Comments on the MOC for Adolescent Mental Health Unit and Day Service from members of the Canberra Mental Health Forum

April 2020

- Bed numbers: the numbers do not seem to include provision for admissions from NSW. I think they might, but the paper is not clear. 6 beds are to be provided, while the ACT numberss are 4.8 in 2021 and 5.5 in 2026. This needs clarification with a commitment to increasing numberss of beds if need, population and access from NSW continue to grow.
- All admissions to AdMHU are to be through the Emergency Dept. This is a pretty scary place. Will there be a separate route to a CAMHS assessment area for young people presenting with MH issues? Will there be triaging to ensure that such adolescents are not required to wait for extended periods before being assessed.
- Expected lengths of stays in AdMHU are short - average 2-3 days, max 4 days or longer. Will there be full staff cover and relevant activities/programs 7 days pw to enable patients to get the care they need in these short times (staffing figures included in document suggest this is might not be the case - eg comprehensive psychiatric assessments are made only during business hours Mon-Fri so someone being admitted on a Friday evening could not have this assessment until Mon am, already >2 days into their stay, ward rounds held twice per week seem insufficient to ensure proper review of every patient within a 2-3 day stay.
- Re CCTV, it should be spelt out if use of this is intended, with specific safeguards and guarantees that it will not breach ACT Health's CCTV guidelines.
- Some concerns about involuntary admissions eg from Bimberi. Some of these could be violent and disruptive, having adverse consequences for already traumatised voluntary patients
- Will the MH Official Visitors have access to the AdMHU?
- The issue of lack of mention of a complaints process for families also applies to the patients.

It is encouraging to see planning for a designated Adolescent Inpatient unit in the ACT. The proposed unit has good linkage to other service components available to younger people in-need of care and support. This connectivity will help with ensuring that no-one is lost to the system and ideally, avoid unnecessary hospitalisation and improve the quality of life for all.

Other pleasing areas in the document include:

- Single point of entry
- Age flexibility, depending on unique circumstances which may necessitate longer than 2-3 day stays
- Medical involvement
- Carer Experience survey as part of monitoring / evaluation tools
- Principles of care
- Multi-disciplinary team approach and involvement of “other” key agencies including families
- Co-location of Day Care alongside the Inpatient unit

In addition, a number of areas that were unclear or needed further comment include:

- Unclear if typo / meaning of "… informed333ed" p14 & "and Fig. 4 "…Servicesanne."
- No specific reference to the actual configuration / layout of bedrooms as this can have major implications with managing the gender set-ups and one feeling safe in their rooms.
- No mention of en-suite in bedrooms.
- Reference to a Seclusion room. Is this necessary given that there will be 2 "Enhanced Care Beds" and a de-escalation / sensory modulation area. There is a National movement away from having Seclusion rooms. There are units now who do not have Seclusion rooms.
- If a young person is placed in Seclusion, will staff inform their parents?
- Are the bed numbers adequate, as experience has shown that this number doesn't account for real needs of a community? Some regions have 10 beds for a population around 380,000.
- Although reference is made to referrals to D & A, why not include co-existence presentations in the criteria for the admission section?
- With regards to staff profiles, has there been any thought given to employing an Aboriginal staff member apart from referral to the Aboriginal Liaison Service?
- Reference is made to group supervision for staff. Working in this area can very be very demanding and turn-over rates of staff are very high. Why not also provide individual clinical supervision for staff - not everyone feels comfortable with discussing clinical moments in a group structure.
- Mention is made to accessing ward class area in the Paediatric unit. Given education is important, can this be provided in-situ or have in-reach from teachers?
- Will the unit have CCTV?
- The document does not mention the proposed physical location of the unit although there are references to the Paediatric unit. Ideally, history tells us that having a ground floor placement is best for a number of reasons, especially for providing a safe environment with a natural outlook.
- Comment is made that the unit accepts admissions 24/7 and each referral is assessed by the Liaison team who approve all admissions however, they do not work the night shift. Further, the registrar is .5 FTE.
- No mechanism mentioned for parents raising their concerns about care provided i.e. complaint processes.
- Governance of the nursing staff on duty is via the ADON for the General hospital whereas medical and allied health are under MHJHADS. This may cause some tension, especially with regards to the three nurses working together with unclear responsibilities and under a generic ADON who may or may not have relevant clinical expertise in managing Adolescent behaviours.
- Finally, the unit culture needs to value involvement of families in all aspects of care.

Good to see integrated model of care and thought that has gone into document. Need to consider issues such as:

1. **Capacity**

Should the unit be adjusted to 10 beds (8 plus 2) with a more flexible remit? Two 4 bed wings, and then if needed could segregate by gender or age if needed. Other

planning work has frequently overshot projections. This is billed as part of the 10 year health plan, we are now in 2020 – projections should continue until 2030, rather than 2026. If this is a physical space then a larger capacity should be designed, built, and then in later years staffing budget enabled to fit to capability and capacity. Hard to discern whether the allowed budget will be sufficient without access to age profile of current presenting clients/consumers.
Transition between 16 to 21 years, other services have a broader definition of young people ie headspace up to 25 years. The World Health Organization (WHO) defines an **adolescent** as any person between ages 10 and 19. WHO's definition of young people refers to individuals between ages 10 and 24. Eg first year at university, 18 year olds where significant stresses impact on those with vulnerabilities. It is noted in the document that there is some flexibility, but this limit at 18 is an artificial legal demarcation that is not helpful in health services. The AMHU is much larger and overwhelming for young people.
Will the design include those glassed-in nurses stations? Concern about staff staying behind the glass areas rather than interacting with consumers.

2. **Assessment for justice system, custodial review and Bimberi**, Involuntary Criteria

"The length of stay will average 2-3 days, however may be up to 4 days (longer if clinically indicated)." Under the Mental Health ACT 2015 initial 3 day review and then potential 11 days extension, could be requested by a Magistrate or the ACT Civil and Administrative Tribunal. ACAT can receive a referral from the **ACT Supreme Court** or the **ACT Magistrates Court** to determine whether a person has a mental impairment as defined in the **Criminal Code 2002**, or for the purpose of making a mental health order. The *Children and Young People Act 2008* is referenced, does the other legislation apply, eg criminal code with reference to 'mental impairment'?
https://www.acat.act.gov.au/case-types/mental-health-cases

Emergency detention

*There are circumstances where a person may be detained without a full mental health assessment. The **Mental Health Act 2015** describes this as emergency detention, and it includes apprehension, assessment and treatment. Emergency detention is authorised by a doctor at a mental health facility for no longer than three days. During the three day period of detention, the Chief Psychiatrist (or their delegate) may apply to ACAT for an extension of the period of detention for a maximum of a further 11 days. A person can apply for a review of emergency detention, in which case ACAT must conduct a review within two working days.*
The four-day limit appears unrealistic.

Also later in the document there is reference to care and access to educational programs (are these care related or vocational, please clarify?). If consumers are in an acute situation then will they be well enough to consider educational programs unless they are there for a longer period, or moved to other accommodation?

Examples from Qbyn and South Coast where psychotic situations resulted in harm to others 16 & 17 year olds. Is ACT accepting any of these patients, as some may be travelling into Canberra? Is it expected if such cases occur in the ACT for <18 year olds are they supported/ managed in the AMHU or AdMHU? Given the references to Bimberi, will AdMHU be gazetted under the Mental Health (Secure Facilities) Act 2016? Refer also to Section 5.2. It has implications for electronic device use, etc. Risk is mentioned, but needs to be considered for both the young person and others in the AdMHU care. Hence the benefit of having two wings or additional configuration. If threatening behaviour escalates and concerns the safety of staff and other consumers, will security staff be involved to assist manage behavior?

There doesn't seem to be input specifically listed from the ACT Human Rights Commission – are they being consulted as this would be under their remit? (The Public Advocate is referenced under 4.3.6, but don't think this is a Brief Therapeutic Intervention).

Other comments

Design of Unit - will be suitably accessible for people with disabilities? Pleasant outdoor space with greenery, space for exercise and relaxation?

ICT – laptop computers – how housed and accessed, for what purposes? Communicating and email to family should be encouraged where clinically supported, refer human rights standards

Discharge - copy of documents to consumer **and** parent/ guardian/carer – please refer to recent discharge document initiative

Transition care – is there any role for discharge and continuity to the University of Canberra Rehabilitation Hospital Mental Health Unit?

Procedural Security and information – Provide a handbook on guidelines to consumers and family members to clarify treatment, activities, processes, expectations and rights, key contacts and outline comment/ complaint procedures.

Training:

1. include reference to the ACAT and potential links and processes with justice system. Some staff that currently provide care at Secure Mental Health Facilities are totally unaware of legal system processes and stressful impact on consumers and their families
2. Values, multicultural issues and staffing. Ensure all training aligns with ACT and Australian government promoted values and behaviours regarding non-discriminatory support etc.

Interaction with private provider facilities for adolescents.