**Feedback on Forensic Mental Health Model of Care: Canberra Health Services.**

**August 2019**

**Response by Canberra Mental Health Forum**

Request for feedback that address the questions of 'does it achieve the specified goals', and 'are there any gaps?'

Thank you for the opportunity to provide feedback. A range of comments are outlined below - a key question is 'Who is the main audience for the document? Would this be addressed in the Foreword? The content ranges from broad principles to very specific lists of criteria. Comments are to be read in conjunction with draft document 2.0 released 26 June 2019 (Although the Header reads Version 1.7 June 2019 DRAFT).

Overall support the principles and helpful positives to clarify service purpose, scope and delivery, and integrate physical health with mental health.

We understand that the document and model is not the main focus for carers or consumers. Although an abbreviated version would be very helpful for the future. Outlines of services had been requested at Dhulwa, and acknowledged by Asst Director of Nursing this would be helpful to families, but no outcome as yet.

What is the time scope for this document and review date?

From a carer perspective with family members who have transitioned from AMHU to AMC to Dhulwa with the expectation of moving to ECU to stepped care in the community, the main response is that the transition journey does not appear to be clearly outlined in the document.

a. The purposes of the units are unclear. The different units at AMC are not included - eg Crisis Support Unit, or what was the Special Care Centre - later moved to Accommodation Unit West, Dhulwa wards are not specified or the role and functions of these units - Lomandra and Cassia. The document needs an appendix with the purpose of these facilities. Additionally the pathways, of how a forensic mental health consumer would be placed based on: remand status, not guilty finding, guilty finding, or how following a judgement of Not Guilty by Mental Impairment, the transition changes. The through care would be different for each of these situations and the detainee/consumers health and life situation. Exit criteria are included but there are only general comments about community transition or GP referral.

b. Other service providers are not clearly specified - eg internal services or external agencies - We appreciate this will change over time - but should there be a specified time on this document? with a renew date? Other services available as of 2019 including Community Outreach by other service providers would be helpful as otherwise the gaps are not apparent. For example, what happens at the age of adulthood border of 18, and a youth 25 focus. Flow charts would be helpful

c. The document refers to recommendations - but cannot find where or what are the recommendations.

Other specific comments:

Should the definition of a forensic mental health detainee/consumer be up front in the document?

1. Principles of recovery are referenced (p. 15), but there does not appear to be an outcome focus - how will these principles be enacted and measured to demonstrate positive outcomes. This is listed as future work. How do you know what the service wants to achieve if you don't specify what outcomes are wanted? There are outputs listed later in the document (p. table 3 & 4), but these do not appear to align with individuals recovery eg - the seven pillars of care that are included as measures as part of Individual Care Plans used at Dhulwa, for example. One of those pillars is Social Connections There is a reference to individual treatment plans p. 15, but no further detail. Recovery Plans are included in exit criteria, but not listed in Table 4.

2. P. 19 Para graph 2 should include a reference to Nominated persons being consulted about decisions in relation to the treatment, care or support and other functions under the Mental health Act - p. 19 & 27. Section 20(2) 'ensure must take all reasonable steps". 'endeavour' is not sufficient. Throughout the document greater emphasis on connections with social network and family is needed.

3. p. 19 This should also included carers or family where consent is provided

4. Stakeholders are referenced in the document and as part of the document development - it would be helpful to know who was consulted and who are considered stakeholder in this document and model?

5. p. 20 Internal or External Services - clearer specification required - and cross agency collaborations.

6. Forensic Mental Health Services - should have an important role in Culture change p. 17 - Police, Corrections, DPP, legal profession, magistrates

7. Principle 4. Problem of communication - Rights of consumers - Dhulwa no access to email or internet to research rights or treatment, information on services, p. 20. This impacts on Human Rights Act adherence.

p. 20 Principle 5 and 6 - Need for adequate resourcing and inclusion of interstate and international input.

8. Diversity , p.23

a) no mention of under 25's youth cohort - specific needs related to adolescence and maturing. Other jurisdictions have specific services for this cohort.

b) other disability eg deaf- need for interpreters/translators

9. Trauma informed - Ensure there is a "do no harm" approach p. 27 and p. 39 - eg Group sessions - sharing of stories and issues that create trauma for others should be limited. Feedback from consumers to family members included having been exposed to other's trauma in retelling, or incidents in AMC and Dhulwa.

10. No mention of Office or Director of Public Prosecution, p. 29-31 or Attorney General's Department p. 59. MHCALS - Courts

11. Forensic patients - inclusion/exclusion - very confusing p. 32. Last sentence reads " *It should be noted that the following are* ***not*** *examples of 'forensic patients' in the* ***absence*** *of a finding of NGMI or unfitness to plead or stand trial."* The following list includes - "*a person under arrest and in police custody*"; and "*a person who is before a Magistrates Court*". Both of these conditions are required before the matter reaches the Supreme Court, or depending on the DPP referred to ACAT. What happens when they are on remand? Family members moved to Dhulwa on a FPTO which then was not needed due to compliance with medication, but in one example due to his vulnerable status, and confirmation that a second trial was to proceed continued at Dhulwa. There are significant issues with the Human Rights ACT - mixing remand with convicted detainees, and least restrictive practices that should be adhered to.

12. p. 33 The whole field of the Orders are very confusing for Carers and consumers- eg Consistency in use of Mental Health Order or Forensic Psychiatric Treatment Orders etc. Appropriate use by ACAT.

p. 35 Referral - does this just include "serious injury or harm to others"? Should it also include 'self-harm'?

13. Key criteria indicating a consumer is suitable for transition from FoCIS to a general community mental health service -**and/or** meaning and precedence of points, p. 37 in definition very confusing -

14. Custodial Child and Adolescent p. 38, Bimberi - includes the statement: "*This can at times, include people aged over 18 years of age* "- on what basis?

14. Stepped Care Model p. 45. Table 2 includes Step 4 reference to intervention "inpatient care" - there is a column for the JHS and Winnunga, should that not also include a reference to Dhulwa?

16. Partnerships - inclusive list - **rehabilitation is poorly covered in this document** - role of Extended Care Unit eg Recovery College - educational providers. What are the range of agencies and allied health that provide support?

17. Priority should be Adequate Resourcing, p.48, p. 59

18. Reference to MDT - Multi-Disciplinary Team - our Forum experience is that for the Carers and Nominated Persons the MDT is **not transparent and accountable** as we are advised that matters are referred to the MDT but we are not advised who sat on that for what decision, or who makes final decisions, or paperwork is completed without names included.

19. There is no reference to Consumer or carer feedback in KPIs described, there is a reference to "Self-report measures of understanding of service" which is not a quality service KPI. There is no indicator on responses to complaints. There is reference to "*Improved definition of community consultation*" what consultation has there been in design of services - p. 54/55, Table 4. there is also no reference to Official Visitors or Public Advocate feedback. There should be indicators of 100% Recovery Plans developed. Plus 100% Individual treatment/Care Plans, with regular review.

20. What are the recommendations - what are the timelines, p.60 and 61. What are the priorities?

21. What is the role of Dhulwa and ECU in this process and model. There are references to Dhulwa as part of key performance indicators. Detainees/consumers should be managed/assisted earlier to ensure the use of this service should be minimised, but only if health of detainees is improved at AMC.

22. What is the Outcome of Healthy Prison Review - there was meant to be a focus on Mental Health services - what will be the input from the Inspector of Correctional Services in this document.

23 What are the options for court diversions p. 32 - Need an 'as of date'?

24. Future opportunities are major issues, what does this document address? What is the before and/or after situation. Future opportunity for mental health support unit in AMC. p. 59. The Disability Justice Strategy (Released 9 August 2019) indicates that there is no data on disability status at AMC - this should be a priority for identifying services and needs.

26. Governance and decision making priorities are required. Where is the principle of co-design?

27. Flow charts of the Journey of a detainee or consumer and what are the key touch points with whom - would be very helpful.