CHIEF PSYCHIATRIST
of Western Australia

The Chief Psychiatrist's Standards for Authorisation of Hospitals under the *Mental Health Act 2014*

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Acknowledgements

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- Clinical Reference Group, the Department of Health, Western Australia
- Consumers of Mental Health of Western Australia
- Mental Health Advocacy Service.

Hospitals previously authorised under the *Mental Health Act 1996*

Previous arrangements under the *Mental Health Act 1996* for authorisation of hospitals continued on proclamation of the *Mental Health Act 2014*. All authorised hospitals maintained their authorisation status under the *Mental Health Legislation Amendment Act 2014*.

Whilst these authorisation standards are aimed at new units there will be significant challenges for services who's authorisation has been historically grandfathered with the *Mental Health Act 1996* and the *Mental Health Act 2014*. The Chief Psychiatrist will work with these units to assist the development of a progressive refurbishment plan.

Message from the Chief Psychiatrist, Dr Nathan Gibson

The *Mental Health Act 2014* (the Act) s.542 invests the Chief Psychiatrist with the responsibility to make recommendation to the Governor of Western Australia for the authorisation of a hospital.

The Chief Psychiatrist is responsible for overseeing the treatment and care of all classes of persons cited in Section 515 of the Act, in public and private hospitals and publicly contracted private providers of mental health services. He discharges this responsibility by publishing the Chief Psychiatrist's Standards for Clinical Care and overseeing compliance with the standards.

In addition, it is important to note that as the Chief Psychiatrist of Western Australia I have endorsed the National Safety and Quality Health Service Standards 2021 as providing a framework for the provision of safe high quality mental health care.

This document outlines the process and the procedural steps before recommendations for authorisation can be made. The document sets out the Standards for Authorisation of Hospitals, which are arranged in a checklist format. Services must demonstrate compliance with the Standards and provide Qualifying Statements/Evidence that will inform the Chief Psychiatrist's decision to make recommendation to the Governor of Western Australia for the authorisation of a hospital.

The Chief Psychiatrist must be consulted before and during the design process of all new mental health facilities requiring authorisation. It is important to note all significant renovations and refurbishments of an Authorised Hospital require agreement/approval of the Chief Psychiatrist to ensure that an Order authorising a mental health unit accurately reflects such changes and meets the Chief Psychiatrist's Standards for Authorisation of Hospitals under the *Mental Health Act 2014* (see Appendix A).

For private hospitals and publicly contracted private providers of mental health services that require authorisation, the Chief Psychiatrist is required to recommend the endorsement of a licence under section 26DA(3A) of the *Private Hospitals and Health Services Act 1927*.

The Standards for Authorisation of Hospitals contained in this document replace the previous set of standards for the authorisation of hospitals under the *Mental Health Act 1996*. These standards are not designed to stifle innovation and so these remain appropriately broad to allow novel and contemporary practice.

Every effort should be made by services to incorporate contemporary practice and advancements in technology in terms of providing a safe and suitable environment for patients, carers and visitors accessing mental health services in an authorised public or private hospital across WA. Design concepts such as appropriate lighting, appropriate views from bedrooms and functional areas that provide social inclusion. Safety, suitability, appropriateness and functionality for a mental health environment should be considered a priority over design aesthetics.

The aim is to ensure that all Western Australians receive the highest standard of mental health treatment and care. I am also committed and support the national imperative to work towards eliminating restrictive practices in mental health services across Western Australia. As such a seclusion room/s within a facility under these circumstances is not essential and services seeking authorisation will need to demonstrate what strategies are in place to minimise restrictive practices. However, I am mindful at all times that the safety of staff, patients and visitors must not be compromised and before seclusion rooms can be closed there must be evidence of a sustainable alternative strategies to maximise safety.

Restraint and Seclusion and the use of seclusion rooms are addressed as Appendices (see Appendix D) to these Standards. A commitment is expected from the Health Service Provider to actively work towards eliminating restrictive practices and to invest in sustainable up skilling and specific support of clinicians that continues beyond Authorisation.

Services should take a trauma informed approach to care for all patients and take active steps to ensure the safety particularly of patients who have experienced trauma and are at risk of further trauma. Services should ensure the physical environment supports sexual safety for all patients, particularly vulnerable cohorts – women, youth, children and adolescents, disabled and the elderly. Appendix E outlines additional standards for Specialised Units, Youth, Child and Adolescent, Older Adult, Forensic and other specialist mental health services.

It is expected all mental health services will adhere to the Charter of Mental Health Care Principles (Schedule 1 of the Act) when providing treatment, care and support to patients, families and carers. Person centred care must always be central to all we do in achieving safe high quality mental health care in Western Australia.

I am committed to a program for reauthorisation of hospitals authorised under the *Mental Health Legislation Amendment Act 2014* which will be initiated in 2020. We will work with Health Service Providers, on a strategy to align these services with the revised set of standards.

Dr Nathan Gibson

CHIEF PSYCHIATRIST

08 October 2019

Reading Notes

The Standards used the term ‘patients’ when it means people who are, or appear to be, experiencing a mental illness. This use of the term is not a recommendation that the term ‘patient’ should be used in practice in preference to other terms such as ‘consumer’, ‘clients’ or similar. It is simply a reflection of the terminology used in the *Mental Health Act 2014*.

Legal Context

Mental Health Act 2014

Section 541 of the *Mental Health Act 2014* (the Act) defines an "authorised hospital" as:

a. a public hospital, or part of a public hospital, in respect of which an order is in force under section 542; or

b. a private hospital the licence of which is endorsed under section the *Hospitals and Health Services Act 1927* s. 26DA(2).

Note for section 541:

The licence of a private hospital cannot be endorsed unless the Chief Psychiatrist recommends the endorsement (*Hospitals and Health Services Act 1927* s. 26DA(3A)) and s. 542 of the Act provides as follows:

1. The Governor may, by order published in the Gazette, authorise a public hospital, or part of a public hospital, for:
   a. the reception of persons under this Act; and
   b. the admission of involuntary patients.
2. The Governor may, by order published in the Gazette, amend or revoke an order made under subsection (1).
3. The Governor cannot make, amend or revoke an order under this section unless the Chief Psychiatrist recommends that the order be made, amended or revoked.

The public hospitals that are "authorised hospitals" for the purposes of the Act are specified in the Mental Health (Authorisation of Public Hospitals) Order 2002 (the Order).

Section 543*(2) of the Act sets out the provisions when a hospital is no longer authorised:

1. This section applies if:
   a. an authorisation of a public hospital or a part of a public hospital is revoked under section 542(2); or
   b. the endorsement on the licence of a private hospital is cancelled under the *Hospitals and Health Services Act 1927* section 26FA(1).
2. Every person received into, and every involuntary patient admitted by, the hospital or that part of the hospital must be transferred in accordance with the *Mental Health Regulations 2015* (r.18) to an authorised hospital or other place.

*Note for section 543:

The endorsement on the licence of a private hospital cannot be cancelled unless the Chief Psychiatrist is consulted (see the *Hospitals and Health Services Act 1927* section 26FA(2A)).

Health Services Act 2016

S.8 meaning of hospital and public hospital:

4. Each of the following premises is a hospital for the purposes of this Act:
    a. premises where medical, surgical or dental treatment, or nursing care, is provided for ill or injured persons and at which overnight accommodation may be provided; and
    b. a day hospital facility; and
    c. a nursing post.
5. In subsection (4) an ill person includes a person who has a mental illness (as defined in the *Mental Health Act 2014* section 4) but this section does not affect any requirements under that Act that a person be detained at an authorised hospital (as defined in section 4 of that Act) or at another place.
6. Subject to any order made under subsection (8), each of the following premises is a public hospital for the purposes of this Act:
    a. a hospital controlled or managed by a health service provider or the Department CEO; or
    b. a hospital declared to be a public hospital under subsection (7).
7. The Minister may by order published in the Gazette declare any hospital to be a public hospital for the purposes of this Act.
8. The Minister may by order published in the Gazette declare that any hospital is not a public hospital for the purposes of this Act or the *Private Hospitals and Health Services Act 1927*.

S.9 Application of Act to hospital where mentally ill treated

Where a public hospital or part of a public hospital is an authorised hospital under the *Mental Health Act 2014*, this Act has effect in relation to the hospital or part of the hospital, and persons received or admitted into it, subject to the provisions of that Act.

Private Hospitals and Health Services Act 1927

S.26DA. Private hospital not to treat etc. mentally ill unless licence endorsed.

1. A person shall not conduct or manage a private hospital in which any person is detained for the treatment of mental illness unless the licence for that hospital is endorsed under this section.
2. A licence may be endorsed by the CEO to allow persons to be received and admitted to the hospital under the *Mental Health Act 2014* and to be detained as involuntary patients under that Act.
    a. The CEO cannot endorse a licence unless the Chief Psychiatrist recommends the endorsement.
3. An application may be made to the CEO for an endorsement under this section:
    a. on the application for a licence; or
    b. on an application under regulations referred to in subsection (5).
4. The CEO may make an endorsement under this section subject to any condition or restriction.
5. Regulations may be made under section 26O making provision for and in respect of applications for endorsements under this section, including the payment of fees in connection with the application.

Standards

Standard One: Safety – Design and Structure

The Hospital to be authorised is designed and structured and operates in a manner that minimises risk for patients, visitors and staff.

Research and consultation should be undertaken to ensure current use of quality anti ligature fittings and fixtures and that advancements in technology are applied in providing a safe and suitable environment for staff, patients and visitors.

Standard Two: Governance and Legislative Requirements

The operations of the hospital to be authorised meets the standards for the development and implementation and regular review of policies, protocols or procedures.

The operations of the hospital to be authorised meets the requirements of the *Mental Health Act 2014* and other applicable industry standards.

Standard Three: Information Management

The hospital to be authorised has a systematic and planned approach to the management of information as required by the *Mental Health Act 2014* and regulations.

Standard Four: Patient Care

The Hospital to be authorised has policies and procedures that ensure optimum patient care.

These policies and procedures facilitates the continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of patient and carers.

Standard Five: Staffing

The hospital to be authorised has staffing arrangements that enable high quality patient care, compliance with the *Mental Health Act 2014* and associated regulations and guidelines, and allow for optimum staff, patient and visitor safety.

Standard Six: Protection of Rights

Hospitals to be authorised have mechanisms in place to protect the rights of involuntary patients as determined by the provisions of the *Mental Health Act 2014* (s.243-262).

The Authorised Hospital is to ensure that there are policies and procedures to ensure that the rights of Involuntary patients, Mentally Impaired Accused (MIA) persons detained in an authorised hospital, persons referred under s. 26(2) or s.(3)(a) or s.36(2) and those under an order made under s.55(1)(c) or s.61(1)(c), as well as all patients of the *Mental Health Act 2014* designated mental health services.

Standard One:
Safety – Design and Structural

The Hospital to be authorised is designed, structured and operates in a manner that minimises risk for patients, visitors and staff.

Standard Criteria		Yes	No
1.0	Does the design of the facility prioritise and promote patient safety including sexual safety?		
1.1	Does the design of the facility provide gender specific areas and accommodate gender diversity, including bedroom and bathroom facilities?		
1.2	Does the facility integrate into the surroundings and are the necessary security measures discrete and unobtrusive?		
1.3	Does the facility have certified fire detection and response systems in place?		
1.4	Is the facility designed to incorporate modern and current technologies that assist the improvement of health care and the management of patient information?		
1.5	For facilities that are located on above ground levels; does the design maximise patient safety and eliminate the risk in accessing dangerous areas that increase the potential for self-harm?		
1.6	Within the design, does it provide for unobstructed automatic observation of all patient areas including outdoor areas?		
1.7	Has the design of the facility eliminated dead end corridors? For existing buildings is there a management strategy that mitigates risk to patients and staff?		
1.8	When blind spots or isolated spaces do exist and are unavoidable, e.g. in pre-existing buildings, are there specific measures in place to ensure staff, patient and visitor safety?		
1.9	Is there an appropriate balance between a welcoming design and safety features that provides protection for reception and other staff?		
1.10	Does the facility/unit entrance provide direct safe access and preserve confidentiality and dignity for patients referred for admission arriving either with relatives, via ambulance or police?		
1.11	Are patients arriving via ambulance and or police, received in a secure area, away from public view?		

Standard Criteria		Yes	No
1.12	If the facility has a secure ambulance bay does it mitigate the risk of absconding and ensures patient safety and privacy?		
1.13	Does the facility provide for admissions which minimises disruption to other patients, especially for night time admissions?		
1.14	Has a secure gun safe been provided that allows the opportunity for Police to disarm and store weapons and related equipment when they are in attendance at the Inpatient Unit?		
1.15	Does the unit have a secure safe for storage of any weapons confiscated from patients?		
1.16	Are all units capable of secure lockable isolation, area by area within the facility?		
1.17	Are mirror domes installed in appropriate places for increased visibility?		
1.18	Are ceiling spaces in patient areas secure and do they prevent unauthorised access?		
1.19	Are the designated visitor rooms/areas provided able to be observed by staff?		
1.20	Are there suitable areas ensuring safety and access for child visitors to secure/open wards?		
1.21	Are all fixtures and fittings within the facility – such as windows and door furniture, door closers and hinges, taps, showerheads, and coat hooks designed, tested and approved products specifically designed to prevent ligature and other forms of self-harm?		
1.22	Does the design of bathrooms allow for the use of wheelchairs, stretchers and eliminate a single person entry and egress?		
1.23	Are ensuites equipped with doors and hardware that permit access in an emergency?		
1.24	Has the service considered appropriate grab rails and other fittings in areas where older adult patients and or physical disability are issues?		
1.25	Is the ensuite door designed to be anti – ligature? eg piano hinge, cambered to an appropriate angle, with due consideration for privacy and personal safety?		
1.26	Does the facility provide sensory/quiet rooms?		
1.27	Are outdoor areas large enough to accommodate all the patients and designed for therapeutic requirements whilst maintaining patient safety?		

Standard Criteria		Yes	No
1.28	Do any outdoor fittings and fixtures pose risk of self-harm or the concealment of prohibited and unauthorised items?		
1.29	Are all outdoor fittings and fixtures tamper resistant?		
1.30	Do outdoor areas have adequate ventilation and where required the ability to control temperature – such as heating and cooling systems?		
1.31	Do outdoor areas have adequate shaded areas for protection from ultraviolet rays?		
1.32	Are the fencing and or walls in outdoor areas of no less than 4.27 metres in height?		
1.33	What are the strategies in place that mitigate the risk of absconding and patient safety?		
1.34	Do all interview rooms have a discrete anti ligature duress alarm system?		
1.35	Do interview rooms have an appropriate viewing panel with integral blinds that staff are able to operate from both sides?		
1.36	Do interview, consultation rooms have dual egress and an outward opening door to assist staff egress in an emergency?		
1.37	Do interview rooms have emergency egress to a suitable area?		
1.38	Are interview rooms equipped with furniture that cannot be potentially used to harm someone?		
1.39	Are there appropriate facilities available for the Mental Health Tribunal to conduct reviews?		
1.40	Are lockable doors provided in all recreational and therapeutic activity areas; that prevent unsupervised patient access?		
1.41	Is the therapy room furniture robust, heavy duty and suitable for purpose?		
1.42	Are the therapy areas utilising paints/chemicals/etc appropriately ventilated?		
1.43	Are there suitably designed exercise areas available for patient on all wards including secure wards, to use with consideration given to age appropriateness? e.g. youth and older adult.		
1.44	Is there a clear plan to manage risk of accidental or self-inflicted injury when installing and the use of exercise/therapy apparatus?		
1.45	Does the design of kitchen areas allow staff to serve meals in safety and permits restrictions to be placed on patients' access when required?		

Standard Criteria		Yes	No
1.46	Where patient access is permitted to access kitchen facilities;		
	a. are cupboards lockable?		
	b. are chemicals securely stored and inaccessible by patients?		
	c. are items that may harm the patient and others, such as knives restricted?		
	d. is hot water temperature staff controlled?		
	e. are safety/RCD switches installed? (e.g. water and electricity)		
	f. is there a regular documented stocktake of equipment?		
1.47	Are essential wall and ceiling fixtures and fittings incapable of supporting a patient's weight and do they have a breaking strain of not more than 15kgs or are they anti ligature?		
1.48	Are all fixtures and fittings, manufactured, fitted and maintained to mitigate the possibility of accidents, misuse, use as weapons or to aid self-harm or suicide?		
1.49	Are fittings that are potentially dangerous for patients and staff absent from patient areas, or designed so that the potential for harm is mitigated e.g. Holland and Venetian blinds, pelmets, curtains, curtain cords and curtain tracks, and door closers?		
1.50	Are telephone cords and other electrical cords short enough to mitigate self-harm or suicide?		
1.51	Can the service ensure that heavy-duty cutters, capable of severing a ligature eg thick leather belt, are available and are accessible on each ward and therapy areas?		
1.52	Are paintings, mirrors and signage including emergency signage strongly attached to walls with tamper proof fixings?		
1.53	Are mirrors made of safety glass and recessed; or are they anti ligature?		
1.54	Are the doors of a type which ensures good observation of exterior spaces at entry/exit to the facility?		
1.55	Does the service have strategies in place for when rooms with dividers e.g. privacy curtains, obscure observation of the entire bedroom space or interview room?		
1.56	Does the door have the capacity to provide staff a clear unobstructed observation of entire bed room space or interview room?		

Standard Criteria		Yes	No
1.57	Does the door have observational windows that also enable privacy – controlled by staff?		
1.58	Does the door allow access to the room in the event of the barricading of the door?		
1.59	Is all door hardware in patient areas tested and approved anti ligature specifically designed to prevent self-harm?		
1.60	Are doors in all patient areas free of ventilation grills?		
1.61	Glazed doors or large glazed panels any type at upper floor level is not recommended, prior consultation with the Chief Psychiatrist is requires in terms of strategies to mitigate risk of harm to patients.		
1.62	Are the windows supplemented by metal frames, restricted openings and of high grade safety/laminated glass?		
1.63	Are staff assist, emergency, and duress alarms provided in all patient and staff-assist areas and are they fully functioning?		
1.64	Do staff duress alarms have technology that identifies emergencies with accurate room location capabilities?		
1.65	Is the staff alert/alarm system easily accessible by staff?		
1.66	Are indicator boards mounted in the nurses station and staff rooms and do they identify the location of the emergency?		
1.67	Are staff rooms located away from the patient areas but close enough for rapid access to them in case of emergencies?		
1.68	Is all plant equipment at the facility securely housed to prevent unauthorised access, especially in areas accessible by patients?		
1.69	Is there a documented routine maintenance plan for the facility?		
1.70	Are maintenance activities carried out at the facility in a way that do not endanger the safety of staff, visitors, patients?		
1.71	Is there a documented process for checking fixtures and fittings and the removal and or replacement of old and unused fittings? e.g. taps, curtain tracks.		

Standard Two:
Governance and Legislative Requirements

The operations of the hospital to be authorised meets the standards for the development and implementation and regular review of policies, protocols or procedures.

The operations of the hospital to be authorised meets the requirements of the *Mental Health Act 2014* and other comply with legislative requirements and applicable industry standards.

Does the facility have policies that comply with legislative requirements and relevant industry standards?

Standard Criteria		Yes	No
2.0	Does the service have a policy that ensures compliance with the Chief Psychiatrist Delegation Schedule?		
2.1	Does the facility have a policy that ensures compliance with the Charter of Mental Health Care Principles?		
2.2	Does the facility have a quality improvement program?		
2.3	Does the service demonstrate active involvement with patients and carers in service development and service provision?		
2.4	Does the facility have in place policies and procedures for reviewing and evaluating clinical program outcomes?		
2.5	Are there policies and service delivery protocols that enable staff to effectively identify carers/personal support/nominated person (s.7(2)(b) as soon as possible in all episodes of care, and is this recorded and prominently displayed within the patient's medical record?		
2.6	Is there a policy acknowledging the role and rights of personal support persons, and number of important relationships?		
2.7	Does the service have a policy which considers the needs of carers/ personal support person in relation to people of Aboriginal and Torres Strait Islander descent, culturally and linguistically diverse (CALD) persons, religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age profile and socio-economic status?		
2.8	Does the service consider the special needs of children and aged persons as carers and makes appropriate arrangements for their support?		
2.9	Does the service have a policy that ensures the capacity of an adult is considered in decision making and the involvement of persons who by law can make decisions on the adult's behalf?		

Standard Criteria		Yes	No
2.10	Does the service have a policy that ensures the capacity of a child is considered in decision making and the involvement of persons who by law can make decisions on the child's behalf?		
2.11	Does the service have a policy and process regarding nominated persons?		
2.12	Does the service have a clinical risk assessment and management policy?		
2.13	Does the service have a policy considering personal safety of all inpatients, in particular those patients who are vulnerable?		
2.14	Does the service have policies and procedures that promote sexual safety and respond to incidents that compromise sexual safety?		
2.15	Does the service have a policy regarding the prevention and management of distressed patients? (see also Staffing)		
2.16	Does the service have a policy regarding the prevention and management of challenging behaviours?		
2.17	Does the service have a procedure for the receival of a referred person on a Form 1A or Form 3D?		
2.18	Can the service ensure staff are aware they are required to receive a patient under the Act?		
2.19	Does the service have a procedure for the admission of a detained involuntary patient transferred to the authorised hospital on a Form 4C?		
2.20	Does the service have a procedure for a patient on a community treatment order (CTO) being admitted as a voluntary patient to an authorised hospital?		
2.21	Does the service have a procedure for detaining a person subject to a Form 2 – Order to detain voluntary patient in authorised hospital for assessment?		
2.22	Does the service have a procedure for admission of patient on an involuntary inpatient order (ITO Form 6A) and continuation of an ITO on a Form 6C		
2.23	Does the service have a procedure for informing a referred person, a voluntary and involuntary patient and personal support persons about their rights under the *Mental Health Act 2014*? (s.244,246, 292-294)?		
2.24	Does the service have a procedure for granting, monitoring and cancelling leave and returning and accepting the patient to the authorised hospital? (s. 105-110)		
2.25	Does the service have a procedure for making an involuntary detained patient no longer involuntary or subject to a CTO on the advice of an mental health practitioner or medical practitioner while the patient is on leave? (s. 109)		

Standard Criteria		Yes	No
2.26	Does the service have a procedure for making a voluntary or involuntary detained patient subject to a CTO on discharge from the facility? (s.55)		
2.27	If the service has an ECT service is this approved by the CP?		
2.28	Does the service have an auditable system in place that ensures patient medication is managed safely and securely in accordance with legislative requirements and best practice?		
2.29	Can the service ensure that medication notifiable incidents are recorded, reported through the appropriate reporting procedures, e.g. CIMS, reviewed and acted upon? (s.5.25)		
2.30	Does the service have a process to support the workforce recognition and reporting of notifiable incidents and near misses?		
2.31	Does the service have a policy and process to support staff, patients and visitors during and after critical incidents?		
2.32	Does the service have a policy and procedure for reporting the use of seclusion (s.211-225) and bodily restraint (s.226-240)?		
2.33	Does the service have a policy and procedure for the use and management of emergency sedation?		
2.34	Does the service have a policy and procedure for the use and management of 'pro re nata' medication (PRN)?		
2.35	Does the service have a procedure for requests for access to documents including the patient's medical records and a procedure when that right is restricted?		
2.36	Does the service have a policy and procedure upholding the rights of inpatients generally (subdivision 2, division 2, Part 16) which include:		
	a. The right to keep personal possessions ? (s.259)		
	b. The right to an interview with a psychiatrist ? (s. 260)		
	c. The right to freedom of communication and when that right might be restricted? (s. 261/262		
2.37	Does the service have a procedure for the request by the involuntary inpatient and others such as a personal support persons for a further opinion regarding treatment? (s.182-183)		
2.38	Does the service have a procedure related to the right to request admission? (s.255-257)		
2.39	Does the service have a policy and procedures in relation to personal possessions? (s. 259)		

Standard Criteria	Yes	No
2.40 Does the service have procedures in relation to search and seizure and return of property? (Part 11)		
2.41 Does the service have procedures in relation to treatment support and discharge planning and do these procedures ensure the involvement of the patient, personal support persons, psychiatrist and multidisciplinary team? (s. 186)		
2.42 Does the service have procedures in relation to Transfer of Care to ensure continuity, timeliness, safety and quality of care for patients and carers is maintained during transfer either between or within services including among General, Private and Authorised Hospitals?		
2.43 Does the service have a procedure for when a person is to be returned to custody under another law? (s.96)		
2.44 Does the service have a procedure for the receival of a patient on a hospital order and a patient who is mentally impaired accused under *Criminal Law Mentally Impaired Accused Act*? (s.177 (b))		
2.45 Does the service have a procedure for informing the Chief Psychiatrist in relation to off-label treatment for children who are involuntary patients?		
2.46 Does the service have a procedure for advising the Chief Psychiatrist of the measures taken to ensure a child admitted as an inpatient in a service that does not ordinarily provide treatment to children is protected and individual needs are met? (s.303)		
2.47 Does the service have a procedure for capturing and accessing information on CCTV, including who is able to access the footage, storage and security/ confidentiality protocols and retrieval process?		
2.48 Does the service have appropriate placement of CCTV monitors (Note: not to be a replacement for automatic observation by staff)?		
2.49 Does the service have policies and procedures available that demonstrate that arrangements are in place to effectively manage:		
a. Involuntary inpatients who may be absent without leave, voluntary patients who are deemed to be missing or discharge against medical advice?		
b. Discharge of patients?		
c. Patients receiving visitors?		
d. manage visitors, who may be intoxicated, drug affected, aggressive or banned from the premises?		
e. Patients who require treatment or assessment for a medical condition?		
f. The death of a patient?		

Standard Criteria		Yes	No
2.50	Does the service have a process for reporting the use of emergency psychiatric treatment? (Part 14 Division2)		
2.51	Does the service have policies and processes in place with regard to control and access to and from the facility?		
2.52	Does the service have policies and procedures in place for the identification, observation, restriction, transport and security of patients who are at high risk to themselves or others?		
2.53	Does the service have policies and procedures that demonstrate environmental and clinical risks, actual and potential, are identified, assessed and managed to ensure a safe environment?		
2.54	Does the service have operational strategies in place that mitigates ligature risk when the infrastructure may not be modified?		
2.55	Does the service have policies and procedures in place for the safety and management of patients who are sedated, unconscious or disorientated?		
2.56	In the event of an emergency does the service have a comprehensive Business Continuity Plan?		
2.57	Does the service have a disaster management plan in place which includes evacuation for all patient cohorts in the event of fire or other emergencies?		
2.58	Does the service have evacuation procedures and maps displayed throughout the facility?		
2.59	Has the service installed a duress system throughout the mental health unit that has capabilities of room level accuracy?		
2.60	Does the service have a policy for staff to carry personal duress alarms that identify emergencies and the location?		
2.61	Does the service have documented policy and procedures for staff response in emergency situations and when a duress alarm is activated?		
2.62	Does the service have a policy for the reconciliation and storage of potentially harmful items used in therapeutic or rehabilitative activities after each session against stock held, e.g. therabands, snooker cues/saws?		
2.63	Does the service have policies and procedures in place for staff escorting patients outside the facility/hospital areas including the provision and use of communication equipment (mobile phones/ pagers)?		
2.64	Does the service have policies and procedures in place for involuntary detained patients granted unescorted ground leave?		

Standard Three:
Information Management

The hospital to be authorised has a systematic and planned approach to the management of information as required by the *Mental Health Act 2014* and regulations.

Standard Criteria		Yes	No
3.0	Does the person in charge of the authorised hospital have arrangements in place that ensure proper records are kept for each patient admitted to the hospital and each patient who is provided with treatment and care by the mental health service? (s. 582)		
3.1	Does the service have a policy for sharing of clinical information as it applies to Confidentiality? (s.576)		
3.2	Does the service have a policy addressing the procedure of amendments to referrals and orders under the Act? (s.581)		
3.3	Does the service have a policy regarding consent and communication of information that addresses:		
	a. The requirements of informed consent? (s.16-20)		
	b. Preparing reports authorised by the *Mental Health Act 2014*? (s.343)		
	c. Investigation of any suspected offence? (s.571)		
	d. That personal information is de-identified in statistical data? (s.342 (2))		
3.4	Does the service have a policy regarding the respectful collection of a person's sex and gender information?		
3.5	Does the clinical record allow for systematic audit of the contents?		
3.6	Does the service have policies, procedures and protocols in the use of electronic information management systems – including accuracy of information and entry in a timely manner?		
3.7	Can the service ensure that management of information during transfer of care ensures continuity of safety and quality of care for patients and carers during transfer between or within services?		
3.8	Does the service have a procedure for recording and maintaining particulars of:		
	a. when a referred person is 'received' into the authorised hospital, date, time of receival or revocation as noted on Form 1A ? (s.34, 35)		

Standard Criteria	Yes	No
b. the legal status of patient: whether voluntary, referred person, detained involuntary, subject to a CTO when in the community but voluntary in hospital or mentally impaired accused?		
c. when a person is admitted into hospital either as a voluntary or involuntary patient?		
d. when a referred person is made an involuntary patient on a CTO, noted on a Form 5A (s.55)?		
e. when a referred person is made a detained involuntary patient as noted on Form 6A? (s.55,56,72,89,90,120,123 and 131)		
f. when a person is discharged from hospital, whether voluntary basis or subject to a CTO?		
g. when a patient's status under the MHA is changed from involuntary to voluntary, from voluntary to detained either as a referred person or an involuntary patient?		
h. if a patient dies (including inpatients on leave or missing persons from the hospital) and the death is a reported under the *Coroners Act 1996*?		
i. all forms, notifications and reports provided to the Mental Health Tribunal? (s.380 – 385)		
j. when a person is given an explanation of their rights, details of the person to whom the explanation is given? (s.243, 244, 245 and 246)		
k. all periods of leave granted under or any periods of absence without leave (s.97 and 105)?		
l. a patient's medication history in a way that ensures this history is available throughout the episode of care?		
3.9 Does the service use appropriate, flexible (language and medium) and patient friendly medication information and ongoing education?		
3.10 Does the service have a process for the communication of medication information during transitions of care to other places of care and including the patient's general practitioner?		
3.11 Can the service ensure that a complete list of a patient's medications is provided to the receiving clinician and patient when handing over care?		
3.12 Can the service ensure the Western Australian Therapeutics Advisory Group (WATAG) Operational Circulars on medication issues are available on each unit of the facility and are adhered to?		

Standard Criteria	Yes	No
3.13 Does the service have policies and procedures in place for reporting to the Chief Psychiatrist:		
a. *Notifiable Incidents (s.526)?		
b. **Seclusion (s.212)?		
c. **Restraint (s.227)?		
d. Electroconvulsive Treatment (s.201)(3)?		
e. Urgent Non-Psychiatric Treatment (s.242)?		
f. Segregation of children from adult patient's (s.303)?		
g. Off-label prescription to a child who is an involuntary patient (s.304)?		
h. Inpatient treatment order in general hospital (attachment to Form 6B) (s.65)?		
i. Deaths?		
j. Assault and or/Aggression?		
k. Sexual contact and or allegation of sexual assault?		
l. Unlawful sexual contact with patient by staff member?		
m. Non suicidal self-injury/harm?		
n. Attempted suicide?		
o. Absent without leave?		
p. Missing person?		
q. Serious medication error?		
r. The patient is harmed by suspected unreasonable use of force by a staff member?		

*Note – Please see Chief Psychiatrist Policy for Notifiable Incidents

https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2016/11/Notifiable-Incidents-Policy-Public-Services-2015.pdf

****Note** – The *Mental Health Act 2014* does not set out the requirement for services to maintain a register of seclusion and restraint, however the Chief Psychiatrist encourages services to maintain such a register.

Standard Four:
Patient Care

The Hospital to be authorised has policies and procedures that ensure optimum patient care.

Facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of patients and carers.

Standard Criteria		Yes	No
4.0	Is the service responsive to patient and carer input and needs and is this reflected in the treatment support and discharge/care plan?		
4.1	Does the service collaborate with family members and carers in patient management?		
4.2	Does the service promote dignity compassion and respect as one would expect for themselves and or a family member?		
4.3	Does the service treat all people with compassion dignity and respect, regardless of their sex and/or gender identity?		
4.4	Does the service promote optimism and hope; and support patient's efforts in their recovery from mental illness?		
4.5	Does the service have a policy that ensures all patients receive a physical health assessment upon admission and as required, and management of their physical health care needs?		
4.6	Does the service have a policy ensuring an explanation of patient rights is given in a language or medium that is understood by the patient?		
4.7	Are payphones, cordless telephones, or mobile phones, available for patient use in reasonable privacy?		
4.8	Are single bedrooms available for vulnerable patients?		
4.9	Can the service ensure patients who have experienced trauma and are at no risk of further trauma.		
4.10	Can the service safeguard the security and sexual safety of female patients is ensured via the provision of same gender clusters or equivalent strategies?		
4.11	Can the service ensure that individual patient doors are lockable (mechanical or electronic) by the patient but able to be overridden by the staff in the case of an emergency?		
4.12	Regarding risk can the service ensure that patient care balances risk mitigation and dignity/rights?		

Standard Criteria	Yes	No
4.13 Can the service ensure that patients from Aboriginal communities, or from ethnoculturally diverse groups receive treatment and care appropriate to and consistent with their cultural beliefs and community views?		
4.14 Can the service ensure patients returning to Corrective Services are examined by a medical practitioner prior to discharge?		
4.15 Can the service ensure that patients (and when applicable family/ carer/nominated person) involved in a notifiable incident are provided appropriate support and a prompt review of the incident?		
4.16 Can the service ensure that treatment, support and discharge planning commences upon admission, involves patients, families and carers collaboratively and includes written information provided to them before discharge?		
4.17 Can the service ensure there is appropriate and consistent transfer of care planning in keeping with the Chief Psychiatrist Statutory Standards?		

Standard Five:
Staffing

The hospital to be authorised has staffing arrangements that enable high quality patient care, compliance with the *Mental Health Act 2014* and associated regulations and guidelines, and allow for optimum staff, patient and visitors safety.

Standard Criteria		Yes	No
5.0	Does the service have a consultant psychiatrist in the clinical leadership and governance role:		
	a. Does this person have oversight for all patients undergoing psychiatric treatment programmes?		
	b. Is this person regularly and frequently available on site?		
	c. Is this person available should there be a crisis?		
	d. Is there an on call consultant psychiatrist available to act as proxy clinical director?		
5.1	Does the service have a Consultant Psychiatrist who is present during the working week?		
5.2	Does the service have a Consultant Psychiatrist who is available on call at all other times?		
5.3	Is there a plan for continuity of care during periods of staff leave planned or unplanned?		
5.4	Does the service have a Psychiatric Registrar or equivalent Medical Practitioner on duty (available on site) at all times? (There may be negotiated arrangements in a non-metropolitan setting)		
5.5	Does the service have a robust recruitment and selection process that ensure staff have the qualifications, skills and capability to perform the duties required of them?		
5.6	Does the service have an ongoing credentialing process for all senior medical staff as per Department of Health Credentialing and Defining the Scope of Clinical Practice Policy? (effective 10 May 2018)		
5.7	Does the service have a policy that ensures relevant *Mental Health Act 2014* training at point of orientation and for all staff a relevant yearly refresher?		
5.8	Does the service have a workforce that are aware of their functions under the *Mental Health Act 2014*, delegated safety and quality roles and their responsibilities?		

Standard Criteria		Yes	No
5.9	Does the service have a review process that defines the requirements and numbers of Authorised Mental Health Practitioners?		
5.10	Does the service have a regular auditing process to ensure psychiatrists within their service are legally (where required, Gazettal) able to administer the *Mental Health Act 2014*? (see Regulation 4A of the *Mental Health Regulations 2015* and OCP website)		
5.11	Does the service have clerical/support staff to assist with the administrative requirements of the *Mental Health Act 2014*?		
5.12	Does the service have a gender mix of staff relevant to safety and care procedures?		
5.13	Does the service have staffing numbers and skill set which are appropriate for managing people with mental illness?		
5.14	Does the service have a process that ensures staff are responsive to and capable of managing a range of diversities within this patient cohort – including gender, religious, cultural and other diversity?		
5.15	Does the service have staff with a comprehensive knowledge of community services and resources and collaborates with patients, carers and personal support persons to assist them to identify and access appropriate and relevant services?		
5.16	Does the service invest in sustainable ongoing training and up skilling of clinicians with a commitment that this training continues beyond Authorisation?		
5.17	Is there a policy requiring non-clinical staff to receive training in strategies to support safety, respect and dignity in all interactions with consumers.		
5.18	Does the service have a documented program to ensure that clinical staff:		
	a. are appropriately trained, developed and supported to safely perform the duties required of them?		
	b. are appropriately trained, understand and apply recovery principles?		

Standard Criteria	Yes	No
c. are appropriately trained and regularly updated in the prevention and management of distressed patients and aggressive behaviours that include de-escalating techniques and working towards eliminating restrictive practices?		
d. participate in professional development and networking opportunities in relation to the improving care for people of Aboriginal and Torres Strait Islander descent?		
e. participate in professional development regarding care for diverse cohorts eg gender, religion and culture?		
f. have access to appropriate, regular and timely clinical supervision?		
g. maintain compliance with relevant professional standards maintained by professional boards?		
5.19 Do clinical staff receive ongoing training that is current in prevention and management of distress and aggression and use of alternatives to restrictive practices?		
5.20 Are clinical staff trained and competent in risk assessments and the management of patients who are a risk to themselves or others?		
5.21 Are non-clinical staff trained in strategies to support safety, respect and dignity in all interactions with consumers?		
5.22 Does the service have procedures to ensure that agency staff have sufficient knowledge of the *Mental Health Act 2014* and are appropriately trained and have received regular updates in the prevention and management of distressed patients and aggressive behaviour that includes de-escalation techniques?		
5.23 Does the service have procedures to ensure that security staff have sufficient knowledge of the *Mental Health Act 2014* and are appropriately trained and receive regular updates in the prevention and management of distressed patients and aggressive behaviour that includes de-escalation techniques?		
5.24 Are staff supported and provided with access to a staff health and wellbeing service?		
5.25 Are agency staff afforded an induction to immediately relevant ward processes and policies, prior to commencing work and are they appropriately supervised?		

Standard Six:
Protection of Rights

Hospitals to be authorised have mechanisms in place to protect the rights of involuntary patients as determined by the provisions of the *Mental Health Act 2014* (s.243-262).

The Authorised Hospital is to ensure that there are policies and procedures to ensure that the rights of Involuntary patients, Mentally Impaired Accused (MIA) persons detained in an authorised hospital, persons referred under s. 26(2) or s. (3)(a) or s.36(2) and those under an order made under s.55(1)(c) or s.61(1)(c), as well as all patients of a designated mental health services are met.

Standard Criteria		Yes	No
6.0	Can the service ensure that the psychiatrist or delegate of the psychiatrist gives an explanation of and facilitates an understanding of rights for the patient and other persons as appropriate? (s. 246)		
6.1	That the referred person and patient is given a copy (as soon as practicable) of any order/s Form 1A (only the information in the Form needs to be provided), 1B, 2, 3A, 3B, 3C, 3D, 3E, 4A, 4B, 4C, 4D, 4E, 5A (including attachment), 5B, 5C, 5E, 5F, 6A, 6B, 6C, 6D, 7A, 7B, 7C, 8A, 9A, 9B, 10A, 10B, 10C, 10D, 10E, 10F, 10G, 10H, 10I, 11A, 11B, 11C, 11D, 11E, 11F, 11G, 12B, 12C?		
6.2	Can the service ensure that the written and verbal information provided to the patient is understandable, meeting the accessibility standards accessibility and are provided in the patient's preferred language/format? (s.9)		
6.3	Can the service ensure an independent accredited interpreter is readily available for patients across all phases of their stay and aspects of care and what is the process in circumstances when there is a lack of availability? (s.9)		
6.4	Does the service have a process for effective feedback that supports the rights of patients, staff, visitors or carers to make a complaint and have that complaint addressed? (s.308)		
6.5	Does the service have policies and procedures that ensure that patients are assessed and reviewed and receive treatment and care in accordance with *Mental Health Act 2014* requirements and best practice clinical guidelines?		
6.6	Does the service have a policy ensuring that patients have the right to be treated with respect and dignity at all times?		
6.7	Does the service have a policy in place to ensure patients and person support persons are given information orally and in writing about their rights to access the Mental Health Advocacy Service and other relevant advocacy and legal support?		

Standard Criteria		Yes	No
6.8	Does the service have procedures and or the facilities that allows patients to access the Mental Health Advocacy Service whenever they wish to do so?		
6.9	Does the service have a policy ensuring that patients have the right to be acknowledged and known by their preferred sex/gender?		
6.10	Can the service ensure that patients are treated as partners in the management of all aspects of their treatment, support, care and recovery planning?		
6.11	Does the service have a system in place to support people at risk of not understanding their healthcare rights?		
6.12	Does the service have a policy that patients and carers/personal support person (where relevant) are fully informed about any proposed treatment?		
6.13	Does the service have policies which reflect that informed consent is always sought prior to the administration of any medication?		
6.14	Does the service have a process in place for communicating information to the patient, including potential benefits and risks regarding medications?		

Chief Psychiatrist Process for Authorising a Hospital in Western Australia

Standard Criteria	
Step 1	Area Mental Health Clinical Director or the Chief Executive Officer * prepares a submission for the Chief Psychiatrist. * these titles are interchangeable and depends on the services hierarchy of position titles
Step 2	Chief Psychiatrist seeks the approval from Minister for Mental Health to draft the appropriate Order.
Step 3	Minister for Mental Health acknowledges the request.
Step 4	Chief Psychiatrist submits to Department of Health, Legal and Legislative Services attaching Ministerial advice and Qualifying Statement/Evidence.
Step 5	Legal and Legislative Services instruct Parliamentary Counsel's Office to draft Order.
Step 6	The process involves liaison between Legal and Legislative Services and the Office of the Chief Psychiatrist to enable Legal and Legislative Services to provide further instruction to the drafter. More than one draft maybe required before the final Order is finalized.
Step 7	Legal and Legislative Services submits the final Order together with a Minute and Explanatory Note to Executive Council. Executive Council meets every second Tuesday
Step 8	Legal and Legislative Services advise the Chief Psychiatrist of approval.

*Private hospitals and those with public/private partnerships must meet licensing obligations with Licensing and Accreditation Regulatory Unit and the Department of Health of Western Australia.

Note – Timeframes are not set by the Chief Psychiatrist and delays may occur, for example information and clarification may be request by Legal and Legislative Services, Executive Council and Parliamentary Counsels Office.

Gazettal

- Legal and Legislative Services arrange the publication of the Order in the Government Gazette
- Private hospitals and those with public/private partnerships are not published in the Government Gazette.
- The Government Gazette is published by noon every Wednesday and Friday.

The Chief Psychiatrists requirements for authorisation of a Hospital in Western Australia

1. The Area Mental Health Clinical Director or The Chief Executive Office is to prepare a submission for the Chief Psychiatrist. The submission is to include the following:
    - the reason for the application for authorisation
    - letter of support from Area Health Service Chief Executive Officer
    - qualifying Statements/Evidence addressing the Standards criteria
    - a comprehensive suite of policies and procedures
    - site maps – as per the following:
        - an electronic copy
        - a hard copy
        - 1 map of the Mental Health Unit/Ward
        - 1 map of the general hospital/health service where the Mental Health Unit/Ward is located, including all street names bordering the facility
        - 1 map indicating the location of CCTV monitors
        - 1 map indicating the perimeter of the area to be authorised bordered in bold red
        - the map be of a resolution that can be printed clearly as an A3 document
        - text on the maps are required to be clear and easily read and to include;
            - a title which clearly states the name of the unit/ward and the authorised area and which hospital it is located in – the title must include the term 'hospital'
            - date
            - identifier number – Plan no
            - include details of where the plan can be accessed (a copy will be maintained by the Office of the Chief Psychiatrist).

2. a. the Chief Psychiatrist when formally requested will visit the facility for the purpose of ensuring compliance and that the service meets the required standards, particularly the safety and suitability for patients, visitors and staff

   b. it is expected that services will invite the Chief Psychiatrist to make preliminary visits to a unit seeking authorisation for the purpose of maximising the opportunity for authorisation.

3. The Chief Psychiatrist once satisfied will make recommendation to the Minister for Mental Health and seek the appropriate order under s.541 for submission to the Governor in Executive Council. (see Appendices).
4. Once the Minister for Mental Health has approved the recommendation, the Chief Psychiatrist will liaise with Department of Health, Legal and Legislative Service who will draft the necessary Order.
5. Department of Health, Legal and Legislative Service presents Orders for making by the Governor.
6. The Governor makes an Order and the Legal and Legislative Service arranged for the Order to be published in the Gazette.
7. The Order will take effect from the date of publication in the Gazette or later if stated in the Order.
8. The Health Service is notified accordingly through the Chief Psychiatrist.
9. The new authorised hospital will be entered into the register* maintained by the Chief Psychiatrist*.

*The *Mental Health Act 2014* does not require the Chief Psychiatrist to maintain a register of Authorised Hospitals. The Chief Psychiatrist however for recording purposes will continue to maintain a register. The register will be available on the Chief Psychiatrist website,

Private Hospitals and those with Public/Private Partnerships

'Private Hospital' has the meaning given in the *Hospital and Health Services Act 1927*, s.2 (1).

> 'a private hospital means a hospital that is not a public hospital'

'Mental health service' can include a private hospital but only to the extent that the hospital provides treatment and care to people who have or may have a mental illness (s.4).

A pre requisite for authorisation of private hospitals and those with public/private partnerships in Western Australia is the hospital must be licensed by the Department of Health of Western Australia. The Director General of Health must be satisfied all requirements and standards are met before a private hospital is granted a licence or the licence renewed.

As per s.541 (b), this is carried out under the authority of Parts 111A and B of the *Hospitals and Health Services Act 1927* and the provisions of the *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987* and the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*.

The *Mental Health Act 2014* notes 'the licence of a private hospital cannot be endorsed unless the Chief Psychiatrist recommends the endorsement' (*Hospitals and Health Services Act 1927* section 26D(3A)).

The Licensing and Accreditation Regulatory Unit (LARU) is responsible for the licensing and monitoring of private hospitals in Western Australia. Private Hospitals must meet the minimum criteria as indicated in the Licencing Standards for the Arrangements for management, staffing and equipment Private Hospitals (currently under review) and as a mental health facility the 'Licensing standards for the arrangements for management, staffing and equipment Psychiatric day hospitals – Class D'.

For more information about licensing of Private Hospitals:

Licensing and Accreditation Regulatory Unit
Department of Health
Level 1, B Block
189 Royal Street
East Perth WA 6004

Phone: 9222 4027
Fax: 9222 4077

Authorisation under the *Mental Health Act 2014*

Once a private hospital has met licensing obligations with LARU and the Department of Health of Western Australia and satisfies The Chief Psychiatrist's Standards for the Authorisation of Hospitals in Western Australia and becomes an authorised hospital, its licence will be endorsed to allow persons to be received and admitted to the private hospital and be detained as involuntary patients under the *Mental Health Act 2014*, pursuant to s.26DA(2) of the *Hospitals and Services Act 1927*.

Note – Private Hospitals or those with Public/Private partnership are not published in the Government Gazette.

Non Authorised Private Psychiatric Hospitals in Western Australia

The Chief Psychiatrist has statutory oversight of non-authorised private psychiatric hospitals in Western Australia. The Chief Psychiatrist's remit as per the *Mental Health Act 2014* (MHA2014) has responsibility for the treatment and care of all involuntary patients, Mentally Impaired Accused (MIA) persons detained in an authorised hospital, persons referred under section 26(2) or (3)(a) or 36(2) and those under an order made under section 55(1)(c) or 61(1)(c), as well as all patients of the MHA 2014 designated mental health services.

The Chief Psychiatrist is responsible for overseeing the treatment and care of all voluntary patients in a private psychiatric hospital (s.515) Non-authorised private psychiatric hospitals are designated mental health services under the MHA 2014.

As a mental health service, the facility would be subject to the Chief Psychiatrist's Clinical Review process and will be a part of the Chief Psychiatrist's monitoring program. As a designated mental health service, the facility would be required to report notifiable incidents to the Chief Psychiatrist as per the MHA 2014. Please see the links below to the Chief Psychiatrist's documents for standards of clinical care and private hospital requirement of reporting of notifiable incidents.

Chief Psychiatrist Standards for Clinical Care

http://www.chiefpsychiatrist.wa.gov.au/wpcontent/uploads/2015/12/CP_Standards_2015.pdf

Notifiable Incidents – Private Hospitals

http://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/reporting-notifiable-incidents-private-hospitals/

The Chief Psychiatrist or delegate may visit a private psychiatric hospital, whenever he or she reasonably suspects that proper standards of treatment and care have not been, or are not being maintained by the mental health service (s.521).

The Chief Psychiatrist may review any decision of a private psychiatrist about the provision of treatment to an involuntary patient, either detained in a private general hospital or under a CTO and either affirm, vary, revoke or substitute another treatment decision (s.520).

Relevant Legislation

Building Act 2011

Carers Recognition Act 2004

Conduct of Private Hospitals Regulations 1987

Corruption, Crime and Misconduct Act 2003

Criminal Law (Mentally Impaired Accused) Act 1996

Disability Services Act 1993

Electronic Transactions Act 2011

Freedom of Information Act 1992

Guardianship and Administration Act 1990

Health and Disability Services (Complaints) Act 1995

Health Services Act 2016

Hospital and Health Services Act 1927

Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987

Medicines and Poisons Act 2014

Mental Health Act 2014

Mental Health Legislation Amendment Act 2014

Mental Health Regulations 2015

Occupational Safety and Health Act 1984

Occupational Safety and Health Regulations 1996

Privacy Act 1988

Public Sector Management Act 1994

Surveillance and Devices Act 1998.

Guidelines

- Australasian Health Facility Guidelines – https://healthfacilityguidelines.com.au/
- Australasian Health Facility Guidelines – Part B – Health Facility Briefing and Planning HPU 131 Mental Health – Overarching Guideline
- Clinical Risk Management Guidelines for the Western Australian Health System.

Standards

- Australian/New Zealand Standard AS/NZS 4360:2004
- Chief Psychiatrist's Standards for Clinical Care 2015
- Chief Psychiatrist's Practice Standards for the Administration of Electroconvulsive Therapy 2015
- Licensing Standards for the Arrangements for management, staffing and equipment Private Hospitals 2006 (currently being updated)
- National Safety and Quality Health Service Standards 2021
- Licensing and Accreditation Regulatory Unit (LARU).

Glossary

Patients

The Standards refers to 'patients' when it means people who are, or appear to be, experiencing a mental illness. This use of the term is not a recommendation that the term 'patient' should be used in practice in preference to other terms such as 'consumer', 'clients' or similar. It is simply a reflection of the terminology used in the *Mental Health Act 2014* itself.

Carers

Carers play an integral role in the patient's journey during admission ongoing care and support. The *Mental Health Act 2014* s.280 defines a carer as a person who is that person's carer under the C*arers Recognition Act 2004*.

The *Carers Recognition Act 2004* s.5 defines a carer as an individual who provides ongoing care or assistance to, (b) a person who has a chronic illness, including a mental illness as defined in the *Mental Health Act 2014* s. 282.

Nominated Person

A nominated person is defined in Part 16, Subdivision 3 of the *Mental Health Act 2014*.

Seclusion

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

Restraint

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

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

Mechanical restraint is the restraint of a person by the application of a device (for example, a belt, harness, manacle, sheet or strap) to a person's body to restrict the person's movement.

Appendix A

Renovation and Refurbishment Post Authorisation

There may be occasions when an Authorised Hospital undertakes renovations and or refurbishments of a ward or an area particularly for the use of patients that may have impact on the compliance with the Chief Psychiatrist's Standards for Authorisation of Hospitals under the *Mental Health Act 2014*. The Chief Psychiatrist must be consulted and have oversight of any significant changes within the Authorised area.

Renovations and or refurbishments that extend beyond the current Authorised area, Health Service Providers will be require to undertake a re authorisation process to include the new area.

The Health Service Provider ensures the Chief Psychiatrist is consulted prior to the commencement of any significant renovations and or refurbishment of an Authorised area.

The Health Service Provider ensures Consumer and Carer co-design during renovations and refurbishments.

The Health Service Provider ensures all fittings and fixtures post Authorisation meet current standards and ensure safety and suitability. For example though not limited to:

- Replacement of door hardware
- Replacement of bathroom fittings
- Replacement of curtains, blinds or window treatments
- Fencing (particularly height that may enable absconding)
- Sporting and physical exercise equipment.

The Health Service Provider ensures architects, designers and contractors are briefed and provided with the relevant Standards that pertain to an Authorised Hospital and the safety of those being cared for in a mental health facility.

The Health Service Provider ensures the clinical care and the safety of patients is not compromised during any renovations and or refurbishments.

Appendix B

Sexual Safety

Mental health services have a responsibility to promote sexual safety and preserve consumers' privacy and dignity. The Chief Psychiatrist is developing sexual safety guidelines and a sexual safety standard which all services will be expected to comply with.

Most of the approaches to promoting sexual safety can be implemented in all services. This includes trauma informed and gender sensitive care, a leadership culture and policies and practices which prioritise sexual safety, information for consumers, training and support for staff and identifying those most vulnerable to sexual safety incidents and planning their safety in a collaborative way.

The design of the physical environment and how it is used can also contribute significantly to improving sexual safety on authorised units. The majority of sexual safety incidents in inpatient settings consist of male to female breaches and many women report feeling unsafe during inpatient stays. The evidence available suggests that establishing women only areas in mental health inpatient units is effective in improving the safety and experience of care for women.

A number of environmental features can contribute to sexual safety and they are listed below. Whilst it is recognised that implementing these in some existing facilities may be difficult, services should consider the following when upgrading services or planning any new facilities:

- Establish gender specific areas including accommodation, lounge/activity areas and bathroom facilities
- Provide locks to bedrooms (with emergency staff access), particularly for security at night
- Provide single rooms for patients who are vulnerable and are distressed by the lack of privacy and dignity
- There are policies for the management of the environment, including those that do not permit patients in each other's rooms
- Ensuite bathrooms and toilets are preferable at a minimum gender specific bathroom and toilets in separate gender areas
- There are adequate family friendly visiting areas that facilitate privacy and safety
- There are nurse call buttons for consumers to call for staff assistance in case of emergency
- There are sensor motion detectors/CCTV promoting safety and privacy, however does not remove the requirement of automatic observation by staff in these areas
- Clear signage throughout the inpatient units to stop inadvertent accessing of gender specific areas
- The service has a system of environmental audit in place to monitor and support sexual safety
- The service has policies and procedures for the reporting of notifiable incidents to the Chief Psychiatrist.

Appendix C

Ligature

When this term anti ligature is used in this document, it is expected the product will be of a type specifically manufactured as anti ligature and installed in accordance with the manufacturer's instructions.

Areas that are distant from automatic observation or infrequently observed require greater attention to the design of fittings and environment to minimise the risk of self-injury.

The availability of CCTV does not mitigate the requirement for adequate environmental design.

Anti ligature design, fittings and fixtures will not eliminate risk or replace the need for adequate observation in high risk areas.

The service maintains a risk register and documents associated mitigation strategies.

The service conducts an annual ligature review to identify, mitigate and resolve any safety issues.

Staff are trained and receive ongoing training in identifying and managing environmental ligature risk.

There is a policy and procedure for reporting potential ligature risks.

All fixtures and fittings within the facility – such as windows and door furniture, door closers and hinges, and coat hooks designed, tested and approved anti ligature products specifically designed to prevent accidental and or intentional injury.

For exposed services:

- Toilet cisterns must be enclosed behind the wall
- Shower heads must be flush to the wall and downward facing
- Taps with no ligature point
- Outdoor taps are enclosed
- Reticulation is installed appropriately.

Paintings, mirrors and signage must be rigidly fixed to walls with tamper proof fixings.

Door hardware must be anti ligature:

- Ensuite door design may vary (eg cambering bi swing, magnetic, soft doors) but must be high anti ligature.

Anti ligature fittings must either be robust and able to withstand forced damage or be easily collapsible such they do not act as a ligature point:

- Fittings such as curtain tracks, blinds of weight bearing of not more than 15kg
- Consideration needs to be given to load release items such as a heavy magnetised curtain rails with a breaking strain of 15kgs as there is a high risk of being used as a weapon.

Outdoor areas that are distant from auto observation required greater level of anti ligature.

Landscaping and garden design should not pose a ligature risk.

External furniture design must avoid the risk of ligature points; bench seats and tables must be constructed of solid surface materials and securely fixed to the ground.

External sporting equipment/fixtures either will not provide ligature points or there will be adequate observation and operational strategies to manage risk.

Appendix D

Restrictive Practices

The National Safety Priorities in Mental Health: A National Plan (2005) seeks to reduce harm and the use of and, where possible, eliminate restraint and seclusion as both are associated with adverse events. A first line of strategy is self-management usually undertaken in a range of spaces accessible within the inpatient unit (e.g. quiet, activity and sensory modulation spaces). De-escalation strategies provide an opportunity for the patient to choose to separate for a period of time from others. This can be done within a segregated area of the inpatient unit. Seclusion is an intervention of last resort and generally must only be implemented after other de-escalation strategies have failed.

As previously stated I am committed and support the national imperative to reducing the rate of seclusion and move toward elimination of the use of restrictive practices in mental health services across Western Australia.

The Health Service Provider ensures all staff are aware of the statutory requirements under the *Mental Health Act 2014* in terms of seclusion and restraint.

The Health Service Provider ensures all staff are aware of the penalties under s 213 of the *Mental Health Act 2014*.

The Health Service Provider ensures all staff are aware of the penalties under s. 229 of the *Mental Health Act 2014*.

The Health Service Provider ensures all staff are aware and committed to upholding the Chief Psychiatrist's Standards for Clinical Care.

The Health Service Provider has strong leadership and a documented commitment for organisational change toward eliminating restrictive practice.

Health Service Providers has a clear responsibility to track, respond and oversight the use of restrictive practice with in their service.

Health Service Provider has a responsibility to ensure that staff understand the:

- National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services
- National Principles for Communicating about Restrictive Practices with Consumer and Carers.

The Health Service Provider has suite of policies and procedure for the management of restrictive practices.

There is a documented commitment from the Health Service Provider to invest in sustainable ongoing training and up skilling of clinicians in reducing and eliminating restrictive practices that continues beyond Authorisation.

The service engages with consumer and carers groups when developing guidelines and strategies in reducing and eliminating restrictive practices.

Seclusion

Division 5 of the *Mental Health Act 2014* sets out the statutory responsibility and requirements of mental health services when using seclusion to manage patients with challenging behaviours.

s.212 Seclusion: meaning

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

Services with dedicated seclusion facilities must meet the Chief Psychiatrist Standards. However the Chief Psychiatrist does not expect all services to have dedicated seclusion facilities available. It is recognised that there may be valid reasons why they are not required or policies and procedures are in place to manage those with challenging behaviours ensuring their safety and safety of others.

It is expected the Health Service Provider has policies and procedures for collection of seclusion data required by the Chief Psychiatrist.

It is expected the Health Service Provider has policies and procedures for collection of the data of individual staff members involved in seclusion events.

The seclusion room/area must be located in an area that provides patient privacy – or can be locked down eliminating any thoroughfare whilst in use.

The seclusion room/area must be located in an area that does no impact on the wellbeing of other patients e.g. traumatise/re-traumatise.

It is expected the Health Service Provider has a documented risk assessment process.

It is expected Health Service Provider has a documented debriefing procedure for:

- Staff
- Patients
- Family/Carers/Nominated Person.

A seclusion area must:

- provide a safe annex for the opportunity for staff to undertake de-escalation techniques
- provision to be utilised as a comfort and sensory room
- have CCTV that provides unobstructed viewing and monitoring
- have a patient to staff/staff to patient intercom system
- provide safe access to music, television and a clock
- availability to variable lighting – including natural light
- externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- doors outward opening

- strong, tamper proof hinges to top, middle and bottom of door
- a viewing panel with double glazed safety glass to doors
- have no blind spots and alternate viewing panels must be available where required (for example dome safety mirrors)
- an integral blind only operable by staff
- direct (but lockable) access to an ensuite toilet that meet anti ligature fitting and fixture standards
- no internal door handles
- a ceiling that is beyond reach
- continuous plasticated coatings to walls and floor
- sufficient space to allow staff reasonable access for restraint if required
- a tear proof mattress and when appropriate the option of tear proof bed clothes
- recessed fittings that provide no opportunity for self-harm or aggression.

Additional criteria for services not using a designated seclusion room and are using alternatives (for example patient bedrooms):

- a risk assessment of the area is conducted prior the episode of seclusion.
- items having potential to be used for self-harm are removed.
- safety of other patients, staff and visitors is a considered a priority.
- adequate supervision is provided during the period of seclusion.
- there is a procedure for reporting seclusion occurring in an alternative area to the Chief Psychiatrist.

Restraint

Division 6 of the *Mental Health Act 2014* sets out the statutory responsibility and requirements of mental health services when using bodily restraint to manage patients with challenging behaviors.

s.227. Bodily restraint: meaning:

1. Bodily restraint is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.
2. Physical restraint is the restraint of a person by the application of bodily force to the person's body to restrict the person's movement.
3. Mechanical restraint is the restraint of a person by the application of a device (for example, a belt, harness, manacle, sheet or strap) to a person's body to restrict the person's movement

It is expected Health Service Provider has policies and procedures for collection of restraint data required by the Chief Psychiatrist.

It is expected the Health Service Provider has policies and procedures for collection of the data of individual staff members involved in restraint events.

Appendix E

Specialised Units

In Western Australia mental health care is also delivered in specialised units that meet the needs of particular cohorts:

- Child Adolescent and Youth
- Forensic
- Older Adult
- Mother and Baby.

For these specialised units the environment must reflect the specific needs and is designed and maintained to a high standard in order to mitigate risk. There is an expectation that all staff are skilled in the cohort they are working and receive ongoing training and support in the specialised area of practice.

The RANZCP doesn't have a specific standard for inpatient units, however services may wish to consider the Royal College of Psychiatrists (UK) range of standards for specialised inpatient services.

Child Adolescent and Youth

Services with specialised youth and adolescent units need to ensure the model of care and the environment is suitable for the cohort intended.

The environment should be conducive to the management young people with challenging behaviours. There should be the capacity for observation of young people by staff in the least restrictive environment. The environment is therapeutic, however the safety and security of patients, staff and visitors is non-intrusive and does not convey a custodial environment.

- Service has a policy and procedures for the use of electronic items, such as mobile phones, laptops and other devices that may have access to social media platforms.
- Service has a policy when patients access to social media is non therapeutic – e.g. cyber bullying including bilateral bullying.
- The service is able to provide patients with safe access to health and wellbeing, personal support or counselling online services e.g.: Youth beyondblue, Reachout and eheadspace.
- Kitchen and meals areas should allow for patients, parents, carers to prepare simple meals e.g. breakfast and sandwiches etc.
- There is a multipurpose space that can be used for schooling.
- Staff are trained and skilled in dealing with challenging behaviours and de-escalation techniques.

Forensic

The key function of a Forensic unit is to provide safe mental health treatment to patients within the criminal justice system who may be violent, aggressive, and or dangerous and those patients who are subject to the *Criminal Law (Mentally Impaired Accused) Act 1996*

Care should be provided in a therapeutic and safe environment in the least restrictive manner whilst maintaining appropriate levels of security. There needs to be a balance between providing a therapeutic environment, the use of therapeutic security and is fit for purpose that is considerate of patients who are admitted for extended periods of time.

- The design provides appropriate safe rooms for patients to receive visitors, including children.
- There is a multipurpose space that can be used for schooling/continuation of study.
- The service is able to provide safe access to technologies such as computers, laptops for accessing online health and wellbeing services.
- Staff are trained and supported in working in a forensic environment.
- Staff are knowledgeable and understand the relationship between Forensic mental health services and the criminal justice system.
- Security is to provide a safe, secure environment for patients, staff and visitors, which facilitate appropriate treatment for patients while protecting the wider public.

Older Adult

The design of an Older Adult unit should provide a suitable environment that maximises the quality of life for older patients experiencing or living with mental illness.

- The design provides for the treatment and care of older adults that is therapeutic and appropriate for the intended cohort.
- Staff are trained and supported in working in an older adult setting.
- The service can provide appropriate levels of staffing that form a multi-disciplinary team including psychogeriatric consultant psychiatrists, psychiatric registrar, medical officer, psychologist, occupational therapist, social worker and nursing staff.
- The facility has the appropriate mobility aids and where possible these are anti ligature eg bathroom handrails, cupboards are cambered.
- There are feedback loops embedded in policy that include (when applicable) the patients general practitioner, private psychiatrists, psychologists, supporting non-government organisations, and aged care facilities.

Mother and Baby

The key function of a mother and baby unit is to provide treatment and support to women with mental health concerns in the perinatal period. The environment, whilst maintaining safety must be family friendly and one that is supportive and responsive to mothers' needs, as well as the needs of the baby and families.

- The design is considerate of the intended cohort and provides a balance between a hospital setting and a family like environment.
- Staff are trained and supported in working in a perinatal mental health setting.
- There are appropriate rooms/private lounges for families to meet.
- There are policies and procedures in place for the transfer of care from the Mother Baby Unit to the place of birth and for the return after delivery.

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