Government of **Western Australia**
Office of the **Chief Psychiatrist**

Chief Psychiatrist's Standard

Authorisation of Hospitals under the *Mental Health Act 2014*

Version 3.0

Issued under section 547 of the
Western Australian *Mental Health Act 2014*

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Version Control

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Acknowledgements

We acknowledge Aboriginal peoples as the Traditional Custodians of our State and its waters. We pay our respects to Elders who were, who are and who will be, and extend this to all Aboriginal people seeing this message.

We recognise the individual and collective expertise of those with a living or lived experience of mental health, alcohol and other drug issues. We recognise their vital contribution at all levels, and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

We are committed to embracing diversity and eliminating all forms of discrimination in the provision of health and mental health services.

This document would not have been possible without the invaluable contribution from the Chief Psychiatrist's Lived Experience Consultation Group and the clinicians, subject matter experts, broader agencies and individuals involved in feedback.

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Overview

Purpose of Standard

Under section 515 of the *Mental Health Act 2014* (MHA), the Chief Psychiatrist is responsible for overseeing the treatment and care of voluntary and involuntary patients, as well as supervised persons detained at an authorised hospital or required to undergo treatment as a condition of an order made under the *Criminal Law (Mental Impairment) Act 2023* (CLMIA). The MHA explicitly requires the Chief Psychiatrist to fulfil this responsibility by:

> *"publishing under section 547(2) standards for the treatment and care to be provided by mental health services to the persons referred to in subsection (1)"*
> (MHA s 515(2)(a))

This legislative requirement establishes the mandate for the Chief Psychiatrist to develop and publish formal standards of care, with which mental health services must comply.

In the context of hospital authorisation (for both public and private hospitals), this is particularly critical. For a hospital to admit involuntary patients under the MHA, it must be formally authorised. Authorisation required is as follows:

- A public hospital (or part thereof) must be authorised by the Governor, based on a recommendation from the Chief Psychiatrist (MHA s 542).
- A private hospital licence may be endorsed by the Director General under the *Private Hospitals and Health Services Act 1927*, but only after receiving a recommendation from the Chief Psychiatrist (MHA s 541).

The Chief Psychiatrist will only recommend authorisation if the hospital meets the criteria outlined in the *Chief Psychiatrist's Standard for the Authorisation of Hospitals under the Mental Health Act 2014* (the Standard).

While the Standard is only legally mandatory for facilities seeking authorisation, other mental health services - such as those offering voluntary care - may also find the standards valuable. The Standard provides a framework for safe, contemporary, and effective mental health services.

Development Process

The standards outlined in this document replace those released in October 2019. They have been revised to reflect growing evidence on how the built environment and design features of mental health facilities influence psychological wellbeing, as well as lessons learnt from past builds, and a thorough consultation process. The Office of the Chief Psychiatrist (OCP) acknowledges and expresses sincere appreciation for the contributions of all participants, particularly the OCP Lived Experience Consultation Group.

Scope

The Standard sets the minimum requirements for mental health services, both new builds and refurbishments, seeking authorisation under s 524 of the MHA to support safe, recovery-oriented, and trauma-informed environments across Western Australia. This includes public and private mental health services as defined by the MHA.

While the Standard does not apply to non-authorised hospitals, it should be considered as a guide to best practice.

The Standard is designed to support innovation and contemporary practice, while remaining appropriately broad to accommodate a range of service models. It is grounded in principles of dignity, consent and minimising coercion and is structured into three parts: Model of Care, Design, Build and Operational Planning and Specialised Services.

Authorisation Principles and Process

General principles

- Authorisation is granted for the service in its entirety, not only the infrastructure.
- Early and ongoing engagement with OCP minimises redesigns, delays, and non-compliance, while significantly increasing the likelihood of successful service authorisation.
- The formal authorisation process is governed by the MHA and can only occur once a construction is completed, the facility is furnished, and the service is operationally ready to admit individuals under the MHA.
- There is no provision for conditional authorisation; approval cannot be granted subject to conditions or qualified statements.
- The Standard applies to new mental health facilities as well as all refurbished or renovated authorised areas, including anywhere the footprint of the authorised area has changed.

Authorisation process

To assist services in meeting the Standard and obtaining authorisation, the OCP has developed the Chief Psychiatrist's Advisory: Mental Health Service Planning and Authorisation Process (the Advisory). The Advisory outlines the recommended pathway for the OCP's involvement in mental health builds. It promotes early and ongoing collaboration - from initial planning through to design, construction, and commissioning - to ensure alignment with the Standard at all stages.

Other relevant Standards and Guidelines

The purpose of this Standard is not to duplicate existing requirements. Therefore, services seeking authorisation are also expected to comply with the following Standards and Guidelines.

Chief Psychiatrist's Standards and Guidelines: All mental health services must comply with the Chief Psychiatrist's standards and must have regard to the guidelines under the MHA. The Standards set mandatory expectations for treatment, care, and patient safety, ensuring services operate lawfully and in line with clinical best practices.

The National Safety and Quality Health Services (NSQHS) Standards: Endorsed by the Chief Psychiatrist, the NSQHS Standards are legally binding on all mental health services. They ensure consistent, safe, and high-quality care across the sector.

Licensing Standards for Private Hospitals (if relevant): Administered by the Licensing and Accreditation Regulatory Unit (LARU), these standards establish mandatory requirements for private healthcare facilities in Western Australia under the *Private Hospitals and Health Services Act 1927*.

Australasian Health Facility Guidelines: These evidence-based guidelines support the planning, design, and construction of health facilities. This Standard aligns with the guidelines, and it is recommended that they are used as a minimum benchmark for infrastructure development.

Charter of Mental Health Care Principles and Objects of the *Mental Health Act 2014*: The Charter and the Objects of the *Mental Health Act 2014* set out the core principles, values and legislative intent underpinning mental health care in Western Australia. Mental health services must make every effort to integrate these into the provision of care and treatment.

Section One – Model of Care and Operational Planning

Context

A Model of Care defines the principles under which the service operates and the ways those principles are operationalised across care pathways, clinical practice, staffing, governance, and the built environment.

For the purpose of this Standard, the term 'Model of Care' is used to include service delivery components, recognising that these may be documented across multiple documents with different titles.

The Model of Care aligns with contemporary clinical practice, relevant legislation, and professional standards, and sets out how these will be reflected in practice to support care that is responsive, holistic, and tailored to individual needs. It articulates the core values of the service and how they will be enacted, including key principles such as person-centred, recovery oriented, trauma-informed, inclusive, gender responsive, and culturally safe care. In addition, it establishes how safety is maintained through physical, relational, and procedural approaches.

A well-defined Model of Care drives design that supports safety, autonomy and dignity, enables least-restrictive practice, offers genuine choice and responds to diverse needs. It shapes how spaces are used, how therapeutic relationships are supported, and how patient wellbeing is promoted through the built environment.

To obtain authorisation, services must have a clearly articulated Model of Care that informs design and operational decisions and demonstrates alignment with the requirements outlined in this Standard. Whilst it is a living document that evolves over time to reflect new evidence, emerging best practice and service-specific learnings, it is strongly recommended that services submit their Model of Care, with the supporting Business Case, to the OCP early in the planning process and following any major updates. This enables preliminary review against the Standard, supports alignment with expectations for safe, high-quality mental health service delivery, and increases the likelihood of successful authorisation.

1. Care delivery principles

1.1 Core principles of care

The Model of Care demonstrates the following core principles which guide the practice and culture of the service:

1.1.1	Person-centred care that actively protects and upholds the human rights of all patients, regardless of background, identity or circumstance.
1.1.2	Trauma-informed practice that recognises the impact of ongoing, systemic and intergenerational trauma and actively avoids re-traumatisation.
1.1.3	Recovery-oriented principles that foster optimism and hope are embedded across care pathways and organisational culture.
1.1.4	Care provision is anchored in dignity and respect for individuality, inclusive of disability, neurodiversity and gender diversity.
1.1.5	Cultural, religious and spiritual beliefs of individuals and families are respected and factored into person-centred care.
1.1.6	Partnerships developed with Aboriginal communities to centre cultural safety in workforce design, assessment methodologies, care planning and therapeutic approaches.
1.1.7	Engagement with cultural experts and communities to ensure equity of access for people of all cultural and language groups, including guaranteeing communication access through language services and adaptable communication methods.
1.1.8	Patient and support persons recognised and engaged as essential partners in individual care and broader service evaluation, development, and governance, in alignment with co-production principles and a commitment to genuine partnership.
1.1.9	Care grounded in contemporary evidence and clinical best practice, with suitably skilled staff supported to deliver effective interventions through a team based, multidisciplinary approach to deliver high-quality care.
1.1.10	Safety of all people in the unit, including patients, staff and visitors, upheld through integrated physical, relational and procedural safety strategies with lived experience engagement informing cohort-appropriate practice.
1.1.11	Least restrictive practice, de-escalation and therapeutic communication strategies embedded in service delivery and organisational culture and are central in the response to distress, agitation and arousal.

1.1.12	Sexual safety demonstrated through respectful practices, prevention of harm and trauma-informed responses.

2. Model of Care

2.1 Development of Model of Care

2.1.1	The Model of Care is developed through genuine consultation with key stakeholders, including: • People with lived experience, including priority groups to reflect the service's intended cohort. • Clinical experts, frontline staff and other key stakeholders. • People from diverse cultural backgrounds. • Aboriginal people and Aboriginal peer workers/Aboriginal mental health workers. • People with diverse identities and abilities (e.g. LGBTQI+ individuals, neurodiverse people, people with disabilities).
2.1.2	The Model of Care is grounded in contemporary research and evidence-based practice frameworks, including: • Relevant literature and academic research. • Service population-level data. • Applicable legislation, standards and strategic frameworks. • Alignment with current policy directions and strategic priorities.
2.1.3	The Model of Care has been shared with relevant stakeholders for feedback and support, including: • Office of the Chief Psychiatrist. • Partner organisations or service providers (if applicable).

2.2 Model of Care content

2.2.1	The Model of Care overview includes: • Background, including a summary of the development process. • Care Philosophy - core values and guiding principles underpinning service delivery. • Service Delivery Model – high level structure and staffing model, scope, purpose and intended outcomes.

	• Service Configuration - bed numbers, unit composition and how they relate operationally.

2.2.2	The Model of Care clearly outlines population and context:
	• Target population or patient cohort.
	• Service type (e.g. acute, rehabilitation).
	• Expected length of stay.
	• Scope of service.
	• Cohort-specific requirements including tailored accessibility considerations for:
	  ○ Aboriginal people.
	  ○ Culturally and linguistically diverse communities.
	  ○ LGBTQIA+ individuals.
	  ○ People with disabilities.
	  ○ People with diverse religious and spiritual beliefs.
	  ○ Neurodiverse individuals or people with a neurocognitive disability.
	  ○ Other priority groups if applicable (e.g. young people, older adult).

2.2.3	The Model of Care addresses the patient journey: • Admission. • Orientation. • Assessment. • Care planning. • Transfer and discharge. • Risk management.
2.2.4	The Model of Care outlines service delivery, including the following treatment components: • Mental health assessment and care planning. • Psychiatric and therapeutic interventions targeted to the needs of the cohort. • Physical health assessment, screening, monitoring and treatment including access to primary and specialist care when needed. • Identification, screening, and specialist treatment and support for people experiencing alcohol and other drug issues. • Smoking cessation. • Allied health interventions (Occupational Therapy, physiotherapy, dietetics, pharmacist). • Traditional healers and cultural support. • Peer-led support. • Psychosocial needs assessment, support and skill-building.

	• Structured daily routines and therapeutic programs, including the arts. • Access to outdoor and green spaces. • Opportunities for rest, reflection, and downtime. • Self-directed activities and autonomy-supportive options. • Recreational and social activities that promote engagement, connection, and wellbeing.
2.2.5	The Model of Care outlines access to care: • Access to care and programs outside standard hours, including weekends, with sufficient staffing to ensure safe and effective delivery. • Access to cultural and spiritual support appropriate for the local community including out of hours and at weekends. • 24/7 access to interpreter and communication services, with consideration that in small communities an interpreter from outside the local area may be required to protect privacy and confidentiality. • Access to primary and specialist medical care, advice and support when required. • Access to pharmacist, physiotherapist, and dietitian, even where these are inreach functions rather than part of the core team. • Access to security and emergency response teams. • Clearly defined pathways of care and/or partnership agreements with external agencies including specialist services, linguistic support providers, primary care, Aboriginal health services, schools, community services and the Department of Justice, where these functions are not part of the core staffing model.
2.2.6	The Model of Care outlines a staffing structure that ensures: • Specialist-trained multidisciplinary staff with expertise and scope of practice relevant to the cohort (e.g. acute, youth, forensic). • Team-based approach, including staffing profiles, discipline roles, shared care planning, and information flow. • On-site clinical leadership by senior clinician available at all times. • 24/7 psychiatrist cover, with on call psychiatrist available outside standard hours. • 24/7 access to urgent or emergency physical health care. • Management and administrative staffing and systems to support care delivery, workforce management, service coordination, operational governance, compliance with legislative obligations under the MHA

	(including data collection and reporting), quality improvement and service development. • Capacity to respond to the cultural needs of the cohort, including dedicated cultural roles such as Aboriginal Mental Health Workers (note that patients may require access to workers of specific gender). • Peer workers integrated as valued members of multidisciplinary teams, with clearly defined roles, appropriate supervision (including lived experience peer supervision, ideally external to the organisation, alongside clinical supervision/line management) and recognition of their unique contribution to recovery-oriented care. • Support services to ensure safe, efficient delivery of essential functions such as cleaning, catering, linen and other operational supports.
2.2.7	The Model of Care outlines clinical and operational governance including: • Defined oversight structures and lines of accountability. • Mental health clinical leadership and oversight. • Mechanisms for monitoring compliance with relevant legislation, e.g. MHA and CLMI. • Mechanisms for monitoring compliance with Chief Psychiatrist's Standards and statutory reporting requirements. • Mechanisms for monitoring compliance with safety and quality standards. • A system that ensures policies and procedures are contemporary, evidence-informed, and regularly reviewed. • A risk management framework which outlines systems for identifying, monitoring and managing risks.
2.2.8	The Model of Care identifies key enablers that support effective implementation, including: • Physical environment. • Technology. • Partnerships.
2.2.9	The Model of Care outlines mechanisms for measuring performance and driving improvement, including how data and risk insights are used to inform service design and drive continuous improvement. This includes: • Performance metrics. • Clinical and operational data. • Consumer feedback. • Population data relating to the target cohort.

3. Operational planning

3.1 Policies and procedures

3.1.1	Policies and procedures are in place to support the Model of Care. These demonstrate how care-delivery principles are integrated into service delivery and daily practice.

3.2 Compliance with legal frameworks

3.2.1	Policies and procedures are in place to support compliance with the MHA.
3.2.2	Policies and procedures are in place that embed the statutory requirements of the Chief Psychiatrist's Standards into the day-to-day function of the service.
3.2.3	Operational policies are in place around consent and capacity to consent in accordance with Part 5 of the MHA.
3.2.4	Processes are in place around identifying and responding to advanced care directives and working with guardians and substitute decision makers.
3.2.5	Access to legal advice is in place and accessible to support the service and guide complex scenarios.

3.3 Upholding patient and support person/s rights

3.3.1	Clear, freely accessible information for patients and support person/s about their rights and care, and the pathways available if they feel those rights have not been met. Information is available in multiple formats (written, verbal, pictorial), culturally appropriate and tailored to cognitive and literacy needs, and includes: • Patient's rights under the MHA. • Chief Psychiatrist's Standards of Care. • Mental Health Advocacy Service access. • Complaints pathways under the *Health and Disability Services Complaints Act 1995*.
3.3.2	Welcome information (e.g. welcome packs or digital equivalents) is provided for patients, families, support persons and nominated persons, outlining

	rights, ward routines, involvement in care planning, advocacy pathways and escalation processes.
3.3.3	Patient and support person rights are addressed at admission, revisited and reinforced throughout care. These are communicated in ways that are accessible, meaningful, and appropriate for each cohort, addressing cohort specific complexities and principles, with clear pathways to independent advocacy.
3.3.4	Operational processes support communication access for patients and support persons, including: • Availability of telephones or other communication tools for patient use, with reasonable privacy. • Procedures that ensure safe use of communication devices, including supervision protocols where clinically indicated.
3.3.5	Support persons have a clearly defined role as a core part of the treatment and recovery team, aligned with the patient's consent, cultural context and wishes, and only where this is in the patient's best interests. They are supported and actively involved in care, including through videoconferencing for regional patients, with facilitated access to appropriate external support services.
3.3.6	Systems are in place that demonstrate the service's commitment to working towards the principles of co-production including structured lived experience roles in governance, advisory processes or workforce.

3.4 Risk management

3.4.1	Risk management and safety strategies are aligned with the Model of Care and tailored to the patient cohort, with strategies applied across physical, relational, and procedural domains.
3.4.2	Risk management includes risks to self and others, including ligature points, weaponisation of furniture, fixtures, and equipment, and the potential misuse of everyday items to cause harm (e.g. batteries in remote controls, cutlery, linen, plastic bags). Where risks cannot be physically mitigated, operational strategies are in place.
3.4.3	Risk management considers not only physical hazards but also relational dynamics (e.g. patient mix, interaction patterns, sexual safety).
3.4.4	Risk management considers contraband control.

3.4.5	A documented safety and risk management program is in place, tailored to the mental health service, with risks regularly assessed and mitigated through planned reviews (at least annually) and through operational strategies where infrastructure changes are not feasible.
3.4.6	Identification and mitigation of environmental, ligature and clinical risks supported by risk registers.

3.5 Procedural safety

3.5.1	Procedural measures reinforce physical and relational safeguards through clear roles, responsibilities, and escalation protocols.
3.5.2	Policies and procedures support consistent supervision, patient movement, contraband control, and emergency response.
3.5.3	Operational procedures ensure sexual safety to align with the Chief Psychiatrist's Standard for the Sexual Safety of Consumers in Mental Health Services and the Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services.

3.6 Emergency management and response

3.6.1	Business Continuity Plans are in place.
3.6.2	Personal duress alarms are provided for staff, and external visitors if required.
3.6.3	Emergency response protocols are in place, including the use of duress alarms.
3.6.4	A duress alarm testing framework is in place to ensure systems always remain fully functional.
3.6.5	Protocols for emergency response including team roles, incident reporting, patient and staff supports, structured debriefing and scheduled emergency response training.
3.6.6	Protocols for response to sexual safety incidents in accordance with the Chief Psychiatrist's Standard for the Sexual Safety of Consumers of Mental Health Services, and the Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services.

3.6.7	Policies on CCTV ensure use is proportionate, privacy-conscious and clearly defined in scope, access and storage with emphasis on safety and ethical oversight.

3.7 Workforce capability and development

There is a clear framework for supporting staff to deliver safe, high-quality, and culturally responsive care.

3.7.1	A structured orientation and induction process for all staff, including agency staff.
3.7.2	Appropriate mentoring and supervision provisions to support staff including junior staff, Aboriginal mental health workers and students on placement.
3.7.3	Support for professional training programs e.g. supervision and protected time for staff to meet their professional requirements.
3.7.4	Staff wellbeing and support processes provide structured debriefing and ongoing assistance following emotionally challenging events, actively monitor staff satisfaction and burnout, and implement meaningful wellbeing initiatives that strengthen resilience and sustain a healthy workforce.
3.7.5	Documented education, training and development program to ensure ongoing training for clinical and non-clinical staff.
	(a) Training is specific to the cohort.
	(b) Training includes legal obligations under the MHA including reporting requirements, procedures for involuntary treatment, the Charter of Mental Health Care Principles and the Chief Psychiatrist's standards. (annually, including e-learning and face to face training on the MHA legal requirements for the management of voluntary, referred and involuntary patients in authorised settings).
	(c) Training program includes comprehensive training on aggression management, de-escalation, and communication strategies, including scenario-based training on de-escalation and the safe use of restraint in accordance with the principle of least restrictive practice.

3.8 Continuous improvement

3.8.1	Systems are in place to support continuous quality improvement, including regular evaluation of service delivery and data, and the development of improvement initiatives that integrate lived experience perspectives.
3.8.2	Systems are in place for mandatory reporting and review of all patient related incidents, including those affecting safety, dignity, or rights, with criteria for when independent review is required.
3.8.3	Regular audit, training, and reflection is in place to ensure procedures remain effective.

3.9 Facility maintenance

3.9.1	Processes in place for maintaining the built environment to a high standard, with planning that supports timely upgrades and repairs.
3.9.2	A documented routine maintenance program, including ligature testing, is in place covering indoor and outdoor areas.
3.9.3	A responsive system exists for replacing damaged fixtures and fittings, including a stocked supply of critical items (e.g. doors, tap hardware, anti-ligature fittings, furniture) and a procurement process that prevents delays and bed closures.

Section Two – Design and Build

Context

Design and build go beyond construction - they are a tangible representation of the Model of Care. Facility layout, materials, and spatial planning must align with patient outcomes and support recovery, safety, and dignity. Design decisions should be grounded in evidence and therapeutic intent, incorporating evidence-based design principles, contemporary practice and a collaborative process that engages clinicians, staff, and people with lived experience.

To obtain authorisation, mental health units must demonstrate that the facility has been designed and constructed in accordance with the following criteria. These will be reviewed by the Chief Psychiatrist as part of the authorisation assessment. While authorisation occurs at the final stage of commissioning, it is strongly recommended that services engage in early consultation with the Office of the Chief Psychiatrist - ideally commencing at the business case, functional brief or concept design stage, whichever occurs first, and continuing throughout the entire design and development process.

4. Planning and design

4.1 Alignment with the Model of Care

4.1.1	Building plans reflect the Model of Care, support therapeutic recovery principles and accommodate the unique needs of the population and supporting service delivery model.

4.2 Compliance with legal frameworks

4.2.1	Evidence of compliance with relevant legislation.
4.2.2	Design reviewed against the Australasian Health Facility Guidelines.
4.2.3	Design strategies demonstrate alignment with the Chief Psychiatrist's Standards.

4.3 Consultation

4.3.1	Demonstrated consultation with key stakeholders and subject matter experts including cultural experts and lived experience to inform unit design.
4.3.2	Demonstrated application of lessons learned from recent mental health infrastructure projects and any relevant coronial inquest findings.
4.3.3	Support services incorporated into planning and design to ensure safe, efficient delivery of care and essential functions such as cleaning, patient food services/catering, linen, facility maintenance, and other operational supports.
4.3.4	Research and consultation undertaken to ensure that advancements in technology are applied and that high-quality anti-ligature fittings and fixtures appropriate to mental health settings are used.
4.3.5	Consultation with the OCP in the development of key design documents (functional brief) with designs sent to the Deputy/Chief Psychiatrist for review against the Chief Psychiatrist's Standards and support.

5. Core design principles

Mental health unit design creates environments that promote physical and emotional safety, reduce triggers and re-traumatisation, and support autonomy, dignity, choice and therapeutic engagement.

5.1 Therapeutic environments

5.1.1	All patient areas designed to be non-custodial, therapeutic and supportive of everyday living.
5.1.2	Use of natural light, calming materials and colour design throughout.
5.1.3	The design demonstrates specific features that support individual autonomy and choice (e.g. controllable features such as vision panels or lighting, flexible spaces and furniture layouts).
5.1.4	Ventilation is considered as part of therapeutic design, providing patients and staff with access to fresh outdoor air and ensuring high-quality indoor air through effective mechanical ventilation.

5.1.5	Acoustic design minimises intrusive noise and manages auditory stimuli through appropriate sound-absorbing materials, zoning, and spatial planning to support calm, therapeutic environments.
5.1.6	Design supports holistic care planning, including integration of physical health care and treatment, cultural safety and therapeutic engagement.
5.1.7	Designs and furnishings support orientation, safety and therapeutic engagement for people with cognitive impairment.
5.1.8	Unit design supports least restrictive practice through the inclusion of accessible calming spaces, activity areas, outdoor spaces, and access to sensory modulation tools that enable self-management and emotional regulation.

5.2 Privacy, dignity, and personal safety

5.2.1	Design supports personal privacy and autonomy through the unit.
5.2.2	Private bedroom and ensuite access for all patients.
5.2.3	Lockable doors with the capability for staff to over-ride when clinically required.
5.2.4	Vision panels in doors which are occupant controlled with the capability for staff to over-ride when clinically required.
5.2.5	Ability for accommodation and shared spaces to be zoned in ways that support safety, privacy and dignity for all patients, including gender-specific spaces, gender-neutral options, arrangements based on vulnerability, safety considerations and patient mix.
5.2.6	Design must prevent external overlooking to protect the privacy, dignity, and confidentiality of mental health patients at all times. This may be achieved through architectural layout, screening, and landscaping.

5.3 Cultural safety

5.3.1	Aboriginal design elements are visibly and meaningfully incorporated (e.g. use of natural made elements that support connection with country and welcome to country, colour schemes, use of Aboriginal art and language throughout, wayfinding, layout and design of outdoor areas).

5.3.2	Spaces are designed to support cultural safety and inclusion for the communities serviced (e.g. dedicated spaces for cultural practices including traditional healing, yarning circles, and multi-faith spaces).
5.3.3	Demonstrated engagement with Aboriginal communities.
5.3.4	Demonstrated engagement with cultural groups (including culturally diverse, linguistically diverse and faith-based communities), as informed by patient demographics.

5.4 Inclusivity and accessibility

5.4.1	Planning and design apply universal design principles to guarantee accessibility, dignity and independence for patients and support persons with diverse disability needs e.g. mobility, sensory, cognitive and bariatric.
5.4.2	Facilities provide flexible arrival and connection pathways that assist family and support person access and visibly reflect diversity through inclusive use of symbols and artwork, wayfinding, pictorial or plain language elements, and multilingual signage.

5.5 Adaptability and flexibility of spaces

5.5.1	Units offer a variety of spaces that allow patients to choose when and with whom they socialise and interact.
5.5.2	Design enables spaces to serve multiple purposes and be easily adapted for different clinical activities, patient cohorts, sexual safety or operational requirements without major structural change.
5.5.3	Designs allow for the capacity to receive individuals referred from courts and correctional facilities (e.g. Hospital Order or under the MHA), in circumstances where higher physical security (such as that outlined in Standard 8 – Forensic Mental Health Inpatient Services) is not required. This may include proximity to the staff station, the ability to accommodate corrections or security staff when required, and appropriate door and window security, integrated in a way that maintains a therapeutic, non-custodial environment.

5.6 Physical safety design features

5.6.1	Ligature and safety risks (both indoor and outdoor) are assessed with consideration of the patient cohort, and mitigation strategies are applied through environmental design, operational protocols, and relational practices.
5.6.2	Design ensures clear lines of sight maintained in communal areas, corridors and entrance/ exit areas to avoid isolated or unsupervised areas (e.g. blind spots, alcoves).
5.6.3	Rooms for vulnerable cohorts are positioned to enable enhanced observation and timely support.
5.6.4	Multi-storey designs eliminate access to dangerous areas.
5.6.5	Ceiling height sufficient to avoid access to roof space.
5.6.6	Service access panels are tamper-proof and located away from high-risk areas.
5.6.7	Non-patient areas secured, including external roof space, plant rooms, and service zones.
5.6.8	Structures near perimeter fencing or rooflines assessed for climbing and absconding risks, with location-specific controls applied.
5.6.9	Spaces are integrated throughout the unit - indoors and outdoors - to support therapeutic responses to agitation and distress.
5.6.10	Units are constructed using high-grade anti-assault materials across all walls, ceilings and doors.
5.6.11	Rooms that present increased risk (e.g. kitchens, therapy rooms, equipment or storage areas) have the capacity to be secured or restricted when required, with access controlled according to clinical need and patient safety.
5.6.12	High-risk rooms where staff and patients will be together in the same space require dual egress.

5.7 Fixtures, furniture and equipment

5.7.1	All furniture and equipment, including outdoor areas, are appropriate to the cohort considering age, specific risks and needs. They should be practical,

	durable, and strength-tested to ensure safety, functionality, and resilience in a dynamic care environment. Design and selection also minimise potential misuse and address the specific risks and needs associated with the cohort, while promoting safe and therapeutic interactions.
5.7.2	Anti-ligature fixtures, furnishings, and fittings are installed in all high-risk areas, using design strategies such as collapsible or load-release components (breaking strain of no more than 15kg) to prevent self-harm.
5.7.3	All fixtures, furnishings and equipment are installed in a manner which eliminates the creation of any ligature points.
5.7.4	All fixtures, furnishings, and equipment are designed to be tamper-proof and robust to prevent dismantling, concealment, misuse, or weaponisation. Design strategies include tamper-proof fittings, shatterproof materials, reinforced components, and anti-assault furnishings (e.g. weighted or lightweight designs). Including: • Windows (including curtain tracks, blinds). • Doors include vision panels, soft-close mechanisms, and monitoring technologies appropriate to the patient cohort with no internal handles in high-risk rooms. Free of ventilation grills. • Ensuite components (e.g. plumbing, handrails, toilet roll holders). • Mirrors (shatterproof and break-resistant). • Fixtures and fittings (e.g. CCTV cameras, artwork, televisions). • Equipment (e.g. exercise items). • Consumables and everyday items (e.g. batteries, plastic bags). • Outdoor areas and landscaping (e.g. reticulation systems).
5.7.5	Heavy-duty cutters capable of severing ligatures are accessible in each ward and therapy area.
5.7.6	All furniture and equipment across the unit, including outdoor areas, should be practical and tested for durability and strength.

5.8 Innovation and sustainability

5.8.1	Use of sustainable materials and energy-efficient systems.
5.8.2	Innovative technologies used to enhance safety and care.

5.9 Monitoring, communication and emergency response systems

5.9.1	Duress, staff assist, and emergency alarm systems are installed throughout all patient and staff-facing areas and are easily accessible in high-risk zones.
5.9.2	Alarm systems include technology that identifies emergencies with accurate room-level location tracking, supported by indicator boards in staff stations and staff rooms.
5.9.3	Alarm systems are integrated across the authorised site and remain functional during patient escorts outside the mental health unit.
5.9.4	CCTV is installed in all high-risk areas, with monitors strategically placed throughout the facility to support effective observation noting these systems are intended to complement, not replace, active staff supervision.
5.9.5	Motion detection, call bells and location finding duress alarm systems are integrated to support sexual safety.

6. Functional zones and room requirements

6.1 Point of entry

6.1.1	The physical route used for admission supports consumer dignity, privacy, and comfort by minimising unnecessary exposure to public or highly populated areas during entry to the service.
6.1.2	Reception area is secure, welcoming and sets a therapeutic tone with design elements that promote calm, privacy, dignity, and cultural safety for all individuals upon arrival.
6.1.3	Clear signage is provided to support orientation and to assist patients, families, support persons and nominated persons to identify how to raise concerns or seek assistance.
6.1.4	The reception counter includes safe access for staff and dual egress points.

6.1.5	A private space is available for patient admissions to be performed.
6.1.6	A secure entry point (separate to the main reception area) is available for patients arriving via ambulance or police that ensures safety, privacy and dignity.

6.2 Staff areas

6.2.1	Staff station design supports therapeutic engagement while maintaining safety, enabling visibility and interaction tailored to the needs of the patient cohort without creating barriers to connection.
6.2.2	Staff-only areas are secure and separate from patient zones, including offices, workstations, meeting rooms, and tea rooms. Staff can move between these areas via staff only accessible routes.
6.2.3	Spaces to support staff access to learning and innovation tools such as online learning and simulations.

6.3 Patient bedrooms and ensuites

6.3.1	Ensuite design prioritises patient privacy and safety through integrated anti-ligature features. This includes high-privacy doors (e.g. cambering, bi-swing, magnetic, soft-close), concealed toilet cisterns, recessed fixtures, secure drains, high-powered exhaust systems and anti-ligature fittings - all designed to eliminate ligature risks and prevent access to plumbing infrastructure.
6.3.2	Tear-proof mattress or suitable alternative provided.
6.3.3	Bedrooms are welcoming, with seating, workspace, storage, and appropriate technology access, designed for the intended cohort.
6.3.4	Bedroom doors incorporate monitoring technologies appropriate for the patient cohort and the mental health setting such as door-top sensors.
6.3.5	Where patient bedrooms are not within direct staff line of sight, technologies (e.g. movement sensors, CCTV) are installed to support monitoring of corridors and bedroom access. CCTV is not to be used inside bedrooms.
6.3.6	Wherever safe and feasible, design supports patients to exercise choice over environmental conditions such as lighting, heating and cooling.

6.3.7	Suitable and safe storage options for patient property are provided.

6.4 Sensory and comfort spaces

These are therapeutic spaces within the inpatient area that consumers can access independently to regulate distress or agitation through sensory modulation. These spaces support self-soothing and do not typically require continuous staff supervision. A specific room is not required.

6.4.1	Sensory spaces support strategies to accommodate individual sensory thresholds and modulation needs.
6.4.2	Adjustable lighting, sound systems and temperature controls are available to allow personalised sensory input.
6.4.3	Access to sensory items (e.g. weighted blankets, tactile objects).
6.4.4	Spaces designed for emotional regulation.

6.5 De-escalation areas

These are supervised, low stimulus spaces, separate from the main inpatient area and designed to support individuals experiencing escalating distress, strong emotions or potentially aggressive behaviour. These areas allow space for staff and patient to be together safely and support least restrictive practice. They are not designed to be accessed independently by patients. A de-escalation area is not suitable to be used for seclusion.

De-escalation areas are a requirement for authorisation, with the exception of Mother and Baby units or services where the cohort is unlikely to experience acute behavioural disturbance.

6.5.1	The de-escalation area is located away from patient areas to provide a private, low stimulus environment away from others.
6.5.2	The de-escalation area includes outdoor space.
6.5.3	The de-escalation area includes space for pacing.
6.5.4	The de-escalation area has safe egress for staff.

6.6 Seclusion room

A seclusion room is not a mandatory requirement for service authorisation, provided that the service has operational procedures in place to ensure the safety and wellbeing of patients, staff, and visitors. However, if seclusion is to be used, it must be in a room designed for this purpose.

6.6.1	The seclusion room is located away from patient areas to provide patient privacy and avoid any impact on the wellbeing of other patients e.g. traumatise/re-traumatise.
6.6.2	The seclusion room is nearby and has easy access to de-escalation spaces, to assist with transition and provide less restrictive options wherever possible.
6.6.3	There is sufficient space for staff access.
6.6.4	There is a staff observation area which supports unobstructed observation of the patient (Note: direct observation must occur every 15 minutes in addition to CCTV monitoring).
6.6.5	The seclusion room has integrated CCTV monitoring from the observation area.
6.6.6	The ability for patients and staff to communicate must be maintained. Where communication through the door is not adequate, a two-way intercom system must be installed within the seclusion room.
6.6.7	There are outward-opening doors with tamper-proof hinges.
6.6.8	There are no internal door handles.
6.6.9	Line of sight is required, with no blind spots. Dome mirrors used if needed.
6.6.10	Viewing panel(s) contain double-glazed safety glass.
6.6.11	Direct access to an ensuite toilet featuring anti-ligature fittings and fully recessed fixtures throughout.
6.6.12	A clock is located within the area outside the seclusion room and is visible from within the seclusion room (i.e. through the observation window or door vision panel).
6.6.13	Adjustable lighting and temperature externally controlled allowing those observing the patient to clearly monitor conditions.

6.6.14	Patients in the seclusion room have the ability to listen to music. Music input is controlled from a device/control panel in the staff observation area. Speakers are flush-mounted.
6.6.15	Tamper-proof mattress or suitable alternative.

6.7 Kitchen, dining and laundry

6.7.1	Dining area accommodates all patients comfortably.
6.7.2	Secure food storage and temperature control are maintained.
6.7.3	Laundry access is appropriate to bed numbers and patient needs.
6.7.4	Patients have easy, independent access to drinking water without needing to request staff assistance.
6.7.5	Access to an Activities of Daily Living kitchen is provided on site, where appropriate to the Model of Care.
6.7.6	Kitchen/servery design eliminates meals hatch and supports safe staff-patient interaction.
6.7.7	Dining area design considers patient movement, personal space, and supports vulnerable patients.
6.7.8	Risks are assessed and appropriate physical, relational and operational measures are implemented (e.g. safe and secure storage solutions, lockable cupboards for chemicals and cutlery/knives, safety switches, and regular stocktakes).

6.8 Patient lounge

6.8.1	Patient lounge and shared spaces are welcoming, comfortable, and home-like.
6.8.2	Patient lounge is clearly observable by staff.

6.9 Activity spaces

6.9.1	Space is available to support therapeutic engagement, social programs, art programs, inreach services, and other holistic health care needs aligned with the Model of Care.
6.9.2	Activity areas are clearly observable by staff.
6.9.3	Designs support multipurpose use through flexible spatial planning.
6.9.4	Storage solutions are safe, secure, and appropriately located.

6.10 Treatment room

6.10.1	Physical health assessment and care is enabled by access to private consult space, appropriate medical equipment and space for other support services.
6.10.2	Design promotes privacy and meets infection control standards.
6.10.3	Dual egress available.
6.10.4	Design considers access to refrigeration and secure storage for medications.

6.11 Interview and Mental Health Tribunal spaces

Note: An interview room may be suitable for use by the Mental Health Tribunal, so long as access is ensured for Tribunal use.

6.11.1	Dual egress available, with at least one outward-opening door.
6.11.2	Duress alarms installed.
6.11.3	Soundproofing for confidentiality.
6.11.4	Telehealth capability included.
6.11.5	Multi-use design for flexibility is recommended.
6.11.6	Safe, non-weaponisable furniture.
6.11.7	Appropriate furnishings and art that softens the clinical feel of tribunal spaces, creating a calmer and more supportive atmosphere.

6.12 Outdoor and green space

6.12.1	Area is large enough to accommodate all patients and designed for therapeutic requirements appropriate for the patient cohort whilst maintaining safety.
6.12.2	Secure perimeter fences and/or walls in outdoor areas are a minimum of 4.5 metres in height, measured from any potential foothold to prevent scaling and ensure safety (noting that Forensic mental health facilities have distinct physical security requirements which are outlined in Standard 8 – Forensic Mental Health Inpatient Services).
6.12.3	Privacy from public view and consideration of surroundings and risk context. (Note: where outdoor screening is used, aperture size is between 1.5mm and 6.0mm).
6.12.4	Cohort-specific design (e.g. youth, older adults) including consideration of built in equipment (e.g. safe exercise equipment).
6.12.5	Cultural elements included (e.g. yarning circle, bush tucker gardens).
6.12.6	UV protection and shaded areas provided.
6.12.7	Non-slip, non-toxic surface materials used.
6.12.8	Indoor and outdoor exercise areas available on all wards, tailored to patient cohorts (e.g. youth, older adults).
6.12.9	Outdoor fixtures and environmental features are tamper-resistant, prevent concealment of prohibited items, and are assessed to eliminate features that could be weaponised or cause harm (e.g. rocks, mulch, sharp objects, easily removed reticulation).
6.12.10	BBQs are electric operated with secure housing; gas BBQs are prohibited.
6.12.11	Outdoor areas are designed for minimal supervision with high levels of automatic observation from within the unit.
6.12.12	Plants are incorporated into outdoor design where appropriate to enable access to nature and promote wellbeing. Plant species are chosen to balance patient amenity with risk reduction (ligature, weaponisation and self-harm risks).

6.13 Visitor areas

6.13.1	Design encourages and supports visitors by providing welcoming, flexible amenities—including private areas, toilets, and safe spaces for children—with options for family and support person/s interaction both indoors and outdoors, ensuring they can be involved in care and connection when appropriate and supported in a variety of settings.

6.14 Plant equipment and maintenance

6.14.1	Plant equipment securely housed.
6.14.2	Plant rooms designed to prevent unauthorised access, especially in areas accessible by patients.
6.14.3	Physical layout is designed to support contractor safety protocols, ensuring that maintenance activities within the facility do not compromise the safety of staff, visitors or patients.

Section Three – Specialised Units

Context

Service planning for specialist units, whether operational, clinical, or in the design and build phase - must place the patient cohort at the centre. Planning must account for the additional challenges these cohorts frequently face, including complex legal requirements, social circumstances, systemic discrimination and the expanded role of support persons and advocates. Thoughtful integration of these factors ensure that services are not only clinically appropriate but also responsive to the broader vulnerabilities of the cohort.

Specialised Units are required to meet the criteria in Sections One and Two of these Standards, in addition to the relevant detailed standards outlined below:

- 7. Child, Adolescent and Youth Mental Health Inpatient Services
- 8. Mother and Baby Mental Health Inpatient Services
- 9. Forensic Mental Health Inpatient Services
- 10. Older Adult Mental Health Inpatient Services

7. Child, Adolescent and Youth Mental Health Inpatient Services

Context

A Child and Adolescent Mental Health Unit is a specialist inpatient facility that provides assessment, treatment and care for children and adolescents, generally operationalised in Western Australia as those up to 16 years of age unless otherwise specified. Currently in Western Australia, Youth Mental Health Units provide inpatient services for young people aged 16 -24 years. For the purposes of this Standard, the collective term 'young people' refers to children, adolescents, and youth up to 24 years of age. Transitions between child/adolescent and youth/adult services must be planned early, with clear handovers and shared care to minimise service gaps.

7.1 Care and engagement

7.1.1	Families, carers, and support persons are supported and actively engaged through emotional support, education and counselling. Flexible visiting arrangements and opportunities for onsite participation where therapeutically beneficial and in the best interest of the young person.
7.1.2	Protocols around patient use of personal devices (e.g. mobile phones, laptops) balancing therapeutic benefits with safety, privacy, and developmental appropriateness. This includes managing access to social media and addressing risks such as cyberbullying, peer conflict, and non-therapeutic use.
7.1.3	Young people have accessible means of contacting parents, family, friends or loved ones via the ward phone at all times, in line with a pre-agreed contact list.
7.1.4	Services implement a patient onboarding process for first admissions that allocates a key contact for families and support persons, provides information to young people and families prior to admission wherever practicable, and ensures each young person is introduced to their named nurse with clear guidance on how to access information.
7.1.5	Autonomy must be upheld wherever possible, with opportunities for choice, self-expression, and meaningful participation in shaping their therapeutic and recreational experiences.
7.1.6	Services recognise and respond to the diverse identities and developmental stages of young people - including gender, sexuality, disability,

	neurodivergence, and culture - through inclusive practices, culturally safe care, tailored interventions, and staff training informed by lived experience.
7.1.7	Care planning incorporates education, vocational goals, and community engagement in ways that are developmentally appropriate, to support continuity, prevent social and or cultural isolation, and promote long-term wellbeing.
7.1.8	Risk protocols address cohort specific vulnerabilities (e.g. self-harm, suicidal ideation, eating disorders, behavioural dysregulation in young people), as well as risks related to gender, sexual and personal safety, with staff trained to recognise and respond in developmentally appropriate, trauma-informed ways.
7.1.9	Services address guardianship complexities and mature minor decision making, upholding legal and ethical responsibilities for young people through clear policy, procedures and comprehensive staff training.
7.1.10	Staffing profiles include experienced child and adolescent/youth mental health clinicians and allied professionals supported by educational, vocational, creative practitioners to deliver holistic care.
7.1.11	Access to therapeutic approaches that promote creative expression, sensory regulation, and physical wellbeing, such as art therapy, music therapy, and exercise physiology, are available to support engagement, emotional regulation and healthy activity patterns for young people.
7.1.12	Staffing and supervision practices adhere to child-safe principles, ensuring appropriate visibility, minimising unsupervised one-to-one interactions, upholding professional boundaries, and embedding procedures that prevent, identify and respond to risks of grooming or sexual harm.
7.1.13	Services demonstrate clear, developmentally appropriate pathways for young people, families and staff to report concerns or disclosures, with timely escalation in line with safeguarding policies and relevant regulators.
7.1.14	In accordance with s 303 of the MHA, protective measures must be implemented to safeguard those under 18 years of age when admitted to facilities that also accommodate adults. This includes: • Treatment, care and support appropriate to their age, maturity, gender, culture and spiritual beliefs. • Procedures that clearly define responsibilities for assessing sexual safety needs and for engaging young people in discussions about their

	personal and sexual safety within the ward environment in a way that is trauma-informed.
7.1.15	Processes which ensure that the Chief Psychiatrist's "Segregation of children from adult inpatients notification form" is completed in accordance with s 303(3) and sent to the Chief Psychiatrist as well as the child's parent or guardian.
7.1.16	The Model of Care specifies circumstances where an adult is not suitable for admission to a youth service in order to protect younger and more vulnerable patients.

7.2 Design and build

7.2.1	Units are designed to enable flexible, age-appropriate separation. In youth services, this includes the ability to segregate children under 18 from adults (18 and above) as per s 303 of the MHA.
7.2.2	Facilities cater to the social, educational, and recreational needs of different developmental stages, including equipment storage areas (e.g. arts and sports) ensuring the delivery of programs that are age appropriate and responsive.
7.2.3	Safety controls are tailored to the unique capabilities, vulnerabilities and behaviours of young people. Design must account for high energy levels, physical strength, and emotional dysregulation. This includes durable, resilient furniture is provided and secured as required, and equipment, structures, and landscaping are positioned to prevent climbing and perimeter access.
7.2.4	Dedicated quiet and active spaces for therapy, arts, relaxation, and education.
7.2.5	Dedicated schooling/education areas that offer writable surfaces (chalk boards/whiteboards) and digital access.
7.2.6	Child and Adolescent inpatient units must be physically and visually separate from adult mental health facilities. This includes distinct entrances, treatment areas, and recreational spaces, as well as design features that prevent visibility from adult wards, neighbouring services, or public areas. (s 303 MHA).

7.3 Partnerships

7.3.1	Partnerships are established with the following organisations: • Support services for families. • Partnerships with schools and education system. • Community mental health services. • Drug and alcohol services. • Other relevant non-governmental organisations (NGO) including specialists in neurodivergence and cognitive and behavioural support. • Department of Communities - Child Protection. • Department of Justice. • Mental health transport services. • Vocation support services.

8: Forensic Mental Health Inpatient Services

Context

A forensic mental health unit provides specialist treatment and care for individuals who intersect with the criminal justice system. This includes people found unfit to stand trial, not guilty by reason of mental impairment, or transferred from custodial settings due to acute mental illness. In Western Australia, pathways include Hospital and Custody Orders under CLMIA, as well as referrals under the MHA.

8.1 Care and engagement

8.1.1	Services have clear governance and operational pathways across justice, health, and other core agencies, with defined roles, escalation protocols, and collaborative arrangements. Partnerships with relevant criminal justice agencies are supported by written agreements and/or procedures that enable coordinated legal access, prisoner movement, and timely, integrated service delivery in accordance with legislation.
8.1.2	The Model of Care aligns with the National Statement of Principles of Forensic Mental Health Care including equivalency of care, safe and secure treatment, integration with justice systems and individualised and ethical care.
8.1.3	The Model of Care defines pathways for clinical and legal progression as well as the corresponding security needs.
8.1.4	The service outlines how physical, procedural, and relational security will be embedded throughout the unit to ensure the safety of patients, staff, visitors and the community, including custodial safety requirements.
8.1.5	Care is responsive to the individual's current challenges including stressors related to criminal justice involvement or emotional vulnerability at critical points in the legal journey such as sentencing or tribunal hearings.
8.1.6	Services recognise and support the role of support person/s and are aware of and responsive to the emotional toll of forensic care, with appropriate supports available.
8.1.7	Staffing configuration considers both clinical and security personnel in alignment with the Model of Care. Staff-to-patient ratios must be tailored considering patient acuity, legal status, dynamic risk factors, and the supervision requirements of each zone or care area. Where the Model of Care includes off-site activities or appointments, staffing plans must also account

	for appropriate patient escort arrangements to ensure safety, therapeutic continuity, and legal compliance.
8.1.8	Service planning, including staffing profiles and partnerships, is responsive to the over-representation of Aboriginal people and those from ethnoculturally diverse populations in the justice system.
8.1.9	Service planning including design, is responsive to the over-representation of gender diverse population in the justice system.
8.1.10	Service planning is responsive to those with additional vulnerabilities and risks within the forensic population, including youth, individuals in protective custody, people affiliated with organised groups or networks, individuals with intellectual disability or neurodivergence, and those with complex health needs.
8.1.11	A clearly defined security model is developed to guide the design, build and operational planning. This should include security classifications established in partnership with the Department of Justice/Corrective Services and outline the corresponding physical, procedural, and relational measures.
8.1.12	Security staff are trained to build therapeutic relationships, engage appropriately, foster trust through positive interaction, use de-escalation techniques, and work collaboratively within the multidisciplinary team to support least restrictive practice.
8.1.13	Staff are equipped to navigate the intersection of clinical care and legal process, with an understanding of relevant legislation, including reporting (e.g. Court or Mentally Impaired Review Tribunal), risk assessment, and liaison with custodial, court and community teams.
8.1.14	Staff are well-trained in managing challenging behaviours and applying de-escalation techniques which support least restrictive practice, with appropriate support to work safely and effectively within a forensic mental health environment. This support includes access to staff supports, supervision, ongoing professional development and clear safety protocols including use of duress alarms and emergency response.

8.2 Design and build

8.2.1	The design is informed by the security model and ensure the safety of patients, staff, visitors, and the broader community. Security ratings for

	each zone or area are assessed against the highest risk patient profile expected in that space, addressing both clinical risk (e.g. acuity, behavioural volatility) and legal risk (e.g. custodial status, security classification, offence severity). The following must be considered and inform the design: • External and internal perimeter fencing. • Secure entry and exit points. • CCTV monitoring. • Material robustness (in accordance with security ratings for zones). • Controlled movement zones including door and window security. • Security equipment including security management system, duress alarms, staff communication system and detection systems. • How design will deter escape. • Furniture design. • Procedural safety measures that inform and support design (e.g. emergency response, defined clinical/security roles, patient transport and monitoring, contraband control, equipment audits, etc). • How design can support the application of relational security (must be informed by lived experience.
8.2.2	Design and planning ensure access to holistic care and account for the limited ability of patients who are prisoners to leave the facility. This includes consideration of: • Physical health care needs. • Religious, spiritual, and cultural support. • Recreational and social engagement. • Smart integration of multipurpose spaces for flexible, efficient service delivery. • Flexible, multipurpose spaces and resource planning aligned with the Model of Care.
8.2.3	Design and planning support the full range of legal and procedural requirements for patients. This includes: • Teleconferencing for court appearances, tribunal hearings, and inter-agency case conferences. • Private interview rooms for legal consultations. • Meeting rooms for case conferences with patient involvement. • Family and support person/s visits (including child-friendly design where appropriate). • Meetings with mental health advisors, support services and community reintegration services.

	• Consideration of access to de-escalation space (ideally outdoors) to support emotional regulation and recovery, particularly following distressing legal outcomes. • Consideration of how décor, art, materials and furnishing can be used to create a calm, welcoming and culturally safe environment that reduces stress and supports patient wellbeing during legal and procedural processes.
8.2.4	Equipment, structures and landscaping are set back from the perimeter fence and roofs to reduce the likelihood of climbing and access.

8.3 Partnerships

8.3.1	Partnerships are established with the following organisations: • Department of Justice. • Custodial mental health and alcohol and drugs teams. • Courts and legal representatives. • Community forensic mental health services. • General mental health services. • Disability Justice Service. • Court Liaison and mental health courts. • CLMIA teams. • Aboriginal communities, Elders, traditional healers and support systems across the State. • Other cultural communities and consulate support. • WA Police Force. • Mental Impairment Review Tribunal. • Mental health transport providers. • Vocational support services.

9. Mother and Baby Mental Health Inpatient Services

Context

Mother and baby mental health units provide specialist inpatient care that deliver comprehensive assessment, treatment and support for mothers, babies and their families during the perinatal period. These units enable mothers to receive treatment in a therapeutic environment without separation from their baby, recognising the mother-infant relationship as a core component of care, preserving the maternal-infant bond and involving families and support persons.

9.1 Care and engagement

9.1.1	Services embed a dual focus on maternal mental health and infant wellbeing, including developmental needs and early emotional health. Care prioritises the connection between mother and baby, supporting co-location wherever possible. Individualised care plans must address both mother and baby's needs, recognising their interdependence.
9.1.2	Other primary caregivers are offered emotional support, education and counselling to strengthen their role in the mother–infant relationship, alongside flexible visiting arrangements and opportunities for onsite participation - including overnight stays when therapeutically beneficial.
9.1.3	Therapeutic programs are provided to support mothers in caring for their baby and building confidence in practical tasks such as feeding, hygiene care, sleep routines, and responsive interaction. These programs must be underpinned by the most recent evidence and standards of maternal and newborn care.
9.1.4	Care models provide flexible support for maternal–infant care, including appropriate overnight arrangements and staff assistance when independent care is not possible or when sleep preservation is required.
9.1.5	Care models affirm the importance of culture and family in parenting and adapt approaches to ensure services are welcoming and inclusive for mothers and babies from diverse cultural backgrounds.
9.1.6	Care recognises how past experiences shape a mother's current presentation and parenting capacity, and respond to psychological needs such as perinatal trauma, loss, and other stressors that may affect bonding and infant development.

9.1.7	Staffing supports the wellbeing of mother and baby, with core expertise across mental health, perinatal, and infant care. Ratios reflect the complexity of mother–infant dyads and the need for 24/7 support, including overnight, with partnerships established to fill any gaps.
9.1.8	Governance structures combine mental health and maternity oversight to ensure integrated, family centred care with clearly documented partnerships and pathways of care.
9.1.9	All staff, regardless of discipline, are trained to recognise early risk indicators for both mother and baby and to understand their interdependent care needs.
9.1.10	Staff training for mental health clinicians includes perinatal mental health challenges and the fundamentals of supporting mothers in caring for their babies, including guidance on infant feeding (breast, bottle, or mixed), sleep, and settling.
9.1.11	Services recognise and respond to the specific needs of young mothers, ensuring staff are trained in developmentally appropriate communication, decision making support, and practical parenting guidance tailored to this cohort.
9.1.12	Safeguarding practices ensure children and infants are protected from harm, with staffing models, supervision practices, and physical environments that minimise unsupervised one-to-one interactions, maintain appropriate visibility, and uphold clear professional boundaries.
9.1.13	All staff understand and follow child-safe reporting pathways and escalation requirements.
9.1.14	There are clear policies and procedures on the following: • How maternal mental health risks and infant safety are balanced through recovery and trauma-informed approaches, focusing on relational safety, multidisciplinary and inter-agency collaboration, and coordinated care pathways - including collaborative transfer/discharge planning with maternity wards, child health, and other appropriate community supports. • The specific clinical and legal circumstances for mother–infant separation, with protocols to ensure it occurs only when necessary and is managed in a way that minimises trauma and supports reunification as quickly as possible.

	• How the service will ensure that care is culturally safe and inclusive of diverse family structures, recognising and respecting different cultural approaches to raising children. • Preventing, reporting, and responding to sexual harm or family and domestic violence, including immediate safety planning, referral pathways, and follow up that prioritises privacy, emotional safety, consent, and appropriate support for mothers and babies that prioritises privacy, emotional safety, consent, and appropriate support for mothers and babies. • De-escalation and behavioural support protocols must be implemented using least restrictive practices that consider the presence and safety of infants and prioritises preserving the mother–infant bond.

9.2 Design and build

9.2.1	Private rooms include safe space for cots/cribs, infant safe fittings and accommodation for the mother's partner, family or support person to stay overnight when appropriate, and aligned with therapeutic goals.
9.2.2	Units are designed to provide a warm, family-oriented environment that feels as close to home as possible, while prioritising the safety and wellbeing of both mother and baby.
9.2.3	Facilities are designed and equipped to support breastfeeding, play, and bonding activities for mother and babies. This includes access to breast pumps, sterilising equipment for infant feeding, and safe, comfortable spaces to bathe and change babies.
9.2.4	Unit design includes natural light, quiet zones, and outdoor spaces tailored to the perinatal cohort, supporting sensory regulation, emotional wellbeing, daily routines, and meaningful bonding between mother and baby.
9.2.5	Discreet security features that maintain a therapeutic environment.
9.2.6	Unit design enables flexible maternal-infant care, including safe arrangements and spaces, such as a nursery, that support mothers when independent care is not possible, or sleep preservation is needed.
9.2.7	Bedrooms are designed to support mother-baby bonding, with adjustable lighting, space for visits, comfortable areas for nursing or feeding, and suitable facilities to change, bathe, and care for babies.

9.2.8	Any nurseries have dual egress and are equipped with safe, infant-friendly fittings and designed to support mother-baby contact, with features like chairs positioned near cots, soft lighting, art, and space for staff-supported care.
9.2.9	Units include dedicated indoor and outdoor visitor spaces for families, including young children, with furnishings that support comfort, play, and meaningful connection.
9.2.10	24/7 access to kitchen or kitchenette facilities, providing water, snacks, and safe storage for breast milk to support family needs.

9.3 Partnerships

9.3.1	Partnerships are established with the following organisations: • Maternal and newborn specialists including physiotherapists, dietitians, pharmacists, speech pathologists, lactation consultants (if not part of core staff). • Maternity units/perinatal services. • Midwives. • Reproductive health services. • Family and partner support services. • Physical health. • Children and family services liaison officers. • Domestic violence specialists. • Alcohol and other drug services (including FASD expertise). • Culturally specific services. • Community mental health services. • Community Child Health Nurses. • Patient transport providers.

10. Older Adult Mental Health Inpatient Services

Context

Older adult mental health units provide assessment and treatment for individuals aged 65 and over (or 50+ for Aboriginal people or where medically relevant) where a specialist older adult service is most appropriate for their needs. In addition to caring for mental health needs, these units must respond to the complexities of cognitive decline medical comorbidities and physical vulnerability.

10.1 Care and engagement

10.1.1	The multidisciplinary team includes aged care specialists, with strong links to mental health and aged care community and external providers.
10.1.2	Care promotes autonomy and dignity with patients supported to participate in care planning, decision making, and daily routines to the fullest extent possible.
10.1.3	Where guardianship arrangements or advance care planning are in place, services must ensure patient values, preferences, and rights are upheld.
10.1.4	Relational security and de-escalation are central to the Model of Care with staff building consistent, respectful relationships that promote dignity and foster trust and emotional safety supported by awareness of the challenges and triggers common in older adult mental health.
10.1.5	Risk management strategies consider both mental health and physical risks (such as ligature and falls) in the context of the older adult population. Solutions must promote autonomy, including safe mobility, while mitigating ligature risks through physical, relational, and operational safety measures.
10.1.6	Staff training and development are tailored to an older adult cohort and supported by policies and procedures and include: • Supporting the cognitive needs of older adults, including recognising dementia and delirium, using effective communication strategies, applying non-pharmacological and sensory-based interventions. • The identification of behavioural and psychological symptoms of dementia (BPSD), including potential triggers and trauma-informed responses to agitation, aggression, and other non-cognitive symptoms, ensuring the use of least restrictive practices. • Holistic care planning which integrates physical and mental health needs and risks, including coordinated support for mobility, sensory

	function, falls prevention, mobility, nutrition, continence, and other age-related health considerations. • Recognising the support needs of older adults, working with guardians and substitute decision makers and recognising elder abuse.
10.1.7	Any security is discreet, and security staff are trained in de-escalation techniques and working with a vulnerable often physically frail older adult patient cohort.

10.2 Design and build

10.2.1	Dementia-friendly design supports clear spatial orientation, reduced overstimulation, and safe mobility through intuitive layout, clear wayfinding and environmental cues and reflects dementia enabling environment principles.
10.2.2	Mobility support is embedded through ergonomic furnishings, fixtures and assistive equipment (e.g. handrails, walking frames, wheelchairs, lifters), accessible bathrooms (with the ability to facilitate equipment such as hoists), handrails on both sides of corridors and use of colour contrasted for visibility.
10.2.3	Fixtures, fittings, and equipment balance risk reduction (e.g. anti-ligature) with the needs of older adults, supporting independence and safe mobility utilising up to date equipment/anti-ligature designs wherever possible and supported by operational and relational security.
10.2.4	Furniture provides functional support for age-related physical limitations, including appropriate seat height, armrests, falls risks and fabrics suited to continence needs.
10.2.5	Design promotes autonomy by enabling independent movement and personal choice, with features such as resting points along corridors, visual interest, art and conveniently located toilets.
10.2.6	Interior design and choice of art enhances spatial orientation and ease of navigation through subtle colour contrasts, floor-wall variation, and visual cues that highlight key areas while reducing environmental stressors.
10.2.7	Bedrooms support orientation through natural light, external views, personalisation options, and visual aids (e.g. day/date clocks, noticeboards). Note that a non-anti-ligature bed is appropriate for this

	patient cohort when there are appropriate operational procedures in place that include high level patient observations during the day and night.
10.2.8	Tailored bedrooms are available to accommodate specific patient needs, as anticipated in Model of Care (e.g. bariatric, oxygen therapy, wheelchair access), with sufficient space for additional physical health equipment.
10.2.9	Dining rooms provide defined spaces for individual or small group meals, with nearby accessible toilets that are discreetly located.

10.3 Partnerships

10.3.1	Partnerships are established with the following organisations: • Primary health care providers, (GPs, geriatricians, allied health, podiatrist, dentist, dieticians, etc.). • Aged care services (residential, community and transitional care). • Community mental health services. • National Disability Insurance Scheme services (NDIS) or other disability services. • Alzheimer's WA – Dementia Care Experts (to inform design). • Physical health and Chronic Disease Management. • Hospitals (Emergency, Acute and Subacute). • Acute and Diagnostic Health Services (imaging, pathology). • Palliative and End of Life Care service. • Mental health transport providers.

Terminology used in the Standard

Aboriginal

For the purpose of this Standard, the term "Aboriginal" is used in preference to "Aboriginal and Torres Strait Islander", in recognition that Aboriginal people are the First Peoples of Western Australia. This terminology is intended to be respectful and inclusive, and no disrespect is intended to Torres Strait Islander colleagues and community.

Anti-ligature

In this Standard, the term anti-ligature means fixtures, fittings and design features that, when correctly selected via risk assessment and installed/maintained as specified, do not provide a sustainable point of attachment for cords, ropes, bedsheet or other fabric/material to be looped or tied that may result in self-harm or loss of life. Products must be specifically manufactured as anti-ligature and have been tested (or have a proven track record) for mental health use, installed per manufacturer instructions, with an emphasis on documented risk assessment.

Carer/Support person/s

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

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

We have used the overarching term 'support person' to refer to a family member, carer, or personal support person for a mental health patient.

Children

The MHA 2014 refers to anyone under the age of 18 as a child, so the term 'child' or 'children' has been used in preference to terms such as young person, when referring to anyone under 18.

Co-Production

Co-production refers to an approach in which people with lived experience work in equitable partnership with services to shape, develop, and contribute to mental health programs, policies, and service delivery.

This document references the requirement to work towards the principles of co-production, this includes:

- genuine partnership built on trust and mutual respect.
- valuing lived experience knowledge as critical to effective decision-making.
- collaborative involvement across key stages of development and implementation.
- processes that are intentionally designed to redistribute power and foster meaningful participation.

Inpatient mental health service

A mental health service which provides acute inpatient mental health treatment – either voluntary or involuntary.

Mental health service

An inpatient or community-based service providing mental health treatment or care to people who have or may have a mental illness.

Mother

In this document, *"mother"* refers to the birthing parent admitted for perinatal mental health care, acknowledging that some birthing parents may not identify as women.

Patient

We have used the term "patient" to refer to a person who has used or may use mental health services; a person receiving mental health treatment; and when quoting from the MHA, as this is the term used in the Act.

Relational safety

Refers to a secure environment created through the knowledge, understanding, and trust developed between patients, families, and staff.

Restraint

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

S.227. Bodily restraint: meaning

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

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

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

Seclusion

Division 5 of the MHA sets out the statutory responsibility and requirements of mental health services when using seclusion to manage patients with challenging behaviours.

S 212. Seclusion: meaning:

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

Trauma-informed care/practice

- Trauma-informed practice is an evolving concept which emphasises that trauma is a possibility in the lives of all individuals and communities.
- Trauma may be defined as the broad psychological and neurobiological effects of an event, or series of events, that produces experiences of overwhelming fear, stress, helplessness or horror.
- Many people who have experienced trauma, report adverse experiences and outcomes when engaging with psychiatric and/or mental healthcare services.
- Psychiatrists have a responsibility to practice in a trauma-informed manner, in order that individuals receive care that maximises their potential for recovery and minimises the risk of re-traumatisation.
- An individual's experience of a potentially traumatogenic stressor may vary according to a range of factors including genetics, developmental stage, previous life experiences, cultural beliefs and available social supports.
- Future approaches to trauma-informed practice must be developed using the complementary expertise of individuals, family, carers and community, psychiatrists and other mental healthcare professionals.

Ref: RANZCP Position Statement: Trauma-informed practice.

Schedule 1: Transitional provisions

These transitional provisions outline how the Chief Psychiatrist's Standard for the Authorisation of Hospitals under the *Mental Health Act 2014*, published June 2026 (New Standard), applies to existing authorised hospitals operating under previous versions of the Standard (Previous Standards) and to mental health capital infrastructure projects already underway. The provisions are intended to ensure continuity, fairness, and risk-based regulatory oversight during the transition from Previous Standards.

The transitional provisions address the following scenarios:

1. Existing (legacy) services
2. Mental health capital infrastructure projects underway, including:
    - 2.1 Funding already approved where extra funding is required
    - 2.2 Funding already approved where no extra funding is required
    - 2.3 Funding not yet approved.

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1. Existing (legacy) services
    - (a) Services authorised under Previous Standards that are not fully compliant with the requirements of the New Standard will not lose their authorisation.
    - (b) These services will be requested to provide documentation outlining a gap analysis against the New Standard to the Chief Psychiatrist, supported by plans and actions to mitigate identified risks and demonstrate progress towards compliance.
    - (c) The HSP will be requested to prioritise addressing high-risk gaps that directly impact safety, clinical care and therapeutic environment, followed by medium- and lower-risk items. The OCP will work with services to identify reasonable and workable solutions towards compliance. The OCP recognises services face building constraints and are expected by Government and the DoH to remain within agreed funding, scope and scheduling parameters.

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2. Mental Health Capital Infrastructure Projects underway

2.1 Funding already approved – extra funding required

(a) Authorisation of a facility, the funding for which was approved by the Department of Treasury prior to commencement of the New Standard, will be authorised in accordance with the requirements of the Previous Standard, if:

(i) changes to the facility are necessary to ensure compliance with any relevant changes or additional requirements in the New Standard; and

(ii) the changes will require extra funding.

(b) A recommendation for authorisation by the Chief Psychiatrist under the Previous Standard for a facility referred to in paragraph 2.1 (a) will be taken to be a recommendation under the New Standard.

2.2 Funding already approved – no extra funding required

(a) Authorisation of a facility, the funding for which was approved by the Department of Treasury prior to commencement of the New Standard, will be authorised in accordance with the requirements of the New Standard, if:

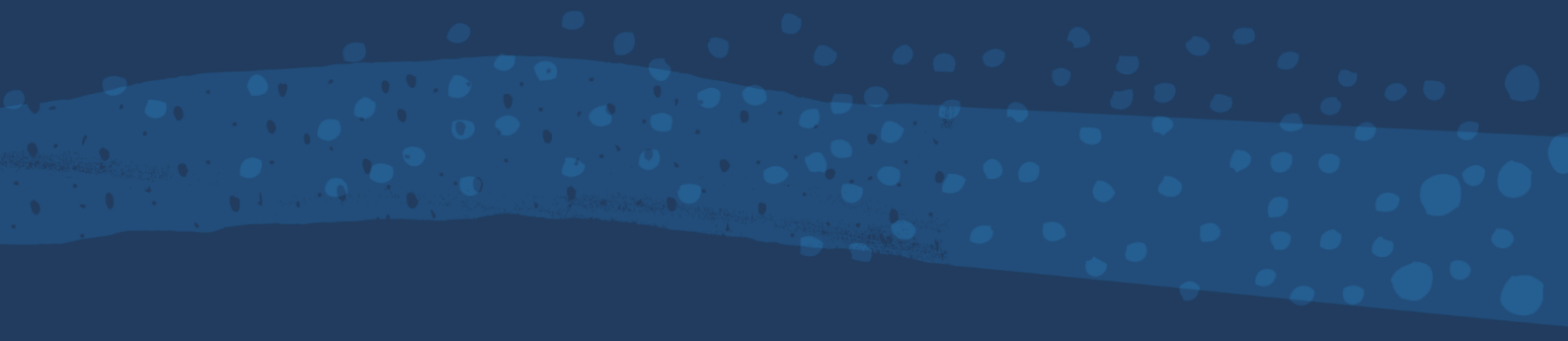
(i) changes to the facility are necessary to ensure compliance with any relevant changes or additional requirements in the New Standard; and

(ii) the changes will not require extra funding.

(b) The Chief Psychiatrist may recommend authorisation of a facility, even if it does not meet one or more requirements of the New Standard, if the Chief Psychiatrist determines that, in all the circumstances, it is appropriate to do so.

2.3 Funding not yet approved

(a) Authorisation of a facility, the funding for which was not approved by the Department of Treasury prior to commencement of the New Standard, will be authorised in accordance with the requirements of the New Standard.



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