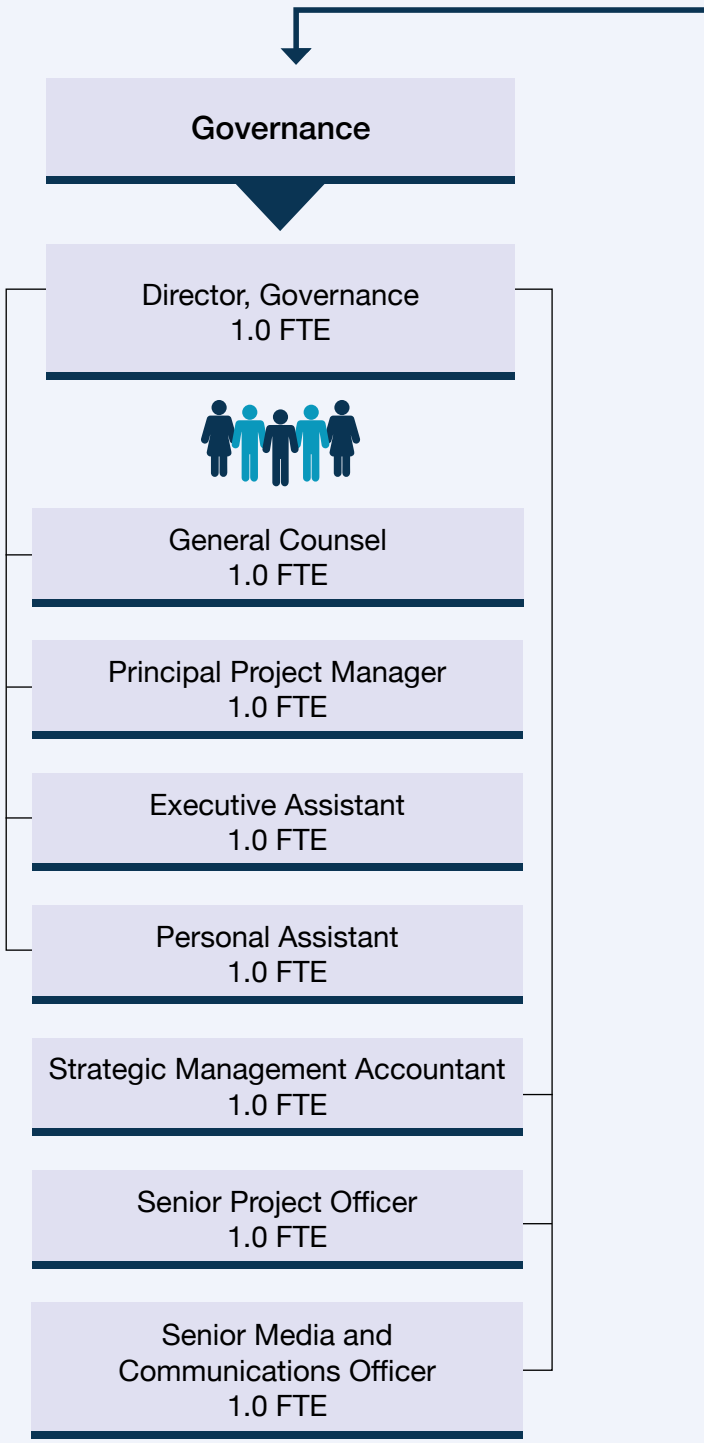
COMMITMENT

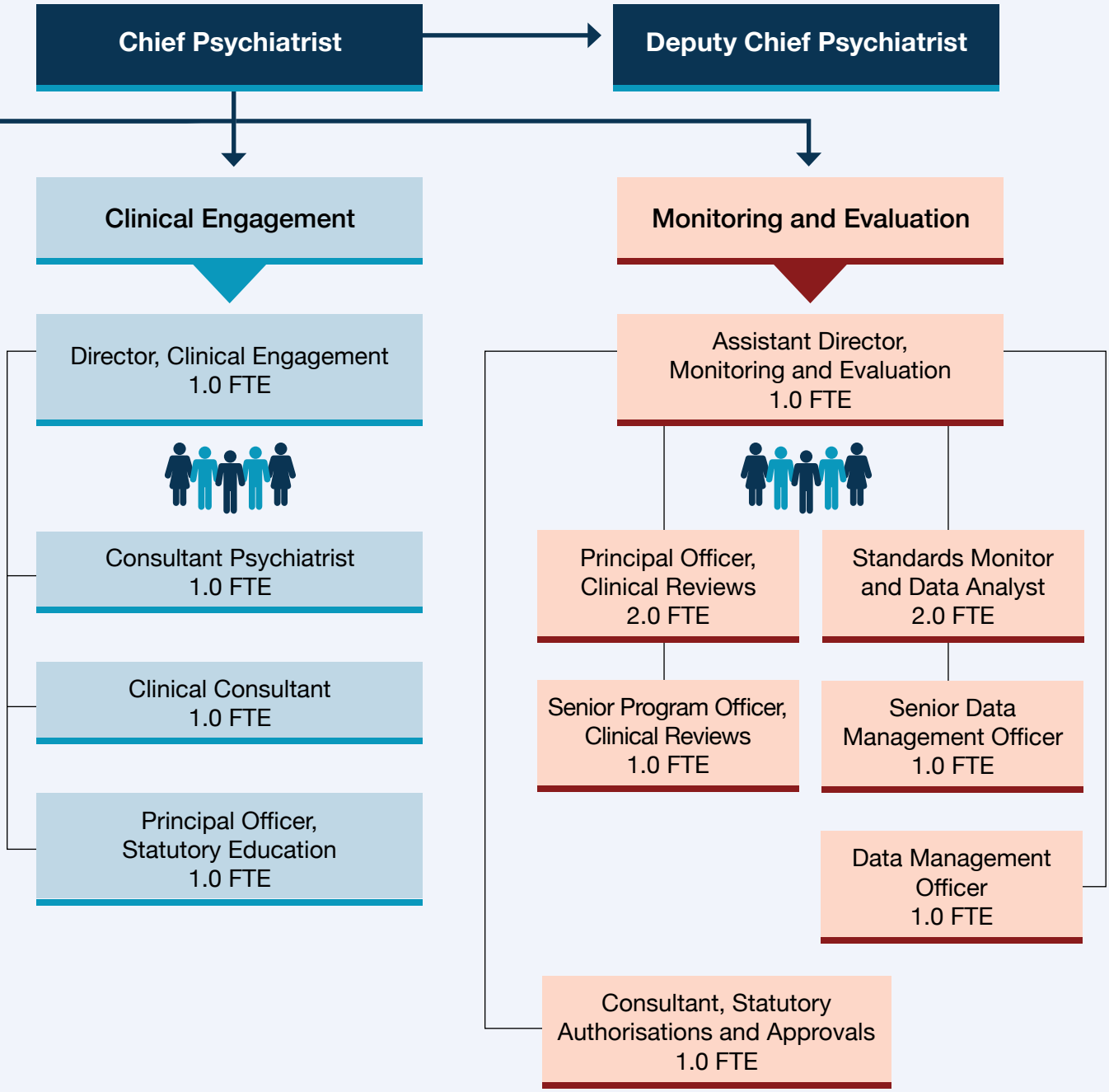
Structure of the OCP

The Chief Psychiatrist is supported by 22 staff.

Executive Governance Team:

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





OCP organisational chart

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

Governance

The Governance Stream provides strategic leadership, advice and management support to the OCP through:

- developing and implementing 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.

Other functions include:

- acting as the interface between the Chief Psychiatrist, the OCP, 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 OCP in respect of its obligations under the various legislative requirements, e.g. *Financial Management Act 2006*, *Health Services Act 2016*, *Freedom of Information Act 1992*, *Mental Health Act 2014*, *Public Sector Management Act 1994*, OSH and Equal Opportunity legislation
- providing high level legal advice to the Chief Psychiatrist and the OCP
- acting as the liaison between the Chief Psychiatrist and the State Solicitors Office and the Legal and Legislative Services – Department of Health WA
- managing all budgetary and fiscal responsibilities of the OCP
- overseeing the provision of administrative and executive support to the Chief Psychiatrist and staff of the OCP.

Monitoring and Evaluation

The Monitoring and Evaluation Stream implements programs and strategies to assist the Chief Psychiatrist to discharge statutory responsibilities for standards of 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
- authorisations of mental health services.

These teams comprise highly skilled staff with clinical, policy and data monitoring expertise. Their roles and responsibilities include conducting independent clinical and targeted reviews, monitoring and evaluation of statutory notifications, authorisations of hospitals and research collaboration with academics. The team works closely with mental health clinicians and other stakeholders to support good clinical practice and provide policy, guidelines and information through a range of mediums including online forums.

Clinical Engagement

The Clinical Engagement Stream focuses 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 strategic solutions, supporting and promoting innovation and contemporary practice, and enhancing the capability of the mental health workforce. Key functions include:

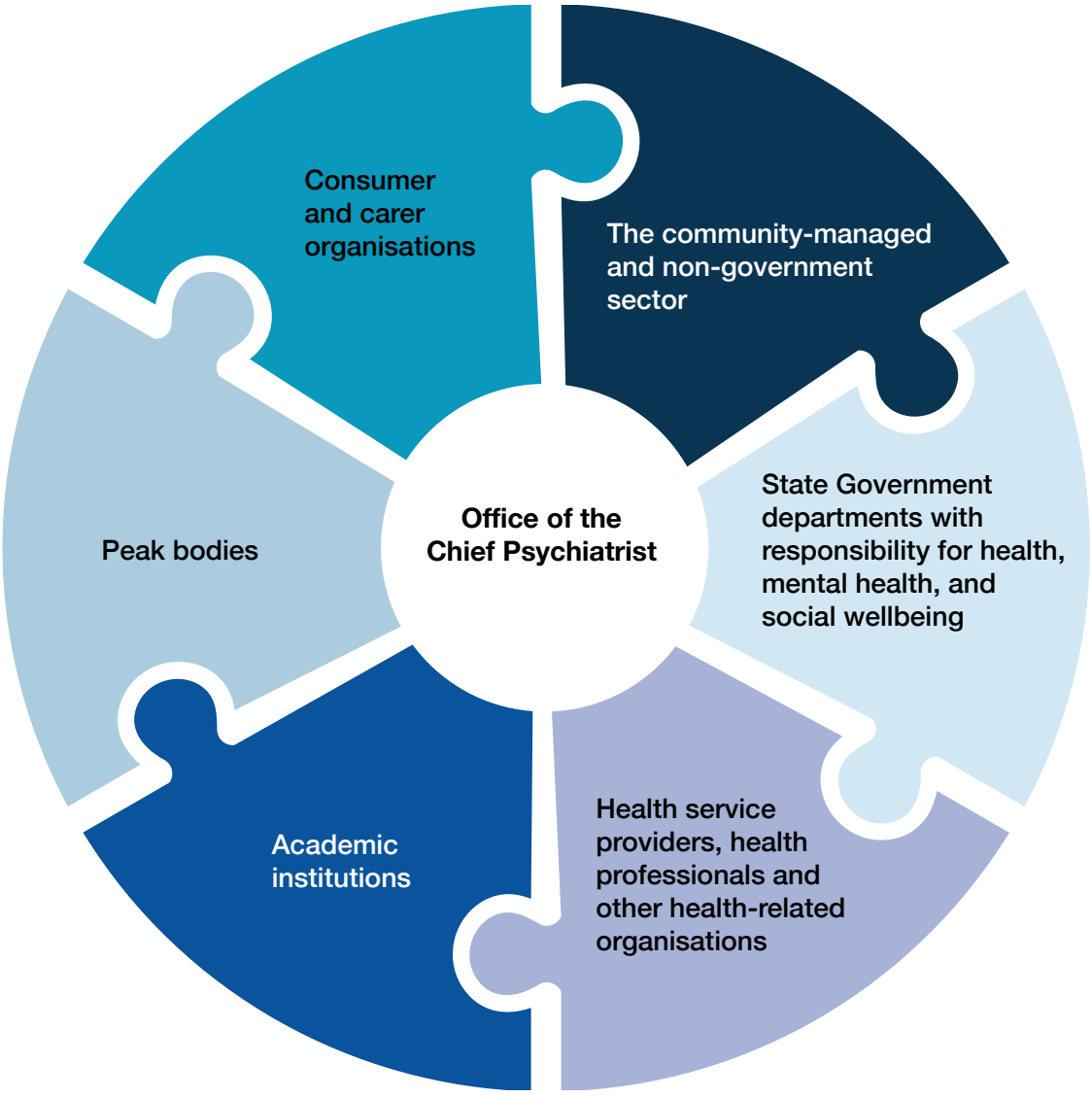
- supporting services to implement initiatives to continuously improve the delivery of treatment and care
- undertaking targeted or commissioned reviews into complex issues
- providing guidance on complex clinical and ethical treatment and care issues
- delivering education programs
- monitoring and 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 at a cost and on a cost-neutral basis.

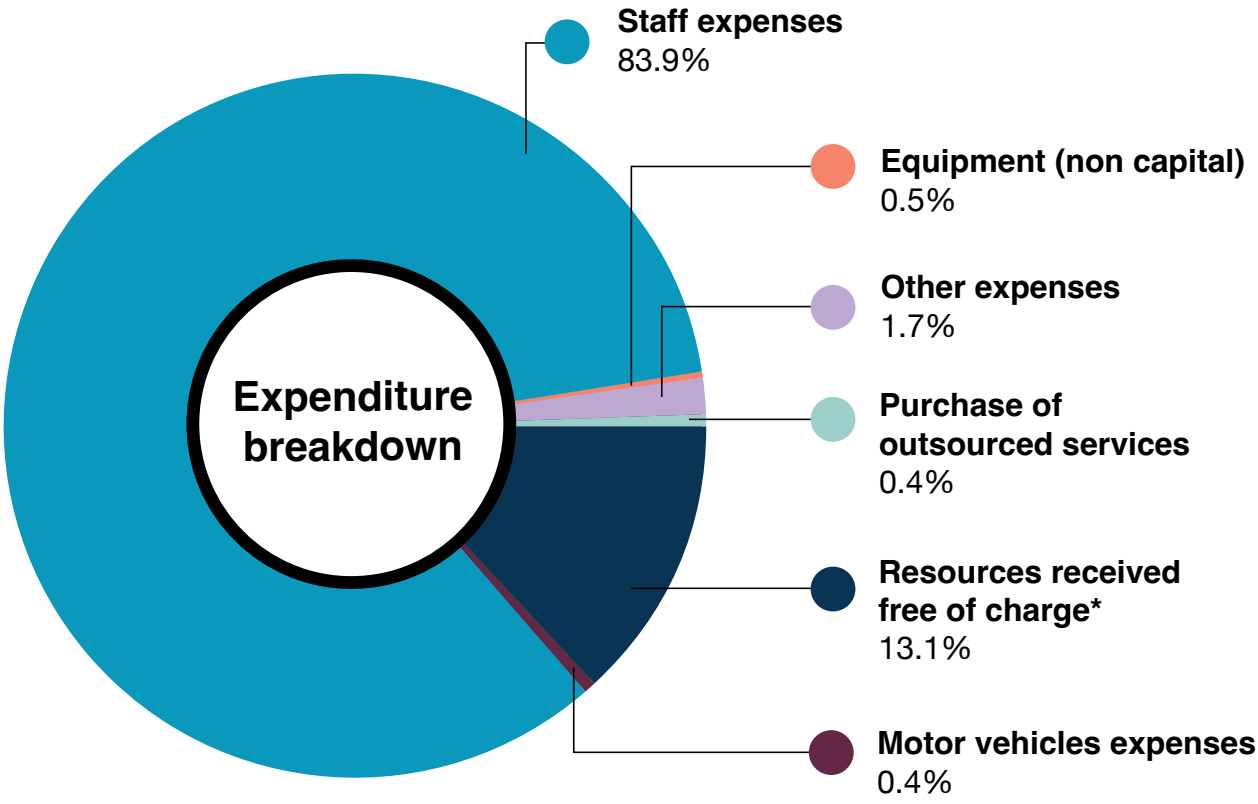
Who we work with

Our stakeholder engagement strategy helps maximise our reach as we seek to influence mental health care. It includes:



How we spend our money

An overview of expenditure for the OCP for 2022-23 is represented in percentages in the diagram below:



* Corporate Services is provided by the Mental Health Commission as *Resources received free of charge*, and is part of the overall Chief Psychiatrist's budget.

Services under the Chief Psychiatrist's statutory oversight

Services under the Chief Psychiatrist's statutory oversight

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

The Department of Health provides the data for this section. Due to the rigorous data cleaning undertaken, the OCP requests data for the calendar year to overcome any potential delays in receiving the financial year data.

It is noted there has been a decrease in the number of patients utilising public community and inpatient services, private psychiatric hospitals and emergency departments from the 2021-22 Annual Report. The reason for this is unclear, however, it should be noted that the number of occasions of service taking place within the community remained consistent.

In the 2022 calendar year, 61,732 patients received public sector specialist inpatient and/or community mental health care. A total of 7,980 (13%) were Aboriginal and Torres Strait Islander (respectfully referred to as Aboriginal people hereafter) and 53,743 (87%) were non-Aboriginal people. Just over two-thirds (68%) of these specialised mental health services were provided to adults aged 18-64 years, 21% were provided to children under 18, and 11% to adults 65+ years of age.

A total of 8,368 (14%) patients received both inpatient and specialist clinical community mental health services during 2022. Of these, 9.9% were Aboriginal and 90% were non-Aboriginal patients. The majority (82%) of patients who had both inpatient and community mental health care were 18-64 years of age, 8% were children, and 10% were 65+ years.

Specialised clinical community mental health services

Specialised clinical community mental health services (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 (GP). Services include child and adolescent, and adult and older adult CMHS, along with a number of other specialist services, e.g. Aboriginal Mental Health Services, Mental Health Co-Response.

A total of 57,799 patients accessed community mental health services in 2022, of which 88% were non-Aboriginal and 12% Aboriginal patients. There were 1,035,089 service contacts of which 87% involved non-Aboriginal and 13% Aboriginal patients. The majority of patients accessing community mental health services (70%) were aged between 18-65 years, 20% were less than 18 years and 10% were 65 years or older.

Community treatment orders

A Community Treatment Order (CTO) is a legal order enabling an involuntary patient to receive treatment in the community. Some consumers may transition from a voluntary status to being on a CTO (and vice versa) within a single community episode of care. In the 2022-23 financial year, 781 patients were treated on a CTO, with a total of 963 CTOs recorded. The number of patients on a CTO increased from 717 people in 2020-21 to 726 people in 2021-22. The number of CTOs increased 9% from 884 in 2020-21 to 963 in 2022-23.

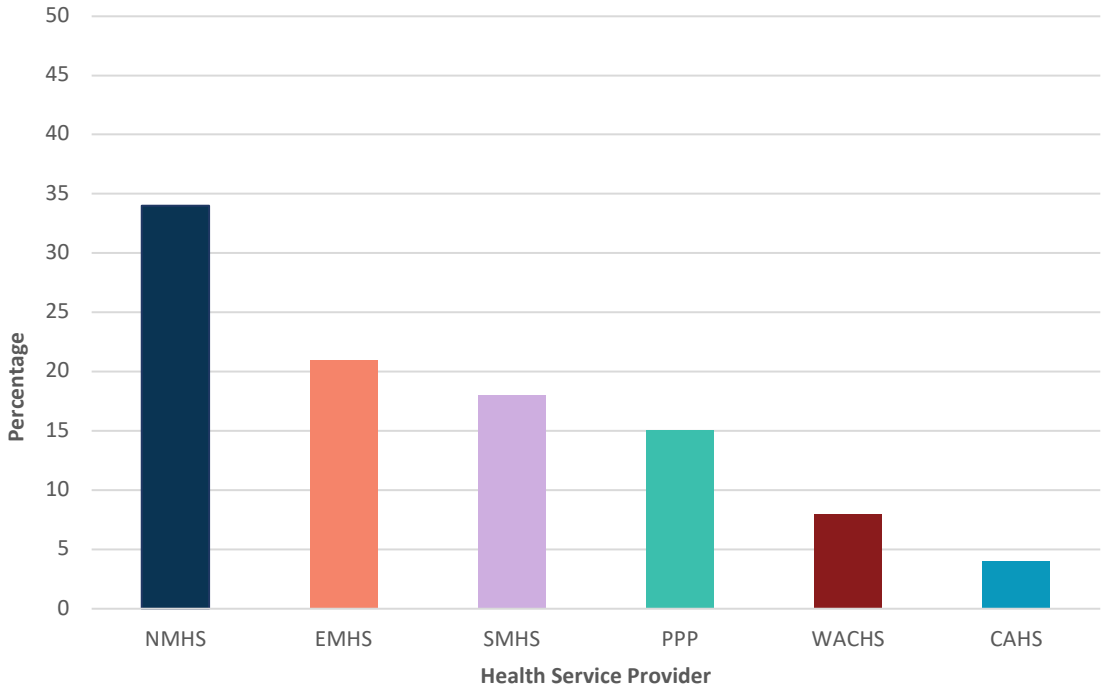
* Please note CTO data is for the financial year 2022-23

Inpatient mental health services

Public hospitals providing inpatient mental health services

There was an average of 818 available beds in the 2022 calendar year, of which 47 were Hospital in the Home (HiTH) beds provided by the North Metropolitan Health Service (NMHS) and South Metropolitan Health Service (SMHS). There was an average of 771 inpatient beds available across WA, with 92% in the Perth metropolitan area and 8% in the WA Country Health Service (WACHS) regions. The proportion of mental health beds located in each of the Health Service Providers can be found in Figure 1.

Figure 1: Location of mental health beds in Western Australia by Health Service Provider



* 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

A total of 8,488 people had one or more inpatient admission to a specialised public inpatient mental health service (acute and non-acute wards), for a total of 14,138 separations in 2022. Aboriginal people accounted for 10% of admissions and 10% separations. The majority of people admitted (82%) were adults 18-64 years, 10% were 65 years or older and 8% were children. One-quarter (25%) of non-Aboriginal and 42% of Aboriginal inpatients had involuntary mental health status at some stage during their admission. The majority of involuntary inpatients were aged 18-64 years for both non-Aboriginal (89%) and Aboriginal (96%) patients.

In the 2022 calendar year, 685 children accessed acute specialised mental health inpatient wards, involving 1,148 separations. Of the 1,148 separations, 415 (36%) were from Perth Children's Hospital, and 733 (64%) were separations from youth wards (which admit children, adolescents and young adults 16-24 years) and adult wards (which admit adults 18 years of age and older). Under the MHA 2014 s.303, separations of young people less than 18 years old 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, inpatients classified as a 'public' patient in a public/private mental health service and Hospital in the Home (HiTH) separations.

Hospital in the Home (HiTH)

HiTH is designed to provide an equivalent level of care to a patient as they would receive in a hospital, in their own home. The clinical team visits at least daily. HiTH services are provided for child and adolescent, youth, adult and older adults.

Private hospitals providing inpatient mental health services

Five private hospitals provide mental health services in WA and three publicly contracted private providers may admit some private patients.

Private hospitals providing private mental health services:

- Abbotsford Private Hospital
- Bethesda Clinic (licensed 13 March 2023, first patients received 27 March 2023)
- Hollywood Private Hospital
- Marian Centre
- Perth Clinic.

Private hospitals providing public mental health services:

- Joondalup Hospital
- St John of God, Mt Lawley Hospital
- St John of God, Midland Hospital.

During the 2022 calendar year, 2,695 private inpatients were discharged from these services, involving 5,554 separations. The majority of patients were adults 18-64 years (89%), 8% were adults 65+ years and 3% 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.

In WA, 17 health campuses have authorised mental health facilities, providing a total of 683 authorised beds (Table 1).

Table 1: Number and location of **authorised** beds in Western Australia

Health Service Provider/Facilities	Number of Authorised beds
Child and Adolescent Mental Health Service	
Perth Children's Hospital	20
East Metropolitan Health Service, Mental Health	
Armadale Hospital and Health Service	41
Bentley Hospital and Health Service	88
Royal Perth Hospital	12
North Metropolitan Health Service, Mental Health	
Graylands Health Campus:	
Graylands Hospital	121
Frankland Centre	30
Selby Older Adult	32
Sir Charles Gairdner Hospital	30
South Metropolitan Health Service, Mental Health	
Fiona Stanley Hospital	30
Fremantle Hospital and Health Services	64
Rockingham General Hospital	30
WA Country Health Service	
Albany Health Campus	16
Broome Hospital	13
Bunbury Hospital	27
Kalgoorlie Regional Hospital	6
Women and Newborn Health Service	
King Edward Memorial Hospital	8
Private Hospitals Providing a Public Service	
For North Metropolitan Health Service, Mental Health:	
Joondalup Hospital	47
For East Metropolitan Health Service, Mental Health:	
St John of God, Mt Lawley Hospital	12
St John of God, Midland Hospital	56
Total	**683**

A register of authorised hospitals is maintained by the Office of the Chief Psychiatrist and can be found on the Chief Psychiatrist's website.

Emergency departments

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

In the 2022 calendar year, 5.6% of attendances at an emergency department were for a mental health issue, totalling 60,574 attendances, of which 80% involved a non-Aboriginal patient, 18% an Aboriginal patient and for 2% the ethnicity was unknown.

Other services under the Chief Psychiatrist's statutory oversight

Private Psychiatric Hostels

A private psychiatric hostel is a home where people can live when they need support because of their mental health. Private psychiatric hostels are run by non-clinical mental health staff. Clinical mental health care is provided to hostel residents by CMHS and GPs.

WA has 35 private psychiatric hostels. The 2023 Psychiatric Hostels Snapshot conducted 20 January 2023 found 606 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.

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.

Telehealth and telephone mental health services

WA has a number of hotlines people can contact in a mental health emergency including the Mental Health Emergency Response Line (MHERL), Rurallink and the 'Here For You' helpline. Clinicians assess people over the

phone and, if necessary, refer a person to a local mental health service, usually a CMHS. The WACHS Mental Health Emergency Telehealth Service (MHETS) provides emergency mental health care via telehealth to people in rural and remote emergency departments, hospitals, nursing posts and some Aboriginal Medical Services. Child and Adolescent Mental Health Service (CAMHS) Crisis Connect is a phone and telehealth service for children and their families experiencing a mental health crisis in the metropolitan area.

Safe haven cafes

Safe haven cafes 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.

Step-up step-down services

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. The Chief Psychiatrist **does not** have remit for the non-government step-up step-down services, but may review care provided to patients in these services by the CMHS.

Specialised mental health emergency units (MHOA and MHEC)

Some emergency departments in WA hospitals have 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 between four and 72 hours.

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 their mental health, a C-L team completes an assessment and provides assistance, whether it's the person's first episode, or if the person has had mental health issues before. The C-L team supports the treating team and ensures the person gets the mental health care they need.

Kaatadjiny Walbraaniny Danjoo (Learning to Heal Together)

The Office of the Chief Psychiatrist has made a long-term commitment to work with Noongar Aboriginal Elders and young people to co-design better ways of engagement and mental health care by establishing trusting, sustaining and authentic relationships.

This work is underpinned by the OCP's recognition of the Aboriginal peoples of Western Australia and their ongoing connection to the land and waters on which our office operates, as well as acknowledgment of the systemic discrimination that creates barriers to Aboriginal people accessing safe high-quality mental health treatment and care.

In acknowledging the need for truth telling, our intention is to embed cultural safety into all modes of treatment and care by building cultural knowledge amongst our staff, mental health clinicians and health service providers. Our hope is that it will result in better mental health outcomes for Aboriginal people across WA.

Picture: Yilliminning Rock

Over the past year, the OCP has begun the process of developing the necessary strategies and principles for Aboriginal ways of being and doing, under the guidance of our colleagues from Curtin University, using the Debakarn Koorliny Wangkiny (Steady Walking and Talking) framework. We are privileged to be supported by the wisdom and leadership of Aboriginal Elders and young people as we do this work.

The value of immersing ourselves in this process has been profound on both a personal and professional level in recognising that meaningful relationships are both necessary and critical to work effectively with Aboriginal people and their communities. We attended On Country events and held our meetings at places of significance to our Aboriginal Elders and young people to ensure the work we are doing is meaningful.

We look forward to our continued engagement in this project, which will enhance our capacity to create a culturally safe environment and an employment destination of choice for Aboriginal people in the future, whilst positively impacting the mental and emotional wellbeing of Aboriginal people who use our services.

Picture: George Brockway Tree, Shire of Narrogin

Prescribed Medical Practitioners in WA

Concerned Health Service Provider (HSP) representatives and senior psychiatrists directly approached the Chief Psychiatrist seeking help to address the shortage of psychiatrists in WA. A shortage of psychiatrists is an acknowledged risk for public and private mental health services, both nationally and locally. It has traditionally been particularly acute in rural areas of the state but is now also seriously impacting metropolitan services. All public mental health services typically recruit overseas specialists into key clinical roles and require locum or short-term cover to provide continuity of service. Both these routes have become more challenging since the COVID-19 pandemic.

As well as its overall impact on service provision and access for consumers, the workforce shortage has led to increasing difficulties in administering the MHA 2014, particularly Inpatient Treatment Orders and Community Treatment Orders.

The MHA 2014 uses the term 'psychiatrist' to describe classes of persons prescribed to carry out functions under the MHA 2014.

While the term 'psychiatrist' is often used in common parlance to mean a medical practitioner who has specialist registration in psychiatry, in Western Australia the term 'psychiatrist' also has a specific definition in the MHA 2014 Part 2, Division 1 s. 4 which directs that only the following medical practitioners can administer various aspects of the MHA 2014 as 'psychiatrists':

- a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP), or
- a person or a person in a class of persons prescribed by the *Mental Health Regulations 2015* (MHR 2015) for this definition

In practice this means a medical practitioner with FRANZCP can automatically administer the MHA 2014, but there is also provision in the legislation to allow other medical practitioners to do so through their name being formally prescribed by the MHR 2015 and published in the Western Australian Government Gazette.

A comparison with other jurisdictions in Australia

Queensland, Victoria, and New South Wales all allow medical practitioners who do not hold specialist registration in the specialty of psychiatry to be approved to carry out various functions under their respective Mental Health Acts and have a range of mechanisms for doing this.

The Chief Psychiatrist's Standard for Prescribed Medical Practitioners

In response to this critical situation, and to bring WA in line with other states, the Chief Psychiatrist established a project to develop a robust and standardised route for individual medical practitioners to be prescribed in Regulation 4A(3) of the MHR 2015 for the definition of 'psychiatrist' under the MHA 2014.

Following extensive consultation, the Chief Psychiatrist published the Chief Psychiatrist's Standard for the appointment of Prescribed Medical Practitioners issued under Section 547 of the MHA 2014 and Mental Health Regulations 2015 (the Standard) in September 2022.

Medical practitioners who are gazetted under this Standard are called Prescribed Medical Practitioners (PMPs).

The Standard establishes, for the first time, clear eligibility criteria for a medical practitioner to have their name prescribed in the MHR 2015, based on both qualifications and experience, to carry out defined elements of the role of a psychiatrist for the sole purposes of the MHA 2014. It also defines the assessment process, training requirements and ongoing governance of PMPs.

Applications for the first cohort of PMPs were invited in late 2022. Of the original 19 applicants, following rigorous assessment, 14 medical practitioners successfully completed all requirements, including a two-day training course, and had their names prescribed in the MHR 2015 in June 2023. The group of 14 new PMPs come from all the state's HSPs, and work across emergency, adult, child and older adult services. The OCP offers a monthly peer supervision program for the PMPs and will continue to support their skills and learning in aspects of their work with the MHA 2014. A register of PMPs is available on the Chief Psychiatrist's website. A second cohort of PMPs will progress to training for the role in August 2023.

Prescribed Medical Practitioners exercise significant powers and functions which impact the rights of individuals. The need for accountable procedures and processes and the establishment of rigorous knowledge and skill requirements are fundamental to the proper and effective administration of the MHA 2014 for the protection of individual rights, and patient, carer and community confidence in the system of care.

The group of 14 new PMPs come from all of the state's Health Service Providers, and work across emergency, adult, child and older adult services.

Picture: Dr Emma Crampin, Deputy Chief Psychiatrist (L), with WA's inaugural Prescribed Medical Practitioners in 2023.

Working with the sector

Working with the sector

Mental health workforce

Workforce difficulties across the sector have significantly impacted the ability to provide the breadth of mental health services needed for the WA community. National and state strategies are being developed to bolster the mental health workforce and the OCP has taken steps also to provide enhanced workforce capability.

In the context of these workforce challenges, the Chief Psychiatrist continues to expect high standards of care, although it is acknowledged that this will require innovative strategies.

Prescribed psychiatrists

Not every psychiatrist can carry out the functions of a psychiatrist under the MHA 2014. For a psychiatrist to be legally able to do so they must be:

- a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- a psychiatrist with specific 'Specialist' or 'Limited' registration with the Australian Health Practitioners Regulation Agency (AHPRA)
- a psychiatrist prescribed by the MHR 2015.

For the reporting period, the Chief Psychiatrist received four applications for a psychiatrist to be prescribed in the MHR 2015; one in the metropolitan area, and three from regional WA. Applications were approved by the Chief Psychiatrist and included in the MHR 2015.

As set out in the Chief Psychiatrist's Standards for Authorisation of Hospitals Under the *Mental Health Act 2014*, Health Service Providers have a responsibility to ensure the workforce is qualified and aware of their functions and responsibilities under the MHA 2014.

- *5.5 Does the service have a robust recruitment and selection process that ensures staff have the qualifications, skills and capability to perform the duties required of them?*
- *5.8 Does the service have a workforce that are aware of their functions under the Mental Health Act 2014, delegated safety and quality roles and responsibilities?*

In 2023, the Chief Psychiatrist wrote to all HSPs reiterating this responsibility. HSPs must ensure psychiatrists who are new to Australia are made aware of the requirements and the penalties that apply when legally not able to perform functions under the MHA 2014.

The OCP continues to work closely with the Mental Health Commission to facilitate timely gazettal of the amendment to the MHR 2015 to

include new prescribed psychiatrists so as to reduce impact on service delivery, particularly in regional areas.

Further information on who can carry out the functions of a psychiatrist under the MHA 2014 can be found on the Chief Psychiatrist's website.

Prescribed medical practitioners

The MHA 2014 uses the term 'psychiatrist' to describe a medical practitioner who can carry out certain MHA 2014 functions.

The Chief Psychiatrist's Standard for Prescribed Medical Practitioners describes the criteria for individual medical practitioners to demonstrate their suitability for gazettal as a 'psychiatrist' under the MHA 2014. Medical practitioners who are gazetted under this standard are called Prescribed Medical Practitioners.

See the Prescribed Medical Practitioners in WA section of this report for details of this initiative.

Authorised mental health practitioners

The Chief Psychiatrist has statutory oversight of Authorised Mental Health Practitioners (AMHPs) and has a responsibility to ensure that they are provided with appropriate ongoing training to ensure that they maintain a contemporary knowledge of the MHA 2014 related to their functions and responsibilities. As at 30 June 2023, a total of 647 AMHPs had a status of "authorised" on the Chief Psychiatrist's AMHP Register.

The Chief Psychiatrist views the AMHPs as beacons of both good practice and knowledge of the relevant components of the MHA 2014.

Clinical monitoring of private psychiatric hostels

The Chief Psychiatrist is responsible for overseeing the treatment and care of all patients at mental health services in Western Australia (MHA 2014 s. 515), including residents of a private psychiatric hostel (MHA 2014 s. 507).

The Chief Psychiatrist's monitoring of private psychiatric hostels includes all facilities operating under a private psychiatric hostel licence granted by the Department of Health, Licensing and Accreditation Regulatory Unit (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 that also have a role in the oversight of private psychiatric hostels, such as LARU, the Mental Health Advocacy Service and the Mental Health Commission.

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 section).

Snapshot

The Snapshot commenced in its current form in 2020. The data are collected through the hostel snapshot survey, and the Department of Health's Psychiatric Services Online Information System (PSOLIS), and are published on the Chief Psychiatrist's website. The 2023 Snapshot included all 35 hostels and their 606 residents.

Most residents live in hostels for the short-to-medium term. On the census date (20 January 2023), 55% of residents had been living in the hostel for four years or less. The majority of residents (96%) had a GP and 38% had seen their GP within 6 months prior to the census date.

Data received from PSOLIS indicated that 64% of hostel residents received mental health treatment and care from a public CMHS, a similar proportion to all cohorts since 2020. However, in 2023 hostels reported that the primary mental health care provider for 87% of residents was a public CMHS. This discrepancy between who the hostel believed was providing care and whether the person was receiving care is an indicator of communication issues between the two services. A total of 29% of residents had a discrepancy between the hostel's report and whether the person was active within PSOLIS, when previously this has been steady (2020-22 aggregate 11%). A closer examination of the 2023 data (Table 2) revealed that the discrepancy could not be explained by recent admissions to or discharges from the CMHS, infrequent contact between the clinical care team and the resident, or the resident being new to the hostel.

Liaison between the provider of clinical mental health care and the hostel is essential for safe, high-quality care. This cannot occur if the hostel does not know who is providing clinical mental health treatment and care.

Table 2: Discrepancies in perception of who is providing mental health care

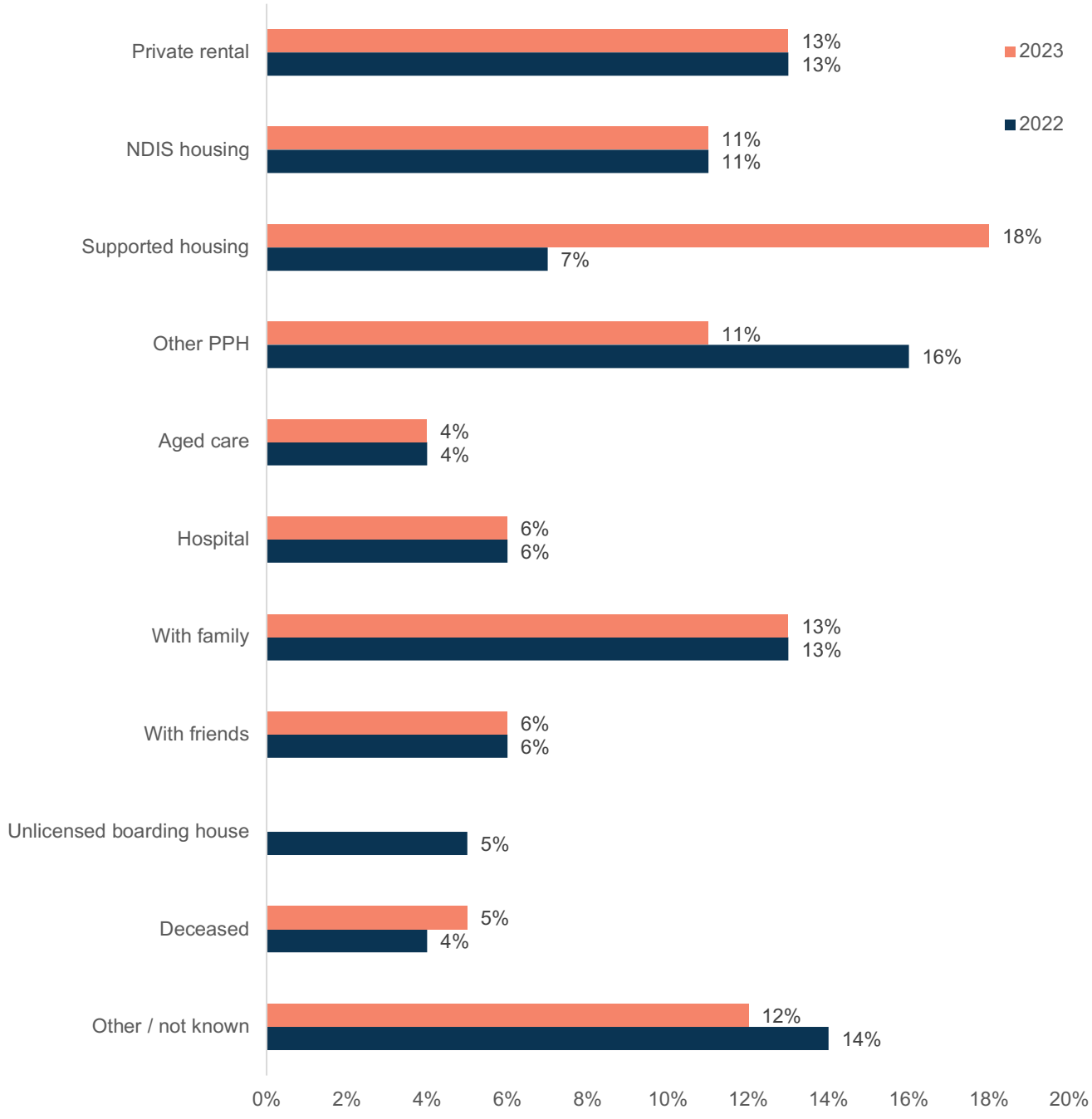
Primary mental health care provider discrepancy	Number of residents	Average time since CMHS admission or discharge	Average time since last contact with a CMHS*	Average time residents have lived at the hostel
Hostel believes resident is receiving care from a CMHS, but the resident is *not currently* receiving care from a CMHS.	138	4.0 years since discharge	10.7 years	11.5 years
Hostel believes resident is receiving care from a CMHS, but the resident *has never* been admitted to a CMHS.	14	Not applicable	3.5 years	5.1 years
Hostel is unaware that the resident is receiving care from a CMHS	22	1.5 years since admission	20 days	3.2 years

* Individuals may have contact with a CMHS without being admitted to receive care.

The snapshot showed that 54% of residents who left a hostel had lived there for less than two years, with a further 23% moving out in less than four years.

Figure 2 shows the type of housing residents move into when they leave.

Figure 2: Where residents go when they leave the hostel

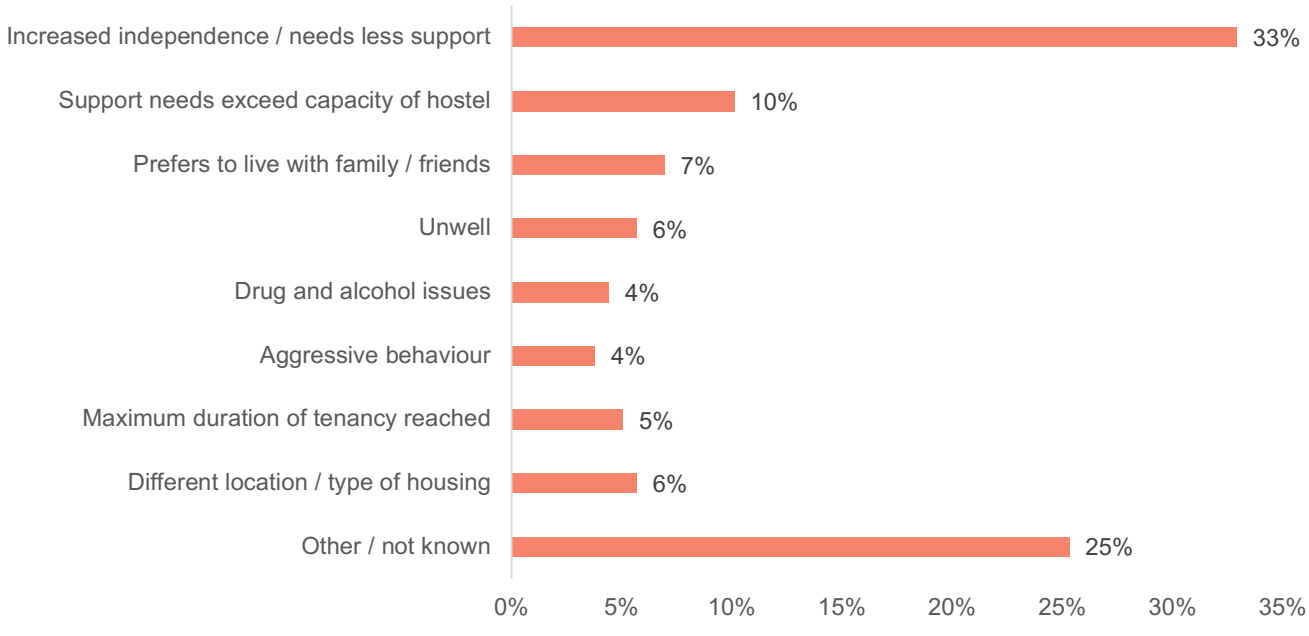


Note: data may not add up to 100% due to rounding

In 2023, a question was added to the snapshot to understand why residents leave a private psychiatric hostel. Of the 158 residents who moved out of a hostel in 2023, 33% left due to increased independence, which aligns with the recovery goals of the current short-term model of care (Figure 3). The majority of residents leaving for this reason move to a private rental or supported housing provider tenancy.

The second most common reason for leaving a hostel was that the resident's support needs exceeded the capacity of the hostel (10%). In these instances, residents went to aged care, their families, NDIS housing, a different private psychiatric hostel or were admitted to hospital. This indicates a gap for a proportion of residents and aligns with the hostel review findings that hostels are having difficulty meeting the needs of those with the most complex needs.

Figure 3: Reasons residents move out of 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 methodology of the reviews was revised in early 2023 to ensure all hostel reviews could be completed by the end of the 2023 calendar year, and is available on the Chief Psychiatrist's website.

On completion of the hostel reviews in late 2023, an overarching report, *The Chief Psychiatrist's Review of WA Private Psychiatric Hostels*, will summarise the themes from all the reviews conducted across the state since 2019. The report will also make recommendations for what is needed to ensure a high standard of holistic mental health care to residents of hostels. A key theme will be the central partnership between the hostels and CMHS, the NDIS, tertiary mental health services and primary care in the delivery of holistic and timely care, while supporting choice for hostel residents and their carers.

Table 3 outlines the Chief Psychiatrist's reviews of private psychiatric hostels in 2022-23. The final licensee will be reviewed in the second half of 2023.

Table 3: Completed private psychiatric hostel reviews 2022-23

Licensee	Private Psychiatric Hostel
Fusion Australia	Geraldton CSRU – Ngurra Nganhungu Barndiyigu
Casson Homes	Casson House
Legal Accounting and Medical Syndicate Pty Ltd & Calder Properties Pty Ltd	Salisbury Home
AJH Nominees	Devenish Lodge
St Vincent de Paul	Vinnies Mental Health Service – Bayswater House Vinnies Mental Health Service – Duncraig House Vinnies Mental Health Service – Vincentian Village Vinnies Mental Health Service – Viveash House
Richmond Wellbeing	Bunbury CSRU Busselton CSRU Kelmscott Community Options Living Well Community Care Unit Mann Way Momentum QP Ngulla Mia Queens Park Service

Post-review follow up

As part of this review process, the Chief Psychiatrist monitors the implementation of recommendations made to hostels and other agencies interfacing with care provision. The OCP routinely provides support to organisations to implement the recommendations.

During this period, Southern Cross Care implemented all recommendations. The following organisations continue their process of implementation:

Hostels:

- AJH Nominees - Devenish Lodge
- Albany Halfway House – Community Supported Residential Units (CSRU)
- Casson House
- Fusion Australia – Ngurra Nganhungu Barndiyigu, Geraldton
- Salisbury Home
- St Bart's
- St Jude's & Pu-Fam (Guildford Care Facility).

Health Service Providers:

- East Metropolitan Health Service – Armadale CMHS, Bentley CMHS, Midland CMHS
- North Metropolitan Health Service – Stirling CMHS and Subiaco CMHS
- South Metropolitan Health Service – Rockingham CMHS
- WA Country Health Service – Central West CMHS.

Chief Psychiatrist's targeted clinical review of adherence to *Mental Health Act 2014* s. 303, segregation of children from adult inpatients

Reasons for the review

The Chief Psychiatrist must be notified when a child under 18 is admitted to a ward which also admits adults (MHA 2014 s. 303). The service must report to the Chief Psychiatrist, and to the child's parent or guardian, prior to admitting a child that:

- The service can provide appropriate treatment and care having regard to the child's age, maturity, gender, culture and spiritual belief
- The measures they will take to protect the child's individual needs including providing treatment and care in a part of the mental health service separate from adults.

The OCP Monitoring and Evaluation team identified that mental health services were not meeting their reporting requirements under s. 303 of the MHA 2014. Therefore, it was unclear whether the services were meeting the required standards of treatment and care.

In October 2022, the Chief Psychiatrist's review team conducted a review of the services with the most admissions of children on adult wards: East Metropolitan Youth Unit, Fiona Stanley Hospital Youth Unit, Sir Charles Gairdner Hospital MHOA and Joondalup Health Campus MHOA. The team reviewed relevant s. 303 notifications, medical records and incident notifications made to the OCP, and conducted interviews with children, parents/support persons and staff.

Findings

The review found that around 94% of children aged 16 or 17 years requiring an inpatient mental health admission are admitted to a Youth Unit, Mental Health Observation Area or Emergency Centre, or Perth Clinic. As with all inpatient mental health admissions, there is a risk of exposure to distressing experiences. Challenging incidents in these environments may be related to the behaviour of either children or adults.

Communication was found to be an important mitigating factor. Reviewers found that frequent communication with children and parents/supports, by familiar and skilled staff, aids understanding of risks and benefits of treatment and contributes to feeling safe, especially for first admissions. Reviewers heard that children and families value giving feedback, being heard and having a say in their care. Seeking timely feedback from children and their families is essential to providing high-quality care which respects and responds to their choice, autonomy and individual needs.

Overall, the review found that compliance with s. 303 reporting needed improvement; for example:

- There is under-reporting to the Chief Psychiatrist under s. 303 of the MHA 2014 of the decision to admit a child to a mental health service with adult inpatients.
- Services with good compliance and reporting have clear processes and responsibilities to support and ensure comprehensive reporting under s. 303.
- Mental health clinicians reported they are implementing strategies to keep children safe in mental health inpatient services with adults. However, these strategies are not captured in either the s. 303 form or in the patient's medical record.
- There is insufficient governance and oversight of compliance with s. 303 statutory reporting. The report must be consistently completed and individualised to each child's needs.

The OCP has implemented monthly comparison of s. 303 notifications with admissions to/separations of children from mental health wards that also admit adults to ensure compliance with the MHA 2014 s. 303. The full report, which outlines specific recommendations for each service, is available on the Chief Psychiatrist's website.

Compliance with the MHA 2014

Expert literature identifies that compliance with mental health legislation is a challenge across jurisdictions. However, compliance is critically important and the Chief Psychiatrist remains focussed on proactively monitoring and addressing those aspects under the Chief Psychiatrist's remit.

Through feedback from monitoring processes, clinicians, the Mental Health Advocacy Service, consumers and carers, the Chief Psychiatrist has noted ongoing issues related to compliance with the MHA 2014. The OCP has also identified significant gaps in a range of governance areas relating to compliance oversight of the MHA 2014 across the mental health sector.

The Chief Psychiatrist does not hold statutory responsibility for the operational aspects of MHA 2014 training, credentialing and all administrative functions.

MHA 2014 Compliance Steering Group

The OCP is partnering with the Mental Health Commission, as the agency principally assisting the Minister for Mental Health in the administration of the MHA 2014, to establish the MHA 2014 Compliance Steering Group. The aim of this group is to develop, with stakeholders across the sector, an action plan to improve operational compliance with the MHA 2014 throughout Western Australian HSP and Public Private Partnership (PPP) entities. Outcomes from this initiative will be captured in the OCP's 2023-24 annual report.

Training in the MHA 2014

To ensure continuous improvement in the standard of treatment and care provided to patients by mental health services, the OCP, led by the Principal Officer – Statutory Education, delivered 98 MHA 2014 training sessions to a total of 1,080 mental health clinicians, AMHPs, nursing graduates and other clinicians working in the public and private mental health sector.

In recognition of the ongoing significant stresses within the mental health system over the last year, the OCP:

- continued to accommodate a training program with increased sessions to provide flexibility and availability for existing AMHPs and other mental health clinical staff in the sector
- maintained a strong presence at AMHP clinical supervision sessions across the state to provide timely advice and support
- responded to the increased requests from mental health services to train new AMHPs by training 96 new AMHPs across the state
- developed a new MHA 2014 training program, which was delivered to the first intake of 14 Prescribed Medical Practitioners who, after gazettal, are able to apply the provisions of the MHA 2014.

Further opinions

MHA 2014 s. 182. Further opinion may be requested

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

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

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

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

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

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

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

The Chief Psychiatrist recognises the importance of patients being able to obtain a further opinion about their treatment from a psychiatrist other than their own. The patient and a patient's support person, as listed above, have the right to request this assessment under MHA 2014 s.182.

Facilitating further opinions remains problematic across the broader mental health system with the overarching Department of Health directive having been previously rescinded, leaving the HSPs to develop their own policies and procedures for the facilitation of further opinions. While within service requests for further opinions are facilitated with some ease, requests received from another service are administratively onerous for services as they rely on the availability of psychiatrists.

Currently there is no consistency with regard to processes or timeframes for further opinions requested through HSPs. The Chief Psychiatrist has raised concerns with the Department of Health regarding this variability.

For the 2022-23 financial year, the OCP received seven requests for further opinions. Six of the seven requests for further opinions were successfully facilitated.

The Chief Psychiatrist received less than five requests for a refusal of a further opinion (s. 183(2)). Upon reviewing the information, the Chief Psychiatrist has the option to either agree to the refusal or decline the refusal. Due to the small numbers, further details cannot be provided to protect patient confidentiality.

Chief Psychiatrist's 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 increased COVID-19 community transmission and consequent clinical challenges. The sessions have now been broadened to include other topics, complementing 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 the state.

The sessions are short, informal and online, to minimise the impact on clinical time and to allow access by clinicians across the state. From Broome to Albany, and across the metropolitan area, attendees have returned to multiple sessions. External collaborators, such as the Mental Health Advocacy Service, the Department of Justice, and Emergency Department and security staff have joined sessions of interest for collaborative, cross-sector learning.

There were over 736 attendances to the Community of Practice over 8 sessions in 2022-23 – an increase of 4 sessions and 579 attendances from the previous financial year.

In 2022-23 the Community of Practice grew significantly, with the average number of attendees to each session more than doubling to 92 per session (often with multiple staff dialling in together, but being counted as one attendee). Total number of attendances was over four times that in 2021-22.

Community of Practice sessions in 2022-23

- Talking with the Multicultural Sub-network
  - 13 July 2022 (34 attendees)
- Working with imminent risk in a non-authorised setting. Part 1 – legal context
  - 3 August 2022 (94 attendees)
- Working with imminent risk in a non-authorised setting. Part 2 – clinical scenarios
  - 10 August 2022 (82 attendees)
- Eating disorders. Part 1 – Eating disorders and decision-making – clinical, legal and lived experience perspectives
  - 12 October 2022 (94 attendees)
- Eating disorders. Part 2 – What is risk in eating disorders, co-occurring needs and complexity
  - 26 October 2022 (119 attendees)
- Eating disorders. Part 3 – Q&A with lived experience and clinicians
  - 16 November 2022 (52 attendees)
- Developing an Aboriginal culturally secure service: How Aboriginal referrals went up 40%
  - 2 February 2023 (72 attendees)
- Duty of care and restraint in mental health and emergency – legal and clinical perspectives from OCP and Royal Perth Hospital Emergency Department
  - 30 March 2023 (189 attendees)

Summaries and resources from the sessions are available on the Chief Psychiatrist's website.

This year's sessions encouraged collaboration with leaders across sectors and the state, including psychiatrists, ED physicians, lived experience leaders, eating disorder clinicians and Aboriginal mental health coordinators. Each shared their expertise, local experience and personal journeys. Together with the Chief Psychiatrist, Deputy Chief Psychiatrist, the OCP Legal Counsel and staff, the grey areas of practice were questioned and discussed. A key theme across sessions was how to weigh up the difficult decisions where multiple perspectives and factors need consideration – legal, clinical, cultural, contextual, ethical and the personal.

A survey evaluation of the sessions was conducted to inform topics and the format of future sessions. The feedback and comments received demonstrate the positive impact of reflective practice and having a space for the diverse voices of clinicians working at all levels across health services and the state.

Feedback received from Community of Practice attendees

"Thanks to the Team that organised this series (eating disorders series). It's been excellent! Kudos to all involved."

— *Occupational Therapist*

"It is a very valuable piece of education."

— *Rural CNS*

"I would like to congratulate the team for bringing this together. At a time when CMHT (Community Mental Health Teams) are under-staffed and clinicians are under pressure, it is so useful to connect with colleagues and share ideas, hear of innovations and good practice."

— *Anonymous clinician*

Restrictive practices

In line with a national and state commitments, the Chief Psychiatrist is actively working towards eliminating seclusion and restraint events, avoiding prone restraints and ensuring the time spent in seclusion is kept to the minimum required to manage and de-escalate the situation. The ultimate goal is, where possible, to eliminate the use of restrictive practices in mental health services.

The rates of seclusion and restraint within Western Australia have plateaued over the past few years. Although they are among the lowest in Australia, the Chief Psychiatrist has prioritised work aimed at achieving further reductions in the use of restrictive practices.

In Western Australia, the use of restrictive practices in authorised hospitals is strictly governed through the MHA 2014 ss. 215-224 (seclusion) and ss. 230-240 (restraint) and the Chief Psychiatrist's Standard *'Seclusion and Bodily Restraint Reduction'*. Under the MHA 2014, authorised mental health services are required to report all episodes of seclusion and/or restraint to the Chief Psychiatrist, ideally within 48 hours of the event. These notifications are reviewed by OCP staff to ensure compliance with the MHA 2014, the Chief Psychiatrist's Standard, and with reporting to the Chief Psychiatrist. Consultation is continuing with the North Metropolitan Health Service working group, which was established to trial the new seclusion and restraint electronic forms.

Strategies to reduce the use of restrictive practices include active follow-up with mental health services regarding compliance with the MHA 2014 and standards of care, with a focus on prolonged seclusion events greater than six hours, prolonged restraint events greater than 30 minutes, patients having multiple seclusion or restraint events within one admission, and prone restraint events greater than three minutes. Prolonged prone restraint increases the risk of positional asphyxia and is closely monitored. Follow-up also occurs with services that have rates above three standard deviations for more than two quarters. The strategies used for follow-up depend on the issue of concern, and may include a formal written letter, clinical review of patient medical records, a visit to the service to discuss issues of concern with the clinical leadership, and working with the service to develop strategies to minimise the use of restrictive practices.

To ensure the rates of seclusion and restraint in mental services are open and transparent, the Chief Psychiatrist publishes the rates biannually for each authorised mental health service on the Chief Psychiatrist's website. In addition, the Chief Psychiatrist requests all authorised mental health services to provide a list of their seclusion and restraint rates in an open location in their unit where these can be viewed by patients, carers, visitors and staff.

The Chief Psychiatrist also reports these rates to the Australian Institute of Health and Welfare annually for inclusion in the national reporting.

Towards Elimination of Restrictive Practice Forum

In February 2023, the OCP and Department of Health Mental Health Unit jointly hosted a Mental Health Community Forum: Working Towards the Elimination of Restrictive Practices. The aim of the forum was primarily to bring together mental health clinicians, with representation from consumers and carers, Aboriginal mental health workers, emergency department physicians, and other key stakeholders. The forum focused on restrictive practices, the continuation of the low restrictive practice rates in WA, and ideas to further reduce, and ultimately eliminate, the use of these practices. The agenda included not only restrictive practices in authorised mental health units, but also included other public health services settings where restrictive practices are being used, including emergency departments and general wards. The objectives of the forum were:

- to develop a statewide 'Statement of Intent' about the elimination of restrictive practices in WA
- to identify strategies and actions to progress and maintain momentum in pursuing the elimination of restrictive practices in WA.

The forum included robust discussion, and many participants submitted written responses. Attendees identified a number of themes as key for progressing the aim of eliminating restrictive practices, including:

- consumer and carer involvement and co-design of strategies
- education, training and cultural change
- leadership, commitment and accountability
- site design
- de-escalation and peer support workers.

This event has seeded a renewal of interest in this important area. A range of issues were discussed, but it has been identified that the development of a statewide Statement of Intent will require a true co-design process. This will proceed in 2023-24.

Restraint and detention in non-authorised settings

Good clinical translation of statute when considering restraint and detention of individuals in non-authorised settings (e.g. emergency departments) has become a significant focus across WA Health.

The Director of Governance, with the expertise of the OCP General Counsel, has initiated the development of guidelines and a training package for all hospital staff in the public health system on the law relating to the restraint and detention of persons in non-authorised settings. These will be available in the latter part of 2023.

A consistent policy across the health sector will also be developed by the Department of Health, which will be aimed at ensuring that staff are confident and supported in managing high risk situations and that patient legal and human rights are kept in sharp focus.

Forensic mental health

Forensic mental health remains among the highest priorities for the Chief Psychiatrist. WA still has the lowest number of forensic mental health beds per capita population of all the states. The announcement of the expansion of forensic mental health beds on Graylands campus was an important government announcement in 2023.

Representatives from the OCP collaborated with key stakeholders on the development of a model of care for forensic mental health services for both adults and young people. 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.

Criminal Law (Mentally Impaired) Act

The *Criminal Law (Mental Impaired) Act* was passed during this reporting period and comes into effect on 1 July 2024. The OCP has continued to be actively engaged in supporting the Department of Justice by providing advice and applying knowledge and expertise within the OCP to progress the reformed Criminal Law Mental Impaired (CLMI) legislation.

The introduction of the *Criminal Law (Mentally Impaired) Act* will be a welcome legal reform and the practical translation will require significant input from the OCP.

The OCP will now move on to developing a training package to support the rollout of this legislation when it comes into effect, ensuring both AMHPs and PMPs are knowledgeable about the requirements of the reformed legislation.

Chief Psychiatrist's visits to services

Scheduled visits

The Chief Psychiatrist and team visit services throughout the year to meet with staff and consumers, and to view the physical environment. During the year, a number of visits occurred, including those required for the reviews of approved ECT services and authorisation visits.

During scheduled visits by the Chief Psychiatrist, the following matters were raised.

Consumers and carers:

- protection of personal belongings
- improved engagement between patients and staff on nightshift
- enhanced involvement of families and carers in discharge planning
- improved liaison with General Practice
- improved consistency of physical health care checks and treatment within mental health services
- challenges for mental health care within emergency departments.

Health service staff:

- workforce shortages and increased demand for services
- availability of beds
- need for specific training in management of eating disorders
- difficulties navigating National Disability Insurance Scheme (NDIS) impacting length of stay
- difficulties discharging older adult mental health patients to nursing homes, as some nursing homes struggle to manage these residents.

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

Visits without notice

Under the MHA 2014 s. 521(1)(b) and s. 521(2), the Chief Psychiatrist may visit, without notice, an authorised hospital at any time, and other designated mental health services where a concern has arisen.

The Chief Psychiatrist and/or a Delegate may visit:

- when investigating or seeking further information about a notifiable incident
- when there is media attention around a particular issue
- when it is reasonably suspected that proper standards of treatment and care are not being met
- for other reasons determined by the Chief Psychiatrist.

The Chief Psychiatrist has made the service visit and review process more effective, efficient and contemporary. To that end, the addition of an increased number of visits without notice will enable greater oversight and generally less preparatory impact for staff.

The Chief Psychiatrist and the Deputy Chief Psychiatrist conducted less than five without notice visits in the reporting period, and these numbers will increase in the following reporting period.

Authorisations and approvals

The OCP continues to work closely with mental health services and external stakeholders, including consumer and carer groups. The aim is to share knowledge and provide advice on current national and international research in terms of contemporary design including, safe ligature fittings and fixtures.

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. In the reporting period, the Chief Psychiatrist did not receive any applications for the authorisation of a mental health facility.

Western Australia has 19 authorised units across 16 health campuses, and another four are in development.

New and planned mental health facilities

The OCP works closely with services when they are developing new mental health facilities. Over recent years there have been many learnings resulting in a significant shift from designing mental health facilities as a place of containment, to places that are therapeutic, promote hope and aid recovery, but maintain safety. They are homelike – or better still, hotel-like – and provide opportunities for rehabilitation and empowerment. This requires designers to have a greater understanding of the requirements of a mental health facility and their functions.

Several mental health units remain in development or in the final stages of planning (Table 4).

Table 4: Mental health facilities in the planning or development phase

HSP/Facility	Planned number of beds	Estimated date of completion
Ramsay Health Care (PPP with North Metropolitan Health Service) Joondalup Hospital	121 Beds (adult, youth and older adult)	2023
South Metropolitan Health Service Fremantle Hospital V Block	40 beds (adult, older adult open and secure)	2025
WA Country Health Service Geraldton Health Campus	12 beds (8 open – 4 secure)	TBC
East Metropolitan Health Service Secure Extensive Care Unit	24 beds	TBC
North Metropolitan Health Service Graylands Reconfiguration	53 forensic mental health beds, 48 non-acute male beds 5 adolescent beds	TBC

Private psychiatric hospitals

The Chief Psychiatrist has a statutory responsibility under the MHA 2014 for oversight of the standards of treatment and care in private psychiatric hospitals. In addition, the *Private Hospitals and Health Services Act 1927* s. 26DA3(A), provides that *"The CEO cannot endorse a licence unless the Chief Psychiatrist recommends the endorsement."* Practically, the Chief Psychiatrist provides the recommendation to the Licensing and Accreditation Regulatory Unit of the Department of Health.

There are five private psychiatric hospitals in WA (see section 'Private hospitals providing inpatient mental health services').

The Chief Psychiatrist and the Consultant for Statutory Authorisations and Approvals visit services seeking to be licensed when they are in the planning and construction phases. The aim of these visits is to ensure consideration has been given to operational and relational safety in their infrastructure and modelling design, particularly in the context of the relevant Chief Psychiatrist's Standards.

For the reporting period, the Chief Psychiatrist received two notifications from private services seeking recommendation for the endorsement of a licence to operate a private psychiatric hospital.

- Bethesda Clinic
  Bethesda Clinic's licence was recommended by the Chief Psychiatrist and the subsequent licence was granted by the Department of Health, Licensing and Regulatory Unit on 13 March 2023.
- Abbotsford Private Psychiatric Hospital
  The licence for Abbotsford Private Psychiatric Hospital (new build) is pending. The OCP continues to liaise with the service and architects on matters relating to design and infrastructure safety.

More information on Licensed Private Psychiatric Hospitals can be found on the Chief Psychiatrist's website.

Review of Authorisation

The Review of Authorisation is progressing with the purpose of ensuring authorised hospitals in Western Australia continue to comply with the Chief Psychiatrist's Standards for Authorisation of Hospitals under the *Mental Health Act 2014*. While less formal visits have occurred throughout the year, visits pertaining to the Review of Authorisation were undertaken for King Edward Memorial Hospital – Mother and Baby Unit.

A large number of new mental health developments are currently being built or are in the planning stages across the state, requiring regular meetings and visits with the services. The OCP has prioritised its resources to support these projects.

Physical environment upgrades resulting from recommendations from the Review of Authorisation

Previously visited services have continued to implement recommendations relating to infrastructure made by the Chief Psychiatrist. The OCP has provided ongoing consultation to services to effect appropriate changes and upgrades to infrastructure that enhance the patient experience and ensure safety.

The OCP has had a particular focus on therapeutic outdoor spaces, access to sensory rooms, and removal of equipment with potential self-harm risks.

Changes and upgrades to inpatient mental health units include:

- increased perimeter heights for increased patient safety
- renovation of the outdoor areas including gardens, Aboriginal art and yarning circles, increased shaded areas
- greater access to health and fitness equipment
- refurbishment of patient kitchen and meal areas
- decommissioning of seclusion rooms
- upgrades to patient bedrooms and ensuites
- installation and upgrading of anti-ligature fittings and fixtures and monitoring systems
- upgrades to patient areas, including mental health intensive care units, specifically in terms of therapeutic value and amenity (including furnishings and décor)
- introduction or enhancement of specialised areas for vulnerable patients
- upgrades to patient sensory/chillout rooms and purchasing of resources
- replacement of dining room and outdoor furnishings
- replacement of patient bedroom door viewing panels – increasing patient privacy
- addressing maintenance and upkeep of the outdoor areas.

Renovations and refurbishments of mental health facilities

The Chief Psychiatrist and staff work closely with services to ensure that all major renovations and/or refurbishments meet the Chief Psychiatrist Standards for Authorised Hospitals under the MHA 2014.

Metropolitan mental health unit refurbishments and upgrades include:

- **Armadale Hospital** – Upgrades include refurbishment of courtyards and some internal spaces including a patient bathroom upgrade and a door replacement program.
- **Bentley Hospital** – Several wards have been refurbished with patient bedrooms and ensuite bathrooms receiving upgrades, including safe ligature fittings and fixtures. Upgrades to outdoor areas and increasing the perimeter fence remain on the service's list of upgrades.
- **Perth Children's Hospital** – The refurbishment of the 5A Mental Health Unit includes remodelling of staff areas to increase lines of observation, upgrades to patient areas and enhancements to outdoor courtyards to increase their use and therapeutic value.

- **Rockingham Hospital** – Planning continues for development of the Mental Health Emergency Care Centre and the Mental Health Behavioural Assessment Unit. The OCP has provided advice on models of care, mental health design principles and the application of standards.

Regional mental health unit refurbishments and upgrades include:

- **Albany** – Upgrades to the High Dependency Unit and replacement of patient bedroom viewing panels for increased privacy.
- **Broome** – Upgrades of the outdoor courtyards have been completed, including increasing the perimeter fencing for increased patient safety. Preliminary planning for the refurbishment of Mabu Liyan has begun, with the work to commence once funding is allocated.
- **Bunbury** – Upgrades of all courtyards and perimeter fencing, including landscaping and a yarning circle are underway. The service has also developed a sensory modulation room, providing a calming and relaxing environment.
- **Kalgoorlie** – The service has recently renovated their outdoor space, which was co-designed with consumers including Aboriginal Groups. Upgrades include improved perimeter fencing to ensure patient safety, landscaping, increased shaded areas and a yarning circle.

Electroconvulsive therapy, approved ECT suites

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

In the 2022-23 reporting period, the Chief Psychiatrist received one new application from Bethesda Clinic, Cockburn, a private service seeking approval to perform ECT. While the application was received in the reporting period, the formal approval is pending at the time of writing this report.

Approved ECT Suites

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

All Approved ECT services listed above will be reviewed by the Chief Psychiatrist and/or Delegate in 2024-25.

Review of Chief Psychiatrist's ECT Guidelines

The Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2006, are an important part of the Chief Psychiatrist's work. While the Guidelines have undergone several editorial reviews in recent years, they require a full review and update. The Chief Psychiatrist is grateful to the range of ECT expert clinicians, consumers and carers who have contributed to the development of updated guidelines, being led by the Deputy Chief Psychiatrist.

It is anticipated the review of the Guidelines will be completed in the 2023-24 financial year.

Clinical Consultant

The 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. In the 2022-23 financial year, the Clinical Helpdesk assisted 423 clinicians with clinical enquiries, and 115 consumers and carers, often with multiple calls and contacts to resolve matters

Of all multidisciplinary clinician enquiries received by the Clinical Consultant over the past 12 months, the majority (39%) came from Consultant Psychiatrists and related to the clinical translation and application of the MHA 2014. The helpdesk also routinely provided support to other professionals including nurses (23%) and authorised mental health practitioners (10%).

Most calls to the helpdesk related to various aspects of Community Treatment Orders (approximately 36%). Other common enquiries related to Referral Orders, Inpatient Treatment Orders, Transport Orders, and restraint and seclusion in non-authorised settings.

General Counsel

The OCP continues to take strong and positive steps to assist mental health clinicians to correctly and appropriately apply the provisions of the MHA 2014.

Our General Counsel supports the OCP in identifying and addressing legal and policy issues that arise in situations faced by mental health professionals in the clinical setting. This role provides significant rigour to the Chief Psychiatrist's oversight of standards under the MHA 2014.

The General Counsel allows the Chief Psychiatrist greater expertise in considering laws and related policies, and by recommending change where appropriate. In 2022-23, the General Counsel represented the Chief Psychiatrist on a number of legislative reform project committees, presented to a range of mental health and general health clinicians, and made submissions on behalf of the Chief Psychiatrist on a number of law reform projects.

Review of the MHA 2014

The review of the MHA 2014 continued, led by the Mental Health Commission. The Chief Psychiatrist has an ongoing focus on contemporary legislation, enhanced patient rights and the minimisation of administrative burden on clinicians administering the MHA 2014 in order to improve compliance with the MHA 2014. The identification of priorities in the reform process will be critical to the success of this review.

The Chief Psychiatrist (General Counsel as proxy) is a member of the Mental Health Act Review Committee.

Investigating mental health service pathways and outcomes for people seeking urgent mental health care

The Chief Psychiatrist, the Deputy Chief Psychiatrist and Assistant Director of Monitoring and Evaluation continued their work with Professor David Preen and colleagues from the School of Population and Global Health at the University of Western Australia. This work aims to develop a research program to investigate the relationship between access to and use of mental health services, standards of psychiatric care and patient outcomes for people presenting to ED for mental health, self-harm and suicidal behaviours.

The first stage of this partnership was to conduct a systematic review to examine secondary mental health service contact following a presentation to the ED with suicidal behaviours between 2000 and 2020. The review, recently published in the *Australian New Zealand Journal of Psychiatry**, found just over a quarter (27.1%) of adults presenting for suicidal behaviours were referred to a mental health service and 26.2% had contact with a secondary mental health service within four weeks of presenting to ED. For young people less than 24 years old the proportions were higher, 44.8% were referred and 33.7% had contact with a mental health service within four weeks of presenting to ED. The poor utilisation of secondary mental health services following ED presentation for suicidal behaviours highlights the need for this research project.

The second stage is to obtain funding for the project. The OCP team is working closely with its UWA colleagues to submit a grant application.

The value of this project to WA is significant. If the second stage is able to proceed, it will provide significant information on cohorts, pathways and outcomes which will aid state planners and give a greater understanding of expectations regarding standards.

* Feng YR, Valuri GM, Morgan VA, Preen DB, O'Leary CM, Crampin E, Waterreus A. Secondary mental health service utilisation following emergency department contact for suicidal behaviour: A systematic review. Aust N Z J Psychiatry, 2023 May 10;DOI:10.1177/00048674231172116.

Statutory reporting

Statutory reporting

Data are provided for each incident type notified to the Chief Psychiatrist, for all patients of mental health services (as defined by the MHA 2014) as a whole during the 2022-23 financial year. A separate section follows to break down the incidence in the Aboriginal mental health patients. Please note the Aboriginal consumer data are captured over a different reporting period – the 2022 calendar year – so is not directly comparable to the whole of population data which covers from 1 July 2022 – 30 June 2023 (see section Statutory Reporting – Aboriginal patients)

Restrictive practices

The Chief Psychiatrist is committed to working towards the 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 WA. The Chief Psychiatrist expects that, in line with the state and national commitments to work towards eliminating the use of restrictive practice in mental health services, seclusion and restraint 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 on rates of restrictive practices at a service.

Clinical review and follow-up of restrictive practices

The Chief Psychiatrist monitors the use of seclusion and restraint on an ongoing basis, and seeks further details when there are concerns around the standards of care, patient outcomes or non-adherence to the MHA 2014 requirements. The types of events that may require follow-up include but are not limited to, a patient being secluded or restrained for a prolonged period, patients having multiple seclusions or restraints within an admission, or where they are held in a prone restraint position for a prolonged period. When follow-up occurs it is to ensure that adequate review of incidents had taken place, and that services had undertaken planning to, wherever possible, prevent further need for seclusion and restraint. The Chief Psychiatrist and Deputy Chief Psychiatrist also visit services where there are ongoing concerns about the frequency of restrictive practices being used, to ensure the required standards of patient care are being provided and to discuss what strategies have been, or might be, employed in order to support clinicians to reduce the use of restrictive practices.

Seclusion

Of the 5,818 people who accessed care and treatment in an authorised hospital in the 2022-23 financial year, 7% (413)* had a seclusion event at some point during their stay, with 1,084 seclusion events reported during the financial year.

* 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 143 seclusion events involving 44 children and youth under 18 years of age, over two-thirds of whom were female (68%). Of the 143 seclusion events reported, 47% were less than 60 minutes, 43% between 60 and 120 minutes and 10% lasted more than 120 minutes. The median duration for each of these categories was 39 minutes, 80 minutes, and 156 minutes, respectively.

Adults aged 18-64 years

The Chief Psychiatrist received notification of 940 seclusion events involving 368 adults 18-64 years of age, almost two-thirds of whom were males (65%). Of the seclusion events reported, 24% were less than 60 minutes, over half (52%) had a duration of between 60 and 120 minutes, and 24% lasted more than 120 minutes. The median duration for each of these categories was 41 minutes, 97 minutes, and 228 minutes, respectively.

Adults aged 65 years and older

The Chief Psychiatrist received notification of less than five 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 5,818 people who accessed care and treatment in an authorised hospital in the 2022-23 financial year, 8% (478)* had a restraint event at some point during their stay. Of the 1,039 restraints reported, 99.6% comprised physical restraints with 0.4% involving mechanical restraint. Three-quarters of the mechanical restraints involved patients aged 18-64 years, with one-quarter involving patients aged less than 18 years of age.

* 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 169 restraint events involving 66 children and youth under 18 years of age, over two-thirds of whom were females (73%). This is consistent with published literature from other Australian jurisdictions*. The majority (71%) of restraint events were for less than five minutes, with a median duration of one minute. Restraint events lasting 5 to 10 minutes comprised 17% of all events and 12% lasted more than 10 minutes.

* Sealey, L., Sheppard-Law, S., Stein-Parbury, J., Roche, M., & Cruickshank, M. 2021, Restrictive Practices in the SCHN Child & Adolescent Mental Health (CAMH) Units 2015 – 2018, Report to NSW Ministry of Health. Sydney Children's Hospitals Network.)

Adults aged 18-64 years

There were 820 restraint events involving 384 adults 18-64 years of age, just over half of whom were males (52%). The majority (79%) of restraint events were less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 16% of all events and 5% lasted more than 10 minutes.

Adults aged 65 years and older

There were 50 restraint events involving 28 adults over 64 years of age, most of whom were males (71%). The majority (78%) of restraint events lasted less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 14% of all events, and 8% 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."* Restraint duration is monitored and prone restraints lasting more than three minutes are investigated as required.

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 1,039 restraints that occurred in the 2022-23 financial year, 634 (61%) involved the use of the prone position. Of the 634 prone restraints, 59 (9%) involved the use of prone position for more than three consecutive minutes.

Australian Institute for Health and Welfare national reporting 2022-23

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.

Seclusion

The overall WA rate of seclusion for the 2022-23 financial year was 4.5 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 5). The rate for adults 18-64 years of age was 5.6 per 1,000 bed days. The rate for children and adolescents below 18 years of age was 16.4 per 1,000 bed days. Older adult mental health services had no seclusions for this age group and forensics had a rate of 2.3 per 1,000 bed days.

Restraint

The overall rate of restraint for the 2022-23 financial year was 4.4 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 5). The WA restraint rates were 5.1 per 1,000 bed days for adults 18-64 years of age, 0.9 per 1,000 bed days for older adults 65 years and older, and 2.7 per 1,000 bed days for forensics. The rate of restraint for children and adolescents below 18 years of age was 16.8 per 1,000 bed days in the 2022-23 financial year.

Comparison with national rates

Over the last five years, WA has had consistently lower rates of restrictive practices than the national average. The rates of both seclusion and restraint for WA during the 2022-23 financial year were lower than the previous year.

Table 5: Overall national and Western Australian rates of seclusion and physical restraint

	Seclusion per 1,000 bed days		Restraint per 1,000 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	7.0	5.6	10.0	4.8
2022-23	*	4.5	*	4.4

* Not available at the time of publication

Notifiable incidents

The Chief Psychiatrist receives notifiable incident reports in line with s. 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 (84%) were reported through Datix CIMS, with the remaining 16% 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. A total of 475 serious incidents were flagged for review by the Deputy Chief Psychiatrist and, of these, 38% were flagged for further follow-up with the mental health service. The follow-up ranged from requesting an investigation report or treatment 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
- allegations of unreasonable use of force by a staff member
- alleged homicide.

Notifiable incidents reported to the Chief Psychiatrist in the 2022-23 financial year may contain more than one incident category and, therefore, the notifications are coded as primary and secondary notifiable incident notifications.

Clinical review and follow-up of serious clinical incidents

All notifiable incidents reported to the Chief Psychiatrist are reviewed and coded by the data monitoring team. Serious incidents, with a severity assessment code 1 (SAC1), and other incidents where concerns are noted in the report, are flagged for clinical review.

The weekly incident review meeting, led by the Deputy Chief Psychiatrist, focuses on the standards of psychiatric care being provided to the patient, the service's support for the patient, the overall handling of the incident, and whether

there were any potentially modifiable risk factors that may have contributed to the incident occurring. When concerns are identified, these are followed-up by a letter, phone call, or visit to the service, depending on the circumstances and urgency of the matter.

Incidents confirmed as SAC1 undergo in-depth review by the service to determine whether there were any aspects attributable to healthcare provision or lack thereof, or any systemic learnings, whereby recommendations are made and actioned by the service. When the SAC1 review and report have been completed, the investigation report and other relevant documentation are reviewed by the Deputy Chief Psychiatrist and data monitoring team to identify issues of concern and to ensure these and other potential risk factors have been, or are being, addressed by the service. The Chief Psychiatrist may also monitor the progress of recommendations emanating from the investigation review.

Where the structural design of a mental health unit or emergency department is identified to be a potential contributing factor, the issue is flagged for review by the Chief Psychiatrist through the hospital authorisation process.

Emerging trends are flagged with mental health services.

Primary incidents

There were 3,411 notifiable incidents reported for 1,610 patients, with a median of one incident reported per patient. One-third of these patients (34%) had two or more incidents reported. The majority of incidents involved an involuntary patient (61%), 34% involved a voluntary patient and 5% involved a person who was referred under the MHA 2014 for assessment, or who was not currently active with a mental health service. More than half (54%) of incidents involved patients identified as male.

The most frequently reported primary incident, involving 65% of all notifications, was aggressive behaviour/assault. The next most frequently reported primary incidents involved patients who were AWOL (12.5%) and attempted suicide (8.5%). Incidents involving a missing high-risk voluntary patient are also reported to the Chief Psychiatrist, equating to 4% 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 notifiable incidents reported included serious medication errors, or allegations of murder/homicide.

Secondary incidents

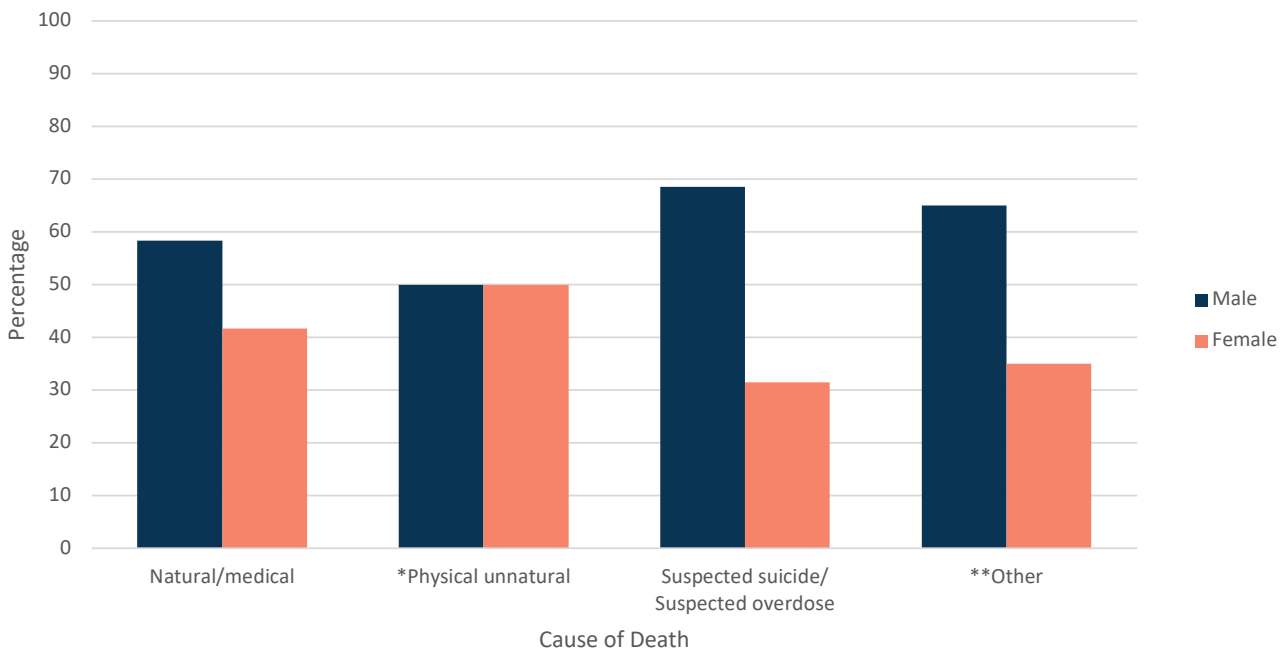
There were 116 secondary notifiable incidents reported for 98 patients. Two-thirds of secondary incidents reported comprised aggressive behaviour/assault (35%), and alleged sexual behaviour (38.5%). Attempted suicide comprised 6% of secondary incidents, AWOL of involuntary/referred patients 13%, missing high-risk voluntary person 4%, with the remaining 3.5% 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 they become aware of the death after the 28-day period (in accordance with MHA 2014 s. 52 and the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist).

The Chief Psychiatrist received 201 notifications from mental health services regarding deaths of patients during the 2022-23 financial year, of which 42% 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, 35% were suspected to be suicide or suspected accidental overdose, 3% were reported to be due to physical unnatural causes, and 20% other at the time of reporting. A higher proportion of the deaths reported involved men (63%) than women (37%), and this was consistent across most of the causes of death, except for physical unnatural, where equal proportion of deaths involved men and women. (Figure 4).

Figure 4: Proportion of deaths in mental health patients by gender and cause of death



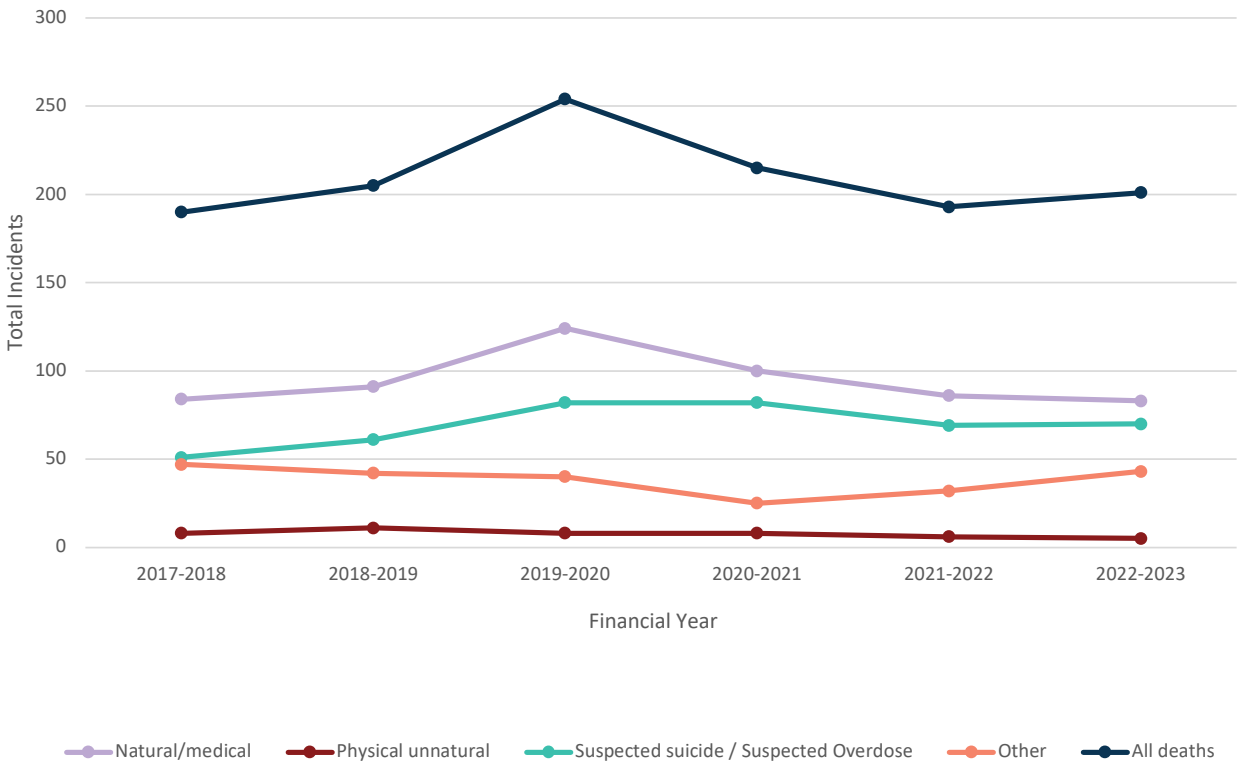
* Physical unnatural deaths included, but were not limited to, deaths due to falls, motor vehicle accidents, homicide, and medication errors.

** Other includes cause of death is not yet known or cause reported as VAD (Voluntary Assisted Dying).

All of the deaths due to natural causes and physical unnatural involved a person aged 18 years or older. Of the 70 notifications of suspected suicide deaths, 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 5). 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. Death notifications increased slightly during the 2022-23 financial year (n=201).

Figure 5: Trends in death notifications of mental health patients

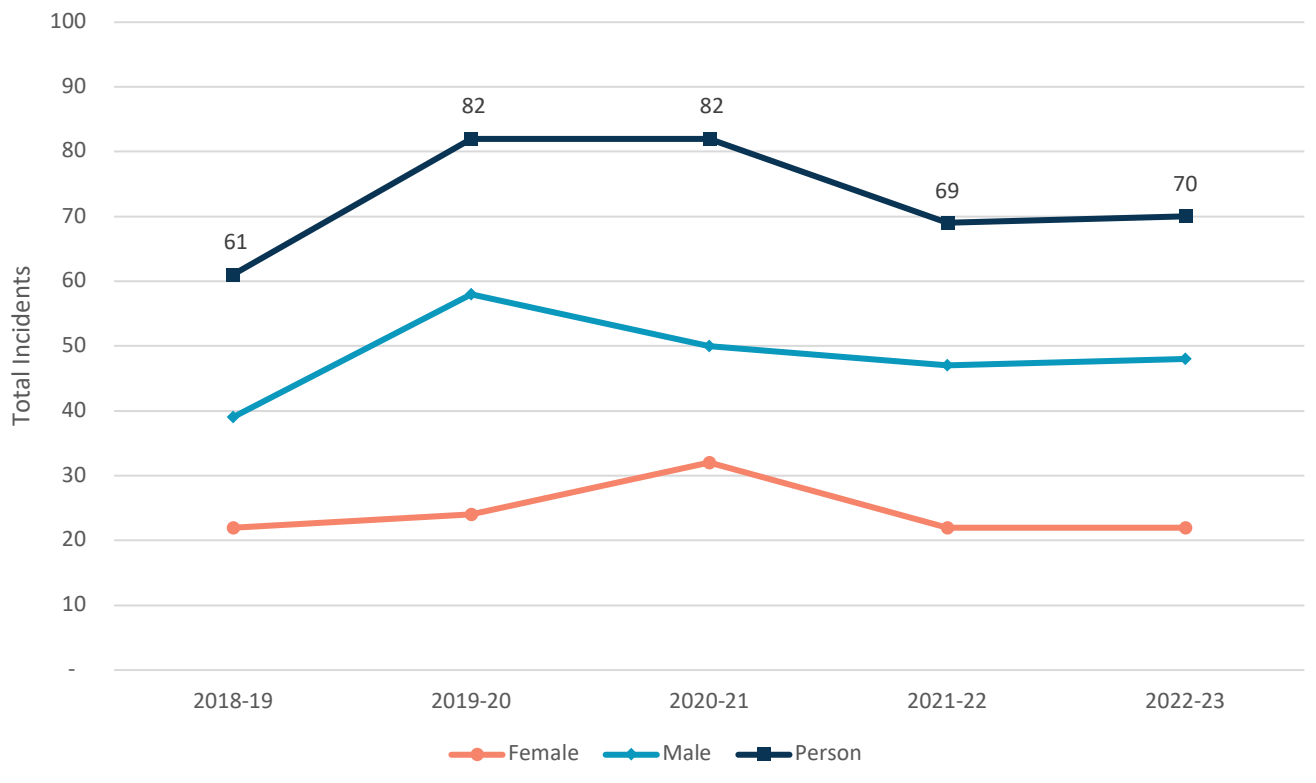


Trends in suspected suicide

The Chief Psychiatrist received 70 notifications of death by suspected suicide in 2022-23 financial year. This was similar to total suspected suicide notifications received in 2021-22 (n=69), and lower than 2019-20 (n=82) and 2020-21 (n=82) (Figure 6).
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. This number also includes deaths involving suspected overdose, which made up 4% (n=8) of total death notifications in 2022-23.

Over two-thirds (69%) of suspected suicides in 2022-23 involved male patients, which is consistent with previous years with males comprising more than 60% of notifications. Notifications of suspected suicides for males increased in 2019-20 (n=58) and has since remain similar in 2021-22 (n=50), 2021-22 (n=47), and 2022-23 (n=48). Notifications of suspected suicides for females remained the same in 2021-22 and 2022-23 (n=22) after a steady increase between 2018-19 (n=22) and 2020-21 (n=32).

Figure 6: Trends in number of suspected suicides notified to the Chief Psychiatrist*



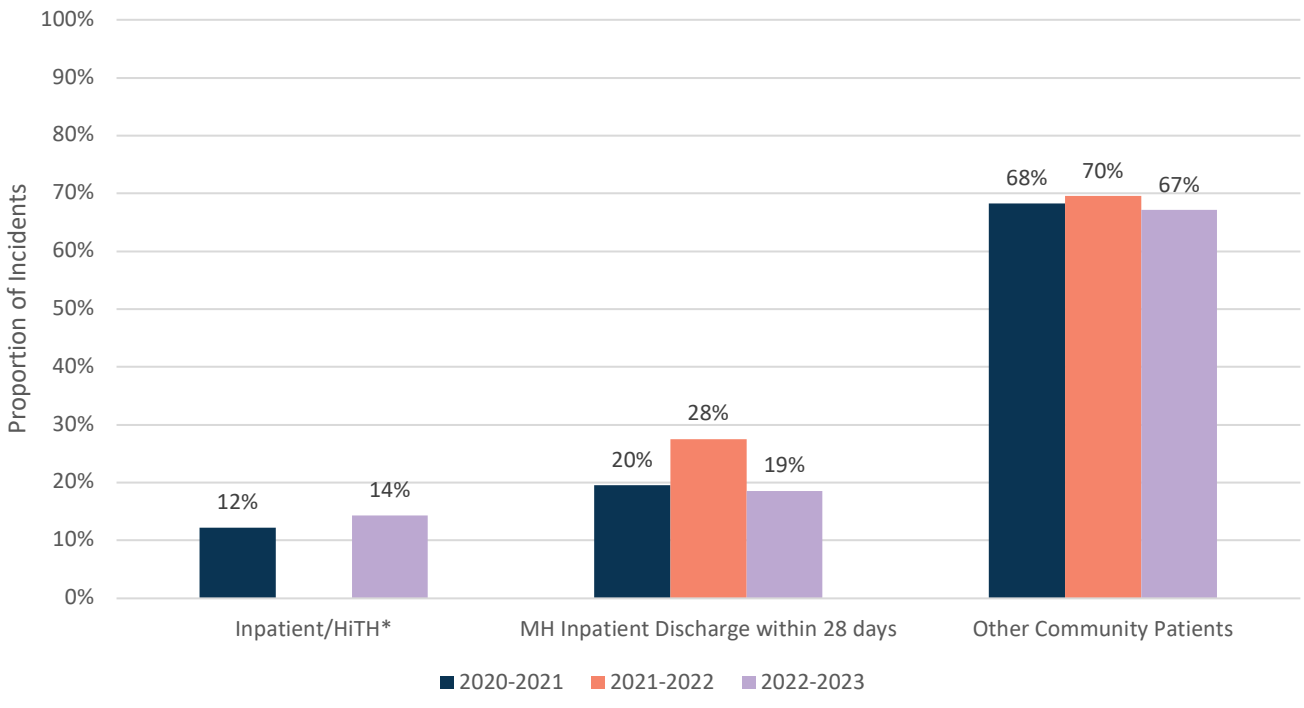
* Some data difference in previous financial years due to data validation and late notifications received after the data were published.

The majority of suspected suicides notified to the Chief Psychiatrist during the 2022-23 financial year took place in the community setting (94%), i.e. not within an inpatient ward or emergency department. There were less than five suspected suicides which occurred on an inpatient ward in 2022-23 and the previous financial years.

Notifications of suspected suicides involving a patient who had been discharged within 28 days from a mental health inpatient admission – including HiTH – was 19% in 2022-23, down from 28% in 2021-2022 (Figure 7). Of the suspected suicide notifications in 2022-23, 14% of notifications involved inpatients, including those admitted to HiTH, compared with less than five notifications who were inpatients in 2021-22 and 12% in 2020-21. Two-thirds (67%) of suspected suicides in 2022-23 involved community patients not recently discharged from hospital, which is similar to the previous two financial years: 2021-22 (70%) and 2020-21 (68%). The notifications to the Chief Psychiatrist are 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.

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.

Figure 7: Suspected suicide of patients by setting*

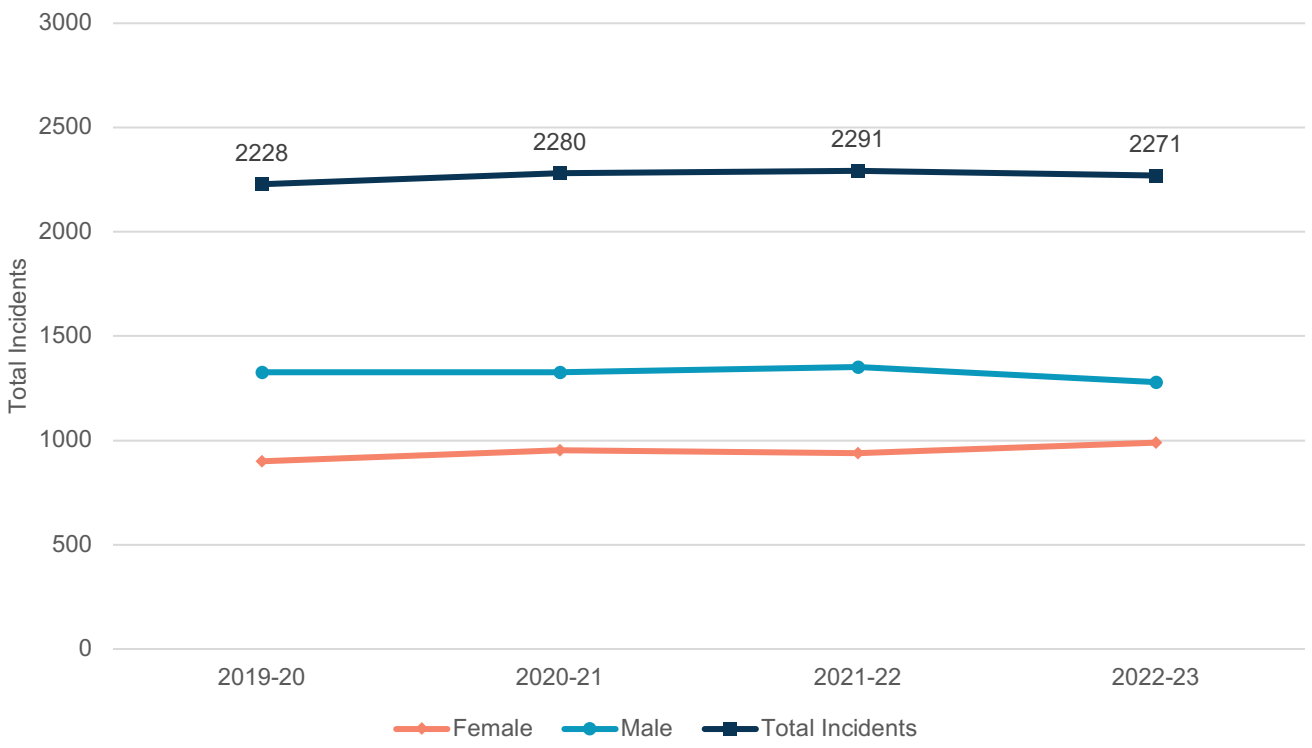


* Some data difference in previous financial years due to data validation and late notifications received after the data were published.

Assault and/or aggression

There were 2,271 notifications of aggression incidents reported to the Chief Psychiatrist during the 2022-23 financial year, which was similar to the number of events reported in previous financial years (Figure 8). 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 41% of the 2,271 aggression incidents had more than one type of aggressive behaviour, with a total of 3,200 aggression events reported.

Figure 8: Trends for aggression notifications



More than half (56%) of the aggression incidents reported in 2022-23 involved males (n=1,280) and the majority (86%) of aggression incidents involved patients aged 18 years and over (n=1,957) (Table 6). There was a decrease in total aggression incidents reported for children and adolescents under 18 years, from 351 incidents in 2021-22 to 314 incidents in 2022-23. For children and adolescents under 18 years, three quarters (75%) of aggression incidents involved females whereas for mental health patients aged 18 years and over, close to two-thirds (61%) of aggression incidents involved males.

Table 6: Notifications of aggression incidents by gender and age group

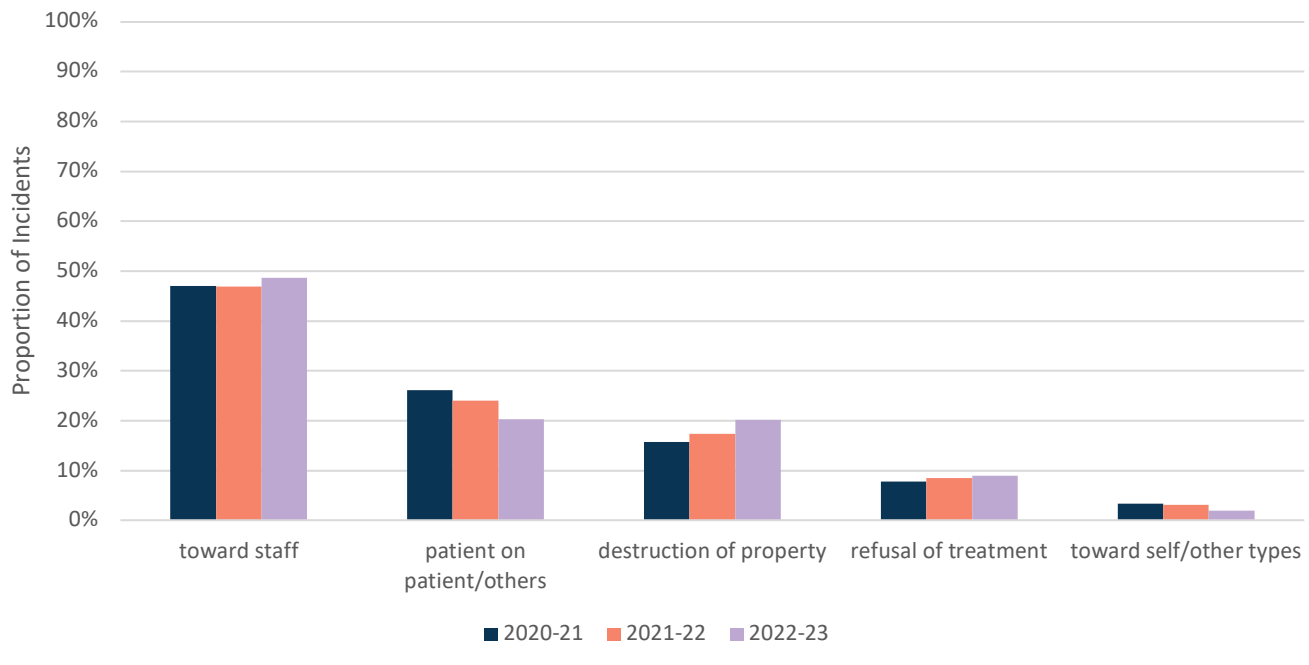
Age (Years)	Female	Male	Total Incidents
Under 18	235	79	314
18 and over	756	1,201	1,957
Total incidents	**991**	**1,280**	**2,271**

During the 2022-23 financial year, over two-thirds (69%) of reported aggression incidents involved an inpatient who was involuntary or referred. The majority (92%) of aggression incidents occurred on inpatient wards and 8% occurred at a community mental health clinic, private psychiatric hostel or ED.

More than half (60%) of the patients had one aggression incident, 24% had two or three incidents, 13% had between four and 10 incidents, and 3% had more than 10 incidents reported in the 2022-23 financial year.

Of the aggression incidents reported in 2022-23, nearly half (49%) of the notifications involved a patient being aggressive towards a staff member, which is a slight increase from 2019-20 and 2021-22 at 47% respectively (Figure 9). There was a decrease in the number of aggression incidents toward patients or other person e.g. visitors (from 26% in 2020-21 to 20% in 2022-23). An increasing trend in notifications was noted for aggression incidents involving destruction of property (from 16% in 2020-21 to 20% in 2022-23). Aggression incidents involving refusal of treatment remained similar to the previous reporting period at 9% of total aggression incidents.

Figure 9: Proportion of incidents by aggression behaviour type

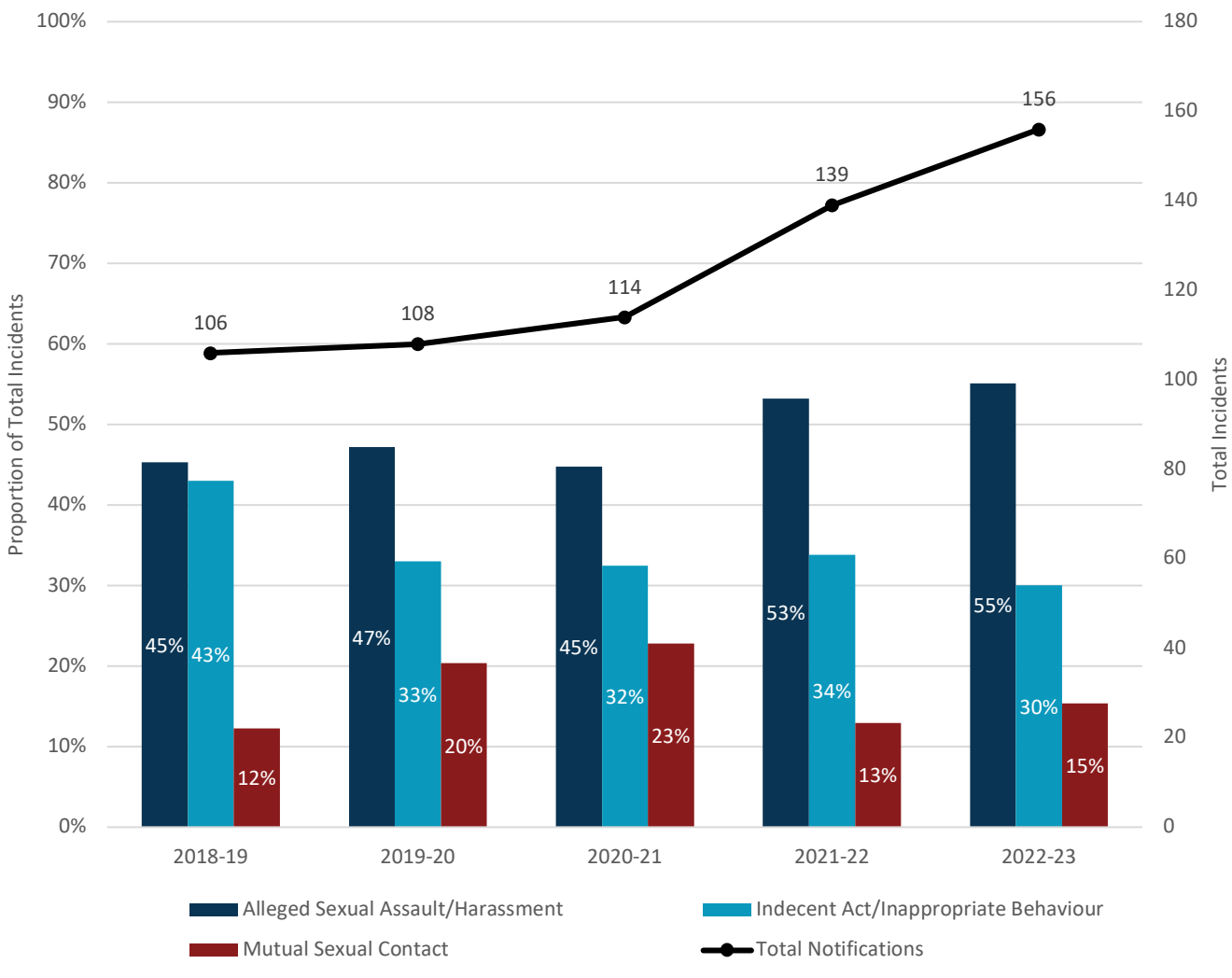


Alleged sexual behaviour incidents

A total of 156 alleged sexual behaviour incidents were notified to the Chief Psychiatrist in the 2022–23 financial year (Figure 10), which was a 12% increase from the previous financial year. Of the total alleged sexual behaviour incidents reported in 2022-23, over half (55%) were alleged sexual assault/harassment, 30% were indecent act/inappropriate behaviour and 15% were reported as consensual sexual contact (prohibited in inpatient wards).

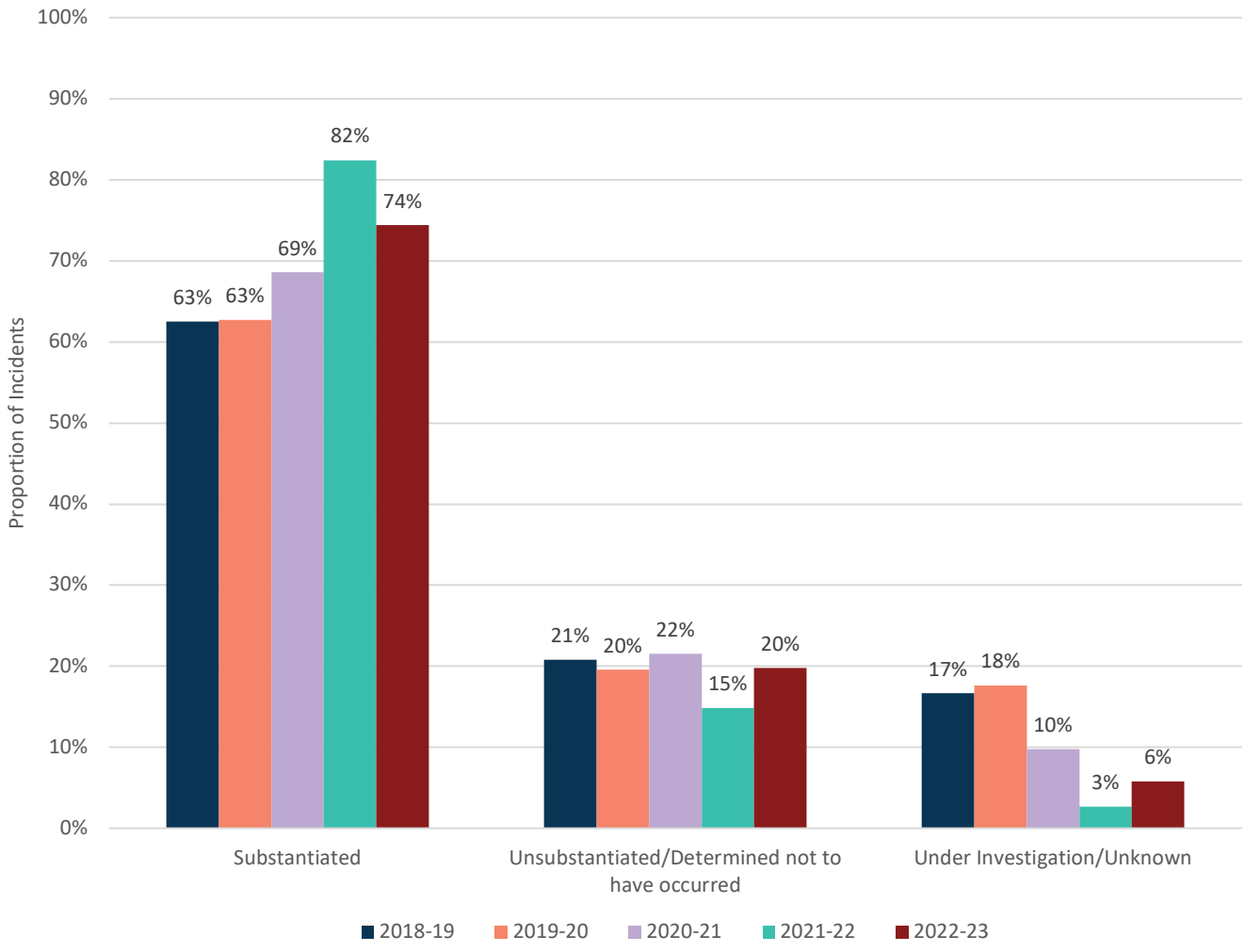
The majority (81%) of alleged sexual assault/harassment incidents reported occurred in an inpatient setting, 12% occurred at a private psychiatric hostel, and 7% occurred at a community mental health clinic or an ED. Of the alleged sexual behaviour incidents reported in the inpatient setting, nearly half (48%) were allegations of sexual assault/harassment. For hostels, the majority (95%) were allegations of sexual assault/harassment.

Figure 10: Types of alleged sexual behaviour and trends in total incidents notified to the Chief Psychiatrist



Of all allegations of sexual assault/harassment incidents that were notified to the Chief Psychiatrist in 2022-23, 74% were substantiated, 20% were unsubstantiated, and 6% were still under investigation or outcome unknown as of 1 July 2023 (Figure 11).

Figure 11: Investigation outcome of alleged sexual assault/harassment incidents



The Chief Psychiatrist remains focused on monitoring and investigating alleged sexual behaviour incidents. In 2022-23, 50% 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 set out in the Chief Psychiatrist's Sexual Safety Guidelines.

The Chief Psychiatrist believes the effective roll-out of the guidelines, released in December 2020, has led to an increase in reporting of alleged sexual behaviour incidents, from 108 in 2019-20 to 156 in 2022-23. To promote knowledge translation, a copy of the Guidelines is emailed to the notifying service on receipt of a sexual safety notification. The Chief Psychiatrist is committed to ensuring that staff respond appropriately to all allegations and to investigate and report allegations of sexual behaviours. In addition, it is expected that services will put in place strategies that help to reduce the risk of sexual safety incidents occurring. However, the OCP will continue to closely monitor these incidents.

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 300 notifications of attempted suicide involving 232 individuals during the 2022-23 financial year. Of these incidents:

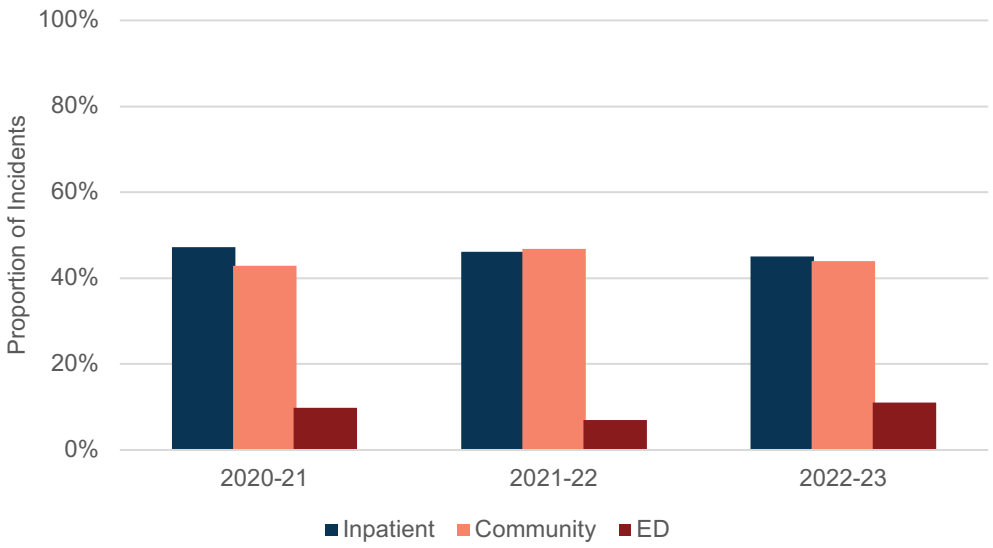
- The majority (85%) of the individuals had one reported attempted suicide and 15% had two or more attempted suicides.
- Less than one-tenth (8%) of attempted suicides were reported to have resulted in serious harm to the patients.
- Nearly three out of four (72%) attempted suicides involved voluntary patients and more than one out of four (28%) involved involuntary patients and patients referred for assessment.
- The majority of reported attempted suicides involved females (n=217, 72%), with one-third (n=75, 35%) of the women aged less than 18 years (Table 7).
- For males, the highest proportion of attempted suicides occurred for those age 18 years and older (n=58, 70%).

Table 7: Notifications of attempted suicide by gender and age group

Age (Years)	Female	Male	Total Incidents
Under 18	75	25	100
18 and over	142	58	200
Total incidents	**217**	**83**	**300**

Notifications of attempted suicides were reported to occur mostly in an inpatient ward (45%) and in the community (44%) such as private psychiatric hostels or residential homes. The remaining incidents occurred when the person was attending an ED (11%). This was consistent with figures reported in the previous financial year (Figure 12).

Figure 12: Proportion of incidents by location of the attempted suicide



Absent without leave (AWOL)

Under s. 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 440 AWOL notifications involving 290 involuntary patients or patients referred for assessment under the MHA 2014 during the 2022-23 financial year. Of those:

- In around half (46%) of AWOL notifications, the patients were located on the same day, 24% a day later, and 25% were located two to seven days later, with the remaining 5% located between 8 and 26 days later.
- The majority (98%) of AWOL patients had been located by the end of the 2022-23 financial year and less than five patients experienced serious harm while they were AWOL.
- The majority of AWOL patients (74%) had one event, 14% had two events, and 12% of patients had three or more AWOL events reported.
- The majority of AWOL notifications (92%) involved patients who were involuntary at the time they went AWOL and 8% were patients who had been referred for assessment.
- The majority (96%) of AWOL events involved patients who were 18 years of age or older (Table 8).
- More than half (57%) of reported AWOL incidents involved male patients, of which less than five were aged under 18 years.

Table 8: Notifications of absent without leave by age group

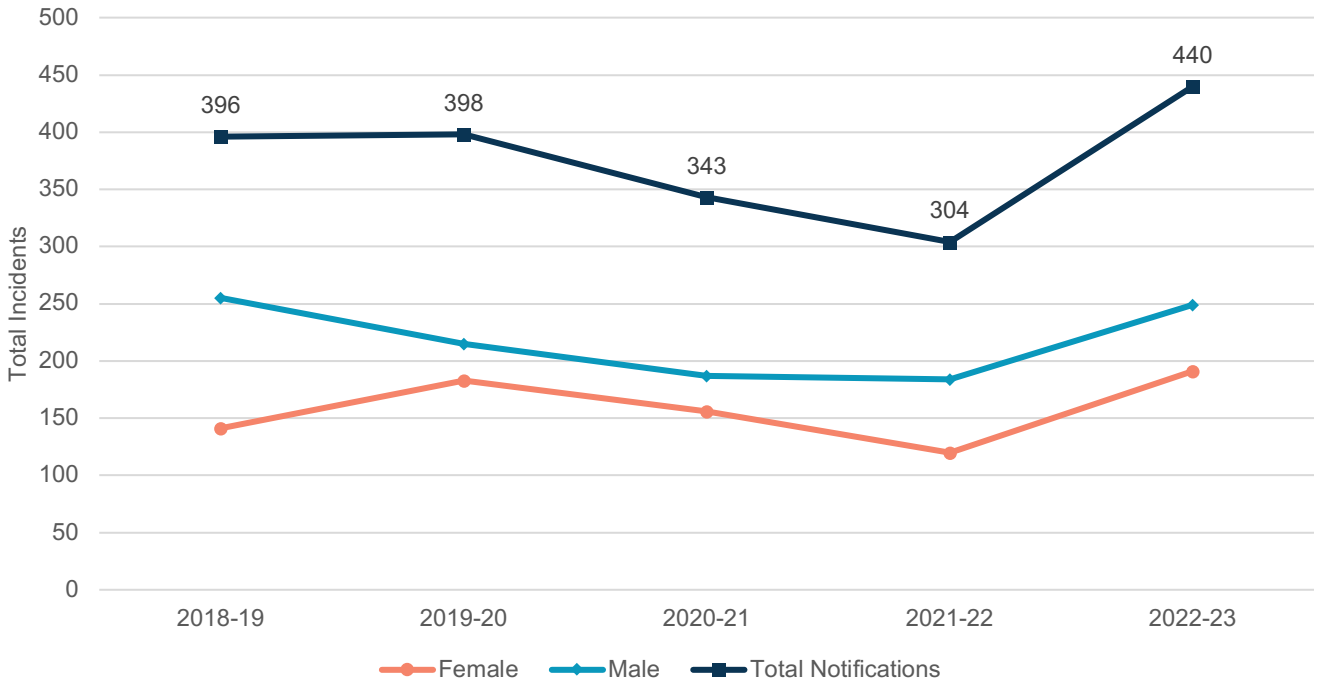
Age (Years)	Total Incidents	Proportion of Incidents
Under 18	16	4%
18 and over	424	96%
Total	**440**	**100%**

Notifications of AWOL incidents decreased from 398 in 2019-20 to 304 in 2021-22, however, there has been an increase of AWOL incidents reported in 2022-2023 (n=440) (Figure 13). More than half of AWOL incidents reported from 2018-19 to 2022-23 involved male patients.

One of the reasons for the increase of reported AWOL incidents in 2022-23 was due to an increase of individual patients having multiple AWOL events. For example, 12% of all reported AWOL patients had three or more AWOL incidents in 2022-23 (n=36 patients, n=145 incidents), compared to 9% of all reported AWOL patients in 2021-22 (n=19 patients, n=81 incidents). There has also been an increase of reported AWOL incidents where patients failed to return from authorised leave or unescorted ground leave in 2022-23 (n=218, 50%) compared with 2021-22 (n=132, 43%).

Internal review of AWOL incidents identified structural issues at some mental health services as a contributing factor, resulting in multiple events at a small number of services. Where the structural design of the site was identified as a possible contributing factor, the issue was reviewed through site visits through the authorisation process.

Figure 13: Trends for AWOL notifications*



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

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 150 notifications of high-risk voluntary patients reported as missing from a mental health service, involving 126 individuals, of whom 56% were male and 44% were female. The majority (82%) of missing person incidents involved patients aged 18 and over (n=130) (Table 9), of which 41% were females (n=53) and 59% were males (n=77). In contrast, for children and adolescents under 18 years, a 60% of notifications involved a female (n=12) than a male (40%, n=8).

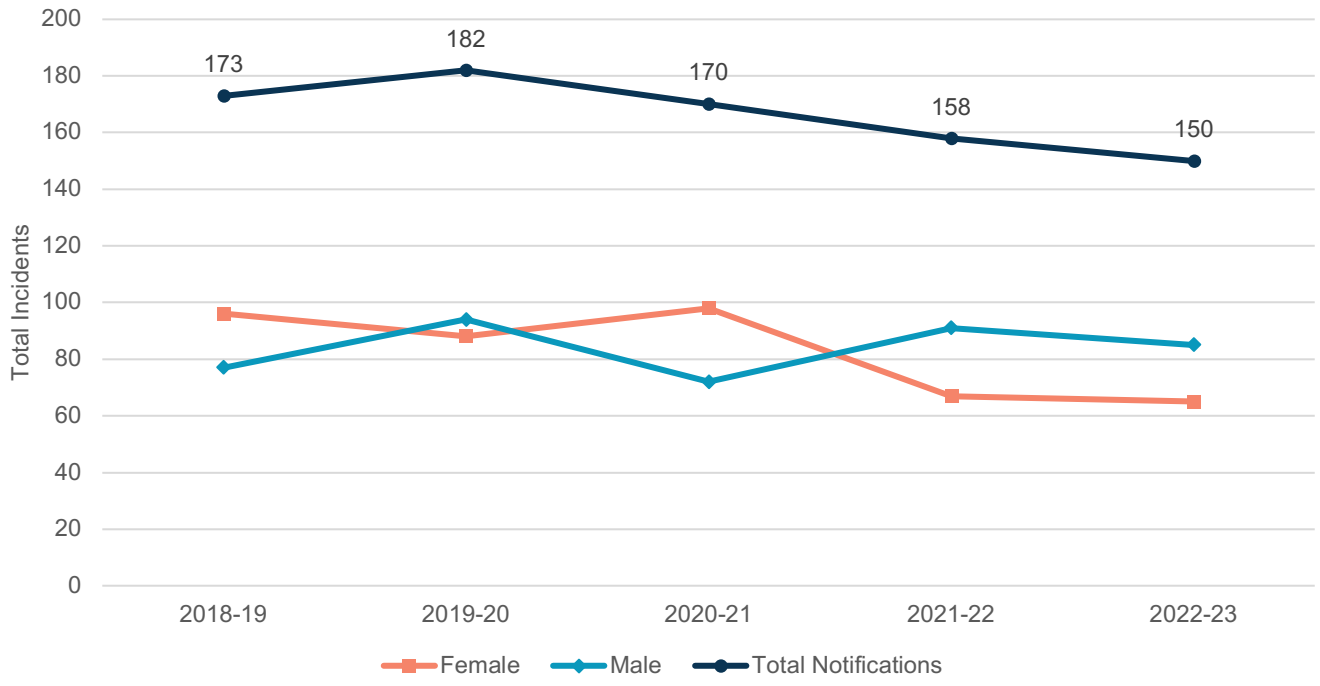
Table 9: Notifications of missing person by gender and patient age group

Age (Years)	Female	Male	Total Incidents
Under 18	12	8	20
18 and over	53	77	130
Total incidents	**65**	**85**	**150**

Most patients (90%) had one missing person notification and 10% had between two and four events reported. Less than five incidents reports resulted in serious harm to patients following the missing person notification.

Total notifications for missing persons decreased from 182 in 2019-20 to 150 in 2022-23 (Figure 14). Notifications for female and male patients fluctuated between 2018-19 and 2020-21, however, these have remained similar in 2021-22 and 2022-23.

Figure 14: Trends for missing person notifications



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 2022-23 financial year, of which all incidents were reviewed by the Deputy Chief Psychiatrist.

Allegations of unreasonable use of force by a staff member

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 and 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 six notifications of suspected 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 by the Deputy Chief Psychiatrist and, where required, was flagged to the Chief Psychiatrist for further investigation to ensure an appropriate response was actioned by the service.

Alleged homicide

Less than five notifications of homicide allegedly committed by a person who was a mental health patient were received during the 2022-23 financial year. The number of notifications was similar to the previous two financial years.

Aboriginal patients

Aboriginal status is not reliably reported through the data notification process. In order to monitor outcomes and trends for Aboriginal mental health patients, Chief Psychiatrist data are linked to the Department of Health Aboriginal flag. The data are linked for the 2022 calendar year in order to meet the Annual Report timeframe.

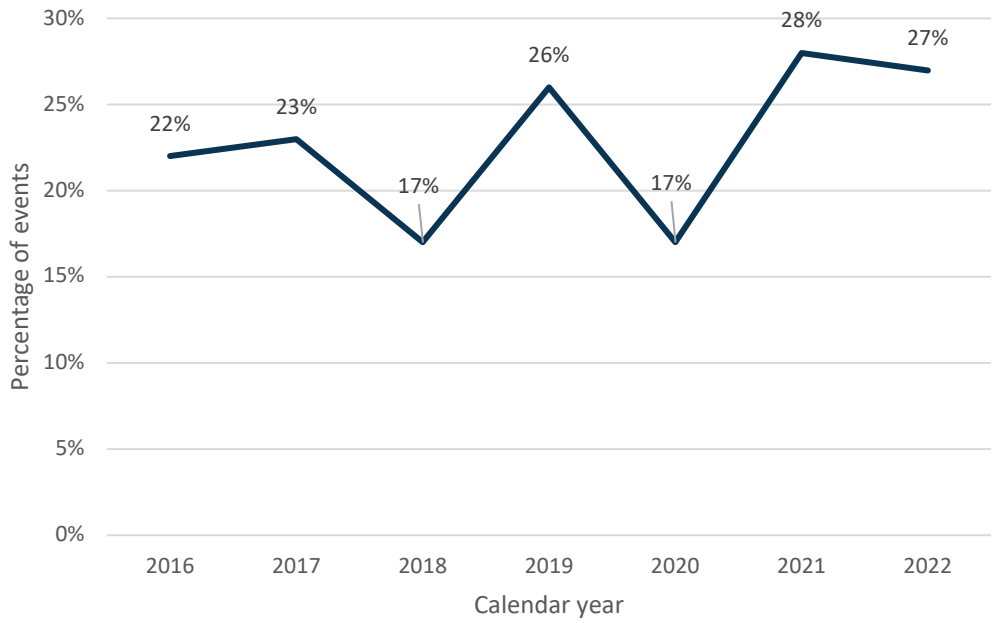
The over-representation of Aboriginal people in mental health inpatient services, and subsequently also with restrictive practices and notifiable incidents, highlights the gaps that still exist in the provision of high-quality mental health care which meets the social and emotional wellbeing needs of Aboriginal peoples, including the issues of regional and rural gaps. The Kaatadjiny Walbraaniny Danjoo project remains critical to the OCP's ability to drive standards of care and address this gap. This remains a high priority for the Chief Psychiatrist.

Restrictive practices

Use of seclusion

In the 2022 calendar year, there were 358 seclusion events involving an Aboriginal patient, equating to 27% of the total 1,330 seclusion events. This is slightly lower than the proportion of seclusion events that involved an Aboriginal patient in the previous year (Figure 15). Of the 400 individuals secluded in the 2022 calendar year, 113 (28%) were Aboriginal.

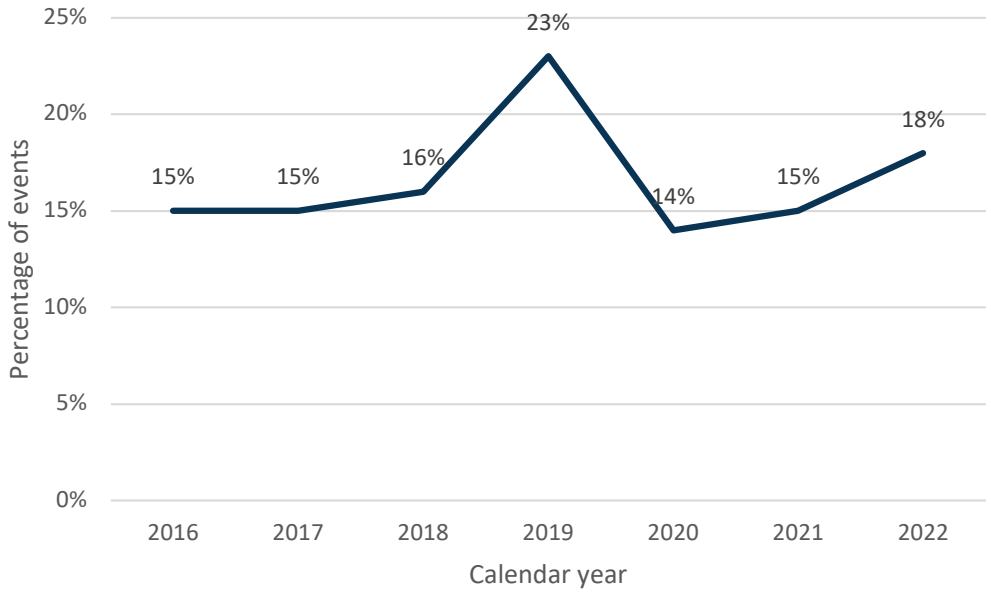
Figure 15: Trends in the percentage of seclusion events involving an Aboriginal patient since 2016



Use of restraint

In the 2022 calendar year, there were 188 restraint events involving an Aboriginal patient, equating to 18% of the total 1,051 restraint events. The proportion of restraint events involving an Aboriginal patient has risen steadily over the last three years, increasing from 14% in 2020 to 18% in 2022 (Figure 16). Of the 445 individuals restrained in the 2022 calendar year, 75 (17%) were Aboriginal.

Figure 16: Trends in the percentage of restraint events involving an Aboriginal patient since 2016



Notifiable incidents

Primary incidents

Of the 3,399 primary notifiable incidents reported for 1,543 patients during the 2022 calendar year, 727 (21%) incidents were reported for 283 (18%) Aboriginal patients. Over half (60%) of the notifications involved a male Aboriginal patient and 91% of notifications involved adults 18 years and over. Of the 727 primary incidents involving an Aboriginal patient the type of incident reported included:

- aggressive behaviour/assault – 70.5% of notifications
- absent without leave, involuntary/referred patients – 12.5% of notifications
- missing, high-risk voluntary patients – 5% of notifications
- deaths – 4% of notifications
- attempted suicides – 4.5% of notifications
- alleged sexual behaviour – 3% of notifications
- other – less than 1% of notifications. Incidents not specified due to small numbers.

Secondary incidents

There were 123 secondary notifiable incidents reported for 101 patients for the 2022 calendar year. Of the 123 notifications, 30 (24%) of the notifications were reported for 25 (25%) of Aboriginal patients. The most frequently reported secondary incidents involving an Aboriginal patient were AWOL (36.5%), aggressive behaviour/assault (27%) and incidents of a sexual nature (20%). Attempted suicide and missing person comprised 7% and deaths 3% of notifications.

Death notifications

The Chief Psychiatrist received 188 notifications in the 2022 calendar year advising of the death of a mental health patient. Of the 188 death notifications, 28 (15%) related to an Aboriginal patient. Of the 188 deaths, Aboriginal patients comprised 14% of deaths that were due to natural/medical causes, 14% of deaths due to unknown or physical unnatural causes, and 18% that were due to suspected suicides. Of the 28 Aboriginal deaths reported, 46% of the deaths were due to natural/medical causes, 18% were due to unknown or physical unnatural causes, and 36% were due to a suspected suicide. All the suspected suicides involving an Aboriginal patient related to adults aged 18 years or older.

Aggression incidents

There were 2,354 notifications of incidents relating to aggression, involving 924 patients. Of these, 521 (22%) were reported for 171 (19%) Aboriginal patients. Incidents relating to aggression may involve more than one type of aggressive behaviour. For the 521 incidents involving an Aboriginal patient, there were 756 aggression events reported. Of these, 41% involved aggression towards staff, 11% involved assaults on staff, 9% involved aggression towards other patients, 7% involved assault of another patient, 17% involved aggression towards property, and 5% involved destruction of property. The low numbers of the remaining 10% of aggressive incidents prevents further information being provided.

Alleged sexual behaviour incidents

There were 137 notifications of incidents of alleged sexual behaviours reported for 108 mental health patients. Of the 137 notifications, 29 (21%) were reported for 23 (21%) Aboriginal patients, of which less than 5 were under 18 years of age. Of the 29 notifications, 69% of the alleged sexual behaviour comprised of sexual assault/harassment. Of these, 70% involved a female patient as either the perpetrator (36%) or victim (64%).

Attempted suicide

The Chief Psychiatrist was notified of 349 attempted suicides involving 247 individuals. Of these, 36 (10%) incidents involved 25 (10%) Aboriginal mental health patients. The majority (72%) of Aboriginal patients were 18 years of age or older, and 56% of the attempted suicides involved a male.

Absent without leave (AWOL)

There were 340 AWOL notifications of an involuntary patient or a patient referred for assessment under the MHA 2014, relating to 237 patients. Of the 340 notifications, 103 (30%) involved 70 (30%) Aboriginal patients, of which 57% were female. Of the 70 Aboriginal patients, over 90% were located.

Missing persons

There were 148 notifications relating to 125 voluntary patients reported as missing from a mental health service, with 38 (26%) notifications involving 29 (23%) Aboriginal patients. The majority (59%) of missing Aboriginal patients were male.

Other

There were less than 5 incidents comprised of allegations of committed murder or serious medication error involving an Aboriginal patient. Each incident was flagged to the Deputy Chief Psychiatrist and reviewed.

Summary and trends over time

All notifiable incidents for Aboriginal patients are outlined in Table 10 and trends in the proportion of notifiable incidents for Aboriginal patients from 2018-2022 are outlined in Table 11.

Table 10: Proportion of notifiable incidents reported to the Chief Psychiatrist that involved an Aboriginal patient during 2022

Type of Incident	All Notifications N	Aboriginal %	All Individuals N	Aboriginal %
Aggression	2,354	22	924	19
Alleged Sexual Behaviour	137	21	108	21
Attempted Suicide	349	10	247	10
AWOL	340	30	237	30
Death	188	15	188	15
Missing Person	148	26	125	23

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

Table 11: Trends in the proportion of notifiable incidents (primary and secondary) reported to the Chief Psychiatrist per calendar year from 2018-2022 for Aboriginal patients

Type of Incident*	2018 %	2019 %	2020 %	2021 %	2022 %
Aggression	64	70	64	71	69
Alleged Sexual Behaviour	5	4	2	4.5	4
Attempted suicide	3	3	4	3.5	5
AWOL	15	15	18	13	14
Death	3	3	5	3	4
Missing Person	9	6	7	5	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 Electroconvulsive Therapy (ECT) in WA is strictly regulated under MHA 2014 s. 194-s. 199. 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 maintains a register of health services that have been approved as meeting the standards to perform ECT. A total of 11 services are approved to perform ECT in Western Australia.

It is noted there has been a reduction in the total number of ECT courses and treatments during this reporting period. The reason for this is not clear. ECT remains a well-evidenced and valuable treatment option for specific indications.

Mandatory reporting of ECT data to the Chief Psychiatrist

Mental Health Services are required under the MHA 2014 s. 201 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 2022–23, there were 689 completed ECT courses involving adults 18 years and above and reported to the Chief Psychiatrist, compared with 789 courses in the 2021-22 financial year (Table 12). There were no ECT courses reported for patients under 18 years of age. Of the 689 courses, 628 (91.2%) were for patients with a voluntary status, 47 (6.8%) were for involuntary or referred status, and 14 (2%) were for mixed status (both voluntary and involuntary).

There were 7,545 ECT treatments completed in the 2022-23 financial year, of which 5,816 (77.1%) were acute treatments, 1,707 (22.6%) were maintenance treatments and 22 (0.3%) consisted of emergency treatments (Table 12)

In the 2022-23 financial year, there were 34 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 2022-23 reporting period, they are not reflected in Table 12. These emergency

ECT treatments will be included in the reporting period in which the ECT course is completed. The number of emergency ECT treatments given in ECT courses that were completed during 2022-23 are shown in Table 12. These include some emergency ECT treatments authorised in the previous financial year.

Table 12: ECT courses and treatments completed in the 2022-23 financial year

Age	Status	Number of ECT courses completed in 2022-23	ECT treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
All patients[a]	Voluntary	628	5,015	1,345	0	6,360
	Involuntary / Referred[b]	47	591	47	14	652
	Mixed[c]	14	210	315	8	533
	Total	**689**	**5,816**	**1,707**	**22**	**7,545**

* ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2022 – 30 June 2023).
[a] patients under 18 not reported separately as no ECT courses reported for this group;
[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 decreased in the last financial year compared with the previous three years (Figure 17). The types of ECT treatments per year are outlined in Figure 18.

Figure 17: Total ECT courses by status and year

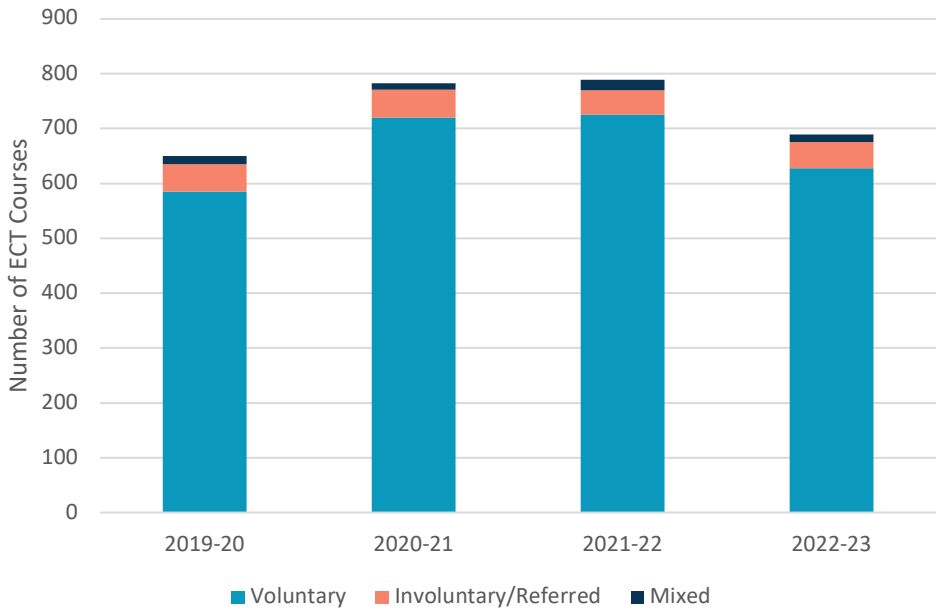
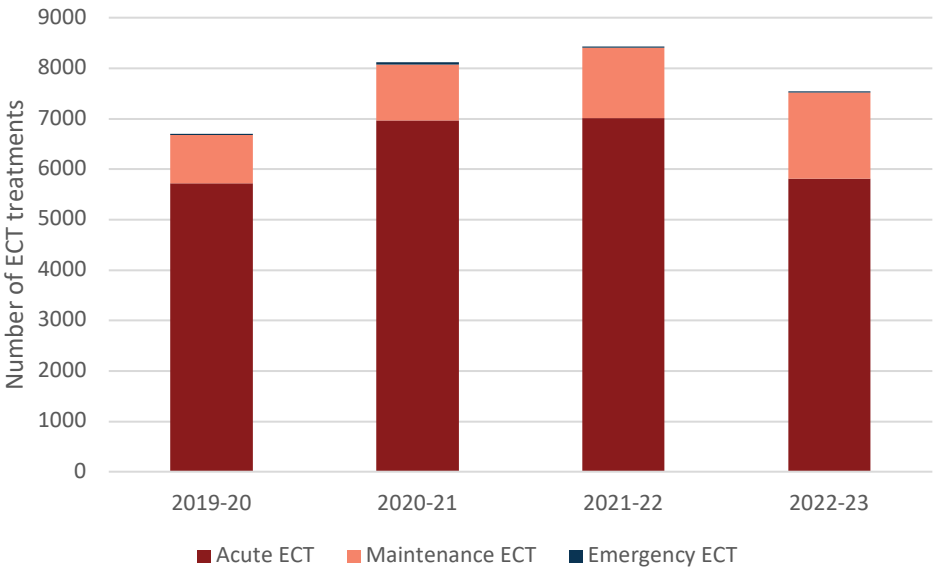


Figure 18: Type of ECT treatment by year



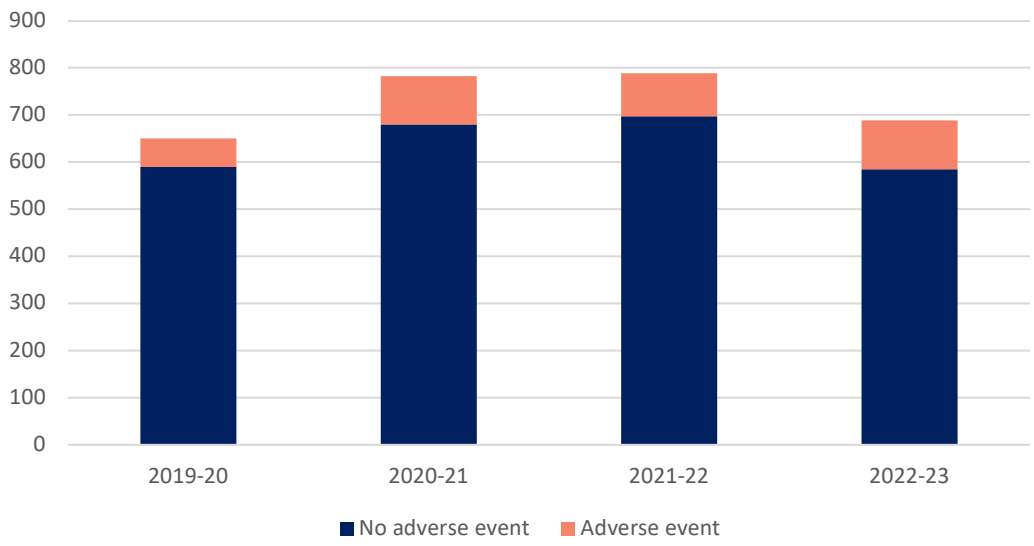
The majority of all ECT courses (63.4%) were provided in a private hospital, 28.3% were provided in a public hospital, and 8.3% were provided in a publicly contracted private hospital.

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, and persistent memory deficit.

The majority (84.9%) of the 689 courses of ECT reported during 2022-23 did not have any serious adverse events reported. An adverse event during one or more treatments was reported for 15.1% (n=104) of these courses. This is higher than the previous year, where serious adverse events were reported for 11.5% of ECT courses. Trends in serious adverse events are shown in Figure 19.

Figure 19: Serious adverse events by year



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 282 involuntary treatment orders in a general hospital setting during the 2022-23 financial year.

Of the 282 orders, 43% (n=122) were in general hospital for seven days or less, 27% (n=76) were in general hospital for between 8 to 14 days and 30% (n=84) were in a general hospital for more than 14 days. A small number of patients (n=28) 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 orders that were valid for more than seven days, the Chief Psychiatrist received 56% of the required approved 6B attachment forms. When these are overdue, Chief Psychiatrist staff follow-up with the mental health clinicians with the aim of ensuring compliance with reporting under the MHA 2014.

The OCP 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 230 cases of EPT reported to the Chief Psychiatrist, of which 50% were female and 50% male patients. The majority of notifications were from metropolitan hospitals (84.4%), with 15.6% from the WA Country Health Service. Of the patients who received EPT, 68% were adults aged between 18 and 64 years, 8% were 65 years or older and 24% were under 18 years of age. The types of EPT provided to the patients included medication alone (27%) or medication in conjunction with the patient being secluded and/or restrained (73%). The method of administration of EPT was also reported: 89% of EPT was administered via intra-muscular injection, 8% was administered orally and the other methods reported were sublingual, intravenous, or not specified (3%). The most commonly reported medications were Clonazepam (24%), Midazolam (18%), Droperidol (15%), Haloperidol (14%), Olanzapine (10%), and Lorazepam (8%), and which together account for 89% 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.*

Under s. 242 of the MHA 2014, the person in charge of the Authorised Hospital must report the provision of urgent non-psychiatric treatment to the Chief Psychiatrist through submission of the approved form. In the 2022-23 financial year, there were 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 610 notifications of a child under 18 years of age being admitted to an adult mental health service in the 2022-23 financial year, compared with 259 notifications in the 2021-22 financial year. Data from the

Department of Health indicated there was significant under-reporting in 2021-22. To assess whether services were implementing the requirements of MHA 2014 s. 303 the Chief Psychiatrist undertook a targeted clinical review of four inpatient services regularly admitting children to wards with adult patients. This has resulted in a 135% increase in the number of s. 303 forms received for the 2022-23 financial year (610 notifications compared with 259 notifications in the previous financial year). Of the 610 notifications received, 439 (72%) of these were for females, and 171 (28%) were for males. Validation with admission data from WA Health is ongoing and is used to identify gaps in reporting. Where gaps are found, this is addressed with the service.

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.

For the reporting period, there were less than five notifications of children who were involuntary patients receiving off-label treatments. The small number of notifications prevents further examination of these data.

The Chief Psychiatrist believes that this section within the MHA 2014 may not be the most effective indicator to track safety around medication use in children who are involuntary. Recommendations have been made by the Chief Psychiatrist to the Statutory Review of the MHA 2014 regarding a potentially more effective tracking process for safety and quality around medication use in children.

Other activities of the OCP

Other activities of the OCP

OCP contributions to consultation

The OCP has continued to make contributions to consultation activities in 2022-23, including the following:

- The Independent Governance Review (WA Health) made reference to significant proposed changes to mental health governance in WA. A further process to consult and consider appropriate governance options for mental health services in WA was undertaken during this period. The Chief Psychiatrist was a member of the Independent Governance Review Working Group.
- The Statutory Review of the *Mental Health Act 2014*.
- The consultation paper for a nationally consistent scheme for access to digital records upon death or loss of decision-making capacity.
- The survey for amendments to the Medicines and Poisons Regulations 2016 and Schedule 8 Medicines Prescribing Code.
- At the request of the Health Service Providers (HSPs), the Office contributed to reviews of new service Models of Care including Fremantle Hospital Mental Health Service V Block, Rockingham and Peel Group Behavioural Assessment Unit, and Mental Health Emergency Care Centre, and the Joondalup Health Campus Mental Health Service.
- The OCP has contributed to reviews of HSP policy documents with a focus on enhancing the standards of care.
- The OCP provided comment on the Mental Health Commission's Step-Up Step-Down Program Review.
- Statewide Forensic Model of Care Working Group.
- Statewide Youth Forensic Model of Care Working Group.

Statewide committees

Accountability Agencies Collaborative Forum

WA Mental Health and Alcohol and Other Drug Governance Working Group

Clinical Advisory Group to the Graylands Reconfiguration and Forensic Taskforce (GRAFT)

Coronial Review Committee

COVID-19 Mental Health Working Group Meeting

Developing Leaders Peer Review

Forensic Model of Care Working Group

Gayaa Dhuwi (Proud Spirit) Declaration I Expert Advisory Group Meeting

Hospital-Acquired Complications Curation Clinical Advisory Group

Jurisdictional Round Table for Improving Mental Health in Patient Consumer Safety

Mental Health Advisory Group

Mental Health and Suicide Prevention Senior Officials Group

Mental Health Act 2014 Statutory Review – Steering Group

Mental Health Quality Surveillance Group

Mental Health Workforce Planning Project – Program Control Group

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) Advisory Group

Private Hostels Association Committee

Reform of the Criminal Law Mentally Impaired Legislation Working Group

The Royal Australian and New Zealand College of Psychiatrists WA Branch Committee

Statewide Anti-ligature Audit Committee – Department of Health

Statutory Review of the *Mental Health Act 2014* – Regulation of Treatment and Other Interventions Workshop

Statutory Review of the *Mental Health Act 2014* – Aboriginal People & MHA 2014 Workshops

Statutory Systems Change Project Working Group / Kaatadjiny Waalbraniny Danjoo Project

Stimulant Assessment Panel

Mental Health Workforce Planning Project – Program Control Group

WA Forum: Working towards eliminating restrictive practices in mental health settings

WA Psychotropic Medication Group

WA Therapeutics Advisory Group

The Department of Justice's Criminal Law (Mental Impairment) Reform Project

National/Binational activities

The National Mutual Recognition of Mental Health Orders Legislation Project

National Summit on Youth Radicalisation – Australia-New Zealand Counter-Terrorism Committee.

The Royal Australian and New Zealand College of Psychiatrists Congress

The Royal Australian and New Zealand College of Psychiatrists Gender Equity Working Group Workshop

The Royal Australian and New Zealand College of Psychiatrists Education Committee Meeting

The Royal Australian and New Zealand College of Psychiatrists Committee for Exams

The Royal Australian and New Zealand College of Psychiatrists Membership Engagement Committee

The Royal Australian and New Zealand College of Psychiatrists Overseas Trained Psychiatrists Committee

The Royal Australian and New Zealand College of Psychiatrists Committee for International Medical Graduate Education

The Royal Australian and New Zealand College of Psychiatrists Corporate Governance and Risk Committee

Other visits/external engagement

OCP and Department of Health Mental Health Unit co-hosting the *Mental Health Community Forum: Working Towards the Elimination of Restrictive Practices*

Secure Extended Care Unit Clinical & Practice Working Group – Royal Perth Bentley Group

Royal Perth Bentley Group, Major Projects Capital

Mental Health Emergency Care Centre and Behavioural Assessment Unit Working Group – Rockingham Hospital

Joondalup Health Campus Redevelopment

Bentley Health Service Anti-Ligature Works – Working Group

Fremantle Hospital Redevelopment Working Group

Geraldton Health Campus Design Development User Group

WACHS Capital Works Working Group – Regional

Perth Children's Hospital Ward 5A Refurbishment Project – Project Control Group

Social and Emotional Wellbeing Gathering (SEWB) 3

Mental Health Summit: Towards the elimination of restrictive practices

6th National Social and Emotional Wellbeing Forum

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, five private psychiatric hospitals, 35 private psychiatric hostels, and 16 NGOs providing clinical mental health care. This amounts to overseeing the treatment and care of approximately 62,000 patients each year.

There are other services where individuals with mental illness receive care that are not under the statutory oversight of the Chief Psychiatrist, these include primary drug and alcohol services, step-up/step-down services, and others. The Chief Psychiatrist is cognisant of the interface among statutory mental health services and these services.

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 OCP 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 OCP 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).