JOINT STANDING COMMITTEE ON THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

INQUIRY INTO THE MONITORING AND ENFORCING OF CHILD SAFE STANDARDS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 8 MAY 2019

SESSION TWO

Members

Hon Dr Sally Talbot, MLC (Chair)
Mr K.M. O'Donnell, MLA (Deputy Chair)
Hon Donna Faragher, MLC
Mrs J.M.C. Stojkovski, MLA

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Hearing commenced at 10.41 am

Dr NATHAN GIBSON
Chief Psychiatrist of Western Australia, examined:

The CHAIR: On the behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the Joint Standing Committee on the Commissioner for Children and Young People's inquiry into the monitoring and enforcing of child safe standards. My name is Sally Talbot, and I am the chair of the committee. I will get my colleagues to introduce themselves.

Hon DONNA FARAGHER: I am Hon Donna Faragher, member for East Metro Region.

Mrs J.M.C. STOJKOVSKI: I am Jessica Stojkovski, member for Kingsley.

The CHAIR: We have an apology from our deputy chair, Kyran O'Donnell, who is not able to join us today.

It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside of today's proceedings. Before we begin, do you have any questions about your attendance here today?

Dr Gibson: No. I have prepared some notes, but I am very happy to have whatever process you think fit.

The CHAIR: That is excellent. Would you like to make any kind of opening statement?

Dr Gibson: I think the opening issue for me is that this is an incredibly important matter. The Mental Health Act 2014 highlighted the importance of better oversight of the needs and safety of children within mental health services, and I think we are still on a pathway to improving that at the moment. There are still many areas I think we can improve in with regard to the monitoring and tracking of that. I am happy to discuss those first today.

The CHAIR: That is good. As you know, one jumping-off point for this particular inquiry by the committee is the commissioner's 2017 oversight report, which he prepared in response to a recommendation of this committee's previous report, specifically into the Blaxell recommendations. There is a long history to this, as you would know. One of those areas that the commissioner looked at was the provision of mental health services, and you will be aware that his recommendations, which I think we might be able to get on the screen, certainly give the impression that oversight of services and resources for young people is not robust in this state. Have you been able to do anything specific, using your powers as Chief Psychiatrist, to address the recommendation that the commissioner has made there, which you now see on the screen—recommendation 2?

Dr Gibson: Certainly, I can provide some data around those figures as well. Going through that broadly, to take the first broad statement, I do agree that we could improve oversight, looking at the specifics there. On the issue of facilities and review of practices such as restraint and seclusion, I think we are actually doing quite well with that at the moment. Currently, WA has the lowest rates of seclusion in Australia, the lowest average duration of seclusion in Australia and the second lowest rate of restraint in Australia. That is overall. Child and adolescent seclusion and restraint rates are higher nationally, and our figures also reflect that as well, and I am happy to talk about those. We are higher in our seclusion figures than the national rate, so the Perth Children's Hospital seclusion figures—the most recent figures—are higher. The national rate for children for seclusion is 8.1 episodes per 1 000 bed days. That is how it is measured. PCH at the moment is 16.9, so it is

above the national rate. Over the last year, they have reduced the average duration down from 70 minutes to 61, so there has been some movement down, and the number of total episodes has actually reduced marginally as well, from 124 to 118. There is some movement there. With regard to restraint, we are doing better than the national average in under-18s. For under-18s, it is 23 episodes per 1 000 bed days, and at Perth Children's Hospital it is 14.3, so we are doing much better with regard to restraint. But we have had an increase in the number of individuals and the number of episodes of restraint in total. Having said that, the duration of restraint is also reducing. Over the last 12 months, the median duration has been reduced from five minutes down to three minutes.

These might seem like dry questions, and any issue of restraint or seclusion for any individual child, first, we understand is going to be traumatic; and, second, we also acknowledge that the vast majority of children that come into the units have had a history of trauma as well, so that is far from ideal. Just to give that framework, what we are doing at a statewide level is to develop an oversight process for seclusion and restraint, driven by services. We oversight seclusion and restraint—the Chief Psychiatrist does—but we want services to own that issue, and they do, but we need to keep that going, because these figures are actually fragile. They can easily go up again—very easily. We are actually looking at getting together groups of interest from each service and having these working parties driven by the health service providers, rather than by an oversight agency, because it actually needs to be owned.

The strategies to reduce seclusion and restraint are well known. It is not like there is actually some magical process that needs to be found. They are well documented, and there is good evidence around them. It is about resourcing for the units; it is about culture within the units; and it is about keeping the leadership of the units focused on that particular issue, not just the downstream issues of seclusion and restraint, but the upstream issues of reducing trauma for kids in mental health services, because that will naturally reduce seclusion and restraint. To answer that first point, I think we are doing quite well at the moment. It is not something we can take our foot off the pedal on, and we have got a further step, as I said, to try and get the health service providers together more frequently to talk about this and to work on this issue.

The CHAIR: The figures you have given us relate specifically to the children's hospital.

Dr Gibson: Yes, they do.

The CHAIR: Do you have figures for other health providers, or are children not restrained and secluded at other institutions?

Dr Gibson: There are two figures that are helpful that we do not have. One is the youth units, so Fiona Stanley youth unit, and the EMYU at Bentley—the mental health youth unit. Because they are both adults and children within those units, because it is 16 to 24, those figures are mixed up at the moment, so we do not have the specific figures for those units.

The CHAIR: The data is not collected?

Dr Gibson: It is not collected at the moment separately, and, again, going forward, that is something that we can actually do to try and split out that data.

The CHAIR: Would you need a legislative change to collect that data?

Dr Gibson: Not at all. We can actually do that, and I think that is something we have talked about doing, going forward, in the coming year, so that is important. So there is that issue.

Hon DONNA FARAGHER: Could I just jump in here just quickly? I just want some clarification. With respect to seclusion and restraint with respect to the hospital, I am presuming and understanding from what you have said that there is a requirement to report when that occurs.

Dr Gibson: Yes, a statutory requirement within mental health authorised hospitals.

Hon DONNA FARAGHER: Is it a statutory requirement but it is not being undertaken with respect to the other two facilities that you have referred to? I appreciate that you indicated, with respect to the age range, but why is that not being recorded?

Dr Gibson: I am sorry; I am probably not clear. It is recorded for the group, so we actually have —

Hon DONNA FARAGHER: I see, so you are not delineating between —

Dr Gibson: We are not delineating between children and under-18s.

Hon DONNA FARAGHER: That seems odd, I would have thought.

Dr Gibson: At a national level, the way they collect the data is slightly different. The Australian Institute of Health and Welfare publishes this data every year, and it is on their website. They usually only take the children's hospitals, and they do not look at the mixed data for under-18s, so the data we compare with is the national data. There are problems collecting the national data, but we can, at a local level, dissect out that data, and I think that is something we should do.

Hon DONNA FARAGHER: So you can do that?

Dr Gibson: Yes, we can.

Hon DONNA FARAGHER: Sorry; I was not quite sure what you were referring to there.

[10.50 am]

The CHAIR: You spoke about the fact that there are some recognised strategies that you can use to reduce isolation and seclusion. What are some of those?

Dr Gibson: If you do not mind, can I just add that second component that I thought was really important that you raised?

The CHAIR: Yes, please do.

Dr Gibson: I will come back to that issue of those components.

The other issue is outside of mental health units—in emergency departments, general hospitals. It is a big issue at the moment with eating disorders and kids needing to be restrained for nasogastric feeds. It is absolutely clear that, for example, when you have a 13-year-old, a 12-year-old, a 14-year-old with a severe eating disorder who is at risk of death, you actually need to do something to ensure that child survives. So, it is not a problem that there is restraint being done to ensure that kids survive in those situations. Those figures are not collected, so there is no statutory requirement to collect restraint and seclusion figures outside of mental health units. It is trickier to do because there is a whole range of scenarios regionally—emergency departments, general medical hospitals—so to actually do that would be a challenge. When services have rung me and said, "Do we have to report to you outside of mental health units?", my comment is always, "You don't have to report from a statutory perspective but good governance absolutely requires you to keep this information, use this information and work to actually reduce seclusion restraints in those and to ensure appropriate documentation." Whilst it is not statutory, good clinical governance would require people to keep those figures. But we do not have that at the moment.

The CHAIR: You are not talking about the non-government sector; you are talking about within government?

Dr Gibson: No, the non-government sector is obviously another issue of itself. I am not talking about that.

The CHAIR: Even within the government sector, there is no statutory requirement to collect that data?

Dr Gibson: Not for emergency departments, general hospitals or non-mental health supports.

The CHAIR: Do you think there should be?

Dr Gibson: Down the track, yes.

The CHAIR: I mean, clearly, it is a principle of good practice.

Dr Gibson: Yes, down the track. There are a number of tricky hurdles to reach. Last year, the Australasian College for Emergency Medicine had a national roundtable on mental health in the emergency department, where they actually talked about the importance of applying good clinical practice. It was not just about trying to get people out of emergency departments; it was about how they provide better practice within. One of the key points that came out of that national communiqué was to work towards reducing seclusion and restraint in emergency departments. So they are on board, but there are practical issues of how you get that recorded. So the answer is yes, but it will take time. I think we have to work towards that.

The CHAIR: Is that because it requires cultural change and/or because it requires more resources?

Dr Gibson: Both, I think. I think you cannot do one without the other.

The CHAIR: Do you have any input into the DPC group that is working on the data collection and management mechanisms in WA?

Dr Gibson: No, we do not at this stage. We do have good relations with a range of other agencies and they usually approach us, but we have not been approached about that particular issue yet.

The CHAIR: While we are on the subject of what you are involved in—either you or your office—I might ask Michele to put the organisational chart from DPC relating to the implementation of the royal commission recommendations up on the board. Are you involved in any of those working groups?

Dr Gibson: Not directly, no.

The CHAIR: Indirectly?

Dr Gibson: No, not at this stage. In many ways, that happens directly through the health service providers, I think, and the Department of Health, which is as it should be. It is really important that this is owned at that level rather than have yet another oversight body trying to push that issue. At this point, it is helpful for that to be embedded there.

The CHAIR: I am sure you are familiar with the commissioner's oversight report, but if I can just share with you something that he said and then ask for your views. He said —

> … the Chief Psychiatrist is invested with broad inspectorial powers that include the right to carry out unannounced visits and inspections of mental health service. However, while he is able to exercise these powers in the course of systematic reviews of clinical standards, the Chief Psychiatrist is not an inspectorial body responsible for undertaking regular inspections of facilities independent of his clinical monitoring role.

Is your view that your office would be enhanced—or should I rather say, outcomes for children and young people would be enhanced—if you were an inspectorial body?

Dr Gibson: Well, there are three things to add to that. At the moment, we still have very much both a regulatory function and a clinical engagement function to try to leverage standards at a clinical level, so we straddle both of those issues, so that is a challenge. The second thing to note is that in the OPCAT process, it is yet to be defined who will be the national preventive mechanisms within WA. We have put our hand up for that, so should we be involved in that, we would have to have more of an inspectorial role.

The CHAIR: So you have put your hand up to be the driver—the lead agency?

Dr Gibson: Yes, the preventive mechanism for mental health in WA. It makes most sense because we have, for lots of reasons. And we would of course work with any other agency that was involved in that if there were more than one agency. Certainly, that would require us to take on more of that role.

The third thing to say is that the way we monitor standards is quite broad. Section 519 allows me to have quite broad powers as to performing the functions of the office. It is not outside of reason for me to change or have a modified way that we do the review process. At the moment, the reviews are that we give the services notice. We have a panel of reviewers, including consumers and carers on that review panel, that go in, and we now also speak with staff, consumers and carers when we do those reviews. We have just finished a round of reviews and we are just looking at how we do the next round. We are very aware that groups like the Grattan Institute have suggested that we need to change the way we do our regulatory stuff—things like, rather than having all these pre-prepared reviews where people can just prepare and present their best face, more without-notice reviews have been recommended. I think, going forward, that is something that we have started to consider as we re-look at our review process in the next three to four years.

The CHAIR: So it is more like an inspection than an audit?

Dr Gibson: Yes. There has to be, I think, some audit component, because that is important and that data feedback is really important for services.

The CHAIR: You would not want to dispense with it.

Dr Gibson: No, but we have to get the balance right. I think it is reasonable for us to take on a more without-notice type of role with services, so I agree with the commissioner in that regard. The statute does not prevent me doing that.

The CHAIR: Yes. Thank you for that.

You mentioned three stakeholder groups, being consumers, carers and staff. Children and young people might be represented in the first two of those. Do you have a mechanism for making sure that the voices of children and young people are heard in your reviews and inspections?

[11.00 am]

Dr Gibson: In the previous review that we did—we started it three years ago and finished it a couple of years back—we did not include children, it was really only staff, and we found that to be significantly problematic, I think. We get the voice of children in a range of ways, but as I mentioned, going forward, I think having reviewers who are consumers, carers and staff members is helpful. During those review processes we had different fora to which we invited consumers, carers and staff to get their views, which is helpful; we hear their voice. Reviews are in some ways a specific type of way to get feedback. We do get the voices of kids in other ways—for example, through the mental health advocacy service. They will come to us directly with issues relating to concerns from the youth advocate around children, so whilst we may not actually speak directly to that child, we have that voice that is provided. I know that is a best-interest voice rather than a direct voice,

necessarily, but that is another way we do that. We also hold community forums. The reality is, of course, that children do not necessarily come to community forums, I think, so some of the mechanisms we have had in the past have not been particularly helpful. We do have informal visits to child and adolescent mental health services, where we advertise to meet with children and their parents. We get very little uptake on that, so the issue for me going forward is: how do we actually access that voice? Some of the strategies we have used to try to access that voice have had low levels of response, I think, at this stage.

The CHAIR: Do you work with the Commissioner for Children and Young People on these sorts of issues?

Dr Gibson: We do; we have met with him on different occasions to talk about this. We have not actually met with him post the review to talk about the follow-up process yet.

The CHAIR: I think the work of the commissioners over the years has shown us that many of the mechanisms we have assumed worked for everybody in the community have absolutely zero success when it comes to handling not just complaints but commentary from young people. As you say, the committee forum probably does not work; neither does the suggestion box in the corner—that sort of thing. Children and young people communicate in quite different ways.

Mrs J.M.C. STOJKOVSKI: To that end, have you investigated any ways to engage with young people using technology?

Dr Gibson: We have not to this point, but that is an issue. It is tricky for us in the sense that we are not necessarily a complaints agency and there is a clinical focus, I think, in this process, so we often get involved, either through the review process, or when specific cases are brought to our attention. In those cases, we are often working with the youth advocate in that regard to view the voice directly of the child. I think, in the ways that we operate, we do have capacity to get voices. When we have tried to go outside of that, we have been unsuccessful, I think. But it is tricky. I guess the question is: are we the point-of-contact agency, or are we an upstream agency? That is the challenge for us.

The CHAIR: We had a hearing with the Mental Health Advocacy Service a few weeks ago and Debora Colvin was talking about the desirability of children and young people being actively encouraged to make contact with her service rather than simply being informed. I think we have taken some small steps towards that, but we have not gone the whole way. Presumably you would support her in that proposition—that it should be an active engagement with the young person, rather than just a background offer of assistance?

Dr Gibson: That is right, and again, I think the Mental Health Act has given greater capacity for the advocacy service to do that. I am aware, as amendments are being considered for the Mental Health Act—I will not go into specifics—that clearly the Advocacy Service is looking to embolden the act in that regard.

The CHAIR: Yes, indeed. She did speak to us about that.

Dr Gibson: We are supportive of that.

The CHAIR: The inspections that you were referring to a few minutes ago I assume are under the clinical monitoring program that started in 2016?

Dr Gibson: Yes.

The CHAIR: So you have done a review under that provision of the child and adolescent mental health service. Can you tell us a bit about what process was involved in that monitoring program, and how effective you think it has been to this point in time?

Dr Gibson: Sure. Can I just note that reviews have been done by the Office of the Chief Psychiatrist for many years prior to that; this was the first review under the new Mental Health Act in 2016. Can I also note that, from a resource perspective, we have moved from having oversight for roughly 2 000 people to 60 000 people plus, so it has been a challenge, I think, to ensure that we cover that aspect. The process for the child and adolescent mental health service review, I think it is not that we got it wrong—we got a lot of good information—but I think the first couple of reviews we did, we rapidly identified that the process we were using was not inclusive enough for consumers and carers, and —

The CHAIR: Right, so it was feedback from the staff rather than the other two elements?

Dr Gibson: Exactly. The review we did—the child and adolescent mental health service was one of the first cabs off the rank for review—was primarily a clinically focused and staff-focused review. Reviews since that time have actually included consumers and carers, and sought the consumer and carer voice more actively in that process. I think the review was a good review, and it actually identified that there were some issues around consumer and carer engagement within the service itself. Staff identified that, and so we fed that back and CAMHS has been working on that. CAMHS feeds back its updates on that, but I would say that the way we would do a review with CAMHS next time would be different.

The CHAIR: That is an interesting observation. As part of that review process, presumably you make recommendations for change?

Dr Gibson: We did.

The CHAIR: Is the service obliged to respond to those recommendations?

Dr Gibson: There is no statutory obligation, if you like, but the services do. They respond to that, and it is a rare scenario that a service would not agree with a recommendation. The reason they often respond is that these things are really obvious, and these things are issues that are not new issues; they are issues that have been there previously as well. These are constant struggles. The services are aware of these and they are often looking for support to drive change in these, and they use these reports as a way to do that. So there is no statutory driver for these, but they are responded to and they are used as a driver for change.

The CHAIR: I would imagine, from the tenor of those remarks, that you do not think there is a need for there to be a statutory component in the compliance of the agency with your recommendations?

Dr Gibson: I do not think so.

The CHAIR: You see it as more of a collaborative —

Dr Gibson: I think so. There is good evidence from the King's Fund and others to show that leverage of standards and quality improvement is about clinical leadership and engagement, so whilst we have a regulatory role, that is why we also try to leverage the clinical engagement in services around that. To have a statutory driver for that I do not think is helpful. There are so many other oversight bodies as well—the coroner et cetera—that will require reporting. There will be reporting on particular reviews that have occurred, for example the Stokes report has occurred. There is a feedback mechanism for reporting on that through the Department of Health, so there are multiple reporting processes. I am concerned about the administrative burden that goes with just trying to report back. They then often become a tick-box process; that is the risk of those things. They become a tick-box process, which does not necessarily get the change we are looking for, hence I do not think there is value for the community or for services to have that as driven by statute.

The CHAIR: I am not sure you will be able to provide a closed end to this question, but I just wanted to ask you: this committee has found, in many instances, that agencies implement change in terms of informing the service providers about what they need to do to cater for the needs of children and respond to the things that children might be requiring, but they seldom have a mechanism for measuring how successful those things are. You have talked about the fact that in future reviews, and we talked specifically about CAMHS, you would include consumers and carers. Why do you want to do that? How do you think that will change the system of service delivery? How will it improve things?

[11.10 am]

Dr Gibson: There is power in the use of consumers and carers in those processes, for a start. Number one, they often ask the really clear questions that are perhaps sitting there—they ask the "why" questions. It is really helpful from that regard. It is also in national standards that that is required. We have our own standards here which require the engagement of consumers and carers, so if we were not to do it, we would be in breach of those standards ourselves. It is both driven by standards and it has power as well to engage. I think any process which actually brings consumers and carers together with clinicians is a good process for improving outcomes in care. For example, there is good evidence that peer review workers within mental health services actually improve outcomes in mental health services. I think the evidence is there; we just need to move from the position that we had before, which was not doing it, to doing that more regularly.

The CHAIR: Before we move on to the royal commission recommendations themselves, I just wanted to take you back to the statistics you gave us at the beginning of this hearing. Is there a reason, in your view, why those figures are so high in Western Australia?

Dr Gibson: I think there are two things to say. Certainly within small services—most CAMHS services, inpatient services, are small services, and you see this with other small services that are not CAMHS around Australia—one individual can completely skew the figures. In this case, we are aware that there are—I will not give figures because I do not want to breach confidentiality—small numbers of individuals who services struggle to work with and manage. That is often despite having second opinions, getting the family involved, bringing NGOs—non-government agencies—into the mix. Whilst there is good evidence of how to reduce seclusion restraint across the board, certain individuals will continue to prove extremely challenging in dealing with that. Often these cases relate to small numbers of individuals who have very large numbers of seclusion or restraint. That is not an excuse per se, but it is just the reality of what does happen. In the process for reducing seclusion restraint and other restrictive practice, it has to work with those individuals—it has to accept that there will be those individuals. We have seen elsewhere that it can be successful even with those folk as well.

The CHAIR: Thank you for that. I do not know whether you have had a chance to read it, but the commissioner himself made a submission to this inquiry. One of the things he says is that —

> … despite the best efforts of the current oversight agencies, where they do operate, there has not been any discernible improvement in quality of care or wellbeing outcomes of these children and young people overall, with many oversight reports repeatedly highlighting the same concerns and recommendations over significant periods of time.

You have spoken specifically about seclusion and restraint. How do you think services in the mental health area to children and young people might be improved outside those two areas of seclusion and restraint?

Dr Gibson: I think the word on everyone's lips is around trauma-informed care. I alluded to that earlier. I think that is really important. We, for example, are drafting a sexual safety guideline for WA mental health services in which we have specific reference to children; the needs of children in that process. Last year there were no reported sexual assaults by adults on children within mental health services, although there was a small number of child-to-child sexual contacts noted. That, I think, is part of that process of changing the culture within services; a culture that the prime focus is to actually reduce trauma for children as well as others—adults as well. Having a focus on trauma-informed care is really a number one priority for us in WA. It goes across children into adults as well, and there are a number of ways to look at that. The seclusion restraint figures are just a downstream representation of that upstream process.

The CHAIR: How confident would you be about the resources that might be available to a child who was—you said there have been some incidents of children sexually abusing other children —

Dr Gibson: Sexual contact, at least, yes.

The CHAIR: How robust is the system that is in place for those children who are the victims of that kind of behaviour for reporting that behaviour?

Dr Gibson: I think it is always tricky, because we know that a large number of sexual harassments, sexual assaults are just not reported. We know that. There is the issue about making that okay to report this. I think having the youth advocate, under the Mental Health Act, having a more active role, has seen the advocacy service more proactive in that space and that has been very, very helpful in that regard. I do not think there is any easy answer. The idea of us producing a sexual safety guideline is really to actually work on the culture of services to actually focus on the importance of that within all services, so that it is not a case of if someone reports it, we will look into it; it is a case of we actually really want to do something to make this as safe a place as possible. When I think of many, many years ago at mental health units—I will not mention them—individuals who were sexually vulnerable were not given the protection that they required. I think there is a lot more focus on that at the moment, but I think there is still cultural work to do. I think that is one particular area that can drive this. It is not until it becomes culturally important in the service to keep individuals sexually safe that individuals will then feel more able to come forward when they have concerns. The issue is still also with kids in adult services. Youth services are a challenge, of course, because you have got 16 to 24-year-olds. Sure you have got some very mature 16-year-olds and some very immature 24-year-olds, but that still cuts between children and adults. There are small numbers—we had 19 in the last financial year—of kids who ended up in adult wards or wards that were not designed for children. Youth wards are designed for children, and some general wards are. In those cases, the question is: how do you keep those individuals safe? I know about three-quarters of those had a nurse with them all of the time, but a quarter did not, and they were segregated. I still have concerns about when a child is going into an adult ward. My personal belief is that they should have a nurse with them all the time.

The CHAIR: Yes, because in a sense they become vulnerable. You have spoken just now about vulnerable children. They become vulnerable when they are put in an adult ward, despite any other circumstance.

Dr Gibson: Yes, that is right. They are in the adult ward because it is perceived that is the least-worst outcome for them at that particular point, but there is still a clear onus on services. Most services respond to that, but I am surprised to hear that there were still a quarter of those—it would have been four or five—that did not have nurse specials with them during that period.

The CHAIR: I want you to explore just a little bit more that concept of vulnerability which you raised. The royal commission made a number of recommendations in relation to independent oversight

across areas where children are clearly vulnerable. They included out-of-home care and youth detention, both of which I would imagine has a fair overlap with the services that you provide or that Mental Health provides. Do your systems ensure the wellbeing of children? You talked about the complaint side with the advocacy service. Do you also have a way of determining whether a child is vulnerable?

[11.20 am]

Dr Gibson: That is a very good question. I think that really the clinical responsibility to assess that vulnerability sits with each clinician and the clinical service as well, and that then gets down to risk-management strategies within mental health services. I think that at the moment we still have a cumbersome recording process for that. We have a risk assessment and management form which does not particularly highlight sexual vulnerability on the form. I am aware that there are moves afoot to try to change that and have a more—not a more detailed form because it is too detailed at the moment; it needs to be more focused on the practical areas. Again, can that be regulated? It is whether you regulate good clinical practice. Really, that is about embedding that kind of assessment within good clinical practice. It is a bit like domestic violence. I think that is something that has been hard to get into first assessments on a regular basis. I mean, it has always happened intermittently, but to be more focused on that and to be more alert for that. I think it is the same. On balance, I think most clinicians do look at the sexual vulnerability of kids. I am not saying it does not happen. I think in the vast majority of cases it does, but how we move that to 100 per cent is the issue for me.

The CHAIR: You may have noticed that you followed the TKI data person, so our minds are very focused on that at the moment, as was the royal commissioner in his recommendations, of course—he was quite extensive with that data collection and the early intervention and the recognition of vulnerability. You referred to what we call "harmful sexual behaviours". We were struck by the fact that, from memory, somewhere between 20 and 30 per cent of the witnesses before the royal commission were reporting harmful sexual behaviours of other children. There is clearly some indecision amongst policymakers about how you deal with that problem—whether it is a punitive approach through the criminal justice system or whether it is a therapeutic approach through the health system. Do you have any views about that?

Dr Gibson: Are you talking about the offenders themselves?

The CHAIR: Yes.

Dr Gibson: It is a challenge, I think. Number one, we know that the youth forensics system is still under-resourced. I think there are no youth forensic beds in mental health at the moment within mental health services, so there is no specific area to actually try to perhaps address those individuals from a clinical justice channel. It is done within Banksia Hill and in general wards. It is a struggle, because you do not want to go through a punitive process which down the track will increase the likelihood of that person offending because they have not had an associated therapeutic engagement as well. I think it is tricky. I tend to think each case has to be judged on its merits and on the wishes of the victim as well. The message I would give is that we do not necessarily have the youth forensic focus within mental health services that we need at the moment. We do not have the beds nor do we have the breadth of services. My office has been pushing that for the last two to three years, as has the advocacy service.

The CHAIR: Yes. I am just going to ask you to define a "youth forensic bed". Is that a—you tell me what it is.

Dr Gibson: It is a secure mental health bed; it is not a prison bed. It is a secure mental health bed ideally outside the prison that has appropriately trained staff from both an age perspective and also from a forensic perspective.

The CHAIR: So this is for a young person who has already come in contact with the justice system?

Dr Gibson: Yes, that is right. There are two ways—someone is either in Banksia Hill already or they are on charges and a magistrate refers them for assessment.

The CHAIR: So at the moment the only two places would be Banksia or a general ward?

Dr Gibson: At the moment we have the Frankland unit, which technically can take youth, but it is a diabolical environment for youth and women, as you can imagine, because there are very few women and you have a lot of people with very significant forensic histories and predatory behaviours in that unit.

The CHAIR: That is a secure ward.

Dr Gibson: That is a secure forensic mental health unit at Graylands. The youth mental unit at Fiona Stanley and the youth mental health unit at Bentley do take individuals from Banksia Hill from time to time, so it is not like they do not take them.

The CHAIR: So they can provide secure units?

Dr Gibson: Yes, they can provide secure—usually because they are not to the level of security that the prison superintendents would accept. There is usually a prison guard with them in the ward, which has its own problems as well, but it is the least-worst scenario at the moment. So, yes, they can get care. But, again, those units are not designed around a forensic model in the sense that the psychiatrists are not regular forensic psychiatrists.

The CHAIR: How big would such a facility have to be?

Dr Gibson: It is probably not large. It is probably only a handful of beds in WA. The difficultly is that when you have small numbers like that, it is expensive to run with small numbers. The question is: where do you sit those and how do you model those? The numbers are not large but it is important. It is a bit like the number of beds for women, too, which does not necessarily need to be large, but they do need to be separate from the men.

Mrs J.M.C. STOJKOVSKI: I only have one question. Do you have any oversight of the Kath French centre?

Dr Gibson: No. My oversight covers mental health services. Certainly, over the years, I have had a lot of interface with Disability Services and the Department for Child Protection and other agencies where patients have been in and out of Kath French, but no direct oversight.

The CHAIR: Do you have direct oversight of the mental health patients in Banksia? I am hesitating there. If somebody is in Banksia and they have a mental health problem, do you have oversight of the provision of services?

Dr Gibson: Yes and no. If they are referred under the act waiting to get to hospital, I have oversight. We know there are lots of kids in Banksia with mental health issues, because there is a full-time mental health nurse there at Banksia. Those children who are not under the Mental Health Act awaiting transfer are not under my remit. We have had specific advice around that.

The CHAIR: So they would come under OICS as the oversight agency, not you.

Dr Gibson: Yes. We have worked with OICS in this sphere as well and continue to do that; for example, the OICS review of mental health transport that was released at the end of last year. That

was not a Banksia Hill one, but we had significant involvement in that. We have some of our staff assist the OICS reviews as well. We have a good working relationship with OICS.

The CHAIR: You could have children and young people in Banksia receiving mental health services and yet not be under your oversight because they are not covered by the act.

Dr Gibson: Yes. Several months ago—Deborah Colvin may have probably mentioned this—there was a meeting at Banksia Hill with a range of stakeholders, and we were there as well, to try to drive better access to mental health care. Whilst we do not have direct oversight, we still use levels of influence, I guess, to try to leverage change there.

The CHAIR: Presumably, you have the same lack of jurisdiction in the adult prison system as well.

Dr Gibson: Exactly the same, yes.

The CHAIR: Thank you very much. I am now going to formally close the hearing. Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary document for the committee's consideration when you return your corrected transcript of evidence.

Thank you so much for coming in today, it has been most interesting. We really appreciate your time.

Hearing concluded at 11.29 am

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