GOVERNMENT OF
WESTERN AUSTRALIA

Chief Psychiatrist
of Western Australia

ENSURING SAFE
AND HIGH-QUALITY
MENTAL HEALTH CARE

Annual Report of the Chief Psychiatrist of Western Australia

1 JULY 2023 – 30 JUNE 2024

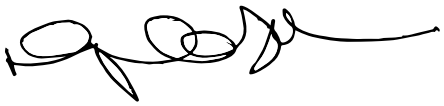
Produced by the Office of the Chief Psychiatrist, Western Australia

Statement of compliance

Hon Amber-Jade Sanderson MLA

Minister for Health; Mental Health

In accordance with sections 533 and 534 of the *Mental Health Act 2014*, I hereby submit for your information and presentation to Parliament the Annual Report of the Chief Psychiatrist of Western Australia for the financial year ended 30 June 2024.



Dr Nathan Gibson
Chief Psychiatrist
18 September 2024

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 2024 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.

Byron Savage
Finance Officer
Mental Health Commission
18 September 2024

**The Office of the Chief Psychiatrist is an affiliated body of the Mental Health Commission funded by a separate administered appropriation. Under the Treasurer's Instruction 951(5) Related and Affiliated Bodies, the MHC is required to disclose in its annual financial statements the nature, and where practicable, the amount or value of financial assistance provided to the OCP during the financial year.*

Disclosures and legal compliance

Record keeping

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

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

Board and committee remuneration

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

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

Legal and Government policy requirements and financial disclosures

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

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

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

Conflicts of interest

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

Compliance with Public Sector Standards and Ethical Codes

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

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

Occupational safety, health and injury management

For the reporting period, the Office of the Chief Psychiatrist was compliant with the *Work Health and Safety Act 2020*. All new staff to the Office were provided with a comprehensive induction and orientation and one member of staff was the nominated Work Health and Safety Representative.

Acknowledgement of Country

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

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

Acknowledgement of lived experience

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

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

CONTENTS

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Steady

From the Chief Psychiatrist

Kaya.

The Chief Psychiatrist's Annual Report is a statutory requirement. It remains an important point of feedback about standards of care in mental health services for Western Australians. Given the numbers of Western Australians who use mental health services, the Chief Psychiatrist's role is an important part of the government's commitment to provide quality, evidence-based care.

The Chief Psychiatrist does not oversee all mental health care across WA but has a role under the *Mental Health Act 2014* to monitor treatment and care in public sector mental health services, licensed private psychiatric hostels and private psychiatric hospitals.

The vast majority of public sector specialist clinical mental health care happens in the community. Hospital care is critically important, but the development of strong community care pathways for clinical care and psychosocial care remains the cornerstone of public sector mental health services.

Across 2023-24 in WA, there have been important steps in the development of forensic mental health services, clinical rehabilitation services, eating disorders and child and adolescent mental health services. This work must continue as priorities, as the development work will require time to show significant benefits for WA.

All aspects of mental health care are important. As Chief Psychiatrist, I have an intensified focus on a number of areas which currently need close attention: Aboriginal mental health care, working towards the elimination of restrictive practice, sexual safety and neurodevelopmental issues.

Social and emotional wellbeing is a paradigm which works better for Aboriginal peoples when used together with existing services, rather than having a Western mainstream mental health service model alone. Over two years now, my staff and I have been working with esteemed Noongar Elders and young people. Our *Kaatadjiny Walbraaniny Danjoo (Learning to Heal Together)* Project has seen us learning and engaging in better, relational ways. We are committed to this changed way of working. Over time, together, we will bring better care for Aboriginal Peoples.

Working towards getting rid of restrictive practices such as seclusion and restraint in mental health services remains critically important across Australia, as much as in WA. WA inpatient mental health services, and particularly staff, have done an incredible job to reduce the use of restrictive practice. For several years now, WA has led the country in having the lowest (at times second lowest) seclusion and restraint rates. What does this mean? It means less trauma for patients, families and staff. It means better care. But our rate reductions have slowed - we have work

to do. Mental health services remain committed to this, and we also look to the future work needed to reduce restrictive practice outside of mental health services, in places such as emergency departments.

Every person needs to be sexually safe. Every family who has a loved one in a mental health service expects them to be safe from unwanted sexual behaviour. The Chief Psychiatrist's Sexual Safety Guidelines were released in 2020. The *Chief Psychiatrist's Standard: Sexual Safety of Consumers of Mental Health Services* has now been developed and will be released in July 2024. Mental health services in WA will be required to comply with this statutory standard. Reported rates of alleged sexual harassment and assault have not yet reduced in WA inpatient mental health services – these services now have an opportunity to take the next steps to improve the sexual safety of consumers.

People with intellectual disability, autism and other neurodevelopmental disorders who may have associated significant mental illness, at times have had a difficulty getting access to appropriate mental health care in WA. Given this group's disproportionately high usage of public sector mental health services, the next state mental health plan must consider how mental health services can best meet the needs of this sometimes-underserviced cohort.

Complex, co-occurring care, with continuity, is the primary remit of public sector specialist clinical mental health services. Our responsibility is to ensure that access to quality mental health care is enhanced for Western Australians.

I'm extremely grateful to the high-quality colleagues at the Office of the Chief Psychiatrist whose expertise, dedication and insight are essential to this important work.

My sincere hope is that the information in this Annual Report is useful for the mental health sector.

Dr Nathan Gibson
Chief Psychiatrist of Western Australia

Executive summary

Executive summary

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

It is not possible to review the 2023-24 year without considering the broader mental health sector, of which the Office of the Chief Psychiatrist is an important part. The year has clearly been a challenging one for the sector, with the issue of workforce continuing to significantly impact service delivery across the state, as it is also impacting services across the country. We note and applaud all efforts, at individual, service, government and professional levels, to find solutions and attract staff into our mental health system, and as an office have contributed to these initiatives wherever possible.

The OCP's Prescribed Medical Practitioner (PMP) Program, which allows selected medical practitioners to work to the top of their scope in relation to the *Mental Health Act 2014* (MHA 2014), continues to thrive and grow, with 24 PMPs now added to the *Mental Health Regulations 2015*, and attending supervision sessions run by OCP staff. In addition, we have oversight of 665 Authorised Mental Health Practitioners (AMHPs) in WA, and our staff manage applications and ongoing professional development throughout the year. Overall, the OCP Statutory Educator delivered 116 training sessions to a total of 1,426 clinicians from the mental health sector.

This training forms part of the OCP's commitment to compliance with the MHA 2014, another major focus this year. This year, the Chief Psychiatrist led the development of a sector-wide Mental Health Act Compliance Action Plan and continues to monitor its implementation. In addition, the OCP developed and published a series of Frequently Asked Questions to support clinicians in their interpretation of the MHA 2014, as well as an updated version of the Clinicians' Practice Guide to the MHA 2014. These measures were supported by the OCP Clinical Helpdesk, which provided MHA 2014 support and advice to clinicians throughout the year.

The Chief Psychiatrist publishes statutory Standards and Guidelines, which provide expectations of standards of care. This year the OCP carried out work to build on the existing Chief Psychiatrist's Sexual Safety Guidelines, published in 2020, by developing a Standard for Sexual Safety in mental health services, which services will need to follow when providing care. Following consultation, it is expected that this Standard will be published in July 2024.

The Chief Psychiatrist is committed to the minimisation, and ultimately elimination, of restrictive practices as part of a national and international drive to improve mental health care.

Where there is a high risk of a person coming to harm, and the use of restrictive practices is considered, it is crucial that this occurs correctly and lawfully, and only when there is no alternative to manage the situation. This year, the OCP developed the training content for the lawful use of restrictive practices in non-authorised settings (such as emergency departments) and provided this to the Department of Health to support training for health service staff across the state. We also published the Chief Psychiatrist's Guideline on the Use of Detention and Restraint in Non-Authorised Healthcare Settings, which has been well received by the sector, supported by our ongoing clinical engagement and training functions.

During the 2023-24 reporting period, we continued to prioritise Kaatadjiny Walbraaniny Danjoo – Learning to Heal Together, our journey towards meaningful embedding of Aboriginal wisdom and ways of working into the operations of the OCP. The end of the 2023-24 reporting period marks the end of the OCP's formal collaboration with Curtin University in this work, and a new phase where we work alongside Aboriginal Elders and young people to make change.

Another milestone reached this year was the completion of a program to review all the private psychiatric hostels in the state, who provide accommodation and support to over 550 residents. The OCP has summarised the themes and findings from the program, and looks forward to working closely with the Mental Health Commission, the Department of Health and other agencies to monitor standards of care for hostel residents.

Despite the current workforce pressures, it is important to recognise the unswerving efforts of people working at every level across the sector to maintain and improve the services they provide. The OCP has continued to visit services, and to provide opportunities for clinicians, consumers, Aboriginal Mental Health Workers and other experts to share their innovations, knowledge and best practice through our facilitation of the Chief Psychiatrist's Community of Practice, a well-attended, regular forum run by this office. During the 2023-24 reporting period we were pleased to see attendance increase by 30%, and will continue to build on this opportunity to bring diverse perspectives together with the shared aim of improving care through collaboration.

In addition to these highlighted pieces of work, the OCP continues to carry out a wide range of core functions, guided by the statutory requirements of the MHA 2014, our vision of mental health care to the highest standard for the people of WA, and our values of leadership, integrity, respect, accountability and commitment. This work involves engagement with a wide range of stakeholders across the lived experience, statutory, community and service delivery sectors. In 2023-24 we have visited services, monitored authorised units for safety and compliance with *The Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014*, provided education and training, reviewed and investigated clinical incidents occurring in mental health services, worked with services to manage complex clinical scenarios and ensure effective pathways for individual consumers, responded to clinical queries, provided expert advice, and continued to develop our internal corporate and operational structures to maximise our reach and effectiveness.

Key achievements

Monitored treatment and care of over 63,000 consumers in a range of mental health services across WA.

Assisted with 452 clinical enquiries through the Clinical Helpdesk.

Deepened our relationships with Aboriginal Elders, young people and the Aboriginal community through Kaatadjiny Walbraaniny Danjoo.

Welcomed 11 new Prescribed Medical Practitioners and trained 51 new Authorised Mental Health Practitioners (AMHPs).

Completed consultation and development on a standard for the sexual safety of mental health consumers.

Facilitated seven clinical knowledge-sharing sessions with over 900 clinicians through the Chief Psychiatrist's Community of Practice.

Continued our advocacy for a reduction in restrictive practice through new guidelines, training and partnerships.

Visited 19 mental health facilities across WA to ensure safe and high quality care.

Who we are

The Chief Psychiatrist upholds the standards of mental health treatment and care in Western Australia.

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

Our vision

Mental health care to the highest standard.

Our mission

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

Our purpose

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

Our scope

- Setting standards
- Collaborating, investigating, advocating and intervening across the mental health sector
- Providing advice and publishing guidelines
- Educating and credentialling
- Identifying gaps and improvement opportunities through data collection, analysis, service and incident review.

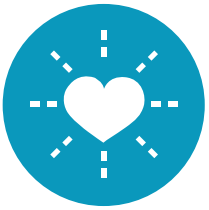
Our strategic objectives

- Support and promote contemporary practice and innovation
- Identify, respond to and advocate for priority issues
- Foster productive relationships
- Continue to build a strong and sustainable Office.

Our values

LEADERSHIP

INTEGRITY



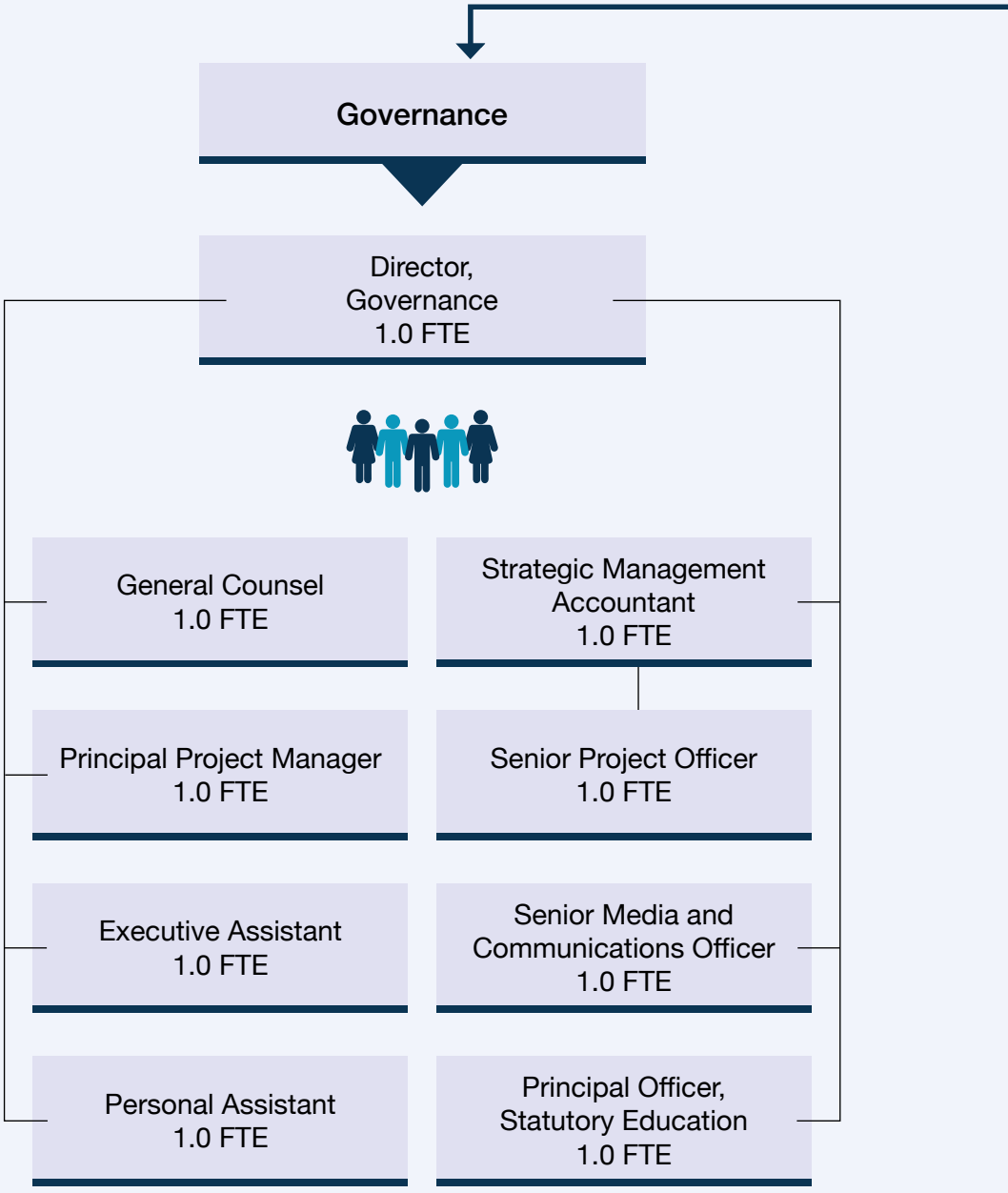
RESPECT

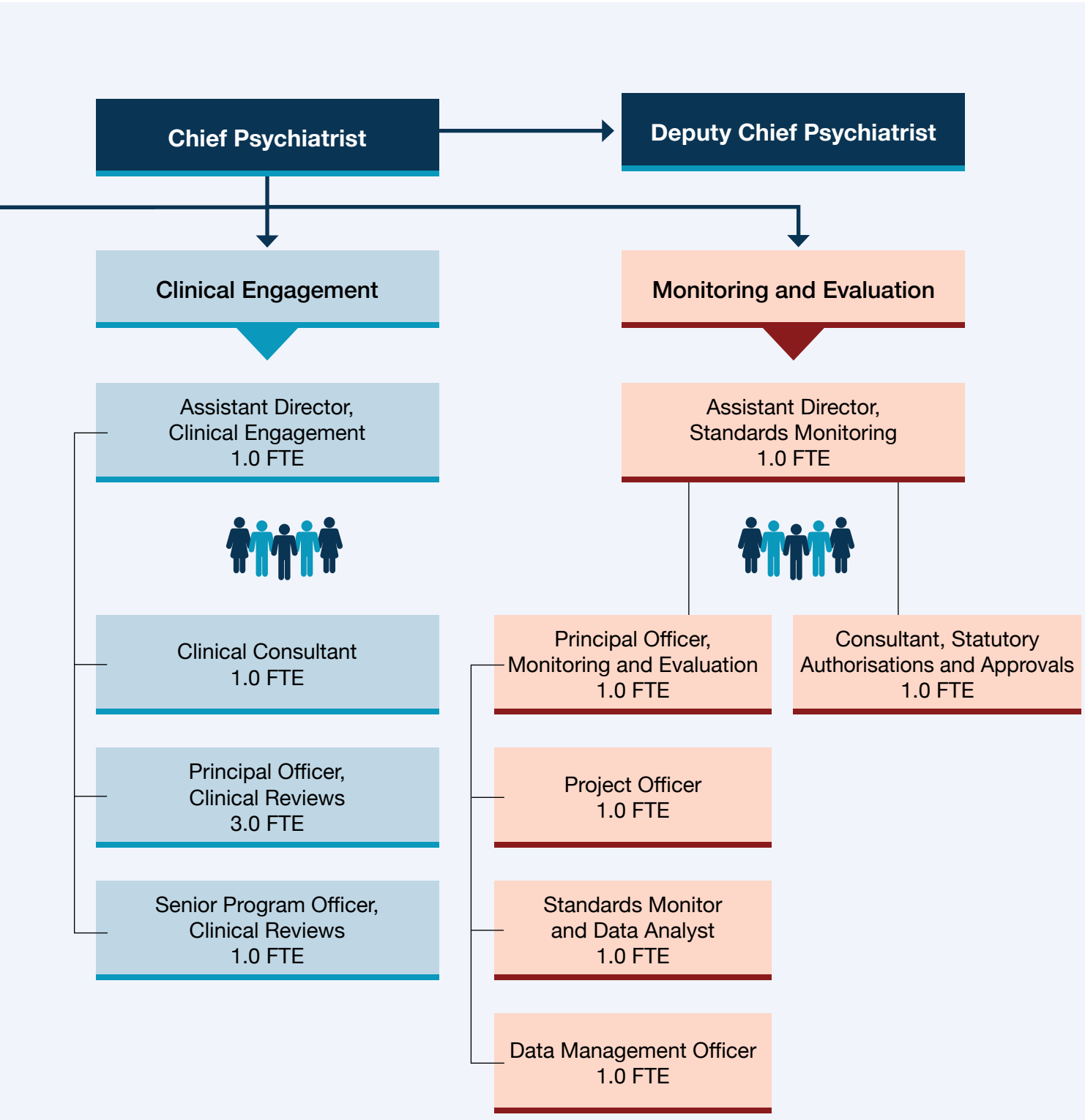
ACCOUNTABILITY

COMMITMENT

Structure of the OCP

OCP organisational chart




Chief Psychiatrist
Deputy Chief Psychiatrist
Clinical Engagement
Monitoring and Evaluation
Assistant Director, Clinical Engagement 1.0 FTE
Assistant Director, Standards Monitoring 1.0 FTE
Clinical Consultant 1.0 FTE
Principal Officer, Clinical Reviews 3.0 FTE
Senior Program Officer, Clinical Reviews 1.0 FTE
Principal Officer, Monitoring and Evaluation 1.0 FTE
Consultant, Statutory Authorisations and Approvals 1.0 FTE
Project Officer 1.0 FTE
Standards Monitor and Data Analyst 1.0 FTE
Data Management Officer 1.0 FTE

The Chief Psychiatrist is supported by 22 staff.

Executive Governance Team

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

Governance

As a Western Australian Government agency, the Office of the Chief Psychiatrist (OCP) is committed to being a well-coordinated, efficient and accountable administration.

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

- developing and implementing proactive strategies to support best practice in mental health policy, frameworks and systems
- ensuring governance systems and operational processes are in place and resources are allocated to deliver on the Chief Psychiatrist's role and function in respect of systemic improvement and statutory responsibilities under the MHA 2014 and other relevant legislation
- developing and maintaining key stakeholder relationships on behalf of the OCP
- authorising mental health clinicians to perform the functions of an Authorised Mental Health Practitioner.

Monitoring and Evaluation

The Monitoring and Evaluation Stream uses data to track and improve standards of treatment and care.

The Monitoring and Evaluation Stream assists the Chief Psychiatrist to discharge statutory responsibilities for the treatment and care of mental health patients and the monitoring of standards of care delivered across Western Australia. The Monitoring and Evaluation Stream is responsible for data monitoring and evaluation and authorisations of mental health services. The stream is comprised of highly skilled staff with clinical, research and data monitoring expertise.

Key functions include:

- monitoring and evaluating statutory notifications
- reporting on data trends in clinical and community services
- overseeing the authorisations of new facilities.

Clinical Engagement

The Clinical Engagement Stream supports and influences clinicians to provide better care.

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

Key functions include:

- supporting services to implement initiatives to continuously improve the delivery of treatment and care
- undertaking targeted or commissioned reviews into complex issues
- providing guidance on complex clinical and ethical treatment and care issues.

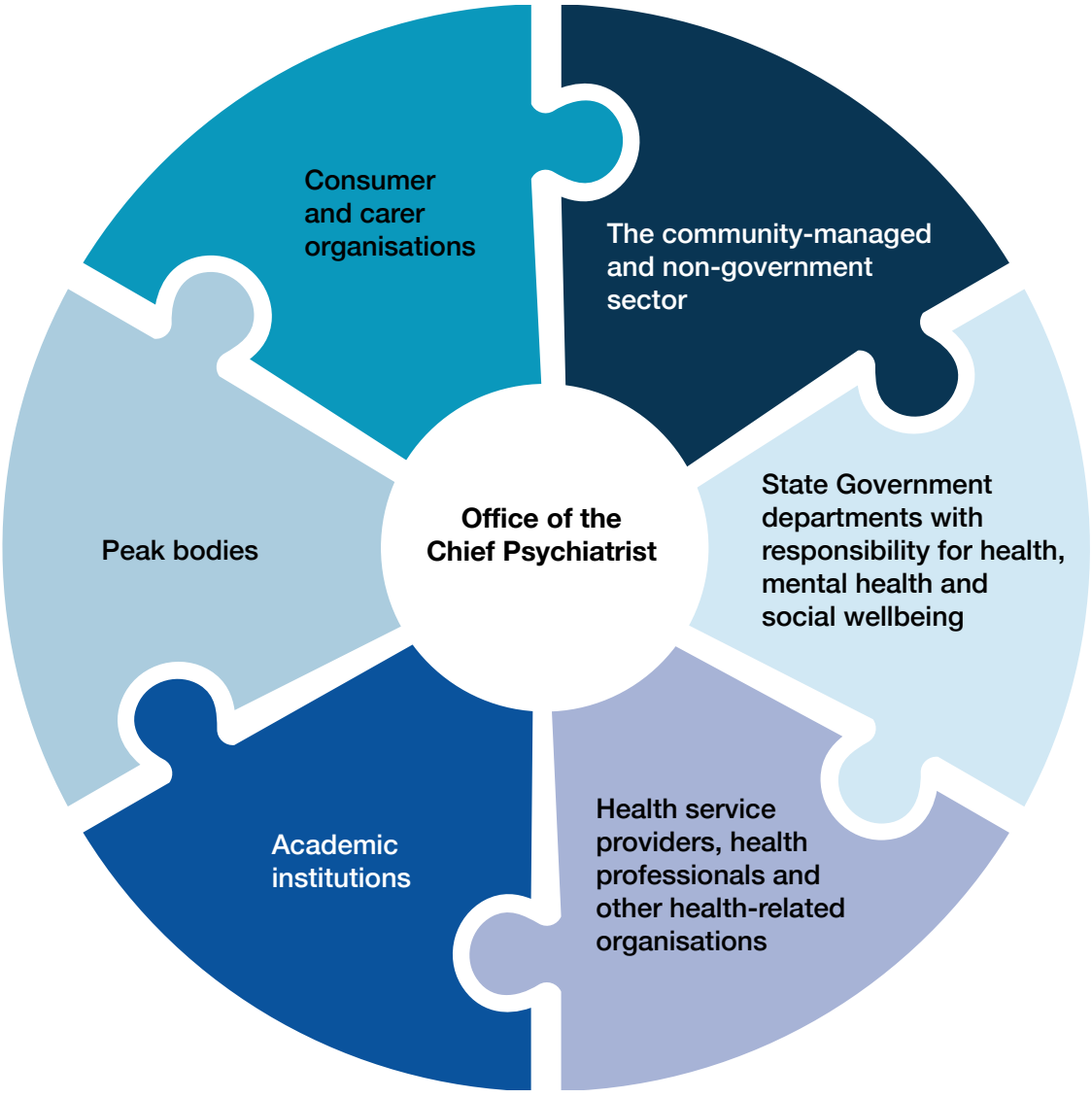
Professional Development

The Office of the Chief Psychiatrist strives to be a just and learning organisation.

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

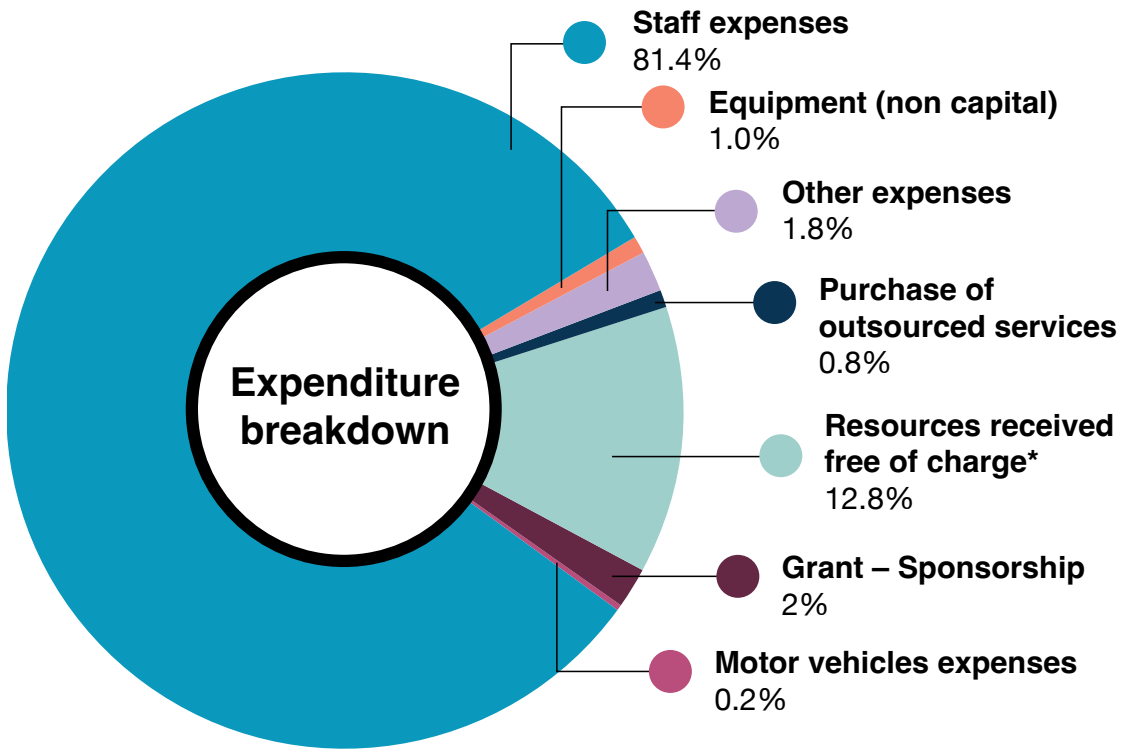
Who we work with

Our stakeholder engagement helps maximise our reach as we seek to positively impact better mental health care. It includes:



How we spend our money

An overview of expenditure for the OCP for 2023-24 is represented in percentages in the following diagram:



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

Services under the Chief Psychiatrist's statutory oversight

Services under the Chief Psychiatrist's statutory oversight

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

The Department of Health provides the data for this section. Due to the rigorous data cleaning undertaken, the OCP requests data for the calendar year (2023) to overcome any potential delays in receiving the financial year data.

It is noted there has been an increase in the number of patients utilising public community and inpatient services, private psychiatric hospitals and emergency departments from the 2023-24 Annual Report.

The average available beds under the remit of the Chief Psychiatrist increased by 1.6% from 771 beds in 2022 to 783 beds in 2023. HiTH beds increased by 93% from 47 beds in 2022 to 91 beds in 2023.

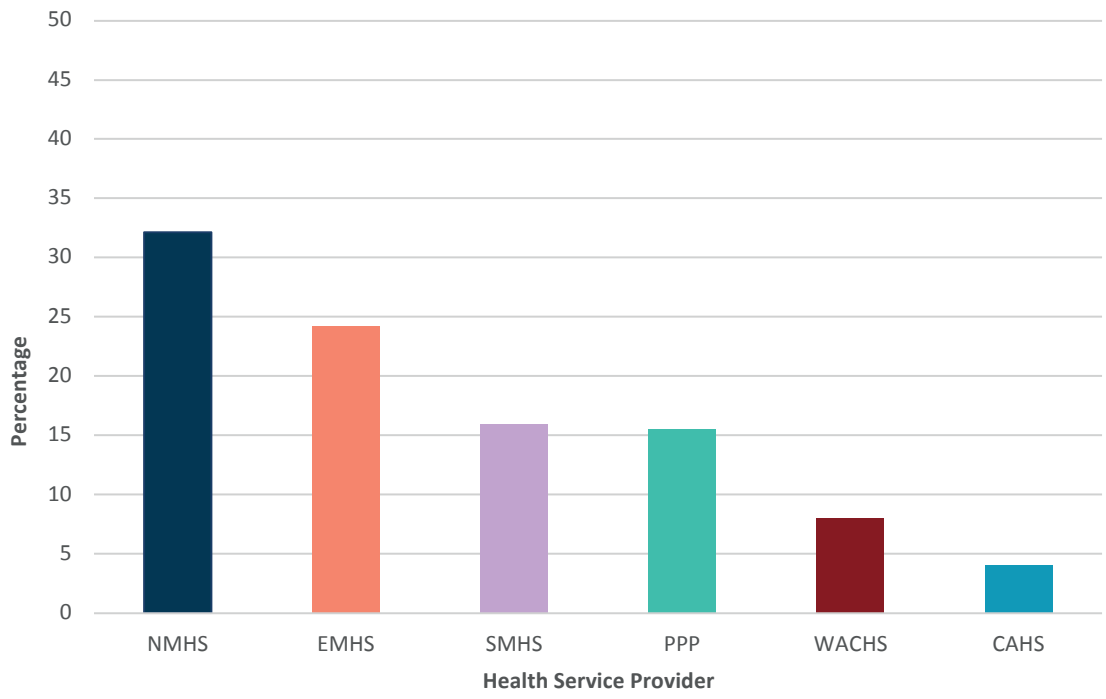
Inpatient mental health services

In the 2023 calendar year, 63,340 patients received public sector specialist inpatient and/or community mental health care, of which 8765 (14%) were Aboriginal and 54,575 (86%) were non-Aboriginal people. Just over two-thirds (67.5%) of these specialised mental health services were provided to adults aged 18-64 years, while 20.5% were provided to children less than 18 years of age and 12% to adults 65+ years of age. There were 8,962 (14%) patients who received both inpatient and specialist clinical community mental health services during 2023. Of these, 11% were Aboriginal and 89% were non-Aboriginal patients. The majority (81%) of patients were 18-64 years of age, 8% were children under 18 years and 11% 65+ years.

Public hospitals providing inpatient mental health services

There was an average of 874 available beds in the 2023 calendar year, of which 91 were Hospital in the Home (HiTH) beds provided by the North Metropolitan Health Service, East Metropolitan Health Service and South Metropolitan Health Service. An average of 783 inpatient beds were available across WA, with 92% available in the Perth metropolitan and 8% in WACHS regions (Figure 1).

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



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

There were 8,830 people with one or more inpatient admission to a specialised public inpatient mental health service (acute and non-acute wards), for a total of 14,526 separations in 2023. Aboriginal people accounted for 11% separations. The majority of people with one or more inpatient admission (81.5%) were adults 18-64 years, 10.5% were 65 years or older and 8% were children under 18 years of age.

Nearly one quarter (24%) of non-Aboriginal and 39% of Aboriginal inpatients had an involuntary mental health status at some stage during their admission. Most involuntary in-patients were aged 18-64 years for both non-Aboriginal (88%) and Aboriginal (94%) patients.

In the 2023 calendar year, there were 743 children under 18 years of age who accessed acute specialised mental health inpatient wards, involving 1,254 separations. Of the 1,254 separations, 765 (61%) were from Perth Children's Hospital, while 489 (39%) related to separations from youth wards which admit children and adolescents 16-24 years, as well as adult wards which admit adults 18

years of age and older. Under the section 303 of the MHA 2014, these 489 separations of young people less than 18 years from mental health wards admitting adults are required to be reported to the Chief Psychiatrist. For more information, please refer to the Statutory Reporting section of this report.

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

Specialised community mental health services

There were 63,231 patients who accessed community mental health services in 2023, of which 86% were non-Aboriginal and 14% Aboriginal patients. There were 1,056,948 service contacts of which 85% involved non-Aboriginal and 15% Aboriginal patients. Most patients accessing community mental health services (68%) were aged between 18-65 years, 21% were less than 18 years and 11% were 65 years or older.

Community Treatment Orders

A Community Treatment Order (CTO) is a legal order enabling an involuntary patient to receive treatment in the community. Some consumers may transition from a voluntary status to being on a CTO (and vice versa) within a single community episode of care. There were 808 patients treated on a CTO with a total of 1,004 CTOs recorded for the 2023-24 financial year.

Hospital in the Home (HiTH)

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

Private hospitals providing inpatient mental health services (4a&4b)

There are four private hospitals providing mental health services in WA and three publicly contracted private providers that admit some private patients.

Private hospitals providing private mental health services:

- Abbotsford Private Hospital (77 beds)
- Hollywood Private Hospital (101 beds)
- Marian Centre (69 beds)
- Perth Clinic (100 beds)

Bethesda Clinic provided 75 beds until 23 February 2024.

Private hospitals providing public mental health services:

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

During the 2023 calendar year, 2,657 private inpatients were discharged from these services, involving 5,329 separations. Most patients were adults 18-64 years (90%), 8% were adults 65+ years and 2% were under 18 years of age.

Authorised mental health facilities

Under the MHA 2014, authorised hospitals are hospitals that have mental health facilities where people can receive involuntary inpatient treatment and care. In WA, 17 health campuses have authorised mental health facilities, providing a total of 739 authorised beds (Table 1).

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

Health Service Provider/Facilities	Number of Authorised beds
Child and Adolescent Mental Health Service	
Perth Children's Hospital	20
East Metropolitan Health Service, Mental Health	
Armadale Hospital and Health Service	41
Bentley Hospital and Health Service (including East Metropolitan Youth Unit)	88
Royal Perth Hospital	12
North Metropolitan Health Service, Mental Health	
Graylands Health Campus:	
Frankland Centre	30
Graylands Hospital	122
Selby Older Adult	32
Sir Charles Gairdner Hospital	30
South Metropolitan Health Service, Mental Health	
Fiona Stanley Hospital	30
Fremantle Hospital and Health Services	64
Rockingham General Hospital	30
WA Country Health Service	
Albany Health Campus	16
Broome Hospital	13
Bunbury Hospital	27
Kalgoorlie Regional Hospital	6
Women and Newborn Health Service	
King Edward Memorial Hospital	8
Private Hospitals Providing a Public Service	
For North Metropolitan Health Service, Mental Health:	
Joondalup Hospital	102
For East Metropolitan Health Service, Mental Health:	
St John of God, Mt Lawley Hospital	12
St John of God, Midland Hospital	56
Total	**739**

Emergency departments

In the 2023 calendar year, 5.6% of attendances at an Emergency Department were for a mental health issue, totalling 64,847 attendances, of which 80% involved a non-Aboriginal patient, 20% an Aboriginal patient.

Other services under the Chief Psychiatrist's statutory oversight

The Chief Psychiatrist's remit extends to people who have been referred for examination by a psychiatrist under the *Mental Health Act 2014*, regardless of where they are. This may include emergency departments, prisons and other facilities.

Private psychiatric hostels

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

WA has 34 private psychiatric hostels. The 2024 Psychiatric Hostels Snapshot found 560 residents living in a private psychiatric hostel on the day of the snapshot. For further information, please see the clinical monitoring of private psychiatric hostels section of this report.

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

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

Telehealth and telephone mental health services

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

Safe haven cafes

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

Step-up step-down services

Step-up step-down services are short-term live-in services. They are designed for people who need more time after discharge from hospital to recover, or for people experiencing a deterioration in their mental health in the community. The Chief Psychiatrist does not have remit for the non-government step-up step-down services but may review care provided to patients in these services by the CMHS.

Specialised mental health emergency units (MHOA and MHEC)

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

Consultation-Liaison services (C-L)

C-L services are for people who are in hospital for their physical health. When a person experiences a deterioration in their mental health, a C-L team completes an assessment and provides specialist advice and treatment.

Kaatadjiny Walbraaniny Danjoo

Kaatadjiny Walbraaniny Danjoo – Noongar for Learning to Heal Together – is about centring Aboriginal voices in the work of OCP, embedding Aboriginal ways of working into our operations and ensuring our function as a regulator is culturally responsive, engaged and models culturally appropriate practice to the WA mental health sector.

This work is fundamental to our office. We recognise systemic discrimination and institutional racism has created significant barriers for Aboriginal people in accessing mental health services. Social and Emotional Wellbeing is the model identified by Aboriginal peoples as best practice in Aboriginal mental health. Part of our responsibility is to ensure standards and encourage better systems that break down these barriers for mental health services to embed cultural understanding and culturally safe practices into their models of care.

We do this by listening. Our work has been guided by a collective of Noongar Elders and Aboriginal young people, alongside Curtin University's Looking Forward team. We have met with this group monthly for the last two years to build foundational relationships, better our understanding of Aboriginal ways of working and embed truth-telling and culturally responsive practice into everything we do as an office.

The change for our office has been profound. We've seen a significant increase in our engagement with Aboriginal mental health consumers in our clinical reviews and with Aboriginal clinicians in our sector engagement initiatives. Engagement among participants at the Chief Psychiatrist's Community of Practice has risen significantly, with a growing recognition of the importance of Aboriginal Mental Health Workers; an enhanced understanding of the need to develop the Aboriginal health workforce; and an increased uptake of social and emotional wellbeing models of care.

This work is ongoing and ever-changing. We are grateful for the guidance of Curtin University's Looking Forward team, whose involvement in the project formally concluded in June 2024. Their stewardship has been essential to developing the OCP's capacity and empowering our staff to understand Aboriginal ways of being and equipping us with the tools to continue this vital work, walking and learning alongside Aboriginal Elders and young people. We are similarly grateful to the Mental Health Advocacy Service (MHAS), who have embarked on a parallel process to enhance their agency's understanding of and engagement with Aboriginal mental health consumers.

We look forward to the next phase of this work with the Noongar Elders and the Aboriginal young people who continue to guide us in producing better outcomes for Aboriginal mental health consumers in WA.

Chief Psychiatrist Dr Nathan Gibson with Noongar Elder Aunty Cheryl Phillips at the Langford Aboriginal Association

Working with the sector

Working with the sector

Mental health workforce

Staff of the Office of the Chief Psychiatrist have actively participated in a range of initiatives examining pathways for increasing the mental health workforce and provide enhanced workforce capability. The importance of mental health care combined with an appropriately trained and supported workforce to deliver it cannot be overstated. The mental health and wellbeing needs of Western Australians can only be met by a workforce of people with a diverse range of skills, backgrounds and life experience that are complemented by the inclusion and active participation of people with lived experience, their family, friends and carers.

The Deputy Chief Psychiatrist represented the OCP at a series of Ministerial Roundtables examining ways to support and grow the multidisciplinary mental health workforce, and contributed to work on pathways for overseas trained psychiatrists wishing to gain specialist registration in Australia.

Prescribed Medical Practitioners

The Chief Psychiatrist's commitment to support the Health Service Providers and their mental health workforce through the introduction of Prescribed Medical Practitioners (PMPs) in the last reporting period, continues.

The work of the Prescribed Medical Practitioners is governed by the *Chief Psychiatrist's Standard for Prescribed Medical Practitioners* issued under Section 547 of the MHA 2014 and the *Mental Health Regulations 2015*. In addition, the Chief Psychiatrist's governance processes include a monthly peer group supervision session for all PMPs provided by staff of the OCP, and an annual audit of compliance aligned with the professional development, employment and probity requirements of the Standard.

The Chief Psychiatrist has provided three training programs over the past year, each of three days' duration, resulting in 24 PMPs serving in Health Service Providers across the State.

Authorised Mental Health Practitioners

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

As of 30 June 2024, there were 665 AMHPs with a status of authorised on the Chief Psychiatrist's AMHP Register. The Statutory Educator trained 51 new AMHPs in services across WA.

In recognition of the ongoing significant stresses within the mental health system over the last year, the Statutory Educator maintained a clear presence at AMHP clinical supervision sessions across the State to provide timely advice and support.

Training data

The Statutory Educator, alongside the Chief Psychiatrist and the Deputy Chief Psychiatrist, delivered 120 MHA 2014 training sessions to a total of 1,546 AMHPs, PMPs, psychiatrists, mental health clinicians, nursing graduates and other clinicians working in the mental health sector.

Table 2: Training delivered by the Office of the Chief Psychiatrist, 2023-24

Training Sessions for FY 2023-24	Number of sessions	Number of Attendees	Clinician Type
AMHP Initial 2-day Training	3	51	Mental Health Practitioners (MHP)
AMHP Peer Supervision	50	501	AMHPs
AMHP Refresher training	28	268	AMHPs
Community Treatment Orders	7	120	AMHPs, mental health clinicians, medical practitioners, psychiatrists
Confidentiality	6	98	AMHPs, MHP, medical practitioners, psychiatrists
Capacity	2	73	AMHPs, mental health clinicians
MHA 2014 open question forums	3	22	AMHPs, mental health clinicians
Overview of the MHA 2014 - Graduate Nurses	1	11	Graduate nurses
Overview of the MHA 2014 - other	2	18	Medical practitioners & psychiatrists
Overview of MHA Referral Process	1	130	AMHPs, mental health clinicians, medical practitioners, general medical practitioners & psychiatrists
PMP Initial 3-day Training	2	16	Senior medical practitioners & psychiatrists
PMP Peer Supervision	10	88	Prescribed Medical Practitioners
Chief Psychiatrist training around systems standards legislation and leadership	4	120	Psychiatrist trainees & occupational therapy students
Other	1	30	AMHPs, mental health clinicians
Total	120	1,546	

Compliance with the MHA 2014

Research indicates compliance with mental health legislation is a challenge across jurisdictions. Nevertheless, legislative compliance is a vital part of improving mental health treatment and care.

In response to an apparent need to improve compliance with the MHA 2014, the Chief Psychiatrist, in partnership with the Mental Health Commission, established the *Mental Health Act 2014* Compliance Steering Group. Membership of the Group included the Department of Health, Health Service Providers, Mental Health Advocacy Service, Mental Health Tribunal and Health and Disability Service Complaints Office, as well as Aboriginal, consumer and carer representatives.

As Chair of the Group, the Chief Psychiatrist committed to facilitating the development of agreed strategies and actions required to improve compliance with the MHA 2014, and the development of an action plan for implementation within, and across, state mental health services.

The Chief Psychiatrist led the development of the action plan and an agreement relating to the provision of the resources required. The Group agreed to the timeframes and steps necessary to embed the agreed processes through a coordinated system wide approach.

Chief Psychiatrist's Community of Practice

The Community of Practice has continued to grow in 2023-24. This demonstrates the workforce's demand for up-to-date training and for opportunities to connect with each other to unpack shared challenges in our public mental health services. This year there has been a continued interest in bringing legal, clinical, lived experience and Aboriginal perspectives together. LGBTQIA+ needs and sexual safety have also featured across sessions and were requested in the past evaluation of the sessions.

The foundations of quality care are confidentiality, respect and collaborative care planning. These build trust and authentic therapeutic relationships through meaningful conversations. Embracing diversity means better person-centred care for everyone - consumers and carers and staff. The Chief Psychiatrist remains invested in providing opportunities to engage, support, connect, and inform clinical staff, executives and those collaborating with mental health services across the sector.

There were at least 940 attendances at the Community of Practice over seven sessions in 2023-24.

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

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

On average attendances per session and over the year grew 30% with around 132 people at each session.

Community of Practice Sessions in 2023-24

- Sexual Assault Resource Centre (SARC): Recent sexual assault disclosures within mental health facilities – Call SARC early
  - 20 July 2023 (126 attendees)
- Addiction Prevention and Treatment Service – Fiona Stanley Hospital Addiction Prevention and Treatment Service Team
  - 3 August 2023 (112 attendees)
- Waalbirnininy Wirran Healing Spirits: Co-designing a culturally secure Child and Adolescent Mental Health Service
  - 9 November 2023 (65 attendees)
- Confidentiality and information sharing – Part 1: Legal and clinical perspective
  - 28 February 2024 (220 attendees)
- Confidentiality and information sharing – Part 2: Guardianship, responsible persons, cultural and clinical scenarios
  - 5 March 2024 (95 attendees)
- Care planning – What "good" looks like
  - 16 April 2024 (180 attendees)
- Yarning about the Cultural Gathering Tool and Aboriginal governance
  - 18 June 2024 (140 attendees)

Restrictive practices

In Western Australia, all authorised mental health inpatient units collect and record data regarding the use of restrictive practices. The data includes the use of seclusion and/or restraint under the MHA 2014.

For this reporting period, the Chief Psychiatrist has continued to lead initiatives to reduce the use of restrictive practices both in mental health settings and in non-authorised healthcare settings. The aim is to work towards the elimination of the use of restrictive practices in healthcare settings.

Statement of intent

An outcome of the Mental Health Community Forum: Working Towards the Elimination of Restrictive Practices, held in 2023, was the development of a Statement of Intent to support mental health services to work towards the elimination of the use of restrictive practices.

The Chief Psychiatrist has partnered with the Mental Health Unit – Department of Health to bring together a group of consumers, carers and clinicians to co-produce the Statement. Following nominations being sought a working group has been formed to develop a co-design process for the Statement of Intent.

It is anticipated that the consultation and drafting process for the Statement will take 12 months with an anticipated completion date in the Financial Year 2024-25.

Detention and restraint in non-authorised healthcare settings

Representatives from the Office of the Chief Psychiatrist have continued to work closely with representatives from Health Service Providers (HSPs) and the Department of Health to progress the work begun in the previous reporting period in the use of restrictive practices in non-authorised healthcare settings.

The OCP developed the training content in the use of restrictive practices, and provided it to the Department of Health to support the development of an online training module for staff of health services across WA. Representatives from the OCP continue to support the Department of Health in the development of a statewide policy for the use of detention and restraint.

The Chief Psychiatrist issued the *Chief Psychiatrist's Guideline on the Use of Detention and Restraint in Non-Authorised Healthcare Settings* in February 2024. This guideline takes a human rights-based approach, emphasising best clinical practice in the lawful use of detention and restraint in non-authorised healthcare settings. It was developed using the expertise of people from across the health sector in WA including people with lived experience, their carers and supporters, mental health advocates, clinicians from diverse healthcare settings and other key stakeholders.

The guideline aims to help service managers, clinical leaders, clinical staff, and support staff such as security officers understand and manage their obligation to provide a safe and therapeutic environment for consumers, carers and staff.

Clinical monitoring of private psychiatric hostels

The Chief Psychiatrist is responsible for overseeing the treatment and care of all patients being provided with treatment or care by a mental health service in Western Australia (MHA 2014 s.515) and includes residents of a private psychiatric hostel (MHA 2014(s.507)).

A private psychiatric hostel, as defined in the is defined as "private premises in which 3 or more persons who — (a) are socially dependent because of mental illness; and (b) are not members of the family of the proprietor of the premises, reside and are treated or cared for" (*Private Hospitals and Health Services Act 1927*). These services operate under a private psychiatric hostel licence granted by the Department of Health, Licensing and Accreditation Regulatory Unit.

The Chief Psychiatrist works closely with the other agencies who also have a role in the oversight of private psychiatric hostels: the Licensing and Accreditation Regulatory Unit, Mental Health Advocacy Service and Mental Health Commission. The Chief Psychiatrist does this through the Annual Private Psychiatric Hostel Snapshot, regular hostel reviews and the monitoring of notifiable incidents.

Snapshot

The Snapshot commenced in its current form in 2020. The data are collected through the Hostel Snapshot Survey, Department of Health's Psychiatric Services On-Line Information System (PSOLIS) and Department of Health's Patient Administration System.

The 2024 Snapshot showed a higher vacancy rate in Private Psychiatric Hostels with 560 residents reported to be residing in the 735 available beds. In most previous snapshots were fewer than 100 vacant beds. This difference may be an artefact of the way the data are collected as the occupancy rate can fluctuate daily.

2024 was the first year when the Snapshot collected whether the resident identifies as a member of the LGBTQIA+ community. Hostels reported that this was not known for 42% of residents. Hostels also reported "not known" for a high proportion of residents when asked if they have co-occurring substance use (23%), disability (18%) and/or a chronic health condition (37%).

Hostel reviews

During the 2023-24 financial year the Chief Psychiatrist completed a series of reviews of all facilities operating under a private psychiatric hostel licence. This series of reviews, which commenced in 2019, examined the relationship between clinical services and private psychiatric hostels and how it impacts on the care that residents receive.

A summary report outlining key findings from the series of reviews has been provided to the Mental Health Commission, the Department of Health and the Mental Health Advocacy Service.

Post-review follow up

As part of this review process, the Chief Psychiatrist monitors the implementation of recommendations it makes to hostels and other agencies interfacing with care provision.

The OCP routinely provides support to organisations to implement the recommendations. In the first half of 2024, when the OCP concluded follow-up of recommendations, the licensees' progress were reported to the Mental Health Commission.

During the 2023-24 period, the OCP concluded follow-up of services operated by:

Hostels:

- Albany Halfway House Association
- Casson Homes
- Legal Accounting and Medical Syndicate Pty Ltd and Calder Properties Pty Ltd (Salisbury Home)
- Pu-Fam (Guildford Care Facility – St Jude's)
- Roshana Care
- Southern Cross Care Community Options

Health Service Providers:

- South Metropolitan Health Service
- WA Country Health Service

Follow-up continues for:

Hostels:

- Fusion Australia - Ngurra Nganhungu Barndiyigu, Geraldton
- Life Without Barriers
- Richmond Wellbeing
- St Bart's

Health Service Providers:

- East Metropolitan Health Service
- North Metropolitan Health Service

Criminal Law (Mentally Impaired) Act

The Criminal Law (Mentally Impaired) Act 2023 (CLMI) comes into effect on 1 September 2024. The OCP has continued to be actively engaged in supporting the Department of Justice by providing advice and applying knowledge and expertise from within the Office to progress the reformed CLMI legislation.

The OCP has continued its involvement to support the rollout of this legislation when it comes into effect, ensuring AMHPs and PMPs are knowledgeable about the requirements of the reformed legislation.

The Chief Psychiatrist has additional statutory responsibilities in the new CLMI legislation, with specific oversight for those persons under a community supervised order with conditions that they actively engage with a mental health service.

The Chief Psychiatrist has recruited a member of staff to support the development and roll out of training to Authorised Mental Health Practitioners and Prescribed Medical Practitioners.

Access to inpatient beds in the forensic sector remains an area of concern, however this will be addressed through the Graylands Reconfiguration and Forensic Program, delivering additional forensic mental health beds.

Authorisations and approvals

The Chief Psychiatrist is responsible for overseeing the standards of treatment and care of the people cited in section 515 of the MHA 2014, in public and private hospitals and public contracted private providers of mental health services. Any facility with the intention of receiving patients who have a mental illness as defined under Section 6 of the MHA 2014 must be licenced pursuant to section 26DA(3A) of the *Private Hospitals and Health Services Act 1927*. A licence cannot be issued without the Chief Psychiatrist's endorsement. The Chief Psychiatrist is therefore required to assess planned and new inpatient services, and to monitor existing services against the *Chief Psychiatrist's Standards for Authorisation of Hospitals under the MHA 2014*.

To reflect contemporary best practice in facility design, the Standards require services to implement concepts that address:

- access to nature including planting and views from bedrooms
- suitable therapeutic outdoor spaces, including provision of shade and seating
- culturally appropriate outdoor areas e.g. yarning circles, Aboriginal artwork
- appropriate lighting
- natural airflow
- functional areas that promote social inclusion and access to amenities
- privacy and autonomy
- sexual safety
- access to separate therapeutic areas for vulnerable patients

- anti-ligature fittings
- sensory modulation and de-escalation
- open nursing station design
- seven-day therapy access
- maintenance of facilities.

New Inpatient Services

In August 2023 the Chief Psychiatrist recommended the endorsement of a licence for Joondalup Health Campus, Mental Health Centre to operate as an authorised mental health inpatient service.

Joondalup Mental Health Centre is a 102-bed mental health facility providing mental health inpatient services to adult patients aged 24 to 65, older adult patients over 65 years and youth aged 16 to 24.

The Chief Psychiatrist and OCP staff were involved from design concept to the final commissioning of the build. Regular visits were conducted throughout the development to ensure authorisation against the Standards would be achieved and to promote principles of best practice in the design of therapeutic spaces. Engagement with the executive, architects, clinicians and other staff and co-design with consumers and people with lived experience ensured a contemporary design based on therapeutic principles.

Planned developments, refurbishments and renovations of inpatient services

During the reporting period, the Office of the Chief Psychiatrist was involved in the planning and design of the following developments, refurbishments and renovations of inpatient services. This included participation in a range of working groups including planning, project development, and schematic design as well as the provision of consultation on specialised areas such as de-escalation areas, sensory rooms, and outdoor spaces.

Planned developments

- Bentley Health Campus Secure Extended Care Unit
- Graylands Redevelopment
- Fremantle Hospital V Block
- Geraldton Hospital, Integrated Mental Health Unit
- Kalgoorlie Hospital, Integrated Mental Health Unit
- Bunbury Hospital
- Aegis Health Murdoch

Renovations and refurbishments

- Perth Children's Hospital
- East Metropolitan Health Service, Bentley Health Service
- East Metropolitan Health Service, Armadale Health Service
- East Metropolitan Youth Unit (EMyU), Bentley
- State Forensic Mental Health Service, Dryandra Rehabilitation Unit
- Fiona Stanley Hospital Mental Health Unit
- Rockingham Hospital Mimidi Park Mental Health Unit
- Broome, Maybu Liyan Mental Health Unit
- Bunbury Hospital Mental Health Unit
- Kalgoorlie Health Campus Mental Health Unit
- St. John of God Midland Health Campus

Reviews of Authorisation

Reviews of Authorisation continued throughout the year, with the purpose of ensuring that authorised hospitals in Western Australia continue to comply with the Standards.

Visits to facilities include a formal inspection of the physical environment, as well as meetings with consumers, carers, executive, clinical and non-clinical staff and relevant non-government organisations. Supporting documentation including policies and procedures is also reviewed and assessed. Following a site visit, a report is prepared and recommendations issued where required.

During 2023-24 the Office of the Chief Psychiatrist conducted formal inspections of:

- Fremantle Hospital – Alma Street Centre
- Fiona Stanley Hospital – Mental Health Unit
- St John of God, Midland Health Campus – Mental Health Unit.

The Office of the Chief Psychiatrist acknowledges that services with older infrastructure have unique challenges and works closely with them, providing consultation and advice based on current research and best practice principles.

Private psychiatric hospitals

Licensing of a private hospital is managed by the Department of Health Licensing and Accreditation Regulatory Unit. The Chief Psychiatrist considers any development of a private hospital in the context of their responsibility for standards of treatment and care. Therefore, services are strongly encouraged to involve the Chief Psychiatrist in any new developments, to ensure consideration has been given to operational and relational safety in their infrastructure and design, in the context of the Chief Psychiatrist's Standards and Guidelines. Private psychiatric hospitals are also subject to the Clinical Monitoring Program and are required to report notifiable incidents to the Chief Psychiatrist.

For the reporting period the Chief Psychiatrist/ Delegate conducted site visits to:

- Abbottsford Private Hospital, Leederville (2)
- Aegis Health, Murdoch (new development due to open late 2024) (2)
- Bethesda Clinic*, Cockburn (3)
- ESUS Eating Disorder Treatment Centre, Subiaco (1)
- Hollywood Hospital – Mental Health Unit (3)

* The Chief Psychiatrist is involved in the planned reopening of Bethesda Cockburn under South Metropolitan Health Service. Meetings have occurred around models of care, workforce requirements and the OCP provision of training of clinicians in the use of the MHA 2014 in a non-authorised setting.

Approved Electroconvulsive Therapy Services

There are 11 Approved Electroconvulsive Therapy (ECT) Services in Western Australia.

The MHA 2014 s.544 requires the Chief Psychiatrist to approve mental health services to provide ECT. In WA, only Approved ECT Services can provide ECT as a treatment.

To be approved, mental health services must meet the Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy and the Standards of the Licensing and Accreditation Regularly Unit – Department of Health.

The Chief Psychiatrist did not receive any applications from new services seeking to operate an ECT Service during the 2023-24 year.

Due to the Bethesda Clinic Cockburn ceasing operations as a private facility, the Chief Psychiatrist undertook the legislation process for the revocation of Gazettal. Revocation occurred on the 23 February 2024.

A list of Approved ECT Services can be found on the Chief Psychiatrist's website.

Review of approved ECT Services

A review of approved ECT Services will commence following the release and implementation of updated Chief Psychiatrist ECT Guidelines and Standards. These are in development and it is anticipated that they will be published during the next reporting period.

Visits to approved ECT Services may still occur during this period. Under section 521 of the MHA 2014, the Chief Psychiatrist or staff of the Chief Psychiatrist may visit mental health service with Approved ECT Services at any time, with or without notice.

Chief Psychiatrist's visits to services

Scheduled visits

The Office of the Chief Psychiatrist visits authorised mental health facilities and hospitals operating as a public private partnership to inspect on going works or, on request from a service, to offer and advise on ongoing developments or changes to the authorised space. Several visits were made to the same mental health unit over the course of the reporting period.

Visits included:

- Bentley Hospital
- Broome Hospital – Maybu Liyan Mental Health Unit
- Bunbury Health Campus
- Fiona Stanley Hospital
- Joondalup Health Campus
- Midland Health Campus
- Perth Children's Hospital
- Rockingham Hospital – Mimidi Park Mental Health Unit
- State Forensic, Dryandra Rehabilitation Unit

Visits without notice

Under the MHA 2014 s. 521(1)(b) and s. 521(2), the Chief Psychiatrist may visit, without notice, an authorised hospital and other designated mental health services at any time where a concern has arisen. The Chief Psychiatrist and/or a delegate may visit at any time when seeking further information regarding that service.

The Chief Psychiatrist or delegates conducted nine without notice visits in the reporting period. These numbers may increase in the following reporting period, visits may occur within and outside of core business hours.

Without notice visits were undertaken at the following authorised mental health facilities:

- Armadale Hospital, Leschen Unit
- Bentley Hospital, Mental Health Unit
- Bunbury Hospital, Mental Health Unit

- Fiona Stanley Hospital, Mental Health Unit
- Joondalup Mental Health Centre
- Perth Childrens Hospital, Ward 5A
- Rockingham Hospital - Mimidi Park Mental Health Unit
- Royal Perth, Dabakarn Mental Health Unit
- Sir Charles Gairdner Hospital, Isdell Mental Health Unit
- St John of God Midland, Mental Health Unit

System engagement consultation and development

National/binational committees

- The National Mutual Recognition of Mental Health Orders Legislation Project
- Medical Board of Australia Specialist International Medical Graduate Advisory Group
- RANZCP Corporate Governance Committee
- RANZCP Accreditation Committee
- RANZCP Membership Engagement Committee
- RANZCP Committee for International Medical Graduate Education
- RANZCP Overseas Trained Psychiatrists Committee
- RANZCP Education Committee
- RANZCP Examinations Committee
- Restrictive Practices Mandatory Policy Advisory Group

Statewide committees

- Accountable Agencies Collaborative Forum
- Coronial Review Committee
- Criminal Law Mentally Impaired Implementation Steering Committee
- Graylands Capital Projects Control Group
- Graylands Reconfiguration and Forensic Project (GRaFP)
- Forensic Model of Care Working Group
- *Mental Health Act 2014* Statutory Review – Steering Group
- Mental Health Agencies CLMI Implementation Group
- Mental Health Deep Dive Dashboard User Group
- Mental Health Quality Surveillance Group
- Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) Advisory Group
- Private Psychiatric Hostels Associations Committee
- Stimulant Assessment Panel
- WA RANZCP Branch Committee

Other visits, consultations and external engagements

- 7th National Social and Emotional Wellbeing Forum
- Mental Health Tribunal Members CPD Session (panel)
- MHAS Advocate Induction and Training presentation
- Navigating Complexity Symposium (NMHS)
- RANZCP Congress, Canberra
- Statement of Intent on the use of restrictive practices in WA health services

Clinical Consultant

The Clinical Consultant engages directly with the mental health sector, providing timely support by responding to Clinical Helpdesk enquiries from clinicians, consumers, carers, families, and other community members.

This role is crucial for maximizing compliance with the MHA 2014. In the 2023-24 reporting period, the Clinical Helpdesk assisted clinicians with clinical enquiries and supported consumers and carers, often requiring multiple calls and contacts to resolve matters.

Of all multidisciplinary clinician enquiries received by the Clinical Consultant over the past 12 months, the largest number (38%) came from Consultant Psychiatrists and were related to the clinical translation and application of the MHA 2014. The Clinical Helpdesk also routinely provided support to other professionals, including nurses (28%) and authorised mental health practitioners (12%).

Most calls to the Helpdesk concerned various aspects of Community Treatment Orders (approximately 40%). Other common enquiries included Referral Orders, Inpatient Treatment Orders, Transport Orders and issues related to restraint and seclusion in non-authorised settings.

General Counsel

The General Counsel provides high-quality legal and policy advice to the Chief Psychiatrist and the staff of the OCP, and plays a central role in the effective delivery of the OCP's core function as a leader in ensuring high standards of treatment and care in Western Australia.

The General Counsel supports the OCP in the delivery of consistent, coherent and effective guidance on mental health issues to the Western Australian community, particularly in assisting mental health clinicians to correctly and appropriately apply the provisions of the MHA 2014. This guidance focuses on information sharing, collaboration, professional standards and training.

The General Counsel does this through:

- the delivery of high-quality legal services
- assisting in the design, implementation and evaluation of policy frameworks to promote better mental health outcomes for the people of Western Australia
- managing legal risk within the OCP.

There has been a strong focus in the OCP on workplace health and safety to protect the health, safety and welfare of all workers and those that may be affected by our work.

In 2023-24, the General Counsel represented the Chief Psychiatrist on a number of legislative reform project committees, presented to a range of mental health and general health clinicians, and made submissions on behalf of the Chief Psychiatrist on a number of law reform projects.

Statutory reporting

Statutory reporting

Data are provided for each incident type notified to the Chief Psychiatrist, for all patients of mental health services (as defined by the MHA 2014) during the 2023-24 reporting year. A separate section follows to break down the incidence in the Aboriginal mental health patients.

Please note the Aboriginal consumer data are captured over a different reporting period – the 2023 calendar year – so are not directly comparable to the whole of population data which covers from 1 July 2023 – 30 June 2024 (see section Statutory Reporting – Aboriginal patients).

Restrictive practice

The Western Australian Government is committed to working towards elimination of restrictive practices within mental health settings.

Reporting rates of restrictive practice

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

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

Clinical review and follow-up of restrictive practice

The Chief Psychiatrist monitors the use of restraint and seclusion on an ongoing basis and seeks further details when a patient is secluded or restrained for a prolonged period, has multiple seclusions or restraints within an admission, or is held in a prone restraint position for a prolonged period.

In the 2023-24 reporting year, the Chief Psychiatrist sent 27 pieces of correspondence regarding instances of restraint and seclusion that did not fall into the Chief Psychiatrist's guidelines for clinical practice, due to the use of prolonged prone restraint >3 minutes duration, prolonged restraint >30 minutes or seclusion >6 hours, or multiple restraint or seclusion events within an admission. These correspondences were to ensure that adequate review of incidents has taken place and that services have undertaken planning to prevent further need for seclusion and restraint.

The Chief Psychiatrist and Deputy Chief Psychiatrist also visit services where there are ongoing concerns about the frequency of restrictive practices being used to ensure the required standards of patient care are being provided and to discuss what strategies have been, or might be employed, in order to support clinicians to reduce the use of restrictive practices.

Seclusion

Of the 6,763 people who accessed care and treatment in an Authorised Hospital in the 2023-24 financial year, 5% (363) had a seclusion event at some point during their stay, with 1,032 seclusion events reported during the financial year.

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

Children aged less than 18 years

The Chief Psychiatrist received notification of 94 seclusion events involving 44 children and youth under 18 years of age, over half of whom were female (57%). Of the 94 seclusion events reported, 52% were less than 60 minutes, 38% between 60 and 120 minutes and 10% lasted more than 120 minutes. The median duration for each of these categories was 37 minutes, 89 minutes, and 177 minutes, respectively.

Adults aged 18-64 years

The Chief Psychiatrist received notification of 937 seclusion events involving 318 adults 18-64 years of age, the majority of whom were males (61%). Of the seclusion events reported, one quarter (25%) were less than 60 minutes, over half (53%) had a duration of between 60 and 120 minutes, and 22% lasted more than 120 minutes. The median duration for each of these categories was 34 minutes, 88 minutes, and 220 minutes, respectively.

Adults aged 65 years and older

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

Restraint

Of the 6,763 people who accessed care and treatment in an Authorised Hospital in the 2023-24 financial year, 7% (506) had a restraint event at some point during their stay. Of the 1,325 restraints reported over 99% comprised physical restraints with less than five restraints involving mechanical restraint.

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

Children aged less than 18 years

There were 232 restraint events involving 68 children and youth under 18 years of age, over two thirds of whom were female (72%). The majority (71%) of restraint events were for less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 19% of all events and 10% lasted more than 10 minutes.

Adults aged 18-64 years

There were 1,030 restraint events involving 402 adults 18–64 years of age, just over half of whom were male (51%). The majority (78%) of restraint events were less than five minutes, with a median duration of 2 minutes. Restraint events lasting 5 to 10 minutes comprised 15% of all events and 7% lasted more than 10 minutes.

Adults aged 65 years and older

There were 63 restraint events involving 38 adults over 64 years of age, with 57% being male. The majority (78%) of restraint events lasted less than five minutes, with a median duration of two minutes. Restraint events lasting 5 to 10 minutes comprised 13% of all events and 9% lasted more than 10 minutes.

Use of prolonged prone restraint

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

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

A number of deaths in other Australian jurisdictions prompted closer examination of the use of prone restraints in Western Australia, and closer monitoring by the Chief Psychiatrist. Of the 1,325 restraints that occurred in the 2023 24 financial year, 729 (55%) of those involved the use of the prone position. Of the 729 prone restraints, 36 (5%) involved the use of prone for more than three consecutive minutes.

Australian Institute for Health and Welfare national reporting, 2023-24

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

Seclusion

The overall WA rate of seclusion for the 2023-24 financial year was 4.1 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 3). The rate of seclusion in WA for adults 18-64 years of age was 4.9 per 1,000 bed days. The rate of seclusion for children and adolescents below 18 years of age was 9.1 per 1,000 bed days in the 2023-24 financial year. Older adult mental health services had no seclusions for this age group and forensics had a rate of 12.1 per 1,000 bed days.

Restraint

The overall rate of restraint for the 2023-24 financial year was 5.3 per 1,000 bed days including child and adolescent, older adult and forensic services (Table 3). The WA restraint rates were 5.9 per 1,000 bed days for adults 18-64 years of age, 1.2 per 1,000 bed days for older adults 65 years and older, and 12.1 per 1,000 bed days for forensics. The rate of restraint for children and adolescents below 18 years of age was 18.9 per 1,000 bed days in the 2023-24 financial year.

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

	Seclusion per 1,000 bed days		Restraint per 1,000 bed days	
	National	WA	National	WA
2019-20	8.1	5.0	11.0	4.8
2020-21	7.3	4.2	11.6	4.3
2021-22	7.0	5.6	10.0	4.8
2022-23	6.0	4.5	10.0	4.4
2023-24	*	4.1	*	5.3

* Not available at the time of publication

Notifiable incidents

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

Public mental health services report notifiable clinical incidents to the Chief Psychiatrist through the Department of Health's Datix Clinical Incident Management System (Datix CIMS). Mental health services outside the public health system, such as non-government organisations and private psychiatric hostels do not have access to Datix CIMS, so they report using the Chief Psychiatrist's Notifiable Incident Form. The majority (85%) of notifiable incidents were reported through Datix CIMS, with the remaining 15% reported through the Chief Psychiatrist's Notifiable Incident Form. For clinical incidents reported through Datix CIMS, the severity of the incident was coded for all events where health care was determined to have contributed to, or caused, the incident.

The Deputy Chief Psychiatrist reviews all serious notifiable incidents and, where indicated, follows up directly with the relevant service, provides advice as required, and/or undertakes a targeted review of the incident. A total of 480 serious incidents were flagged for review by the Deputy Chief Psychiatrist and, of these, 48% were flagged for further follow-up with the mental health service. The follow-up ranged from requesting an investigation report or treatment or mandatory information, such as risk assessment and management plans, or sending the service the *Chief Psychiatrist's Sexual Safety Guidelines*. Notifiable incidents required to be reported to the Chief Psychiatrist include:

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

Notifiable incidents reported to the Chief Psychiatrist in the 2023-24 financial year may contain more than one incident category and, therefore, the notifications are coded as primary and secondary notifiable incident notifications.

Clinical review and follow-up of serious clinical incidents

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

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

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

Incidents confirmed as SAC 1 undergo in-depth review by the service to determine whether there were any aspects attributable to healthcare provision or lack thereof, or any systemic learnings, whereby recommendations are made and actioned by the service. When the SAC 1 review and report have been completed, the investigation report and other relevant documentation are reviewed by the Deputy Chief Psychiatrist and data monitoring team to identify issues of concern and to ensure these and other potential risk factors have been, or are being, addressed by the service. The Chief Psychiatrist may also monitor the progress of recommendations emanating from the investigation review.

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

Emerging trends are flagged with mental health services.

Primary incidents

There were 3,515 notifiable incidents reported for 1,555 patients, with a median of one incident reported per patient. Of these:

- Over one-third of these patients (35%) had two or more incidents reported
- Nearly two-thirds (64%) of incidents involved an involuntary patient, nearly one-third (31%) involved a voluntary patient and 4% involved a person who was referred under the MHA 2014 for assessment, or who was not currently active with a mental health service
- More than half (52%) of incidents involved patients identified as male.

The most frequently reported primary incident, involving 65% of all notifications, was aggressive behaviour/assault. The next most frequently reported primary incidents involved patients who were AWOL (13%), attempted suicides (7%), and deaths (7%). Incidents involving a missing high-risk voluntary patient are also reported to the Chief Psychiatrist, equating to 4% of notifications received. A small proportion of notifications (3%) related to allegations of sexual behaviour such as sexual contact, assault, harassment or an indecent act. The remaining notifiable incidents reported included allegations of unreasonable use of force by a staff member, serious medication errors, and allegations of murder/homicide.

Secondary incidents

There were 153 secondary notifiable incidents reported for 120 patients. Of these:

- Over half (51%) of secondary incidents reported comprised of alleged sexual behaviour
- One quarter (25%) were aggressive behaviour/assault
- AWOL of involuntary/referred patients comprised 11% of secondary incidents
- Attempted suicide 8%, with the remaining comprising of missing high-risk voluntary person, and allegations of unreasonable use of force by a staff member.

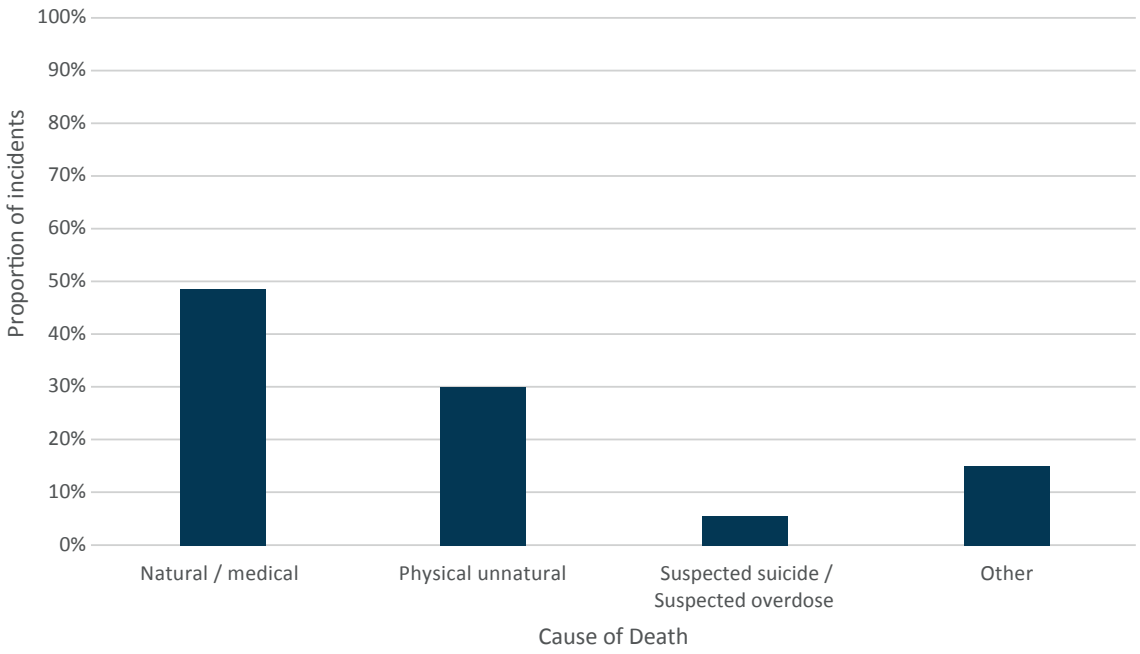
Death

Deaths of patients actively receiving mental health care and any deaths that occur within 28 days of discharge or deactivation of a patient from a health service must be reported to the Chief Psychiatrist by the person in charge of the mental health service, even if they become aware of the death after the 28-day period (in accordance with MHA 2014 s.525 and the *Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist*).

The Chief Psychiatrist received 237 notifications from mental health services regarding deaths of patients during the 2023-24 financial year, of which:

- Nearly half (49%) were reported to be due to natural or medical causes
- Nearly one-third (30%) were suspected to be suicide or suspected accidental overdose
- Less than one-tenth (6%) were reported to be due to physical unnatural causes
- Less than one-fifth (15%) were reported as unknown to other at the time of reporting (see Figure 2).

Figure 2: Cause of deaths reported to the Chief Psychiatrist

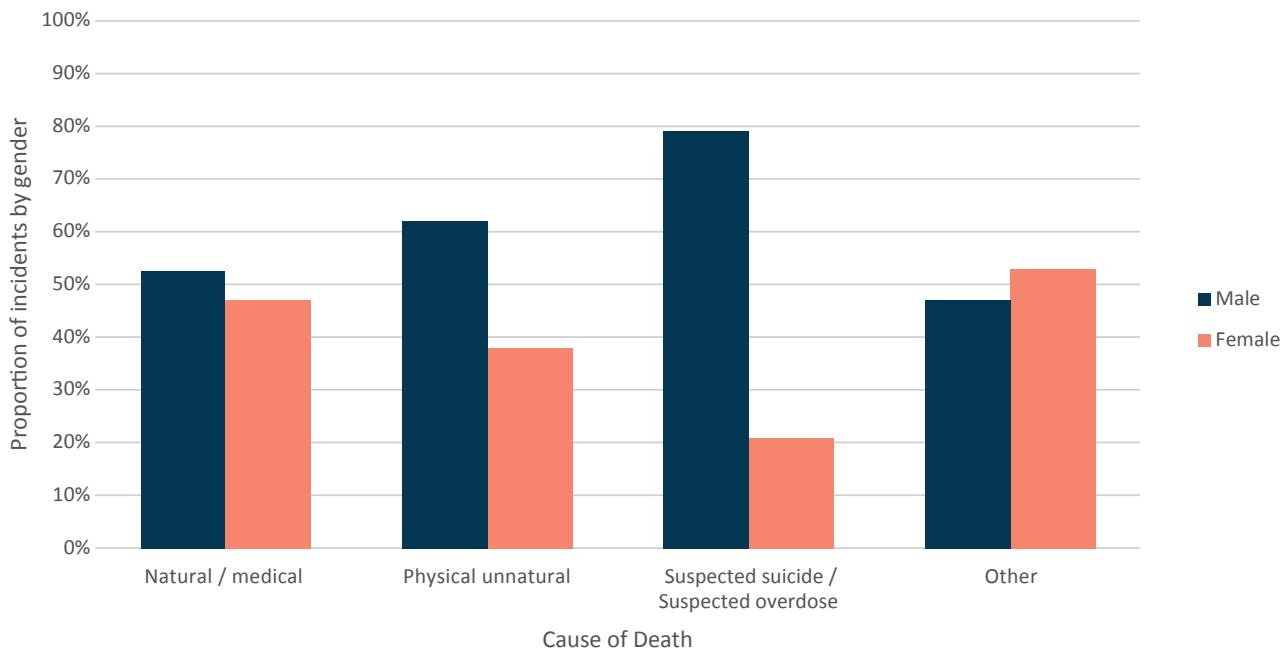


* Physical unnatural deaths included, but were not limited to, deaths due to falls, motor vehicle accidents and homicide.
** Other includes cause of death is not yet known.

The majority (97%) of deaths reported involved adults aged 18 years and older, with less than five deaths involving persons aged under 18 for each of natural/medical cause and suspected suicide, or suspected overdose.

There was a higher proportion of deaths reported for men than women where the cause of death was natural/medical (53%), physical unnatural (62%), and suspected suicide/ overdose (79%). Where the cause of death was unknown or other, there was a higher proportion of deaths reported for women (53%) (Figure 3).

Figure 3: Deaths in mental health patients by gender and cause of death



* Physical unnatural deaths included, but were not limited to, deaths due to falls, motor vehicle accidents and homicide.
** Other includes cause of death is not yet known.

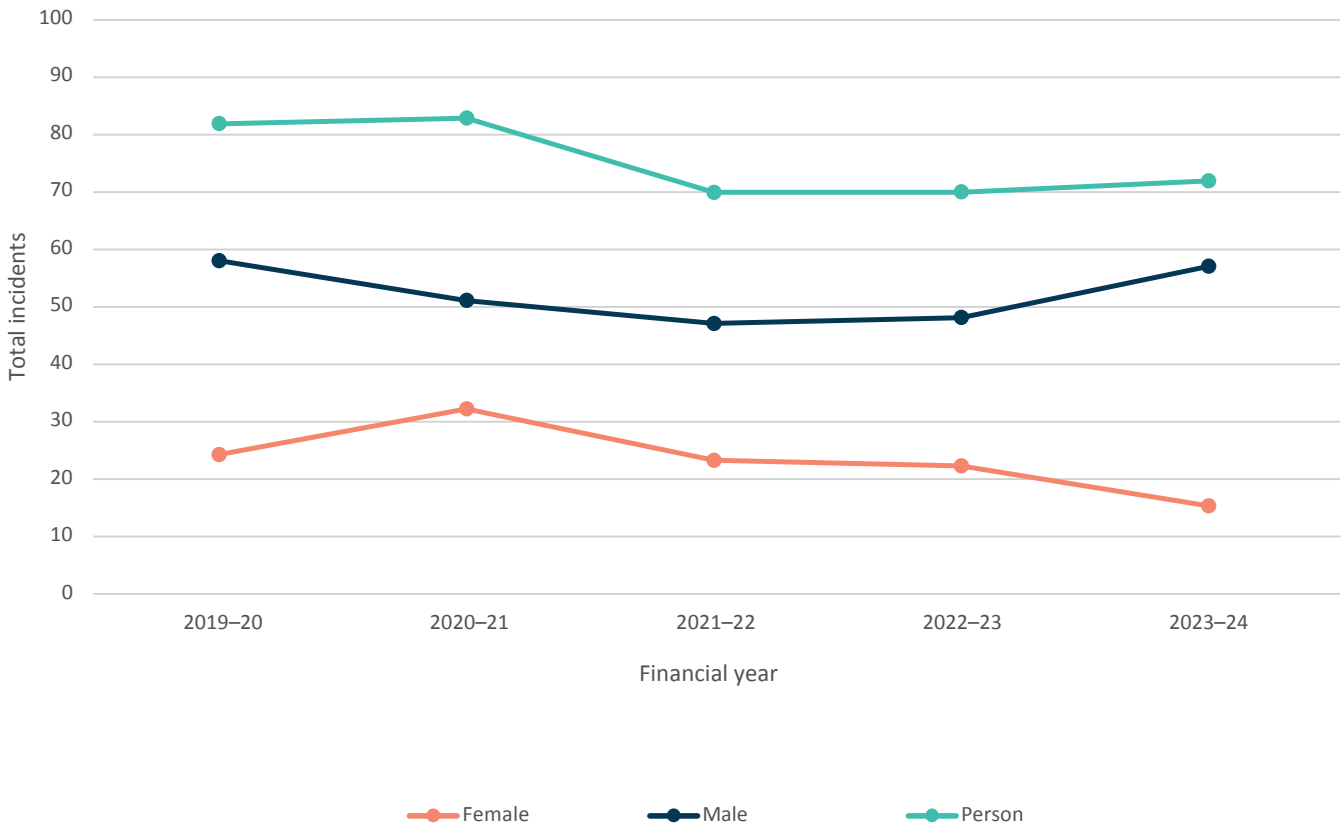
Suspected suicides

The Chief Psychiatrist received 72 notifications of death by suspected suicide in the 2023-24 financial year, which includes deaths by suspected accidental overdose comprising 4% (9) of total death notifications. The majority (over 95%) of suspected suicide death notifications occurred in the community setting, i.e. not within an inpatient ward or emergency department, with less than five suspected suicides in an inpatient ward.

Of the suspected suicide death notifications in 2023-24:

- Over one-tenth (12.5%) involved inpatients and those admitted to Hospital in the Home (HiTH)
- One quarter (25.0%) involved a patient who had been discharged within the previous 28 days from a mental health inpatient admission or HiTH
- Nearly two-thirds (62.5%) involved community mental health patients not recently discharged from hospital.

Figure 4: Trends in number of suspected suicides



Notifications to the Chief Psychiatrist are reported as deaths within 28 days after discharge, following confirmation of the date of discharge, and the categories are correct to the best of our knowledge.

All deaths reported as suspected suicide/overdose or unknown cause of death are reviewed through a process overseen by the Deputy Chief Psychiatrist. Where required, services are contacted to obtain further information or to request for the investigation review outcome when completed. The team will also review the investigation outcome report of suspected suicides or unexpected deaths and where required, monitor the progress of recommendations made.

Assault and/or aggression

There were 2,331 notifications of aggression incidents reported to the Chief Psychiatrist during the 2023-24 financial year, which was a slight increase of 3% compared to the previous financial year.

Of the aggression incidents reported in the 2023-24 financial year:

- more than half (52%) involved male patients (1,217)
- the majority (87%) involved patients aged 18 years and over (2,022)
- the majority (94%) occurred on an inpatient ward, with the remainder occurring at a community mental health clinic, private psychiatric hostel, or emergency department
- the majority (80%) involved an inpatient who was involuntary or referred
- more than half (58%) of the patients had one aggression incident, 27% had two or three incidents, 12% had between 4 and 10 incidents, and 3% had more than 10 incidents.

For children and adolescents under 18 years, two-thirds (66%, 203) of aggression incidents involved females. For mental health patients aged 18 years and over, over half (55%, 1,112) of aggression incidents involved males.

Of the 2,331 aggression incidents reported in the 2023-24 financial year, over two-thirds (68%) involved aggression towards staff, 29% involved aggression towards property, 24% involved aggression towards other patients, 15% involved refusal of treatment, and 5% were other types of aggressive behaviour.

Incidents of aggression may involve more than one type of aggression, such as aggression towards staff and aggression towards another patient in one incident. In addition, some incidents may involve more than one person directly or indirectly. Around 41% of the 2,331 aggression incidents had more than one type of aggressive behaviour, with a total of 3,278 aggression events reported.

Of the 3,278 aggression events reported in the 2023-24 financial year, the most common type of aggressive behaviour involved aggression towards staff (48%), followed by destruction or aggression towards property (20%), aggression towards other patients (19%), refusal of treatment (11%), and other types of aggressive behaviour (2%).

Serious aggression incidents are flagged to the Deputy Chief Psychiatrist for review, where further information regarding patients' behaviour management and care plan may be requested to assist with supporting services in managing serious aggression incidents.

Table 4: Notifications of aggression incidents by gender and age group

Age (Years)	Female	Male	Total Incidents
Under 18	203	105	308
18 and over	910	1,112	2,022
Total incidents	**1,113**	**1,217**	**2,330**

*One incident was reported where the gender of the adult patient was not specified (1).

Alleged sexual behaviour incidents

A total of 189 alleged sexual behaviour incidents were notified to the Chief Psychiatrist in the 2023-24 financial year, which was a 21% increase from the previous financial year (156).

Of the total alleged sexual behaviour incidents notified to the Chief Psychiatrist in 2023-24:

- Over half (56%) were reported to be alleged sexual assault/harassment, 29% were indecent act/inappropriate behaviour and 15% were reported as consensual sexual contact (prohibited in inpatient wards)
- The majority (78%) of alleged sexual assault/harassment incidents reportedly occurred in an inpatient setting, 19% occurred at a private psychiatric hostel, and 3% occurred at a community mental health clinic or an ED
- Of the alleged sexual behaviour incidents reported in the inpatient setting, over half (51%) were allegations of sexual assault/harassment
- Of the alleged sexual behaviour incidents reported at a private psychiatric hostel, the majority (95%) were allegations of sexual assault/harassment
- Nearly two-thirds (66%) of alleged sexual assaults/harassments reported were considered to be substantiated following investigation, 18% were unsubstantiated or determined not to have occurred, and 16% were still under investigation or the outcome unknown as of 1 July 2024.

Notifiable incidents received for alleged sexual behaviour incidents are regularly monitored for the investigation outcome and immediate actions taken upon disclosure of the incidents. In 2023-24, 55% of alleged sexual behaviour incidents reported including all alleged sexual assaults were flagged to the Deputy Chief Psychiatrist for review. Follow-up may include contacting services to obtain further information or suggest actions, and offering support to

staff in implementing sexual safety measures set out in the *Chief Psychiatrist's Sexual Safety Guidelines*. To promote knowledge translation, a copy of the Guidelines is sent to the notifying service on receipt of a sexual safety notification.

The Chief Psychiatrist is committed to ensuring that staff respond appropriately to all allegations, and report and investigate all allegations of sexual behaviours. Regular themes observed from reported alleged sexual behaviour incidents in the 2023-24 financial year were shared with health service providers as an area of focus for learning purposes.

The OCP arranged training by the Sexual Assault Resource Centre (SARC) open to all clinicians, through the Chief Psychiatrist's Community of Practice in July 2023. Services are also encouraged to contact SARC for more in-depth staff training in responding to alleged sexual behaviour incidents. In addition, it is expected that services will put in place robust strategies to help reduce the risk of sexual safety incidents occurring and to consider the sexual safety of all patients on the wards when responding to alleged sexual behaviour incidents. The OCP has been working on the development of a statutory Standard for sexual safety in mental health services, which will be published in early 2024-25.

Attempted suicide

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

The Chief Psychiatrist received 245 notifications of attempted suicide involving 193 individuals during the 2023-24 financial year. Of these incidents:

- The majority (84%) of individuals had one reported attempted suicide and 16% had two or more attempted suicides
- Less than one-tenth (7%) of attempted suicides were reported to have resulted in serious harm to the patients
- Nearly three-quarters (71%) of attempted suicides involved voluntary patients and over one quarter (29%) involved involuntary patients and patients referred for assessment
- The majority of reported attempted suicides involved females (170, 69%), where nearly one-quarter (39, 23%) of the women were aged under 18 years (Table 5)

- For males, the highest proportion of attempted suicides occurred for those age 18 years and older (62, 83%).

Notifications of attempted suicides were reported to occur mostly in an inpatient ward (42%) and in the community (49%) such as private psychiatric hostels or residential homes. The remaining incidents occurred when the person was attending an ED (9%).

All notifications of attempted suicides are reviewed and serious incidents flagged to the Chief Psychiatrist, with further information requested from services as required. Where the structural design of a mental health unit or emergency department is identified to be a potential contributing factor, the issue is flagged for review by the Chief Psychiatrist through the hospital authorisation process.

Table 5: Notifications of attempted suicide by gender and age group

Age (Years)	Female	Male	Total Incidents
Under 18	39	13	52
18 and over	131	62	193
Total incidents	**170**	**75**	**245**

Absent without leave (AWOL)

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

There were 491 AWOL notifications involving 316 involuntary patients or patients referred for assessment under the MHA 2014 during the 2023-24 financial year. Of those:

- 98% of AWOL patients had been located by the end of the 2023-24 financial year
- Less than five patients experienced serious harm while they were AWOL; these incidents were flagged for further review
- For less than half (42%) of AWOL notifications, the patients were located on the same day, 26% a day later, and 27% were located two to ten days later, with the remaining 5% located more than ten days later
- The majority (72%) of AWOL patients had one event, 15% had two events, and 13% of patients had three or more AWOL events reported
- The majority (93%) of AWOL notifications involved patients who were involuntary at the time they went AWOL and 7% were patients who had been referred for assessment
- The majority (97%) of AWOL events involved patients who were 18 years of age or older (Table 6)

- More than half (60%) of reported AWOL incidents involved male patients, of which less than five were aged under 18 years.

All AWOL incidents reported are reviewed and where required, are escalated to the Deputy Chief Psychiatrist for further review and services may be requested to provide more information. Where the structural design of the site was identified as a possible contributing factor, the issue was reviewed through site visits via the authorisation process.

Table 6: Notifications of absent without leave by age group

Age (Years)	Total Incidents	Proportion of Incidents
Under 18	15	3%
18 and over	477	97%
Total	**492**	**100%**

Missing persons – voluntary patients at high risk

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

There were 156 notifications of high-risk voluntary patients reported as missing from a mental health service, where majority (over 95%) of missing persons were located.

Missing person notifications involved 124 individuals, of whom 48% were male and 52% were female.

The majority (90%) of missing person incidents involved patients aged 18 and over (140) (Table 7) with even numbers of notifications for females (68) and males (72).

Missing person notifications involving children and adolescents under 18 years made up 10% of total missing person notifications, with less than five notifications for male patients.

Most patients (91%) had one missing person notification and 9% had between two and ten events reported. Less than five incident reports resulted in serious harm to patients following the missing person notification.

Table 7: : Notifications of missing person by age group

Age (Years)	Total Incidents	Proportion of Incidents
Under 18	16	10%
18 and over	140	90%
Total	**156**	**100%**

Serious medication error

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

There were less than five serious medication errors with major adverse effects reported to the Chief Psychiatrist during the 2023-24 financial year, of which all incidents were reviewed by the Deputy Chief Psychiatrist in the first instance and where required services were contacted to provide further information on actions taken. A clinical investigation of serious medication error incidents is conducted by services and the report is reviewed by the Deputy Chief Psychiatrist, where recommendations arising from the investigation report are monitored for the progress and implementation.

Allegations of unreasonable force used by a staff member

Allegations of unreasonable use of force by a staff member of a mental health service (including staff of psychiatric hostels) must be reported to the Chief Psychiatrist and investigated by the notifying mental health service. To ensure the continued safety of patients and residents, the Chief Psychiatrist has powers to investigate further as required.

For the reporting period, the Chief Psychiatrist received 11 notifications of alleged unreasonable use of force on a patient by a staff member of a mental health service, of which seven incidents were substantiated upon further investigation. Each incident was reviewed by the Deputy Chief Psychiatrist and, where required, was flagged to the Chief Psychiatrist for further investigation to ensure an appropriate response was actioned by the service.

Alleged homicide

For the reporting period, the Chief Psychiatrist received five notifications of alleged homicide committed by a person who was a mental health patient. The Chief Psychiatrist reviewed all information pertaining to the treatment and care provided to the alleged perpetrators while health service providers concurrently conducted a serious incident review of each allegation. The investigation review reports of the alleged homicides were also reviewed by the Chief Psychiatrist.

Aboriginal patients

Aboriginal status is not reliably reported through the data notification process. To monitor outcomes and trends for Aboriginal mental health patients, Chief Psychiatrist data are linked to the Department of Health Aboriginal flag. **The data are linked for the 2023 calendar year to meet the Annual Report timeframe.**

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

Restrictive practices

Use of seclusion

In the 2023 calendar year, there were 389 seclusion events involving an Aboriginal patient, equating to 37% of the total 1038 seclusion events. Of the 391 individuals secluded in the 2023 calendar year, 116 (30%) were Aboriginal.

Use of restraint

In the calendar year 2023, there were 230 restraint events involving an Aboriginal patient, equating to 20% of the total 1,133 restraint events. Of the 464 individuals restrained in the 2023 calendar year, 97 (21%) were Aboriginal.

Notifiable incidents

Primary incidents

Of the 3,302 primary notifiable incidents reported for 1,534 patients during the 2023 calendar year, 847 (26%) incidents were reported for 330 (22%) Aboriginal patients. Nearly two-thirds (64%) of the notifications involved a male Aboriginal patient and majority (89%) of notifications involved adults 18 years and over. Of the 847 primary incidents involving an Aboriginal patient, the type of incident reported include:

- aggressive behaviour/assault – 65% of notifications
- absent without leave, involuntary/ referred patients – 19% of notifications
- missing, high-risk voluntary patients – 7% of notifications
- deaths – 3% of notifications
- attempted suicides – 3% of notifications
- alleged sexual behaviour – 2% of notifications
- other – less than 1% of notifications. Incidents not specified due to small numbers.

Secondary incidents

There were 112 secondary notifiable incidents reported for 101 patients in the 2023 calendar year. Of the 112 notifications, 31 (28%) of the notifications were reported for 26 (26%) of Aboriginal patients. The most frequently reported secondary incidents involving an Aboriginal patient were alleged sexual behaviour (48%) and aggressive behaviour/assault (45%). The remaining secondary notifications comprised of AWOL and attempted suicides with fewer than five notifications.

Death notifications

The Chief Psychiatrist received 217 notifications in the 2023 calendar year advising of the death of a mental health patient, of which 29 (13%) notifications related to an Aboriginal patient.

Of the 217 deaths reported, Aboriginal patients comprised of:

- over one-tenth (11%) of all deaths due to natural/medical causes
- over one-tenth (12%) of all deaths due to suspected suicides/overdose
- nearly one-fifth (19%) of all deaths due to physical unnatural, unknown or other causes.

Of the 29 deaths reported for Aboriginal patients,

- nearly one-third (31%) of deaths were due to natural/medical causes
- over one-third (34.5%) of deaths were due to suspected suicide/overdose
- over one-third (34.5%) of deaths were due to physical unnatural causes or unknown causes.

Less than five of the suspected suicides involved an Aboriginal patient under 18 years of age.

Aggression incidents

There were 2,184 aggression incidents involving 883 patients in the 2023 calendar year, of which 562 (26%) notifications were reported for 199 (23%) Aboriginal patients. Incidents relating to aggression may involve more than one type of aggressive behaviour. For the 562 incidents involving an Aboriginal patient, there were 829 aggression events reported where:

- 39% involved aggression towards staff
- 15% involved assaults on staff
- 6% involved aggression towards other patients
- 6% involved assault of another patient
- 21% involved aggression towards property
- 5% involved destruction of property.

The low numbers of the remaining 8% of aggressive incidents prevents further information being provided.

Alleged sexual behaviour incidents

There were 150 notifications of alleged sexual behaviour incidents reported for 123 mental health patients. Of the 150 notifications, 30 (20%) notifications were reported for 22 (18%) Aboriginal patients who were mostly (83%) over 18 years of age. Of the 30 notifications for Aboriginal patients:

- nearly half (47%) of the alleged sexual behaviour comprised of sexual assault/harassment
- the majority (71%) of the alleged sexual assault/harassment allegations were substantiated, with the remaining incidents determined to be unsubstantiated or had an unknown outcome
- the majority (86%) of the alleged perpetrators were males
- the majority (71%) of alleged victims were females.

Attempted suicide

The Chief Psychiatrist was notified of 245 attempted suicides involving 204 individuals. Of these, 25 (10%) incidents involved 24 (12%) Aboriginal mental health patients, where:

- the majority (72%) of incidents involving Aboriginal patients were age 18 years or older
- over half (52%) of attempted suicides involved a female
- the majority (64%) of attempted suicides occurred in an inpatient setting or ED, with the remainder occurring in the community.

Absent without official leave (AWOL)

There were 454 AWOL notifications of an involuntary patient or a patient referred for assessment under the MHA 2014, relating to 297 patients. Of the 454 notifications, 165 (36%) notifications involved 96 (32%) Aboriginal patients, of which over half (52%) were male. Over 95% of Aboriginal patients who were reported as AWOL were located.

Missing persons

There were 147 notifications relating to 118 voluntary patients reported as missing from a mental health service, with 60 (40%) notifications involving 43 (36%) Aboriginal patients. There were slightly more missing person notifications for female patients (53%) compared to male patients (47%). Over 90% of Aboriginal patients reported as missing person were located.

Unreasonable use of force by a staff member

There were 13 notifications of unreasonable use of force by staff member involving 12 individuals. Of these, six (46%) notifications involved six (50%) Aboriginal mental health patients and were investigated to be substantiated. All reported incidents of unreasonable use of force by staff member were flagged to the Deputy Chief Psychiatrist for further investigation to ensure appropriate responses were undertaken by the service.

Other

There were less than five incidents comprised of allegations of committed murder or serious medication error involving an Aboriginal patient. Each incident was flagged to the Deputy Chief Psychiatrist and reviewed with request for further information as required.

Summary

All notifiable incidents for Aboriginal patients are outlined in Table 8.

Table 8: Notifiable Incidents reported to the Chief Psychiatrist that involved an Aboriginal patient during 2023.

Type of Incident	All Notifications	Aboriginal %	All Individuals	Aboriginal %
Aggression	2,184	26	883	23
Alleged Sexual Behaviour	150	20	123	18
Attempted Suicide	245	10	204	12
AWOL	454	36	297	32
Death	217	13	217	13
Missing Person	147	41	118	36
Unreasonable Use of Force by Staff	13	46	12	50

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

Electroconvulsive therapy (ECT)

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 an effective evidence-based treatment for serious mood disorders, including major depression and mania, catatonic states and occasionally with schizophrenia or other neuropsychiatric disorders.

The provision of Electroconvulsive Therapy (ECT) in WA is strictly regulated under 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 a delegate must be obtained prior to the ECT being performed. Voluntary patients must provide informed consent prior to receiving ECT.

The Chief Psychiatrist maintains a register of health services that have been approved as meeting the standards to perform ECT. A total of 11 services are approved to perform ECT in Western Australia.

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 2023–24, there were 607 completed ECT courses reported to the Chief Psychiatrist which included less than five children. Of the 607 courses, 540 (89%) were for patients with a voluntary status, 47 (8%) were for involuntary or referred status, and 19 (3%) were for mixed status (both voluntary and involuntary).

There were 6,329 ECT treatments completed in the 2023-24 financial year, of which 4,933 (77.9%) were acute treatments, 1,379 (21.8%) were maintenance treatments and 17 (0.3%) consisted of emergency treatments (Table 9).

In the 2023-24 financial year, there were 23 emergency ECT treatments authorised by the Chief Psychiatrist or a delegate. Where these emergency ECT treatments are part of a completed course, they are included in Table 9.

The majority of all ECT courses (57%) were provided in a private hospital, 32% were provided in a public hospital, and 11% were provided in a publicly contracted private hospital.

Serious adverse events

Under the MHA 2014, a serious adverse event in relation to ECT means premature consciousness during a treatment; anaesthetic complications (for example, cardiac arrhythmia) during recovery from a treatment; an acute

and persistent confused state during recovery from a treatment; muscle tears or vertebral column damage; severe and persistent headaches; and persistent memory deficit.

The majority (86.2%) of the 607 courses of ECT reported during 2023-24 did not have any serious adverse events reported. An adverse event during one or more treatments was reported for 12.6% (84) of these courses.

Table 9: ECT courses and treatments completed in the 2023-24 financial year.

Age	Status	Number of ECT courses completed in 2023-24	ECT treatments			
			Acute ECT Treatments	Maintenance ECT Treatment	Emergency ECT Treatment	Total
All patients[a]	Voluntary	540	4,096	1,240	0	5,336
	Involuntary / Referred[b]	48	557	18	13	588
	Mixed[c]	19	280	121	4	405
	Total	**607**	**4,933**	**1,379**	**17**	**6,329**

Table 9: ECT statistics reported to the Chief Psychiatrist during the reporting period (1 July 2023 – 30 June 2024).
[a] patients under 18 not reported separately due to small numbers reported for this group (less than five)
[b] Mentally Impaired Accused are included in this category
[c] Patients who had both an involuntary and a voluntary status in the same course.
Source: Office of the Chief Psychiatrist Database

Involuntary treatment orders in a general hospital

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

The Chief Psychiatrist authorised 331 involuntary treatment orders in a general hospital setting during the 2023-24 financial year.

Of the 331 orders, 46% (151) were in general hospital for seven days or less, 31% (104) were in general hospital for between 8 to 14 days and 23% (76) were in a general hospital for more than 14 days. Out of 259 patients, 36 (14%) 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 57% of the required approved Attachment to Form 6B. When these are overdue, Chief Psychiatrist staff follow-up

with the mental health clinicians with the aim of ensuring compliance with reporting under the MHA 2014.

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

Emergency psychiatric treatment

Under the MHA 2014, there are certain circumstances in which a medical practitioner may provide a person with emergency psychiatric treatment (EPT) without informed consent, if the treatment needs to be provided to save the person's life, or to prevent serious physical injury.

Under section 204 of the MHA 2014, the medical practitioner who provided the 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.

There were 254 cases of EPT reported to the Chief Psychiatrist, of which 57% were female and 43% male patients. The majority of notifications were from metropolitan hospitals (82%), with 18% from the WA Country Health Service. Of the patients who received EPT, 66% were adults between 18 and 64 years, 8% were 65 years or older, and 26% were under 18 years of age. The types of EPT provided to the patients included medication alone (45%) or medication in conjunction with the patient being secluded and/or restrained (55%). The method of administration of EPT was also reported; 87% of EPT was administered via intra-muscular injection, 7% intravenously and 5% orally. The remainder were administered either sublingually or the method was not specified. The most commonly reported medications were Droperidol (20%), Midazolam (20%), Clonazepam (16%), Haloperidol (16%), Olanzapine (8%), and Lorazepam (7%), which together account for 87% of all administered medications.

Urgent non-psychiatric treatment

Under section 242 of the MHA 2014, the person in charge of the Authorised Hospital must report the provision of Urgent Non-Psychiatric treatment to the Chief Psychiatrist through submission of the Approved Form. This financial year, there were less than five episodes of urgent non-psychiatric treatment reported. The small number of notifications prevents further examination of these data.

Further opinions

Under section 182 of the MHA 2014, patients can seek a further opinion of their diagnosis, treatment, and care. Requests for the Chief Psychiatrist to facilitate a further opinion on behalf of the patient can be received from the patient, a family member, a nominated person or a mental health advocate.

The Office of the Chief Psychiatrist facilitated five further opinions, three of which were completed and two of which did not progress.

Admission of a child to an adult mental health unit

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

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

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

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

The Chief Psychiatrist received 539 notifications of a child under 18 years of age being admitted to an adult mental health service in the 2023-24 financial year. Of the 539 notifications received, 392 (73%) of these were for females, and 147 (27%) were for males.

Identifying gaps in the reporting of a child under 18 years of age being admitted to an adult mental health service to the Office of the Chief Psychiatrist is currently being addressed using admission data from the Department of Health.

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

Appendix

Appendix

Statutory framework and the role of the Chief Psychiatrist

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

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

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

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

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

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

Currently the Chief Psychiatrist oversees the treatment and care provided by 58 public mental health inpatient units, three publicly contracted private providers of mental health services, four private psychiatric hospitals, 34 private psychiatric hostels, and 15 NGOs providing clinical mental health care. This amounts to overseeing the treatment and care of approximately 63,000 patients each year.

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

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

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

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

The Chief Psychiatrist's Standards for Clinical Care relate to:

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

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

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

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

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

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

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

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

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

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

The Chief Psychiatrist places a high value on the role and functions of Authorised Mental Health Practitioners (AMHPs).

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

The Office of the Chief Psychiatrist trains mental health practitioners to carry out the functions of an AMHP under the MHA 2014, to ensure their practice is at a reasonable standard before they can be designated as an AMHP.

The OCP provides refresher training, ensures the AMHPs engage in professional development, and provides clinical supervision to them on an annual basis to help them maintain their skills.

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

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

The Chief Psychiatrist is responsible for recommending to the Governor of Western Australia, the authorisation of a public hospital, or part of a public hospital, to receive and admit involuntary patients under the MHA 2014. The Chief Psychiatrist has developed standards that all new units within a public hospital must meet for the purpose of authorisation and has embarked on reviewing the authorisation of existing units: the Chief Psychiatrist's Standards for Authorisation of Hospitals under the *Mental Health Act 2014*. There are currently 20 authorised units (17 public and 3 private). The Chief Psychiatrist requires health service providers that are planning a new unit to liaise closely with the OCP at an early stage of planning to ensure the unit will meet the authorisation standards. Upon acceptance of the Chief Psychiatrist's recommendation, the Governor authorises the unit by order published in the *Government Gazette*.

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

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

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

The Chief Psychiatrist has developed standards for the administration of ECT: the *Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy 2015*.

The Chief Psychiatrist has published guidelines for ECT: *The ECT Guide: The Chief Psychiatrist's Guidelines for the Use of ECT in WA 2006*. These guidelines are currently being updated. Services approved for the performance of ECT are reapproved on a tri-annual basis to ensure they meet the Chief Psychiatrist's Standards.

Publishing guidelines (section 547 MHA 2014)

The Chief Psychiatrist must publish guidelines on the following:

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

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

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

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

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

(f) the performance of ECT;

(g) compliance with approved forms;

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

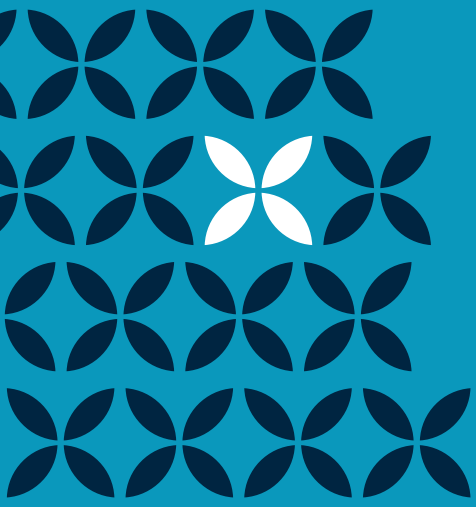
The Chief Psychiatrist may publish other guidelines relating to the treatment and care of persons who have a mental illness.

Other approvals

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

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

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



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