CHIEF PSYCHIATRIST
of Western Australia

'Ensuring Safe and High Quality Mental Health Care'

Annual Report of the Chief Psychiatrist of Western Australia

01 July 2020 – 30 June 2021

Statement of Compliance

HON STEPHEN DAWSON MLC

MINISTER FOR MENTAL HEALTH; INDUSTRIAL RELATIONS AND ABORIGINAL AFFAIRS

In accordance with sections 533 and 534 of the *Mental Health Act 2014*, I hereby submit for your information and presentation to Parliament the Annual Report of the Chief Psychiatrist of Western Australia for the financial year ended 30 June 2021.

Dr Nathan Gibson
CHIEF PSYCHIATRIST
ACCOUNTABLE AUTHORITY

Monday 13 September 2021

Declaration of Financial Accountability

In accordance with section 61(3) of the *Financial Management Act 2006*, I declare that the Annual Report of the Mental Health Commission of Western Australia includes a report for the financial year ended 30 June 2021 of information prescribed by the Treasurer's instruction 951 Related and Affiliated Bodies, in respect of the Office of the Chief Psychiatrist, which is an affiliated body of the Mental Health Commission.

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

Les Bechelli
CHIEF FINANCE OFFICER
ACCOUNTABLE AUTHORITY

Monday 13 September 2021

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 and acknowledges the traditional owners of the lands upon which the Office sits - nidja Wadjuk Noongar boodja nookook nyininy.

The Chief Psychiatrist acknowledges the wisdom of Aboriginal Elders past, present and emerging and pays 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. The voice and insight of people with lived experience is essential and will be central to the development of safe high-quality mental health services.

The Chief Psychiatrist recognises the very large numbers of staff working in the mental health sector who have specific lived experience within their own personal lives.

Feedback Details

If you would like to provide feedback on this report, please go to:

https://redcap.link/OCP-AnnualReport

Disclosures and Legal Compliance

Record keeping

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

Board and committee remuneration

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

Consumer and carer representatives providing their expertise and perspective on a range of committees and working parties have been financially remunerated in accordance with the current policy for consumer and carer participation.

Legal and Government policy requirements and financial disclosures

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

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

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

Conflicts of Interest

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

Compliance with Public Sector Standards and Ethical Codes

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

Staff of the Office of the Chief Psychiatrist, who are employees of the Mental Health Commission, complied with the Mental Health Commission's Code of Conduct, and demonstrated public service professionalism and probity.

Occupational safety, health, and injury management

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

‘Ensuring Safe and High Quality Mental Health Care’

Contents

Foreword

Hearing from people with lived experience of mental illness, their families and carers, their support staff and their clinicians over the past year has again enhanced the efforts of my Office to help improve mental health care outcomes. This still occurs through the Chief Psychiatrist's primary role - the oversight of standards of treatment and care to ensure safe, high quality mental health treatment and care. This is about person-centred, relationship-based care that considers the needs of individuals, families and the wider community.

I am very grateful for the wisdom I have received. This wisdom is given openly, and sometimes in the face of great pain, suffering, and weariness, by those with lived experience and by their supporters and clinicians. This wisdom is given by real people, who are already giving their time and energy generously every day. This wisdom guides the work of my Office.

We are all inter-related. We, who are patients[1] , families, carers[2] , service providers, and those that run or govern services, are all linked. The COVID-19 pandemic has worsened the impact of existing mental illness and has brought increased distress to the majority. We must all suffer in the face of worsening mental health outcomes, and we all can take credit as we battle, and work harder, and achieve in tough times.

We are seeing strong steps. In the Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services, the pain in the community was palpable, and the data was just one indication of the huge pressure clinicians were, and are, facing. I am pleased to see the progress of the Infant, Child and Adolescent Taskforce, and I acknowledge the urgent investment the State Government is currently making to give families and children better and timely access to services. There are many areas and groups on which we need to focus. It will take time to build.

We are addressing gaps. We have commenced reviews of the private psychiatric hostels in Western Australia and our findings identify gaps in the sector. These reviews have provided a clear push for improvements that are monitored by my Office. Psychiatric hostels provide for an incredibly vulnerable and disabled group, who need active specialist and rehabilitative care.

Of course, we have a long road ahead.

I thank my staff. Their dedication is extremely strong. I hope this Annual Report provides a useful understanding of the standards of treatment and care in Western Australia, as seen through the Chief Psychiatrist's role.

Dr Nathan Gibson MBBS FRANZCP
CHIEF PSYCHIATRIST

13 September 2021

1 The Mental Health Act 2014 uses the term 'patient' we use both this term and the term 'consumer' in this report.
2 The term 'carer' is used interchangeably with the term 'personal support person,' 'family member' and 'significant other'

Executive summary

The *Mental Health Act 2014* (MHA 2014) requires the Chief Psychiatrist to prepare and give the Minister a report about the performance of the functions of the Chief Psychiatrist at the end of each financial year.

The 2020-21 financial year has been a busy and effective one for the Chief Psychiatrist and his staff, and this report explicitly details the activities of the Office and its value to the WA community. Past Annual Reports have concentrated on the usual activities of the Chief Psychiatrist from a program perspective, as well as on the statutory reporting requirements. Our quality data is always reflected in the Annual Report. However, this report takes a further step in looking at the systemic view by reflecting on the needs of the mental health sector in Western Australia (WA) and the role the Chief Psychiatrist has played in ensuring safe high-quality mental health treatment and care.

The statutory framework under the MHA 2014 outlines the parameters within which the Chief Psychiatrist exercises governance over the mental health sector in WA. The increased investment in mental health treatment and care across the state of WA, means the Chief Psychiatrist's oversight responsibilities continue to expand.

The Mental Health Snapshot in this report provides a bird's eye view of the mental health sector in graphic form followed by a more detailed look at the interface with this Office and its impact on it.

In establishing close links with the broad spectrum of key stakeholders across the sector, the Chief Psychiatrist is well-positioned to understand and advocate for their needs. In the section of this report relating to Sector Needs, the Chief Psychiatrist has focussed on:

- Sexual safety within mental health services
- Child and Adolescent Mental Health Services
- Specialist clinical community mental health services
- Mental health rehabilitation
- Intellectual and neurodevelopmental disability
- Private psychiatric hostels
- Forensic mental health services

Whilst the above constitute the key areas of focus for this reporting period, the Chief Psychiatrist has continued to exercise his influence and will build on the needs of the areas identified below in the forthcoming year:

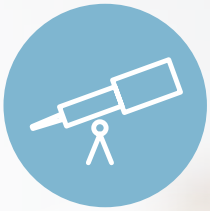
- Mental health of Aboriginal people
- COVID readiness
- Older adult mental health services
- Mental health workforce

The Chief Psychiatrist continues to play a significant role in the national and local interface in areas such as the translation of the 5th National Mental Health and Suicide Prevention Plan and best practice quality improvement, as well as participating in the planning for future mental health services in Western Australia.

The Office of the Chief Psychiatrist

Who we are

The staff of the Office of the Chief Psychiatrist has a range of skills and expertise that complements the statutory role and function of the Chief Psychiatrist in ensuring safe high-quality mental health treatment and care. We seek to influence processes to improve the mental health outcomes for the clinical and non-clinical needs of consumers of mental health services and take a value-based approach to mental health care.



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

Structure of the Office

The Chief Psychiatrist is supported in his role by a staff of 16 FTE.

Our Strategic Objectives

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

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

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

Clinical Statutory Education and Authorisations

The Clinical, Statutory Education and Authorisations team works closely with the Standards Monitoring and Review team to support the Chief Psychiatrist in discharging his statutory functions. The team takes a three-tiered approach to improving the safety and quality of mental health care for those experiencing mental illness in WA. This three-tiered approach involves:

- Consumer and personal support person engagement
- Clinical support and engagement
- Statutory authorisation and approvals

Standards Monitoring and Review

The Standards Monitoring and Review team works to ensure safe high-quality care is provided by mental health services in WA. The team does this through the monitoring and evaluation of service delivery within the context of the:

- *National Standards for Mental Health Services*
- *Chief Psychiatrist's Standards for Clinical Care*
- Recommendations from the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (carried out by Professor Bryant Stokes in 2012)
- *Chief Psychiatrist's Notifiable Incidents and Reportable Events Policy,* under which health service providers have a statutory obligation under the MHA 2014 to report to the Chief Psychiatrist a range of clinical and other incidents and events associated with patient care.

Research and Strategy

The Research and Strategy team is responsible for developing strategy and considering research to support the Chief Psychiatrist's oversight of standards of treatment and care.

Inter-Governmental Relations

The Chief Psychiatrist has a responsibility to interface with other agencies, both intra and interstate, regarding safety, quality and regulation.

Legal Counsel

The Chief Psychiatrist and his staff have generally sought legal advice from the Department of Health's Legal and Legislative Services. However, the Chief Psychiatrist recognises the ongoing need for legal counsel and has recently received funding to temporarily appoint a General Counsel to his Office for the purpose of the review of the MHA 2014.

Professional development

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

Who we work with

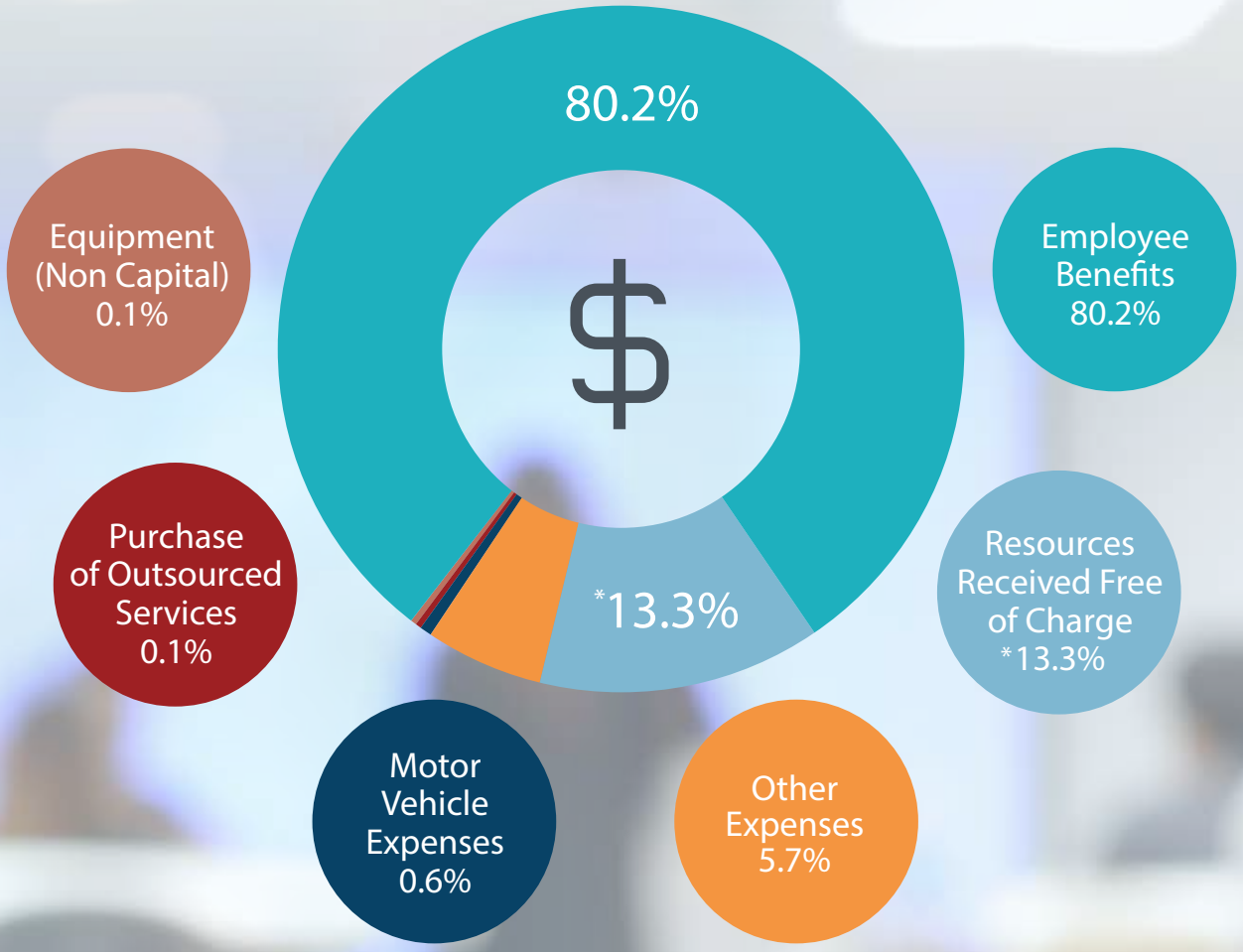
We are constantly focusing on our stakeholder engagement to maximise the value of our interface to ensure that all Western Australians receive the highest standard of mental health treatment and care.

We engage closely with;

Our key strategic objective is to build on our strong external partnerships to facilitate safe, high-quality mental health care. We do this by valuing the voice and expertise of people with lived experience of mental illness and by meaningful co-production and design; and participation by them at all levels of our work. We proactively engage with clinicians, service providers and the community services sector to continuously improve and to ensure our work adds value. We actively seek opportunities to review, reaffirm and build on our stakeholder relationships in-keeping with the aspirations of our *Strategic Plan 2018-23.*

How we spend our money

An overview of expenditure for the office for 2020-21 is represented in percentages in the diagram below:



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

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

COVID-19

COVID-19 continues to impact the Office as it does other government departments and the wider Western Australian community.

The Chief Psychiatrist has and will continue to maximise the function and value of the Office to the WA community during COVID-19.

The Chief Psychiatrist is committed to ensuring his staff are provided with a safe work environment by complying with all COVID-19 related requirements.

Review of the organisational structure and capability of the Office

In acknowledgement of the impact on staff of the expanding workload and the limitations placed on the Chief Psychiatrist's ability to responsibly discharge his statutory functions, external consultants were engaged to review the organisational structure and capability of the Office.

During 2020-21, recommendations made by the consultants, which are designed to advance the Office's capability and to build on its available expertise, were under consideration by the Chief Psychiatrist. Other measures that provide the Office with a broader mandate to influence and provide a more robust clinical governance framework that benefits the mental health sector in WA, are also under consideration.

Statutory framework and role of the Chief Psychiatrist

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

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

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

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

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

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

Currently the Chief Psychiatrist oversees the treatment and care provided by 58 public mental health inpatient units; 3 publicly contracted private providers of mental health services; 7 private psychiatric hospitals; 32 private psychiatric hostels; 16 NGOs providing clinical mental health care; 6 Step Up/Step Down mental health facilities; and 41 alcohol and drug treatment services. This amounts to overseeing the treatment and care of approximately 77,000 patients each year.

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

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

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

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

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

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

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

Under section 525 of the MHA 2014, services must notify the Chief Psychiatrist of any notifiable incident that occurs in the course of providing mental health care to a patient. Notifiable incidents prescribed in the MHA 2014 include the death of a person; an error in medication; unlawful sexual contact; unreasonable use of force; and any other incident that has or is likely to have an adverse effect on a person receiving treatment or care. The Chief Psychiatrist may investigate any of these incidents. Details of notifiable incidents reported to the Chief Psychiatrist are provided throughout this report.

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

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

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

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

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

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

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

The Office of the Chief Psychiatrist trains AMHPs to carry out the functions of an AMHP under the MHA 2014, to ensure their practice is at a reasonable standard before they can be designated as an AMHP. The Office provides refresher training; ensures the AMHPs engage in professional

development; and provides clinical supervision to them on an annual basis to help them maintain their skills.

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

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

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

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

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

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

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

Publishing guidelines (section 547 MHA 2014)

The Chief Psychiatrist must publish guidelines on the following:

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

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

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

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

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

(f) the performance of ECT;

(g) compliance with approved forms;

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

The Chief Psychiatrist may publish other guidelines relating to the treatment and care of persons who have a mental illness. Recently, the Chief Psychiatrist published guidelines for the sexual safety of consumers of mental health services.

Other approvals

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

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

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

Further governance responsibilities

The Chief Psychiatrist has an important oversight role in the system of governance across the mental health sector in WA as summarised in the following diagram.

The roles of these agencies are complex. The diagram below is the Chief Psychiatrist's visual of the largest public sector mental health governance agencies, with the Chief Psychiatrist as reference.

Oversight of MHC (Mental Health Commission), DoH (Department of Health) and the HSPs (Health Service Providers) is part of the Chief Psychiatrist's statutory role regarding influencing standards of care. There are numerous other agencies that also have significant governance responsibility that interface with the above agencies. Governance in the WA mental health sector is extremely complex. The community managed sector is large and diverse. The private sector is a major player made up of multiple stakeholders. In 2020-21, the Chief Psychiatrist has had an increasing focus on mental health sector planning and its impact on standards of care.

Mental health snapshot

Mental health system snapshot

Clinical Rehabilitation Services (CRS)
CRS provide long-term care to people with complex needs; provide intensive support; and help people work towards personal recovery goals whilst also providing clinical care.

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

Hospital in the Home (HitH)
HitH provides care in the home. It provides the same level of care as that provided to an inpatient but is less restrictive. The clinical team visits at least daily. There are child and adolescent, youth, adult and older adult HitH services.

Mental Health Emergency Response Line (MHERL) and Rural Link
MHERL and Rural Link are hotlines people can contact in a mental health emergency. Clinicians assess people over the phone. If necessary, MHERL will refer a person to a local mental health service, usually a CMHS.

Private Mental Health Professionals
Private mental health professionals include private psychiatrists, psychologists, and other counsellors. These services provide mental health treatment and care in the community for a fee, which may be partially covered by Medicare. The Chief Psychiatrist does not have remit over these services.

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

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

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

Inpatient Mental Health Services
Inpatient mental health services provide treatment and care to patients in hospital. Most inpatient services provide "acute care", which means urgent care. Acute mental health issues start suddenly or get worse quickly. Acute care is generally needed for a short time such as two weeks.

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

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

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

How many people used this type of service in 2020?

610
Private Psychiatric Hostels

440
Clinical Rehabilitation Services

572
Step-Up-Step-Down Services

9,790
Inpatient Mental Health Services

66,812
Community Mental Health Services (CMHS)

3,107
Private patients were separated from Private and Private-Public Partnersip Hospitals

10,468
Mental Health Emergency Response Line (MHERL) and Rural Link

(+ 5511 calls from people who preferred not to identify themselves)

162
Safe Haven Cafes

65,412
Emergency Departments

Consultation Liaison Services

Data not consistently collected

Hospital in the Home

32 available beds on average

Private Mental Health Professionals

Not under the remit of the Chief Psychiatrist

61 Non-Government/ Community Managed Organisations

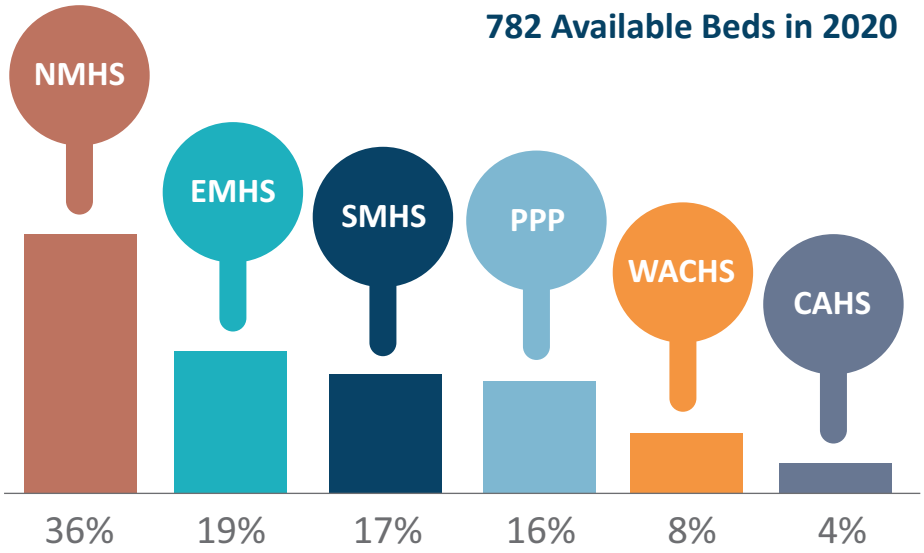
16 of these under the remit of the Chief Psychiatrist

In the 2020 calendar year, public sector specialist inpatient and/or community mental health care was provided to 68,869 individuals. Just over two-thirds (69%) of these specialised mental health services were provided to adults aged 18-64 years, 21% were provided to children less than 18 years of age and 10% to adults 65+ years of age. Of these, 10,464 people received both inpatient and specialist clinical community mental health services during 2020, equating to 15% of all consumers. The majority (80%) were 18-64 years of age, 11% 65+ years and 9% were children under 18 years.

Inpatient mental health services

Public hospitals providing inpatient mental health services

There was an average of 782 available beds in the 2020 calendar year, including 32 Hospital in the Home (HiTH) beds provided by the North Metropolitan Health Service and 750 inpatient beds across the rest of WA:



**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*

There were 9,790 people with one or more inpatient admissions to a specialised public mental health service (acute and non-acute wards), involving 14,961 separations in 2020. The majority (81%) were adults 18-64 years, 11% were 65 years or older and 8% were children under 18 years of age. Just over one quarter (26%) of inpatients had an involuntary mental health status at some stage during their admission and 74% had a voluntary mental health status, equating to 3,427 and 11,534 separations respectively.

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

Private hospitals providing inpatient mental health services

There are four private hospitals providing mental health services in WA and three publicly contracted private providers that admit some private patients. During the 2020 calendar year, 3,107 private inpatients in total were discharged from these services, involving a total of 5,924 separations. The majority of patients were adults 18-64 years (86%), 10% were adults 65+ years and 4% were under 18 years of age.

Authorised mental health facilities

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

Currently in WA there are 16 health campuses with authorised mental health facilities:

Child and Adolescent Health Service

- Perth Children's Hospital

East Metropolitan Health Service

- Armadale Hospital and Health Service
- Bentley Hospital and Health Service

North Metropolitan Health Service

- Graylands/Selby Health Campus
- Sir Charles Gairdner Hospital

South Metropolitan Health Service

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

WA Country Health Service

- Albany Hospital, Lower Great Southern Health Service
- Kalgoorlie Regional Hospital, Goldfields Health Service
- Bunbury Hospital, South West Area Health Service
- Broome Health Hospital, Kimberley Health Service

Women's and Newborn Health Service

- King Edward Memorial Hospital

Private Hospitals Providing a Public Service

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

In the period 2020 – 2021, the Chief Psychiatrist did not receive any new applications for the authorisation of a facility.

Community mental health services (CMHS)

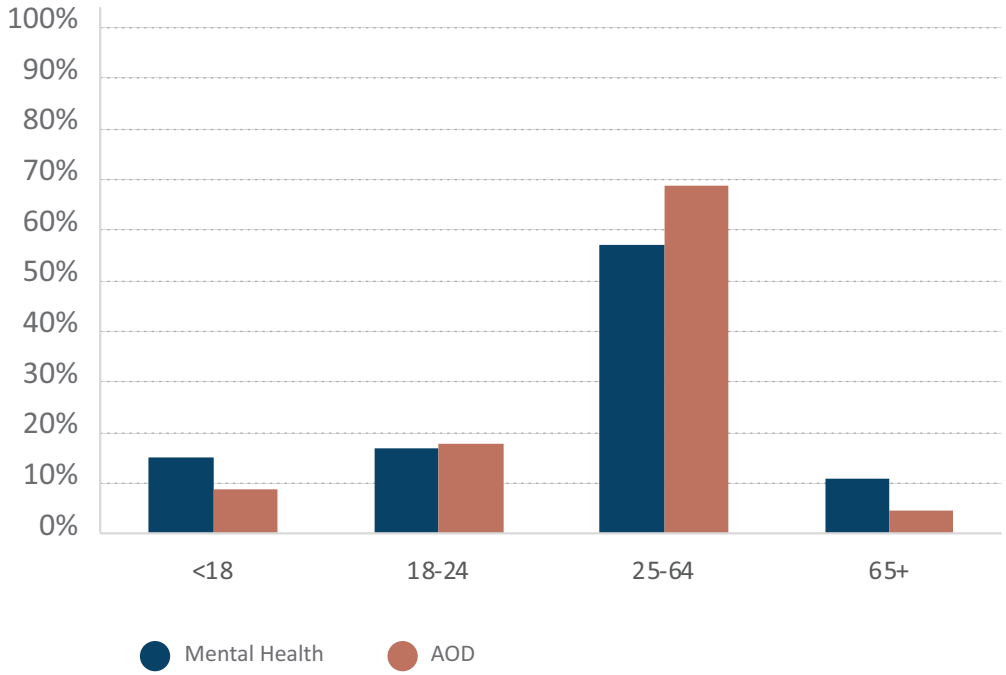
The number of people receiving mental health care from CMHS in the 2020 calendar year was 66,812, involving 1,027,729 service contacts. Just over two-thirds of individuals receiving services in the community (69%) were aged 18-64 years, 21% were under 18 years of age and 10% were 65 years or older.

Emergency departments

In the 2020 calendar year, 5.8% of attendances at an Emergency Department (ED) were for a mental health issue, totalling 65,412 presentations, and 1.9% of ED attendances were for an alcohol and other drug (AOD) issue, equating to 21,373 presentations.

The distribution of age groups presenting with mental health issues showed a similar pattern to AOD presentations (Figure 1). Of note, a higher proportion of mental health presentations involved children and adolescents under 18 years of age (15%) and adults 65 years or older (11%) compared with 9% and 5% (respectively) presenting with an AOD issue. Conversely, a larger proportion of AOD presentations (69%) than mental health presentations (57%) involved adults aged 25-64 years. Presentations for adolescents aged 18-24 years were similar for both mental health and AOD issues (17% and 17.8% respectively).

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



The length of episodes for ED mental health and AOD presentations showed similar patterns across age groups. For mental health presentations, people aged 65 years and over had the longest median length of episode of 308 minutes (min 110; max 919), decreasing steadily by age, to a median length of episode of 232 minutes (min 78; max 856) for children and adolescents under 18 years. For AOD presentations to ED, the median length of episode for adults ranged from 255 minutes (min 79; max 865) for adults 45-55 years, with 55-64 year old's having the longest length of episode of 272 minutes (min 86; max 839). Children <18 years had the shortest length of episode of 221 minutes (min 65; max 764) followed by adolescents 18-24 years of 227 minutes (min 64; max 737).

The majority of people presenting to the ED with either a mental health (55%) or an AOD (54%) issue departed under their own care. The proportion of people admitted to an ED Observation Ward was lower for people presenting with a mental illness (13%) than for those presenting with an AOD issue (22%). However, a higher proportion of people with a mental health issue (20%) was admitted to hospital than people with an AOD issue (11%). A similar proportion of mental health patients (7%) and people presenting with AOD issues (9%) did not wait to be attended to by a medical officer or left at their own risk. Twice as many people presenting with a mental health issue were transferred to another hospital for admission than people presenting with AOD issues (4.5% and 2.2%, respectively).

The ED discharge outcomes varied by age. For mental health presentations, 68% of children and adolescents under 18 years left under their own care, decreasing to 54% for adults aged 25-64 years and 33% of those aged 65 years or older (Figure 2). A similar pattern was seen for AOD presentations (Figure 3). Across all ages, a higher proportion of people presenting with an AOD issue were admitted to an ED Observation Ward than people presenting with a mental health issue. This was most notable for people aged 65 years or older, with 31% of AOD and 10% of mental health presentations admitted to an Observation Ward. For those under 18 years, it was 20% and 10% respectively. A higher proportion of people presenting with a mental health issue was admitted to hospital than those presenting with an AOD issue with the proportion increasing with age. Half (51%) of people aged 65 years or older, who presented with a mental health issue, were admitted to hospital compared with 21% of AOD presentations in this age group. Overall, the proportion of people not waiting to be attended to by a medical officer was low. However, for adolescents aged 18-24 years and adults aged 25-64 years, 8% of mental health and 10% of AOD presentations (respectively) did not wait to be seen or left at their own risk.

Figure 2: Mental health ED outcomes by age group

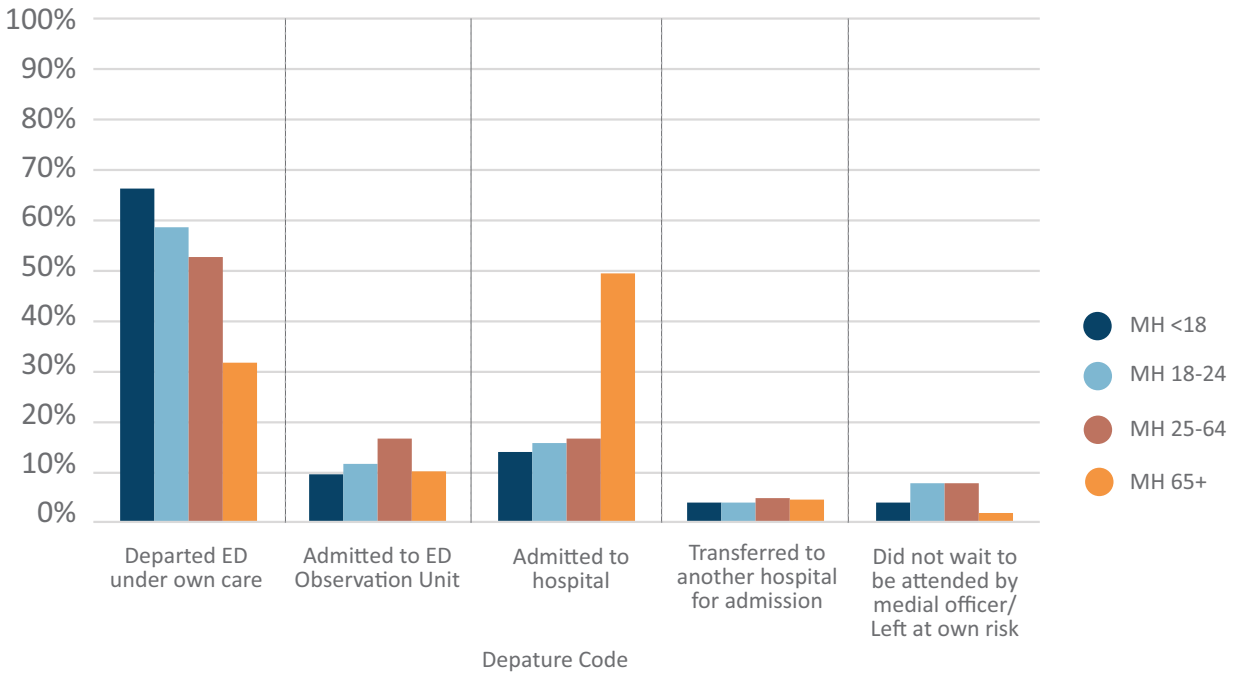
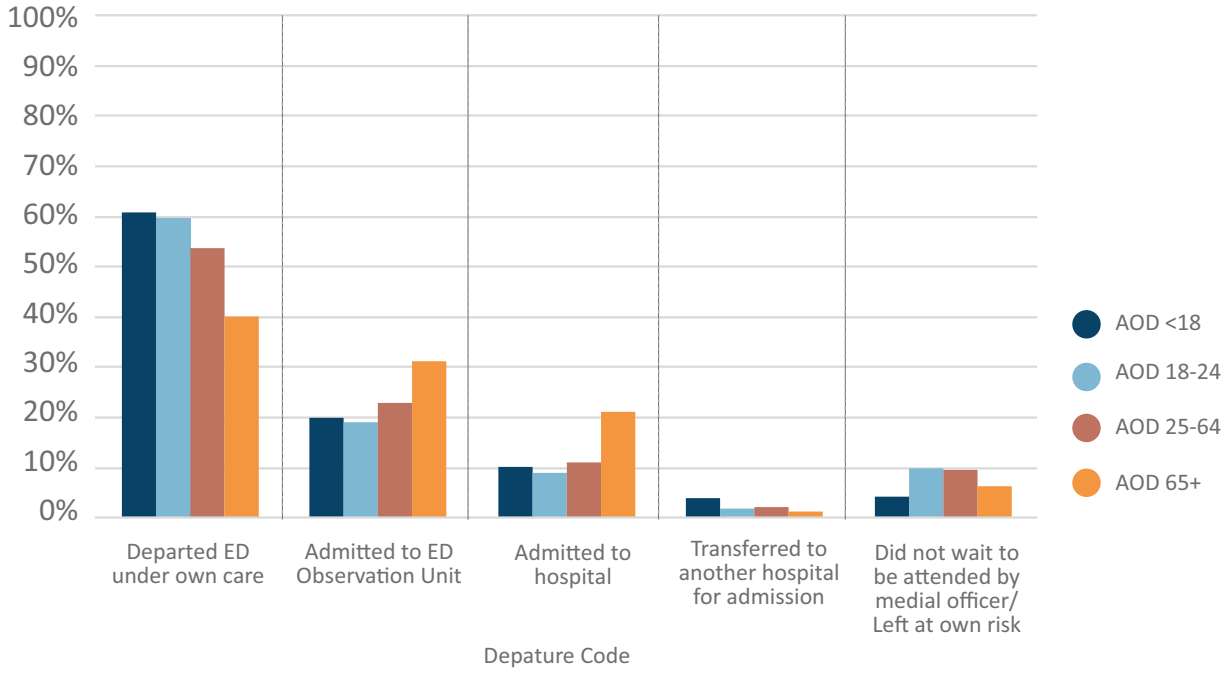


Figure 3: Alcohol and other drug ED outcomes by age group



Mental health services trends - 2018 to 2020

Since 2018, the number of people accessing specialist inpatient and community mental health services has been increasing. There was a 12% increase from 62,006 individuals in 2018 to 69,392 in 2019, with a similar number of individuals in 2020 (68,998). The number of people accessing both inpatient and community mental health services increased by 21.8% from 8,441 in 2018 to 10,285 in 2019, followed by a 4% decrease to 9,862 in 2020.

Inpatient mental health admissions to public hospitals increased by 12.8% from 9,322 in 2018 to 10,517 in 2019, decreasing to 9,793 individuals in 2020, equating to a 5% net increase over the three years. Separations showed a similar trend to admissions. There was a 10.8% increase in separations between 2018 and 2019 from 14,722 to 16,507. However, this increase was not maintained in 2020 with the numbers reducing to 14,962, resulting in a net 1.6% increase in separations over the three years. There was a 25% decrease in Hospital in the Home (HiTH) beds from an average of 43 beds in 2018 to 32 beds in each of 2019 and 2020.

Private mental health hospitals and hospitals classified as public-private-partnerships had a 6% increase in mental health inpatients over the three years from 2,940 in 2018 to 3,107 in 2020 and a 1.5% increase in separations from 5,878 to 5,924 over the three-year period.

Community mental health services have seen an increase in the number of people accessing their services over the three-year period. Numbers have increased by 8% from 61,838 individuals in 2018 to 66,812 individuals in 2020. In contrast, the proportion of all ED presentations involving a mental health presentation has remained relatively constant over the three-year period, ranging between 5.7% and 5.9%.

Step-Up Step-Down services

During the 2020 calendar year, there were 572 admissions to the to the 6 Step-Up Step-Down services provided under service agreements between the Mental Health Commission and three NG0s.

Safe Haven Cafés

Safe Haven Cafés are a peer-run, non-clinical model aimed to provide psychosocial support for individuals where that may be the significant need in a crisis. They often assist individuals before or after they attend an ED.

Two Safe Haven Cafés were opened in WA in 2021, one at Kununurra Hospital in March and a second, *Dabakan Ngowoort Koorliny Mia*, at Royal Perth Hospital in April.

Since the opening of the Kununurra Hospital Safe Haven Café, 134 individuals have attended the Café, with 74 of those returning more than once. Referral sources included self-referrals (37%), ED (36.5%), other services (18%), a mental health team (4.5%) and family or friends (4%). The majority of people were female (70%) and aged between 25 and 50 years (55%) and around two-thirds (67.9%) were Aboriginal and/or Torres Strait Islanders.

Dabakan Ngowoort Koorliny Mia Safe Haven Café received 28 attendees, involving 35 presentations, up to 30 June 2021. In just under three-quarters (71.4%) of presentations, the individuals self-referred, with 14.3% referred from a health service and 14.3% from another source.

In the majority of presentations (80%), the individuals returned home with 20% subsequently accessing a hospital service.

Private psychiatric hostels

There are 32 private psychiatric hostels in WA, containing 707 beds.

The Chief Psychiatrist's Annual Hostel Snapshot was completed on 29 January 2021 and, on that day, there were 610 residents living in a private psychiatric hostel.

See the *Private psychiatric hostels* section of this report for further information.

Non-government organisations

The Mental Health Commission has contracted NGOs to provide a range of mental health services in the community. In the 2020 calendar year, the Mental Health Commission provided 77 mental health services through service agreements with 61 NGOs. Of these, there are 16 NGOs that provide mental health clinical services and are subject to the Chief Psychiatrist's oversight. These 16 NGOs are required to adhere to the Chief Psychiatrist's Standards for Clinical Care and to report notifiable incidents to the Chief Psychiatrist.

Planning for future services

The Chief Psychiatrist notes the significant value of the Mental Health Network and the Sub-Networks in the modelling and planning for key areas such as eating disorders and personality disorders. It remains essential for the Network to have clinical and non-clinical leads.

Planned authorised mental health facilities

With the advancements in design concept for mental health units, there is an expectation that any new mental health unit provide state-of-the-art facilities that promote wellbeing and opportunities for rehabilitation.

During the reporting period, the Office of the Chief Psychiatrist provided information to services on contemporary design of mental health facilities, both nationally and internationally. Modern contemporary design empowers patients and provides hope for recovery, with light, bright, airy rooms and well-planned indoor and outdoor spaces. A modern mental health facility is welcoming for patients, their families and carers, and provides staff with a suitable and safe work environment. Models of care are patient-centric.

Several new authorised mental health facilities are planned for WA. The new Geraldton Health Campus Mental Health Unit was reported in the 2019-20 annual report, as was a secure unit at Royal Perth Hospital. Both Joondalup Health Campus and Fremantle Hospital and Health Services are increasing the number of authorised beds All developments are progressing, and the Chief Psychiatrist remains engaged with those processes.

Upgrading and refurbishment of authorised hospitals

The *Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014* Appendix A sets out the requirements for upgrades or refurbishment of an authorised facility. The Chief Psychiatrist is consulted at the commencement of the project to ensure that the proposed changes align with the Standards and that there has been appropriate consultation with relevant stakeholders, including Aboriginal stakeholders.

In the 2020–21 reporting period, several services undertook major refurbishments or commenced planning for upgrades of mental health facilities. The Office of the Chief Psychiatrist worked closely with these services, providing expert advice on design, safety and suitability and addressing any matters relating to the *Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014.*

In September 2020, the North Metropolitan Mental Health Service advised the Chief Psychiatrist of a Ligature Remediation Project. The project involves several units within the area health service, two of which are authorised facilities. The works include the upgrade of bathrooms, replacement of fittings and fixtures to ensure compliance with anti-ligature requirements. The Office of the Chief Psychiatrist has been involved in providing advice on suitability and design aspects along with finding practical solutions for working within the confines of existing buildings. Remediation works have commenced at Selby Older Adult Mental Health Service, Graylands Hospital and Osborne Park Older Adult Mental Health Unit.

The Chief Psychiatrist was asked to provide guidance and advice to private stakeholders on the development or upgrading of mental health facilities at Bethesda Hospital, Sophron Healthcare - Busselton, SJOG Midland (public/private) and SJOG Murdoch (private).

Other proposed bed-based services under the remit of the Chief Psychiatrist

There are a range of bed-based services planned, including:

- A public sector clinical transitional care unit
- Commencement of planning for forensic redevelopment (Graylands Reconfiguration and Forensic Taskforce)
- Mental Health Observation Areas, or equivalent Mental Health Emergency Centres at Bunbury Regional Hospital and St John of God Midland Private Hospital
- Other private sector developments (Cockburn, Bethesda)
- Peel mental health expansion
- Royal Perth Hospital authorised unit development
- Medihotel adjacent to Fiona Stanley Hospital

Key challenges to standards of treatment and care in the sector

The Chief Psychiatrist recognises that WA is a wealthy state and has significant mental health resources and services. Our state has a highly skilled and diverse mental health workforce provided through a broad range of government, private and community-managed organisations. Despite the complexity of mental health provision in WA, much of the treatment and care provided is good quality. In some areas, such as the steps being taken towards elimination of restrictive practice in mental health settings, WA is the national leader.

Mental wellbeing across the community is a whole-of-government responsibility and must, by nature, be much broader than the mental health sector (other relevant areas include housing, employment, justice, etc). Treatment and care for individuals with serious mental illness is a primary focus for the mental health sector, involving specialist public, community managed, private and primary care components, as well as input from other sectors.

Notwithstanding, the Chief Psychiatrist is in a strategic position to identify the areas of need within the sector. The Chief Psychiatrist generally focusses on working with services to improve care but, in recent years, it has been necessary to focus on mental health planning for WA. In the context of the evidence from the recent Review of Government Services; the Australian Institute of Health and Welfare; the WA Auditor General's Review; the WA Mental Health Commission's State Plan Update; and the multiple reviews by the Chief Psychiatrist, WA is not reaching the comparative mental health outcomes that should be expected for such a wealthy state and in light of the current high levels of investment.

There are reasons why some mental health standards across the sector have been impacted in WA. Although some matters are unforeseeable, for example the timing of COVID, or the sudden spike in child and youth self-harm over last 5-10 years, there have been translational deficits in statewide WA mental health planning in certain areas, which have either not pivoted to the emerging trends (e.g. sustained, escalating child mental health presentations) or are unaddressed longstanding matters (e.g. forensic mental health beds), or where there have been ideological tensions in planning, creating a reduction in key service planks (e.g. clinical rehabilitation), or where issues are extremely complex and there is a cross-society interplay of factors (e.g. suicide).

The following are current standards priorities for the mental health sector, some of which have been reported in previous Annual Reports.

- It is important to note that there is highly active planning work being undertaken for all these areas, but the pressures and deficits remain significantly high.
- It is also important to note that there is significant pressure on our ED and acute mental health bed stock- this is where the pressure shows daily.

But the answers to these pressure points are not about increasing ED capacity or building more acute beds. Rather, we need to address the issues in the community and in those services that cater to those who are the most frequent, long-term and most complex users of our services.

It is absolutely critical to note **that the vast majority of specialist clinical public sector mental health care occurs in the community.** Acute mental health care is not just about hospitals. Public sector specialist clinical mental health care is not just about acute care. Community mental health is a dynamic balance among specialist clinical mental health services, the community-managed sector, primary care and the broader private sector. Mental health governing agencies have found it difficult to explain this effectively to the community.

The most critical aspect of good treatment and care is the interpersonal relationship among the staff member, consumer and carer. Our workforce, our mental health staff across all aspects of the sector, is our most valuable and treasured resource to care for the WA community. If we are to improve care, we need more staff and we need to provide better supervision and support for staff.

Child and adolescent mental health services

Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services

On 6 August 2020, the Minister requested that the Chief Psychiatrist undertake a review into the treatment of Ms Kate Savage, a 13-year-old girl who tragically died whilst under the care of the Child and Adolescent Mental Health Services (CAMHS). The review included consideration of the adequacy of current services to respond to young people with complex needs and high-risk behaviour.

In relation to Kate's treatment, the review found that, while there were some very significant learnings from her death, there was no evidence that clinical staff had been negligent in their duty towards Kate. It did, however, highlight some broader issues: (1) a sense by Kate's family, and shared by a number of families, that they were not being listened to or taken seriously; (2) a lack of any formal system for independent review of diagnosis and treatment when there was an unresolved difference of opinion between the family and the treating team; and (3) the challenges of applying clinical practice guidelines, developed for older adolescents/adults, in the treatment of Emotionally Unstable Personality Disorder in young adolescents.

Data showed that the CAMHS system is under considerable pressure, with an increase of 50% in referrals to community clinics between 2015 and 2019. During that same period, admissions were not able to keep pace with the increase in referrals. The management of 12-17-year-old adolescents with complex needs and high-risk behaviour has progressively come to dominate the work of CAMHS, significantly reducing its capacity to treat younger children. This shift parallels the steep growth in self-harm and attempted suicide being seen in children and young people over the past decade in WA and in other national and international jurisdictions. Kate's story highlighted the significant gap in services between inpatient care and community clinics that operate from 9:00am to 5:00pm weekdays.

Figure 4: CAMHS referrals by age group 2015 - 2019

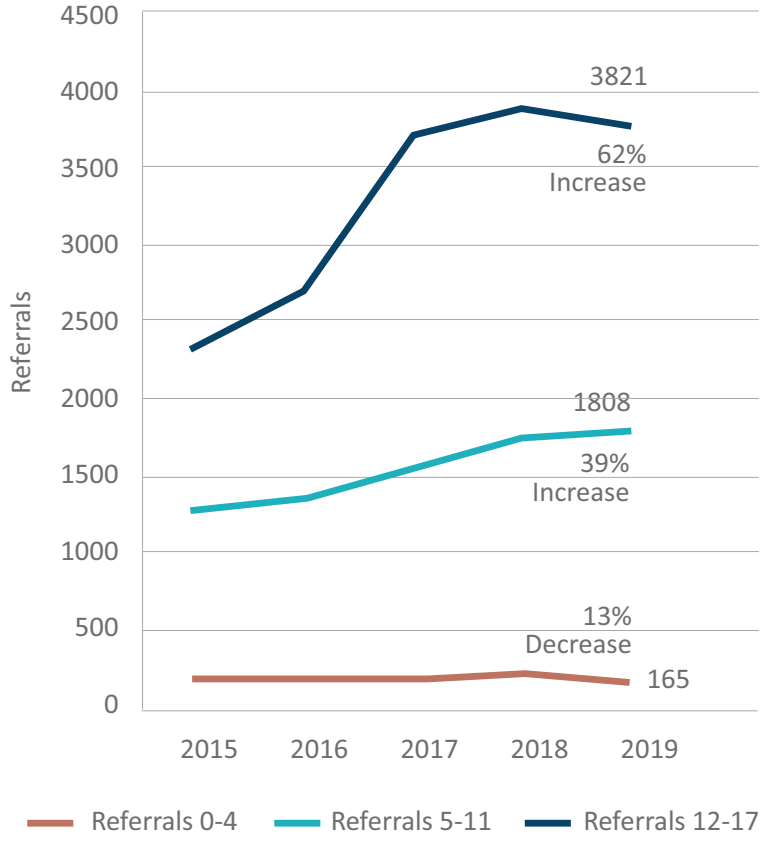


Figure 5: CAMHS activations by age group 2015–2019

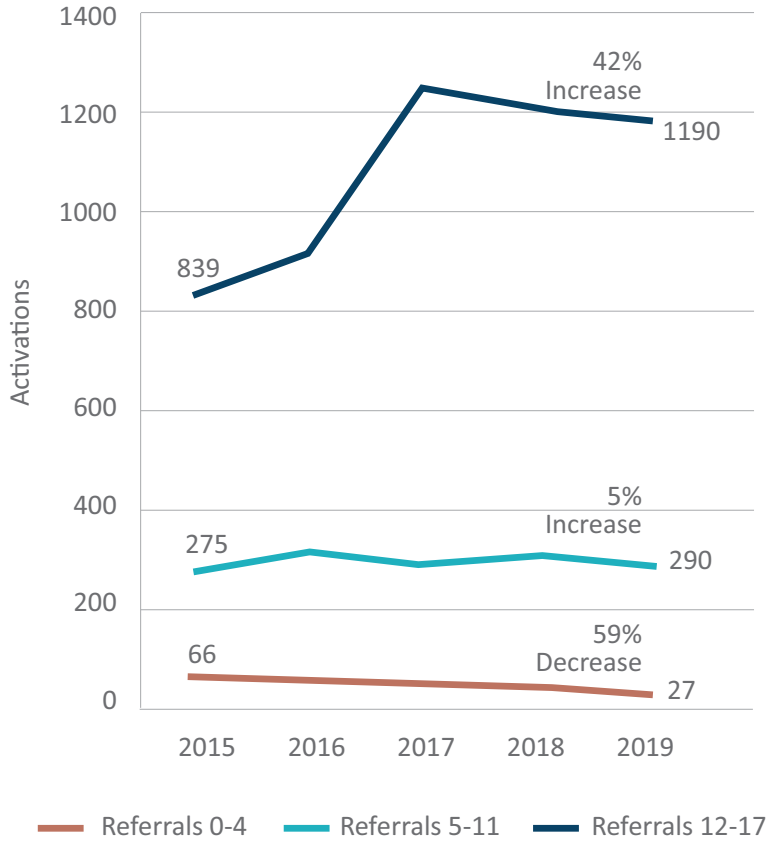
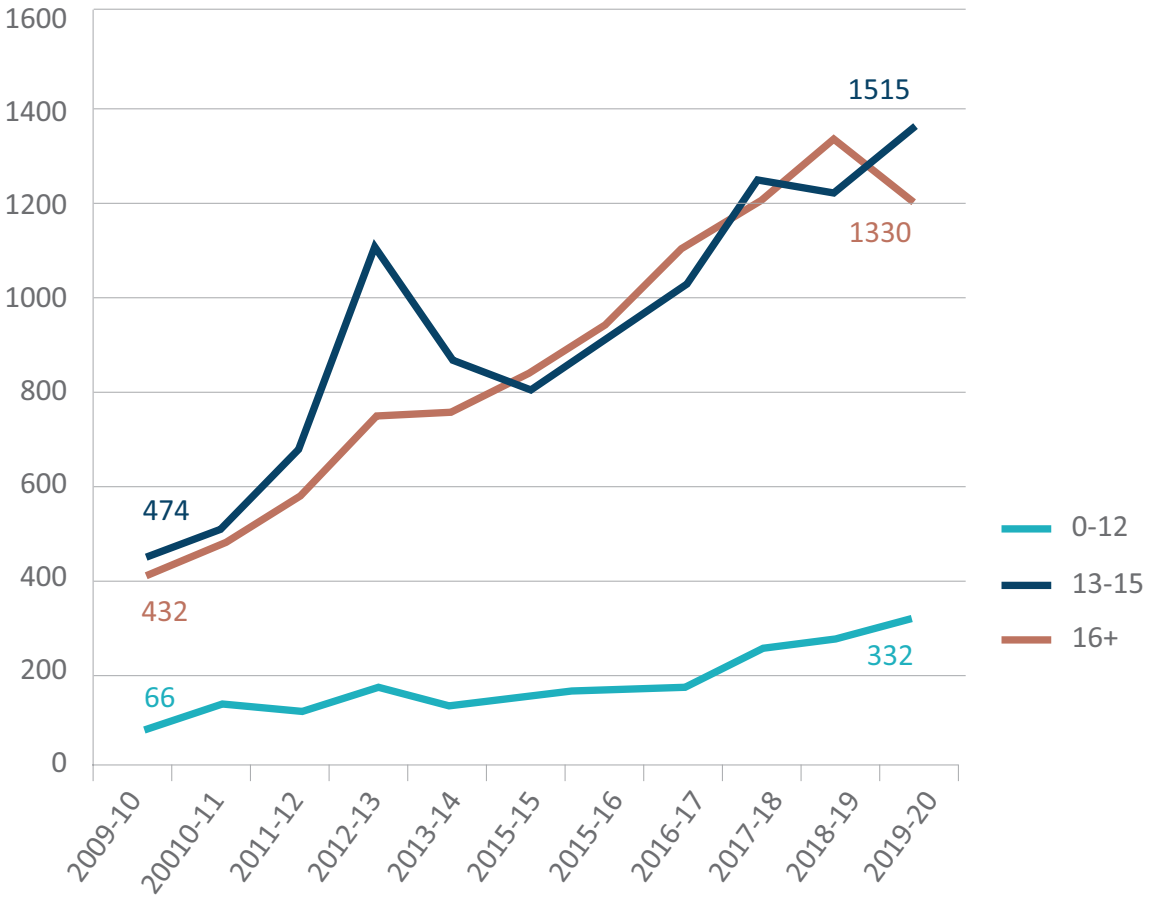


Figure 6: Number of ED attendances in metropolitan Perth by children and young people under the age of 18 that attempted suicide, were a suicide risk, or self-harmed 2009/10–2019/20



*Metro EDs data only as there were changes in reporting in rural area during this period

The Review recommended:

- Positions for family peer workers be established, initially at Perth Children's Hospital, but to be extended to all CAMHS services.
- A formal structure be established for independent review of the diagnosis and treatment of children and young people where there is an unresolved difference of opinion between clinicians and families.
- Consideration be given to a review of the application of the current guidelines for the management of Borderline Personality Disorder in early adolescents.
- Multidisciplinary Community Intensive Treatment Services be established in the northern, eastern and southern metropolitan areas of Perth, to ensure that young people with complex mental health needs receive appropriate, timely care in the community.
- CAMHS Emergency Service, consisting of a multidisciplinary mental health team operating 24/7 and an enhanced emergency telehealth service, be established at Perth Children's Hospital.
- Immediate uplift to the clinical workforce in Community CAMHS.

- A Child and Adolescent Mental Health Ministerial Taskforce be established to: (1) oversee the staged implementation of the review recommendations; and (2) develop a whole of system plan for Perth Metropolitan and WA Country CAMHS.

In January 2021, Ms. Robyn Kruk was appointed to chair the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0–18 years in Western Australia. The Taskforce commenced operation in March 2021.

Read the full report: *Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services*

Sexual safety

All people who use mental health services have a right to feel safe, and to be safe throughout their journey. It has been estimated that at least 40% of men and women accessing inpatient mental health care have experienced sexual abuse or family violence. However, people may not always feel comfortable disclosing their experience of trauma, and so this may be an underestimate (some estimates suggest that the rate for women accessing services may be as high as 90%.)

In WA, mental health inpatient units are generally mixed gender spaces, and sexual safety in these environments is a priority issue for the Chief Psychiatrist. All mental health services (inpatient, residential and outpatient) need to be designed and operated so as to minimise the chance of traumatising, re-traumatising or compounding previous trauma for people using the service, and the services need to foster a culture where everyone can feel and be sexually safe, recognising that national and international evidence shows this is not always the case in practice.

In December 2020 the Chief Psychiatrist published the *Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services in Western Australia* (the Sexual Safety Guidelines). A launch event was held at Fiona Stanley Hospital on 1 December 2020.

The Sexual Safety Guidelines are published under section 547(3) of the MHA 2014. They are designed to help mental health services identify practical steps they can take to ensure the sexual safety of their consumers.

The guidelines include both universal approaches and targeted approaches to sexual safety. Universal approaches are measures that all services can adopt, such as: trauma-informed and gender-sensitive care; empowering and supporting consumers and staff to understand and promote safety and healthy sexual expression; designing residential and clinical spaces to make them safer; and enhancing leadership and governance. Targeted approaches are measures that relate to individual consumers, i.e. identifying people who may be at risk of being sexually unsafe and developing plans that maximise their safety. The guidelines also describe how to manage a situation where sexual safety may have been breached, including medical, forensic and police considerations.

The guidelines were developed following an exhaustive consultation process, with a great deal of input and commitment from everyone involved: people with lived experience as consumers or carers of mental health services; professionals working in a range of mental health services; Aboriginal mental health representatives; people with expertise in gender diversity; and representatives from the WA Police and the WA Sexual Assault Resource Centre. An Expert Reference Group was convened, chaired by the Deputy Chief Psychiatrist and, from this, a smaller steering group was established to oversee and guide the process. Thanks are due to all those

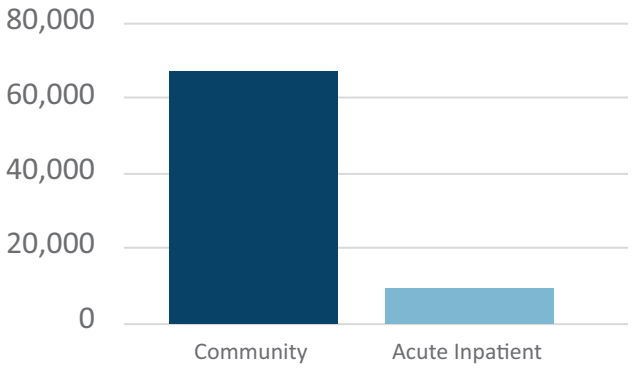
who contributed to the development of the Sexual Safety Guidelines and especially to Dr Sophie Davison, Deputy Chief Psychiatrist, for her leadership and hard work.

Specialist community mental health services

Specialist community mental health services (CMHS) provide clinical treatment and care under the public health care system. When working optimally, the CMHS work closely with non-clinical mental health providers (such as NGOs), NDIS providers and general practitioners to ensure coordinated treatment and care for a full range of clinical and psychosocial needs.

More people receive clinical mental health treatment and care in the community than in hospital (Figure 6). Some CMHS have integrated rehabilitation and recovery service streams. As the population grows, the need for these services is also growing.

Figure 6: Number of people accessing acute inpatient treatment and specialist clinical community mental health treatment in 2020



As identified in the Office of the Auditor General's 2019 report of *Access to State-Managed Mental Health Services*, an increase in resourcing is needed in line with population growth. Currently, the CMHS are struggling to meet increased demand with relatively low rates of overall hours of care provided per person. Furthermore, the number of providers involved in an individual's care has increased dramatically with the implementation of NDIS. The CMHS's role in supporting consumers to access NDIS services is growing and impacting their capacity to provide core mental health treatment and care.

The Chief Psychiatrist is responsible for overseeing the treatment and care of people who receive services from the CMHS. There are three methods for oversight:

- Reviews (including clinical monitoring reviews; targeted reviews; and thematic reviews)
- Monitoring notifiable incidents reported by the CMHS
- Chief Psychiatrist's visits to mental health services

Baseline clinical monitoring reviews were completed for all CMHS between 2016 and 2019. The outcomes of these reviews have been reported in previous annual reports of the Chief Psychiatrist. The Chief Psychiatrist uses this baseline information in engaging with services around ongoing service improvement.

The nature of future reviews is under consideration. The Chief Psychiatrist does not have a dedicated resource for regular reviews of the CMHS; currently resources are directed towards review of private psychiatric hostels. If there are urgent concerns about standards of care in the CMHS (for example, identified via a notifiable incident or an issue raised by staff during a site visit), the Chief Psychiatrist will initiate a targeted review.

Mental health rehabilitation

Chief Psychiatrist's Review Report: Building rehabilitation and recovery services for people with severe enduring mental illness and complex needs – including those with challenging behaviour

This Review was instigated in response to mounting concern from clinicians and families that people with severe enduring mental illness and complex needs are not well-served by the current system - a system which largely provides 'episodic' rather than 'ongoing' treatment and care.

The Auditor General's report, Access to State-Managed Adult Mental Health Services, found that 10% of consumers are using 90% of inpatient mental health services, half the community services and half the mental health services provided through EDs. Furthermore, it found that significant numbers of individuals with severe mental illness remain in acute inpatient beds because of extremely limited access to specialist rehabilitation services. The report confirmed what many already know, that "the current mix of mental health services … does not work as intended for some people."

The Review found that what is required is an investment to build a coordinated network of rehabilitation and recovery services, providing both clinical treatment and psychosocial support for some of the most vulnerable people in our community. Some essential components of a rehabilitation and recovery service system are currently unavailable in WA and others require significant enhancement. For example, the only Statewide tertiary level inpatient rehabilitation service (located at Graylands Hospital), which provides treatment to those with the most complex needs, had, at 30 June 2021, an average waiting time of nine months to be admitted, with nine individuals on the waiting list.

Key recommendations from the Review included:

- the development of a comprehensive range of inpatient, residential and community rehabilitation and recovery services that provide a coordinated pathway of care;
- ensuring that public mental health and non-government services are coordinated in meeting the complex needs of consumers and their families;
- ensuring that rehabilitation and recovery services provide integrated treatment for people with mental health and substance use problems; and
- the establishment of a Specialist Neuropsychiatry Service for the treatment and care of people with co-occurring mental illness and intellectual, cognitive and developmental disability.

In the absence of an appropriately coordinated and resourced rehabilitation and recovery service system, there has been growing demand for acute inpatient beds, which has put increasing pressure on EDs and forensic mental health services. The Department of Health's modelling

supports the findings of this Review, namely that what is needed is not more acute beds, but better use of existing beds through the development of a full range of inpatient, residential and community rehabilitation and recovery services. The recommendations of the Review have met with general support from the health service providers and the Department of Health.

Read the full report: *Building rehabilitation and recovery services for people with severe enduring mental illness and complex needs – including those with challenging behaviour*

Rehabilitation inpatient beds

There has been a historical focus on the development of acute mental health beds, and in the next several years, it is proposed that over 200 additional mental health beds, both public and private, will come on line for WA. It is widely known that there is a considerable lack of rehabilitative beds, which adds to the revolving door of patients returning to inpatient care.

Building new acute metropolitan mental health beds may have short-term impact, but is not likely to be an effective longer term strategy to either address the gaps in community or rehabilitative care, and it will not provide a sustainable improvement in either mental health patient flow or Emergency Department pressure.

There is an urgent need to address the gap in rehabilitation beds.

There is an opportunity for mental health planners to substantively address the primary patient flow issues and the needs for increased rehabilitation beds as these new beds are brought online.

People with a co-occurring intellectual, cognitive or developmental disability and mental illness

People with an intellectual disability experience mental illness at a rate that is two to three times that of the general population.[3] Recent evidence from NSW indicates that people with a dual diagnosis of intellectual disability and mental illness have much higher psychiatric inpatient admission rates, longer admissions to hospital and higher costs related to mental health admissions compared to those without an intellectual disability.[4] In the absence of adequate ongoing treatment and support, individuals with mental ill-health and an intellectual, cognitive or developmental disability often turn to acute healthcare and emergency services. Consequently, this cohort is most commonly treated in a costly hospital setting, often presenting in crisis, requiring interventions that are largely focussed on symptom containment.

There are significant gaps in WA's public mental health services for people with co-occurring mental illness and complex intellectual, cognitive or developmental disability. These service gaps are long-standing and well known.[5] Recently, the Chief Psychiatrist's review into rehabilitation

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3 Cooper, S., Smiley, E., Morrison, J. et al. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. The British Journal of Psychiatry, 190, 27-35.

4 Troller, J., Weise, J., Li, S. (2019). Submission to the Productivity Commission inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth. Sydney, NSW: Department of Developmental Disability Neuropsychiatry University of New South Wales.

5 Department of Health (2015). Western Australian specialist neuropsychiatry disability service model of care. Perth: North Metropolitan Health Service Mental Health, DoH.

6 Smith, G., Williams, T. (2020). Chief Psychiatrist's Review: Building rehabilitation and recovery services for people with severe ensuring mental illness and complex needs – including those with challenging behaviour. Perth, WA. Office of the Chief Psychiatrist.

and recovery services recommended, as a priority, that a Specialist Neuropsychiatry Service be established.[6] Also, some years ago, the Better Choices. Better Lives. Western Australian Mental Health, Alcohol and other Drug Services Plan 2015 identified the need to establish a specialised service for people with co-occurring mental illness and intellectual, cognitive or developmental disability. [7] Unfortunately, little progress has been made to plan, fund and establish such a service.

There is a pressing need for immediate action for the Mental Health Commission to commence planning and secure funds to establish a Specialist Neuropsychiatry Service. In developing a state-wide model of care, consideration needs to be given to:

- building on the significant work already undertaken by key stakeholders on developing a model of care;
- ensuring that the model of care meets the specific needs of relevant cohorts, including children and adolescents, and addresses the need for genuine equity of access for people living in rural and regional areas; and
- addressing the need to increase local expertise, including the significant gap in specialist psychiatrist training places.

Private psychiatric hostels

Under section 515 of the MHA 2014, the Chief Psychiatrist is responsible for overseeing the treatment and care of all patients in a mental health service. For the purposes of the Chief Psychiatrist's responsibilities under the MHA 2014, a "mental health service" includes a private psychiatric hostel. This means that the Chief Psychiatrist is responsible for overseeing the treatment and care provided to mental health patients residing within a private psychiatric hostel.

The Chief Psychiatrist's monitoring of private psychiatric hostels includes all facilities operating under a private psychiatric hostel licence granted by the *Licencing and Accreditation Regulatory Unit* (LARU).

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

- Chief Psychiatrist's annual private psychiatric hostel snapshot (the Snapshot)
- Reviews of the treatment and care provided to residents of private psychiatric hostels (Hostel Reviews)
- Monitoring Notifiable Incidents reported by hostels

Chief Psychiatrist's annual private psychiatric hostel snapshot

The Snapshot commenced in its current form in 2020. Data are published on the *Chief Psychiatrist's website*. In 2021, the Chief Psychiatrist has used the Snapshot to consider the notion that residents of private psychiatric hostels are among the people with the most complex mental health needs. While there are many people with complex needs residing in private psychiatric hostels, people with the most complex long-term needs are still cared for in hospital settings. This is likely due to the lack of availability of rehabilitation beds.

7 Western Australian Mental Health Commission (2015). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, WA: MHC.

Reviews of the treatment and care provided to residents of private psychiatric hostels

The Chief Psychiatrist commenced a program of reviews of the treatment and care provided to residents of private psychiatric hostels in 2019. The program experienced some delays related to COVID-19, however in the 2020-21 financial year, the following hostels have been reviewed:

- Life Without Barriers Ngatti House
- Southern Cross Care Community Options Bentley
- Southern Cross Care Community Options Mount Claremont
- Southern Cross Care Community Options Stirling
- Devenish Lodge
- Pu-Fam (Guildford Care Facility) St Jude's Hostel
- Albany Halfway House Albany Community Supported Residential Units (CSRU)

Key areas for improvement include:

- Sexual safety
- Collaboration with clinical mental health services, especially shared care planning
- Ongoing needs assessment
- Physical health care

Although the Chief Psychiatrist found examples of excellent care, a strong theme was that private psychiatric hostels are operated by non-clinical staff, and often with low staffing ratios. Most do not have the capacity to care for individuals with highly complex needs. The Chief Psychiatrist has also consistently found that the specialist clinical community mental health services designated to provide clinical care for private psychiatric hostel residents are not resourced to provide basic rehabilitative clinical care.

The Chief Psychiatrist has worked collaboratively with *LARU*, *Mental Health Advocacy Service*, the *Mental Health Commission* and the *NDIS Quality and Safeguards Commission* to improve oversight of private psychiatric hostels.

The Chief Psychiatrist has ensured that active remedial steps have been taken, where necessary, by both the private psychiatric hostels and clinical mental health services to improve standards of care provided to residents in private psychiatric hostels.

The mix of hostel accommodation has not changed significantly since 2019. Findings from the hostel reviews are in line with the data analysis from The Snapshot and the findings of the *Chief Psychiatrist's Review: Building rehabilitation and recovery services for people with severe, enduring mental illness and complex needs – including those with challenging behavior.* The system design for private psychiatric hostels in WA requires significant improvement to provide optimum care for the cohort they support and also those who would be able to live in the community, if care capable of meeting their needs was available.

Forensic mental health services

The Frankland Centre provides treatment and care to prisoners who are on either a hospital order (where the court has ordered an assessment of an accused person) or a custody order (where the court has deemed an accused person not fit to stand trial or of unsound mind when the alleged offence was committed) under the *Criminal Law (Mentally Impaired Accused) Act 1996;* and also to prisoners under the MHA 2014, who require admission when their mental health care cannot be managed in the prison setting.

WA continues to have the lowest number of forensic beds in the country at 1.7 per 100,000 population (except for the Northern Territory which has none). By comparison, the national average of forensic beds is 3.5 per 100,000 (AIWH 2018-2019).

Essentially, the number of specialised acute authorised forensic inpatient beds in WA has remained static since 1993 when the Frankland Centre opened.

Table 1: Public sector forensic specialised mental health hospital beds per 100,000 population, 2018–19

Mental health services in Australia: Specialised mental health care facilities

Program type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Acute	2.2	2.2	0.0	1.5	0.6	5.2	3.1	0.0	1.6
Non-acute	2.5	1.1	2.3	0.2	3.1	0.0	3.0	0.0	1.8
Subtotal	**4.7**	**3.3**	**2.3**	**1.7**	**3.6**	**5.2**	**6.1**	**0.0**	**3.5**

During this time, there has been a tripling of the prison population to 7000 and, based on national and local estimates, half of these prisoners have a mental health disorder (OICS Report 2018: Prisoner access to secure mental health treatment).

This past year has not seen any improvement in access to inpatient mental health beds for those people experiencing mental illness within the general prison system. Increasingly over the last 12 months, the majority of the Frankland Centre beds have been occupied by people on custody and hospital orders under the *Criminal Law (Mentally Impaired Accused) Act 1996*, which has severely limited any access to assessment, treatment and inpatient care for prisoners referred under the MHA 2014.

Therefore, it remains common for acutely mentally unwell prisoners to either be unable to access care in hospital or, for those that have been admitted, to be discharged prematurely back to prison to make way for those on hospital and custody orders.

During 2020-21, WA prisons had 1238 prisoners who were reported as requiring specialist inpatient mental health treatment and care. Of these, 210 prisoners were categorised as requiring intensive and/or immediate care in a specialist inpatient mental health bed and 1028 were categorised as having significant ongoing psychiatric conditions requiring treatment in a specialist inpatient or subacute mental health bed.

However, very few were in fact admitted to an inpatient unit (accurate data are not available). This has meant that some prisoners with severe acute psychiatric presentations have had to be managed in isolation cells for days or weeks at a time whilst waiting for an authorised inpatient bed. Thus, for the prisoners who wait for an acute mental health bed to become available, for the majority, that bed never becomes available.

It is acknowledged that the Department of Justice has well-advanced plans to enhance mental health services in prisons. It has opened a dedicated mental health prison wing at Bandyup Women's Prison and is planning to open a mental health prison unit at Casuarina Prison in the next couple of years. These are extremely helpful in the provision of mental health care within those prisons. However, it should be noted that these facilities are not mental health inpatient beds, they are not the equivalent of an authorised inpatient mental health unit, and will not be able to accommodate people who require involuntary inpatient care and treatment under the MHA 2014.

The Graylands Reconfiguration and Forensic Taskforce has a remit to drive planning to increase in the number of authorised forensic mental health inpatient beds- again this is an important initiative. It is noted that there will be a realistic delay of several years before new forensic mental health beds are open.

The highly anticipated Criminal Law (Mentally Impaired) Bill is due to be tabled in Parliament during this term of Government. This is a very welcome and essential step in law reform.

Other areas of significance to the sector

Aboriginal mental health

The *Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014* underpin the requirements for services to ensure patients from Aboriginal communities receive treatment and care appropriate to and consistent with their cultural beliefs and community views that are further reflected in the *Chief Psychiatrist's Standards for Clinical Care.*

The Chief Psychiatrist met with Aboriginal patients, family, staff, Wungen Kartup, community groups and Elders at different sites during 2020-21. An initial discussion was held with Associate Professor Michael Wright regarding engagement models, and subsequently the Office met with Chief Executive Mr Adrian Munro to listen to Richmond Wellbeing's steps to better cultural understanding. The Chief Psychiatrist's staff was grateful for the opportunity to yarn with Noongar Elders, Uncle Charlie and Aunty Helen Kickett.

The Chief Psychiatrist identifies that the Office is only in the preliminary phase of developing an authentic collaboration model, and there is a clearer commitment to consider and much work to be done. This will become a key issue going forward.

This Annual Report provides details of restrictive practices and notifiable incidents relating to Aboriginal peoples. The Office is aiming to improve data collection in collaboration with the Department of Health and Mental Health Commission in the 2021-22 financial year to provide a more complete picture of the state of Aboriginal people's mental health in WA.

Importantly, this Office must speak about the standards of mental treatment and care provided to Aboriginal patients, their families and communities. The Chief Psychiatrist acknowledges that Aboriginal social and emotional well-being is more complex than a western paradigm of mental health, and respects the central roles of Aboriginal Elders. The Chief Psychiatrist acknowledges the existing gaps.

The areas of notifiable incidents shown in this Annual Report show Aboriginal peoples are often over-represented. There remains a significant deficit in services consistently arranging cultural support when an Aboriginal person is being assessed- this is a statutory right. Mental health services have a responsibility to address this immediately.

Physical health

According to *Australia's mental and physical health tracker*, 29.3% of Australians living with a mental health condition have a chronic physical health condition and 30.5% of Australians living with a mental health condition have two or more chronic physical health conditions. People with mental health issues need regular assessment for emerging physical health issues as well as pro-active support to help them overcome the fragmentation of the health care system.

A medical practitioner must carry out a physical examination of a person within 12 hours of the person being received by or admitted to a mental health unit, unless the person is receiving voluntary treatment and care and refuses the physical examination (section 241 MHA 2014). Of the inpatient records reviewed by the Office of the Chief Psychiatrist within the 2020-21 financial year 80% contained a completed physical health examination but, of these, only 50% occurred within 12 hours of admission.

In the community mental health services, 33% of the records reviewed by the Office of the Chief Psychiatrist in the 2020-21 financial year contained a comprehensive physical health examination completed within the past 12 months, 60% had evidence of ongoing monitoring of a physical health issue and 61% had evidence of ongoing liaison with the consumer's general practitioner (GP).

It is the Chief Psychiatrist's position that a minimum standard for a specialist clinical community mental health service is to have a clinician or clinicians embedded or linked to the service who will proactively focus on physical health care, and that all clinicians within that service will take up the responsibility to check and facilitate access to timely screening and physical health care.

It is not the role of private psychiatric hostels to provide physical health treatment, but they have a responsibility to liaise with clinical services to facilitate clinical treatment and care of residents. During the reviews of the private psychiatric hostels, the Chief Psychiatrist's clinical reviewers collected data on indicators of physical health care provided to mental health consumers. Of the hostel records reviewed, 59% had evidence that a physical health examination had been completed in the past 12 months, 71% had evidence that the hostel was undertaking ongoing monitoring of a physical health issue and 69% had evidence of ongoing liaison with the resident's GP.

COVID-safe mental health wards

In response to the COVID-19 pandemic, authorised mental health services have been required to establish COVID-safe wards. COVID-19 poses many challenges for mental health services, and the Chief Psychiatrist was called upon to provide expert advice on safety and suitability for these wards. The Chief Psychiatrist's values and the upholding of standards of care during this time has remained a priority, such that facilities must:

- have a COVID plan to manage individuals who may be exposed to COVID, and who are COVID +
- manage infrastructure risks
- ensure staff safety
- be able to provide continuing mental health care in a COVID environment

Older adult mental health services

Good mental health and wellbeing is as important in older age as in any other stage of life. Between 10% and 40% of older adults in the community experience a mood disorder (Blackburn, Wilkins-Ho, & Wiese, 2017; Pirkis et al., 2009) that manifests in poor physical health and overall quality of life. The Western Australian Auditor General's Report[8] found that 25% of people who accessed mental health care between 2013 and 2017 were over the age of 65. In the Auditor General's view, this over-representation of older adults was in part associated with a lack of suitable aged care services with appropriate clinical support and resulted in some older adults staying in hospital for longer periods.

Mental health services for older adults have historically had a low priority in planning processes. It is critical we ensure that they remain at the forefront of mental health planning. The model of care in mental health services for older adults in WA focusses on the consumer, the value of the

8 Access to State-Managed Adult Mental Health Services – Western Australian Auditor General's Report, August 2019

family and carers and the central role of primary care. This represents a highly effective model and a beacon for other cohorts.

Specifically, in 2020-21 the Chief Psychiatrist was instrumental in facilitating enhanced inpatient medical coverage for Selby and Osborne Older Adult Mental Health Services.

Workforce

Workforce and recruitment of clinical staff, in both the inpatient and community settings, is a significant priority for standards of care in WA. There are two critical workforce challenges in the mental health sector emerging over the next two to three years: the development of new services; and retirement rates of existing staff. Also, the Chief Psychiatrist recognises the significant challenges faced by regional areas in terms of attracting and retaining staff and understands this is a major issue not just in WA but also in other states. There is an absolute shortage of trained clinical mental health staff in Australia. Therefore, retaining and building on the current staff base is critical.

The Chief Psychiatrist has identified that workforce will be a significant risk for standards of mental health treatment and care in WA in coming years.

The Chief Nursing and Midwifery Officer, the Chief Medical Officer Mental Health, the Chief Medical Officer and the Chief Allied Health Officer are undertaking specific work to look at mental health workforce issues.

Other activities of the Chief Psychiatrist

Review of the authorisation of mental health facilities

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

In the period 2020-21, the Chief Psychiatrist commenced the Review of the Authorisation of Mental Health Facilities.

The purpose of the Review is to visit authorised hospitals in WA and align services with the Chief Psychiatrist's Standards for Authorisation of Hospitals under the MHA 2014. The Chief Psychiatrist's vision is for WA to have the safest and highest quality authorised hospitals in Australia.

The Chief Psychiatrist, and representatives from the authorised hospitals, have undertaken preparatory work, and it is envisaged that the Chief Psychiatrist will visit all authorised hospitals by the end of 2022 to ensure their capacity for delivering safe, high quality mental health care.

Chief Psychiatrist's informal visits to mental health services (section 521 MHA 2014)

Although COVID-19 restrictions disrupted the Chief Psychiatrist's visit schedule, it was vitally important during this time that the Chief Psychiatrist continued to visit mental health services to ensure that staff, consumers and carers have the opportunity to raise concerns and that standards of care are discussed and remain a focus.

Visits were made to:

- Armadale Health Service (videoconference)
- Bentley Mental Health Service
- Bunbury Mental Health Service (videoconference)
- Busselton Community Mental Health Service (videoconference)
- Fiona Stanley Hospital
- Graylands Hospital
- Joondalup Community Mental Health Service
- Joondalup Hospital Mental Health Service
- Osborne Older Adult Mental Health
- Peel Community Mental Health Service
- Wheatbelt Mental Health Service
- Wungen Kartup Specialist Aboriginal Mental Health Service.

Consumer Carer Advisory Groups

The Chief Psychiatrist acknowledges the Consumer Carer Advisory Group (CCAG) members who took the time to meet in person and via videoconference during the financial year 2020-21. The purpose of these meetings was to provide the opportunity for CCAG members to raise with the Chief Psychiatrist concerns that affect mental health consumers and carers.

Some mental health services have very active CCAGs. The Chief Psychiatrist encourages all services to actively engage with consumers and carers.

When an issue is flagged, the Chief Psychiatrist formally advises the health service and works with the service to ensure the matter is addressed. Some matters involve complex system-change impacts.

Matters that have been raised by CCAG include:

- The need for youth services outside of the metropolitan area
- NDIS – difficult application process
- Continuity of care - change of clinician every few months due to workforce issues
- Lack of staff with mental health training and understanding when attending ED
- Lack of or no peer support workers in ED
- Access to physical health checks and management of physical health issues
- Active participation in the development of care and management plans
- Better discharge practices and timely discharge documentation
- Access to psychological therapies and counselling by appropriately skilled staff
- Availability of a BBQ in inpatient settings
- Replacement of exercise equipment and broken sporting items.

Chief Psychiatrist's liaison

The Chief Psychiatrist and Office staff regularly meet with a range of stakeholders, including consumers, carers, mental health clinicians, non-government service providers, service leaders, statutory office holders, interstate agencies, among many others about matters relevant to the mental health sector at both State and National level.

National activities

National Mutual Recognition of Mental Health Act Orders Project Steering Committee

The Chief Psychiatrist represented WA on this national steering committee, which was set up to facilitate the movement of patients on involuntary treatment orders across state borders.

Consultation – National Safety and Quality Community Mental Health Service Standards

The Chief Psychiatrist collaborated with the Australian Commission on Safety and Quality in Health Care regarding the development of a set of standards for community-managed organisations.

National Safety Priorities in Mental Health Workshop

The Chief Psychiatrist continued to consult on the safety priorities for mental health across Australian jurisdictions.

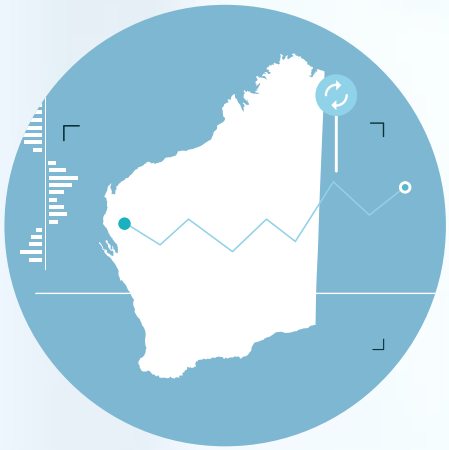
Report launch – Nowhere Else To Go: Why Australia's Health System Results In People with Mental Illness Getting 'Stuck' In Emergency Departments

The Chief Psychiatrist attended (virtually) the launch of the Australasian College of Emergency Medicine's report on why Australia's health system is failing to meet the urgent needs of people presenting to emergency departments for mental health care.

Development of the Digital Mental Health Standards

The Chief Psychiatrist participated in workshops to develop digital mental health standards across Australia.

State-based activities



Attended
the launch of the Western Australian Recovery College at the Helping Minds Head Office

Participated
in a discussion with representatives from the Ombudsman Office on the Ombudsman's expanded Child Death Review

Presented
the keynote address at the National Symposium of Miners' Mental Health

Consultation
on the Psychiatrist Workforce to the Chief Medical Officer Dr Michael Levitt

Participated
in the WA section of Intellectual and Developmental Disabilities Meeting

Attended
Minister's Staff Forum – Chief and Adolescent Mental Health Service

Attended
Graylands Reconfiguration and Forensic Steering Committee and Taskforce Update meeting

Consultation
on the proposed Eating Disorders Unit

Attended
launch of the RUAH Community Care and Protection Service

Accountability
Agencies Collaborative Forum

Consultation and advice
on the proposed Criminal Law Mentally Impaired legislation

Consultation
on the Murdoch Health and Knowledge Precinct Medihotel Project – Leanne Milligan Consulting

Participated
in the Mental Disorder and Serious Offenders Working Group – North Metropolitan Mental Health, Public Health and Dental Services (MHPHDS)

Office of the Chief Psychiatrist staff committee membership

Staff members of the Office of the Chief Psychiatrist sat on the following committees:

National

- Australian Commission on Safety and Quality in Health Care - Mental Health Reference Group
- Australian Commission on Safety and Quality in Health Care - Hospital-Acquired Complications Curation Clinical Advisory Group (ACSQHC HACs CCAG)
- 5th National Mental Health Plan Action 26 National Mutual Recognition Project Interjurisdictional Steering Committee
- National Health and Medical Research Committee - Alcohol Working Committee
- Senior Psychiatrists Peer Review Meeting
- Royal Australian & New Zealand College of Psychiatrists Education Committee
- Royal Australian & New Zealand College of Psychiatrists Committee for Examinations
- Royal Australian & New Zealand College of Psychiatrists Practice Policy and Partnership
- Royal Australian & New Zealand College of Psychiatrists Professional Practice Committee (PPC)
- Royal Australian & New Zealand College of Psychiatrists Evidence Based Medicine Committee (EBPC)
- Royal Australian & New Zealand College of Psychiatrists COVID-19 Education Steering Group

State

- Member, Clinical Senate – Department of Health Western Australia
- Co-Leadership Mental Health Safety and Quality Steering Group – Mental Health Commission
- Coronial Review Committee – Department of Health Western Australia
- Royal Commission into Institutional Responses to Child Sexual Abuse - Independent Oversight Working Group - Department of Premier and Cabinet WA
- Psychiatric Hostels Advisory Committee – Department of Health WA
- State Datix Clinical Incident Management System Committee – Department of Health WA
- Stimulants Assessment Panel – Department of Health WA
- WA Psychotropic Medication Group – Department of Health WA
- WA Psychotropic Drug Committee (WAPDC) – Department of Health WA
- WA Therapeutics Advisory Group (WATAG) – Department of Health WA
- WA Recovery Stakeholder Engagement: COVID-19 Pandemic – Mental Health; Alcohol and Other Drugs Ministerial Roundtable
- Chief Psychiatrist's Electroconvulsive Therapy Working Party
- Geraldton Health Campus Redevelopment User Schematic Design User Group
- Fremantle Hospital Redevelopment, Project Briefing and Schematic Design
- Royal Perth Mental Health Unit Design Development Group
- East St Lodge Closure Steering Group

Statutory reporting and approvals

WA has the lowest rate of seclusion and the second lowest rate of restraint across all Australian jurisdictions (in mental health units) - we are leading the way, but we work towards elimination of restrictive practice.

Use of restrictive practices (seclusion and restraint)

WA remains committed to working towards elimination of restrictive practice in mental health settings. This is a key priority for the Chief Psychiatrist.

Reporting rates of restrictive practices

The Chief Psychiatrist reports the rates of seclusion and restraint and compliance with the MHA 2014 biannually on the Chief Psychiatrist website. The data are reported separately for each mental health service with the aim of promoting openness and transparency around the use of restrictive practices by mental health services in WA. The Chief Psychiatrist expects that, in line with the state and national commitment to eliminate the use of restrictive practices in mental health services, restraint and seclusion data be made readily available by mental health services to facilitate the evaluation of reduction and elimination strategies.

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

The Chief Psychiatrist monitors the use of restraint and seclusion on an ongoing basis and seeks further details when a patient is secluded for a prolonged period or held in a prone restraint position for a prolonged period. In the 2020-21 financial year, the Chief Psychiatrist requested more information regarding a small number of restraint and seclusion events that did not fall within the Chief Psychiatrist's standards for clinical practice. The information requested included an assurance that the event had been reviewed by the service and confirmation that a management plan had been implemented to prevent the need for seclusion and restraint in the future.

Seclusion

Of the 7,255 people who accessed care and treatment in an authorised hospital in the 2020-21 financial year, 5% (354) had a seclusion event at some point during their stay.

Children and Adolescents aged less than 18 years

The Chief Psychiatrist received notification of 86 seclusion events involving 34 children and adolescents under 18 years of age during the 2020-21 financial year, over half of whom were female (62%). Of the 86 seclusion events reported, 63% were for less than 60 minutes, 29% between 60 and 120 minutes and 8% lasted more than 120 minutes. The median duration for each of these categories was 33 minutes, 88 minutes, and 177 minutes respectively.

Adults aged 18-64 years

The Chief Psychiatrist received notification of 890 seclusion events involving 317 adults 18-64 years of age during the 2020-21 financial year, the majority of whom were males (64%). Over half of all seclusion events (59%) had a duration of between 60-120 minutes, 18% were less than 60 minutes and 23% were more than 120 minutes. The median duration for each of these categories was 40 minutes, 105 minutes, and 225 minutes respectively.

Adults aged 65 years and older

The Chief Psychiatrist received notification of less than five adults 65 years of age and over being secluded during the 2019-20 financial year. Due to the small number of patients secluded, further statistics are not reported to prevent identification of individuals.

Seclusion of Aboriginal people

In the calendar year 2020, there were 185 seclusion events involving an Aboriginal person, equating to 17% of the total 1060 seclusion events reported. Of the 345 individuals who were secluded in the calendar year, 66 (19%) were Aboriginal.

Restraint

Of the 7,255 people who accessed care and treatment in an authorised hospital in the 2020-21 financial year, 6% (435)* had a restraint event at some point during their stay. Of the 999 restraints reported, 99% were comprised of physical restraints with 1% involving mechanical restraint. All mechanical restraints involved patients aged 18–64 years.

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

Children and Adolescents aged less than 18 years

During the 2020-21 financial year, there were 146 restraint events involving 53 children and adolescents under 18 years of age, three quarters of whom were females (75%). The majority (66%) of restraint events were for less than five minutes, with a median duration of two minutes. Restraint events lasting five to ten minutes comprised 23% of all events and 11% lasted more than 10 minutes.

Adults aged 18-64 years

During the 2020-21 financial year, there were 772 restraint events involving 346 adults 18-64 years of age, with a relatively even split between males (48%) and females (52%). The majority (62%) of restraint events were less than five minutes, with a median duration of two minutes. Restraint events lasting five to ten minutes comprised 25% of all events and 13% lasted more than 10 minutes.

Adults aged 65 years and older

During the 2019-20 financial year, there were 81 restraint events involving 37 adults over 64 years of age, the majority of whom were males (57%). Three-quarters (75%) of restraint events lasted less than five minutes, with a median duration of two minutes. Restraint events over 10 minutes comprised 25% of all events.

Restraint of Aboriginal people

In the calendar year 2020, there were 130 restraint events involving an Aboriginal person, equating to 12% of the total 1102 restraint events. Of the 453 individuals who were restrained in the calendar year, 59 (13%) were Aboriginal. This is a clear over-representation of Aboriginal people in restrictive practice data.

Use of prolonged prone restraint

Placing patients in the prone restraint position entails a significant risk of respiratory harm and, as such, all jurisdictions nationally and many places internationally have committed to eliminating the use of prone restraint. This is reflected in the Chief Psychiatrist's Standards for Clinical Care (2015), which direct staff and management of authorised hospitals to *"avoid the use of prone restraint where possible to minimize the risk of respiratory compromise".* Different jurisdictions use different criteria but, given that the key risk with prone restraint is respiratory arrest, prone restraint either beyond three minutes or without close physiological monitoring may increase risk of death. Deaths in other jurisdictions prompted closer examination of the use of prone restraints in WA, and closer monitoring by the Chief Psychiatrist. Of the 999 restraints that occurred in the 2020-21 financial year, 537 (54%) of those involved the use of the prone position. Of the 537 prone restraints, 70 (13%) of those involved the use of prone for more than three consecutive minutes.

Following the observation of an increase in the use of prone restraint for more than three minutes, the Chief Psychiatrist sent correspondence to service Chief Executives in 2019. As shown in Figure 7, reductions in the use of prolonged prone restraint were observed following this correspondence, but this effect does not appear to be sustained.

Figure 7: Average ratio of total restraints to restraints where prone exceeded three minutes

Use of restrictive practices across Australia

The Australian Institute for Health and Welfare (AIHW) reports the rates of restrictive practices annually for each state and territory. The Chief Psychiatrist is responsible for reporting WA seclusion and restraint data to the AIHW for inclusion in the national restrictive practices' dataset. WA is a leader in the reduction of the use of restrictive practices in Australia. Episodes per 1000 bed days is the standard measure.

Seclusion

The WA seclusion rate in the 2020-21 financial year was 4.2 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 2). The rate of seclusion in WA during this period for adults 18-64 years of age was 4.8 per 1,000 bed days, which is lower than the rate of 5.3 per 1,000 bed days in the 2019-20 financial year. The rate of seclusion for children and adolescents below 18 years of age was 9.9 per 1,000 bed days in the 2020-21 financial year. Older adult mental health services had the lowest rate of seclusion at <0.1 per 1,000 bed days and forensics had a rate of 17.9 per 1,000 bed days for adult mental health services.

Restraint

The WA restraint rate in the 2020-21 financial year was 4.3 per 1,000 bed days including child and adolescent, older adult and forensic services. The rate of restraint was 4.5 per 1,000 bed days for adults 18-64 years of age, lower than the rate of 4.8 per 1,000 bed days in the 2019-20 financial year. The rate of restraint for children and adolescents below 18 years of age was 12.5 per 1,000 bed days. Older adult mental health services had a rate of restraint of 1.6 per 1,000 bed days, and forensic mental health services had a rate of 11.9 per 1,000 bed days.

Table 2: Overall National and Western Australian Rates of Seclusion and Physical Restraint

	Seclusion per 1,000 bed days		Restraint per 1,000 beds	
	National	WA	National	WA
2017 - 18	6.9	4.3	6.3	5.1
2018 - 19	7.3	6.8	7.3	5.8
2019 - 20	8.1	5.0	11.0	4.8
2020- 21	*	4.2	*	4.3

*Not available at time of publication

Notifiable incidents

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

Public mental health services report notifiable clinical incidents to the Chief Psychiatrist through the Department of Health's Datix Clinical Incident Management System (Datix CIMS). Mental health services outside the public health system, such as NGOs and private psychiatric hostels, report using the Chief Psychiatrist's Notifiable Incident Form. The majority of notifiable incidents (79%) were reported through Datix CIMS, with the remaining 21% reported through the Chief Psychiatrist's Notifiable Incident Form. In the public mental health services, the severity of the incident is coded for all events where health care was determined to have contributed to, or caused, the incident.

The Chief Psychiatrist reviews all serious notifiable incidents and, where indicated, follows up directly with the relevant service and/or undertakes a targeted review of the incident. There were 264 serious incidents that were flagged for follow-up by the Chief Psychiatrist and 22% of these were followed-up with the mental health service. The follow-up ranged from requesting an investigation report, treatment information or mandatory information such as risk assessment and management plans.

Notifiable incidents required to be reported to the Chief Psychiatrist

- Death
- Assault and/or aggression
- Alleged sexual behaviour
- Attempted suicide
- Absent without leave (AWOL)
- Missing person
- Serious medication error
- Unreasonable use of force by a staff member

Notifiable incidents reported to the Chief Psychiatrist in the 2020-2021 financial year may contain more than one incident and, therefore, the notifications are coded as primary and secondary notifiable incident notifications.

Primary incidents

There were 3418 notifiable incidents reported for 1,598 patients, with a median of one incident reported per patient. One third of patients (34%) had two or more incidents reported. The majority of incidents involved an involuntary patient (56%), 39% involved a voluntary patient and 5% involved a person who was referred under the MHA 2014 for assessment, or had been discharged, or who was not under the MHA 2014. Over half (54%) of incidents involved a male patient.

The most frequently reported primary incident was aggressive behaviour/assault, which was the primary incident for 66% of all notifications. The second most frequently reported primary incident related to involuntary/referred patients was absent without leave (AWOL) accounting for 10% of all notifications. Incidents involving a missing high-risk voluntary patient are also reported to the Chief Psychiatrist, equating to 5% of notifications received in the 2020-21 financial year. A small proportion of notifications were related to deaths (6%), 9% to an attempted suicide, and 3% to an incident of a sexual nature, such as sexual contact, assault, harassment or an indecent act. The remaining 1% of notifiable incidents reported included serious medication errors, unreasonable use of force by a staff member, or allegations of murder/homicide.

Secondary incidents

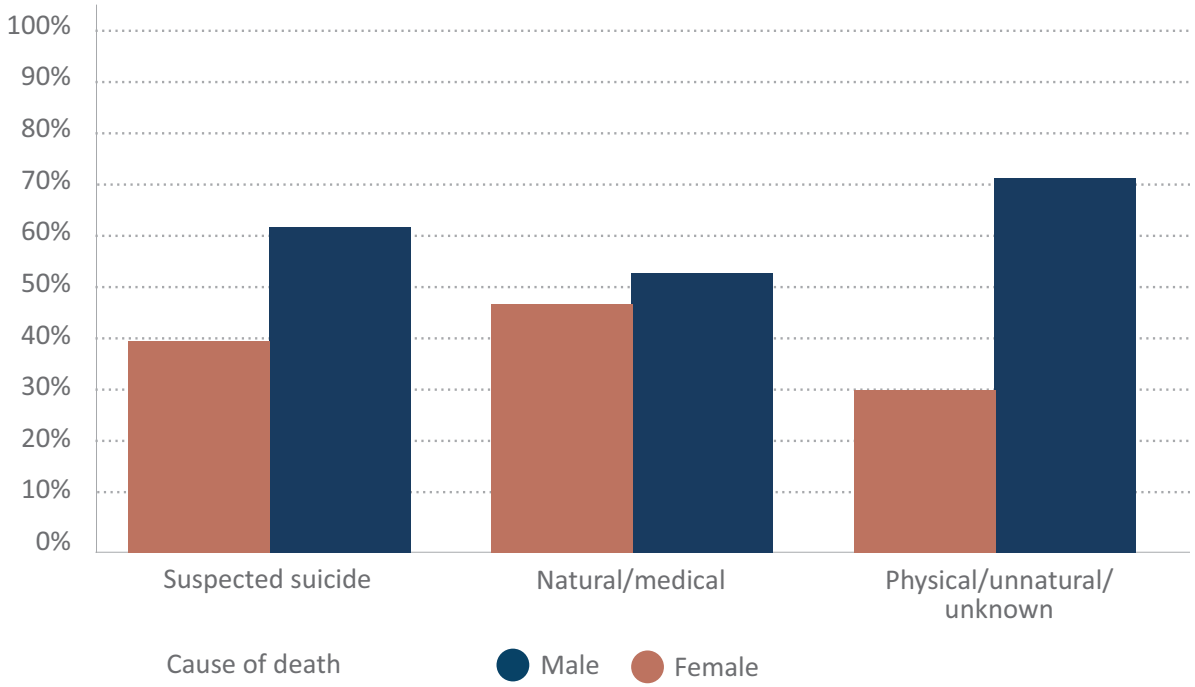
There were 99 secondary notifiable incidents reported for 87 patients. The most frequently reported incidents were aggressive behaviour/assault (44%), an incident of a sexual nature (as above) (30%) and attempted suicide (18%), with 7% comprising of a death, missing person and unreasonable use of force by a staff member.

Death

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

The Chief Psychiatrist received 213 notifications from mental health services regarding deaths of patients during the 2020-21 financial year, of which 43% were reported to be due to natural causes, 36% were suspected to be suicide, 3% were reported to be due to physical/unnatural causes and for 17% the cause was unknown at the time of reporting. A higher proportion of the deaths reported involved men (60%) than women (40%) and this was consistent across each of the causes of death (Figure 8).

Figure 8: Cause of death reported by gender



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

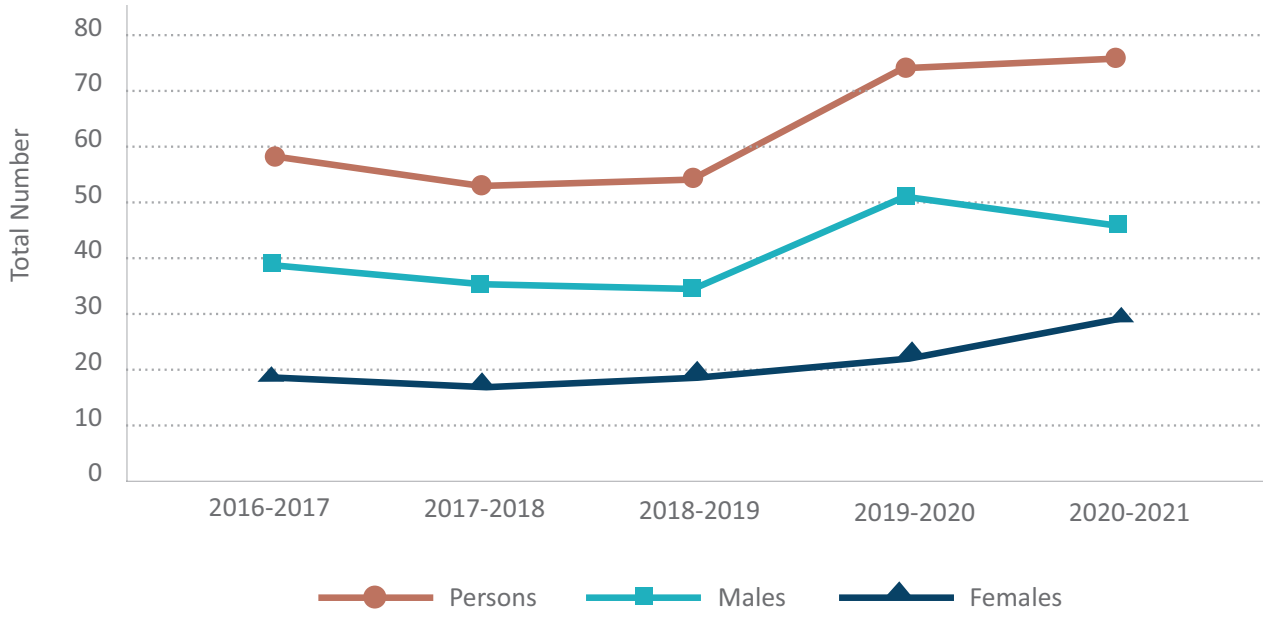
All of the deaths due to natural causes, physical/unnatural and unknown involved a person aged 18 years or older. Of the 77 notifications of suspected suicide incidents, the majority related to adults 18 years of age and older, with fewer than five involving patients less than 18 years of age.

Trends in suspected suicide

Suspected suicides comprised 35% of all deaths notified to the Chief Psychiatrist during the 2020-21 financial year. The number of deaths notified to the Chief Psychiatrist classified as a suspected suicide increased from less than 60 incidents per annum prior to 2019-20 financial year, to 75 incidents in the 2019-20 financial year and 77 incidents in the 2020-21 financial year (Figure 9).

The majority of suspected suicides involved a male with an increase from 34 males in 2018-19 to 53 males in 2019-20, decreasing slightly to 47 males in 2020-21. There has been a steady increase in notifications of suspected suicides involving a female, from 18 in the 2018-19 financial year to 30 in 2020-21. The majority of suspected suicides involved an adult aged 25-64 years (77%) and this has been constant for the last three financial years.

Figure 9: Number of suspected suicides notified to the Chief Psychiatrist



The majority of suspected suicides notified to the Chief Psychiatrist involved community mental health patients, comprising 90% or more of total notifications in the 2016-17 and 2017-18 financial years and decreasing to 78% in 2020-21. There was an increase in notifications of suspected suicides involving a patient in hospital or who had been discharged within 28 days prior to their death, from 9% in the 2016-17 financial year to 22% in the 2020-21 financial year (Figure 10).

Figure 10: Suspected suicide and patient type

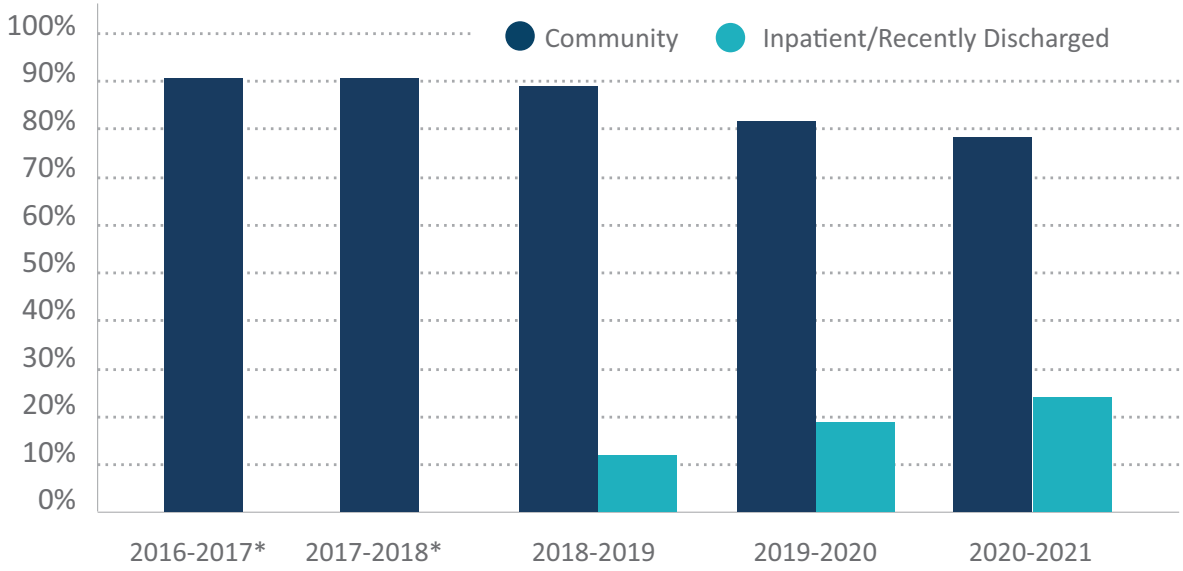


*Figure 10: In the 2016-17 and 2017-18 financial years, at least 90% or more suspected suicides were reported by community mental health services. Fewer than 5 occurred in an inpatient and/or ED setting preventing further examination of these data.

Aggression incidents

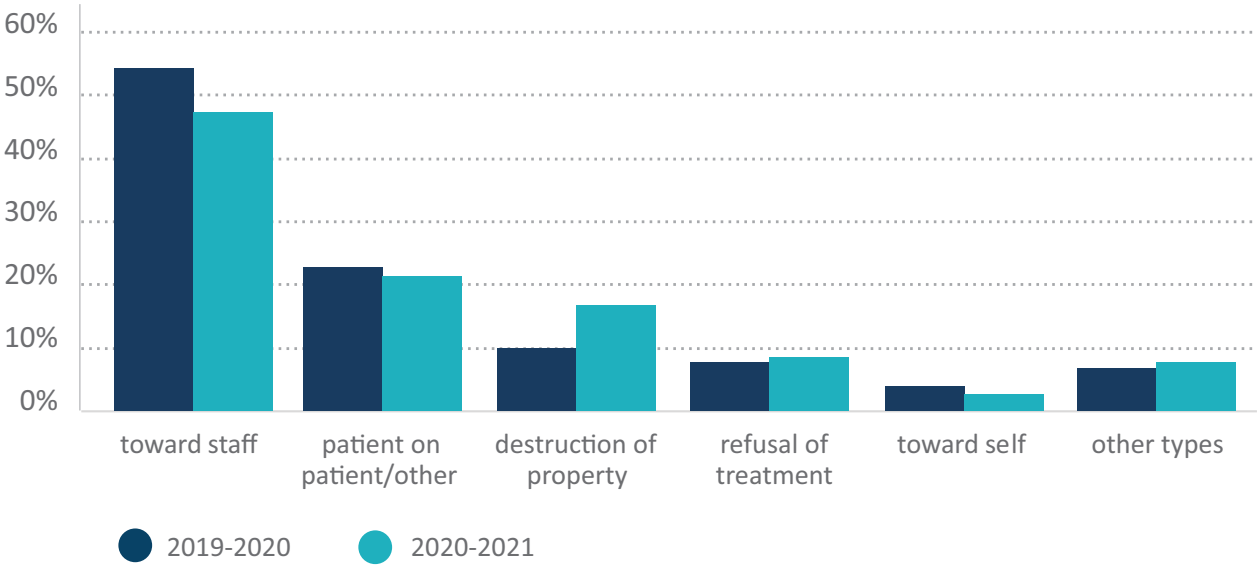
There were 2308 notifications of aggression incidents reported to the Chief Psychiatrist during the 2020-21 financial year. This was a 3% increase in aggression incidents reported compared with the previous financial year. Incidents relating to aggression may involve more than one type of aggression, such as aggression toward staff and aggression toward another patient in one incident.

Some of the 2308 aggression incidents involved more than one type of aggressive behaviour, with a total of 3083 types of aggression reported. Out of the 3083 types of aggression incidents, 47% involved a patient being aggressive towards a staff member, a decrease from the previous year of 54%. One-fifth (20%) of aggression incidents involved a patient being aggressive towards another patient or other person e.g. visitor. Other aggression types include destruction of property (16%), refusal of treatment (8%), aggression toward self (2%) and other types of aggressive behaviour (7%) (Figure 11).

A higher proportion of aggression incidents involved males (58%) compared with 42% involving females. The majority (88%) of aggression incidents involved patients age 18 years and above and the remainder 12% involved patients under 18 years.

Of all aggression incidents reported, 94% occurred at inpatient wards and 6% occurred at community clinics or in an ED. Over two-thirds (72%) of all aggression incidents involved a patient who was involuntary/referred in the inpatient wards, which is a slight increase from the 2019-20 financial year (69%).

Figure 11: Aggression behaviour type



Early in 2021, it was brought to the attention of the Chief Psychiatrist that some adult and older adult mental health services had observed an increase in aggressive behaviour toward staff. Further exploration of notifiable incidents in the past two financial years showed an increase in aggression incidents involving aggression toward staff at older adult wards (Figure 12) and some adult wards (Figure 13). Mental Health service providers (MHS1 – MHS4) have both adult and older adult wards and reported an increase in aggressive behaviour towards staff across both of these service types. Increases in these incidents were also seen for MHS5, MHS6 and MHS9 (Figure 13).

Figure 12: Proportion of aggression incidents involving aggression towards staff – Older Adult wards

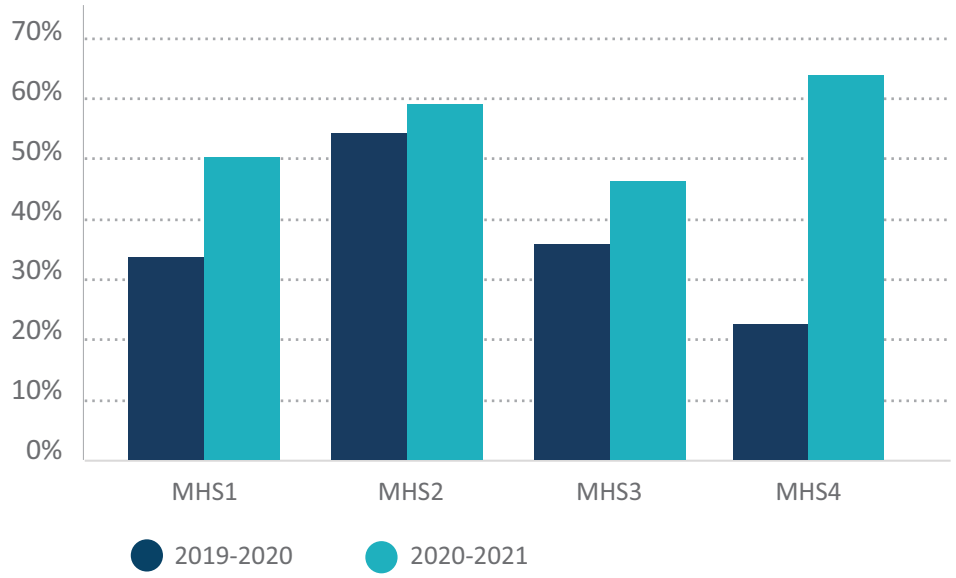
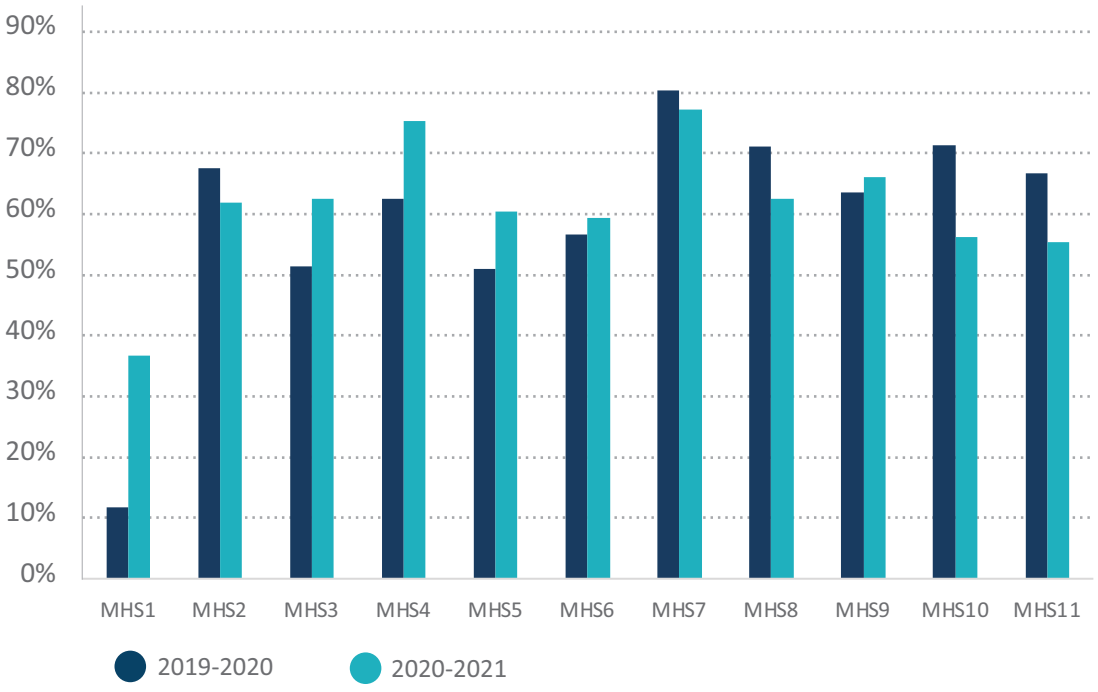


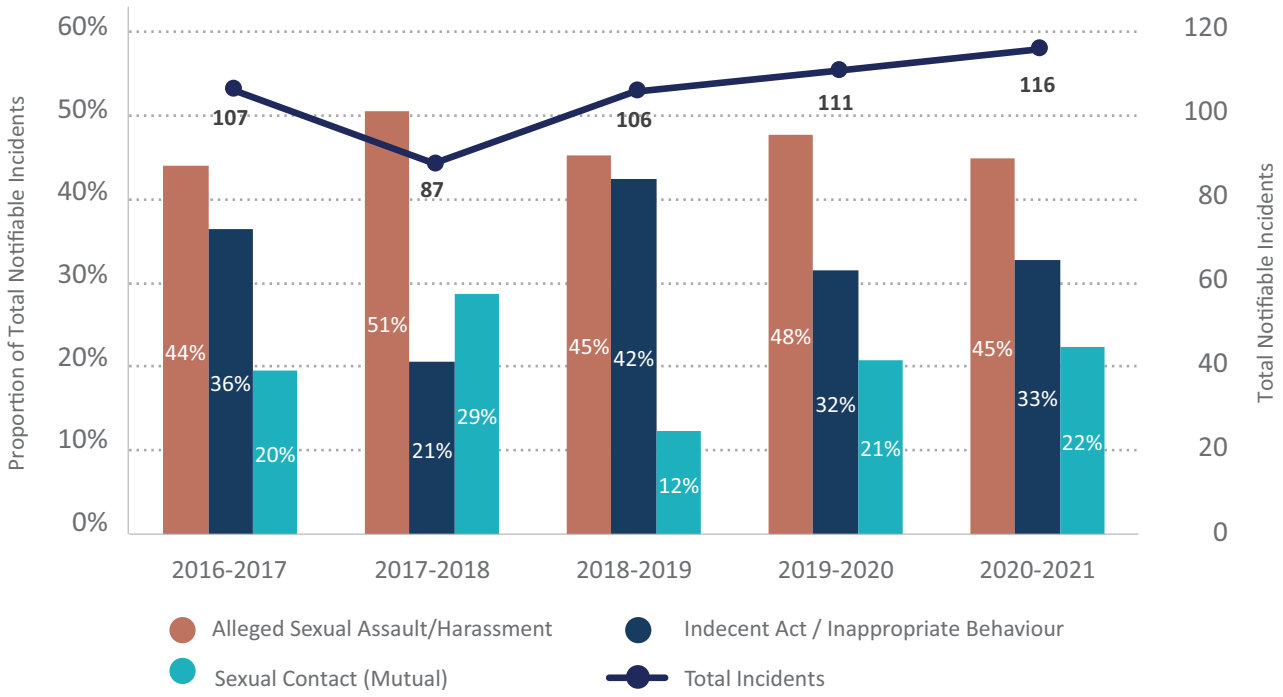
Figure 13: Proportion of aggression incidents involving aggression towards staff – Adult wards



Alleged sexual behaviour incidents

A total of 116 alleged sexual behaviour incidents were notified to the Chief Psychiatrist in the 2020–21 financial year (Figure 14), which is a slight increase from previous financial years. Of the total notifiable incidents reported for alleged sexual behaviour, 45% were alleged sexual assault/harassment, 33% were indecent act/inappropriate behaviour and 22% were sexual contact (mutual). The types of categories notified were similar across the past five years.

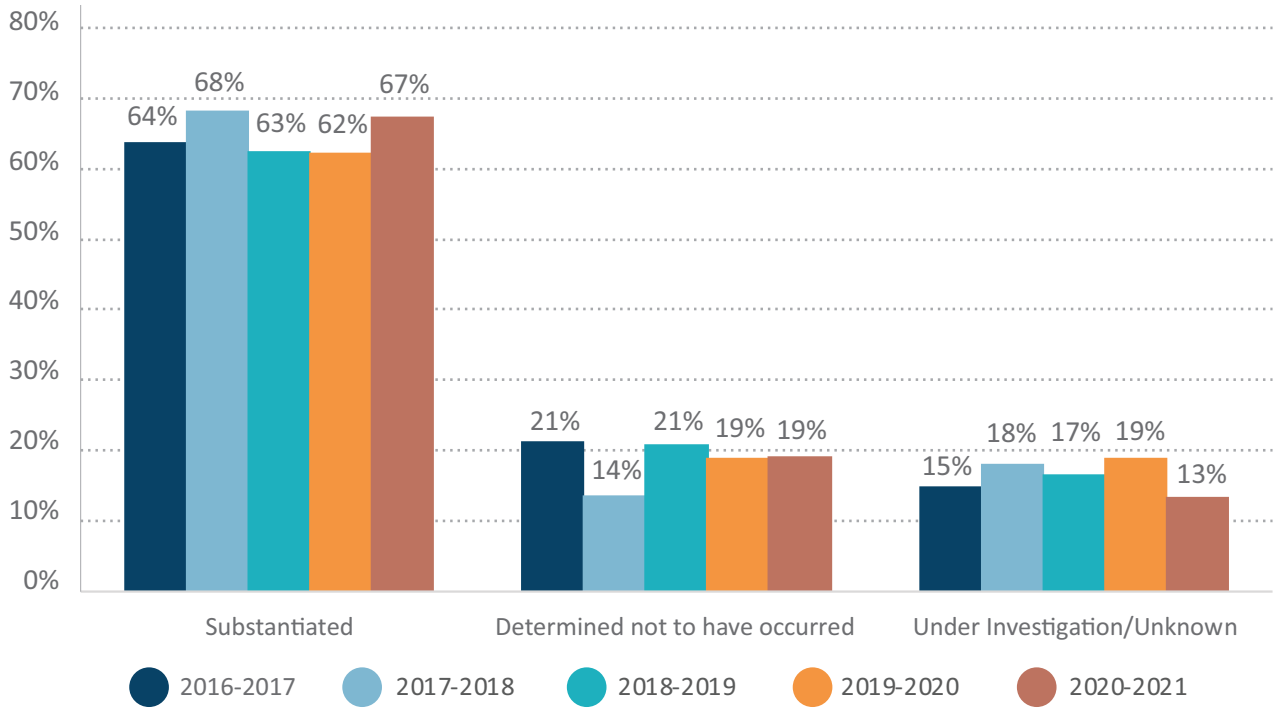
Figure 14: Types of alleged sexual behaviour and total incidents notified to the Chief Psychiatrist



The majority of alleged sexual assault/harassment incidents (91%) reported during 2020-21 occurred in an inpatient setting, with 5% of reports being received from community mental health clinics, 3% occurred in hostels, and fewer than five reports were received from an ED.

Of all allegations of sexual assault/harassment incidents that were notified to the Chief Psychiatrist in 2020-21, 67% of sexual assault allegations were substantiated, 19% were determined not to have occurred, and 13% were still under investigation/outcome unknown as of 1 July 2021 (Figure 15).

Figure 15: Investigation outcome of alleged sexual assault/harassment incidents



Attempted suicide

There were 335 notifications of attempted suicide to the Chief Psychiatrist during the 2020-21 financial year, involving 249 individuals. Of these 249 individuals, 18% had multiple suicide attempts; 12% had two attempts; and 6% had three or more attempts. Around half (53%) of notifications involved an inpatient, 36% involved a patient of a community mental health service, and 11% involved a person attending an ED. The majority of suicide attempts reported involved females (75%), with just over a third (37%) of the women aged less than 18 years (Table 3). For males, the highest proportion of attempted suicides reported occurred in males 18 years of age or older (85%).

Table 3: Notifications of attempted suicide by gender and age group

Age	Female	Male	Total
18 and Over	157	72	229
Under 18	93	13	106
Total	**250**	**85**	**335**

Source: Datix CIMS and Office of the Chief Psychiatrist Database

Attempted suicide

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

Absent without leave (AWOL) - involuntary and referred patients

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

Out of 249 patients, there were 345 notifications of an involuntary patient or a patient referred for assessment under the MHA 2014 being AWOL (Table 4). The majority of AWOL patients (76%) had one event; 16% had two events; and 8% of patients had three or more AWOL events reported. The majority of AWOL notifications (88%) involved patients who were involuntary at the time they went AWOL and 12% were patients who had been referred for assessment. Over half of AWOL patients were male (57%) and the majority (94%) of AWOL events involved patients that were 18 years of age or older.

In around half (49%) of AWOL notifications, the patients were located on the same day, 26% a day later, and 19% were located two to five days later, with the remaining 6% located between six and thirty-one days later. Almost all (97%) of AWOL patients had been located by the end of the 2020-21 financial year. The Chief Psychiatrist was notified that fewer than five patients experienced serious harm while they were AWOL. Where there are fewer than five patients involved in an incident, further details cannot be provided to prevent patient identification.

Table 4: Notifications of Absent Without Leave Involuntary and Referred Patients by Age Group and Gender

Age	Female	Male	Total
18 and Over	145	179	324
Under 18 and Unknown	12	9	21
Total	**157**	**188**	**345**

Source: Office of the Chief Psychiatrist Database and Datix CIMS

Missing persons - voluntary patients at high risk

There were 174 notifications of voluntary patients reported as missing from a mental health service, involving 140 individuals, of whom 60% were female and 40% were male (Table 5). A higher proportion of notifications involved females (59%) than males (41%) for both under 18s and those 18 years and over (Table 5). The majority of patients (84%) had one notification informing the Chief Psychiatrist that they were a missing person and 16% had between two and six events reported.

Table 5: Notifications of Missing Person by gender and patient age group

Gender	18 and over	Under 18	Total
Female	71	31	102
Male	65	7	72
Total	**136**	**38**	**174**

Source: Office of the Chief Psychiatrist Database and Datix CIMS

Serious medication error

During the reporting period, there were fewer than five serious medication errors with major adverse effects reported to the Chief Psychiatrist. Each of these incidents were raised with the Chief Psychiatrist. Given broader literature, it is likely this is underreported.

Missing persons - voluntary patients at high risk

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

Serious medication error

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

Allegations of unreasonable use of force by staff

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

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

Allegations of unreasonable use of force by staff

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

Homicides

The Chief Psychiatrist commenced collecting data on homicides allegedly committed by a mental health patient in the 2020-21 financial year. Less than five notifications of homicide allegedly committed by a person who was a mental health patient were received during the 2020-21 financial year. There was no apparent increasing trend from the year prior.

Aboriginal mental health consumers

Data on Aboriginality are not reliably reported through the notifiable incident reporting system. To ensure accurate ascertainment of Aboriginal status, the Information and System Performance Directorate in the Department of Health linked the Chief Psychiatrist's data with their comprehensive data on Aboriginal status. Therefore, the following section is based on the 2020 calendar year. It is important to note the over-representation of Aboriginal consumers in these figures, raising questions about culturally-safe models of care.

Primary incidents

Out of the 3444 primary notifiable incidents reported for 1632 patients during the 2020 calendar year, 557 (16%) incidents were reported for 259 (16%) Aboriginal patients. Over half (57%) of the notifications involved a male Aboriginal patient and 91% of notifications involved adults 18 years and over. Of the 557 primary incidents involving an Aboriginal consumer the type of incident reported included:

- Aggressive behaviour/assault, 64% of notifications.
- Absent without leave, involuntary/referred patients, 18% of notifications.
- Missing, high-risk voluntary patients, 7% of notifications.
- Deaths, 5% of notifications.
- Attempted suicides, 4% of all notifications.
- The remaining incidents were too few to report separately.

Secondary incidents

There were 75 secondary notifiable incidents reported for 65 patients for the 2020 calendar year. Of the 75 notifications, 12 notifications (16%) were reported for 11 Aboriginal patients (17%). The most frequently reported secondary incidents were aggressive behaviour/assault (58%); incidents of a sexual nature (25%); attempted suicide (8%); and 8% were notifications of unreasonable use of force by a staff member.

Death

The Chief Psychiatrist received 247 notifications in the 2020 calendar year advising of the death of a mental health patient. Of the 247 death notifications, 28 (11%) related to an Aboriginal patient of which 9% were due to natural/medical causes, 16% due to physical unnatural/unknown causes, and 13% were suspected suicides (Table 6). Out of the 28 deaths, a third (36%) were due to natural/medical causes, 36% were for a suspected suicide and 29% were due to unknown or physical/unnatural causes. All the suspected suicides involving an Aboriginal patient related to adults aged 18 years or older.

Table 6: Notifications of deaths, by cause and Aboriginal status

Cause of Death	All Deaths N	Aboriginal Deaths N (%)*
Natural/medical	116	10 (9%)
Physical unnatural/Unknown	51	8 (16%)
Suspected suicide	80	10 (13%)
Total	**247**	**28 (11%)**

*Proportion of deaths notified involving Aboriginal patients compared with deaths of all patients in the 2020 calendar year.

Aggression incidents

There were 2270 notifications of incidents relating to aggression, involving 937 patients. Of these, 363 (16%) were reported for 144 (15%) Aboriginal mental health patients. Incidents relating to aggression may involve more than one type of aggression. For the 363 incidents involving an Aboriginal patient, there were 464 types of aggression reported. Of the 464 types, 37% involved aggression towards staff, 15% involved assaults on staff, 13% involved aggression towards other patients, 10% involved assault of another patients, 6% involved aggression towards property, and 5% involved destruction of property. The low numbers of the remaining 14% of aggressive types prevents further information being provided.

Alleged sexual behaviour incidents

There were 95 notifications of incidents of a sexual nature reported for 85 mental health patients. Out of the 95 notifications, 10 (11%) were reported for 10 (12%) Aboriginal patients, of which all were 18 years of age or older and 50% were males and 50% females.

Attempted suicide

The Chief Psychiatrist was notified of 325 attempted suicides involving 244 individuals and, of these, 23 (7%) incidents involved 18 (7%) Aboriginal mental health patients. The majority (72%) of Aboriginal patients were 18 years of age or older, and 61% of the attempted suicides involved a female.

Absent without leave (AWOL) - involuntary and referred patients

There were 373 AWOL notifications of an involuntary patient or a patient referred for assessment under the MHA 2014, relating to 258 patients. Out of the 373 notifications, 98 (26%) involved 66 (26%) Aboriginal patients, of which 55% were female and 45% male.

Missing persons - voluntary patients at high risk

There were 185 notifications of 152 voluntary patients reported as missing from a mental health service, with 41 (22%) notifications involving 34 (22%) Aboriginal patients. The majority (68%) of missing Aboriginal patients were female.

Serious medication error and Allegations of unreasonable use of force by staff

During the reported period, there were fewer than five incidents reported for serious medication errors with major adverse effects and allegations of unreasonable use of force on a patient by a staff member. The small number of incidents prevents publication of any further details of these events.

Table 7: Notifiable Incidents reported to the Chief Psychiatrist during the 2020 Calendar year, by Aboriginal status

Type of Incident	All Notifications N	Aboriginal %	All Individuals N	Aboriginal %
Aggression	2270	16	937	15
Attempted Suicide	325	7	244	7
Sexual Behaviour	95	11	85	12
AWOL	373	26	258	26
Missing Person	185	22	152	22

Statutory reporting in 2021-22

The Chief Psychiatrist will implement improved monitoring processes for the reporting of seclusion, restraints and notifiable incidents over the 2021-22 FY. These processes will involve:

- cross validating reports of restraint and seclusion with the reporting of aggression via notifiable incidents.
- expanded monitoring of medication errors and near misses that required any medical intervention or GP review regardless of patient outcome and to follow up with services regarding what strategies to prevent any possible future medication errors have been implemented.
- strengthening the notifiable incident review process for identifying incidents and/or trends requiring further investigation by the Chief Psychiatrist and expanding the feedback process advising mental health services about trends in notifications to the Chief Psychiatrist, service safety and quality performance, and other relevant issues.
- trialling and implementing the new electronic forms for the reporting of restraint and seclusion events.

Electroconvulsive therapy

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

The Chief Psychiatrist approved emergency ECT on 11 occasions during the 2020-21 financial year. These included three at private hospitals, two at publicly contracted private hospitals, and six at public hospitals. The Chief Psychiatrist maintains a register of health services that have been approved as meeting the standards to perform ECT. They are:

Private hospitals

- Hollywood Clinic
- The Marian Centre
- Perth Clinic

Publicly contracted private hospitals

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

Public hospitals

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

Electroconvulsive therapy

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

All approved suites will be reviewed in the 2021-22 financial year to ensure compliance with the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy* (2015). The Review of ECT services will coincide with formal visits to authorised hospitals for the purpose of reviewing of their authorisation.

Mandatory reporting of ECT data to the Chief Psychiatrist

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

For the reporting period 2020–21, there were 783 completed ECT courses involving adults 18 years and above reported to the Chief Psychiatrist, compared with 650 courses in the 2019-20 financial year (Table 8). There were no courses reported for patients under 18 years of age. Of the 783 courses, 720 (92%) were for patients with a voluntary status, 51 (6.5%) were for involuntary or referred status, and 12 (1.5%) were for mixed status (both voluntary and involuntary).

There were 8109 ECT treatments completed in the 2020-21 financial year, of which 6971 (86%) were acute treatments, 1109 (14%) were maintenance treatments and 37 (2%) consisted of emergency treatments (Table 8).

In the 2020-21 financial year, there were 40 emergency ECT treatments authorised by the Chief Psychiatrist or his delegate. Because some of these emergency ECT treatments were part of an ongoing course of ECT, that was not completed in the 2020-21 reporting period, they are not reflected in Table 8. These emergency ECT treatments will be reported in the financial year in which the ECT course is completed. The number of emergency ECT treatments given in ECT courses that were completed during 2020-21 are shown in Table 8. These include some emergency ECT treatments authorised in the previous financial year.

Table 8: ECT courses and treatments completed in the 2020-21 financial year.

Age	Status	Number of ETC Courses Completed in 2020-21	ECT Treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
Patients over 18	Voluntary	720	6303	1039	0	7338
	Involuntary / Referred[a]	51	534	16	29	575
	Mixed[b]	12	134	54	8	196
	Total	**783**	**6971**	**1109**	**37**	**8109**

Table 8: ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2020 – 30 June 2021).
Note: [a]Mentally Impaired Accused are included in this category; [b]Patients who had both an involuntary and a voluntary status in the same course.
Source: Office of the Chief Psychiatrist Database

The majority of all ECT courses (66%) were provided in a private hospital, 25% were provided in a public hospital and 9% were provided in a publicly contracted private hospital.

Serious adverse events

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

The majority (87%) of the 783 ECT courses of ECT reported during 2020-21 did not have any serious adverse events reported. An adverse event during one or more treatments was reported for 13% (n=103) of these courses.

Review of Chief Psychiatrist's ECT Guidelines

The Chief Psychiatrist continues to review and update the current ECT Guidelines. A revised draft of the Guidelines is currently being developed.

ECT at a national level

The Clinical Alliance and Research in ECT (CARE) Network, coordinated by the University of NSW, is a national collaboration of hospitals that administer ECT. The CARE Network was established to collect a common clinical dataset, to enable data to be pooled for research, with the aim of identifying the safest and most effective approaches to ECT. The network is providing new knowledge of the benefits and risks of ECT and is identifying areas for improving ECT clinical practice, which it is hoped will further improve patient outcomes.

Approving involuntary treatment orders within a general hospital

Under section 61(2)(b) of the MHA 2014, the Chief Psychiatrist (or delegate) must provide consent for a patient to be detained on an involuntary treatment order in a general hospital setting. The treating psychiatrist must report to the Chief Psychiatrist at the end of each consecutive 7-day period for the duration of the order.

The Chief Psychiatrist authorised 176 involuntary treatment orders in a general hospital setting during the 2020-21 financial year.

Of the 176 patients, 43% (76) were in general hospital for seven days or less, 26% (45) were in general hospital for between 8 to 14 days and 31% (55) were in a general hospital for more than 14 days. A small number of patients (18) were admitted to a general hospital on more than one occasion.

If a patient stays more than seven days in a general hospital, the mental health clinicians must submit a report to the Chief Psychiatrist using the 6B attachment form. For orders that were valid for more than seven days, the Chief Psychiatrist received 47% of the required approved 6B attachment forms. When these are overdue, Chief Psychiatrist staff follow-up with the mental health clinicians with the aim of ensuring compliance with reporting under the Act.

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

Emergency psychiatric treatment

Under section 204 of the MHA 2014, the medical practitioner who provided emergency psychiatric treatment (EPT) must give the Chief Psychiatrist a copy of the record of the EPT provided. EPT does not include the use of ECT, psychosurgery or prohibited treatments, including deep-sleep therapy, insulin coma therapy and insulin sub-coma therapy. A medical practitioner may provide a person with EPT without informed consent.

There were 160 cases of EPT reported to the Chief Psychiatrist, of which 62% were female and 38% male patients. The majority of notifications were from metropolitan hospitals (82%), with 18% from the WA Country Health Services. Of the patients who received EPT, 45% were adults aged between 25 and 64 years, 4% were 65 years or older 22% were 18-24 years and 28% were under 18 years of age. The types of EPT provided to the patients included medication alone (27%) or medication in conjunction with the patient being secluded and/or restrained (73%). Compared with the 2019-20 financial year, more EPT involving seclusion and restraint was reported this financial year. The method of administration of EPT was also reported; 66% of EPT was administered via intra-muscular injection, 15% was administered orally and the other

methods reported were sublingual, intravenous, other or not specified (19%). The most commonly reported medications were Midazolam (30%), Droperidol (22%), Clonazepam (14%), Lorazepam (11%), Olanzapine (9%) and Haloperidol (8%), which together account for 94% of all administered medications.

Urgent non-psychiatric treatment

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

Off-label treatment provided to a child who is an involuntary mental health patient

Under section 304 of the MHA 2014, off-label treatment pertains to the provision of registered therapeutic goods to a child who is an involuntary patient for purposes other than those included in the approved product information. In the public mental health service sector, off-label treatments are rarely used. The use of off-label treatments for a child who is an involuntary patient must be reported to the Chief Psychiatrist, including the type of off-label treatments provided and the reason for the decision. For the reporting period, there were eight notifications of children who were involuntary patients receiving off-label treatments, which is less than the number of notifications received in the previous financial year. Most notifications (63%) were from mental health services in the metropolitan area. The average (mean) age of involuntary children provided with an off-label treatment was 15 years of age.

Admission of a child to an adult inpatient mental health unit

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

- the service is able to provide the child with treatment, care and support that is appropriate having regard to the child's age, maturity, gender, culture and spiritual 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 MHA 2014, the person in charge of the mental health service must report to the Chief Psychiatrist why he/she is satisfied that the above criteria have been satisfied. Since the MHA 2014 came into effect in 2015, a range of new mental services has been developed, including inpatient services catering specifically for youth (children and young people aged 16 to 24 years), as well as the development of Mental Health Observation Areas, which may admit children under 18 years of age.

The Chief Psychiatrist received 363 notifications of a child under 18 years of age being admitted to an adult mental health service in the 2020-21 financial year compared with 107 notifications

in the 2019-20 financial year. The increase is due to legal advice stating that youth mental health services that admit an age cohort of 16 – 24 year-olds fall into this category for the purposes of Section.303 notifications to the Chief Psychiatrist. The trends in these notifications will continue to be monitored by the Chief Psychiatrist, who will continue to work with mental health services to ensure compliance with Section.303 of the MHA 2014 and the safety of children and youth admitted to adult mental health services.

Of the 363 notifications received, 259 (71%) of these were for females, and 103 (28%) were for males.

Prescribing psychiatrists - who can act under the MHA 2014

There are two aspects to acting as a psychiatrist under the MHA 2014:

1) training and
2) definition of a psychiatrist under section 4 of the MHA 2014.

For the reporting period, the Chief Psychiatrist did not receive any applications for a psychiatrist to be prescribed as a medical practitioner who holds specialist or limited registration by regulation 4 of the *Mental Health Regulations 2015.*

Further opinions

Further opinions continue to be a burden on services in terms of the availability of psychiatrists across most services, particularly in regional areas. This is not only frustrating for patients, but also for family members who are seeking the further opinion on behalf of the patient.

A request for a further opinion is not cost-neutral for services. For those seeking an assessment for a further opinion outside of the treating service, psychiatrists must allocate time, factoring in the time for travel, assessing medical records and collating information and on completion of the assessment, writing the report.

The Chief Psychiatrist continually works with services to find workable solutions to facilitate timely further opinions.

In 2020-21, the Chief Psychiatrist received 11 requests for a further opinion. As reported in the previous Annual Report, completion rates for further opinions are relatively low with requests being withdrawn, patients becoming voluntary and requestors seeking a further opinion from a private psychiatrist.

Of the 10 requests:

- 5 were completed
- 6 did not progress

MHA 2014 status at the time of request:

- 4 on a community treatment order
- 7 involuntary

Glossary of terms used

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

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