CHIEF PSYCHIATRIST
of Western Australia

'Ensuring Safe and High Quality Mental Health Care'

Annual Report of the Chief Psychiatrist of Western Australia

01 July 2017 – 30 June 2018

Statement of Compliance

HON ROGER COOK MLA

DEPUTY PREMIER;

MINISTER FOR HEALTH; MENTAL HEALTH

In accordance with section 533 and 534 of the *Mental Health Act 2014,* I hereby submit for your information and presentation to Parliament, the Annual Report of the Chief Psychiatrist for the financial year ended 30 June 2018.

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

Dr Nathan Gibson
CHIEF PSYCHIATRIST
ACCOUNTABLE AUTHORITY

11 September 2018

Declaration of Financial Accountability

In accordance with section 61(3) of the *Financial Management Act 2006,* I declare that the Annual Report of the Mental Health Commission includes a report for the financial year ended 30 June 2018 information prescribed by the Treasurer's instructions, in respect of the Office of the Chief Psychiatrist, an affiliated body of the Mental Health Commission.

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

Les Bechelli
CHIEF FINANCE OFFICER
ACCOUNTABLE AUTHORITY

11 September 2018

Acknowledgements

Acknowledgement of Country

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

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

Acknowledgement of Lived Experience

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

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

Disclosures and Legal Compliance

Record Keeping

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

Board and Committee Remuneration

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

Legal and Government policy requirements and financial disclosures

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

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

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

Conflicts of Interest with Senior Officers

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

Compliance with Public Sector Standards and Ethical Codes

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

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

Occupational Safety, Health, and Injury Management

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

‘Ensuring Safe and High Quality Mental Health Care’

Contents

Foreword

What is the point of having a Chief Psychiatrist? Does the role make a real difference to consumers and carers? Does the role raise the standards of mental health care?

These are the sort of essential questions at the core of the role of any statutory health officer. We should not shy away from asking these each year.

I will start this foreword by addressing the challenges raised in last year's Annual Report.

- Continuity and navigation across services and with primary care remains a challenge. Each week the Office of the Chief Psychiatrist (OCP) responds to concerns
    - About barriers to coordinated care raised by consumers, family, community managed organisations and clinicians; this Office facilitates access to services where communication among service providers has fragmented.
    - This makes an active difference for individuals facing barriers to care within the system. This is a reactive, operational role, and one that must be embedded within Health Service Provider interfaces as a matter of urgency.
- Mental health care for prisoners remains below that of the general community standard. We have participated in the Justice Health Project and across the year have continued to hold agencies responsible to account.
- The East Metropolitan Youth Unit has opened:
    - In its development the OCP was instrumental in enhancing the proposed approach to restrictive practice, including the infrastructure, and ensuring the unit will work towards eliminating restrictive practice.
- The OCP has undertaken formal Clinical Reviews across several Health Service Providers, including WA Country Mental Health Services, North Metropolitan Health Service, and East Metropolitan Health Service to examine the standards of treatment and care being provided. Tracking and highlighting areas needing clinical care improvement within mental health services is one of the most effective ways the Chief Psychiatrist can shine a light on standards and ensure safe high quality care. The issue of suicide reduction remains complex and providing the right quality, safe care is a central component for mental health services to prevent suicide.
    - We have improved our timeliness in providing feedback to services and individuals on matters brought to the attention of this Office and in our reports following our Clinical Monitoring Reviews of mental health services.

As part of core functioning, the OCP has processed, and where required, acted upon numerous reported notifiable incidents. The data in this Annual Report will attest to this. The OCP has

1 The term 'consumer' is used routinely in mental health practice. The Mental Health Act 2014 uses the term ' patient' so this term will also be used in this report.

2 The term 'carer' is used interchangeably with the term Personal Support Person, 'family member' and ' significant other'

provided frequent education sessions for clinicians across 2017-18, with consistently excellent evaluation feedback. The OCP has repeatedly demonstrated its central role in helping clinicians to safely apply the provisions of the *Mental Health Act 2014.*

I regularly visit services and have direct discussions with clinicians, consumers, carers and community managed organisations. I hear their concerns and compliments about safety, quality and clinical standards. I act to address these where necessary and reinforce high quality standards of care at every opportunity. My staff and I have participated in, and at times led, several local, statewide and national fora, workshops, and roundtables that serve to enhance high quality mental health care, and that lead to meaningful change.

The issue of private psychiatric hostels has been a significant focus. In 2017-18, the OCP developed a point-in-time snapshot for private psychiatric hostels to track the client demographics and mental health service involvement and performance. This is a public document, available on the Chief Psychiatrist's website.

The Sexual Safety Guidelines for Mental Health Services have been drafted during 2017-18 we expect to finalise them by early 2019. The Chief Psychiatrist's Standards for Clinical Care, the Standards for the Authorisation of Hospitals and the ECT Guidelines have all been reviewed and rewritten this year with the active participation of consumers, Carers and clinicians and will be released in early 2019. I have directed my Research and Strategy team to commence a formal Targeted Review into the care of individuals with mental illness and challenging behaviours for whom there are significant gaps in the mental health system. This group is at high risk of facing criminal charges or ending up in prison. I anticipate this review will conclude in early 2019.

The role of the Chief Psychiatrist, with the work of the OCP, does make a significant difference. The Chief Psychiatrist actively raises the standards of mental health care in Western Australia.

I thank again the dedicated staff of the OCP, ably led by our Manager, Mr Creswell Surrao. They are staunchly committed to both the community they serve and to best practice in their own work. There remain significant threats to safe, quality and sustainable mental health care particularly relating to interagency governance in Western Australia, but I remain confident in the ability of the leadership and staff within the broader mental health system and Government to enhance the consumer experience. The roles of the consumer, family and wider community as partners in this process has a way to go to be fully accepted within health paradigms, but they are central to an effective and compassionate mental health system.

I trust this report shines a light on the performance of this Office and will assist the Minister, the Parliament and the Western Australian community in their pursuit of a safe, high quality mental health system.

Dr Nathan Gibson
CHIEF PSYCHIATRIST

‘The Chief Psychiatrist leads services to drive reduction in restrictive practice’

Executive summary

"The Chief Psychiatrist is an independent statutory officer who holds powers and duties as prescribed by the *Mental Health Act 2014*[1] reporting to Parliament through the Minister for Mental Health."

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

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

Seclusion rates drop, but physical restraint goes up in Authorised Hospitals

The Chief Psychiatrist leads services to drive reduction of restrictive practice. The 2017-18 financial year has seen a reduction in the rate of seclusion from 4.8 per 1,000 bed days in 2016-17[2] to 4.3 per 1,000 bed days. During that same period, restraint increased from 4.5 per 1,000 bed days[3] to 5.1 per 1,000 bed days. Inpatient mental health services continue to use established strategies to reduce restrictive practice. Seclusion rates have been consistently measured for a decade. Restraint rates have only begun to be consistently measured in the last two-three years. In 2017, Western Australia used significantly less seclusion and restraint in mental health hospitals than most other Australian jurisdictions. I have seen staff working hard to try to eliminate trauma and restrictive practice, but we need to work smarter to further reduce trauma experienced by patients in Western Australian mental health inpatient settings. Reducing restrictive practice for mental health patients in non-mental health settings (e.g. Emergency Departments) needs to be a critical focus for the future. Restraint and seclusion of the mentally ill outside of Authorised Hospitals is not consistently tracked and does not come under the MHA 2014.

1 The Mental Health Act 2014 is referred to as 'the Act' and as the 'MHA 2014' as appropriate, throughout this document

2 Ref AIHW data for WA

3 Ref AIHW data for WA

Notifiable Incidents Policy updated

Active tracking of incidents

The Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist 2015 was updated for public and private health services following consultation with key mental health clinicians and other key stakeholders. This Policy outlines the requirements set out in the *Mental Health Act 2014* for mental health services to report to the Chief Psychiatrist a range of incidents. The updated Policy is expected to be launched in August-September 2018.

Mental health care in prisons is below that of the general community

The Chief Psychiatrist has very limited statutory remit in prisons. Mental health observation rooms in prisons in WA are solitary confinement cells. Mental health care in prisons remains below the standard of mental health care available to the broader community.

Services are reviewed for standards of care, but all staff are not aware of the required standards

The Chief Psychiatrist has reviewed North Metropolitan Mental Health Service, South Metropolitan Mental Health Service, and East Metropolitan Mental Health Service during this period, and the reports have or are currently being finalised. Care was assessed against the Chief Psychiatrist's Standards for Clinical Care, for which he is statutorily responsible for overseeing. Clinicians were surveyed during this period. While the number of survey respondents was better than last year i.e. 554, it remains a concern that only 66% of those surveyed were aware of the Chief Psychiatrist's Standards for Clinical Care. Health Service Providers are responsible for ensuring that their staff have a thorough knowledge and understanding of the requirements of the MHA 2014.

Keeping standards and guidelines current

The Office of the Chief Psychiatrist began a number of projects to upgrade core standards and guidelines that will be completed in early 2019:

- The Chief Psychiatrist's Guidelines for the Use of Electroconvulsive Therapy in Western Australia
- The Chief Psychiatrist's Standards for Authorisation of Hospitals under the MHA 2014
- The Chief Psychiatrist's Standards for Clinical Care

The Office of the Chief Psychiatrist began the development of a Sexual Safety Guideline for Mental Health Services, also to be completed by early 2019. All of these processes involve consumers/patients and carers as active participants in co-design and development.

Private psychiatric hostels are a focus

The Office of the Chief Psychiatrist created a six-monthly snapshot-in-time looking at the demographics, mental health service involvement and care standards for residents of private psychiatric hostels. The closure of a hostel in 2017-18 highlighted that the broader hostel resident group are a significantly disabled cohort and need increased access to mental and physical healthcare, and psychosocial support.

Clinicians raise concerns about the systemic care for patients with challenging behaviours

The Chief Psychiatrist has been approached by senior psychiatrists and clinicians, who are concerned about the systemic care of individuals with challenging behaviours, including those individuals with fluctuating psychoses and associated drug abuse. It has been noted that a number of these individuals continue to fall through the cracks and end up in the justice system. The Chief Psychiatrist has commenced a formal targeted review of this cohort, and this review will be completed in early 2019.

Educating, advising and credentialing

The Chief Psychiatrist is responsible for the training, gazetting and monitoring of Authorised Mental Health Practitioners (AMHPs). The Office of The Chief Psychiatrist trained over 850 mental health clinicians across WA in a range of key practical application sessions around issues such as capacity, confidentiality and community treatment orders. In addition, robust training and monitoring saw over 65 new Authorised Mental Health Practitioners gazetted. 87 clinicians ceased to be AMHPs during this period, predominantly because they no longer met the Chief Psychiatrist's requirements for AMPH status. Clinical Helpdesk actively advised and assisted 650 clinicians with a range of clinical, legal and ethical interface queries- maximising standards and compliance with MHA 2014.

Keeping in touch with consumers, carers, clinicians and the community

The Chief Psychiatrist regularly visited services and organisations across the state, meeting with consumers, carers, community managed organisations and clinicians to understand what was going on at the coal-face in mental health care. While the Chief Psychiatrist is not a statutory complaints agency under the MHA 2014, the Office was frequently contacted by, and responded to, patients and families concerned about care.

Challenging behaviours, a major concern for clinicians

The Health Service Providers and service agencies are responsible for clinical governance, notwithstanding, during 2017-18 the Chief Psychiatrist actively intervened in certain cases to get proper care for patients where interfaces between services had broken down.

National and local interface

The Chief Psychiatrist is the Deputy Chair of the Safety and Quality Partnerships Standing Committee. This key mental health safety and quality coordinating group is made up of the Australian jurisdictions and other peak stakeholder bodies. The Office of the Chief Psychiatrist actively fed into the Department of Health Safety and Quality Review, and the Sustainable Health Review.

What helps us ensure high quality mental health care

In working to ensure safe high quality mental health care, we harness the broadest range of opportunities to improve the mental health of all Western Australians. In addition to already well-established structures, we pursue the most up-to-date information on contemporary approaches to mental health treatment and care. We do this through:

The Mental Health Act 2014

The Chief Psychiatrist continues to play a significant role in supporting clinicians in the application of the provisions of the Act. The ways in which we do this is expanded upon further in this report.

The Chief Psychiatrist has also contributed to the published 'Post-Implementation Review of the Act' and to the development of a series of proposed amendments in collaboration with the Mental Health Commission who are 'the principal agency assisting the Minister for Mental Health in the administration of the Act.'

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

The Charter of Mental Health Care Principles is rights-based, intended to influence the interconnected factors that guide the provision of care, and seeks to promote recovery from mental illness.

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

The Chief Psychiatrist's Standards for Clinical Care

Standards are one component of a strong, consumer-focused mental health system. The *Mental Health Act 2014* requires the Chief Psychiatrist to be responsible for overseeing the treatment and care to a range of users of mental health services.

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

The National Standards for Mental Health Services

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

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

The Fifth National Mental Health and Suicide Prevention Plan

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

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

In his pursuit of safe, high quality care, the Chief Psychiatrist strongly endorses and supports the implementation of the key priority areas and actions of the Plan that are designed to achieve an integrated mental health system that is safe, more transparent, accountable, efficient and effective.

As the Deputy Chair of the national Safety and Quality Partnerships Standing Group, who are responsible for oversight of many of the safety and quality aspects of this Plan, the Chief Psychiatrist has a central role in the Plan rollout.

The National Safety and Quality Health Service Standards

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

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

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

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

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

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

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

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

Our work

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

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

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

Office of the Chief Psychiatrist

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

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

A Support System

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

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

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

Expert Advice

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

A Reporting System

Clinicians and service providers are, by statute, required to report to the Chief Psychiatrist on a range of notifiable incidents, including where there may be a negative outcome. They are also required to track certain processes and treatments (e.g. Electroconvulsive Therapy (ECT), segregation of children from adult inpatients, off-label prescribing to children who are

involuntary patients, and emergency psychiatric treatment, among others). The Chief Psychiatrist is increasingly aware of the importance of data and its use in effective decision making for clinicians, and therefore advocates the necessity of establishing an ethical framework around data use and disclosure by his Office.

A Review System

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

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

An Authorisation and Approval System

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

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

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

A Research and Strategy Role

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

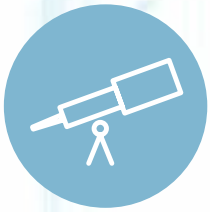
An Inter-jurisdictional Role

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

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

Who we are

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



Our Vision

'Mental Health Care to the highest standard.'

Our Mission

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

Our Values

Leadership

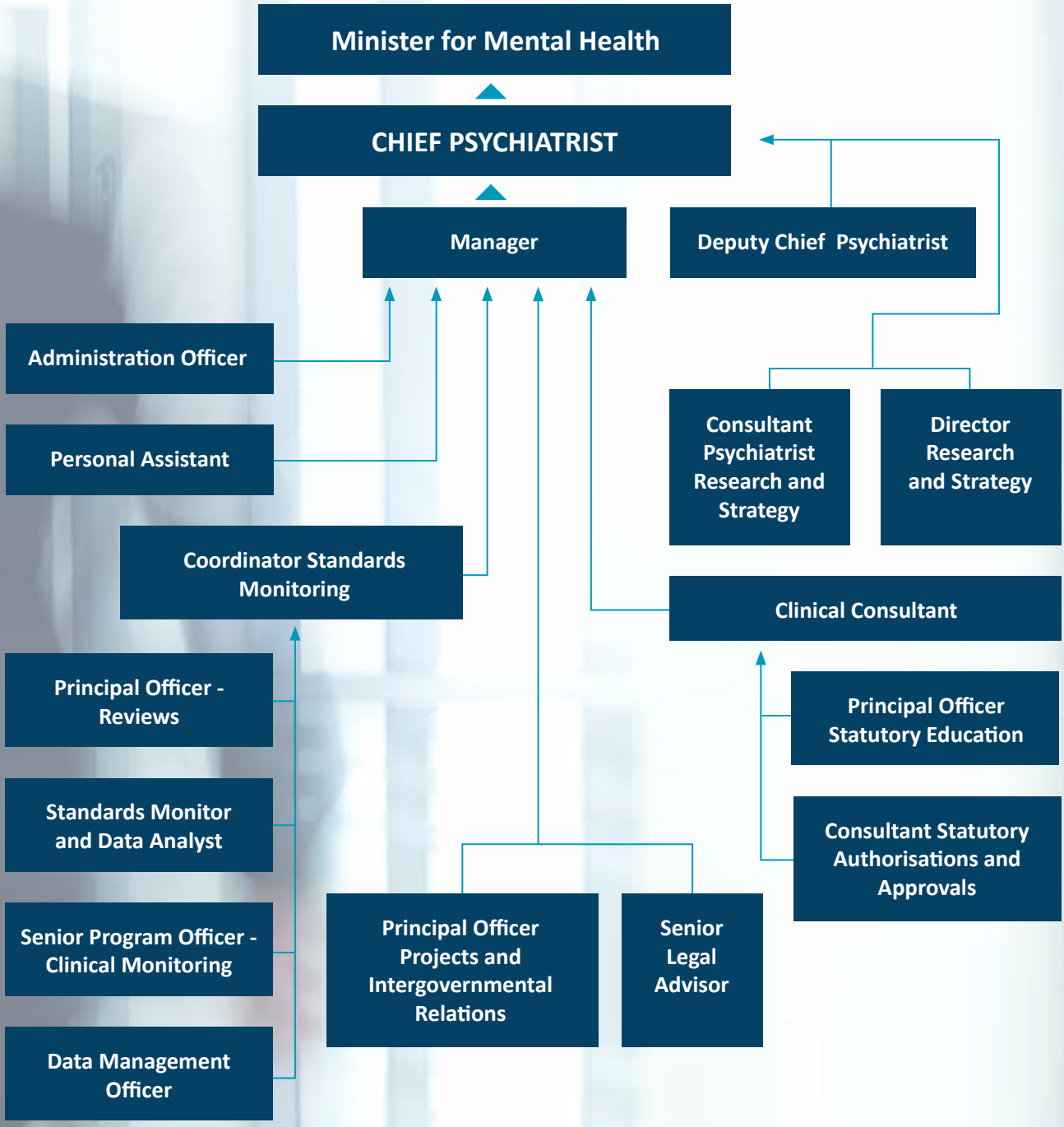
Integrity

Respect

Accountability

Commitment

Office of the Chief Psychiatrist Organisational Structure



Our Support for staff in the Office

Secondments in and out of the Office

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

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

Pressures and Demands

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

The increasing, and important, focus on private psychiatric hostels has required us to reconfigure the focus within our Office. We have increased scrutiny on the interface between clinical mental health services and private psychiatric hostels. This has practical impacts to re-prioritise other work undertaken by a small office such as the Office of the Chief Psychiatrist is. Despite this, the Chief Psychiatrist maintains a rigorous oversight of statutory responsibilities.

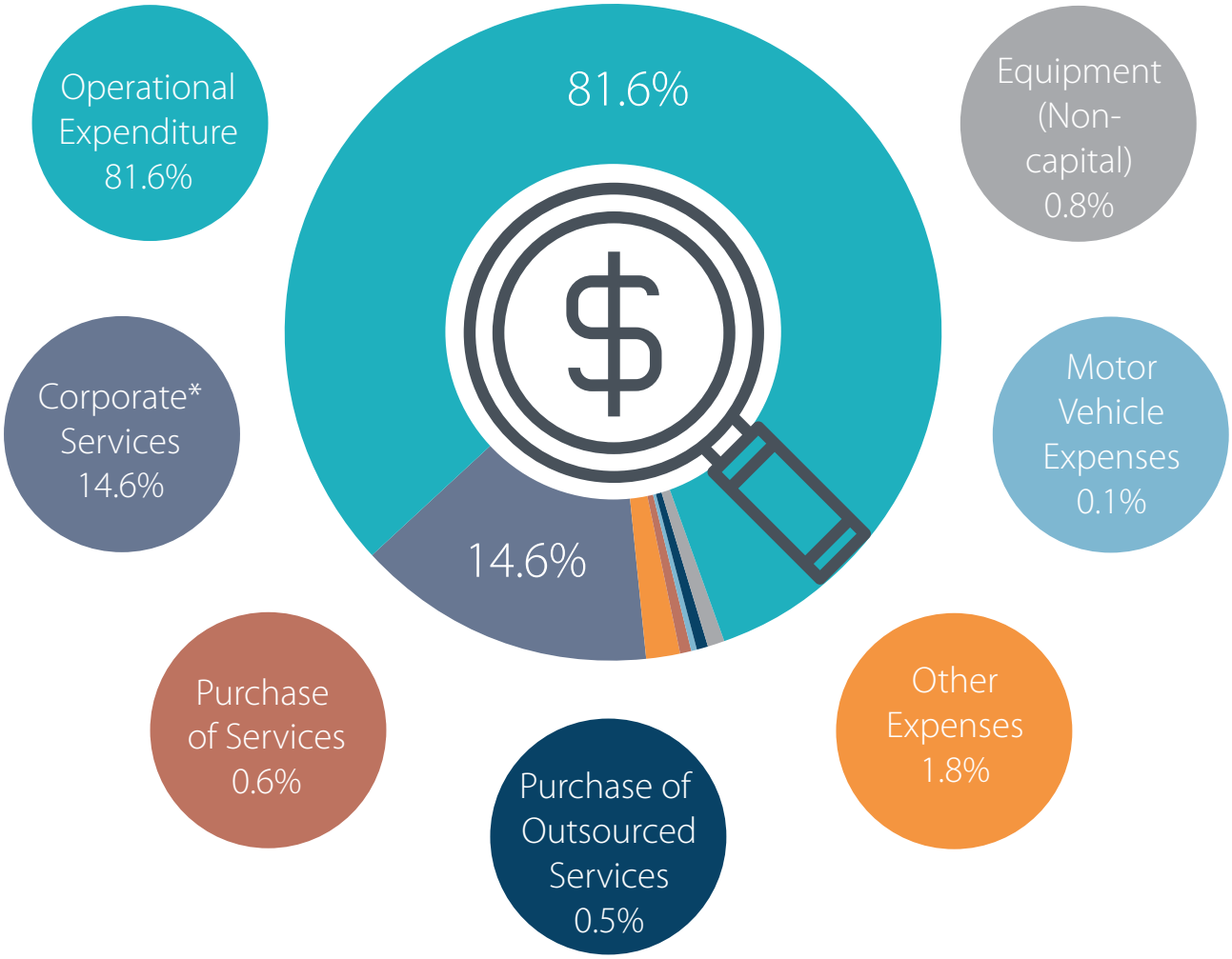
Professional Development

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

How we spend our money

The Office of the Chief Psychiatrist operated on a budget of $2,262,000 for 2017-18. In September 2017, two additional staff and their funding were transferred from the Department of Health to the Office of the Chief Psychiatrist. The funding for these positions was $661,497 for 2017-18.

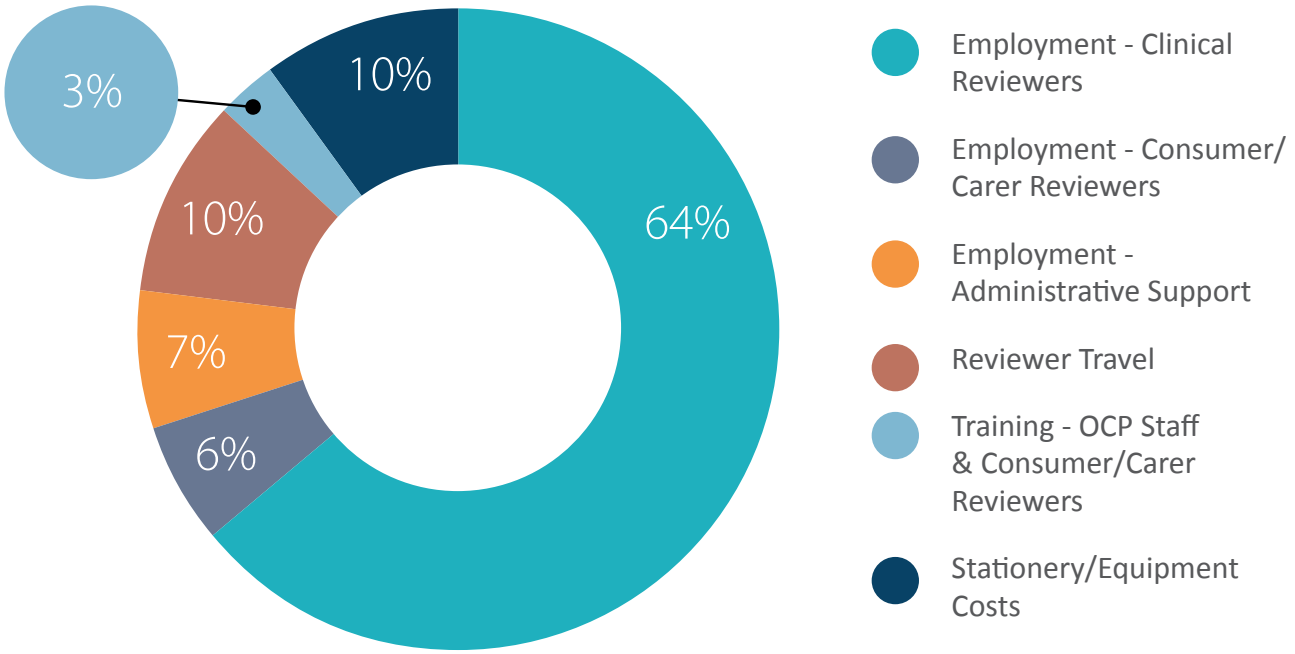
Overview of expenditure for the Office of the Chief Psychiatrist for 2017-18 is represented in percentages in the diagram below:



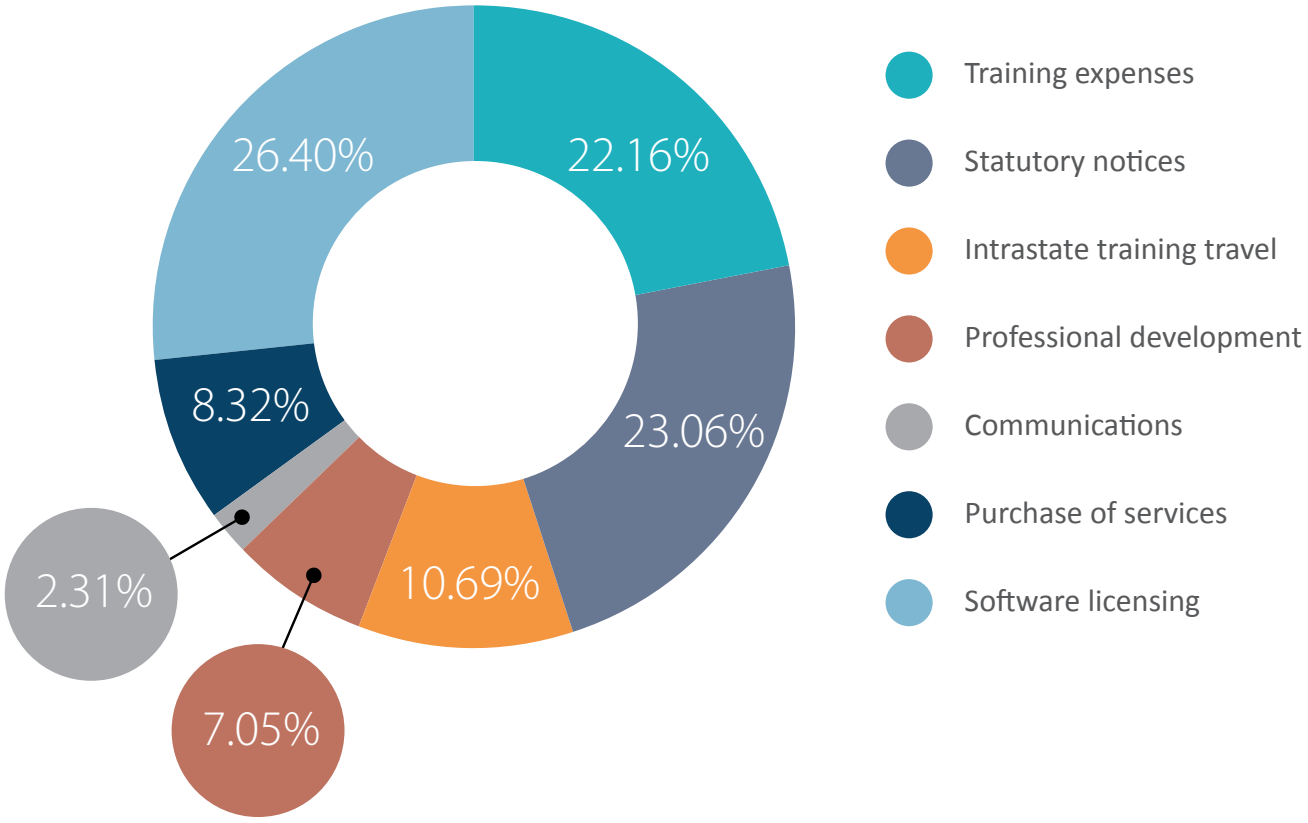
*Corporate Services - provided by the Mental Health Commission as *Resources provided free of charge* by seperate appropriation and not part of the overall OCP budget.

Operational expenditure includes the budgets allocated to the Standards Monitoring and Review Program and the Clinical, Statutory Education and Authorisations Program. A further breakdown of their expenditure is found in the figures below.

The Standards Monitoring Program utilises 7% of the overall expenditure of this Office and is represented by the figure below:



The Clinical, Statutory Education and Authorisations budget utilises 3% of the overall expenditure for this Office and is represented by the figure below:



Our principal collaborators

Collaborating with our stakeholders is integral to the way the Office of the Chief Psychiatrist operates. Delivering on our mission 'the Chief Psychiatrist aims to ensure that all Western Australians receive the highest standard of mental health treatment and care' would not be possible without strong relationships with our key stakeholders. The solid foundations of enabling legislation and robust strategy on which our relationships are built, assist in the aim of delivering high quality mental health services and outcomes for all Western Australians.

Our strong relationships with Health Service Providers are critical to our activities. Much of the work we do via our Clinical Statutory Education and Authorisations Team and Monitoring and Evaluation team, relates to the services provided by health services, including the data collected and reported by us.

Our contribution to National and Statewide initiatives

Nationally - we have

Provided
advice on the *'Inter-Governmental Agreement (IGA) on Ratification and Implementation of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT)'

Participated
in the Mental Health Reference Group for the Australian Commission on Safety and Quality in Health Care

Continued
our involvement and participation in the National Safety and Quality Partnerships Standing Committee

Consulted
on the inter-jurisdictional proposal for the mutual recognition of Mental Health Involuntary Treatment Orders through the Australian Health Ministers Advisory Committee (AHMAC)

Provided
expert advice on indicator specification for the collection, recording and reporting of rates of restraint to the Australian Health Minister's Advisory Council Mental Health Information Strategy Standing Committee

Consulted
on the National Mental Health Clinical Indicator Working Party

State-wide - we have

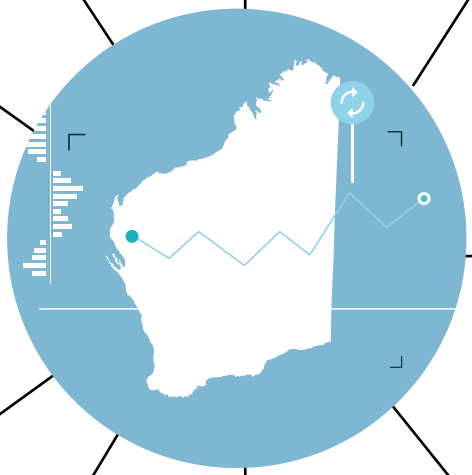
Advised
on the development of the Child and Adolescent Health Service (CAHS) procedure for *'Restraint for Administration of Nasogastric (NG) Feeds'* to mental health patients in non-authorised settings

Participated
and advised on the Justice Health Oversight Committee

Nominated
this Office to be a part of the National Preventive Mechanism (NPM) Network for Western Australia in respect of authorised mental health inpatient units to ensure compliance with the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT)

Advised
on the provision of mental health services to prisoners

Contributed
and provided advice to the Department of Health Western Australia Sustainable Health Review



Participated
and advised on the 'Antipsychotic polypharmacy and high-dose prescribing in acute mental health services in Western Australia' project for the Department of Health WA

Provided
advice on the *'Clinical Care of People Who May Be Suicidal'* policy issued by the Department of Health WA

Contributed
to the development of Western Australia's jurisdictional reporting on Australia's *Combined Second and Third Periodic Report to the Committee on the Rights of Persons with Disabilities* (CRPD report) under the Convention on the Rights of Persons with Disabilities

Contributed
to the Western Australian Accountability Agencies Review Working Group – to produce *'A report on the Machinery of Government options for accountability agencies.'*

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

Our vision for the future

Guiding the Office of the Chief Psychiatrist forward in 2018-19

The Chief Psychiatrist has led the development of a Strategic Business Plan 2018-23 for the Office. The plan was developed through a series of strategy making workshops using the Group Support System (GSS) in order to structure and prioritise the key issues that our staff believed was relevant to this Office's strategic success. Using the GSS meant every staff member had an equal say in the development of the plan thereby ensuring ownership of it.

The Chief Psychiatrist is committed to ensuring a person-centered approach as the foundation to achieving safe, high-quality care resulting in best outcomes and experiences for patients, carers and families.

In positioning the Office to realise the strategic vision, the Chief Psychiatrist has identified four pillars as guiding principles for this Office moving forward;

- Striving for a culture of excellence in our workplace that reflects our values
- Engage proactively with key stakeholders to facilitate change
- Engage proactively with clinicians and service providers to continuously improve within a statutory framework
- Building and enabling transformative leadership both internally and externally

Whilst we readily acknowledge the above will be achieved through incremental change, it is the expectation of the Chief Psychiatrist that all areas of the organisation will commit to it in the long-term.

The Chief Psychiatrist welcomes the Minister for Mental Health's response to the Report of the Sustainable Health Review, in respect of the mental health sector. The Minister's decision to set up a review of the clinical governance of public mental health services will be a pivotal driver to a safe high quality mental health system for the future.

In contemplating his role in the upcoming review, the Chief Psychiatrist will rely amongst

other things, on the findings of his report Clinical Governance Climate in Western Australia's Mental Health Services published in May 2013. Whilst the recommendations in this report primarily centered on the mental health sector, the Chief Psychiatrist is keen that the upcoming review will examine how the clinical governance of public mental health services fits within the broader governance of the health sector.

The issues of leadership, clinical risk management, reflective practice, professional development opportunities with particular regard to skills for critical appraisal and quality improvement activities, and the active participation of consumers and personal support persons in the co-design of a clinical governance system for the mental health sector will be the Chief Psychiatrist's focus.

A Snapshot of Western Australia's Mental Health Services

Consumers of mental health services often transition from community mental health services to specialised mental health inpatient services[4] and during this period their legal status may change from voluntary to involuntary and back to voluntary, depending on how unwell they are. The information provided here is obtained from the Department of Health central data collections - *Mental Health Information Data Collection* (MIND), *Hospital Morbidity Data Collection* (HMDC) and the *Emergency Department Data Collection* (EDDC). Data sourced from MIND and HMDC are subject to data cleansing (for quality), data linkage and clinical coding processes which takes a few months. Therefore, data for the 2017-18 financial year are not available for all variables at the time of reporting so for some variables calendar year data are reported (January – December 2017).

Public mental health services are accessible throughout metropolitan and regional Western Australia (WA). There are four Health Service Providers within the Perth metropolitan area: North Metropolitan Health Service (NMHS); South Metropolitan Health Service (SMHS); East Metropolitan Health Service (EMHS); and Child and Adolescent Health Services (CAHS). Regional Western Australia is covered by WA Country Health Service (WACHS) which includes services for children and adolescents. In addition, there are three publically contracted private providers (PPP) of health services in metropolitan Perth which are: the Mental Health Unit - Joondalup Health Campus (Ramsay Health Care), the Ursula Frayne Unit - St John of God Hospital, Mount Lawley and the Mental Health Unit - St John of God Midland Public Hospital. Public patient activity data for these services are included in this section of the report.

For the 2017 calendar year, 60,777 individuals received care from a mental health service setting, including specialised inpatient and community mental health settings.

60,777 people received mental health care for this reporting period, for whom the Chief Psychiatrist oversees standards of clinical care

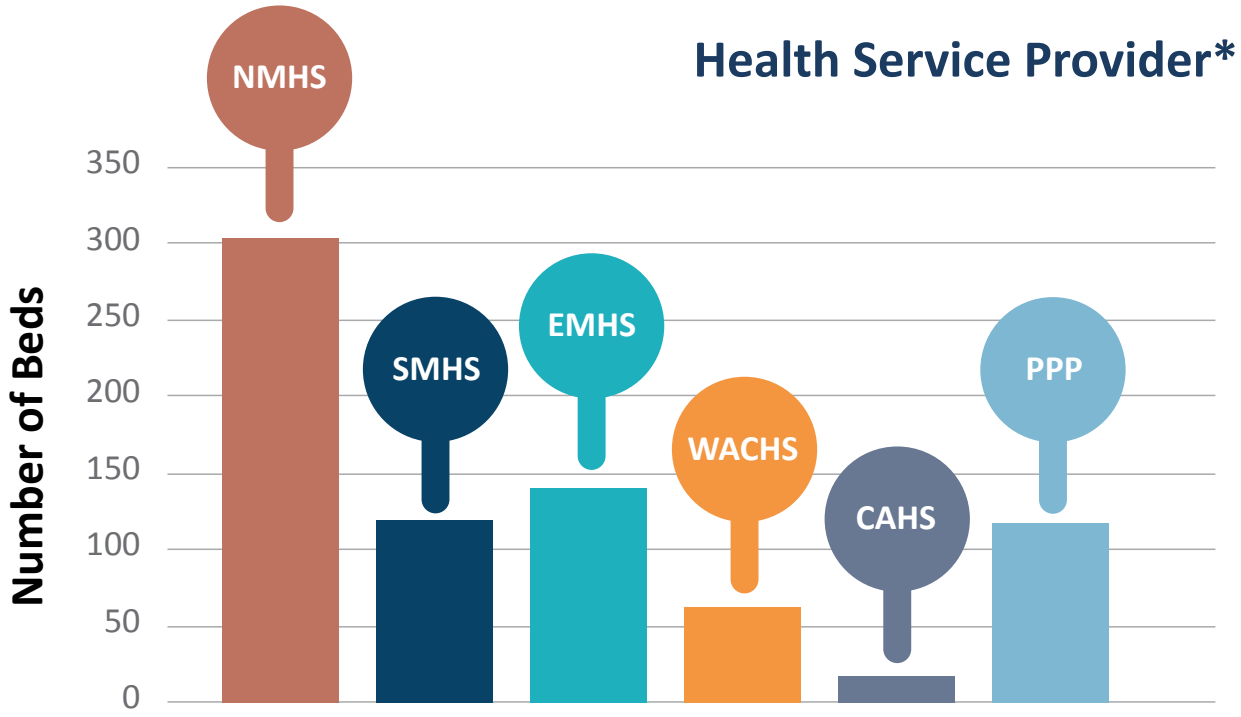
4 Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. http://meteor.aihw.gov.au/content/index.phtml/itemId/288889

Inpatient Mental Health Services

For the 2017 calendar year there were 14,946 mental health inpatient separations (discharges) from specialised mental health inpatient services for a total of 9,388 individuals across WA. Of those, 7,021 were voluntary at some point during their admitted episode of care involving 11,520 separations, and 2,367 patients were involuntary at some point during their admitted episode of care involving 3,426 separations.[5]

On average there were 759 available specialised mental health inpatient beds, which included 46 Hospital in the Home (HITH) beds in WA during the 2017 calendar year. The distribution of beds across the Health Service Providers is shown in Figure 1.

Figure 1: Number of specialised mental health inpatient beds for each Health Service Provider in Western Australia during the 2017 calendar year



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

5 It should be noted that some patients can have both a voluntary and involuntary status within one episode of care. Source: Mental Health Data Collection, Data Integrity Directorate.

In the 2017-18 financial year

61,187

community patients had

975,601

contacts with specialised community mental health services

Community Mental Health Services

The data presented in this section cover the 2017-18 financial year. There were 61,187 voluntary patients treated by community mental health services who received a total of 975,601 service contacts with specialised community mental health clinicians. There were 661 patients on a Community Treatment Order, with a total of 817 Orders notified to the Mental Health Advocacy Service in the 2017-18 financial year.[6] A Community Treatment Order is an order under the MHA 2014, which enables a patient to receive treatment as an involuntary patient in the community. Some patients may transition from a voluntary status to being on a Community Treatment Order within a single community episode of care.

Emergency Department Mental Health Presentations

During the 2017-18 financial year, there were 57,040 mental health presentations to an ED during the reporting period, accounting for 5.5% of the total number of ED presentations (n=1,046,670).

The median length of a mental health presentation for an ED episode of care was 210 minutes. The majority of mental health presentations were discharged under their own care upon completion of the ED presentation (56%), 19% of patients were admitted to an inpatient unit, 12% were admitted to an ED observation ward and 6% transferred to another hospital for admission (Table 1). A small proportion of patients (3%) did not wait to be examined by a medical officer, 3% of patients left at their own risk, 0.1% were discharged to Hospital in the Home (HITH) and 0.1% to a nursing home.

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

Table 1: Emergency Department Episode End Status for Mental Health Presentations 2017-18 Financial Year

Episode End Status	Number	%
ED service event completed; departed under own care	32,020	56
Admitted to ward/other admitted patient unit	10,936	19
Admitted to ED Observation Ward	7,009	12
Transferred to another hospital for admission	3,577	6
Left at own risk	1,649	3
Did not wait to be attended by medical officer	1,500	3
Discharged after admission	<10*	<0.1
Died in ED	<10*	<0.1
Unknown	72	0.1
Admitted to Hospital in the Home	<10*	<0.1
Returned to Hospital in the Home (HITH)	64	0.1
Nursing Home	32	0.1
Returned to Rehabilitation in the Home (RITH)	0	-
Reversal of the ED admission	181	0.3
Total	**57,040**	

Table 1: ED episode end status for mental health presentations for 2017-18 financial year
** To ensure confidentiality, where <10 instances of an event occurred, the actual figure is not reported.*
Source: Emergency Department Data Collections, Data Integrity Directorate

Our performance

‘The standard you walk past is the standard you accept’

General David John Hurley, AC, DSC, FTSE

Clinical, Statutory Education and Authorisations Program

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

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

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

- Providing clinical support and engagement (including education and training)
- Authorising and approving mental health related services in line with the statutory requirements of the *Mental Health Act 2014*
- Listening to and working with consumers and personal support persons regarding issues of mental health care

In 2017-2018, CSEAT were able to deliver on the majority of targets set in the previous annual report. We achieved the following:

- Hosting two public forums for consumers and personal support persons during Mental Health Week
- Visiting mental health services and ensuring each visit included time for consumers, personal support persons and at times local community managed organisations
- Promoting and advocating for the role of the peer support worker to health service executives
- Using information obtained through the Clinical Helpdesk as an active feedback loop to drive education and training content
- Reviewing and improving the Authorised Mental Health Practitioner (AMHP) initial and Refresher training courses
- Providing a range of education opportunities to make clinicians more aware of their responsibilities under the MHA 2014
- Introducing an AMHP monitoring program- a major regulatory step
- Commencing the process of re-approval for mental health services at which electroconvulsive therapy can be performed
- Engaging with external stakeholders and hosting of several local, national and international guest presenters

The review of the *Chief Psychiatrist's Standards for Authorisation of Hospitals* and the standards and guidelines for electroconvulsive therapy has commenced but remains ongoing. Our consultative and collaborative working method through engagement with a large cohort of key stakeholders practically means this process will be completed in the next reporting period.

Listening to and working with Consumers and Personal Support Persons

The Chief Psychiatrist encourages engagement with consumers and personal support persons through public forums and when visiting mental health services. Listening to and acting on issues raised by Consumers and Personal Support Persons are crucial to the development and maintenance of safe quality mental health service delivery.

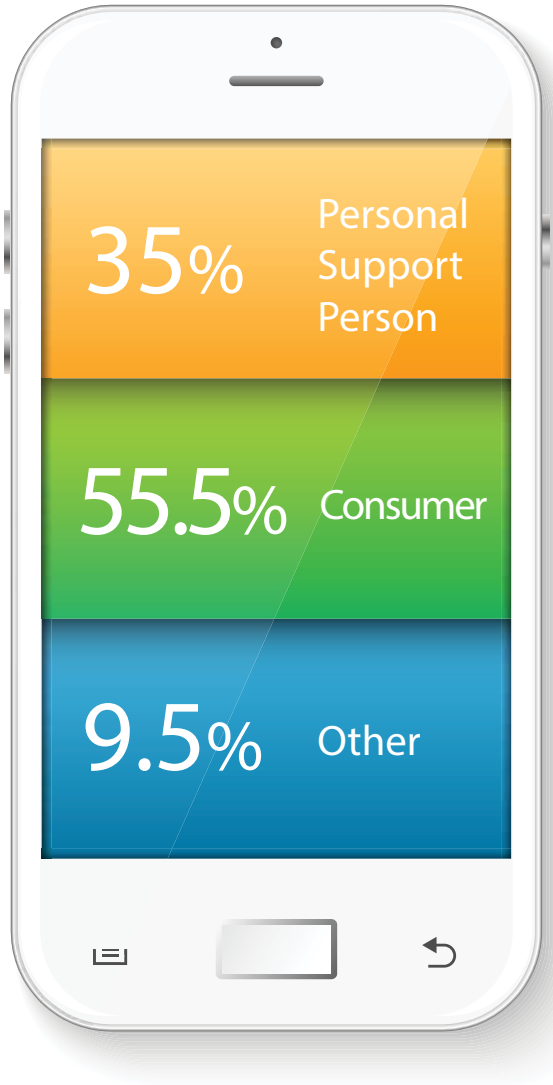
As part of our Mental Health Week activities, the Chief Psychiatrist arranged two public forums for consumers and carers. The forums were held North and South of the river for the convenience of attendees. They were advertised through consumer and carer organisations, health service providers and on the Chief Psychiatrist's website. The forums were well attended and provided an opportunity to have face to face contact with the Chief Psychiatrist and members of his team. The feedback indicated consumers and carers valued the opportunity for direct dialogue with the Chief Psychiatrist and his team.

Consumers and personal support persons contact our Office for a variety of reasons but primarily, to raise concerns about the delivery of mental health treatment and care. These calls are often re-directed at point of contact to the appropriate agency who manage complaints such as the health service delivering the treatment and care or to the Health and Disability Services Complaints Office (HaDSCO).

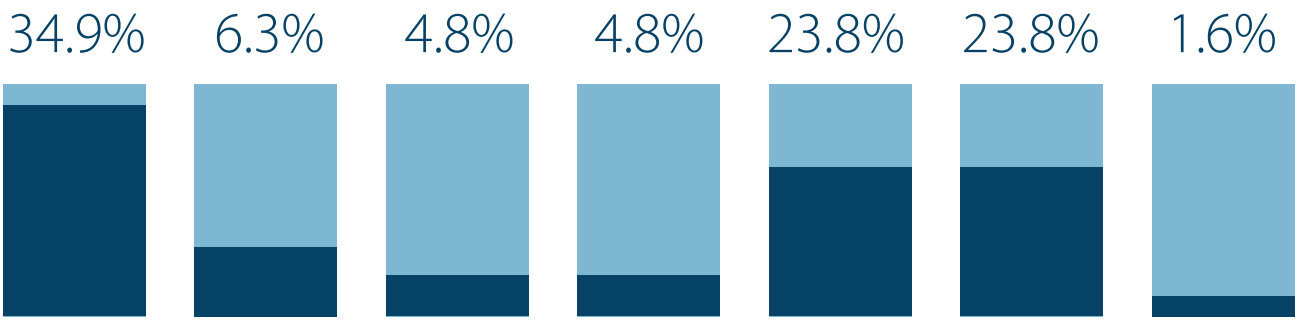
For this reporting period, CSEAT engaged with and assisted 63 consumers and personal support persons who were not re-directed at the point of contact, due to the high degree of complexity of their concerns. As the MHA 2014 places responsibility for managing complaints with mental health services and HaDSCO, there has been a decrease in the number of cases that have required our direct involvement. This decline is expected as the process for complaints resolution becomes more widely known, accepted and utilised.

Consumers relied on the expertise of this Office on 35 occasions, personal support persons 22 occasions and either a member of the community or carer advocate on 6 occasions in the reporting period. The calls were primarily seeking advice or intervention by us (84%) but 7 individuals called in acute distress and 3 others for reasons not identified.

Consumer and personal support person calls to the Office of Chief Psychiatrist



Management of consumer and personal support person contacts



Referred to the Mental Health Service providing care and treatment

Referred to the Mental Health Emergency Response Line (MHERL)

Referred to the Mental Health Advocacy Service

Referred to the Health and Disability Services Complaints Office

Referred to multiple agencies

Other action taken

Not Specified

For this reporting period, during his routine visits to mental health services, the Chief Psychiatrist has continued to meet with consumers and personal support persons. The feedback about mental health services to the Chief Psychiatrist included:

Consumers and personal support persons discussed a range of topics with the Chief Psychiatrist including their experience of the service and made suggestions for service improvement, including the provision of suitable furniture and suitable sporting equipment.

In responding to consumer and personal support person feedback the Chief Psychiatrist and Deputy Chief Psychiatrist made the following comments;

"It was pleasing to meet with such a motivated group of people who not only bring a lived experience perspective but meaningful focused solutions that assist clinicians in their work" *Chief Psychiatrist*

"It was pleasing to hear the group are involved in policy development and also with the Cultural Training being developed for the health service"
Deputy Chief Psychiatrist

CSEAT has also vigorously pursued the engagement of consumers and personal support persons in the review of Chief Psychiatrist's standards and guidelines. Currently, consumer and carer representatives are active participants in the Chief Psychiatrist Electroconvulsive Therapy Guidelines Working Party and the Chief Psychiatrist Authorised Hospitals Reference Group.

The Chief Psychiatrist is committed to a person-centred approach to the work of his office

Clinical Support and Engagement

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

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

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

- Providing a clinical helpdesk that responds to phone or email enquiries
- Providing information and advice on the application of the provisions of the *Mental Health Act 2014* in a clinical setting.
- Authorising and approving mental health services and clinicians in line with the *Mental Health Act 2014* requirements. This includes
    - The training, gazetting and monitoring of Authorised Mental Health Practitioners (AMHPs)
    - Authorisation of hospitals to receive and detain persons requiring mental health inpatient treatment and care
    - Approving mental health services to provide electroconvulsive therapy (ECT)
    - Prescribing psychiatrists to enable them to apply the provisions of the *Mental Health Act 2014*
    - Arranging further opinions for consumers seeking an independent view of their treatment and care
- Providing education and training relevant to functions of this Office and advancing the Chief Psychiatrist's agenda of ensuring safe high quality mental health treatment and care and related matters

Clinical Helpdesk

CSEAT provides a clinical helpdesk that enables clinicians to seek assistance in applying the provisions of the Mental Health Act 2014 specific to the clinical situation they are managing.

The Clinical Helpdesk has a unique role within the mental health sector, supporting clinicians via phone or email for a range of clinical and ethical dilemmas. A recently conducted survey of clinicians and health workers who contacted the clinical helpdesk between January 2018 and March 2018 found;

- the helpdesk easy or very easy to contact
- the clinicians staffing the helpdesk approachable
- the advice provided of high quality.

All respondents indicated they would use the helpdesk again. A brief overview of the survey results, including recommendations, will be made available later this year on the Chief Psychiatrists website, and some of the findings are provided below.

Figure 2: Professional disciplines

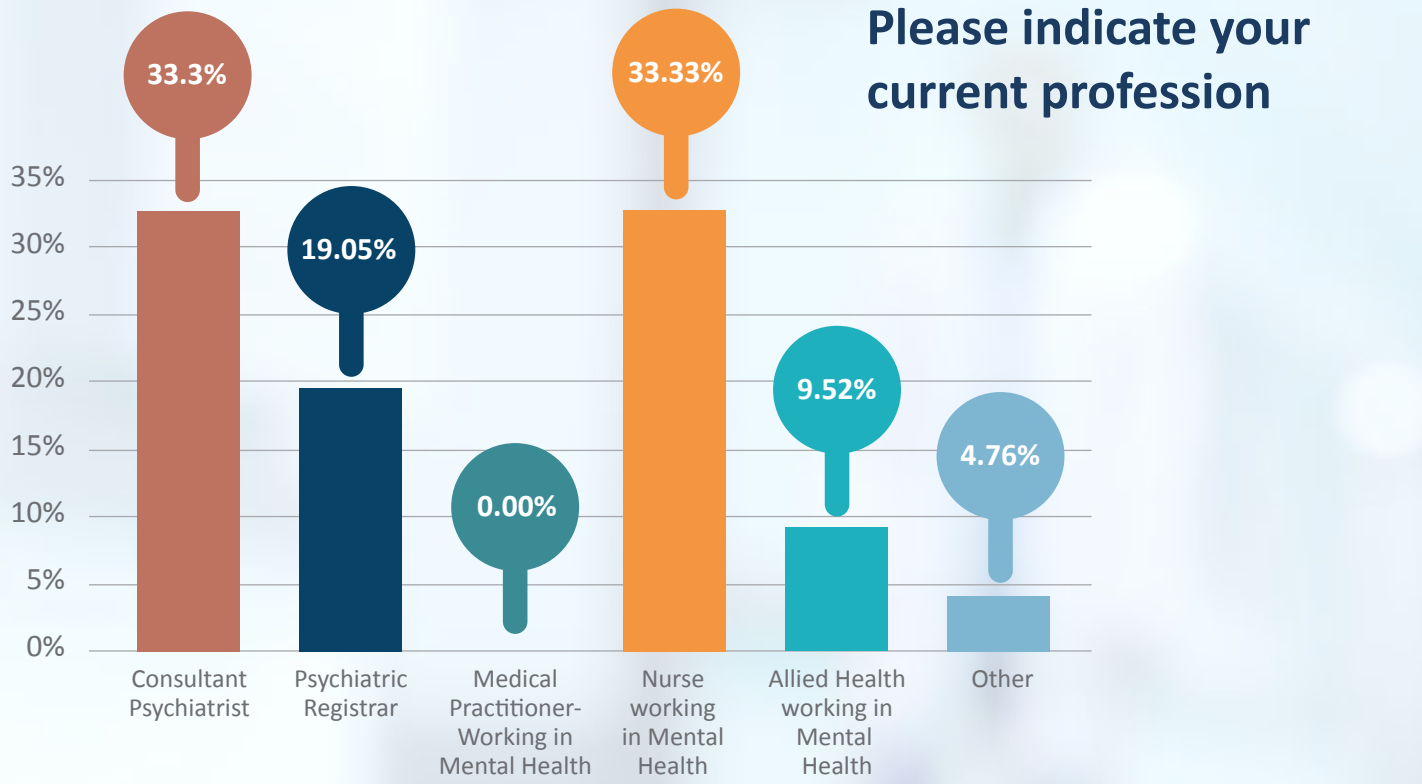


Figure 3: Contact with the Clinical Helpdesk

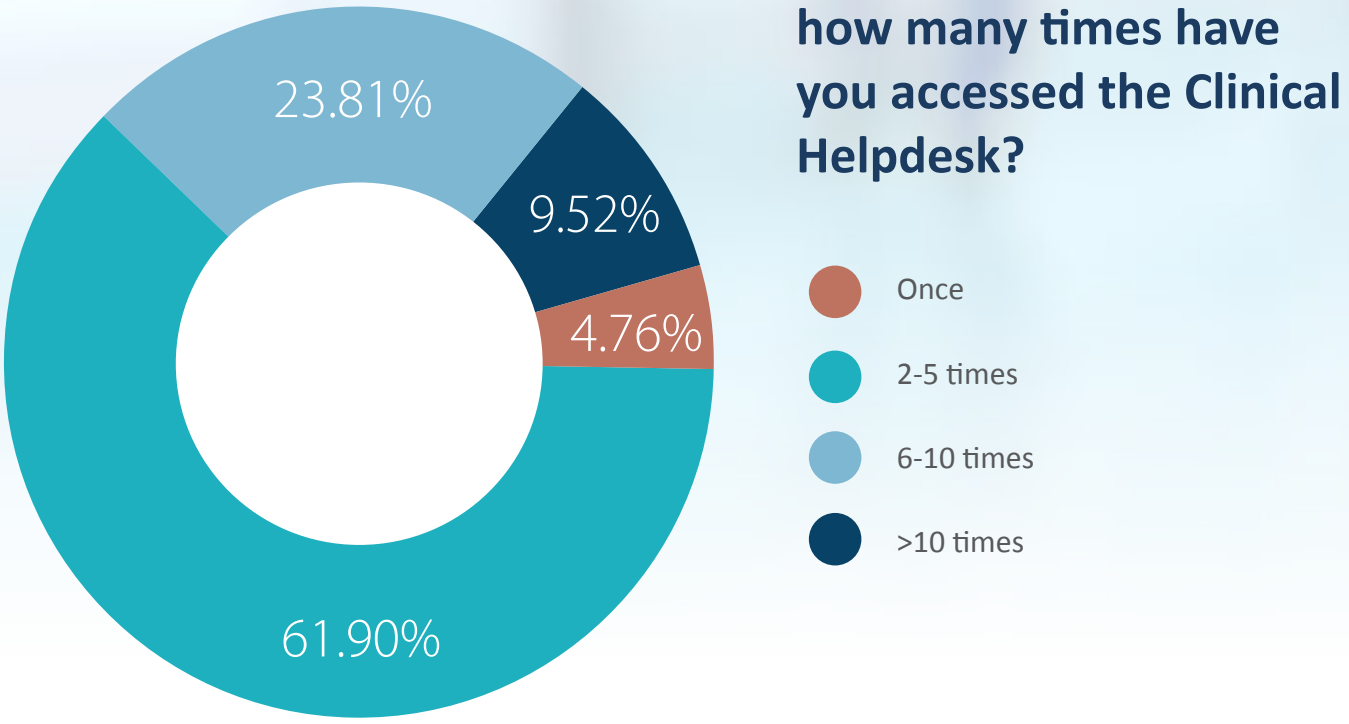


Figure 4: Clinical Helpdesk Responsiveness

Was your Clinical Helpdesk query answered in a timely manner?

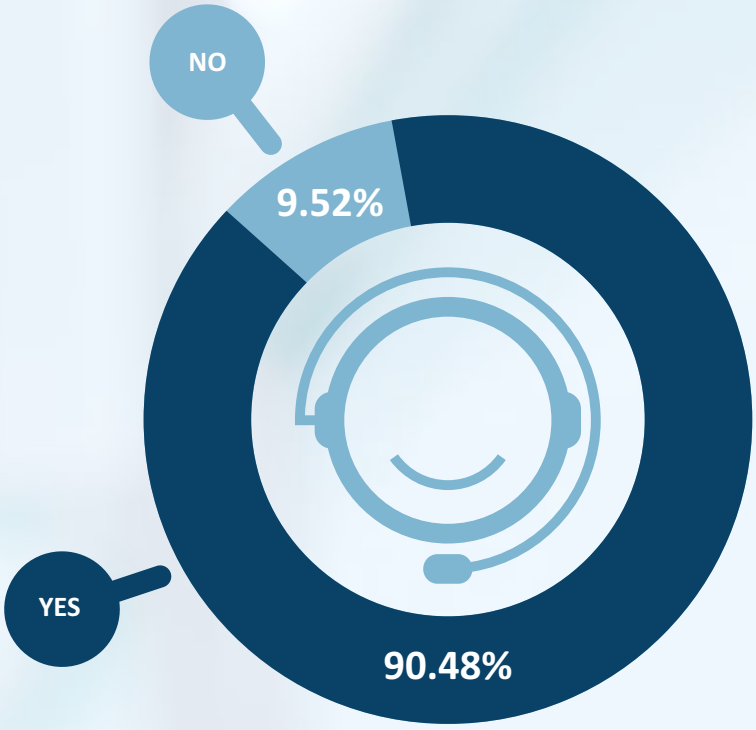


Figure 5: Clinical Helpdesk Approachability

Did you find the clinician on the Clinical Helpdesk approachable?

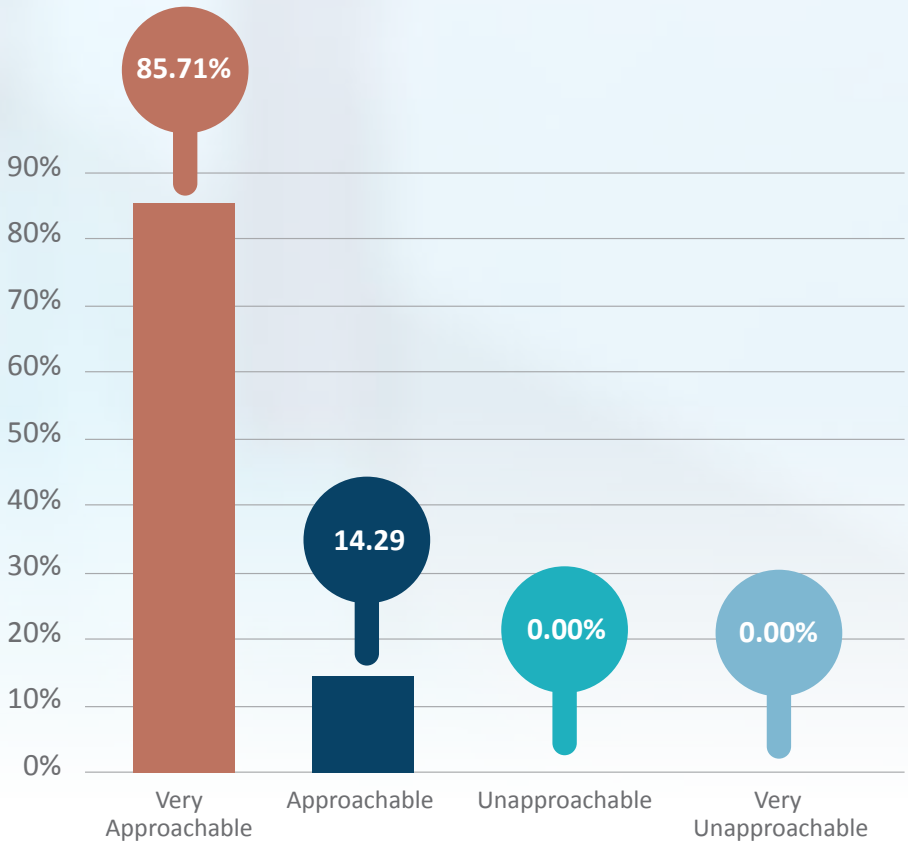
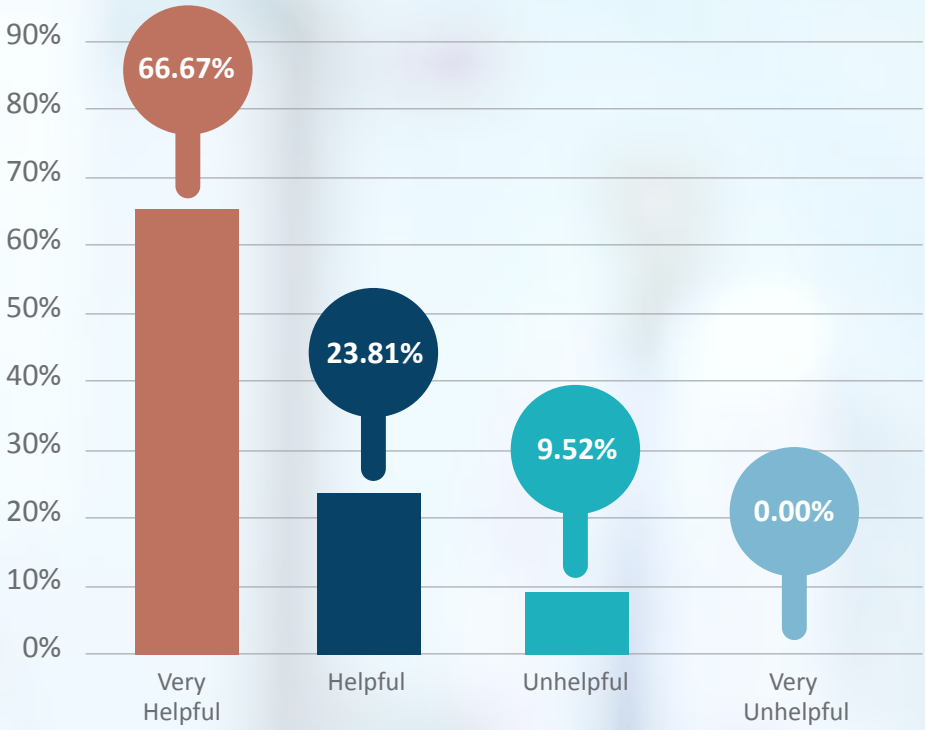


Figure 6: Clinical Helpdesk Helpfulness

Was the information provided by the Clinical Helpdesk helpful?



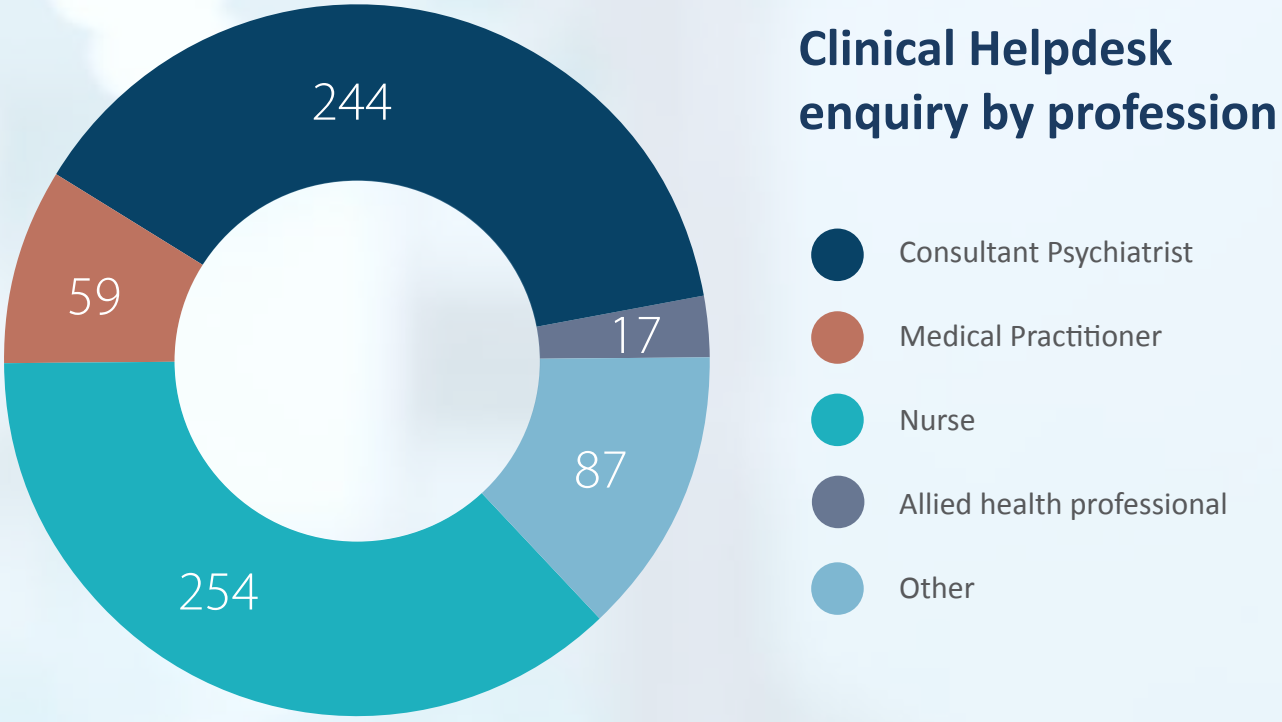
Some quotes from survey respondents included:

Clinical Helpdesk Calls

The number of calls to the clinical helpdesk is consistent with the last reporting period and averaged 55 contacts per month. However, the nature of the enquiries to the Clinical Helpdesk have shifted over time from direct translation of the *Mental Health Act 2014* (the Act), to more complex, ethical questions about the intricacies, complexities and nuances of the Act and how these impact on the treatment and care provided. Whilst our expertise enables us to provide an informed response, we access legal advice as required to provide a more accurate and comprehensive response to queries.

The primary contacts to the Clinical Helpdesk during this reporting period were from Consultant Psychiatrists and nurses. There was a slight decrease in the number of consultant psychiatrist contacts to the helpdesk.

Figure 7: Clinical Helpdesk Enquiries – Professional Breakdown



31% of all enquiries to the Clinical Helpdesk were about Community Treatment Orders (CTOs). Other enquiries pertained to:

Complex and ethical scenarios broadly include whether to use the Act to provide treatment and care to an individual, assessing capacity, restricting a person's rights and providing medical care where someone is an involuntary patient.

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

Statutory Authorisations and Approvals

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

Authorised Mental Health Practitioners

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

For this reporting period there were;

- 541 clinicians authorised to perform the functions of an AMHP

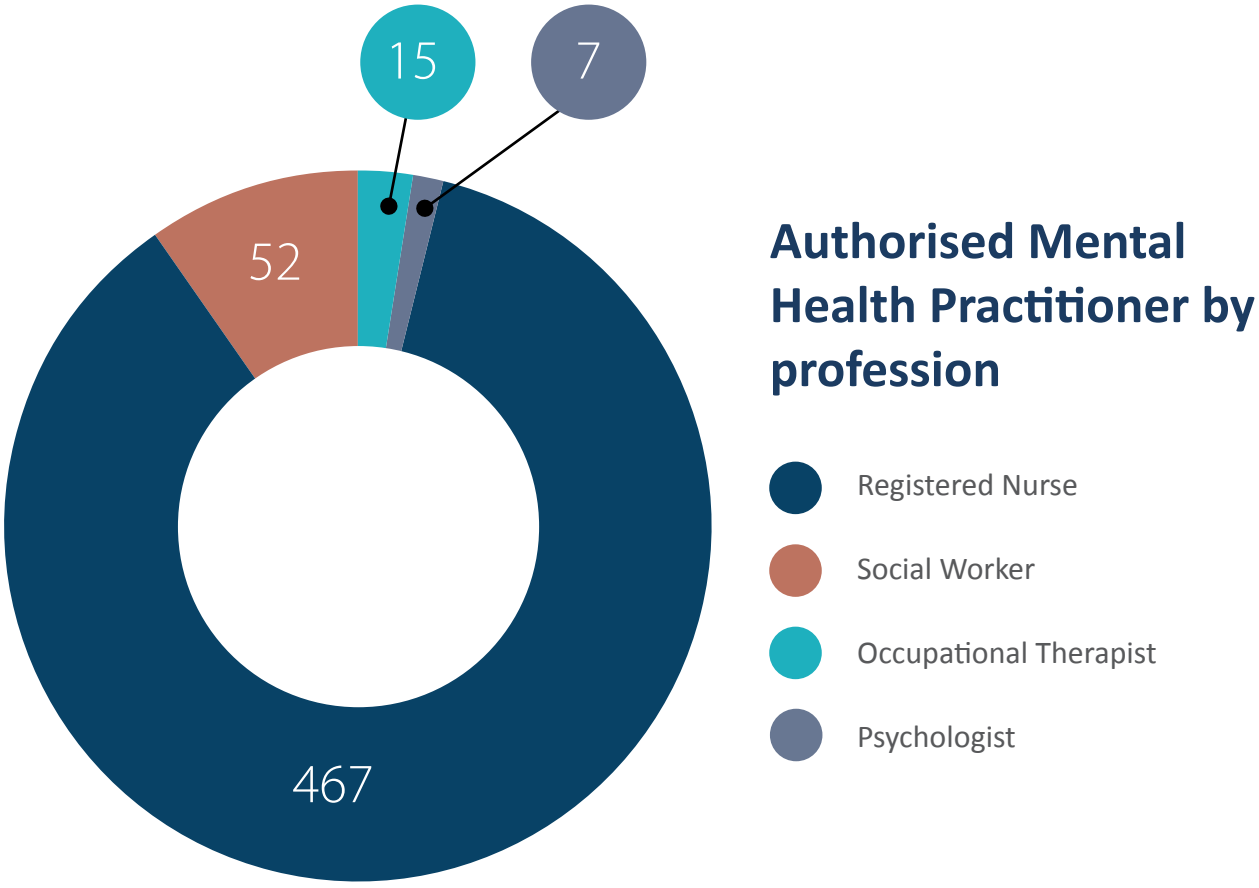
Of which;

- 418 were located in the metropolitan area and;
- 123 throughout regional WA.

Registered Nurses and allied health professionals are eligible to perform the role of an AMHP. The vast majority of AMHPs in Western Australia are Registered Nurses, this is consistent with the mental health workforce of which nurses comprise the largest number.

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

Figure 8: AMHP by Professional Discipline



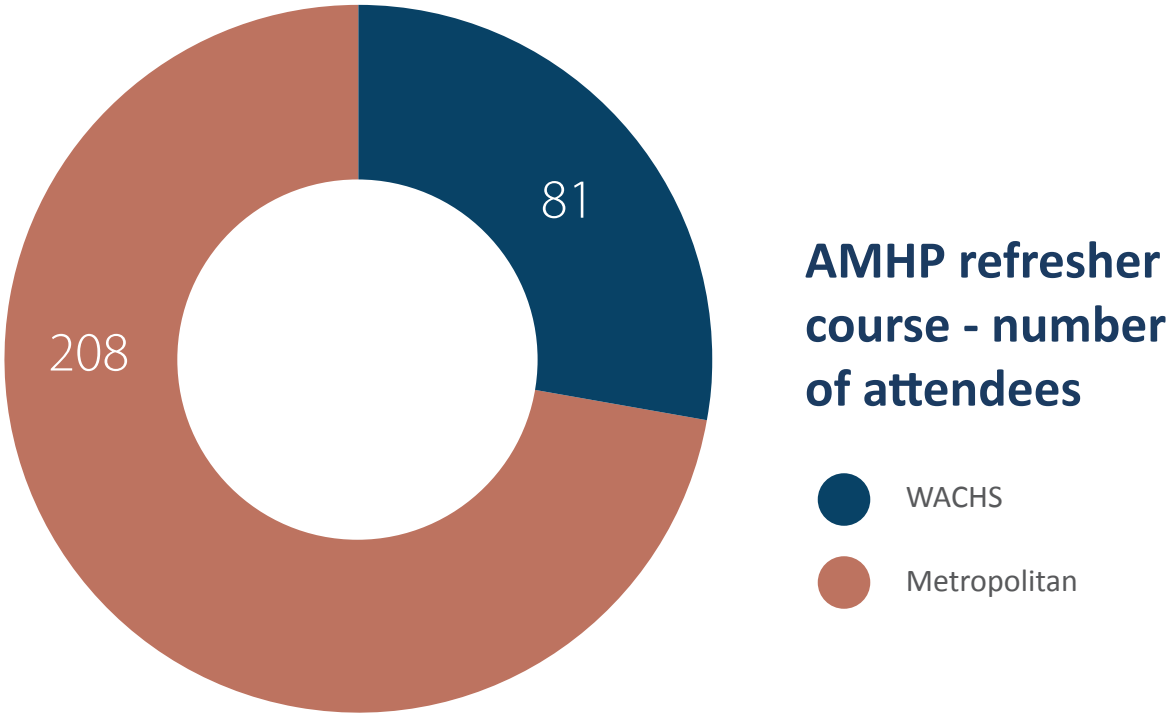
Authorised Mental Health Practitioner Authorisations and Revocations

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

For the reporting period, we ran four (4) initial AMHP training courses for 65 clinicians seeking to become AMHPs. All participants successfully met the stated requirements and were gazetted as AMHPs by the Chief Psychiatrist. Where the personal circumstances or demographic details of AMHPs change for any reason (e.g. a name change through marriage) we re-gazette them to ensure their details remain accurate. Hence, in addition to the 65 cited above we gazetted two additional AMHPs due to a change in personal details.

To ensure currency of contemporary practice and knowledge in the role, AMHPs must attend a refresher course once every two years. For the reporting period, the Principal Officer Statutory Education ran 17 AMHP refresher courses; 11 for metropolitan AMHPs and 6 for regional and remote AMHPs (via video conferencing).

Figure 9: AMHP Refresher Course



How we monitor Authorised Mental Health Practitioners

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

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

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

Our AMHP monitoring has two components:

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

In July 2017, the self-report measure was sent to all AMHPs and completed by 518 (91%). The self-report asked AMHPs if they had met the Chief Psychiatrist's requirements for continuing professional development and supervision.

On completion of the self-report, an audit of 54 (10%) AMHPs was conducted. They were asked to provide evidence of their compliance with the requirements of Regulation 17 with particular regard to undertaking clinical supervision and engaging in continuing professional development (CPD) activities.

Of the 54 AMHPs selected for auditing, 7 requested revocation of their status and did not participate in the audit. Forty-seven AMHPs participated in the audit and of these, 74% met the Chief Psychiatrist's supervision requirements and 81% met all the CPD requirements.

Clinicians who are unable to perform the function of an AMHP, do not meet the Chief Psychiatrist requirements to be an AMHP or, by request may have their AMHP authorisation revoked.

For the reporting period, 87 mental health practitioners had their status revoked. There were a variety of reasons for the revocations; however, the majority were a result of the AMHP self-report survey or the AMHP audit where clinicians were unable to demonstrate that they met the Chief Psychiatrist's requirements for continuing in the role of an AMHP. This was the first year the AMHP program conducted a self-report survey and audit.

Authorisation of Mental Health Facilities

An Authorised Hospital is one that can accept persons referred under the *Mental Health Act 2014* and receive and detain patients against their will (ref. s542 MHA 2014). Generally, it is a specific ward or area of a specified hospital that is authorised, for example a mental health inpatient facility within a hospital.

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

For the reporting period, the Chief Psychiatrist received one request for authorisation of a hospital under the *Mental Health Act 2014*. Another sought an amendment to their authorised order due to re-designing an already authorised unit. We worked collaboratively with this service, providing our advice and expertise to ensure the least disruption to patients occurred with no requirement to amend the order for authorisation already in place.

The Chief Psychiatrist and his staff worked tirelessly throughout the reporting period to assist Perth Children's Hospital's (PCH) mental health unit achieve authorised status well in advance of the scheduled opening, to ensure a smooth transition of children and adolescents requiring mental health inpatient admission.

The Chief Psychiatrist and his staff visited the PCH mental health unit on multiple occasions throughout construction to provide advice that enabled the unit to adhere to the *Chief Psychiatrist Standards for Authorised Hospitals* and ensure a contemporary 21st century therapeutic space firmly grounded in the principles of mental health recovery and wellness for children and adolescents.

Electroconvulsive Therapy and approved suites

The *Mental Health Act 2014* requires the Chief Psychiatrist approve all services that perform Electroconvulsive Therapy (ECT) in Western Australia. In November 2015, in line with the commencement of the *Mental Health Act 2014*, 10 services were approved for three years to deliver ECT and their approved status continued for this reporting period.

In January 2018, we commenced the process of re-approval of services wishing to continue to provide ECT. Although the re-approval date falls outside of this reporting period, there has been significant planning to ensure a streamlined process with no disruption to services.

As part of the re-approval process, we sent out an ECT Re-approval Self-Assessment Questionnaire in the first week of March 2018 with a five-month timeframe for completion and return to our Office. This includes the services ability to;

- Demonstrate compliance with the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy (2015)* with particular regard to the *Mental Health Act 2014* and provide evidence of same
- Provide evidence of qualifications, training and education for all staff who are involved in the administration of ECT

No new services have been approved to perform electroconvulsive therapy in this reporting period

Chief Psychiatrist's Electroconvulsive Therapy Standards and Guidelines

As part of our commitment to a more person-centered approach to mental health treatment and care, the Chief Psychiatrist established a working party to review and update the Chief Psychiatrist's Standards and Guidelines for Electroconvulsive Therapy. This working party is led by the Chief Psychiatrist and consists of consumers, carers and clinician representatives from across services approved to perform ECT.

The working party has met on eight separate occasions with a main focus on revising the Chief Psychiatrist's ECT Guidelines, which will be closely followed by a review of the ECT Standards. We expect to have a report and recommendations in late 2018 or early 2019.

Prescribed Psychiatrist

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

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

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

Mental health services are responsible for ensuring psychiatrists employed by them are credentialed and licensed to practice as a psychiatrist. They must also ensure that psychiatrists receive training in the *Mental Health Act 2014* with access to regular refresher training as required.

The required documentation and application process to be a prescribed psychiatrist can be found on the Chief Psychiatrist website.

For the reporting period, five psychiatrists were prescribed in the *Mental Health Regulations 2015*

Further Opinions

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

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

Whilst the *Mental Health Act 2014* allows a consumer to seek a further opinion by approaching the Chief Psychiatrist, he merely facilitates the provision of a further opinion by an independent psychiatrist but does not provide one himself

The Chief Psychiatrist does not provide the further opinion but facilitates the provision of one by ensuring that it is provided in a timely manner, is objectively independent and reviews any decision by a psychiatrist to refuse a consumer a further opinion.

Involuntary patients and MIA may seek a further opinion from;

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

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

For the reporting period 2017-2018 we received one request to facilitate a further opinion, however the patient then sought to pursue one via a private psychiatrist themselves.

Chief Psychiatrist's Mental Health Service visits

The Chief Psychiatrist visited 16 mental health service sites across the state in the reporting period. Some mental health services received more than one visit from the Chief Psychiatrist. This was due to issues raised by the individual service that required his presence on more than one occasion.

Informal visits to mental health services provide an opportunity for the Chief Psychiatrist and his staff to engage with clinicians, consumers and personal support people and gain insight at the coalface of service delivery. Visits to mental health services are essential to increasing accessibility to the Chief Psychiatrist, promoting the role of the Chief Psychiatrist and fostering stakeholder engagement.

Table 2: Chief Psychiatrist Visits to Mental Health Services

Mental Health Service	Number of site visits	Percentage
WA Country Health Service (Public)	2	12.5%
Private Services	1	6.25%
Metropolitan (Public)	13	81.25%

Statutory Education and Training

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

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

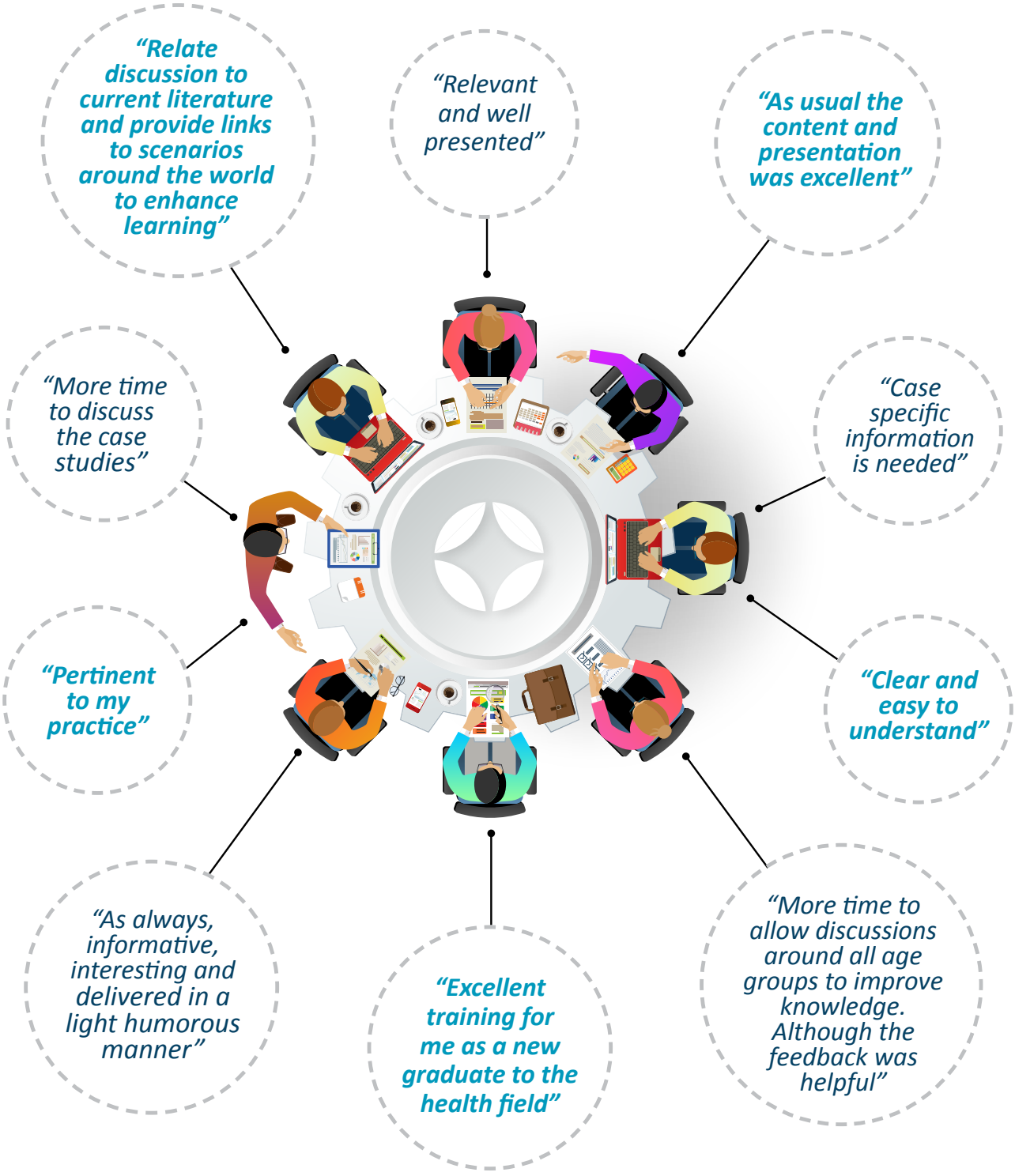
- AMHP Initial training and;
- AMHP refresher training

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

In addition to the AMHP courses, we also developed and delivered education sessions on Community Treatment Orders, Inpatient Care under the MHA 2014, Capacity as provided for in

the MHA 2014 and issues of privacy and confidentiality as they apply to a person's personal health related information. All our courses are highly valued and positively received by attendees.

Feedback from the training include:



The Chief Psychiatrist hosted three education sessions in the reporting period that addressed issues relevant to mental health, these are;

- sexual violence and mental health
- smoking and
- child sexual abuse in institutions (Royal Commission findings).

The above sessions were well attended and with attendees providing very positive feedback.

Overview of training delivered in 2017-2018;

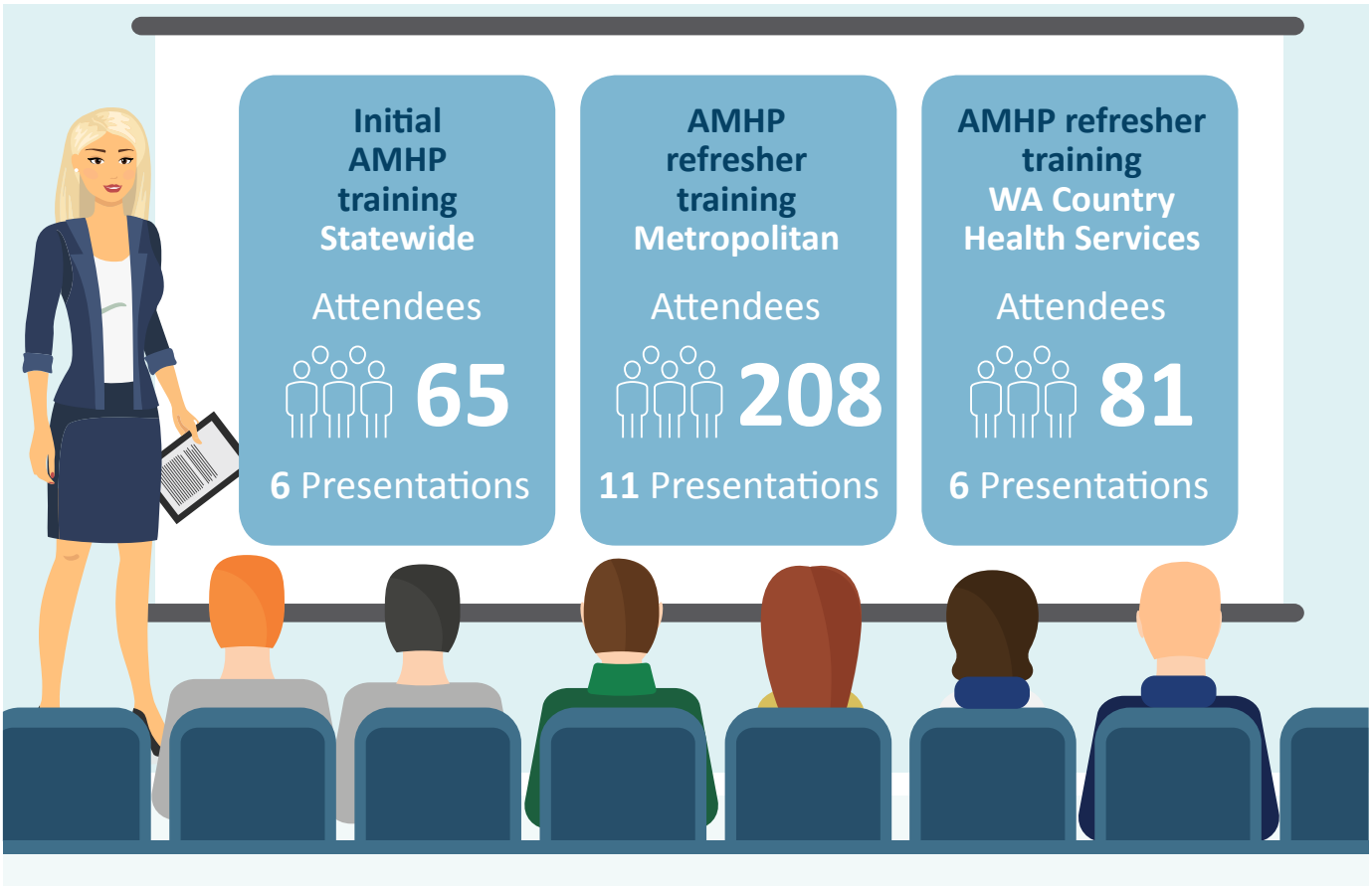


Table 3: Training Opportunities provided

Topic	Number of Presentations Conducted	Region	Number of Attendees
Other Training			
Community Treatment Orders	9	Metropolitan	95
Confidentiality – A legal and clinical perspective	3	Metropolitan	68
	1	WA Country Health Services	19
Capacity	1	Metropolitan	35
Graduate nurse training	2	Statewide and Metropolitan	45
Other training and education	12	Metropolitan	150+
Training from visiting lectures			
Sexual Violence and Mental Health	1	Statewide	60+
Royal Commission into Institutional Responses to Child Sexual Abuse	1	Statewide	35 + video conferencing attendees
Mental Illness and Smoking – can we break the relationship?	1	Statewide	21 + video conferencing attendees

CSEAT initiatives for 2018-19

What we are doing

- Continue to review the type of calls received by the Clinical Helpdesk and use this information to inform training and education.
- Continue to revise, refine and update the Authorised Mental Health Practitioner (AMHP) program to create a robust training and monitoring program that maintains its integrity and good governance.
- Continue to provide high quality contemporary education and training relevant to the AMHP role.
- Monitor AMHP compliance with Chief Psychiatrist's requirements through the annual self-report survey and audit.
- Continue to facilitate further opinion requests as required by closely collaborating with the relevant key stakeholders to ensure the right of a consumer to seek a further opinion is upheld and achieved in a timely manner.
- Where the complexity of a contact from a consumer or personal support person requires a higher degree of clinical and statutory expertise, we have and will to ensure these matters are managed in an appropriate, timely and effective manner.

What we will do

Clinical Support and Engagement

- Actively seek opportunities to work with and draw on the expertise of consumers and personal support persons in CSEAT activities.
- Publish a report outlining the results of Chief Psychiatrist's Clinical Helpdesk satisfaction survey
- Establish an in-house Ethics Panel to guide and advise on particularly complex clinical enquiries that are an ethical dilemma.

Statutory Education and Training

- Develop the OCP education operational and delivery plan to ensure that training meets relevant standards and conforms with the principles for contemporary mental health care.
- Enhance education platforms by capitalising on the use of technology through webinars and podcasts of OCP training and introduce E-learning initiatives.
- Formalise competency assessments in the AMHP training
- Publish the AMHP self-report survey and audit results on the Chief Psychiatrist's website.
- Devise and develop new educational programs relevant to mental health clinicians performing functions under the MHA 2014.
- Advise on learning objectives for Graduate Programs to ensure that new graduates entering the mental health workforce receive contemporary and relevant training and mental health skill sets.

- Collaborate with learning institutions and seek co-production, co-design, co-education and co-badging opportunities to strengthen the learning objectives of clinicians within the mental health workforce across Western Australia.

Statutory Authorisations and Approvals

- Complete the review of *'The Chief Psychiatrist's Standards for the Authorisation of Hospitals'*
- Publish the revised set of the *Chief Psychiatrist's Standards for the Authorisation of facilities under the Mental Health Act 2014.*
- Conduct a review of currently authorised mental health facilities of long-standing duration, to ensure they are consistent with contemporary mental health inpatient environments in providing safe high quality mental health treatment and care.
- Complete the re-approval of services performing Electroconvulsive Therapy (ECT), which will include site visits by the Chief Psychiatrist and his review team consisting of consumer and carer representatives and OCP staff.
- Complete the review and oversee the publication of the Chief Psychiatrist's ECT Standards and Guidelines.
- Work collaboratively with the Mental Health Commission to streamline the process of gazettal for prescribed psychiatrists and limit delays which can impact on a services ability to provide safe high quality care in the best interests of the consumer.

Our Standards Monitoring and Evaluation Program

Our Standards Monitoring and Evaluation Program

The Standards Monitoring and Evaluation program (Monitoring and Evaluation) aims to ensure that mental health services provide safe, high quality care. This is achieved through (i) monitoring and evaluation of compliance with standards and reporting of psychiatric treatments and interventions as stipulated under the Act; (ii) monitoring and evaluation of notifiable incidents; and (iii) routine and ad hoc clinical reviews of mental health services. Over the 2017-18 financial year, the Monitoring Team has collaborated closely with colleagues, mental health services and clinicians, and other key stakeholders through a range of strategies to ensure standards of treatment and care are met.

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

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

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

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

Standards Monitoring and Evaluation Program achievements in 2017-18:

- Clinical reviews of all public mental health services were completed by June 2018. In the 2017-18 financial year, clinical reviews were completed for North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), and East Metropolitan Health Service (EMHS).
- A Clinical Governance review was undertaken across EMHS in conjunction with the broader clinical review.
- Consumers and Carers were recruited and trained in undertaking clinical reviews of the standards of care delivered in mental health services.
- A survey of clinician awareness, knowledge and understanding of the Chief Psychiatrist Standards for Clinical Care was completed.
- Monitoring and Evaluation Team members worked with the Statutory Education Team to provide training on reporting seclusion and restraint events under the Act.
- Worked with mental health services to validate the seclusion and restraint notifications to the Chief Psychiatrist and to reduce reporting errors.

- The two-year review of the *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist* was undertaken following consultation with mental health services and other key stakeholders.
- Mental health services were notified that seclusion and restraint data and reporting errors under the Act will be published on the Chief Psychiatrist website commencing with 2018-19 first quarter data.
- Improved reporting of the prescription of off-label pharmaceuticals to children and youth less than 18 years of age was achieved through communication and collaboration with mental health services.
- A review of the profile of residents of private psychiatric hostels, who were also current public mental health patients between 16 April and 7 May 2018, was undertaken.
- Meetings were held with private psychiatric hostel licensees and managers, the Mental Health Commission and the LARU with the aim of improving strategic governance processes and improving standards of care at private psychiatric hostels.

Chief Psychiatrist's Clinical Monitoring Program

'What you do makes a difference, and you have to decide what kind of difference you want to make.' *Jane Goodall*

The Chief Psychiatrist is required under the MHA 2014 (s.515) to publish standards for treatment and care provided to consumers by mental health services and oversees compliance with those standards. The purpose of standards is to provide a consistent statement about the level of care consumers can expect from health services. The purpose of monitoring is to determine whether health services are meeting that expectation.

The Chief Psychiatrist's Clinical Monitoring Program is an essential strategy for assessing whether the standard of clinical care and treatment provided in WA mental health services meets expectations and standards. The components of the program are:

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

Investment in quality improvement initiatives requires considerable resourcing. While typically undertaken within existing health budgets, the diversion of resources to an improvement project and away from other areas will always create an impact on service delivery. It is essential that decisions made to direct resources into improvements be based on a robust evaluation, which identifies the priority areas for improvement. The Chief Psychiatrist's Clinical Monitoring Program provides services with an independent evaluation of the standard of care they are providing, to guide decision making about quality improvement.

The reviews utilise a combination of qualitative and quantitative methods to establish a rich understanding of current service delivery. Senior clinicians are appointed as reviewers. An improvement to the process for 2016-17 has been the addition of experienced consumer and carer consultants to the review teams. This is part of the Chief Psychiatrist's commitment to a more person centered approach to the work of this Office.

It is the reviewers' knowledge and experience, which assists the depth of the review process and their participation gives reviewers an insight into the type and quality of service delivery being provided by other mental health services. This in turn provides an opportunity to compare processes with their own service and share improvements across the system.

The reviewers use evaluation tools based on the Chief Psychiatrist's Standards for Clinical Care and aligned with key national and local policies and standards. Data are analysed and used to identify key areas of notable practice, which can be shared with other mental health services and make recommendations to guide service improvement. Services are provided with detailed reports outlining the findings of the review. These can be utilised for their own internal quality

improvement processes or as evidence for other monitoring processes, such as accreditation by the Australian Council on Healthcare Standards.

While services have a statutory obligation to comply with standards related to the Act, the Chief Psychiatrist does have a statutory remit to direct recommendations that sit outside of these standards under s.519 of the MHA 2014. In the interests of high quality care, if the review reveals a need for action outside of the standards, the Chief Psychiatrist will make a recommendation and actively seek follow up by those services involved.

Within health care, administrative and regulatory duplication is a significant risk. The Chief Psychiatrist's Clinical Monitoring Program differs from other review processes, such as accreditation, by undertaking a greater degree of inquiry into specific clinical issues. As an independent data collection, it differs from internal monitoring completed for other purposes, such as performance reporting. Additionally, the Chief Psychiatrist's Clinical Monitoring Program facilitates sharing ideas for improvement between mental health services in Western Australia.

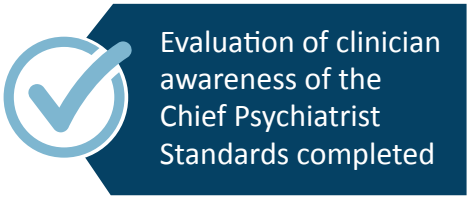
Chief Psychiatrist's Standards for Clinical Care

In November 2015, the Chief Psychiatrist's Standards for Clinical Care were published as per the requirements of the Act (s.547). As intended, a review of these standards has been commenced during the 2017-18 financial year and the first round of consultation has taken place. It is intended that the revised standards will be published during the 2018-19 financial year.

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

In July 2017, the Office of the Chief Psychiatrist released a staff survey to seek knowledge regarding clinician's awareness of the Chief Psychiatrist's Standards for Clinical Care. The results of the survey were published on the website of the Office of the Chief Psychiatrist.

A total of 230 clinicians responded to the survey. The survey found that overall, 87% of respondents were aware of the Chief Psychiatrist's Standards for Clinical care, however it appears that a higher proportion of Authorised Mental Health Practitioners who responded to the survey were aware of the standards than other respondents. The findings of the survey were that more communication about the standards is warranted.



The Chief Psychiatrist wrote to the Chief Executive of each Health Service Provider and mental health service funded under a public-private partnership in Western Australia. The letter requested an action plan for implementation of the Chief Psychiatrist Standards for Clinical Care and was accompanied by the results of the survey and an educational PowerPoint regarding the standards, developed by the Office. This PowerPoint is also available on the Chief Psychiatrist's website. Action plans were received from all public health services and St John of God Mt Lawley. Action plans from St John of God Midland and Ramsay Care Joondalup are yet to be received by the Chief Psychiatrist.

The survey was repeated in June 2018. Results indicated that Authorised Mental Health Practitioners have a good awareness of the Chief Psychiatrist's Standards for Clinical Care, with 93% reporting awareness. However, more work is needed to educate other clinicians, of whom, only 66% reported awareness of the Chief Psychiatrist's Standards for Clinical Care. A possible explanation for this finding is that the training of Authorised Mental Health Practitioners supports learning about the Chief Psychiatrist's Standards for Clinical Care. The results of the survey and an action plan will be published on the website of the Office of the Chief Psychiatrist in the 2018-19 financial year.

Chief Psychiatrist's Clinical Standards and Service Reviews

In 2016 the Chief Psychiatrist implemented a new clinical monitoring program – the Chief Psychiatrist's Clinical Standards and Service Review. It was the intention of the Chief Psychiatrist that all mental health services within WA will be reviewed within two years of the implementation of the clinical monitoring program (June 2018). This commitment has been met, with the reviews carried out in all public mental health services by June this year.

Comprehensive Clinical Record Review

The focus of the 'Comprehensive Clinical Record Review' is to review the quality of clinical care as evidenced within the written clinical record. The record is assessed against the Chief Psychiatrist's Standards for Clinical Care. In the 2016/17 financial year, the review tool was tested for inter-rater reliability to identify questions with poor reliability of the information gleaned from the clinical record review requiring improvement. Identified questions have been re-worded or removed, with a plan for further testing of the tool to occur should that be necessary.

Staff Feedback

Face-to-face feedback is gathered from staff working within the mental health service. To ensure an even mix of viewpoints in the review, staff working in the service are grouped by discipline and level of experience, then randomly selected from within each group and invited to give an interview. Any staff who request an interview are also given the opportunity to provide feedback during the review process.

Interviewers utilize questions designed to provide feedback on key areas relating to safety and quality of clinical care. A new addition to the review process in the 2017-18 review is the inclusion of a staff survey. The purpose of the survey is to seek feedback from a broader group of staff than is possible through interviewing alone. Initially, a locally developed survey was used, however the process was benchmarked with other jurisdictions and now a National Health Service (NHS) survey has been adopted for ongoing use.

Consumer and Carer Feedback

An addition to the review process for 2017-18 has been the introduction of consumer and carer feedback. Multiple formats are made available to provide consumers and carers with options for their preferred method to provide feedback; face-to-face interviews, phone interviews, online and paper-based surveys. The introduction of consumer and carer reviewers to the team has enabled face-to-face feedback to be collected by consumers and carers.

Clinical Review of WA Country Health Service

The WA Country Health Service (WACHS) was the first area health service to be reviewed by the Chief Psychiatrist since the commencement of the Act. All seven mental health regions within the WACHS region were reviewed between May–July 2016. The review identified five areas of notable practice and made seven recommendations for service improvement (see OCP Annual Report 2016-17 p43).

The Chief Psychiatrist has received a progress report from WACHS, detailing their action towards addressing the recommendations. The Chief Psychiatrist has reviewed and responded to this report; the next progress report is scheduled for October 2018.

Clinical Review of Child and Adolescent Mental Health Service

The Child and Adolescent Health Service (CAHS) Mental Health Services were reviewed by the Chief Psychiatrist in May 2017. The report of findings was completed during the 2016-17 financial year and provided to the CAHS Executive and Director General of WA Health.

All ten Community Child and Adolescent Mental Health Services, the Bentley Adolescent Unit and six specialist Child and Adolescent Mental Health Services, were visited by senior clinical reviewers. A total of 244 clinical records were reviewed and 90 staff were interviewed during the course of the review.

The review identified six areas of notable practice:

- Mental health assessment
- Choice Assessment
- Care Planning
- Risk Management
- Transfer of Care
- Inter-Agency Communication

A total of five recommendations have been made across the areas of family and carer involvement, medication safety, and physical health care. The services' actions to address the recommendations will be monitored over the next 12 months.

Clinical Review of South Metropolitan Health Service

The Chief Psychiatrist reviewed South Metropolitan Health Service (SMHS) Mental Health Services in May/June 2017. The report of findings was completed during the 2016-17 financial year and provided to the SMHS Executive.

The review team visited seven SMHS Inpatient and Community Mental Health Services. A total of 114 clinical records were reviewed and 63 staff were interviewed.

The review identified five areas of notable practice:

- Mental Health Assessment
- Mental State Examination
- Risk Assessment on Admission
- Care Planning
- Physical Health Management

A total of eight recommendations have been made across the areas of physical health assessment, consumer and carer involvement in care planning, ongoing risk assessment and management of risk, care of dependents and implementation of the Chief Psychiatrist's Standards for Clinical Care. Action plans and reports of progress against the recommended actions will be submitted by the service over the coming 12-month period.

Clinical Review of North Metropolitan Health Service

The Chief Psychiatrist reviewed all mental health services within North Metropolitan Health Service (NMHS) in November-December 2017. A team of thirty-one senior clinicians and two carer reviewers visited twenty-nine NMHS services.

The team reviewed 218 clinical records and interviewed 113 staff. Analysis of the data is underway, with the report of findings to be provided to the NMHS Executive during the 2018-19 financial year.

Clinical Review of East Metropolitan Health Service

The Chief Psychiatrist reviewed the East Metropolitan Health Service (EMHS) mental health services in April-May 2017. A team of sixteen senior clinicians along with four consumers and two carers visited seven EMHS services.

The team interviewed 110 staff and 74 consumers and carers. The team reviewed 198 clinical records and received 237 survey responses. The report of findings will be provided to the EMHS Executive during the 2018-19 financial year.

Future Clinical Monitoring Reviews

The next task for the Clinical Monitoring Program will be to design and undertake reviews of private mental health services and Private Psychiatric Hostels. These reviews are planned to occur during the 2018-19 and 2019-20 financial year.

The Clinical Monitoring Program has a responsibility to undertake reviews of the treatment and care of consumers who reside in private psychiatric hostels and receive psychiatric care from a community mental health service. Work is underway to design the review methodology for these services.

Chief Psychiatrist's Thematic, Targeted and Case Reviews

Targeted Service Review

In June 2017, in response to a request from the Chief Psychiatrist, the Executive Team of East Metropolitan Health Service (EMHS), commissioned a review of the City East Community Mental Health Service. The Senior Psychiatrist and Medical Director, and the Director of the WA Centre for Mental Health Policy Research undertook the review. A report and recommendations from the review was provided to EMHS in November 2017.

One recommendation from the review was for the Chief Psychiatrist to conduct an independent Clinical Governance Review of City East Mental Health Service, six months following the submission of the report and findings to the Executive Team of EMHS.

The Chief Psychiatrist's Clinical Governance Review was completed in May 2018 and the report of findings and recommendations will be provided to the EMHS Executive during the 2018-19 financial year. The Chief Psychiatrist will follow up with EMHS regarding an action plan to address the recommendations of this report.

Targeted Case Reviews

Where the Chief Psychiatrist has a sufficient concern about the treatment and care of an individual, which is particularly complex and sensitive, he has directed the Research and Strategy Program to conduct an in-depth case review.

The reviews are undertaken in such a way as to encourage those involved in providing treatment and care to learn from and reflect on their practice as well as to identify system hazards or vulnerabilities so action can be taken to make improvements. The confidential nature of patient information in a case review means that detailed findings are rarely made publicly available. However, the outcomes from a case review can highlight systemic issues of sufficient concern, which require further investigation through a thematic review.

At the request of the Chief Psychiatrist one case review was initiated during the reporting period.

Thematic Reviews

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

Over the past year, a number of clinicians have highlighted the difficulties they face in providing treatment and care, which meets the multiple complex needs of people with severe mental illness and challenging behaviours. The Chief Psychiatrist has been alerted to instances where systemic service gaps have contributed to sentinel events and forensic outcomes for some individuals.

Consequently, the Chief Psychiatrist has instigated a thematic review via the Research and Strategy Program, to investigate these issues and, in partnership with mental health services, develop options to enhance future clinical services. The scope of the review extends to all metropolitan adult services, both inpatient and community.

Overall, the review aims to identify and address any systemic issues in the treatment and care of adults with severe mental illness and challenging behaviours and specifically to:

- Identify the characteristics of this cohort
- Gain an in-depth understanding as to why clinicians find these consumers challenging to work with and explore the barriers and enablers to providing them with high quality treatment and care
- Examine the consumer journey through the mental health service system in order to identify patterns of service use and the adequacy of the service response;
- Map the range of service types, configurations and models of care used to provide treatment and care for this cohort
- Identify examples of 'best practice' in other jurisdictions and synthesize the learning from the literature
- Develop options for future service development.

The Chief Psychiatrist's Research and Strategy Program are working closely with Health Service Providers to develop options for future services to this cohort of consumers.

What are we doing?

- Using evaluation data to identify priority areas for quality improvement
- Communicating improvement priorities to mental health services
- Sharing information about high quality care between services, to facilitate system-wide learning

Our Statutory Monitoring

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

Mental health services in Western Australia report on the following:	
Electroconvulsive therapy (s. 201)	Segregation of children from adult inpatients (s. 303)
Emergency ECT approved by the Chief Psychiatrist (s.199)	Off-label prescription provided to children who are involuntary patients (s. 304)
Restrictive practices (s.224; 240)	Approving involuntary inpatient treatment orders in a general hospital (s. 61)
Notifiable incidents (s. 526)	Emergency psychiatric treatment (s. 204)
Psychosurgery (s. 209)	Urgent non-psychiatric treatment for involuntary and MIA patients (s. 242)
Treatment decisions that differ to the Advance Health Directive of an involuntary patient (s. 179)	

We monitor 'Notifiable Incidents' and identify trends. At the discretion of the Chief Psychiatrist, individual cases may be investigated should there be any specific concerns he may have via a direct line of inquiry to the responsible mental health service, and recommendations made as necessary.

The following section presents data for the 2017-18 financial year;

Electroconvulsive Therapy

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

Under the Act, ECT can only be administered in ECT suites or operating theatres approved by the Chief Psychiatrist and these are required to follow the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy 2015* and the *Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia 2006*.

The Act contains specific provisions regulating the use of ECT, including obtaining informed consent from voluntary patients and the circumstances in which a patient can provide informed consent. A medical practitioner must obtain approval from the Mental Health Tribunal in order to perform ECT on an involuntary or Mentally Impaired Accused (MIA) patient.

The person in charge of the Mental Health Service must report at the beginning of each month on any course of ECT which was completed or discontinued in the previous month. A course of ECT is taken to have been completed during a month, if the last treatment in the course was performed during that month, whether or not any of the other ECT treatments in the course were performed during the month. A course of ECT is taken to have been discontinued during a month if;

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

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

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

ECT Statistics

Table 4: ECT courses and treatments completed in the 2017-18 financial year.

Age	Status	Number of ECT Courses Completed in 2017-18	ECT Treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
Patients over 18	Voluntary	520	4261	916	0	5177
	Involuntary / Referred[a]	51	453	7	38	498
	Mixed[b]	23	317	214	8	539
	Total	594	5031	1137	46	6214

Table 4: ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2017 – 30 June 2018).

Note: The data are representative of those who completed their course of ECT between 01 July 2017 and 30 June 2018. It is important to note that the starting date for some of the courses may have commenced prior to the beginning of the reporting period 1 July 2017. Persons having not completed their course of ECT are not included in Table 4. (a) Mentally Impaired Accused are included in this category; (b) Patients who had both an involuntary and a voluntary status in the same course.

For the reporting period 1 July 2017 – 30 June 2018 there were 594 completed ECT courses reported to the Chief Psychiatrist. Of the 594 courses, 520 (88%) were for patients with a voluntary status, 51 (9%) were for involuntary or referred status, and 23 (3%) were for mixed (both voluntary and involuntary) status.

There were 6214 ECT treatments completed of which 5031 (81%) were acute treatments, 1137 (18%) were maintenance and 46 (<1%) consisted of emergency treatments. All patients were over the age of 18 years.

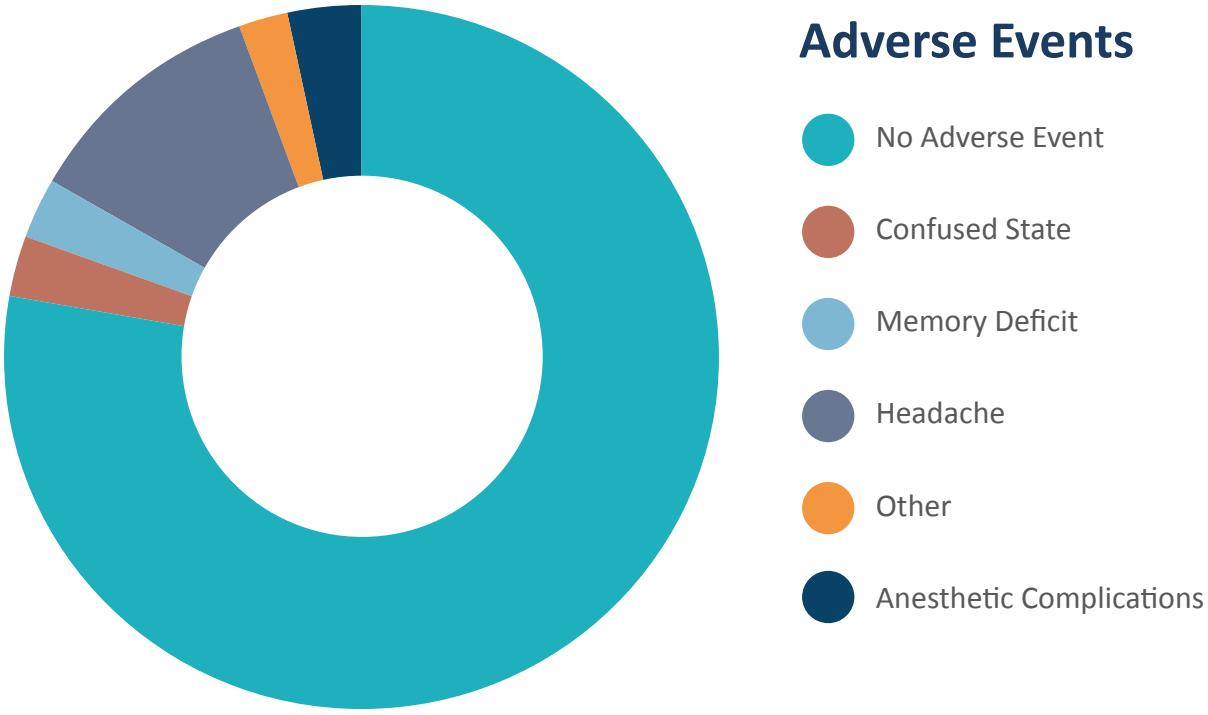
Of all patients who received ECT treatments, 32% were treated in ECT services located within a public hospital, 7% in a publically contracted private hospital and 61% in ECT services within a private hospital.

Adverse Events

Of the 461 patients who received ECT treatments, 389 patients or 84% had no adverse event associated with their treatment.

Of the 72 patients or 16% who had an adverse event associated with their treatment, 58% experienced a headache, 20% an anaesthetic complication, 9% a confused state, 8% a memory deficit, and 8% Other (Figure 11). Fewer than five patients had more than one type of adverse event reported.

Figure 11: Number of patients who experienced ECT associated adverse events



Source: Office of the Chief Psychiatrist Database

Emergency ECT Approved by the Chief Psychiatrist for this financial year

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

There were 64 Emergency ECT treatments authorised by the Chief Psychiatrist or his delegate, for the reporting period. Of these ECT treatments, 67% were completed before 30 June 2018.

Restrictive Practices

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

In WA, mental health clinicians in authorised hospitals use seclusion and restraint as a last resort, when either all other methods of de-escalation have been tried or de-escalation cannot be used. The safety and care of the patient, other patients or visitors and staff is important and should not be compromised.

Patients requiring multiple events of seclusion and/or restraint during their period of care are patients who have particularly challenging behaviours. Consideration needs to be given to the severity of the mental illnesses being experienced by the patients that may have resulted in multiple events and longer periods of restraint and/or seclusion. Further reductions in the rates of seclusion and restraint will only be achieved with the continued commitment of mental health staff to implement evidence-based state-wide best practice clinical/therapeutic interventions.

State and National reporting on restrictive practices includes data on seclusion and physical and mechanical restraint occurring within authorised mental health units. A system of monitoring and evaluating restrictive practice events and their rates has been established in the Office of the Chief Psychiatrist to ensure the data reported are complete and have been validated against the data collected by mental health services. The data collected are shared with mental health services on a regular basis to assist services to track their progress in reducing the use of these restrictive practices.

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

Seclusion

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

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

Mental Health Act 2014

The Chief Psychiatrist is committed to reducing and where possible eliminating the use of seclusion in mental health services across WA.

Significant initiatives have been made in mental health services to reduce and eliminate the use of seclusion.

Seclusion may be used to prevent a person from physically injuring themselves or others, or persistently causing serious damage to property. Seclusion can only be used within an authorised hospital if the person is at risk of physically injuring themselves or another person or if they are persistently causing serious damage to property and there is no less restrictive way of preventing injury or damage other than placing them in seclusion. Seclusion purely for the purposes of preventing self-harm should be avoided.

The *Mental Health Act 2014* relevantly provides for the conditions under which seclusion may be used. Seclusion can be initially authorised for a maximum of two hours and the person being secluded must be observed every 15 minutes by a nurse or mental health practitioner. Seclusion can be extended for periods of up to two hours however, an examination must be completed by a medical practitioner within two hours from the time the person was secluded, or from their last examination. It is the Chief Psychiatrist's expectation that medical practitioners attend the patient as soon as practicable after the patient was placed in seclusion, rather than towards the end of the duration of the order.

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

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

During the 2017-18 financial year, there were 11,830 separations (discharges), for 7,449 individuals. Of these, 354 (5%) individuals were secluded with 968 episodes of seclusion Table 4.

Table 4: Number of seclusions reported to the Office of the Chief Psychiatrist

Age Group	Number of Discharges	Number of Individuals	Number of Individuals Secluded	Number of Seclusion Episodes
Patients under 18 years of age	1,012	515	35	118
Patients aged 18–64 years	9,588	6,207	314	841
Patients aged 65 years and older	1,230	727	5	9

Seclusion Episodes - Total Population (All Ages)

Duration of Seclusion Episodes

Of the 968 episodes reported, 22% lasted less than 60 minutes, 53% lasted between 60 and 120 minutes, and 25% lasted more than 120 minutes (Table 13). The median duration for seclusion was 105 minutes.

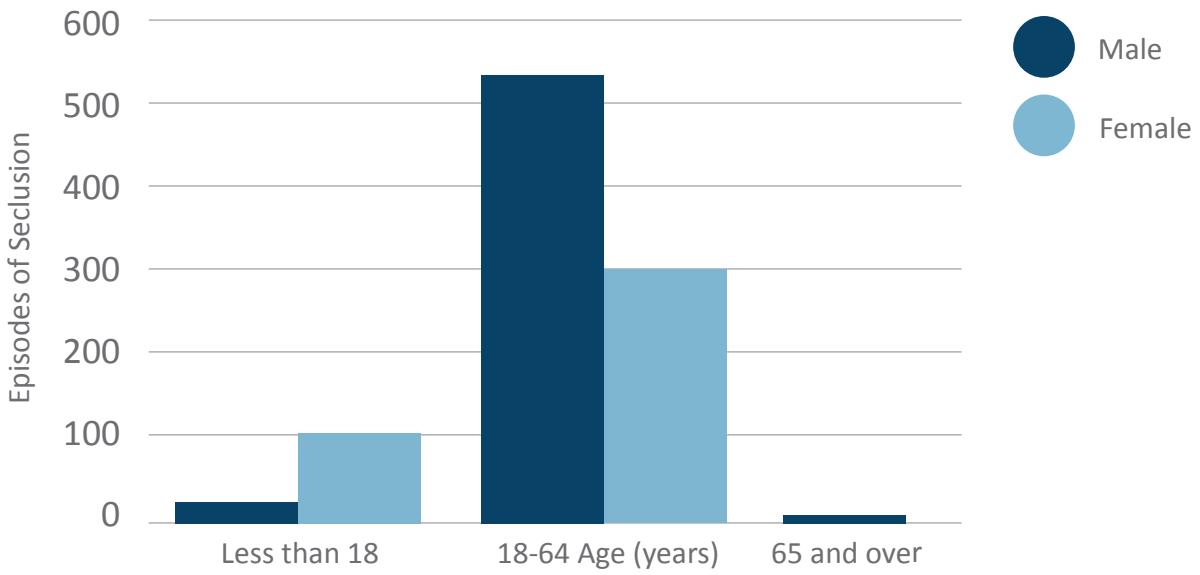
Table 5: Duration of seclusion events in authorised mental health units – Total population

Duration of Seclusion Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 60 minutes	125	212	38
60 to 120 minutes	235	516	105
More than 120 minutes	118	240	239

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

Across all age groups, 65% of patients secluded were male, which accounted for 58% of episodes of seclusion reported. A similar proportion of patients 18-64 years of age (68%) were male and conversely, for patients less than 18 years of age being secluded, a higher proportion were female (69%). Due to the small number of seclusions for patients aged 65 years and over gender will not be identified.

Figure 12: Episodes of Seclusion per Age Group



Source: Office of the Chief Psychiatrist Database

Seclusion Episodes – Patients under 18 Years

Duration of Seclusion Episodes

Of the 35 patients aged less than 18 years who were secluded, 27 were secluded less than 5 times, and 8 patients were secluded more than 5 times.

Of the 118 seclusion episodes reported, 48% lasted less than 60 minutes, 40% lasted between 60 and 120 minutes, and 12% lasted more than 120 minutes (Table 6). The median duration of seclusion was 61 minutes.

Table 6: Duration of seclusion for patients under 18 years

Duration of Seclusion Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 60 minutes	27	57	35
60 to 120 minutes	19	47	87
More than 120 minutes	<5	14	157

*The subtotals for individuals will not add to the total number of individuals secluded as some patients were secluded more than once for varying lengths of time.

Seclusion Episodes – Patients 18 – 64 Years

Duration of Seclusion Episodes

Of the 314 patients aged 18–64 years who were secluded, 280 patients were secluded less than 5 times, 25 patients between 5-10 times, and 9 were secluded more than 10 times. Of the 841 seclusion episodes reported to the Chief Psychiatrist, 18% lasted less than 60 minutes, 55% lasted between 60 and 120 minutes, and 27% lasted more than 120 minutes (Table 7). The median duration of seclusion was 110 minutes.

Table 7: Duration of seclusion for patients aged 18–64

Duration of Seclusion Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 60 minutes	97	154	39
60 to 120 minutes	213	464	105
More than 120 minutes	111	223	239

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

Seclusion Episodes – Patients 65 Years and Over

All five patients aged over 65 years of age and over, were secluded less than 5 times with a total of 9 episodes. Due to the small number of patients secluded, further detailed statistics are not reported in order to prevent potential identification of individuals.

National Key Performance Indicators for Seclusion episodes

The Australian Institute for Health and Welfare (AIHW) reports annually on national and state/territory yearly seclusion rates, in acute mental health facilities. During the current reporting period the overall rate of seclusion within authorised mental health inpatient units in WA was 4.3 episodes per 1,000 bed-days. The rate of seclusion was lowest in older adult mental health services but due to the small numbers the rate is not reported. Adult mental health services had the second lowest rate in WA at 5.0 episodes per 1,000 bed-days, followed by forensics services (11.7 per 1000 bed-days) with the highest rate in child and adolescent (12.6 per 1,000 bed-days).

Restraint

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

Restraint may be initially authorised for a maximum of 30 minutes, and a mental health practitioner or nurse must be in physical attendance with the person at all time, and file a record of the observations made on the approved Form. Restraint can be extended for periods of up to 30 minutes; however, an examination by a medical practitioner must occur within 30 minutes before an extension can be authorised. If the person is restrained for longer than 6 hours, they must be examined by a psychiatrist. A post-restraint physical examination must occur within six hours of the person being released from the restraint. It is our expectation that the post-restraint examination occurs as soon as practicable.

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

For the 2017-18 financial year there were 11,830 separations, involving 7,449 individuals. Of these, 427 patients were restrained (6%) with a total of 1147 episodes of restraint (Table 8).

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

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

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

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

Mental Health Act 2014

Table 8: Number of restraints reported to the Office of the Chief Psychiatrist

Age Group	Discharges	Number of Individuals	Number of Individuals Restrained*	Restraint Episodes
Patients under 18 years of age	1,012	515	66	275
Patients aged 18-64 years	9,588	6,207	317	799
Patients aged 65 years and older	1,230	727	44	73

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

Restraint Episodes – Total Population (All Ages)

Duration of Restraint Episodes

Of the 427 patients who were restrained, 376 were restrained less than 5 times, 34 patients between 5-10 times, and 15 patients were restrained more than 10 times. Of the 1147 episodes reported, 61% lasted less than 5 minutes, 23% lasted between 5 and 10 minutes, and 16% lasted more than 10 minutes (Table 9). The median duration of restraint was 3 minutes.

Table 9: Duration of restraint events in authorised Mental Health units – Total Population

Duration of Restraint Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 5 minutes	306	694	2
5 to 10 minutes	165	264	6
More than 10 minutes	90	189	19

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

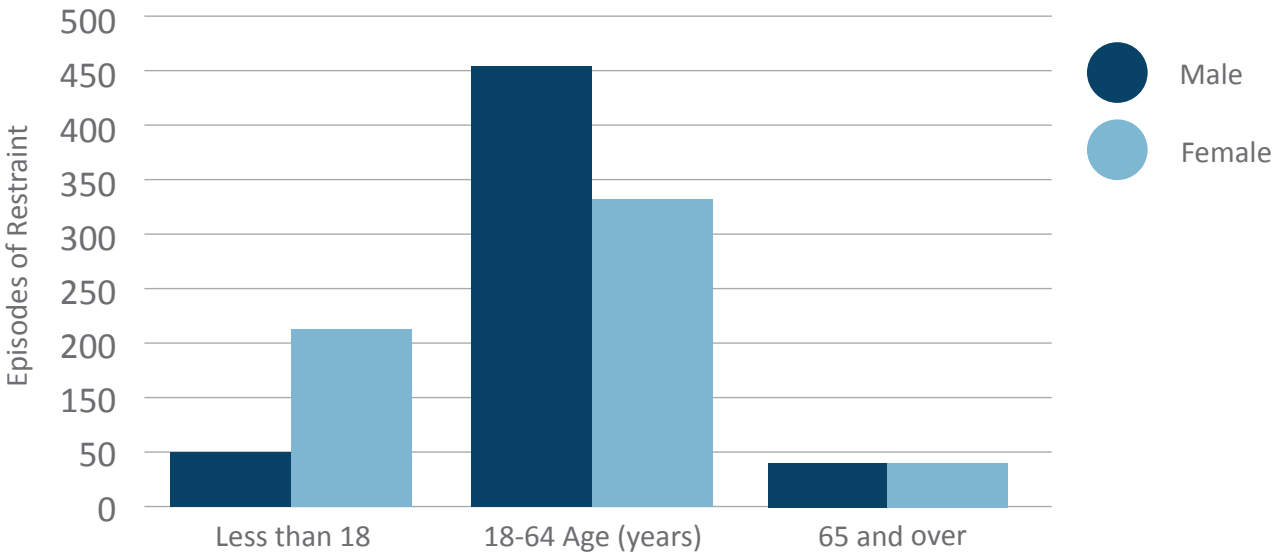
Across all ages, the number of male patients who were restrained was higher than female patients (53% vs 47%, respectively), however female patients accounted for a higher proportion (52%) of all restraint episodes.

Of the 66 patients less than 18 years of age who were restrained, 73% were female and accounted for 80% of restraint episodes for this age group (Figure 13). In contrast, the majority of patients aged 18-64 years of age who were restrained were male (58%) accounting for 58% of restraint episodes. Over half (57%) of patients aged 65 years and over who had an episode of restraint were male, however the number of restraints episodes were almost equal for male and female patients (49%, 51%, respectively).

Physical or Mechanical Restraint across all age groups

The majority of restraints were physical (n = 1139) with fewer than 5% (n = 8) mechanical.

Figure 13: Episodes of Restraint by Age and Gender Group



Source: Office of the Chief Psychiatrist Database

Restraint Episodes – Patients under 18 Years

Duration of Restraint Episodes

Of the 66 patients less than 18 years of age who were restrained, 49 were restrained less than 5 times, 11 patients between 5-10 times, and 6 patients were restrained more than 10 times. Of the 275 episodes reported, 57% lasted less than 5 minutes, 21% lasted between 5 and 10 minutes, and 22% lasted more than 10 minutes. The median duration was 3 minutes (Table 10).

Table 10: Duration of restraint for patients under 18 years

Duration of Restraint Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 5 minutes	50	156	1
5 to 10 minutes	32	59	6
More than 10 minutes	27	60	18

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

Physical or Mechanical

All 275 reports of restraint to the Chief Psychiatrist for patients under 18 years of age were for physical restraint events, with no reports of mechanical restraint.

Restraint Episodes – Patients 18 – 64 Years

Duration of Restraint Episodes

Of the 317 patients aged 18 to 64 years who were restrained, 285 were restrained less than 5 times, 25 patients between 5-10 times, and 7 patients were restrained more than 10 times. Of the 799 restraint episodes reported, 61% lasted less than 5 minutes, 25% lasted between 5-10 minutes, and 14% lasted more than 10 minutes. The median duration was 3 minutes (Table 11).

Table 11: Duration of restraint for patients aged 18–64 years of age

Duration of Restraint Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 5 minutes	225	486	2
5 to 10 minutes	125	196	6
More than 10 minutes	53	117	19

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

Physical or Mechanical

The majority of restraints episodes involved physical restraint (99%; n=791), with the remaining 1% mechanical restraint (n = 8).

Restraint Episodes – Patients 65 Years and Over

Duration of Restraint Episodes

Of the 44 patients aged over 65 years and over who were restrained, the majority were restrained less than 5 times, with fewer than 5 patients restrained more than 10 times. Of the 73 episodes reported, 72% lasted less than 5 minutes, 12% lasted between 5 and 10 minutes, and 16% lasted more than 10 minutes. The median duration of restraint episodes was 2 minutes for patients restrained less than 5 minutes, increasing to 20 minutes for patient restrained for more that 10 minutes (Table 12).

Table 12: Duration of restraint for patients 65 years and over

Duration of Restraint Events	Number of Individuals*	Number of Episodes	Median Duration in minutes
Less than 5 minutes	32	52	2
5 to 10 minutes	9	9	6
More than 10 minutes	11	12	20

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

National Key Performance Indicators for Restraint episodes

Rates of restraint are difficult to benchmark nationally, due to variations in reporting between the states and territories. Significant progress has been made towards a national reporting framework for restraint events across all jurisdictions. The Australian Institute of Health and Welfare and the Safety and Quality Partnerships Standing Committee, have led the initiative to begin national reporting and jurisdictional comparative restraint rates, where possible.

With the implementation of the Act, reporting requirements in WA have been standardised, enabling the accuracy of future benchmarking at state level.

During the reporting period the rate of restraint authorised mental health inpatient units in WA for all age groups was 5.1 episodes per 1,000 bed days. The rate of restraint varied across services, with the lowest rate of episodes observed in Older Person services (2.2 per 1,000 bed days) and Adult services (4.4 per 1,000 bed days, and the highest rate within Child and Adolescent services (28.2 per 1,000 bed days). Forensics services had a rate of 19.7 episodes per 1,000 bed days.

Notifiable incidents reported to the Chief Psychiatrist

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

The *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist,* (the Notifiable Incident Policy), outlines the reporting process for notifiable incidents to be reported to the Chief Psychiatrist. Notifiable incidents must be reported either via the *Datix Clinical Incident Management System* (Datix CIMS) or by completing the OCP[7] Notifiable Incident Reporting Form available on the Chief Psychiatrist website.

The Review of the Notifiable Incident Policy which was due as soon as practicable, two years after commencement of the Act on 30 November 2015 and commenced in January 2018. Following internal review, the Notifiable Incident Policy was released for stakeholder and clinical consultation in March 2018. The updated Notifiable Incident Policy is due to be launched in August-September 2018. The outstanding Department of Health Operational Directive (OD_058815) will be rescinded and the Notifiable Incident Policy released directly to Health Service Providers.

Severity Assessment Codes

Incidents reported through Datix CIMS, require the notifying person to assign a Severity Assessment Code (SAC) of 1, 2 or 3 based on the actual or potential consequences associated with the clinical incident. The SAC rating is used to determine the appropriate level of investigation, action and escalation required. In Datix CIMS the notifying person enters the SAC rating that they assess as best reflecting the level of harm that has, or could have, occurred to the patient as a result of the incident.

All incidents reported through Datix CIMS undergo an investigation by a senior staff member at the hospital or health service involved. The level of investigation required by the Datix CIMS Policy is dependent on the SAC rating. Incidents assigned SAC1 ratings require an investigation via Root Cause Analysis (RCA) or similar methodology. Through this process, potential causative and contributing factors are identified, which enable the service to develop and implement strategies to prevent similar incidents from occurring in the future.

Each notifiable incident relating to a mental health patient is reviewed to determine whether the incident fit within the Chief Psychiatrist's statutory remit and are then coded accordingly.

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

Notifiable Incidents

Notifiable Incidents must be reported as soon as practicable, to the Chief Psychiatrist, ideally within 48 hours of the event occurring.

The majority (87%) of the incidents reported to the Chief Psychiatrist were through Datix CIMS (n=3,431) with the remainder (13%) reported through the *OCP Notifiable Incident Reporting Form* (n=520).

Deaths

Any deaths of active patients receiving mental health care who are in the care of a health service, and any deaths that occur within three months of discharge or deactivation of a patient from a health service, must be reported to the Chief Psychiatrist, even if the health service becomes aware of the death after the three month period.

There were 181 deaths of patients of mental health services reported to the Chief Psychiatrist for the 2017-18 financial year. The majority of these deaths were for active community patients (84%), with 10% relating to inpatients in an authorised or general hospital and 6% were for deaths of patients who had been discharged or deactivated from a mental health service within 3 months of their death. The median days between deactivation/discharge and death was 49 days (range = 6-90 days). Of the 181 deaths, 43% were female and 57% were male patients, with 69% of suspected suicides involving males (Table 13).

- 39% (n = 71) of reported deaths were attributed to natural or medical causes.
- 27% (n = 49) of reported deaths reported were suspected suicides.
- 34% (n = 52) of reported deaths were attributed to 'physical/unnatural or 'unknown' causes.

SAC1: includes all incidents/ near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying conditions or illness. In WA SAC1 includes the eight nationally endorsed sentinel event categories.

SAC2: includes all incidents/ near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.

SAC3: includes all incidents/ near misses where minimal or no harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.

WA Health Clinical Incident Management (CIM) Policy 2015.2.

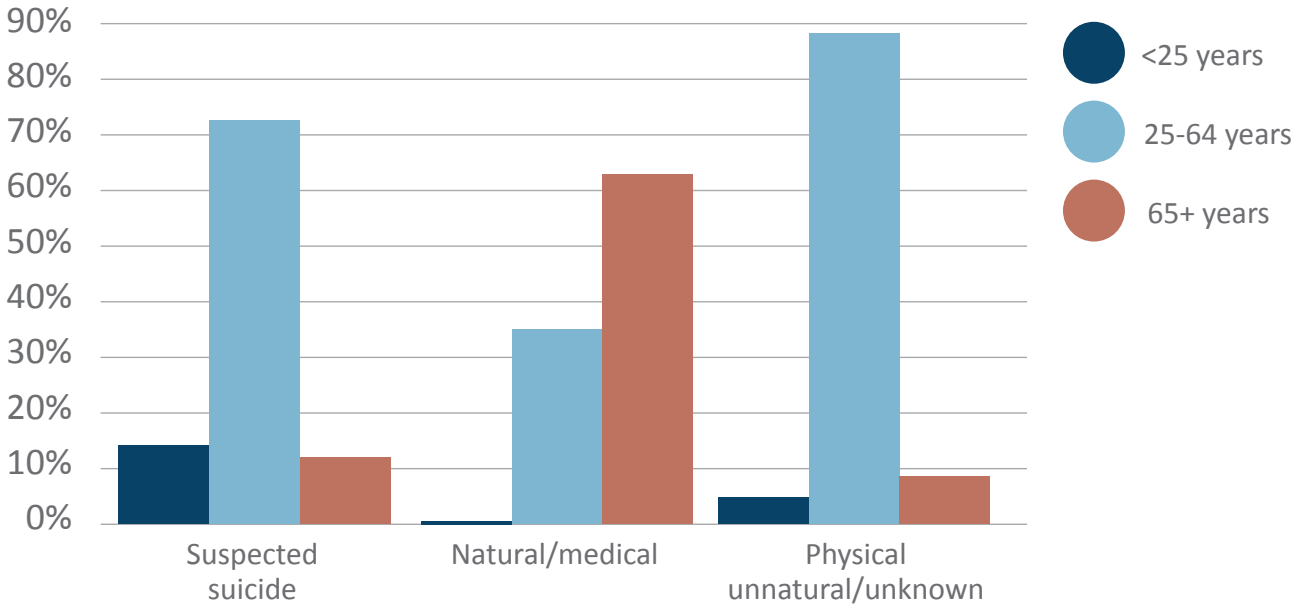
Table 13: Reported cause of deaths reported by gender for the 2017-18 Financial Year

	Suspected suicide n=49	Natural/ medical n=78	Physical/ unnatural*/ Unknown n=54	TOTAL n-181
Female	31%	45%	50%	43%
Male	69%	55%	50%	57%

* Physical/unnatural deaths included but were not limited to, deaths due to homicide, falls, motor vehicle accidents, and unintentional drug overdose.
Source: Office of the Chief Psychiatrist Database and these attributions of cause of death are likely, however the WA Coroner may alter a cause of death following Coronal review.

Three-quarters (73%) of suspected suicides notified to the Chief Psychiatrist related to adults aged 25-64 years of age, with 14% occurring in adolescents <25 years and 12% in people aged 65+ years (Figure 14). The majority of natural/medical deaths notified related to people 65+ years of age (65%), with the remaining 35% occurring in adults aged 25-64 years. The majority of physical/unnatural/unknown deaths were reported for adults 25-64 years of age (85%). There are fewer than five deaths reported for adolescents relating to natural/medical deaths and physical/ unnatural/unknown deaths.

Figure 14: Deaths of patients of mental health services by category of death and age group reported to the Chief Psychiatrist between 1 July 2017 and 30 June 2018



Source: Office of the Chief Psychiatrist Database

Other Notifiable Incidents

There were 3,950 other notifiable incidents reported for 1,623 patients; 49% males and 51% females. There were 2,350 involuntary/referred patients (60%) and 1,593 voluntary patients (40%), (mental health status was missing for 7 patients). Aggressive behaviour was the most commonly reported incident accounting for 63% of notifications for involuntary/referred patients and absconding was the second most common incident (16%) (Table 14). For voluntary patients just under half (47%) of incidents were for aggressive behaviour with self-harm the second most common incident for voluntary patients (24%), followed by missing person (11%). Four percent of patients (n=169) had a secondary incident reported, with 4.6% of involuntary/referred patients and 3.8% of voluntary patients having a secondary incident reported.

Other Notifiable incidents required to be reported to the Chief Psychiatrist

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

The most common secondary incidents reported were assault/aggressive behaviour (37%), non-suicidal self-injury (35%), attempted absconding (12%), sexual contact/alleged sexual assault (6%) and attempted suicide (4%).

Table 14: Other Primary Notifiable Incidents reported to the Chief Psychiatrist for the 2017-18 financial year

Mental Health Status				
	Involuntary and Referred n=2350*		**Voluntary** n=1593*	
Incident Type	**Number**	**%**	**Number**	**%**
Aggressive behaviour/ physical assault	1479	63	754	47
Sexual contact/alleged sexual assault	51	2	38	2
Non-suicidal self-injury/ harm	274	12	377	24
Attempted suicide	61	3	191	12
Absent without leave (AWOL)	365	16	0	0
Missing Person	0	0	178	11
Serious medication error	5	<1%	8	0.5
Other	9	<1%	9	0.6
TOTAL	2350		1593	

*Note: Where the number in a cell is <5, the numbers and percentages have not been provided in order to prevent potential identification of patients. *The numbers do not add up to the total due to the incidents with fewer than 5 notifications for unlawful sexual contact by a staff member and unreasonable use of force by a staff member so the data have not been presented; however, the total number of incidents reported includes these numbers. Source: Office of the Chief Psychiatrist Database.*

Just under half (41%) of patients were involved in one incident, with 34% involved in 2 to 5 incidents, 11% between 6 to 10 incidents and 14% over 10 incidents.

Of the 3,951 incidents, 4% were confirmed as SAC1, 31% as SAC2, and 54% as a SAC3, while the remaining 10% were reported through an OCP Form and therefore did not have an assigned SAC rating. For incidents with a SAC1 rating, a clinical investigation was completed in 85% of cases for the reporting period.

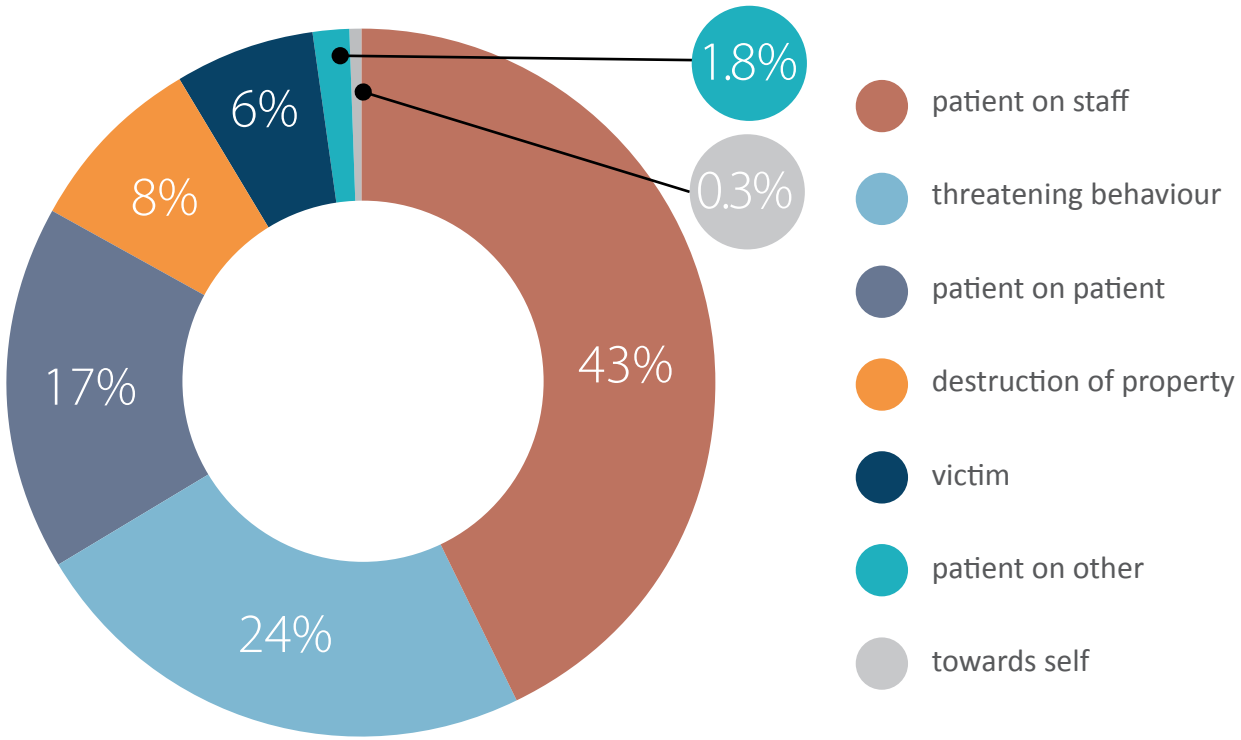
Aggressive Behaviour and/or Assault by a Patient

Aggression and/or Assault (patient to any other person(s)) includes physical or threatening behaviour towards other patients or residents, members of staff or visitors. It also includes self-injurious behaviour that is not an apparent self-harming incident, or where a patient or resident is a victim of aggression or where aggression resulted in destruction of property. Aggression and/or assault can occur within an inpatient setting (including EDs and on hospital grounds), in community mental health services (this includes incidents occurring during staff assessment of the client at their home or other places).

There were a total of 2,237 primary notifications of aggressive behaviour/assault and 62 secondary notifications reported to the Chief Psychiatrist. This equates to 57% of all notifiable incidents reported, of which 39% involved female patients and 61% male patients.

The majority of aggressive behaviour/assault incidents reported to the Chief Psychiatrist were classified as patient on staff 43% and threatening behaviour with no physical harm 24%, equating to 67% of all aggressive behaviour/assault incidents (Figure 15). Other notifications of aggressive behaviour/assault reported include patient to patient assault (17%), destruction of property (8%), as a victim of assault or aggression (6%), patient towards other (includes visitors) (1.8%) and aggressive behaviour towards themselves (0.3%).

Figure 15: Percentage of types of aggressive behaviour/assault incidents reported to the Chief Psychiatrist for the 2017-18 financial year



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

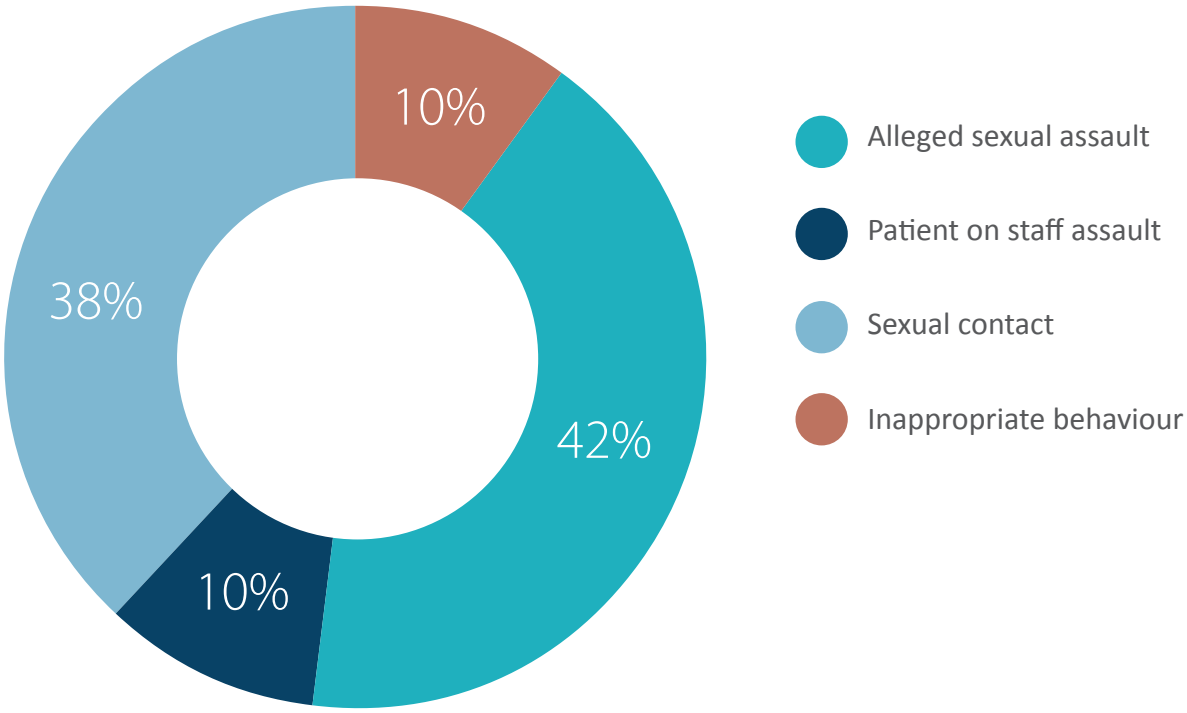
Incidents of Sexual Contact and/or Allegations of Sexual Assault (patient to any other person(s)) that occurred within an inpatient setting (including EDs and hospital grounds), community mental health service (this includes incidents occurring during staff assessment of the client at their home or other place) or at a private psychiatric hostel, must be reported to the Chief Psychiatrist. Any sexual activity/behaviour (including sexual touching) that occurs between people aged over 16 years, where mutual consent has been granted by those involved and they are considered to have capacity to provide consent, is not defined as sexual assault. Sexual contact is prohibited on inpatient wards as it has the potential to further traumatize patients who may have experienced sexual assault in the past. Inappropriate sexual behaviour includes behaviour that is sexual in nature but not directly involving other patients or staff (e.g., removing clothing, disinhibited sexual behaviour).

All allegations of sexual assault reported to the Chief Psychiatrist are investigated by the mental health service who provided notification of the allegation and in some instances, the Chief Psychiatrist will also investigate an incident as deemed appropriate.

'any unwanted sexual behaviour/activity or act that is threatening, violent, forced, coercive or exploitative and to which the person has not given or was not able to give consent'[8]

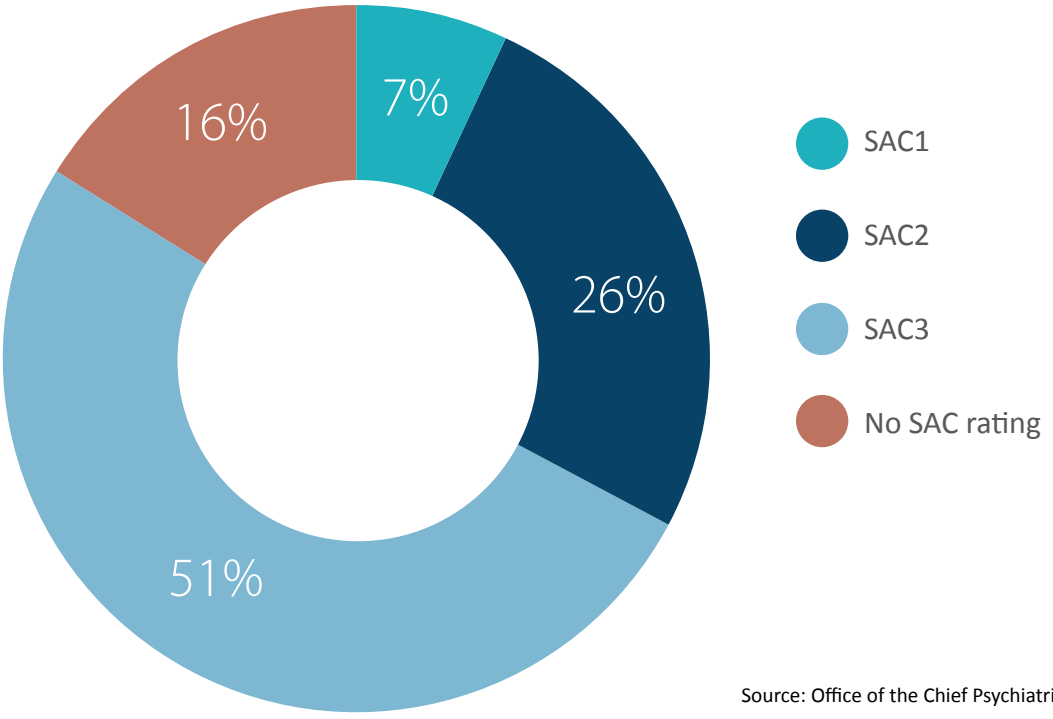
8 Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist. Reference is: Department of Health, Western Australia. Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist. (2015). Perth: Office of the Chief Psychiatrist.

Figure 16: Types of sexual contact reported



Over three-quarters (80%) of notifications of sexual contact related either to allegations of assault (42%) or sexual contact (38%) (Figure 16). Allegations of patient sexual contact against a staff member and incidents of inappropriate behaviour each represented 10% of notifications. Over half the incidents of sexual assault reported involved a male as the perpetrator or victim (56%) and 44% involved a female as the perpetrator or victim. The majority of notifications related to involuntary/ referred patients (61%) and 39% of incidents involved voluntary patients.

Figure 17: SAC ratings for sexual contact/alleged sexual assaults involving patients of mental health services reported to the Chief Psychiatrist for the 2017-18 financial year



Source: Office of the Chief Psychiatrist Database

Over half of the incidents of sexual contact/alleged sexual assault notified to the Chief Psychiatrist were assigned a SAC3 rating (51%), one quarter (26%) a SAC2 rating and 7% were assigned a SAC1 rating. A small proportion (16%) did not have a SAC rating assigned by the end of the reporting period.

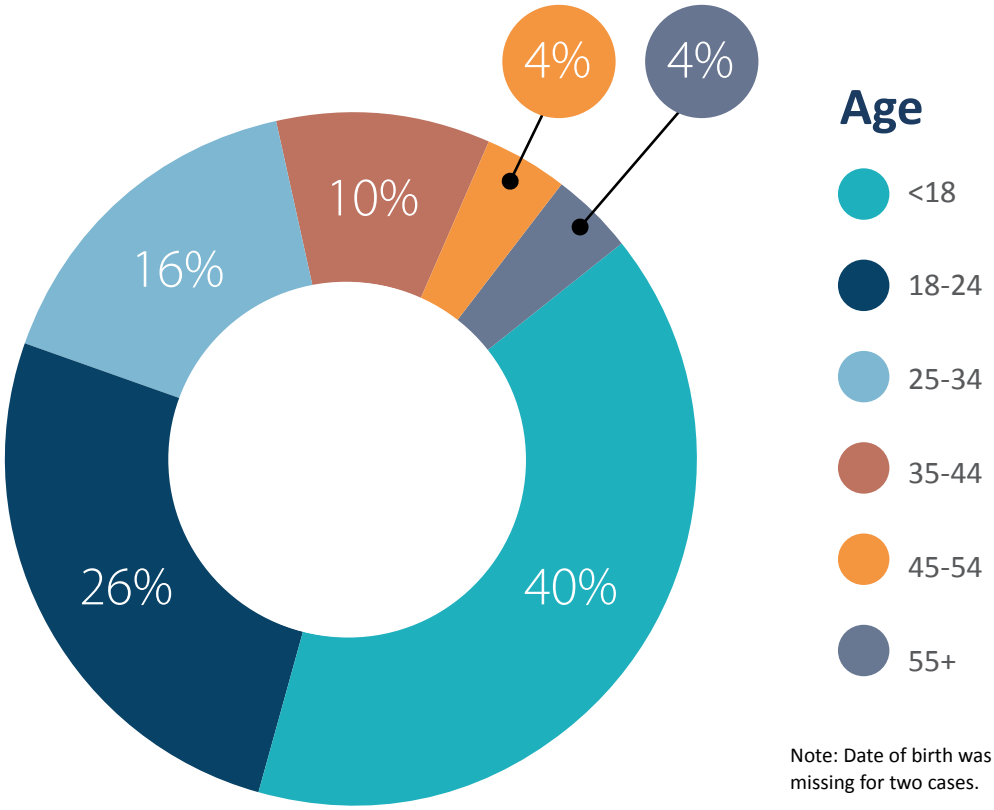
Allegations of unlawful sexual contact between a staff member of a mental health service or a private psychiatric hostel and a patient/resident, or unlawful sexual contact that is alleged to have occurred between the patient within a hospital setting and another person that is not a patient or staff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

Non-Suicidal Self-Injury/Harm

Any deliberate self-inflicted bodily injury where there is no evident intention to die, specifically requiring non-mental health medical or surgical intervention (e.g. sutures, antibiotics, non-mental health hospital admission, admission to an Intensive Care Unit, or ED presentation) must be reported to the Chief Psychiatrist. This includes but is not limited to self-poisoning, overdose, and cutting.[9] These incidents can occur whilst the patient is receiving inpatient or community care or within an ED.

There were 713 notifications of non-suicidal self-injury/harm for 300 individuals. Of these 300 individuals, 42% had one notification, 30% 2-5 notifications, and 27% of individuals had more than 5 notifications of self-injury/harm. The highest proportion (40%) of incidents were reported for youth aged less than 18 years of age and 26% for adolescents aged 18-24 years (Figure 18).

Figure 18: Age distribution of non-suicidal self-injury/harm notifications to the Chief Psychiatrist for the 2017-18 financial year.

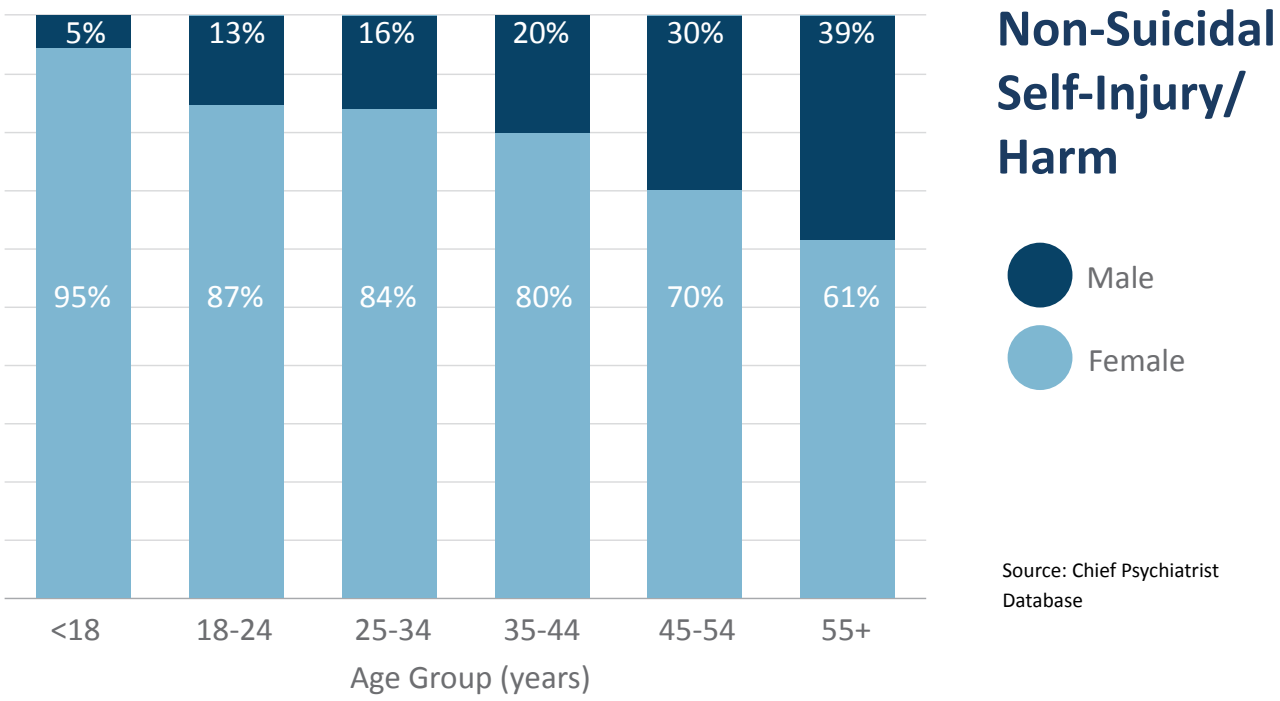


Note: Date of birth was missing for two cases.

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

The majority of notifications for non-suicidal self-injury/harm involved women (87%) with the proportion of incidents involving women decreasing with increasing age (Figure 19). For youth <18 years of age, almost all incidents involved young women (95%), decreasing to 61% of self-injury/harm incidents involving people aged 55 years and older. Conversely, the proportion of self-injury/harm incidents involving men <18 years of age was 5%, increasing to 39% of self-injury/harm incidents reported for people aged 55 years and older.

Figure 19: Age and gender distribution of non-suicidal self-injury incidents reported to the Chief Psychiatrist for the 2017-18 financial year.



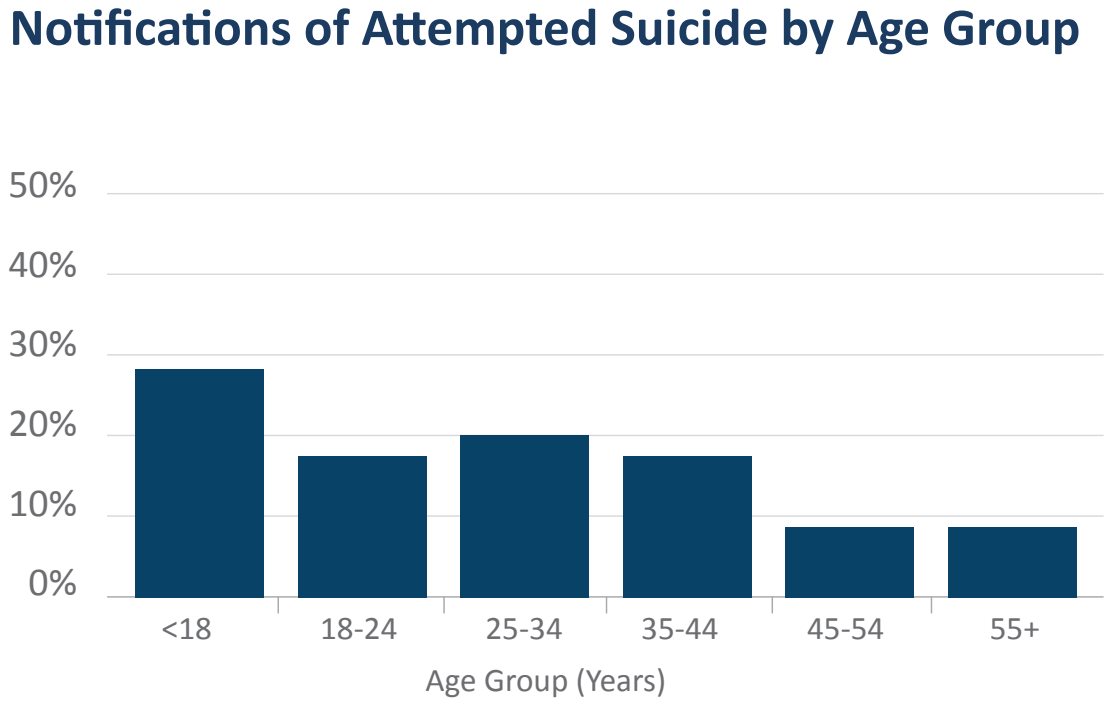
Attempted suicide

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.'[10] This includes, but is not limited to, self-poisoning, overdose, jumping from a height and hanging. These incidents can occur whilst the patient is receiving inpatient or community care or within an ED. The classification of 'attempted suicide' is a clinical judgment made at the time of the incident.

There were 259 notifications of attempted suicide to the Chief Psychiatrist during the 2017-18 financial year, involving 179 individuals. Some individuals had multiple suicide attempts reported over the 2017-18 financial year; 69% individuals had one attempted suicide, 17% had two attempts, and 14% of individuals had three or more suicide attempts notified. Over one-quarter (28%) of attempted suicides involved youth <18 years of age with the proportion decreasing to 20% for the 25-34 age group, 18% for each of the 18-24 and 35-44 age groups, and 8% for each of the 45-54 and 55+ year age groups (Figure 20).

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

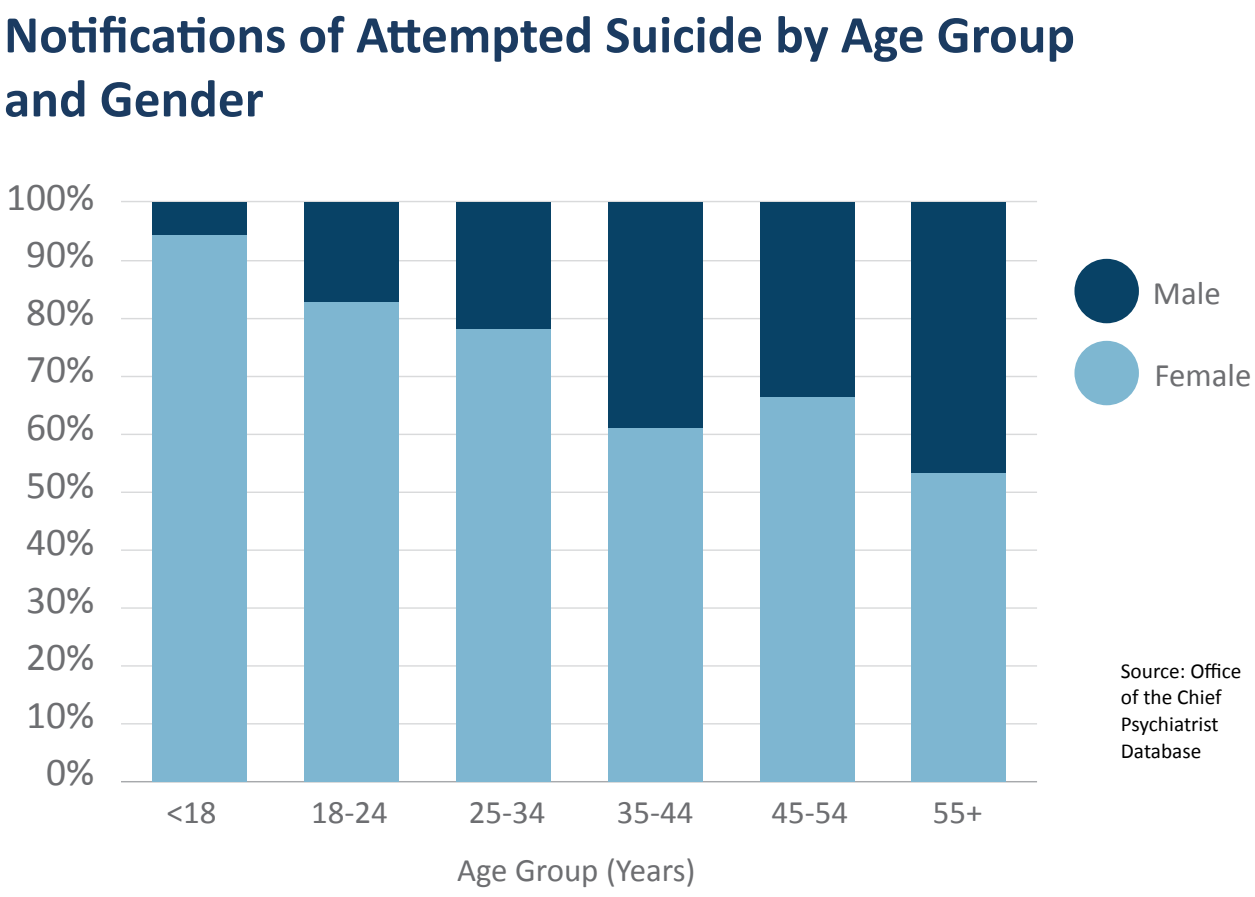
Figure 20: Notifications of attempted suicide by age group



Source: Office of the Chief Psychiatrist Database

Of the 259 notifications of attempted suicide, 77% involved females and 23% involved males. Over three-quarters of attempted suicides in the younger age groups involved females, with females making up 95% of notifications for youths <18 years, 83% for 18-24 year olds and 78% for 25-34 year olds (Figure 21). Conversely the proportion of notifications of males attempting suicide increased with increasing age with 39% of notifications for 35-44 year olds involving males, 33% for 45-54 year olds, and 48% of notifications for people 55 years of age and older.

Figure 21: Age and gender distribution of attempted suicide incidents reported to the Chief Psychiatrist for the 2017-18 financial year.



Absent Without Leave (AWOL) Involuntary and Referred Patients

Under the Act (s.97), AWOL relates to involuntary inpatients, involuntary community patients subject to an order to attend, patients on an order for assessment, and referred patients that meet the following criteria:

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

The Chief Psychiatrist must be notified of the date the person returns or is located, the outcome and whether there were any adverse events whilst the patient was AWOL. In contrast to the process for determining the SAC rating for other notifiable incidents, the Severity Assessment Code for a mental health patient who is AWOL or Missing is determined by the patient's risk status immediately prior to their absence (e.g. High Risk=SAC 1; Medium Risk=SAC 2; Low Risk=SAC 3).

For the reporting period, 410 incidents were reported as AWOL, pertaining to 311 patients of which 76% had one AWOL event, 16% had two AWOL events, and 8% had between three and five AWOL events reported. The majority of AWOL patients (86%) were involuntary at the time they went AWOL and 14% were patients who had been referred for assessment. Over half of AWOL patients were male (60%). In addition, there were 76 notifications of attempted absconding. Fewer than five AWOL patients had not been located at the end of the 2017-18 financial year.

A smaller proportion of AWOL events were confirmed as 'High Risk' (14%) and therefore the patient had been assessed at the time of the incident as high risk of causing significant harm to themselves or others, or being harmed by others. Almost half of all reported AWOLs (48%) were deemed 'moderate risk' and therefore the incidents were reported as a 'Moderate Risk', and almost one third of AWOLs (32%) were deemed 'low risk'. Around half (51%) of patients who were reported AWOL were located on the same day and 36% were located within three days. The average (mean) length of time a patient was AWOL was 2.6 days.

An adverse outcome was reported for 30 (7%) of the AWOL incidents; these outcomes included self-harm, falls and intoxication leading to hospitalisation. There were no notifications during the 2017-18 financial year that a patient had died while AWOL from a mental health service.

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

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

There were 184 voluntary patients reported as missing from a mental health service, of which 48% were female and 52% male. Two-thirds (68%) of patients had one notification of missing person, 15% had two events reported and 17% had three or more events reported. Fewer than five were given a SAC1 rating, with the majority of these notifications (56%) given a SAC3 rating.

Serious Medication Error

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

During the reporting period there were 13 incidents pertaining to serious medication errors, with approximately 62% of events involving patients in a hospital setting and 38% in the community. Of these events, the majority were coded a SAC2 (46%). None of these incidents resulted in the death of the patient.

Allegations of Unreasonable Use of Force by Staff

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

For the reporting period, there were six allegations of unreasonable use of force on a patient by a staff member of a mental health service reported to the Chief Psychiatrist of which all were coded either as a 'Moderate or Low Risk'.

All incidents reported to the Chief Psychiatrist are investigated by the notifying mental health service. To ensure the continued safety of patients and residents, the Chief Psychiatrist has powers to investigate further as required. The Chief Psychiatrist followed up directly with each health service provider involved, to obtain and review the investigation reports.

Chief Psychiatrist Review of Notifiable Incidents

Follow-Up Conducted with Health Service Providers

The Chief Psychiatrist works with health service providers to ensure the safe, high quality care of patients who are engaged in behaviours and activities defined as notifiable incidents. The Chief Psychiatrist follows-up with health service providers on issues relating to the reported notifiable incidents as necessary. During the reporting period, 149 'High Risk' notifiable incidents were followed-up (4% of the total number of incidents) in relation to issues such as:

- Whether absconding patients had been located and the patient's wellbeing;
- Missing information including patient details or other mandatory information;
- Treatment information including current risk assessments and management plans, or details about implemented strategies in place to manage a patient's behaviours or how treatment and management adhere to clinical standards.

Chief Psychiatrist Initiatives for Notifiable Incidents in 2017-18

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

The Notifiable Incident Policy informs mental health and other health staff of the statutory requirement to report notifiable incidents relating to mental health patients, to the Chief Psychiatrist. The Notifiable Incident Policy sets out the individuals and services that are in scope for reporting to the Chief Psychiatrist, the incidents required to be reported, and the processes for reporting incidents to the Chief Psychiatrist.

Reporting to the Chief Psychiatrist is required in addition to all other reporting requirements that services are required to undertake, including both internal management structures within the service and reporting to external government agencies. Separate Notifiable Incident Policies have been developed for public hospitals and community health services, private hospitals and private psychiatric hostels due to the different reporting methods each of these services is required to undertake.

The *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist 2015* (Notifiable Incident Policy 2015) was due for review as soon as practicable, two years after commencement of the Act. The Notifiable Incident Policy 2015 for both public and private mental health services was internally reviewed and discussed by senior OCP staff before being released for stakeholder and clinical consultation in March 2018.

The primary method for consultation with external stakeholders and clinicians was through an online survey with targeted consultation including face-to-face meetings with senior staff in the Patient Safety Surveillance Unit (PSSU) in the Department of Health. The PSSU oversees the Datix CIMS data collection system with the Assistant Director as the data custodian.

The Notifiable Incident Policy is currently being finalised and the updated Notifiable Incident Policy will be released in August-September 2018. Overall, the feedback was positive with comments from clinicians indicating that the current 2015 Notifiable Incident Policy provided clear and useful information. Key changes to the policy include redefining non-suicidal self-injury to give clearer direction to clinicians on the severity of the self-injury required to be reported, more details about how the Chief Psychiatrist accesses the relevant notifiable incidents through Datix CIMS and updating the format to make the policy more user-friendly.

The updated Notifiable Incident Policy will be distributed to Health Service Providers, PSSU, the Mental Health Unit in the Department of Health, and to all stakeholders and clinicians who have provided feedback during the consultation process.

Private Psychiatric Hostels

Private psychiatric hostels are defined as a mental health service under the Act s.507 and are therefore the remit of the Chief Psychiatrist. A scoping of current public mental health patients who were resident at a private psychiatric hostel between 16 April and 7 May 2018 was undertaken, which identified information relating demographic, service provision and performance data.

Over this three-week period, there were 758 residents in private psychiatric hostels, of which 438 (58%) were under the care of a public sector Community Mental Health Service. Of these 438 residents, 61% were male and 39% female and their average age was higher (47 years) than for the age (44.6 years) of all individuals residing at a Private Psychiatric Hostel.

This cohort within the private psychiatric hostels is a significantly disabled cohort:

- 78% have serious mental illness such as schizophrenia or another long term psychotic illness including bipolar and schizoaffective disorders;
- 80% had a General Practitioner listed.

Given the severe and enduring nature of the mental illness in PPHs it is likely that a higher number of the resident cohort would benefit from specialist mental health service involvement.

There is variability in community mental health service performance across private psychiatric hostels:

- Two-thirds (67%) had a current care plan and 60% a current risk assessment completed.

In addition to the Chief Psychiatrist two other agencies, the Mental Health Commission and the Department of Health Licensing and Regulatory Unit also monitor incidents occurring at private psychiatric hostels. The three agencies work closely to ensure that licensees of the hostels comply with regulations and the care provided to residents meet accepted standards and that the factors contributing to incidents are addressed.

A report on Private Psychiatric Hostel residents was completed 2017-18 as planned

Other Statutory Reporting

Admission of Children to Adult Mental Health Inpatient Units

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

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

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

There were 19 notifications to the Chief Psychiatrist of a child being admitted to a mental health service, of which 42% were males, and 58% females. The average age (mean) of children admitted to an adult inpatient unit was 16.2 years of age. Almost one-third (32%) of the children were segregated from the adults in the ward and 74% were observed by a nurse on a one-to-one basis. The majority of notifications (63%) were from metropolitan hospitals and 37% were from regional hospitals.

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

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

All use of off-label treatments provided to a child who is an involuntary patient must be reported to the Chief Psychiatrist, including the type of off-label treatments provided and the reason for the decision. Last financial year, under-reporting of off-label treatment was identified and the Chief Psychiatrist wrote to mental health services reminding them of their statutory requirement to report such treatment to the Chief Psychiatrist. Communication about the statutory obligation to report these events to the Chief Psychiatrist has continued with health service providers over the past financial year. For the reporting period, there were 25 notifications about children who were involuntary patients and received off-label treatments, over three times the 7 notifications received in the 2016-17 financial year. The majority of notifications (68%) were from mental health services in the metropolitan area. The average (mean) age of involuntary children provided with an off-label treatment was 16.6 years of age.

Emergency Psychiatric Treatment

Under s.204 of the Act the medical practitioner who provided Emergency Psychiatric Treatment (EPT) must give the Chief Psychiatrist a copy of the record of the treatment provided on the approved form. EPT does not include the use of ECT and psychosurgery. A medical practitioner may provide a person with EPT without informed consent.

There were 233 cases of EPT reported to the Chief Psychiatrist, of which 53% were female and 47% male. The majority of patients receiving EPT were adults aged between 25 and 64 years (45%), with 6% aged 65 years and older. Just over one-quarter (28%) of patients were aged 18-24 years and 21% were <18 years of age. The types of treatment provided to the patient included the patient receiving medication alone (66%) or the patient receiving medication in conjunction with the patient being secluded and/or restrained (34%). The majority of notifications were from metropolitan hospitals (88%), with 12% from WA Country Health Services.

Emergency Psychiatric Treatment Reporting Requirements

Under s.204 of the Act the medical practitioner who provided EPT must give the Chief Psychiatrist of a copy of the record of the treatment provided on the approved form containing the following information:

- The name of the person provided with the treatment;
- The name and qualification of the practitioner who provided the treatment;
- The names of any other people involved in providing the treatment;
- The date, time and place the treatment was provided;
- Particulars of the circumstances in which the treatment was provided;
- Particulars of the treatment provided.

Urgent Non-Psychiatric Treatment Reporting Requirements

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

There were 7 episodes of urgent non-psychiatric treatment reported and all were treated in the metro hospitals.

Urgent Non-Psychiatric Treatment Reporting Requirements

Under section 242 of the Act the person in charge of the Authorised Hospital must report the provision of Urgent Non-Psychiatric treatment to the Chief Psychiatrist through submission of the approved form containing the following information:

- The name of the person provided with the treatment;
- The name and qualification of the practitioner who provided the treatment;
- The names of any other people involved in providing the treatment;
- The date, time and place the treatment was provided;
- Particulars of the circumstances in which the treatment was provided;
- Particulars of the treatment provided.

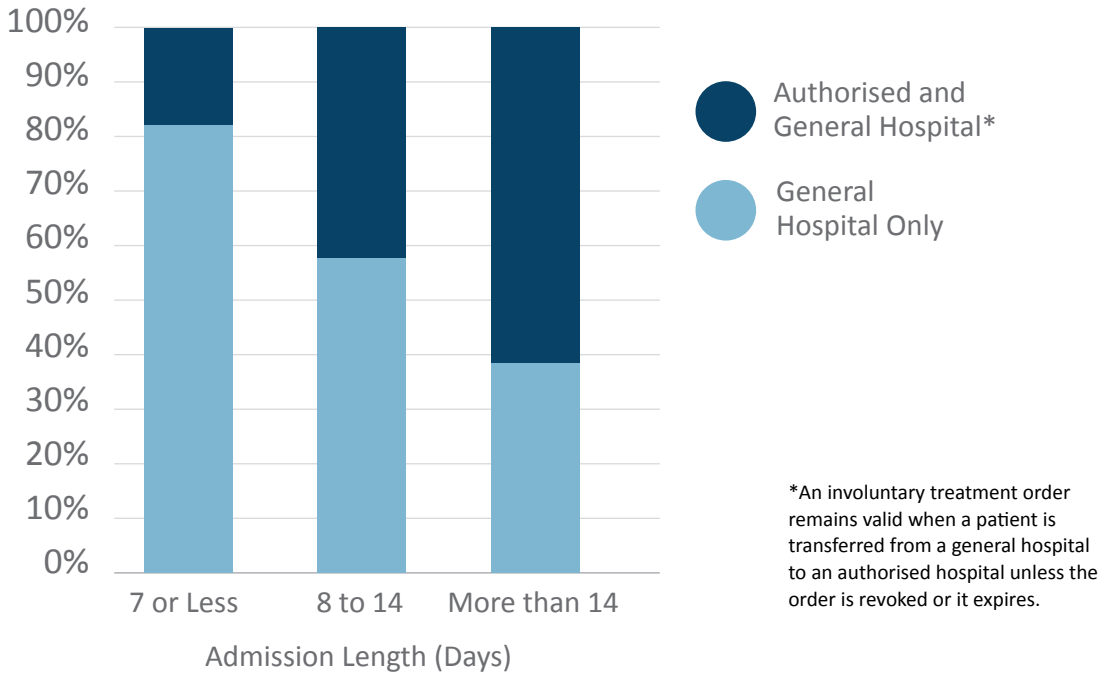
Approving Involuntary Treatment Orders within a General Hospital

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

For the reporting period, 114 patients were subject to an involuntary order in a General Hospital setting, 21 of whom were under the age of 18 years. The Chief Psychiatrist authorised 133 involuntary treatment orders of which 20% were for patients under the age of 18 years of age. Of the 114 patients, 55% (n = 63) were in general hospital for 7 days or less, 19% (n = 22) were in general hospital for between 8 to 14 days and 36% (n = 41) were in general hospital for more than 14 days.

Of the 133 orders, 25% (n = 33) were valid for 7 days or less, 20% (n = 26) were valid between 8 to 14 days and 55% (n = 74) were valid for more than 14 days (Figure 25). Out of the 33 orders that were valid for 7 days or less, 8% comprised of a general hospital admission and 18% comprised of both authorised and general hospital admissions. Of the 26 orders that were valid between 8 to 14 days, 58% comprised of a general hospital admission and 42% comprised of both authorised and general hospital admissions. Of the 74 orders that were valid over 14 days, 39% comprised of a general hospital admission and 61% comprised of both authorised and general hospital admissions (Figure 25).

Figure 25: Treatment Orders by Hospital Type and Admission Length



For orders that were valid for more than 7 days, the Chief Psychiatrist received 85% of the required approved 6B attachment forms. More specifically the Chief Psychiatrist received 70% of the required 6B attachments for patients that were in a general hospital for 8 – 14 days and 87% of the required attachments for patients that were in a general hospital for more than 14 days.

What will we do? Goals for 2018-19

- Finalise the analysis and report of the clinical reviews of North Metropolitan Health Service, East Metropolitan Health Service, and the City East Mental Health Service targeted clinical governance review.
- Commence planning and preparation for undertaking clinical monitoring reviews of private mental health services in the 2019-20 financial year.
- Commence planning and preparation for undertaking clinical monitoring reviews of the treatment and care provided in private psychiatric hostels in 2019.
- Refine the monitoring tool for the private psychiatric hostel reviews.
- Undertake benchmarking exercise using data gathered from clinical reviews.
- Establish a timetable for ongoing routine Clinical Monitoring Reviews.
- Commence planning for a targeted or thematic review.
- Further increase consumer and carer involvement in clinical review processes.
- Improve monitoring of the Aboriginal Practice Standard.
- Continue to provide education sessions to up skill clinicians with reporting under the Act, in conjunction with the Chief Psychiatrist's education team.
- Establish a process for validating notifications to the Chief Psychiatrist of the prescription of off-label treatments to children and young people less than 18 years of age, in consultation with key stakeholders.
- Publish on the Chief Psychiatrist website the quarterly seclusion and restraint data for each authorised mental health service.
- Linkage of data on notifiable incidents of patient aggressive behaviour with seclusion and restraint data to assess associations between patient factors, health service factors and the use of restrictive practices.
- As part of the Notifiable Incidents Policy Review, Health Service Providers to tell us about what reports and data analyses would be beneficial to support them in providing best practice and high standards of treatment and care. In consultation with Health Service Providers a report will be designed to provide health services with timely aggregate-level notifiable incident data at both the Health Service and State-wide levels.

Our Research and Strategy Program

In September 2017, the Chief Psychiatrist established his Research and Strategy Program with the appointment of a Senior Psychiatrist and a Clinical Psychologist.

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

The Program has the following three core components:

Research and Sector Development

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

Reviews and Investigations

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

Stakeholder Engagement

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

Research and Sector Development

Strengthening Quality Improvement (QI) and Innovation

The Office of the Chief Psychiatrist is leading a significant reform initiative, in collaboration with key partners, to build a system-wide QI program for mental health in WA. While there are a number of individual QI projects being implemented within mental health services in WA; there is no systemic approach to building a culture of improvement with the required investment in building organisational capacity and infrastructure required to reach sustainability.

There is growing momentum internationally (Scotland, England, New Zealand) to adopt improvement science methods to underpin QI as a sustainable way of addressing complex quality issues in mental health care. Within Australia, following on from the findings of the *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities,* a QI approach is being actively pursued in NSW with a recommendation to develop a statewide mental health safety program underpinned by contemporary improvement science.

The initial stages of the project are to build a coalition of support for the concept and, in partnership with major stakeholders, further develop the initiative.

Enhancing Trauma Informed Care (TIC)

Providing treatment and care which is trauma-informed is a key principle embedded in the *Chief Psychiatrist's Standards for Clinical Care.*

A number of presentations and discussions have been conducted with senior mental health clinicians and senior managers from all Health Service Providers to raise awareness and knowledge of trauma informed care and to stimulate discussion in services as to how to continue to support practice improvements. The response has been positive and it was noted that a number of initiatives, such as Safe Wards in the South Metropolitan Health Service, are continuing to develop as a way of enhancing trauma informed care and reducing seclusion and restraint.

Long-Term Treatment Outcomes in Early Psychosis Specialist Services

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

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

To date the project has:

- Identified the study cohort from the two EIP services.
- Undertaken a preliminary analysis of data from the two EIP service cohorts.
- Selected a matched comparison control group.
- Linked the EIP cases and standard treatment controls to the Hospital Morbidity Data Collection, the Mortality Data Collection, the Emergency Department Data Collection and the Mental Health Information System.

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

Disseminating Research Findings

At the annual conference of the Royal Australian and New Zealand College of Psychiatrists held in Auckland in May 2017, Dr Smith presented research findings on the topic: *Does training change practice? A survey of clinicians and managers one year on from training in Trauma Informed Care.*

Our Projects and Intergovernmental Relations Program

The Projects and Intergovernmental Relations Program serves as the liaison between the Chief Psychiatrist and other government agencies at state and federal level. This program is the Chief Psychiatrist's conduit with the Safety and Quality Partnerships Standing Committee (SQPSC- the national COAG mental health safety and quality committee).

The Program has been involved in some key initiatives relating to the functions of the Chief Psychiatrist that centered on:

- Relationships with peak consumer and carer bodies that allowed their voice to be heard by the Chief Psychiatrist. The main concerns of consumers and carers related to medication safety, clinician communication skills and true partnerships in their care.
- The ongoing introduction to mental health services of the "My Medicines and Me" tool ("M3Q"- a self-report tool to help improve the dialogue between clinicians and consumer about medication side effects). Consumers of Mental Health WA (CoMHWA), with the support of the Chief Psychiatrist, received a significant LotteryWest grant to engage consumers and the community around the M3Q to enhance consumer ability to have a more meaningful and informed discussion about medication side effects with their doctors.
- Eliminating the use of restrictive practices is a central aim of the Chief Psychiatrist.

Initiatives for 2018-19

Working toward the elimination of Restrictive Practices

The Projects and Intergovernmental Relations program will lead a scoping exercise in partnership with mental health services to actively benchmark against each other and share successful strategies in the drive for the elimination of seclusion and restraint.

Fifth National Mental Health Plan – Priorities and Action Areas

Going forward the priorities and action areas of Fifth National Mental Health Plan will be a key focus for the Intergovernmental Relations.

Working Groups and Committees

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

- Australian Commission on Safety and Quality in Health Care Mental Health Reference Group
- Clinical Senate
- Clozapine Steering Committee
- Co-Leadership Mental Health Safety and Quality Steering Group
- Coronial Review Committee
- Chief Psychiatrist Standards and Guidelines Working Group
- Chief Psychiatrist Electroconvulsive Therapy Working Party
- Health Expert Advisory Group (national)
- Justice Health Project Oversight Committee
- Mental Health Network
- Peak Incident Review Committee
- Prioritising *National Standards for Mental Health Services* Working Group
- Private Mental Health Regulations Reference Committee
- Psychiatric Hostels Advisory Committee
- Reducing Adverse Medication Events in Mental Health Working Party (SQPSC subgroup)
- Restrictive Practice Subgroup (subgroup to SQPSC)
- Royal Australian & New Zealand College of Psychiatrists Committee for Examinations
- Royal Australian & New Zealand College of Psychiatrists Professional Practice Committee (PPC)
- Royal Australian & New Zealand College of Psychiatrists Evidence Based Practice Committee (EBPC)
- Royal Australian & New Zealand College of Psychiatrists Practice Policy and Partnership Committee
- Safety and Quality Partnership Sub-Committee (SQPSC)
- State Datix Committee
- Stimulants Assessment Panel (WA Health)
- Sustainable Health Review- Quality and Value Working Group
- WA Psychotropic Drug Committee
- WA Primary Health Alliance Steering Committee - Statewide Integrated Master Plan for Primary Mental Health, AoD and Suicide Prevention
- WA Therapeutics Advisory Group

Glossary of terms used

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

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