Government of **Western Australia**
CHIEF PSYCHIATRIST

Clinical Monitoring Program Targeted Review

Mental Health Act 2014 s.303

Segregation of Children from Adult Inpatients

February 2023

Acknowledgement

The office of the Chief Psychiatrist would like to thank all the consumers and families who shared their experiences for this review. We would also like to thank the staff of all services visited, for their involvement in this review and their work caring for children every day.

Published by the Chief Psychiatrist of Western Australia.

This document is available as a PDF on the internet at www.chiefpsychiatrist.wa.gov.au.

Version Control

Purpose	Statutory Requirement under the Mental Health Act 2014
Relevant To	All Mental Health Service Providers
Approval Authority:	Dr Nathan Gibson Chief Psychiatrist
Effective Date:	6 February 2023
Responsible Group:	Clinical Reviews
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Chief Psychiatrist's Clinical Monitoring Program Targeted Review 2022

Mental Health Act 2014 s.303

Segregation of Children from Adult Inpatients

Services Visited

Joondalup Health Campus Mental Health Observation Area (MHOA)	**Fiona Stanley Hospital Youth Unit**
East Metro Youth Unit (EMYU)	**Sir Charles Gairdner Hospital Mental Health Observation Area (MHOA)**

Findings

- There is under-reporting to the Chief Psychiatrist under s.303 of the *Mental Health Act 2014* of the decision to admit a child to a mental health service with adult inpatients including the strategies to keep the child safe and to provide individualised treatment and care.
- Services with good compliance and reporting have clear processes and responsibilities to support and ensure comprehensive reporting under s.303. However, few services reviewed had these processes in place and there is insufficient governance and oversight of staff reporting to the Chief Psychiatrist under s.303.
- There is insufficient governance and oversight of compliance with s.303 statutory reporting.
- Mental health clinicians report they are implementing strategies to keep children safe in mental health inpatient services with adults, but these are not captured in the s.303 form or consistently reported.
- Around 94% of children aged 16 or 17 years requiring an inpatient mental health admission are admitted to a Youth Unit, Mental Health Observation Area or Emergency Centre or Perth Clinic.

Recommendations

1. **All services visited during this review** must ensure that there is a clearly documented protocol for completion of the s.303 notification form by a member of clinical staff.
2. **The Office of the Chief Psychiatrist** will continue to quarterly comparison of s.303 notifications with admissions of children to mental health wards that also admit adults.
3. **All services visited during this review** must ensure there is an orientation program to introduce new staff to the challenges and factors in providing mental health treatment and care to children and parents/guardians/other supports.
4. **All services visited during this review** must ensure that there is a clear process and responsibility for assessing personal and sexual safety needs and talking to children about their personal and sexual safety in the ward environment.
5. **EMYU and FSH Youth Unit** must develop and implement a patient onboarding process to support first admissions.

Executive Summary

The *Mental Health Act 2014* (MHA 2014)[1] section 303 (s.303) states that, when the decision is made to admit a child to a ward where there are also adults (aged 18 years and over), services must take steps to ensure that they can protect the child, meet their individual needs. This includes the need to provide care suitable to their age, maturity, gender, culture and spiritual beliefs in a place separated from adults if appropriate to their needs and vulnerability if necessary.

Once the decision is made to admit a child under 18 to a ward which also admits adults, the service must make a report outlining the strategies to keep the child safe, file this in the child's clinical record and provide a copy to both the parents and the Chief Psychiatrist. A form for this purpose is available on the website of the Chief Psychiatrist. The report and associated form are referred to as a "s.303 notification".

In 2022 the Office of the Chief Psychiatrist (OCP) raised concerns that services were not adequately meeting their requirements under s.303 of the MHA 2014 in terms to their duties to children admitted to units with adults. All services that admitted children, with adults, were under-reporting to the Chief Psychiatrist under s.303. In addition, the quality of the reports received by the Chief Psychiatrist did not adequately describe the strategies being used to make sure the child was protected and the child's individual needs in relation to treatment and care were met.

The Chief Psychiatrist undertook a clinical review to examine compliance with reporting under s.303, to review medical records and examine the standards of treatment and care provided to young people to keep them safe of wards that also admit adults. As such, the review was undertaken to understand:

1. adherence to the requirement under section 303 of the MHA 2014 to report children admitted to adult and youth mental health wards,
2. the measures being put in place to protect children on mental health wards,
3. trends of notifiable incidents which have occurred with children admitted to adult wards
4. children, parents, guardians and family perceptions of safety and support on Mental Health Observation Areas/Emergency Centres (MHOA/MHEC) and youth units via interview.

The review confirmed poor compliance with the requirements of s.303 and reporting to the Chief Psychiatrist. Many notifications were completed using generic statements, which did not specifically reflect the needs of the individual child and strategies to keep the child safe were not routinely recorded in the patient medical record. However, interviews with the staff identified the good work that is being done, to ensure that the child receive safe, high quality mental health treatment and care. The interviews highlighted that:

- Staff consistently advised of the strategies implemented to ensure the safety and care of children on wards that also admit adults;
- These strategies were not routinely documented in the clinical record or documented on the s.303 notification form.

- Barriers to completion of s.303 forms included lack of clear processes around which staff were responsible for completion of the form and uncertainty around what information to be included.
- There is limited oversight and review of s.303 reporting by most of the health services reviewed.

The function of these reports is to document a decision about whether the ward can provide suitable care to each person and therefore, the report must be individualised to each consumer's needs. The intent of the s.303 notification is to provide assurance to the parent/guardian and the Chief Psychiatrist that the child will be safe. Practically, any concerns of the parent/guardian should be addressed in the documented plan.

The review also found that, as with all inpatient mental health admissions, there is a risk of exposure to distressing experiences, and that the therapeutic benefit to the child must be weighed against the risks of them being there. Challenging incidents in these environments may be related to the behaviour of either children or adults. However, an important mitigating factor is communication. Reviewers found that frequent communication, with children and parents/supports by familiar skilled staff, supports their understanding of risks and benefits of treatment and contributes to feeling safe, especially for first admissions.

Overall, 5 areas of notable practice have been found and 5 recommendations have been made. It is hoped that these may provide guidance for improving the standards of treatment and care provided within and across services, as well as compliance with the *MHA 2014*.

Going forward, health services reviewed are required to provide an action plan to address the recommendations. This must include a plan for ongoing implementation, monitoring and governance so that changes are made and sustained. Chief Psychiatrist will continue to monitor compliance across health service with s303 reporting requirements, and alert services remaining non-complaint.

Finally, reviewers heard that children and families value giving feedback, being heard and having a say in their care. Seeking timely feedback from children and their families is essential to provide high quality care which respects and responds to their choice, autonomy and individual needs. The Chief Psychiatrist encourages services to continue to develop ways for children and families give feedback during their care.

A number of systemic issues were identified which were out-of-scope for this review. These have been included in section 4.10.

Notable Practice

The Chief Psychiatrist acknowledges the complex operational requirements and patient cohort of youth services. The review team evidenced areas of notable practice which deserve recognition.

Appropriate treatment and care for children 16-17 years of age

Choice, control, autonomy, validation, opportunities to give feedback and developing independence are important to children and the services reviewed were overall providing this. Having children 16-17 years of age, with young adults on youth wards does not appear to impact on safety as much as the balance of acuity and dysregulated behaviour around the child. Services are capable and do consider the safety of the mix of children on their wards.

Key factors were identified that contributed to children and parents/supports being and feeling safe. These include:

- supporting choice and control
- building strong relationships though frequent interactions and choice of staff
- ensuring access to and choice of meaningful activity for all regardless of acuity
- clear boundaries around personal and sexual safety
- a calm atmosphere and de-escalation processes
- reducing all restrictive practices.

Highly engaged staff

Staff involved in providing treatment and care to children were found to be overall consistently kind and capable. Parents/supports and children greatly appreciated being heard and validated by all services. The registrars and consultants in most services were reported to have excellent communication skills as noted by their teams, children, parents/supports and Aboriginal Liaison Officer/Mental Health Worker (ALO/AMHW).

The review team observed positive teamwork culture and attitudes to working with youth across teams between nursing, allied health, specialist in-reach (e.g. drug and alcohol, ALO/AMHW, peer workers, social work). Teaching staff were proactive in re-engaging children in education, despite difficulties with staffing and space.

The collaboration with the Joondalup Emergency Department at Joondalup MHOA in sharing bed-capacity and staff during in the pandemic, is an example of positive flexible practice.

Making the best use of the physical environment

The physical environment presents a challenge for many services and the four sites visited for this review are no exception. Despite the difficulties, staff demonstrated that they have clearly thought about how best to use the spaces available to them. The two MHOAs had identified rooms which were the safest for children. Staff at all services demonstrated sensitivity to how bed allocation might impact on an individual's experience and described how they manage this with the vulnerabilities of children in mind.

Most wards had initiatives to improve the ownership and youth-friendly nature of the ward. Despite limitations of these physical environments, all four services used creativity, consumer involvement or clinical knowledge to make the best of what they have. Children, staff and carers interviewed made suggestions for improvements. In some services, the outdoor and family spaces and youth-friendly staff clothing provide a more relaxed and normalised feel by reducing the clinical atmosphere that can be intimidating for children when mentally unwell. Further consumer and family involvement and supporting staff suggestions would be encouraged.

Collaboration with Aboriginal Liaison Officers

Across all four sites, clinical staff reported strong working relationships and effective collaboration with Aboriginal Liaison Officers and Aboriginal Mental Health Workers (ALO, AMHW). Clinical staff appropriately

reported the need to ask people if they are Aboriginal and offer the ALO, AMHW early in the process. The ALO and AMHW role was highly valued by the clinical team and seen as essential for safe, high quality care.

Consistent implementation of procedures at JHC MHOA

The review team found that all staff interviewed, ranging from the Nurse Manager through to staff who occasionally backfill shifts on the MHOA, demonstrated a very clear understanding of the organisational procedures which had been designed to keep children safe. Reviewer observation and examination of clinical records indicated that the procedures are followed. Consistent implementation of policy requirements is a challenge for all health care organisations and the team at JHC MHOA deserve to be congratulated on how effectively this has been achieved.

Recommendations

Completion of s.303 Notifications

The OCP is not receiving s.303 notifications consistently when children aged under 18 years are admitted to wards which also admit adults. Barriers included the s.303 notification being omitted from documentation checklists, lack of clarity around the clinical role responsible for completion of the s.303 notification, the perception that it must be completed by a consultant psychiatrist and uncertainty around how to complete the s.303 notification most effectively. The review team found that all services visited had clear strategies for ensuring the safety of children on adult wards, which are not adequately captured in the clinical record and should be documented on the s.303 notification.

Recommendation 1

All services visited during this review

Must ensure that there is a clearly documented protocol for completion and reporting of the s.303 notification form and that clinical staff are appropriately oriented to this reporting.

Recommendation 2

The Office of the Chief Psychiatrist

Will continue to undertake a quarterly comparison of s.303 notifications with admissions of children to mental health wards that also admit adults, and alert health services to non-compliance with reporting requirements. The data quality of reports will also be monitored.

Preparing the workforce to work with children

A consistent theme raised during the review was that, due to their developmental stage, the needs of the 16-17-year-old cohort are distinctly different both from adults and from children and younger adolescents.

Topics relevant to this specialty include gender-inclusive practice, emotional regulation and distress tolerance, developmental and social factors in adolescents and parents/supports, including those from ethnically and linguistically diverse and Aboriginal backgrounds. Staff were concerned that the differences involved in working with this cohort can present challenges for staff new to working with youth, which may contribute to burn-out and staff turnover. The review identified a need to provide enhanced training and support to staff in working with young people aged 16-17 years and their parents/supports as a specialised role, especially in supporting behavioural, social, sexual, cultural and developmental needs.

Recommendation 3

All services visited during this review

Must ensure there is an orientation program to introduce new staff to the challenges and factors in providing mental health treatment and care to 16 and 17-year-olds and parents/supports.

Personal and Sexual Safety

Staff demonstrated a good awareness of monitoring the sexual safety of children in the ward environment and intervening where appropriate. This was corroborated by children, who reported that they were aware of the rules around intimate relationships on the ward and had observed staff intervening during their stay.

Although staff were consistently able to identify risk factors which should be considered when assessing sexual safety, there was a perception that "someone else" was responsible for making this assessment. In addition, there was variability around whether staff felt comfortable having discussions with children and parents/supports about how to stay sexually safe, especially when there was felt to be a risk of triggering people who had a history of trauma. Furthermore, children reported that experiences such as others being aggressive or self-harming were major factors in feeling unsafe.

Recommendation 4

All services visited during this review

Must ensure that there is a clear process and responsibility for assessing sexual safety needs and talking to young people about their personal and sexual safety in the ward environment.

Onboarding for first admissions, to inform, prepare and support children and parents/supports

It must be acknowledged that a significant proportion of children admitted to MHOAs and youth units are experiencing their first admission to a public mental health service. Of the sample of 120 admissions, 38% were the person's first admission to a public mental health inpatient service. Children and parents/supports interviewed, said that they did not feel prepared for first admissions, or for what to expect. Any uncertainty, limited information or lack of choice made their first stay more challenging.

On the MHOAs processes were generally clear. However, while waiting for admission to the Youth Units and once admitted, children and parents/supports often did not know who to speak to about how things happen on the ward, the treatment, activities and wellbeing of the child. Despite staff being skilled, friendly and kind, a consistent point of contact, a proactive on-boarding process and routine checking-in throughout the admission was needed. Children and parents/supports need information pre-admission, both verbally and in alternative formats. Information needs to include both practical advice, such as what to pack, rules about phones and information about how treatment and care is provided, such as who the members of the multi-disciplinary team are, how decisions are made and when and how to ask questions about progress.

Where clear communication and consistent care was provided, children and parents/supports having their first experience of inpatient mental health treatment and care felt safe. The function of the s.303 is to pro-actively make parents aware of the strategies to maintain safety within the service at the point of admission. Transparency about safety assists in sharing responsibility and planning with the parent/support and child.

Recommendation 5

EMYU and FSH Youth Unit

Must develop and implement a patient onboarding process to support first admissions, including:

- Identifying a key contact person who will proactively contact parents/supports at the start of the admission and remain their contact throughout the admission.
- Wherever practicable, providing information to the young person and parents/supports prior to admission, for example, an email, an information video that can be watched while in the Emergency Department awaiting admission, a conversation with a peer worker.
- Ensuring that young people know who their named nurse is, and how to get information.

1.0 Project Overview

The aim of the review was to understand:

- Adherence to the requirement under s.303 of the MHA 2014 to report children admitted to adult and youth mental health wards.
- The strategies being put in place to protect children in these settings.
- Patterns in notifiable incidents which have occurred with children in adult wards.
- The experience of the safety of children on wards with adults, from the perspective of the children, parents/supports, and ward staff and stakeholders.

Terms of Reference for the review are available on the website of the Chief Psychiatrist of Western Australia.[2] A summarised methodology is provided in Appendix 1. The conclusions made in this report are based on an analysis of comprehensive data collected through the process described below.

In October 2022, the Chief Psychiatrist's Reviewers visited East Metropolitan Youth Unit (EMYU), Fiona Stanley Hospital (FSH) Youth Unit, Sir Charles Gairdner Hospital (SCGH) MHOA and Joondalup Health Campus (JHC) MHOA. The team reviewed relevant s.303 notifications, medical records, incident notifications made to the OCP, and conducted interviews with children, parents/supports and staff. In addition, the OCP wrote to all inpatient units, which admit children with adults, that had admitted a child under 18 years in the past 12 months, inviting any staff, children and their parents/supports who wished to provide feedback for the review to do so via survey or interview. A stakeholder survey was emailed to all community mental health services, Headspace sites, the Mental Health Advocacy Service and other relevant stakeholders.

Language used in this report

The MHA 2014 uses the term 'child' to refer to any person aged under 18 years and people 18 years and over are referred to as adults. There are broader service-based terminologies around youth, however, this report uses the MHA 2014 terminology.

The MHA 2014 uses the term 'patient' for any person receiving treatment and care in a mental health service and this term is used in this report.

The term 'parents/supports' is used throughout this report. It is recognised that for children there are a range of personal support people who may be involved such as guardians, families, friends, nominated people and other carers.

2.0 Requirements of the *MHA 2014* – Segregation of children from adult inpatients

Under the *MHA 2014*[1] s.303 whenever a child (a person who is under 18 years of age) is admitted to any mental health service (including MHOAs or equivalents) where adults (people aged 18 and over) are also admitted, the person in charge of the mental health service must first be satisfied that:

- the mental health service can 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.

The person in charge of the mental health service, must give the child's parent or guardian a written report setting out:

- the reasons why the person in charge is satisfied of the matters referred to above,
- the measures that the mental health service will take to ensure that, while the child is admitted as an inpatient, the child is protected and the child's individual needs in relation to treatment and care are met.

The report must also be filed in the patient's clinical record and a copy provided to the Chief Psychiatrist. A form which can be used for this purpose, can be found on the website of the Office of the Chief Psychiatrist: https://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/segregation-of-children-from-adult-inpatients/

3.0 Overview of inpatient services for children under 18 years of age

Perth Children's Hospital ward 5A is the sole authorised unit for children and adolescents 15 years of age or under in Western Australia. Authorised, public inpatient services designed specifically for patients aged 16 to 24 years are available at EMYU, run by the East Metropolitan Health Service (EMHS) and FSH Youth Unit, run by the South Metropolitan Health Service (SMHS). Both services accept out-of-area referrals from across the state. There are currently no public inpatient beds for patients aged 16-17 years in the North Metropolitan Health Service (NMHS) catchment area, though a youth unit is under construction at JHC and will be operated by Ramsay Health Care under a public-private-partnership arrangement. Perth Clinic, the Marian Centre and Hollywood Private Hospital are private inpatient services which may accept voluntary admissions of children aged under 18 years of age.

Public Hospital in the Home (HiTH) outreach services are provided by SMHS at FSH and NMHS at Graylands Hospital. NMHS and SMHS HiTH services include a specialised Youth HiTH. HiTH differs from community mental health services in that the support provided has a higher intensity and shorter duration (usually 2 weeks). These services are considered equivalent to inpatient care, for patients who can be cared for safely at home.

Some emergency departments (ED) in Perth have a Mental Health Observation Areas (MHOA) or Mental Health Emergency Centre (MHEC) for people who present to the ED with mental health issues, but for whom it is clinically relevant to provide care for a period of more than four hours. When a person is admitted to MHOA or MHEC it is considered an inpatient admission. There are MHOAs at JHC and SCGH and there is a MHEC at Royal Perth Hospital (RPH). MHOAs and MHECs will accept admissions of people aged 16 and over.

There are no dedicated youth mental health inpatient services outside the Perth metropolitan area. Staff interviews indicated that children aged 16-17 years in rural and remote locations are admitted to WA Country Health Service (WACHS) general wards, or to the Youth Units in the metropolitan areas.

Table 1: Profile of services visited

Service	HSP	Beds	Further Information
East Metropolitan Youth Unit (EMYU)	EMHS	12	https://www.bhs.health.wa.gov.au/Services/Mental-Health
Fiona Stanley Hospital (FSH) Youth Unit	SMHS	14	https://www.fsh.health.wa.gov.au/Our-services/Service-Directory/Youth-mental-health-services
Joondalup Health Campus (JHC) Mental Health Observation Area (MHOA)	Ramsay Healthcare	10	https://www.joondaluphealthcampus.com.au/About-Us/Welcome
Sir Charles Gairdner Hospital (SCGH) Mental Health Observation Area (MHOA)	NMHS	6	https://www.scgh.health.wa.gov.au/Our-Services/Service-directory/Mental-Health-Unit

4.0 Findings

The evaluation of the standards of treatment and care has been made by considering all information obtained through the various data collection methods (Figure 1). For more detail about data collection methodology, see Appendix 1.

Figure 1: Data Collected

4.1 Most children are admitted to Youth Units or MHOAs/MHECS - not adult inpatient units

The OCP requested data pertaining to all public and private health inpatient units for the period 1 July 2021 – 30 June 2022. Table 2 shows all admissions to inpatient mental health services during the 2021-22 financial year for children under 18 years, along with the number of notifications made to the OCP under s.303 of the *MHA 2014* for the same period. The percentage of separations for children under 18 years (from total separations) from each service is also included in the table. Note that Perth Children's Hospital Mental Health has been excluded from the table as it does not accept patients aged over 15 years.

- Most public mental health admissions of children aged under 18 years on wards with adults, appropriately occur at the two youth units, EMYU and FSH Youth Unit (58%). MHOAs/MHECs account for 28%. These public services are admitting 86% of the children aged under 18 years on wards with adults.
- Staff, people with lived experience and stakeholders all reported that children are frequently initially admitted to MHOAs or Mental Health Emergency Centre (MHEC) from ED to await a youth bed and this is likely reflected in the number of admissions to these services. The MHOAs and MHECs also have a legitimate role in short-term crisis containment and a proportion of their admissions will be for this purpose; this review did not examine the proportion of admissions which were crisis containment versus those which were to await a bed.
- There is currently no inpatient mental health service which accepts children aged 16-17 years in the NMHS catchment area. There are therefore a large number of admissions of children to the MHOAs at Joondalup Health Campus (JHC) and Sir Charles Gairdner Hospital (SCGH). The number of admissions of children to NMHS HiTH services show that HiTH are providing care to this cohort when it can safely be provided at home.
- Private clinical services accounted for 12% of admissions of children aged under 18 years to adult wards.

- There were no admissions of children to adult inpatient units outside the Perth Metropolitan area; WA Country Health Service (WACHS) usually admits children to medical (rather than mental health) wards, often while awaiting allocation of a Youth Unit bed in Perth.

Table 2: Notifications made under s.303 during the 2021-22 Financial Year

Mental Health Service	Admissions aged under 18	s303 Notifications to the OCP	Notifications (%)	separations aged under 18 / total separations (%)
Sites Visited by the OCP Review Team				
Bentley Health Service EMYU	243	5	2.1	79.9
Fiona Stanley Hospital Youth Unit	375	0	0	69.8
Joondalup Health Campus MHOA	180	135	75.0	13.8
Sir Charles Gairdner Hospital MHOA	64	0	0	11.1
Other Mental Health Services				
Public				
Armadale Health Service	<5	0	0	1.2
Bentley Health Service (excl. EMYU)	0	N/A	N/A	0.3
Fiona Stanley Hospital (inpatients excl. Youth Unit)	6	0	0	0.4
Fremantle Hospital	<5	0	0	4.7
Goldfields Kalgoorlie Hospital	0	N/A	N/A	0
Great Southern Albany Hospital	0	N/A	N/A	0
Graylands Hospital	0	N/A	N/A	0
Kimberley Broome Hospital	0	N/A	N/A	0
Rockingham Hospital	0	N/A	N/A	0
King Edward Memorial Hospital	<5	<5	+	3.3
Royal Perth Hospital (inpatient)	0	N/A	N/A	0.4
Royal Perth Hospital Mental Health Emergency Centre (MHEC)	48	<5	+	7.2
Sir Charles Gairdner Hospital (inpatients excl. MHOA)	0	N/A	N/A	0
South West Bunbury Hospital	0	N/A	N/A	0
Public-Private Partnership				
Joondalup Health Campus (excl. MHOA)	0	N/A	N/A	0
St John of God Midland	<5	<5	+	1.1
Private				
Abbotsford Private Hospital	0	N/A	N/A	0
Hollywood Private Hospital	18	<5	+	
Marian Centre	23	14	60.9	
Perth Clinic	81	79	97.5	4.5

+ due to small numbers the total is not shown to prevent possible identification

Note: Youth Hospital in the Home (HITH) admissions are not included in the table above, as the inpatient does not stay overnight in a hospital and therefore they are not included under s.303 of the the MHA 2014. Y-HiTH admissions aged under 18 2021-22FY: FSH Y-HiTH: 9 and SCGH Y-HiTH: 78

4.2 Compliance with s303 documentation needs significant improvement

Feedback from clinicians advised that the therapeutic needs and safety of children are being assessed, although there is scant documentation that this is occurring.

Completion of the s.303 notification is a requirement of the MHA 2014. All services must comply with this requirement and recommendation has been made (Recommendation 1).

At most services, there was a degree of uncertainty around what type of information to document on the s.303 notification form, how it should be tailored to individuals, and how to manage changing risk over time. It is important to note that the requirement to report under s.303 relates only to risk on admission and not to further changing clinical circumstances.

The OCP recently initiated a monitoring system to compare the number of s.303 notification received against the number of admissions of children to inpatient mental health units. Services will be notified if the number of notifications does not align with the number of children admitted and asked to complete their statutory requirements.

4.2.1 East Metropolitan Youth Unit

Staff at EMYU reported that they were not clear about the function of the s.303 notification. The review team observed that this is due to uncertainty around how to personalise the information to individual patients.

- EMYU has developed a set of generic statements based on their model of care, which are entered into the s.303 notification form by administration staff, before it is printed and put into the clinical record.
- The forms are then signed by a consultant psychiatrist before the patient is admitted.
- Although very few s.303 notifications are received by the OCP, almost all records reviewed contained a copy of the signed s.303 notification form.

Completion of the s.303 notification by non-clinical staff, using generic, non-personalised statements, does not adequately capture the individualised strategies being used for the child's safety and care. However, based on the staff interviews and clinical record review, the review team found good evidence that the team at EMYU do effectively consider the needs of an individual before they are admitted to the ward. These individual considerations are not effectively documented anywhere in the record.

4.2.2 Fiona Stanley Hospital Youth Unit

At FSH Youth unit there was a lack of clarity between staff regarding the process for completing the form, though most staff reported that they believed it was the responsibility of the consultant psychiatrist.

- FSH Youth Unit has an admission documentation checklist which does not include the s.303 notification.
- Staff at FSH Youth Unit expressed concern that they were not sure what information to include on the s.303 notification, because the risks - and actions taken to address them change constantly throughout the admission.

"It's something we do live all the time, we will have to do a form every hour because it is always changing." Clinical Staff

Staff reported that the culture at FSH Youth Unit is to accept referrals for children aged 16 and 17 when an inpatient admission is clinically warranted, whereas people aged 18 years and older were more closely scrutinised to determine whether there were factors relating to maturity which would warrant admission to a youth service rather than an adult service. Staff reported that there were few admissions of people aged over 18 and that this ward culture drives the provision of safe, age appropriate care. The lack of process around the s.303 notification likely presents the greatest barrier to its completion at FSH Youth Unit.

4.2.3 Joondalup MHOA

Joondalup MHOA were the most consistent in providing s.303 notifications to the OCP at 75% of required forms completed and submitted to the Chief Psychiatrist. This can be attributed to the clear process flow-chart and communication to staff.

- Joondalup has an admission documentation checklist in the front of the medical record which includes the s.303 notification. To assist staff, a comprehensive process flow chart/poster clearly shows the s.303 notification under the CNS and nurse manager responsibilities, and details when it needs to be completed in the admission process.

All staff interviewed consistently and confidently stated the strategies available to them to keep children safe. Joondalup MHOA has four single rooms with sliding doors available and the capacity for parents/supports to board.

- Collaboration between emergency department (ED) staff and MHOA staff was noted to assist in finding the safest place for children across the facility at any given time. This is an asset, given potential for either cohort to quickly escalate. There is flexibility between the MHOA and the emergency department to manage overflow and contrasting individual patient needs in several areas across both units. This also included sharing staff to manage the changeable load in mental health.

The s.303 notification is only required on admission to the MHOA, so strategies implemented across the ED prior to or instead of MHOA admission are not captured, for example, vulnerable younger females may receive treatment and care in the paediatric observation area rather than the MHOA.

4.2.4 Sir Charles Gairdner Hospital MHOA

At SCGH MHOA, the staff are not completing the s.303 notification because staff, including senior staff, stated that they were unaware that this was a requirement of the MHA 2014. However, the care provided to children was comprehensive and considerate of their safety and individual needs.

The service is in the process of updating their policy for working with children and is aware that the new policy and associated procedures/flow-charts should include both the purpose and procedure for notifying the OCP under s.303 along with strategies available to keep children safe, specific to the facility.

4.2.5 Notifications under s.303 are not always completed correctly and not always sent to the Chief Psychiatrist.

The OCP received s.303 notifications for 21% of the sample of 120 admissions (see 4.7) but found s.303 notification forms in 34% of the records reviewed, indicating that the forms are not always sent to the OCP. This discrepancy mostly occurred at EMYU.

A review of the s.303 notifications in the sample of clinical records reviewed found:

- 59% documented strategies which were suitable for the needs of the individual, the physical environment of the ward and the type of care being provided
- 30% did not document suitable strategies
- for the remaining 11%, the review team was unable to establish whether the strategies were useful.

Reviewers considered both information documented on the s.303 notification and in the clinical record. Where the strategies were not useful, they mostly contained general statements without any context to relate them to the individual's needs or the clinical environment. The review team did not find any s.303 notification forms detailing reviewed or updated strategies later in the admission, but this was as expected; the s.303 notification is only mandated on admission.

Section 303 within the Mental Health Act 2014 is explicit that reporting is only completed once: on admission.

4.3 Notifiable incidents

When considering notifiable incidents as defined by the Mental Health Act 2014, it is important to recognise that the number of incidents must not be considered an indicator of safety or quality of care; rather, incident reporting systems exist to facilitate inquiry, investigation and improvement.[3] The review team looked at all incidents from the 2021-22 financial year. Table 3 shows how many incidents involved people aged under 18 and how many individuals aged under 18 were involved in an incident.

Table 3: Incidents notified to the Chief Psychiatrist, 2021-22 Financial Year

Service	Total number of incidents that involved people <18	Total number of individuals <18 who were involved in incidents
Bentley Health Service EMYU	178	53
Fiona Stanley Hospital Youth Unit	155	61
Joondalup Health Campus MHOA	0	0
Sir Charles Gairdner Hospital MHOA	6	6

4.4 What children and carers told us

The review team interviewed 7 people with lived experience of having been admitted as a child under 18 years to the Youth Units or MHOAs, or as their parent/support. Interviews included both current inpatients (or their parents/supports), and those discharged within the last year.

4.4.1 First admissions need better onboarding and consistency of staff

Parents/supports and children described confusion about navigating the mental health system and not knowing what to expect. They also described relief that care is being provided for the acutely unwell child.

> *"I did not know what a social worker was, I did not know what an advocate was, I did not know the difference between the psychologist and psychiatrist. I was disconnected from friends, I had no idea what I was on, now I know, they just told me to take it to get better….there is a whole process, but I felt like I was in the dark I didn't know about it."*

Several strategies were suggested to improve the onboarding and information provision to children and their parents/supports during first admissions, including statutory compliance with s.303. Most children and parents/supports said they were provided with pamphlets and children frequently reported they did not read them when they arrived at the Youth Unit. Rather, they reported asking peers about the routines and rules on wards or had conversations with nursing staff. It was suggested that having a phone call and email with support and information about the receiving unit would have been very useful to assist parents/supports to practically plan for their child's admission whilst waiting for a bed in an emergency department or MHOA - what to pack, visiting hours, what the child will do on the ward, communication. Parents/supports wanted to be supported to parent during first admissions and needed reassurance.

Suggestions from children and parents/supports to improve their on-boarding experience are below:

Emergency Department

- Before the child leaves the emergency department, when waiting for a bed, an initial phone call and email to the parent with information about admission and the ward.
- Provide practical information such as what to pack, ward routines and communication processes.

During First Admission

- Identify "named" staff, where possible, to provide consistent and frequent communication with parents/supports throughout the first admission right through to discharge.
- Consider giving children a choice of key staff where possible, to spend time with to build trust.
- Ensure access to a phone/device for contacting friends, family and advocates especially if children are without a device. Discuss rules and times for phone use and external communication with children and parents/supports,
- Be pro-active about providing information to parents/supports about treatment, risks and side-effects especially what to look for and expect when they interact with children who have started new medications.

- Clarify the carer escalation process and as it is unclear whether the Aishwaryas CARE Call emergency carer phone line and associated pamphlets are for general hospital or mental health in some services.
- Provide information in a variety of formats, such as videos or audio, which may better serve the range of needs of children and parents/supports.
- Have access to adapted information for neurodivergent children and parents/supports.

Before Discharge

- Ensure the child is informed of their diagnosis and self-management strategies before leaving the service.
- Parents/supports valued being told options to prevent readmission and what to do in case of relapse.

4.4.2 Reducing distressing experiences on wards encompasses more than segregation from adults

Reviewers received feedback from some children that the mix of ages on youth wards may not impact on children's sense of safety as much as the experience of acute mental health issues, dysregulated behaviour and restrictive practices.

Surprisingly, several children under 18 years found it beneficial to be on the ward with young adults and liked sharing activities with them. Sometimes the children saw their adult peers as being better able to regulate their emotions, more relaxed and easier to spend time with, compared to peers their age. Children stated they strongly identified or empathised with their peers, which contributed to stress if observing self-harm, dysregulated behaviours or aggression. Several stated they would associate a room where they had witnessed an incident as traumatic and would be reluctant to be in that area.

> *"It is nothing to do with adults, the safety thing, some of the people are my age."*

> *"One of the people next to me was calling their family and saying: "Mum I am not OK.", and then I realised that they might be just another person like me."*

The experience of being segregated from peers due to dysregulated behaviour from themselves or peers was reported to feel like a punishment and was actively avoided by several children interviewed. Yet, some parents/supports reported that segregation to manage the mix of patients was managed competently and confidently by staff. Communication and transparency for the reasons for segregation was valued by parents/supports and children.

> *"I don't think you can say 18-year-olds are more unwell but when you are 16 years old, it's confronting when someone is psychotic, there was nowhere to contain that behaviour."*

4.4.2.1 Restrictive practices were experienced as traumatic and impacted children's sense of safety.

Children described their experiences of restrictive practices such as physical restraint and/or, sedation as scary and traumatising, having a lasting impact on how safe they felt in the inpatient setting and affecting

their ability to form trusting, therapeutic relationships with staff. Parents/supports accepted there may be circumstances where restraint and sedation may be necessary given the acute risk posed by the child but felt more communication regarding these measures would be helpful.

> *"When I say that the ward has made more harm than good - that memory is going to stay with me for the rest of my life."*

The use of restrictive practices has been shown in a review of research evidence and of children's experience as a key influence how children and children experience inpatient care.[4] Due to the negative consequences on children and staff involved physical restraint, it should only be used as a last resort.[4] A 2021 thematic review from the UK's National Institute for Health Care Research suggests their use can trigger memories of or past trauma or abuse for children and can result in feelings of guilt and regret in staff, even if they thought it was necessary.[4] Critically, restrictive practices have been shown to reduce the level of trust between staff and children and negatively impact the therapeutic relationship which is a key indicator of positive outcomes.[4]

Both EMYU and FSH Youth Units are authorised mental health services with the capacity to use restrictive practices if clinically warranted. Staff on both sites reported that their use of seclusion has reduced over time and the acuity and complexity of behaviours between sites may differ.

4.4.2.2 Calm environments, trauma-informed behaviour management and de-escalation should be used as a first option.

Maintaining a calm ward atmosphere and using de-escalation was valued and could be improved through more consistency between staff, according to children. The importance of calm and family-friendly environment for children, was noted by parents/supports.

Children reported staff were skilled in both de-escalation and debriefing following incidents, effectively responding to their differing needs and preferences for support. However, a minority of staff were reported to have use punitive approaches and judgmental language. Respondents observed this to lead to a sense of shame and lack of control in front of their peers, resulting in escalations, aggressive outbursts and 'code blacks'. These escalations were seen to be preventable if a more flexible, and private approach to de-escalation and behaviour management could have been adopted.

> *"They (the staff) respond when there is a code black but de-escalation before then is not always there."*

Some environmental factors used to keep children and staff safe, were triggering or made children feel unsafe. For example, children reported that alarms exacerbate escalations in communal spaces and are triggering. Often, they reported there was no alternative communal space for by-standing patients to retreat to during an incident. The experience of guards being present was described as intimidating by children but reassuring by parents/supports. However, children reported security staff respected their privacy.

> *"When someone was aggressive once I had a staff stay with me but that was ad-hoc, there was not process for that. You don't have much autonomy or agency or choice of where to go when things were escalating on the ward."*

Some children suggested a more proactive approach to reducing risky behaviours and that sometimes thresholds were too high. Additionally, a more compassionate attitude to support alternative coping strategies to self-harm was suggested. The experience of staff minimising concern about risk posed to peers or themselves was felt by children as invalidating – and when distress was not taken seriously this was unhelpful.

Some children had experienced negative effects of medication, feeling their ability to interact was hampered, and had side effects. They considered it should be a last resort and were especially scared of the medication if they did not know what it was for. Parents/supports appreciated doctors discussing using the minimum doses and options available post-discharge.

4.4.2.3 A greater focus on timely communication about sedation and diagnosis by doctors is needed.

Timely and frequent communication is important in mitigating the potential traumatic experiences on inpatient settings, especially for first admissions. There was feedback that communication about sedation could be improved - knowing its effects and what parents/supports can expect in their child's presentation - to reduce concern for parents/supports.

However, frequent communication with registrars and familiar staff through face-to-face and phone conversations was highly valued by children and parents/supports. For those interviewed, registrars and consultant psychiatrists were considered as 'good communicators' skilled at explaining the options and choices in their admission, care and discharge planning. Children and parents/guardians/supports highly valued conversations with the doctors from the very start to the end of their admission.

> *"I was really impressed by the psych. registrar last night, she was insightful, and she gave me tips and tools after a really long and in-depth conversation, and then I had the consultation with the psychiatrist."*

Services need to improve how they consistently communicate information about treatment, ward rules, activities and routines to children and parents/supports that meets their individual needs. A recommendation has been made (Recommendation 5).

4.4.3 Sexual Safety boundaries and rules are clear on youth wards

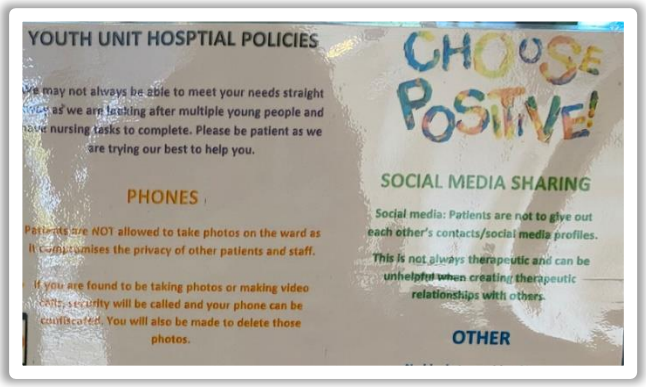
Most children interviewed said they were communicated generally what was expected regarding their behaviour, but this was mixed. Several children reported there were rules, but they appreciated when exceptions were made when necessary, for example, having a longer walk slightly outside the grounds to get some fresh air.

> *"We are told: "Respect others privacy, respect others. If you feel uncomfortable tell us, do not enter others' rooms and violence towards others, staff, or ourselves, is not tolerated. If people took photos, their phone was taken away."*

Most children interviewed advised there were told on admission and during the admission rules about relationships and sexual behaviour, touching and privacy. This was repeated through conversations,

reminders and nurses would intervene as needed. However, some children, carers and parents/supports said sexual safety had not been discussed nor information provided particularly if they were acutely unwell.

"On the ward they separate people if needed. You know the consequences and you know that 'things' cannot happen. I agree with the consequences - you are here to help your recovery and not to get into relationships with others. Everyone knows - no relationships, no going into other people's rooms and no 'messing around' on the ward."



For MHOAs, young females being in environments with much older men must be avoided, especially when there are past histories of trauma. Asking about trauma, preference of staff gender and consideration of separation, assigned companions and/or options to move either patient to ensure a trauma-informed environment is essential and was observed to be considered by staff in the MHOAs. It was also suggested that having a choice of male or female consultant psychiatrist may be beneficial.

4.4.4 Access to communication, advocates and devices.

It is essential that children have a means of communication to parents/supports, friends and guardians wherever this is safe. Many are admitted suddenly, without devices. This may be especially concerning for rural, Aboriginal, or CALD patients. Parents/supports need clear information about the rules around device-use and what communication is available to them during the day and night.

> *"I did not have my phone I had no one to talk about it (the issue). I was on so much medication, I could not talk to my parents/supports, I could not recall what the medication was, side effects, I just took it. You can't just say it one time and not say it again."*

Children subject to the *MHA 2014* must also be able to make contact with the Mental Health Advocacy Service (MHAS) and be able to access all their rights. The designated phone to MHAS was reported as being previously broken in one facility and others children advised they had not been told a phone was available.

"I wanted an advocate who is a third party who is not Mum or Dad. When I was on the ward I was demoralised because all my rights are taken away from me because of 'duty of care' and I don't even know what 'duty of care' is."

4.4.5 Children value choice, autonomy and consistent relationships with staff, but skills in working with children vary.

Choice, control, autonomy, validation, developing independence and opportunities to give feedback are important to children. Reviewers found that whilst there are many examples of positive practice, supporting consistency of capability in working with adolescents could be improved.

All children and their parents/supports interviewed strongly appreciated having a say in their care and their concerns being taken seriously and compassionately from the start. Several children and parents/supports reported the relief at finally feeling heard and understood by specialised youth services and MHOAs,

compared to their experience of emergency departments or ambulance services. They appreciated having options and choices for their admission, care and discharge planning.

> *"When I came in, they told us the process and it's my choice. I had a number of different options - they put the power at my feet really."*

> *"They saw them as a mature and insightful child and it's their mental health at the end of the day."*

Several reported that the benefit of the Youth Units, over children's wards, were having responsibilities, choices of activities, involvement in their care, and greater freedoms such as leave.

Choices that children mentioned they valued and contributed to a sense of safety children included:

- where they prefer to be admitted,
- which nurses look after them,
- timings and types of activities in their daily routine (e.g. choosing when they prefer to shower)
- treatment options and medications
- access to advocacy
- location of room and which patients are around them
- ways to access education on the ward (e.g. in-room/online options if needed)

On youth units as staff got to know the children, including over repeated or longer admissions, and as the children developed more skills in self-regulation they were afforded more choice and control which was well-received. Increased leave was valued but, the limited availability of doctors restricted approval of leave which was very frustrating for some.

Experience of nursing staff enabling choice and control varied; a bargaining or punitive approach was experienced as unhelpful.

> *"You can get guilt-tripped into something quite often or they talk to your parents/supports, so you do it. They could say "We understand your view, but we would really like you to do this…." instead of "If you don't do this, we will take away this privilege." Other times they give you a choice about how you want things done. It is very hit and miss depending on the person you see."*

FSH Youth Unit

All children and carers interviewed valued having high quality, regular interactions with nursing staff and doctors and said that this helped build trust and therapeutic relationships. Most said there were many kind, friendly nurses. Others described fewer rapport-building interactions, which they attributed to staff's perception of their level of risk.

Experiences were mixed regarding the availability of staff; several children stated having more choice about nurses would be positive, while others felt having a daily designated nurse on the whiteboard was enough.

> *"I know you don't have a choice of your nurse. I know they have a limit. I think having flexibility to allocate nurses that people connect with the most or, if they connect with someone better, to change allocated nurse. I understand that you can't always change but it is good to consider. When you look*

at outcomes, the therapeutic relationship is really important, so having the option to work with someone you feel comfortable with is important.".

SCGH MHOA Suggestion Box

Both children and staff valued 'being-with and doing-with' the ward, for example, nurses teaching children to do their laundry or cook independently, or doing other activities with them, such as gardening.

The value of frequent informal interactions is supported by evidence, as it develops trust and buffers experiences when staff need to restrict and manage boundaries, behaviours and risks more assertively.[5]

The value of feedback - feeling heard is validating.

Children value their ideas being sought and contributing to the care of their peers. One service had a suggestion box which was pointed out by a child as positive because then they would not have to speak to anyone to give feedback.

Mechanisms to ensure the prompt feedback and involvement of children may assist health services continually improve experiences of care.

4.4.6 For cultural in-reach and Aboriginal Liaison, provide the name, role and contact details to make seeking help easier.

Children observed that they were treated the same as each other, including their Aboriginal peers or those from ethnically and linguistically diverse backgrounds and this was not considered a problem by children. The only difference was that some had more in-reach workers such as ALOs/AMHWs. However, when children and parents/supports had in-reach workers, their names, roles and how to contact them was not always made clear - which made seeking support from them in future difficult. This occurred in both in-reach into emergency departments or in hospitals.

A choice of nurse or key staff where possible, may support staff to engage with cultural and spiritual beliefs of the individual child they have responsibility for, and to create opportunities to explore this. Where appropriate for the individual, matching staff with patients with similar personal, cultural and spiritual experiences and values may also assist in the process of building a therapeutic alliance and a sense of cultural safety on the ward, however, this may need further consideration by the health service.

4.4.7 Equal access to meaningful activities, education and outdoor time is needed - regardless of acuity

Access to meaningful activities and education suitable for the person's individual interests and goals was considered very beneficial by children, but equity of access across stages of acuity needed greater consideration.

Having a choice of activities, exposure to new activities of interest, engagement in productive and independent self-care, exercise, sport and outdoor time was very highly valued and most children said the Youth Units provided these to a greater or lesser degree. The sensory garden that the children had contributed to creating with staff at EMYU was enjoyed.

"There are more activities here than on other wards - you do get a choice. They ask you your ideas during the group for future groups…Everyone likes different things…They offer a nice range of activities and I discovered this new art which I really like.".

FSH Youth Unit

Access to group and individual activity sometimes depended on nurse availability and was restricted in the more acute settings including the MHOAs and EMYU's Psychiatric Intensive Care Unit (PICU). The need to belong and the sense of increased isolation can lead to a reduced ability to cope with the ward environment. Opportunities for spontaneous engagement in activity with nursing, OT or ALOs was beneficial in these instances. Staff also feedback engagement in meaningful activity throughout the day reduces the escalation of incidents and dysregulation.

"Sport is one of my coping mechanisms, but I could not use it because I could not get a nurse. I am not sure if they are down staffed. I asked a nurse, they said they couldn't as they were on a special and the nurses was shared."

EMYU Sensory Garden

FSH Youth Unit outdoor area

4.4.8 LGBTQA+ inclusive attitudes overall but more consistency in embedding behaviours needed

Most children reported that overall, attitudes and the awareness of gender across staff were very good, however, there remains some in consistency of behaviours and language across the multidisciplinary team. Individualised experiences were mixed, with some reporting their gender diversity needs were addressed proactively, while others felt their individual needs were addressed better as the ward got to know them. Children appreciated proactive referrals to specialised gender services.

Variation was experienced depending on the staff's age, background or discipline. Children and parents/supports suggested that training should be routine for all mental health staff and that health services

should consider a Lived Experience component to demonstrate the impact of a gender-inclusive approach on their patients.

"They have LGBTIQ+ flags up - you can't just do that - you have to embed it in the behaviours of staff. Often, I have had to correct psychiatrists and medical people. They should not come in assuming you are heteronormative."

4.4.9 Other factors impacting on safety, treatment and care of children in adult wards

- The admission process should consider child/family preference.
    - Children did not feel they really had a say on where they were admitted; it came down to bed availability and parents' preference. Having a friend on the ward sometimes limited options, which was an issue for people in the smaller youth LGBTQA+ community.

"When I presented to ED, there was never any discussion where I was at - it was where they had a bed. I was deemed a mature minor."

- Long waits in emergency departments, especially in rural areas, means treatment is delayed.
    - Reviewers heard from staff at MHOAs and consumers and carers that admissions start with a long wait in an emergency department. Whilst considered necessary and tolerable, long waits were traumatic and exhausting for those interviewed. Waits in metropolitan areas of 12 hours were reported and in rural areas - 3 to 5 days. Staff noted parents/supports often did not stay-on in MHOAs with their child as they worked or were quite exhausted.

"Although it was a traumatic timeline (emergency department) I feel like my child is now where they need to be."

- Staffing impacts on contact time with children and parents/supports.
    - Several children and parents/supports commented that registrar doctors seemed very busy - "flat out" across MHOAs and youth wards. Daily contact with the registrars at the MHOAs and frequent contact the wards was well received. However, delays seeing the doctors made it difficult for children to negotiate leave and doctors scheduling may need to take into account regular availability for approving leave.

"It's a bit hard to speak to doctors - they are busy. Information gets lost, you don't get told until the next day… Being told in advance might help."

- Youth-friendly and family meeting spaces and uniforms need improvement following COVID measures.
    - Some children spoke of the atmosphere being important and was sometimes overly clinical and without space to be with parents/supports and spend time together as a family. Wearing scrubs due to COVID-19 was seen to increase the clinical feel and it was suggested staff wear more approachable clothing to help children feel like they were not in a prison setting.

"There's just not a lot of spaces where you can sort of sit down with your kid and feel comfortable. it does feel like you're in a prison waiting room and you kind of remind yourself that it's a mental health unit."

4.5 What staff told us

The review team spoke to 37 staff across the four sites visited. In addition, the Head of Clinical Service at two of the sites not selected for visits requested the opportunity to share their views with the review team. Across all staff interviewed, there was a clear understanding of the vulnerability of children and the need to ensure they were kept safe in the inpatient setting. All services had procedures which were appropriate for the physical environment of the ward, staffing availability and the type of care the ward was designed to provide.

4.5.1 Services are providing appropriate treatment and care

The strongest theme across all interviews was the need to consider the clinical treatment and care needs of the consumer. Paramount in the comments from all staff was that if the child's clinical presentation warranted inpatient care, they felt responsible to ensure the child received inpatient care. Staff understood the inpatient care options available and reflected that bed availability is scarce for consumers aged 16-17 years. Staff reported they would do what they could to keep a child needing care safe on a ward with adults, rather than turn them away.

> *"If they're requiring additional support, they need a youth bed. We look at what's possible, but if they're not well, Youth HiTH might not be appropriate." Clinical Staff*

Across all sites, staff commented on the difficulties they face with discharge planning. In the MHOAs, this generally centred on access to inpatient beds for individuals aged 16-17 who require inpatient treatment and care. Staff advised that the system for prioritising admissions could be improved; is perceived to be based on place in the queue or sometimes location of the referring service, rather than acuity of biopsychosocial and psychiatric needs. MHOA staff also recognised their role in supporting children to access and engage with appropriate treatment and care in the community. For the youth units, the focus was on access to treatment and care in the community post-discharge. As the two youth units are the only services of their type in the state, both are required to provide treatment and care to children from all over Western Australia and therefore are often required to arrange follow-up care outside their catchment area.

Staff from all services commented that children are more likely to engage with community services after discharge if they have met the staff face-to-face while they are still on the ward. Unfortunately, during the COVID-19 pandemic, in-reach by community services was ceased and, in most cases, has not yet been re-introduced. Challenges with access to community services were most pronounced for FSH Youth Unit when discharging children who live in the Perth metropolitan area but not within the SMHS catchment.

> *"We should sit down and make a plan with whoever is seeing them in the community, but we don't get that opportunity. It depends on who they are seeing though, the adult services want you to discharge the patient before they will see them. CAMHS come to the discharge meeting. Private psychologists are very patchy, they have exclusion criteria." Clinical Staff*

4.5.2 Treatment and care takes age and maturity into account

Staff working on all sites described a need to be aware of the vulnerabilities of young patients including sexual vulnerability. Staff from all four services demonstrated sound awareness of observing risk of sexual vulnerability while patients were on the ward. Some clinicians reported that having an experience of sexual

trauma may be an integral part of the reason for the clinical presentation and therefore there was a need for this to be handled sensitively. In addition, staff had a clear understanding of the risks which could be posed by other patients.

However, it wasn't always clear how sexual vulnerability, sexual trauma or risk of predatory behaviour, was initially assessed. There was a consensus that this is part of clinical assessment, but no consensus around how or who in the multidisciplinary team assesses sexual safety. For example, the review team heard from some medical staff that social workers make this assessment, while social workers thought that nurses assess sexual safety and nurses reported that doctors were responsible.

Confidence to broaching this topic varied between individual clinicians. In addition, it wasn't always clear what information is provided to children, with responses varying by site and between clinicians. Some sites reported they had information pamphlets, but it was not clear whether children always receive or read these. The review team observed that, while there was clear evidence that staff are alert to issues of sexual safety during the inpatient admission, a more consistent approach to assessment and provision of information could lead to further improvements in this area. A recommendation has been made (Recommendation 4).

> *"It has happened that sometimes there's a child on the ward and there's a potentially predatory person and we have to keep them separate." Clinical Staff*

Across all four sites, staff often raised comments about appropriate ways to occupy children throughout the day. The challenges were different in the MHOAs when compared with the youth units, as the MHOAs do not provide an allied-health-led, structured therapy program. Staff in the MHOAs commented on their role as a crisis containment service and were concerned that children do spend a lot of time sitting and waiting in the MHOA, becoming bored and ruminating on their crisis. MHOA staff reported they engage through activities such as card games or mindfulness colouring if that is what the child is ready to accept, or through coaching about coping strategies if ready - but their capacity to do this is limited.

Across the board, staff expressed concern that children can learn maladaptive coping strategies from others in the inpatient setting. MHOA staff on both sites reported that they had a role to play in supporting children through a mental health crisis while preventing the need for a longer admission – a role they say is supported by evidence for this cohort.

> *"Encourage them to use MHOA before they self-harm and then we can help them with coping strategies. Using MHOA effectively leads to some good outcomes." Clinical Staff*

In the youth units, the challenges around activities were different. All staff reported satisfaction with the therapeutic program on offer. Staff described some challenges around providing access to activities outside the therapeutic program, while still maintaining a safe environment. Clinical teams were not always certain that they had the right balance between a welcoming ambiance and safety but demonstrated commitment to continuously working towards improving that balance.

> *"In terms of patient safety, they will literally find anything and everything and use it, even laminated pictures, chalk, pens." Clinical Staff*

There was tension around the role of education and teachers were interviewed. Education programs are available on both youth units, but not on the MHOAs. Some staff saw education needs as secondary to mental

health care. Others identified that access to an education program presents an opportunity to engage children with education (especially those who have disengaged because of their mental health) and potentially change the trajectory of the child's life. When required, teaching staff valued the medical staff's engagement and planning with the schools on discharge.

> *"We don't force them to attend schooling, we highly encourage them, but we also don't force them because that's about their authority." Clinical Staff*

When working with children, clinical staff demonstrated good awareness of the importance of family involvement however staffing and COVID-19 had impacted on engagement. This went beyond knowing that parents/supports and guardians need to give consent for treatment. Staff were sensitive to issues of family dynamics, how they may impact on the child's treatment and care and their safety after discharge from the inpatient service. The review team consistently heard that it was important to come to an understanding of the family situation and work with that to seek the best outcome for the child. Staff described a range of situations from parents/supports who were proactively involved, having to work around family commitments, parents/supports who were struggling to support the child through their mental health challenges, children who were estranged from parents/supports, and involvement with the Department of Communities.

Staff clearly described the strategies they use to engage parents/supports throughout the admission, though noting that their capacity to action these is not always satisfactory, usually due to reduced staffing. Clinicians were sensitive to the idea that parents/supports may have different feelings about the child having an inpatient mental health admission – including fear and relief. Staff from the youth units reported that carer and family support groups, which had been ceased due to the COVID-19 pandemic, have recently re-commenced.

> *"Sometimes it's about educating the parents/supports and trying to upskill them about validating their child's emotions more." Clinical Staff*

A strong theme across all staff interviews is that working with children aged 16-17 years is very different to working with children (aged 15 and under), and different again to adults. Staff highlighted they cannot be treated as children, because they have capacity to be involved in their treatment and care and to make some decisions themselves, but they are not adults. Involvement of parents/supports and guardians must be at the forefront of care, but often there are complex family dynamics and sometimes the child is a mature minor.

Several staff reported that when they started working on the youth unit, they were shocked and surprised at the rapidity and extent of emotional escalation in children aged 16-17 years, compared with adults or children. Across all four services, staff consistently reported that there was no training specifically on working with adolescents provided on orientation or as part of the core competency program. There was concern that the limited awareness of the challenges faced when working with this cohort, combined with the lack of training and orientation may contribute to high staff turnover. A recommendation about training specific to the needs of adolescents has been made (Recommendation 3).

> *"When you come from adults, you are extremely un-prepared for working with youth." Clinical Staff*

4.5.3 Consideration of culture and spiritual beliefs is more consistent for Aboriginal children than for those from ethnocultural, linguistically diverse backgrounds, though training is provided

The review team asked staff about their experience of providing care to individuals who are Aboriginal. Staff consistently reported that they had received cultural awareness training for working with Aboriginal people. All services reported having access to ALOs. Staff consistently reported that the ALOs were very helpful and their role was highly valued by the clinical team. Staff were sensitive to the need to ask people whether they were Aboriginal (and not to rely on appearance) and ask them whether they would like to see the ALO. Clinical staff consistently understood that Aboriginal people may have more involvement from extended family and asked about which support people they would like involved.

> *"Having a service for Aboriginal people is necessary. They are more vulnerable, with a higher incidence of language barriers; English could be their 4th Language. It's much more complex with Aboriginal people due to the inter-generational trauma." Clinical Staff*

Support to work with people from ethnoculturally and linguistically diverse backgrounds was not as clear. Most staff reported that they had received training in this area. Staff were aware that family members should not be used as interpreters and how to access an interpreter. No staff reported that their service provides access to multicultural liaison, but many staff noted that there is diversity within the clinical team, and they use their collective knowledge to work more effectively. Staff highlighted the need for clear communication and involvement with parents/supports, who may have ideas about mental health treatment and care based on their home country and which may be different to the views and system in Western Australia.

> *"Families may not have much knowledge about mental health, we need to keep them involved and empower them with knowledge to alleviate their concerns. A lot of people are relieved to know they will go home - and that they will know how long it will take until they go home. We do a lot of safety-netting around going home, we make that a very positive experience." Clinical Staff*

4.5.4 Services take a risk management approach to segregating children from adults

A strategy that was common across all sites visited was to consider other consumers on the ward before the child was admitted. In the MHOAs, this may mean that the child remains in the emergency department if there is an adult who is particularly unwell, acting out or a potential risk to children or others, and is already in the MHOA at the time the child presents. Admission to the MHOA may be expedited if a person who presents a risk is in the emergency department.

> *"I consider their suitability for MHOA, other patients, whether there are any issues that might put this patient at risk, say, there are forensic issues or other patients who are intrusive. If it's not suitable, we keep them in the general area." Clinical Staff*

In the Youth Units, staff reported this often led to conversations between the two units to make sure that children were received by the unit that was most appropriate for them at that time. The review team heard about system-wide plans in place for particularly vulnerable individuals, whereby a case conference was called between inpatient and community services whenever the individual presented to an emergency department, to make sure that the care they received was the best option for current circumstances.

"We consider if they are in the same school as another patient, or if there is a potential perpetrator on the ward. Sometimes they have a relationship with another patient. Often then, it is a negotiation with the other youth unit." Clinical staff

A consistently reported strategy was optimising the existing physical environment to improve safety for the child. Every staff member interviewed in both MHOAs identified specific beds which were more appropriate for children, due to having the best visibility from the nursing station and, at Joondalup MHOA, having a door to give the child more privacy. Both Youth Units have sections of the ward which can be closed to separate the ward into two halves. Staff on both sites described how this is used to separate the ward by age, or separate certain patients from other individuals, to give a disinhibited patient more privacy, or to provide personal space for patients who are very unwell and may escalate into aggressive behaviour. It was noted though, that, depending on the other patients on the ward at the time, this is not always possible. Staff also commented that having a lot of bed changes is disruptive to children's mental health treatment and care.

"It might be that some of our answers [on the s.303 notification] are fairly standard, because of the physical environment of the unit. We have to point that out for all of our patients." Clinical Staff

4.5.5 Use of observation and companions is consistent and appropriate

Procedures around the use of observation and companions varied across the services, but each organisation's policies were clearly described by their staffing group. JHC MHOA has the option of providing a space for parents/supports to board, which is the preferred option where possible. Where a parent is not present, the ward can opt to provide a 1:1 "carer" (Assistant in Nursing) and/or to bring security guards into the ward, to monitor other patients. While the Joondalup MHOA staff reported that they have limited choice regarding carers, the review team consistently heard that they actively seek carers who they know to work effectively with children, who will engage them in games and activities, rather than simply observing them.

At SCGH MHOA, there is no space for boarding parents/supports, however, it is NMHS policy that a 1:1 nurse special must be used for all patients aged under 18 years in the MHOA. The review team heard about the additional clinical benefit gained from having the nurse special, in that over time, the child often warmed to them and may share additional information which supported a more effective clinical assessment. Furthermore, the nurse special used the opportunity of their time with the child to engage them in activities and coach them in emotional regulation strategies, as appropriate for the child's mental state over time.

In the youth units, there was more focus on routine nursing observations. Staff reported that most children started their admission on 15-minute observations, but this would be re-assessed as needed. Like all wards, the youth units have the capacity to implement a 1:1 nurse special if needed.

"The nurses do their observations, say every 15 minutes, 30 minutes, and they do pick up a lot of observations with those and they will consider things like moving their rooms, setting boundaries, telling them what's appropriate." Clinical Staff

Staff across both youth units highlighted the need to intervene in unobtrusive ways. For example, if two patients were watching a movie together, staff might sit and watch it with them, to observe their behaviour and interaction. Alternatively, if patients are having a conversation in a communal area, staff might place themselves close enough to hear what is being said, but only join the conversation if the content broached topics that were considered risky. Clinical staff also expressed the importance of ensuring that children were

aware of the expectations on them while they were on the ward. Both units had an information form, which children sign on admission to ensure the expectations of their behaviour are clear. Nursing staff described having 1:1 conversations with patients both to ensure they understand how to behave on the ward, and to provide skills-coaching to support appropriate behaviour. Allied health staff reported that they include boundary-setting as part of the content of the therapeutic program.

> *"We are explicit that if a person is on a protective behaviours program, the whole family might need that education, we try to target the core of the cause of that behaviour." Clinical Staff*

4.5.6 Other measures

Across the system, there are highly dedicated staff working to provide mental health treatment and care. On this review, the team heard an unexpectedly high number of staff report that they have a passion for working with children, that they love this work and they plan to keep working where they are in the long term. These highly engaged staff are working to ensure that children receive the best service they can provide.

> *"Working with children, you have to have a passion, you can't just do it for money." Clinical Staff*

4.6 What stakeholders told us

A total of 22 responses were received from both clinical and non-clinical community mental health services, staff from other government agencies (including MHAS), general health services and other stakeholders. Feedback from the stakeholder survey is shown as a weighted average in Figures 2 & 3.

Figure 2: Stakeholder Survey – MHOAs and MHECs

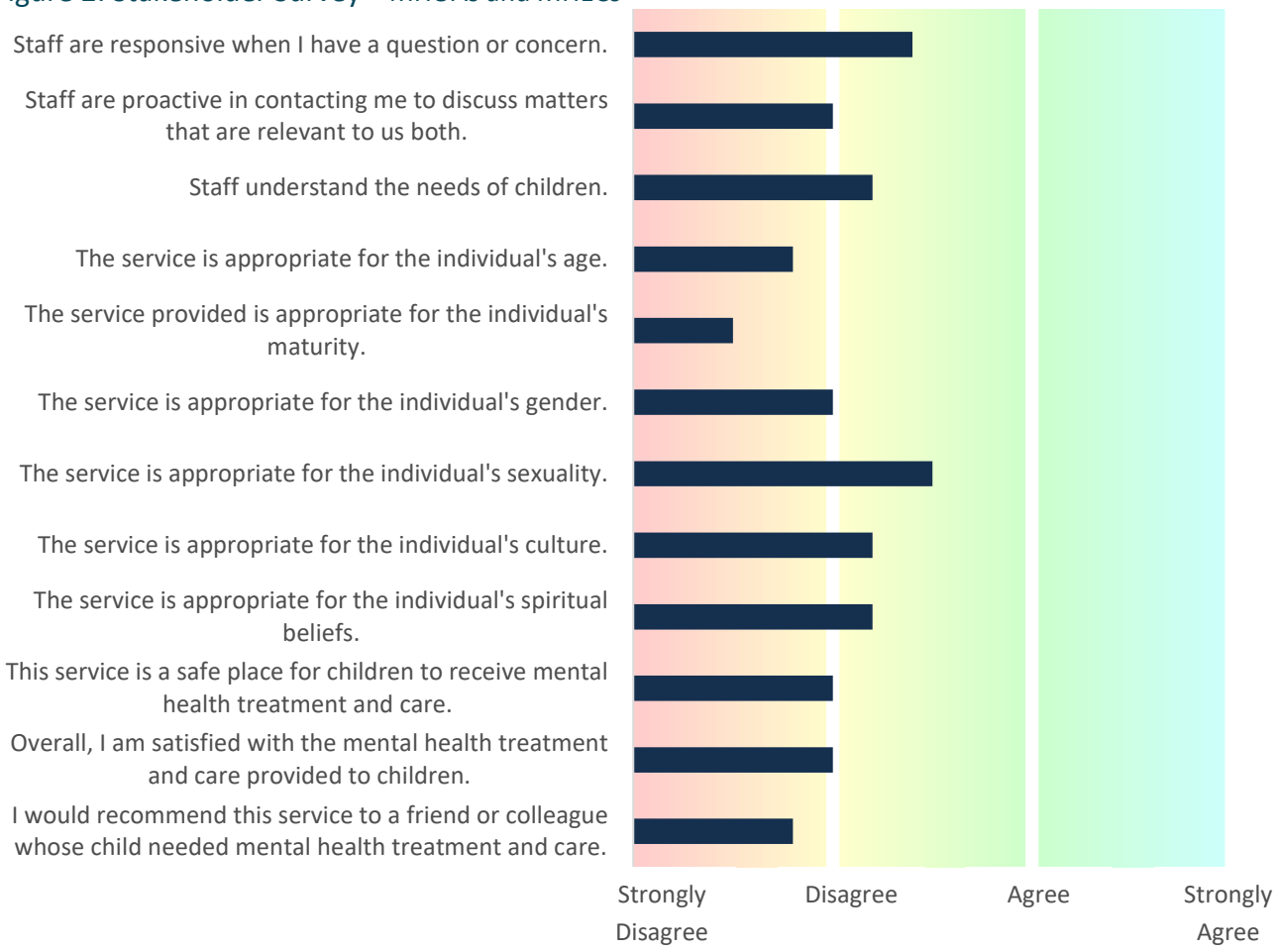
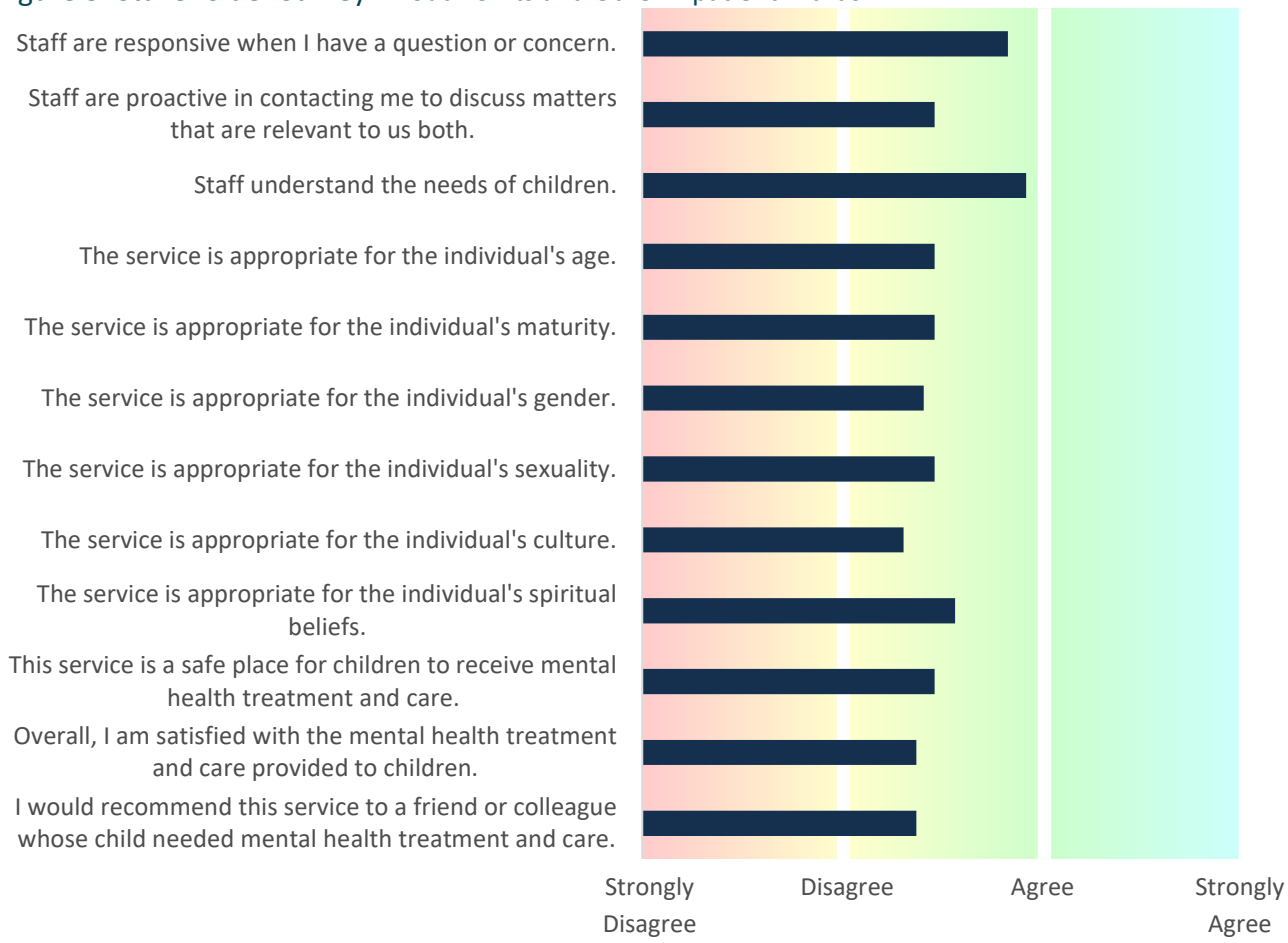


Figure 3: Stakeholder Survey – Youth Units and Other Inpatient Wards



In general, services are perceived as needing improvement. Based on the comments provided, some stakeholders are concerned about the safety of children on wards which also provide treatment and care to adults. There were also comments, though, that stakeholders understand that youth and adults are treated together because of system design. Some stakeholders noted that services manage the situation appropriately and that concerns about satisfaction with care are less related to the presence of adults and more related to staffing levels and to the ability to gain access to services when needed.

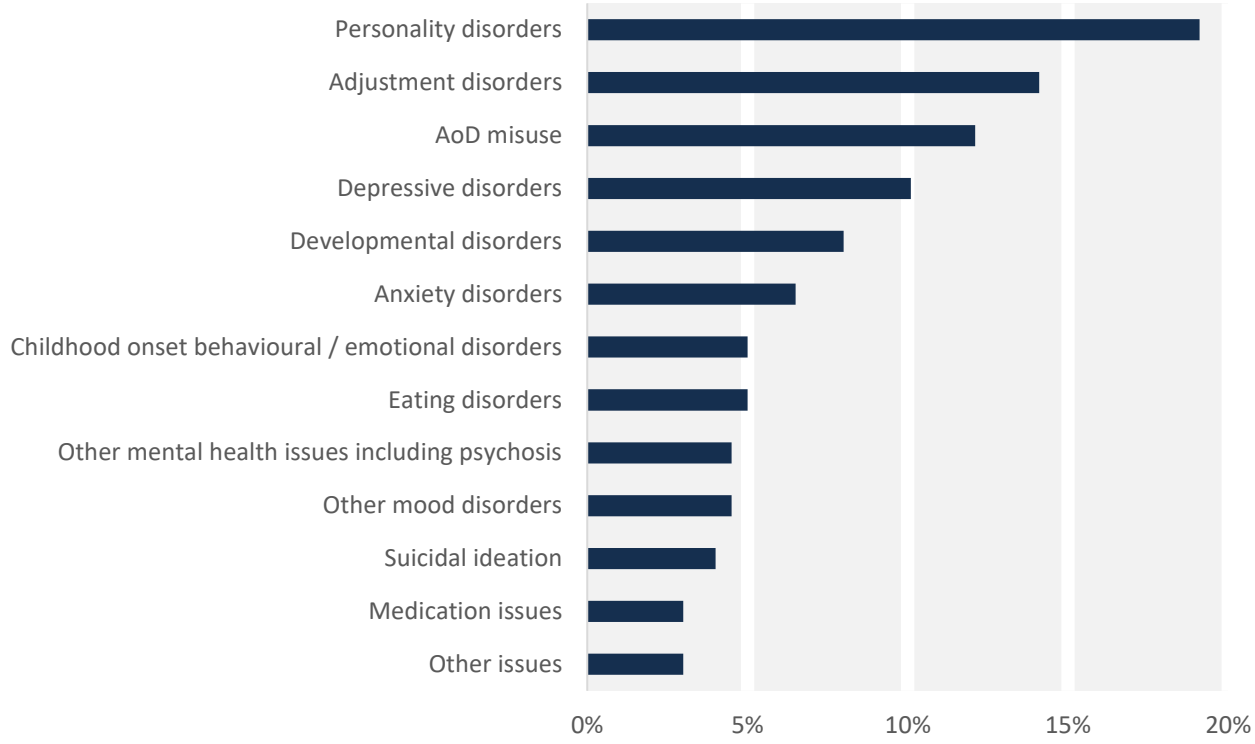
"I think it presents unnecessary safety risks." Stakeholder

4.7 Review of clinical records

The clinical review team selected a sample of the 30 most recent discharges prior to June 2021 for each of the four sites visited (120 total). This small convenience sample may not be representative of all admissions. Of these admissions, 38% were the first time the individual had been admitted to a public mental health service and 29% were active with a public clinical community mental health service at the time of admission.

The team collected the discharge diagnoses for these admissions from PSOLIS; the types of diagnoses found are shown in Figure 4. Note that these data may not accurately reflect bed demand for patients with eating disorders for two reasons; each of the youth units will accept no more than two eating disorders patients at a time and patients who are medically compromised due to their eating disorder are admitted to a medical ward rather than a mental health ward.

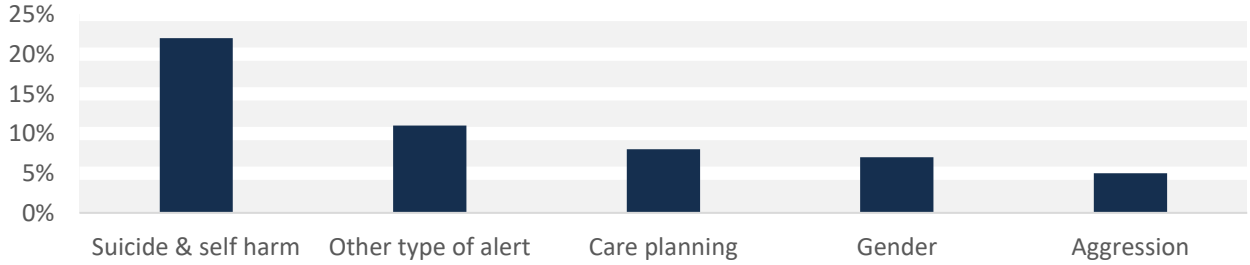
Figure 4: Types of diagnoses – sample of discharged patients



Note: Individuals may have more than one diagnosis per admission

The review team examined the alerts on PSOLIS for individuals in the sample (Figure 5). Of the sample, 65% had no alerts. PSOLIS does not capture gender diversity; the only options are male or female. Clinicians are using the alert system to appropriately identify when individuals have gender diversity needs, including to identify pronouns and preferred names. The alerts corroborated information provided during staff interviews (4.6), with the review team noting that 8% of individuals within the sample had alerts advising the plan for care, should they present to an emergency department.

Figure 5: Types of alerts – sample of discharged patients



Note: Individuals may have more than one alert

Of the 120 identified records, the review team conducted a detailed review of 81 clinical records. The team included any information on the Psychiatric Services On-Line Information System (PSOLIS) that was relevant for consideration at the time of admission and any information documented by the inpatient team during the admission.

The clinical review team sought information to better understand the consumer cohort receiving care in the four units visited. Information was collected from the clinical record and is shown in Table 4. Where this differed between records from different services, or between the record and PSOLIS, the item was counted

if documented in any of these records. For example, if a person had been admitted to two of the inpatient services and one record noted that they are Aboriginal, whereas this was not documented in the other record or on PSOLIS, the person will be counted as Aboriginal in the data below.

Table 4: Consumer Cohort

Age on admission	16.9 years (mean)
Gender	28% Male, 60% Female, 6% Non-Binary, 6% Female-to-Male Transgender
Aboriginal	<5 Aboriginal, 7% Not Documented
Ethnoculturally or Linguistically Diverse (ELD) Background	10% ELD, 10% not documented, <5 need interpreter
Co-occurring alcohol or other drug (AoD) issues	47% yes, <5 not documented
Co-occurring disability	12% yes; of the total, 9% had Autism Spectrum Disorder, some individuals with a co-occurring disability had more than one type of disability.
Co-occurring chronic health condition	6% yes, 11% not documented
Involved parent, guardian, carer, family member	<5 did not have an involved carer or family member
Child protection order in place	<5 yes, 33% not documented
Mature minor	<5 yes, 49% not documented
Has a General Practitioner	<5 did not have a GP, 11% not documented

Reviewers found documentation outlining an assessment that was done to review the suitability of the inpatient service for the individual's needs before they were admitted in 45% of records reviewed. For those individuals where an assessment occurring prior to the admission could not be located, 98% had a documented assessment after admission. The team found all assessments reviewed to be an appropriate assessment of an adolescent and 18% of assessments were identified as particularly thorough.

The review team found care plans were made for 72% of the admissions and 87% had a risk management plan. Shared decision making is recommended in mental health[6] and previous reviews by the Chief Psychiatrist indicate that in Western Australia, the primary way that clinicians report involving patients in their care is via care planning. Table 5 highlights whether the review team found evidence that children and parents/supports were involved in the development of care plans and risk management plans.

Table 5: Consumer and personal support people involvement in care planning and risk management planning

Criterion	Care Plan	Risk Management Plan
Evidence of child involvement	86% of plans reviewed	80% of plans reviewed
Involvement of child was thorough	15% of plans reviewed	14% of plans reviewed
Evidence of parents/supports involvement	81% of plans reviewed	62% of plans reviewed
Involvement of parents/supports was thorough	<5 plans reviewed	<5 plans reviewed

Note: A rating of "thorough" was given only when the level of care significantly exceeded expected standards

The review team looked for situations in which the individual was discharged or transferred from the ward due to concerns about whether they could stay on the ward safely, however, this was found in <5 records.

4.8 Outcome measures

To better understand the complexity of clinical need associated with this cohort, the review team reviewed the Health of the Nation Outcome Measure Scores for both Youth Units, across children and adult cohorts for 2021-2022 FY to demonstrate areas of highest need for the age group and service setting.

Table 6: Mean Health of the Nation Outcome Measure (HoNOS) subscale scores 2021-22 FY

Service / Age	Behaviour	Impairment	Symptom	Social	Number
EMYU / adults over 18 years	2.64	0.78	3.55	2.26	58
FSH inpatient / under 18 years	4.05	0.57	5.82	2.36	342
EMYU / under 18 years	3.59	0.87	4.21	2.67	225

Note: For FSH, PSOLIS data does not separate adult ward from youth ward and was therefore omitted.

The data shows severe needs in the symptom subscale and moderate to severe needs in the behaviour subscales for children. Adults on EMYU were rated lower on behaviour, symptom subscales than the children on both units. The data do not support some staff perspectives that patients attending EMYU have more severe symptoms and behavioural disturbance than those at FSH Youth Unit, however, they do support the perspective that children have more symptoms and behavioural disturbance than adults.

4.9 Reviewer observations

During the site visits, the review team made observations about the physical environment, staffing, culture and improvement-orientation of the services visited, and considered how these impact on the standards of care.

4.9.1 Physical Environment

There is evidence that good design of a hospital's physical environment promotes better clinical outcomes, increases safety, and reduces stress for both patients and staff.[76] Good quality therapeutic spaces are those that are youth and family-friendly and that support education, activity, outdoor and family time and safety contribute to positive ward environments. The physical environment of each of the services visited presented both advantages and challenges to working with children aged under 18.

SCGH MHOA view from nurses' station

4.9.1.1 The physical environment in MHOAs is clinical

When asked about keeping children safe, every staff member interviewed on both of the MHOAs identified specific beds which would be allocated to any children who were admitted. At both MOHAs, this bed was selected because of visibility from the nursing station, at JHC MHOA, the preferred beds also had doors instead of curtains, to allow children more privacy.

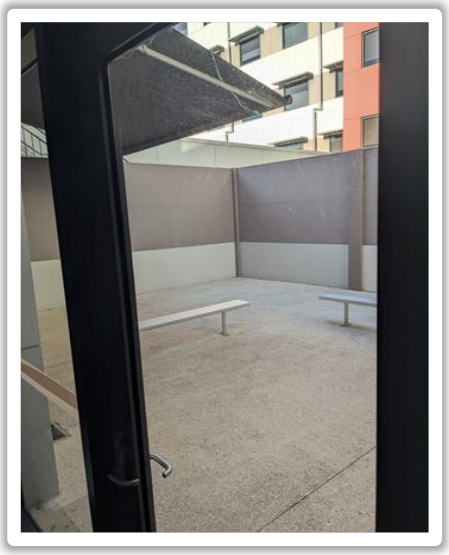
SCGH MHOA bed space

SCGH MHOA communal area

Both MHOAs have communal recreation areas for patients; SCGH has an indoor area only, while JHC MHOA has both an indoor area and a courtyard. The communal space at SCGH MHOA is basic, but there was evidence of consumer involvement in the selection of posters on display, board games and a suggestion box. The communal areas at JHC MHOA appear very clinical; the outdoor space does not have any planting. JHC MHOA staff reported their courtyard is not often used because patients need supervision while they are out there and because the nearby private hospital windows overlook it.

JHC MHOA bed space

JHC MHOA interview room



JHC MHOA courtyard

4.9.1.2 There are challenges in the physical environment of both youth units, but services aim for a welcoming space

Both youth units provide care in an environment where there is a mix of shared and individual patient rooms, where a section of the beds can be physically isolated from the remainder of the beds and where there is access to outdoor spaces.

FSH has worked to make their indoor spaces feel welcoming through the addition of posters which help children to identify staff, availability of snacks and games and through the "Recovery tree" wall, where recovering patients are invited to write a message to inspire future patients onto a leaf, which is added to the tree.

FSH Youth Unit communal area

FSH staff identified that their service does not have enough private rooms for individual therapy sessions, while EMYU identified that they do not have enough spaces for group activities.

Both services had welcoming external courtyards with appealing murals painted on the walls. At EMYU, children have been working with staff to create a 'sensory garden', containing a gazebo, variety of plants and inspirational messages painted on decorative rocks.

EMYU sensory garden

EMYU family room and internet cafe

At EMYU, the review team perceived that the Psychiatric Intensive Care Unit (PICU) communal space was particularly bare, however staff advised that due to the high acuity of patients who receive treatment and care in this area, it is difficult to create a welcoming environment. OCP staff with expertise in physical environments in which mental health services are provided are currently working with both JHC MHOA and EMYU in processes which are separate to this review.

EMYU PICU therapy room

EMYU PICU communal area

4.9.2 There is a positive staff culture, but staffing levels present challenges

Good quality relationships, frequent communication rely on positive staff culture of teamwork and support and having enough staff. All the sites visited presented as though they had a positive team culture. Reviewers observed warm, collegial behaviour in the interactions between staff. A high proportion of staff reported that they love their jobs and feel passionate about the work they do.

The review team did hear that on the two youth units there is high staff turnover, which the majority of staff who commented on this attributed to new staff being unprepared to work with the challenges of the youth cohort (see 4.5.2). Due to the emotional toll on staff managing challenging behaviour whilst also trying to develop a therapeutic rapport, the system must look after staff and seek feedback from staff, children and parents/supports. Tackling the issue of turnover is of high importance given that the EMYU also reported vacant positions and difficulties with recruitment. Challenges recruiting staff are not unusual in the current climate in WA; all sectors are affected however, reduced staffing levels do affect the capacity of mental health services to implement the strategies needed to keep patients safe. EMHS has commenced an initiative to attract and retain staff. It is important that all youth services prepare new staff to work with children and provide existing staff with the support they need to allow a positive culture to continue to flourish.

4.9.3 Service Improvement

Capacity for service improvement on the ground through dedicated positions who proactively undertook improvements to the physical and therapeutic environments of services in response to feedback is a valued resource and had made several positive changes. These positions provide capacity for clinical staff to suggest issues to be rectified, solutions, policy aids and innovate that can be actioned on the ground by using a collaborative approach.

4.9.3 Discharge Planning - meeting community services face-to-face

All services expressed challenges connecting children with suitable follow-up services when they require further treatment and care after discharge from the inpatient setting. A concern expressed by all services was that if the child does not engage with community services after discharge, there may be an increased risk of re-admission. For many children it is their first contact with both inpatient and community services. The review team heard that a "warm handover" or face-to-face meeting between the child and staff who will work with them in the community improves the likelihood that the child will engage with community services.

The Youth Units, as state-wide services, often discharge individuals to services outside of their catchment area. They need clear information about available services in all areas to support effective discharge planning.

Youth Units and MHOAS/MHECS may benefit from, where practicable, implementing a face-to-face (or videoconference) conversation between the community mental health service (or other receiving service) and the child, and parent support, before they leave the inpatient service.

4.10 Issues which were out of scope for this review

Across the staff, consumer and carer interviews, surveys and the stakeholder feedback, there were two themes that were raised so consistently, they have been noted here.

4.10.1 Issues relating to system design and service provision for children aged 16 – 17 years

Every person interviewed volunteered information about challenges with access to services for children aged 16 – 17 years. There were individuals who requested an interview with the review team because they wanted to share their concerns about system design, not realising that system issues were outside of scope for this review. It would be unfair to consumers, parents/supports and the staff who work in clinical services to not recognise their concerns in this report. The Chief Psychiatrist will write to the Chief Executives of each health service provider, the Director General of the Department of Health and the Mental Health Commissioner, detailing the information collected during this review.

> *"Parents/supports are begging for a road-map and I actually don't think it's so complicated, there just isn't enough." Clinical Staff*

Children are being prioritised for admission to the Youth Units over adults however there was shared concerns across the feedback about long waits for services, and that there are not enough, and limited options for the 16 to 17-year-old age group. Also, whilst limited access to youth unit beds is a barrier to timely care, the MHOA function can importantly prevent inpatient admissions. Further improvements of the MHOA environment and boosting their allied health and in-reach could optimise beginning recovery in MHOAs for children.

4.10.2 Treatment and care of children with disordered eating and eating disorders

Several staff in MHOAS and youth units highlighted the unmet needs of children with eating disorders and disordered eating. The allocation for 2 beds per youth ward for children with eating disorders was considered

insufficient resulting in long waits in MHOAs where the food options are frequently limited and there is no dietetics in-reach. Children with eating disorders are currently provided a one-to-one nurse special on the youth units and need a safe and supportive space for nasogastric feeding.

Services raised the risks to other adolescents of being influenced by peers and being vulnerable to adopting behaviours of restricted and disordered eating. Disordered eating behaviours were sometimes considered to be exacerbated on the ward however staff reported they supported children, during mealtimes in the least intrusive manner. The high proportion of adolescents with emotionally unstable personality disorder and co-occurring neuro-developmental needs, poses further challenges in supporting these behaviours.

The Chief Psychiatrist will write to the Chief Executives of each health service provider, the Director General of the Department of Health and the Mental Health Commissioner, detailing the information collected during this review.

4.10.3 Social media and access to devices

Staff and children had differing views on how much access and when children should be allowed to use their devices on the ward. The youth units had different approaches. The benefits and risks alongside psychological and social functions of device-use need further attention as needs and risks can vary greatly between individuals. A focus on a more individualised approach to safe use which supports mental health and maintaining social roles whilst protecting privacy and vulnerability needs consideration. Blanket rules may reduce a sense of normality, autonomy and responsiveness of the ward environment in children.[4]

5.0 Conclusion

The safety of children and children in our inpatient mental health services is paramount. Recovery, so that children can go on to achieve their goals and to live their best life, is contingent on services that provide safe, individualised care that considers a diversity of need.

Overall, the review team found that staff provide excellent clinical care within the boundaries of the type of care that their services are designed to provide. There is a high attention to clinical risk, which the team found was assessed appropriately and often. Meeting the clinical care needs of the individual is the primary driving factor in the decision to admit children to wards which also accept adults. All services visited had well-developed processes to ensure that children received safe, high-quality care in the safest environment available.

The review found that most admissions of children were to youth wards, which are designed with awareness of the vulnerabilities of this cohort. Due to well-developed processes for children aged 16- 17 years, the risks posed on these wards were not primarily due to the presence of adults, but rather, due to the type of risks present in all inpatient mental health services. The risk of being exposed to trauma due to witnessing distressing behaviours or through the experience of being restrained, or the risk of learning unhelpful coping strategies witnessed on the ward were reported as more significant.

Assessing suitability for an inpatient admission goes beyond the individual and must also be social, systemic and environmental. The wards visited had procedures in place to prevent a mix of patients that would contribute to a untherapeutic dynamic and therefore increase risk. All wards visited had appropriate measures to reduce the risk of exposure to traumatic experiences, but these were sometimes limited by ward layouts. The youth wards had appropriate programs to reduce restrictive practices, structured therapeutic programs to support positive coping strategies, exercise and access to outdoor time and access to education services to facilitate engagement with age-appropriate schooling. Ensuring flexibility and equal access to these activities, including for those experiencing high acuity or segregation due to risk, is important for a positive and recovery-orientated inpatient experience. In some instances, access could be further improved. The review found that when children are admitted to a mental health ward, there is consideration of whether the benefits outweigh the risks of being there.

Consumers, carers and staff raised the need for alternatives for children who are suicidal, those with lower acuity but in crisis, especially those first presenting to the emergency department. An important finding was the significant role that the MHOAs are already playing in preventing unnecessary inpatient admissions of children. MHOAs are not currently resourced to provide a structured therapeutic program, yet staff recognise the need for MHOA to contain a crisis, coach emotional regulation skills and link children with appropriate supports in the community. They are doing what they can within their current resourcing, through carefully selecting the staff who work most closely with children as a 1:1 special, exploring options for therapeutic activity and maintaining awareness of the array of services available in their community. Further developing current in-reach from allied health, peer workers, drug and alcohol and Aboriginal mental health workers where available may assist in boosting/building-up recovery-orientated care in MHOAs for youth.

As with all mental health services, there is room for improvement. Some of the areas for improvement reflect issues across the sector – staffing constraints and difficulties recruiting mean that services are not able to provide the care they would like to provide - restrictions put in place during the recent wave of COVID-19 mean that communication processes and supports for parents/supports have become limited - communicating treatment, care, rights and safety must be more than a pamphlet, the opportunity to form a bond with a trusted or compassionate staff member contributes to a sense of safety. Services are aware of these issues and have initiatives in place for those which have been deemed highest priority. This review has identified 5 key improvements which will build on the processes already underway.

This review found that decisions about the right mental health care at the right time are challenging for parents/supports, the staff who work in the system and most of all for children. Many people who contributed to this review raised the need to ensure that children are prioritised and have access to the mental health treatment and care they need from the start. Existing services are committed to providing the best services they can. Children and their parents/supports deserve nothing less.

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Appendix 1: Methodology summary

The aims of the review are summarised in the 1.0 Project Overview.

The scope of the review was determined by admission data which showed that 86% of admissions of children to inpatient services which also admit adults were to the 2 metropolitan youth units (which admit patients aged between 16 and 24) and to the 3 MHOAs/MHECs. Therefore 4 of these services were selected for review. There were no children admitted to adult mental health wards during the review period.

Reviewers are senior clinicians with experience in the management of people who have a mental illness and must be employed by either the Office of the Chief Psychiatrist (OCP) or a public mental health service. The team for this review included specialised child and adolescent mental health clinicians.

Reviewers examine a sample of clinical records at all four mental health services visited and any records kept outside of the clinical record, for example, handover records, which may contain information relevant to this review. An initial review of PSOLIS is conducted for sample records alongside the medical record. While on site, all members of the review team undertake general observation which may include review of handover processes and associated documentation that is not contained within the clinical record to ensure the decision-making context is considered.

Interview questions, survey, posters and flyers were designed with input from child and adolescent clinicians and with feedback from a young person with lived experience of being a child on a ward with adults. Parents and/or guardians, and, with their consent, consumers who are children, were given the opportunity to contribute to the review via face-to-face, videoconference or phone interview, or online survey. Survey data was be collected and managed using REDCap.[1],[2] electronic data capture tools hosted at WA Health. Flyers and posters contained a QR code generated through REDCap.[1,2] which will link respondents to the online survey for ease of access.

External stakeholders were identified through consultation with services or through review of the clinical records and a stakeholder survey designed to elicit stakeholder opinions about service adherence to section 303 requirements.

Prior to the review, the OCP obtained relevant policy documents from the WA Health Intranet, HealthPoint and health service providers were given the opportunity to supply any local service, site, or ward policies

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