REF: FOI:16-52

Dear

I refer to your application under the ACT *Freedom of Information Act 1989* (the Act) received by ACT Health on 9 January 2017. You have requested access to copies of the following documents related to Dhulwa:

1. The needs assessment prepared to justify the expenditure/project,
2. Why were "civil", i.e. people without involvement, with the justice system included,
3. What is the underlying philosophy of treatment of Dhulwa,
4. What is the justification for the security measures, including restrictions on leave, and visitors,
5. Budgetary information including estimates for the operating budget, and
6. Documents relating to involuntary detention and setting of time limits for detention.

As the Acting Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, ACT Health, I am an officer authorised under Section 22 of the Act to make a decision in relation to this matter.

After conducting a thorough search of all relevant ACT Health records, documents were identified that fall within the ambit of your request. We have provided the following documents in response to your request:

Request	**Document**
1	High Security Forensic Mental Health Care Feasibility Study2004 Review of Options for ACT Secure Forensic Mental Health Unit April 2012
2, 3 and 4	Secure Mental Health Unit Model of Care
4 and 6	Dhulwa Mental Health Unit – Referral, Admission and Transfer of Care, Standard Operational Procedure
5	Dhulwa Mental Health Unit Operational Budget

I would also like to extend an invitation to to meet with me and the senior staff of Justice Health Services. We would like to engage with

to have a collaborative discussion regarding the providing documents and an opportunity to answer any further questions that may have about Dhulwa.

Further to that meeting, I would like to extend an to have a guided tour of Dhulwa. I am hoping that the tour of Dhulwa in conjunction with the provided documents will go away in answering and addressing any ongoing concerns that you and U3A members may have about the facility and the clinical care provided at Dhulwa.

If you wish to seek a review of this decision you should write to:

The Principal Officer
c/- FOI Coordinator
Executive Coordination
ACT Health
GPO Box 825
CANBERRA ACT 2601

You have 28 days from the date of this letter to seek a review of the outcome or such other period as the Principal Officer permits.

You also have the right to complain to the Ombudsman about the progression of your request. If you wish to lodge a complaint you should write to:

The Ombudsman
GPO Box 442
CANBERRA CITY ACT 2601

Should you have any queries in relation to this matter please contact Jonas Allen, Freedom of Information Coordinator on 6205 1340 or HealthFOI@act.gov.au.

If you would like to accept the offer to meet with the senior staff of Justice Heath Service and myself, please contact my office on 6205 1313 to organise a date and time that is suitable.

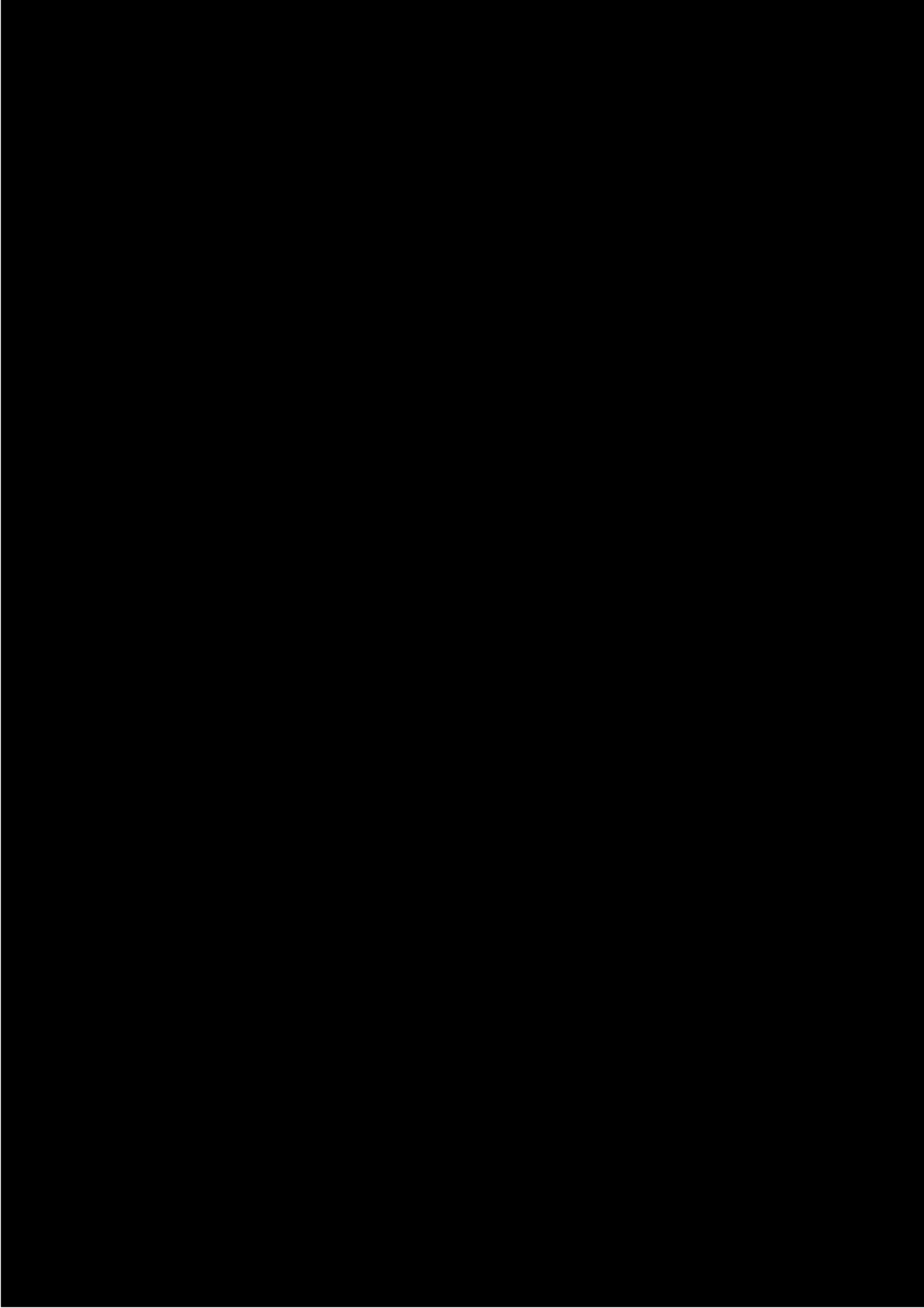
Yours sincerely

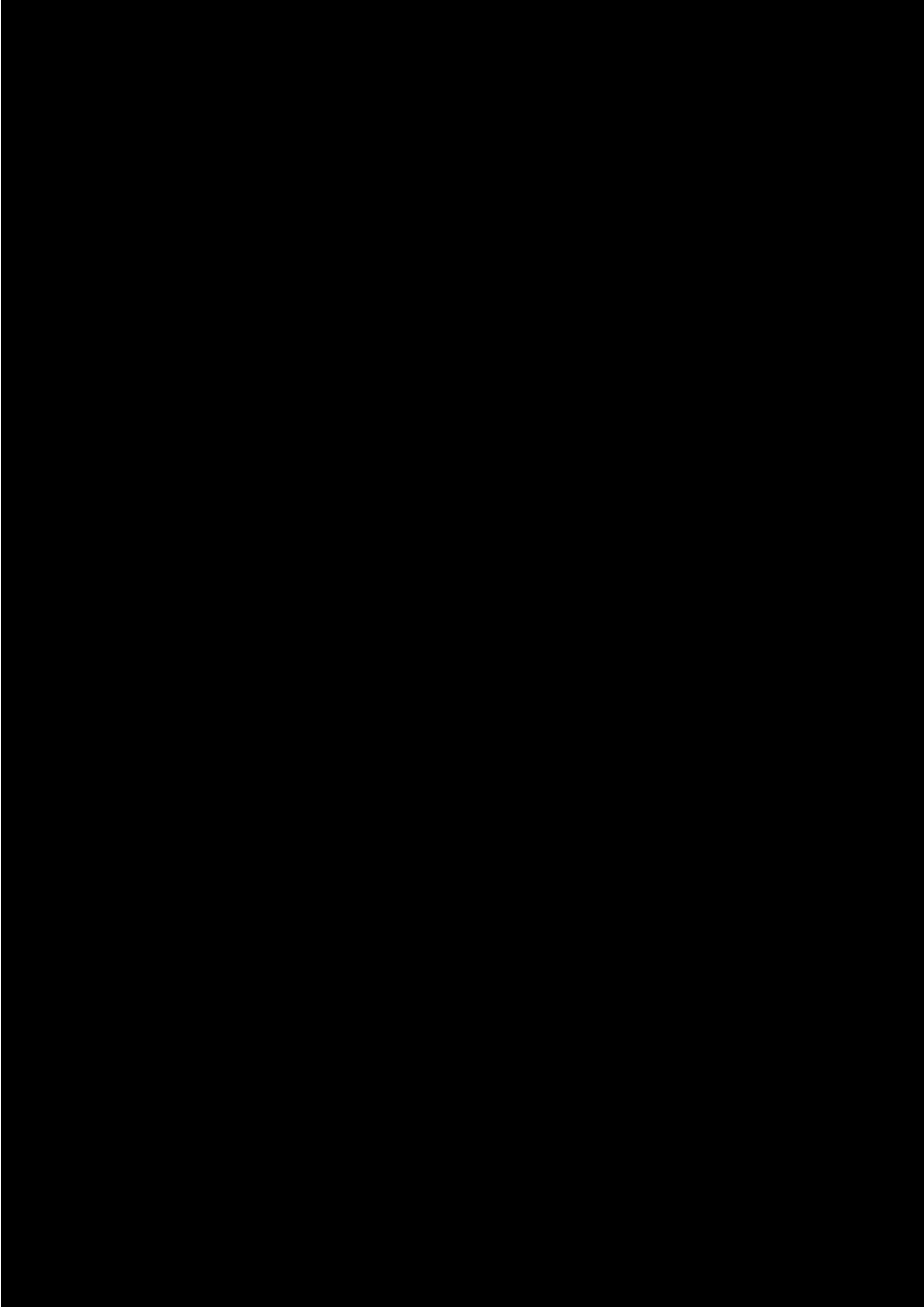
Bruno Aloisi
Acting Executive Director
Mental Health, Justice Health, Alcohol and Drug Services
6 February 2017

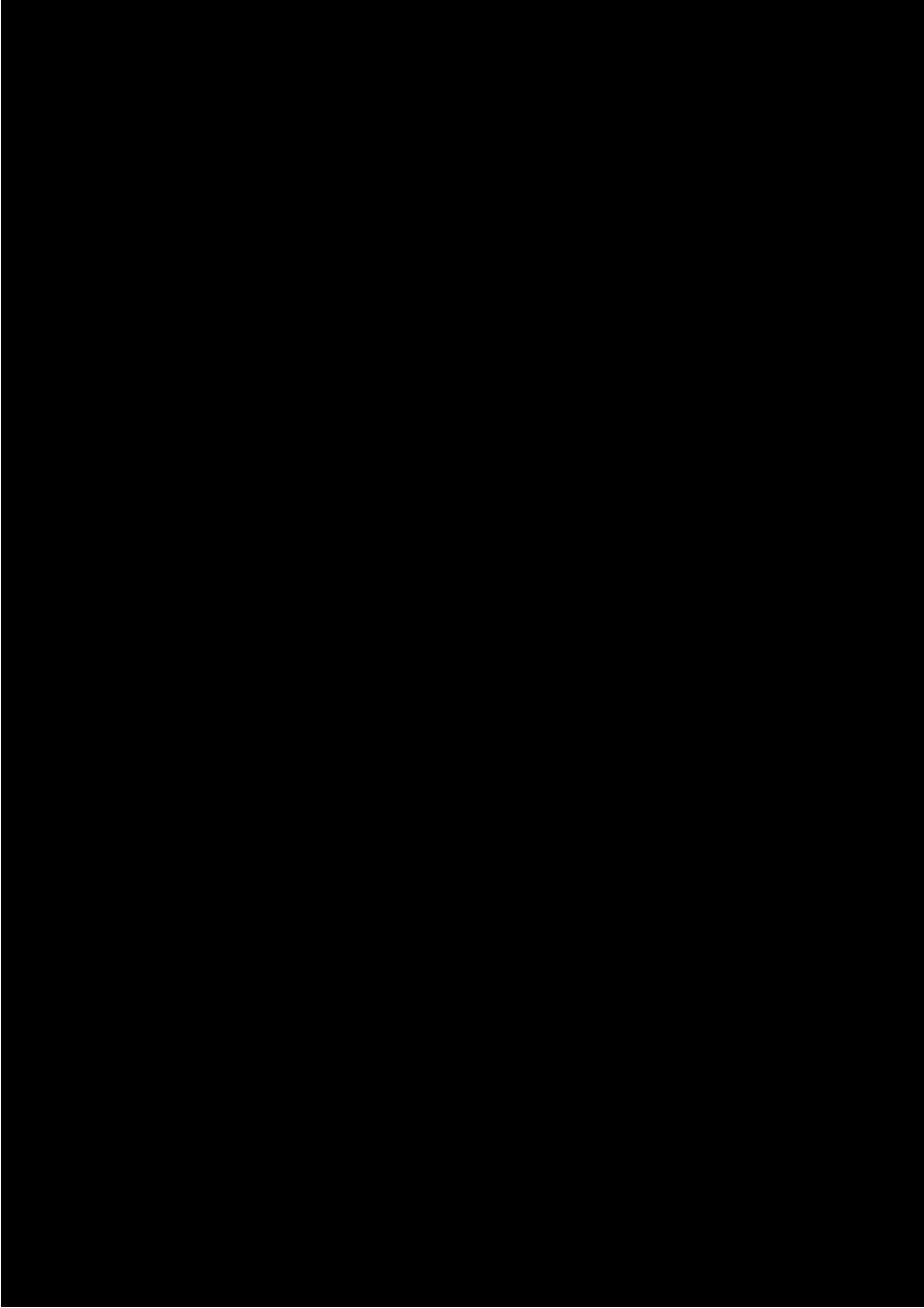
SCHEDULE OF DOCUMENTS

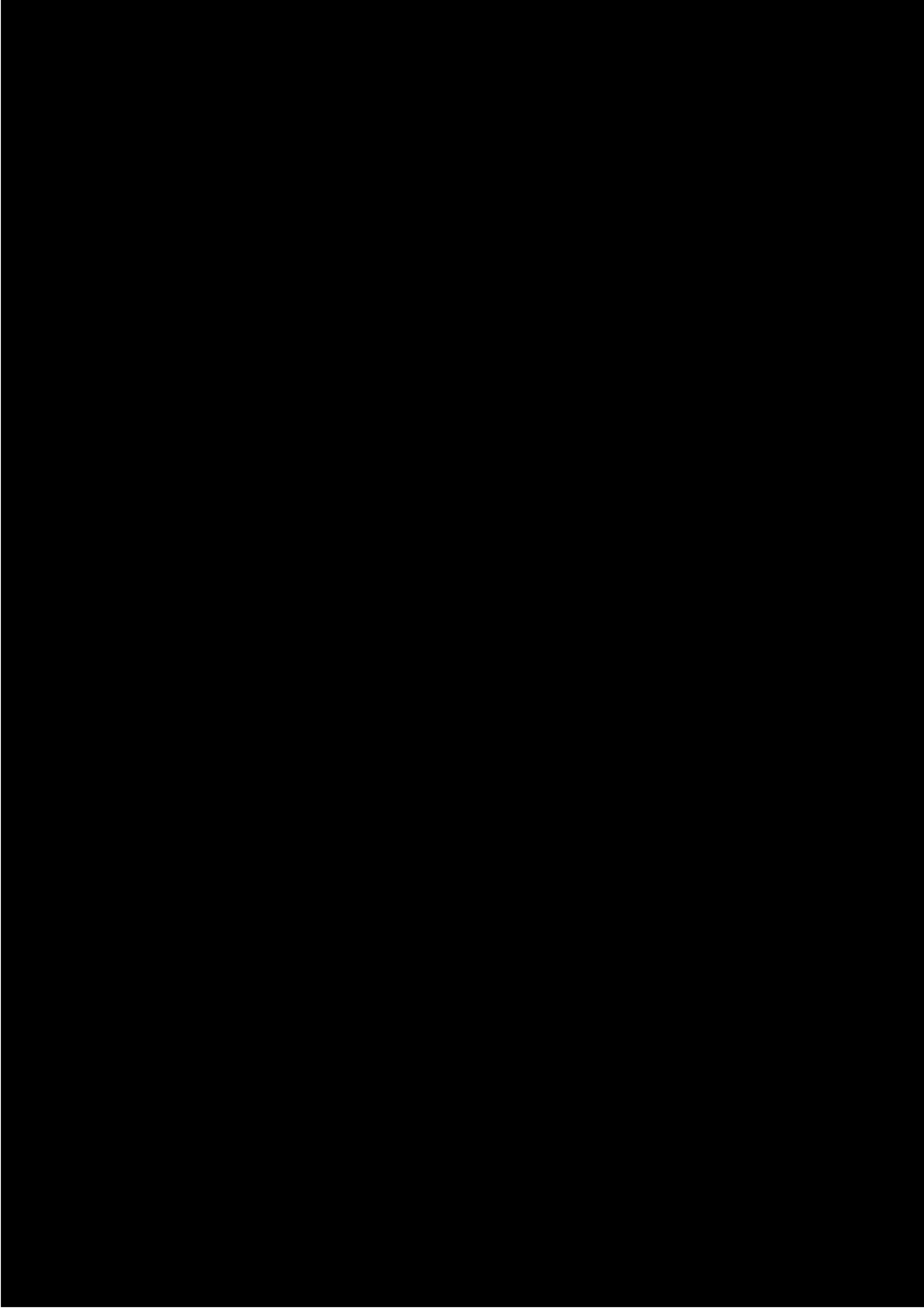
Dhulwa secure mental health unit – FOI16/52

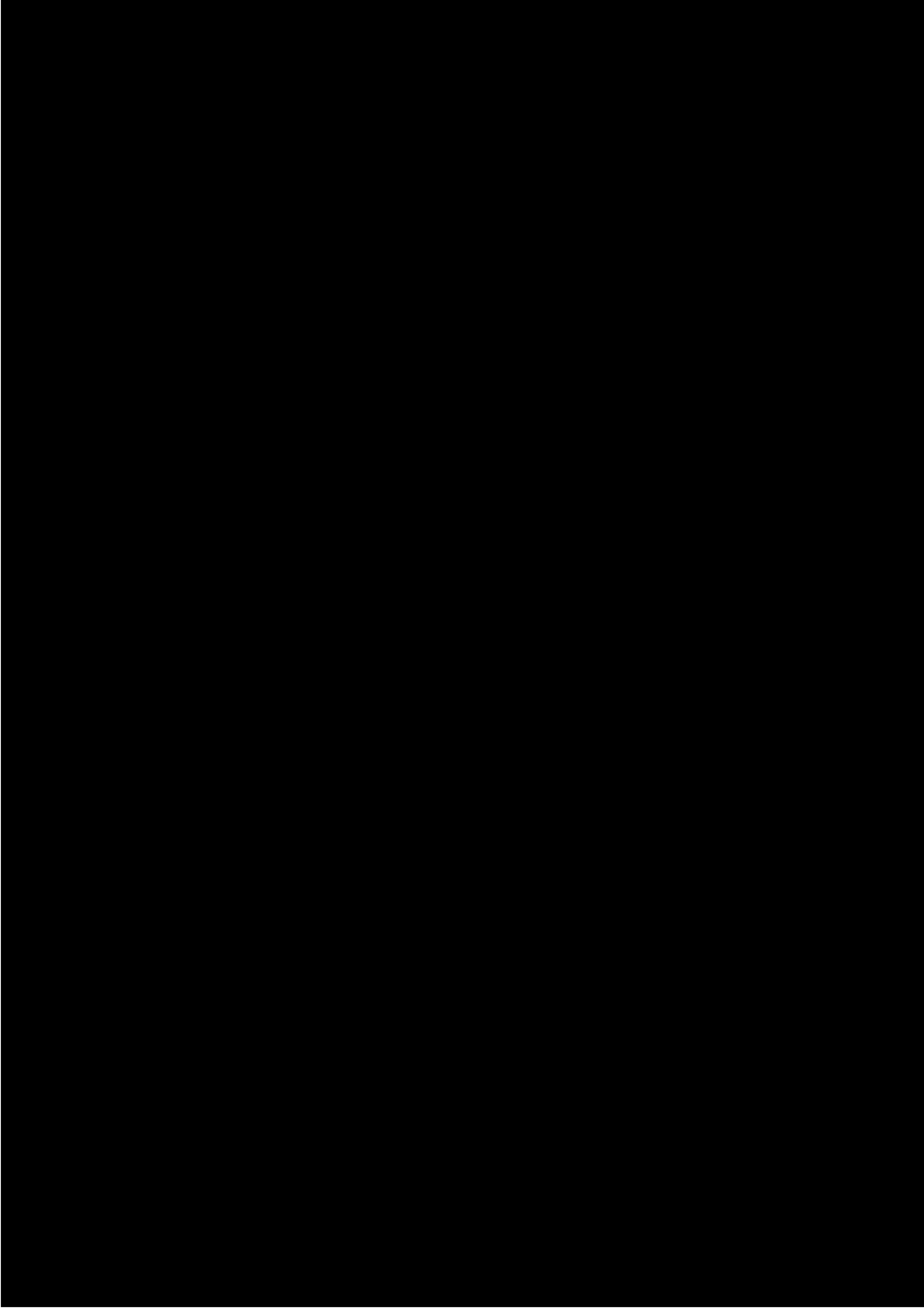
FOLIO	ITEM	DATE	STATUS	REASON FOR EXEMPTION	Internet publication – YES/NO – if no, why not
1-153	High Security Forensic Mental Health Care Feasibility Study	2004	Full release		no
154-191	Review of Options for ACT Secure Forensic Menta Health Unit April 2012	April 2012	Full release		no
192-236	Secure Mental Health Unit Model of Care – final Version – May 2014	May 2014	Full release		yes
237-265	Canberra Hospital and Health Services Operational Procedure – Dhulwa Mental Health Unit – Referral, Admission and Transfer of Care	28 September 2016	Full release		yes
266	Dhulwa Mental Health Unit operational Budget		Full release		No

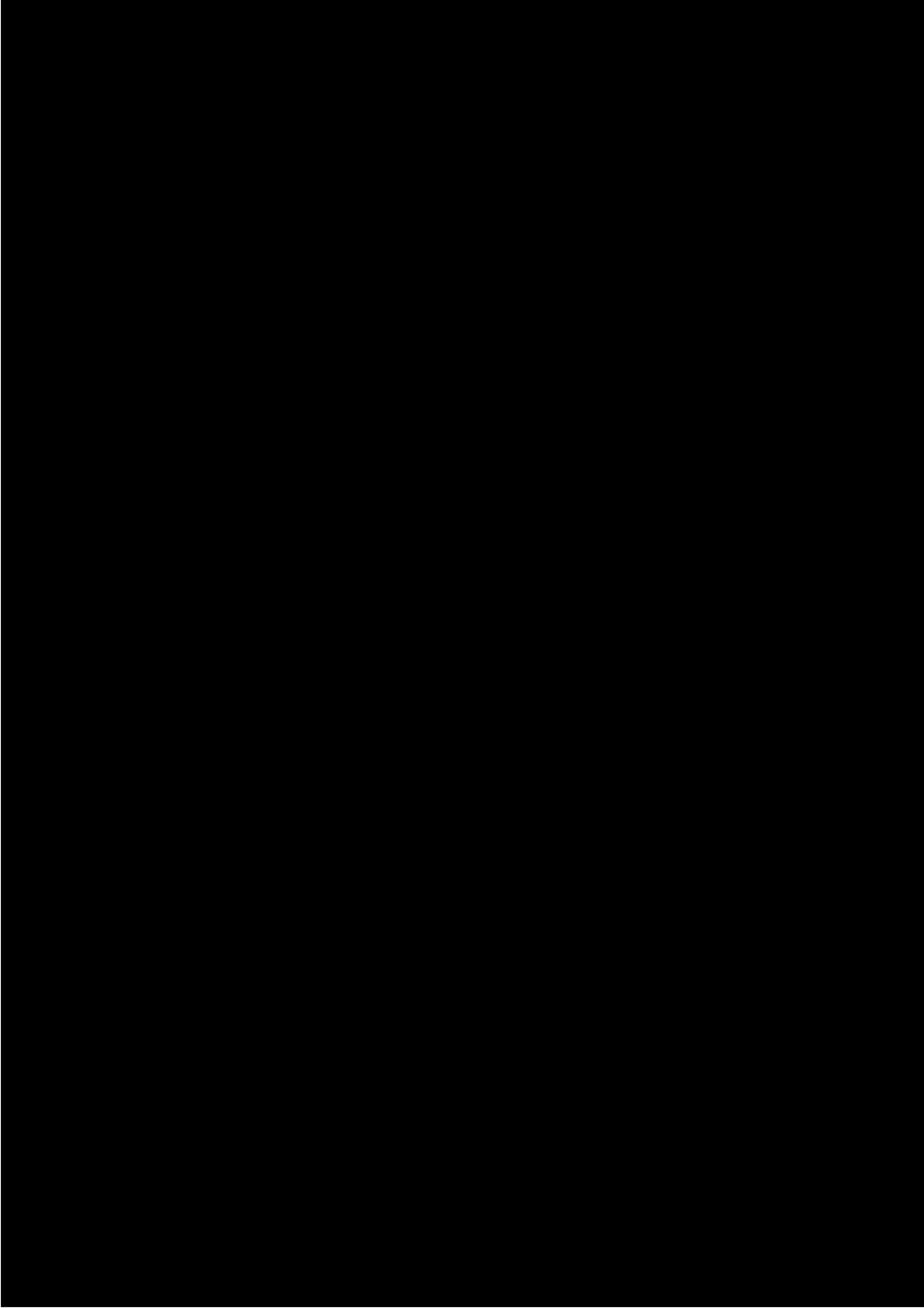


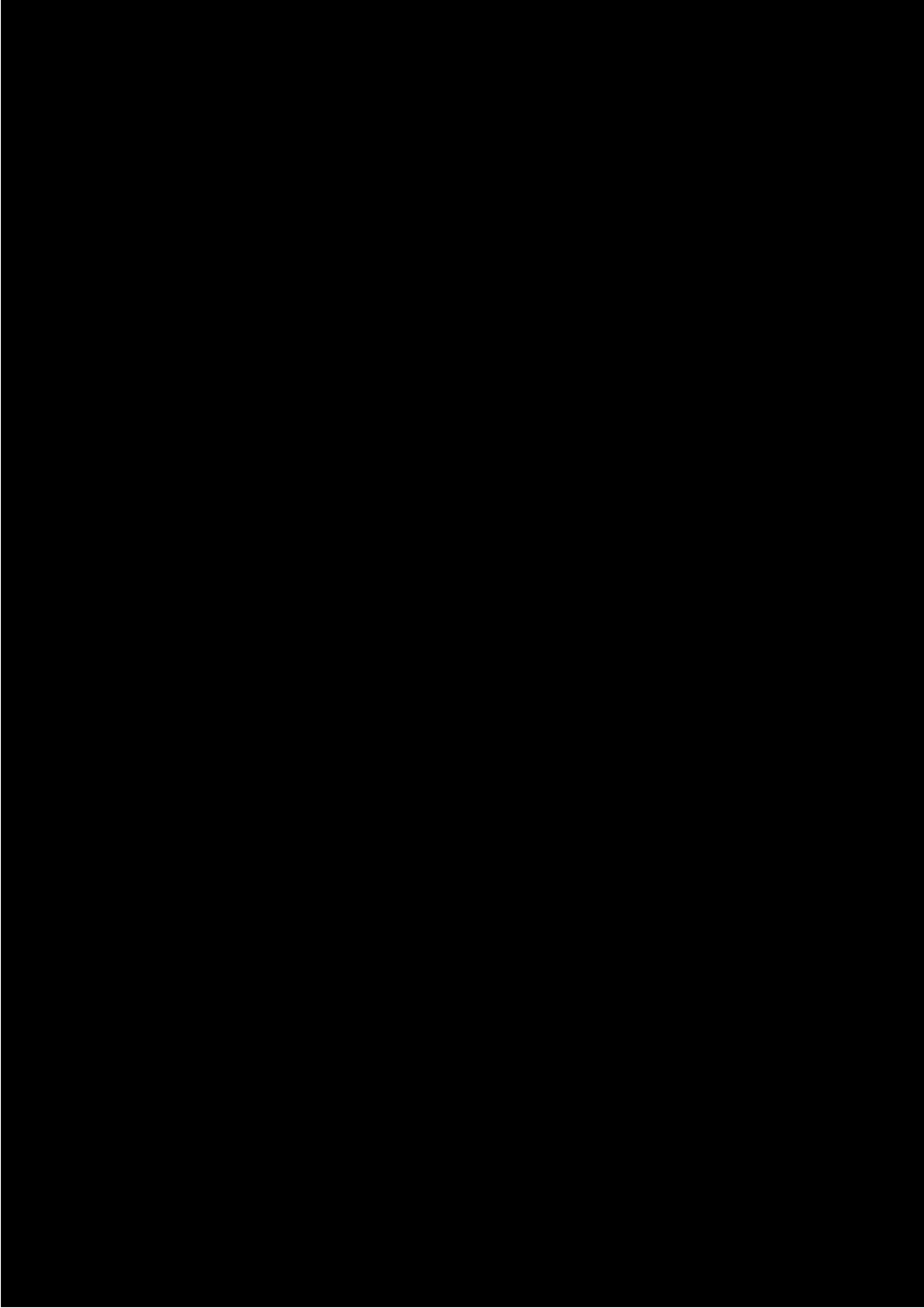


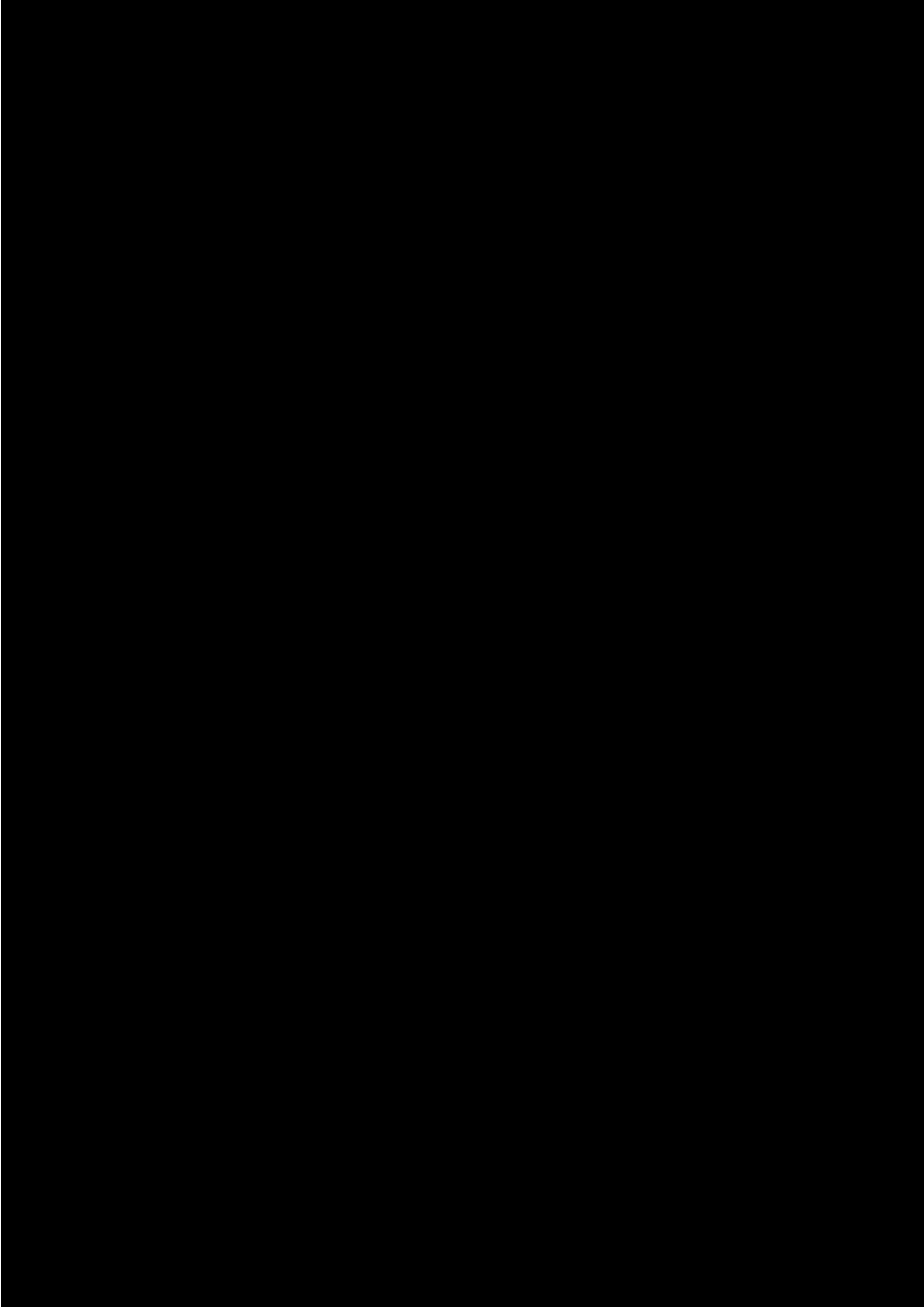


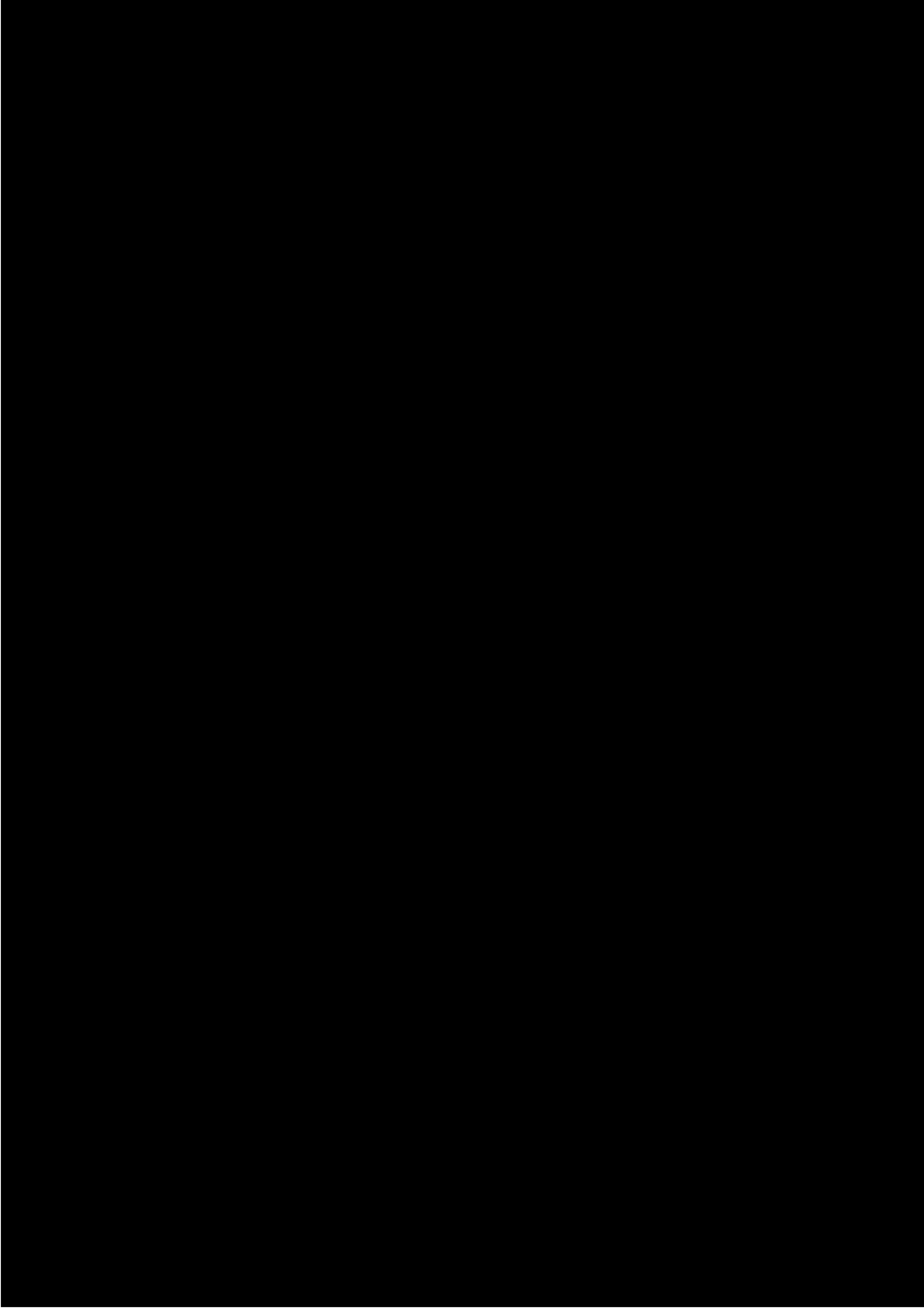


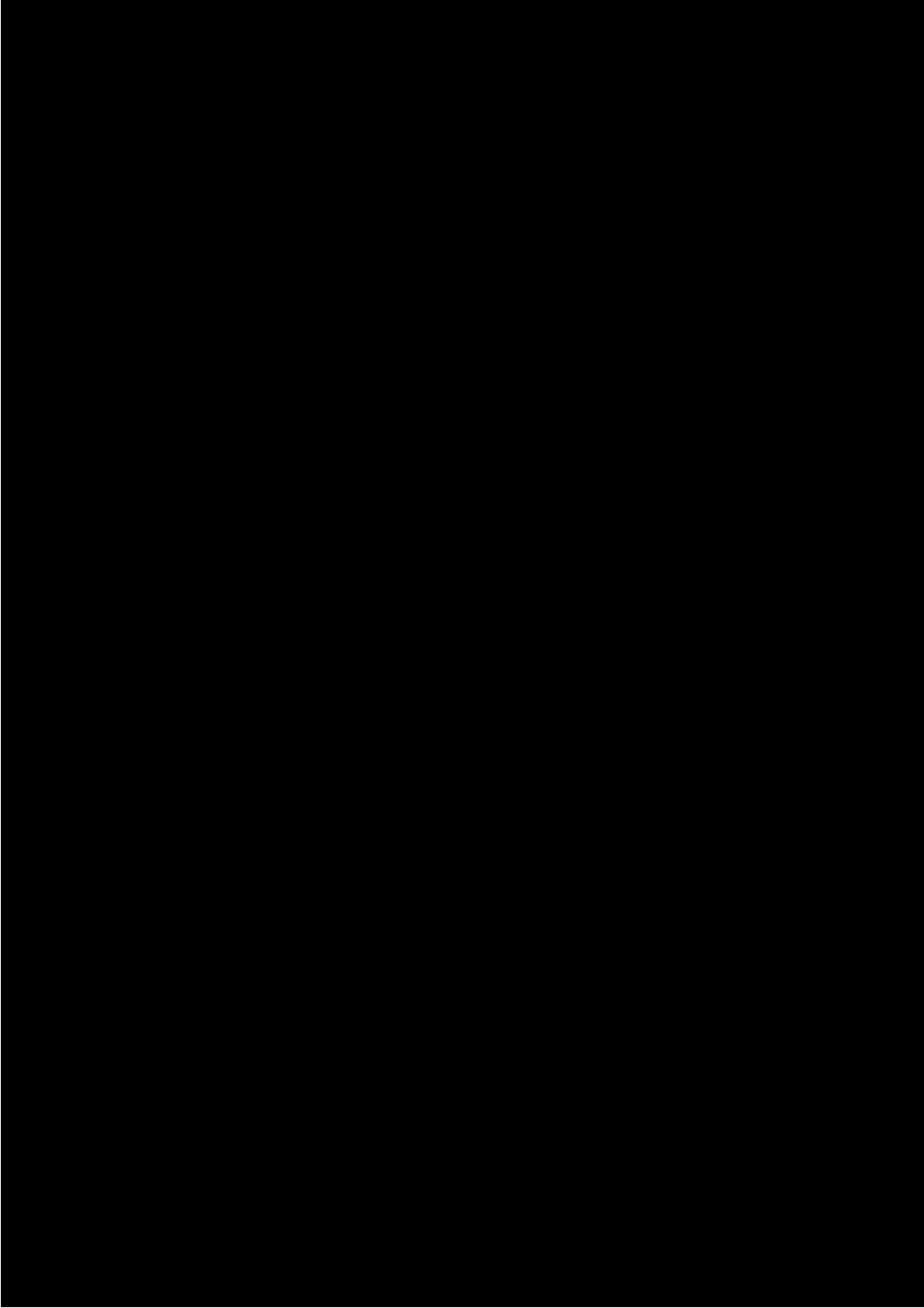


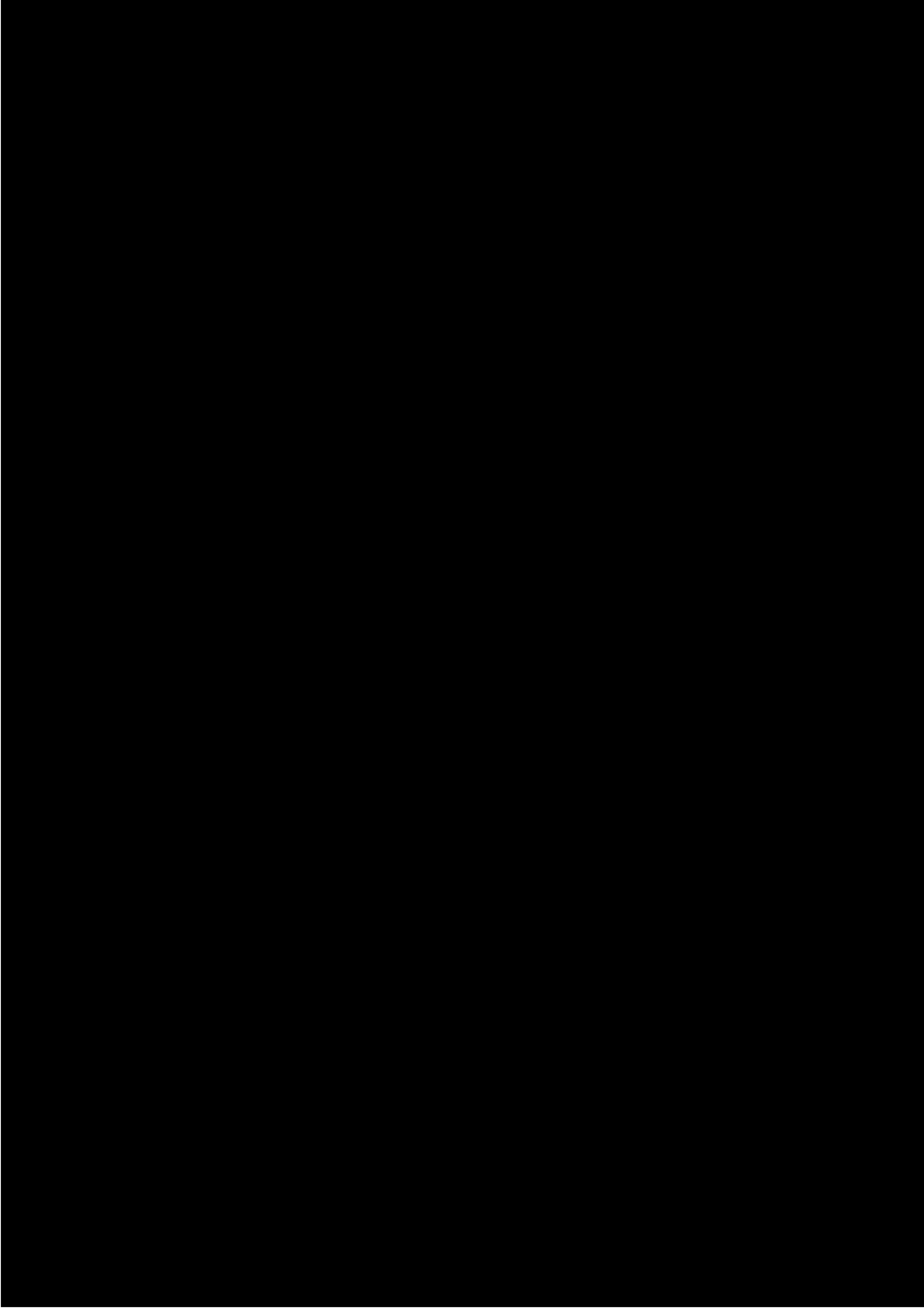


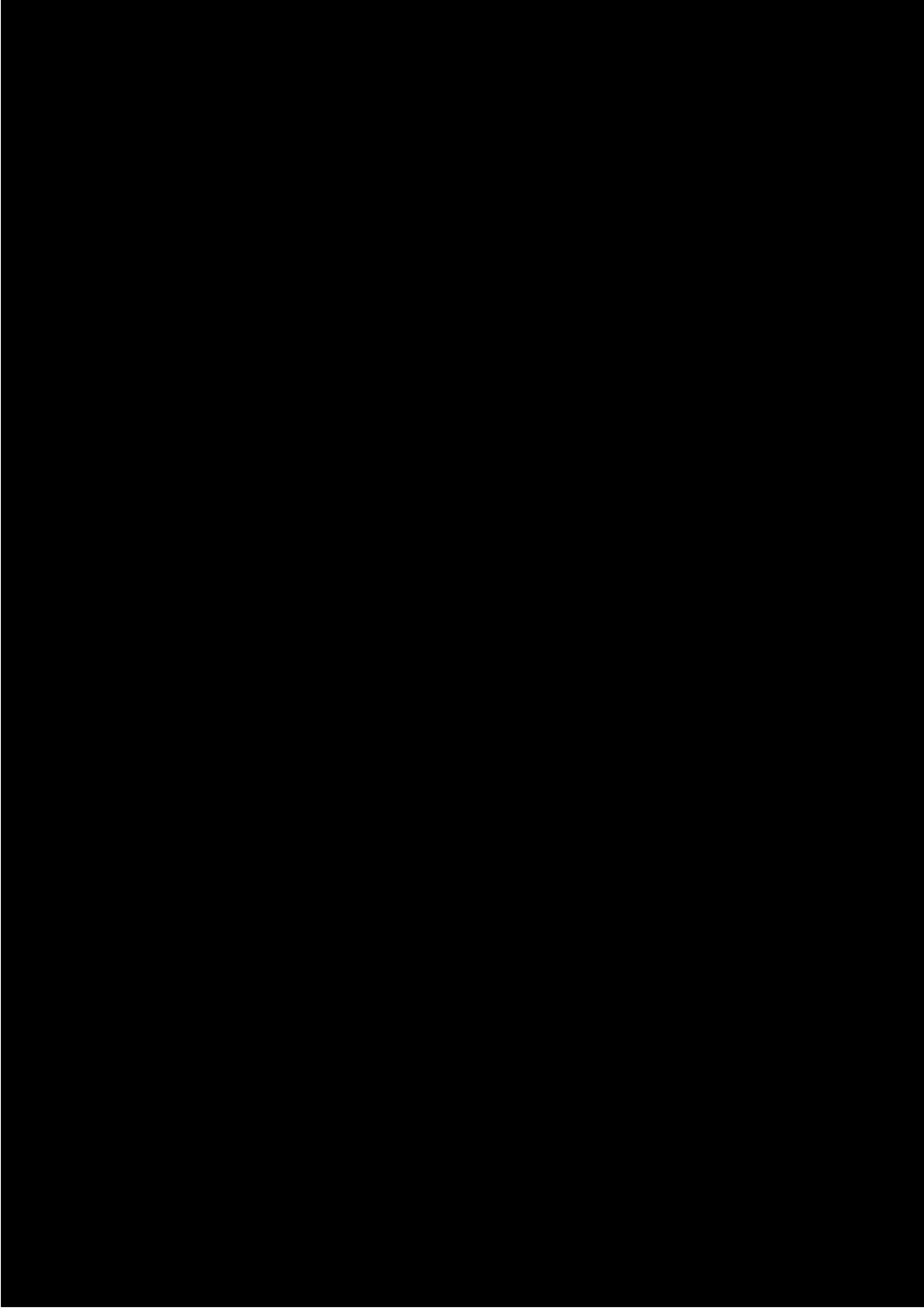


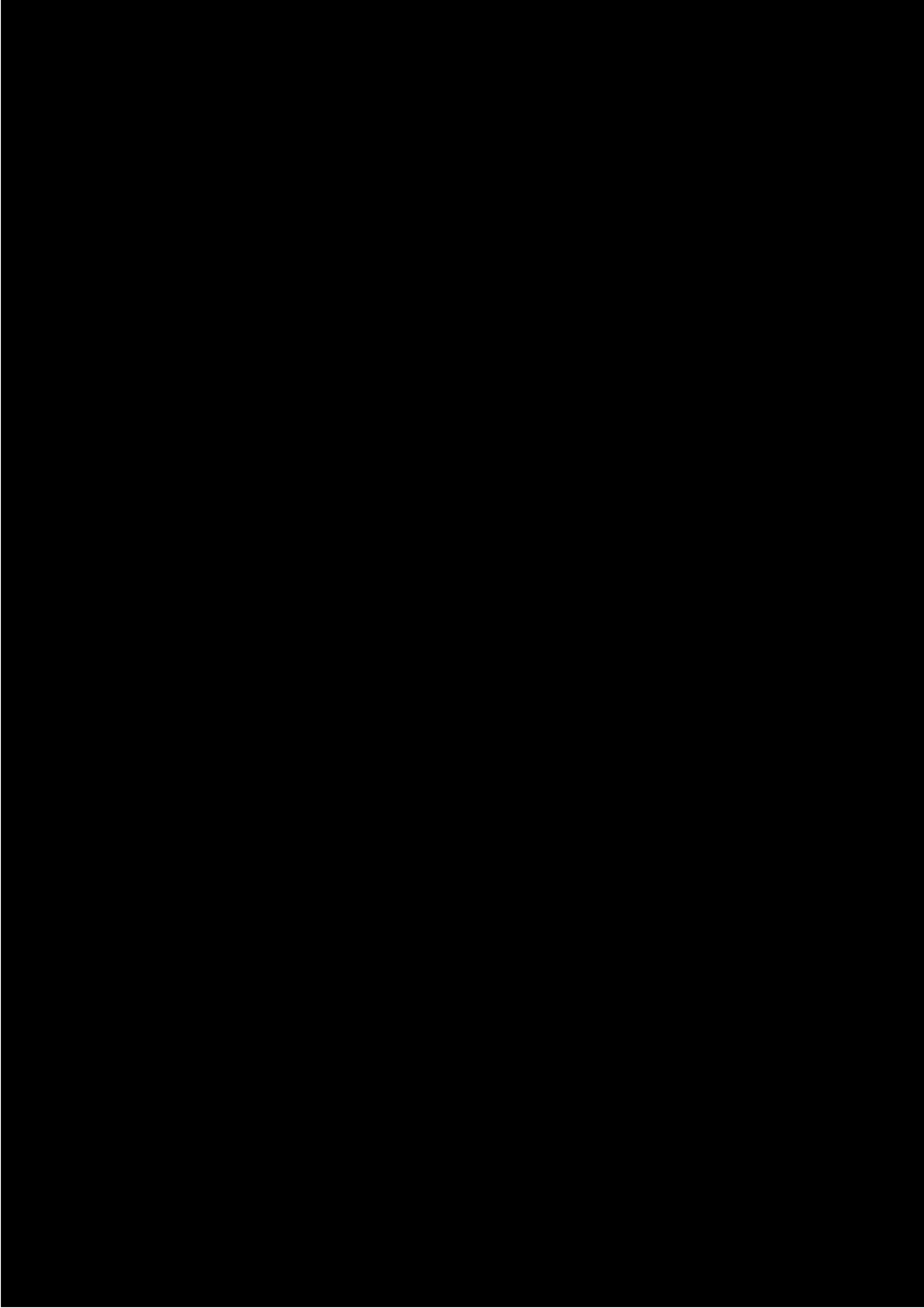


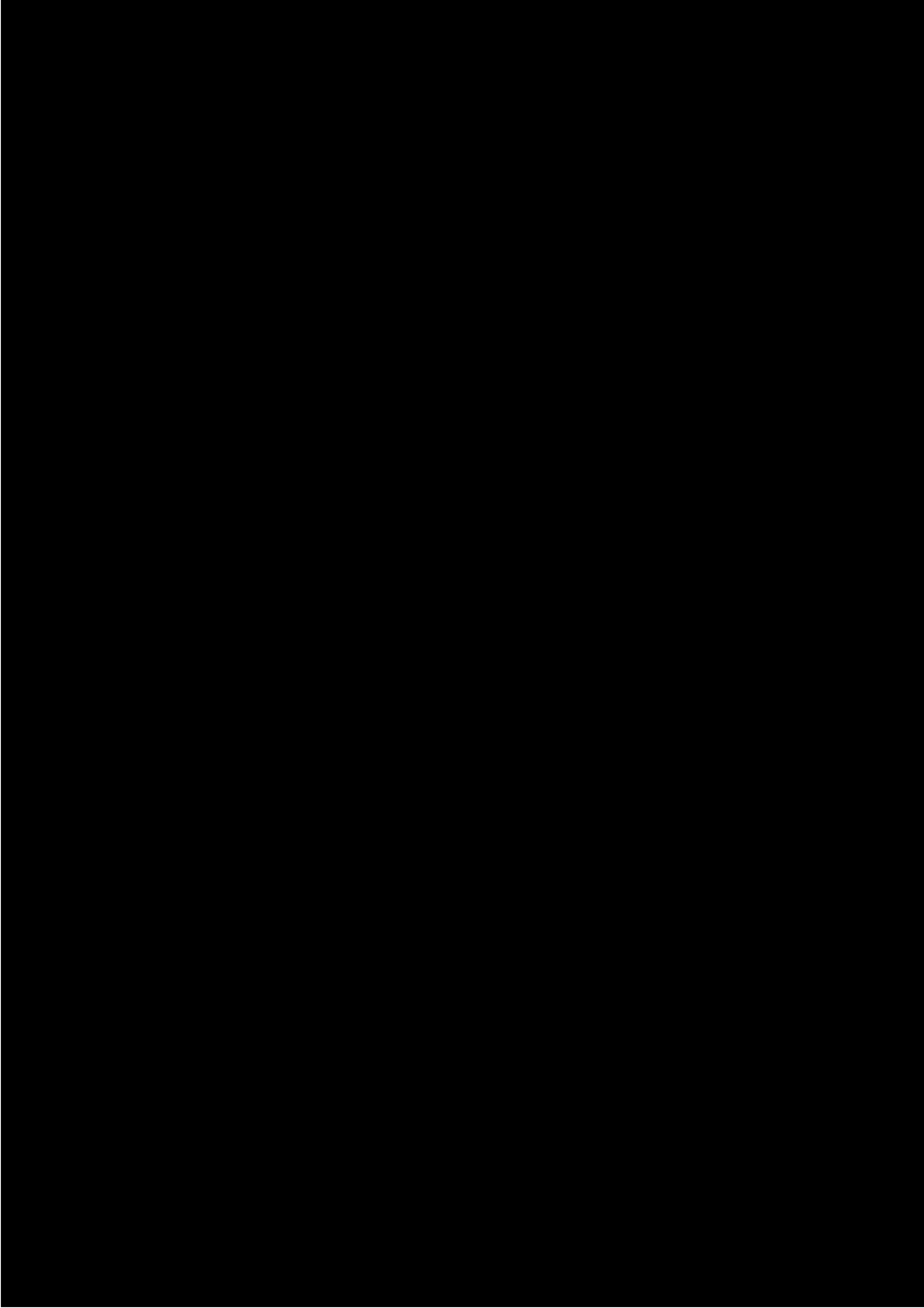


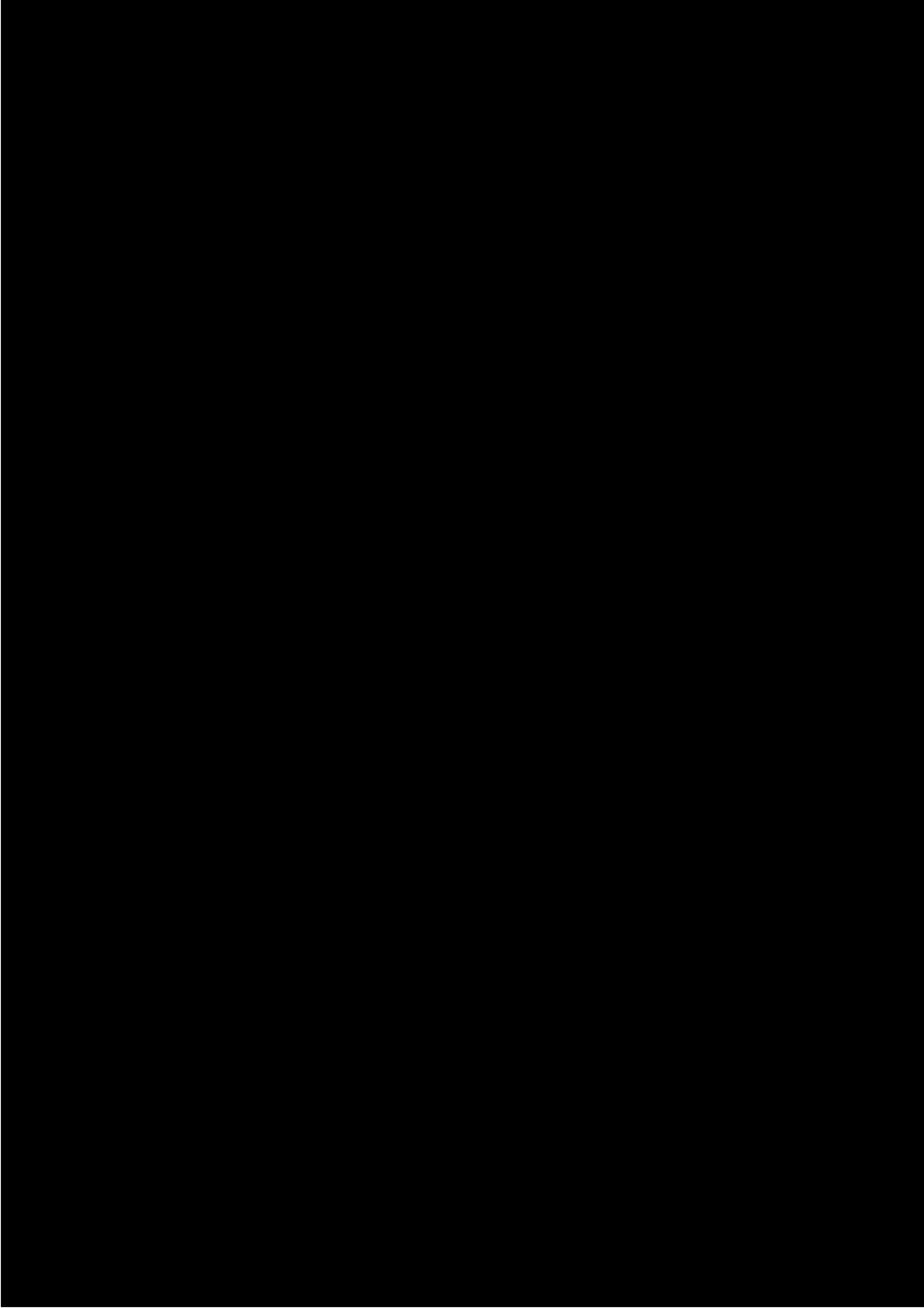


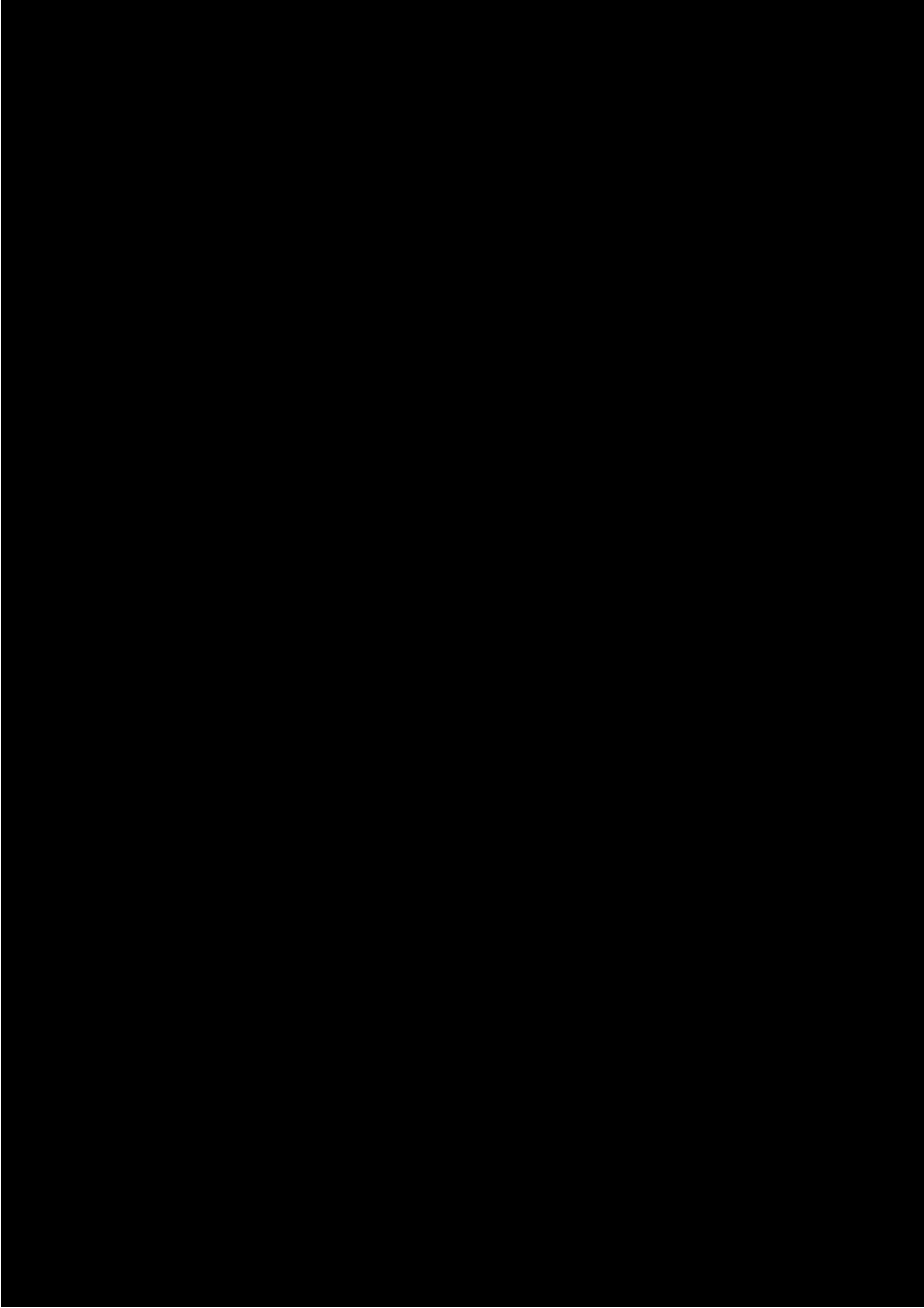


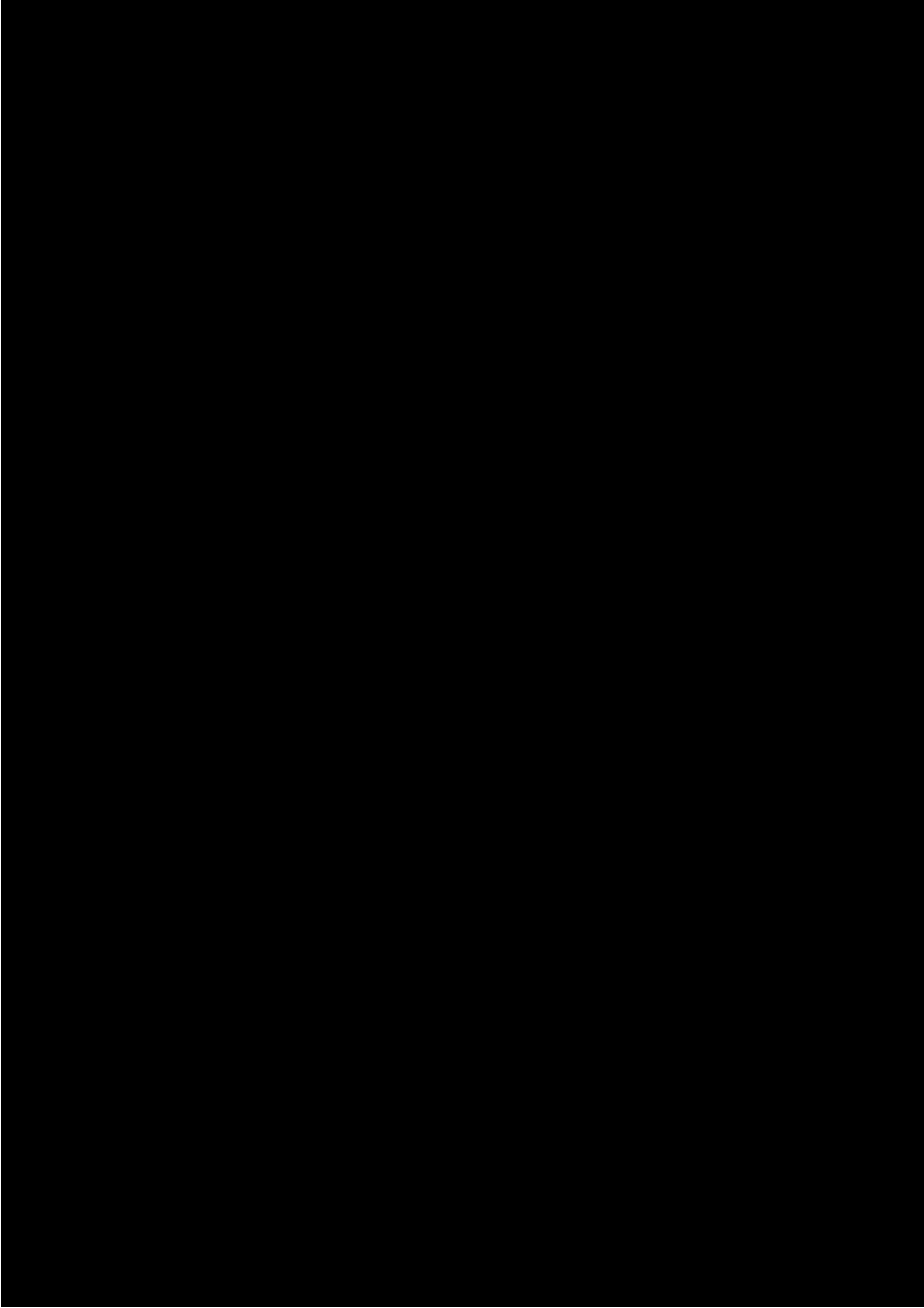


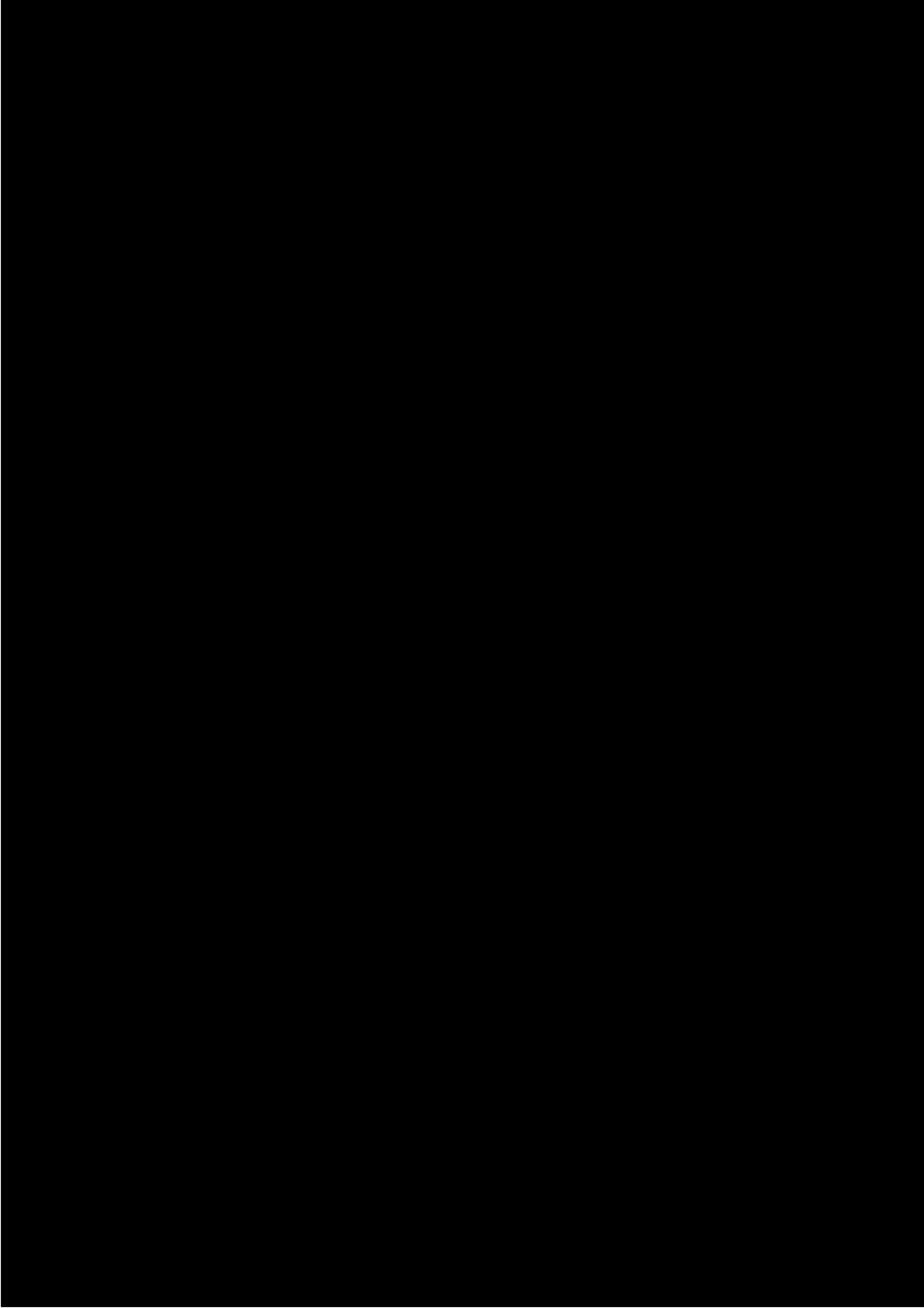


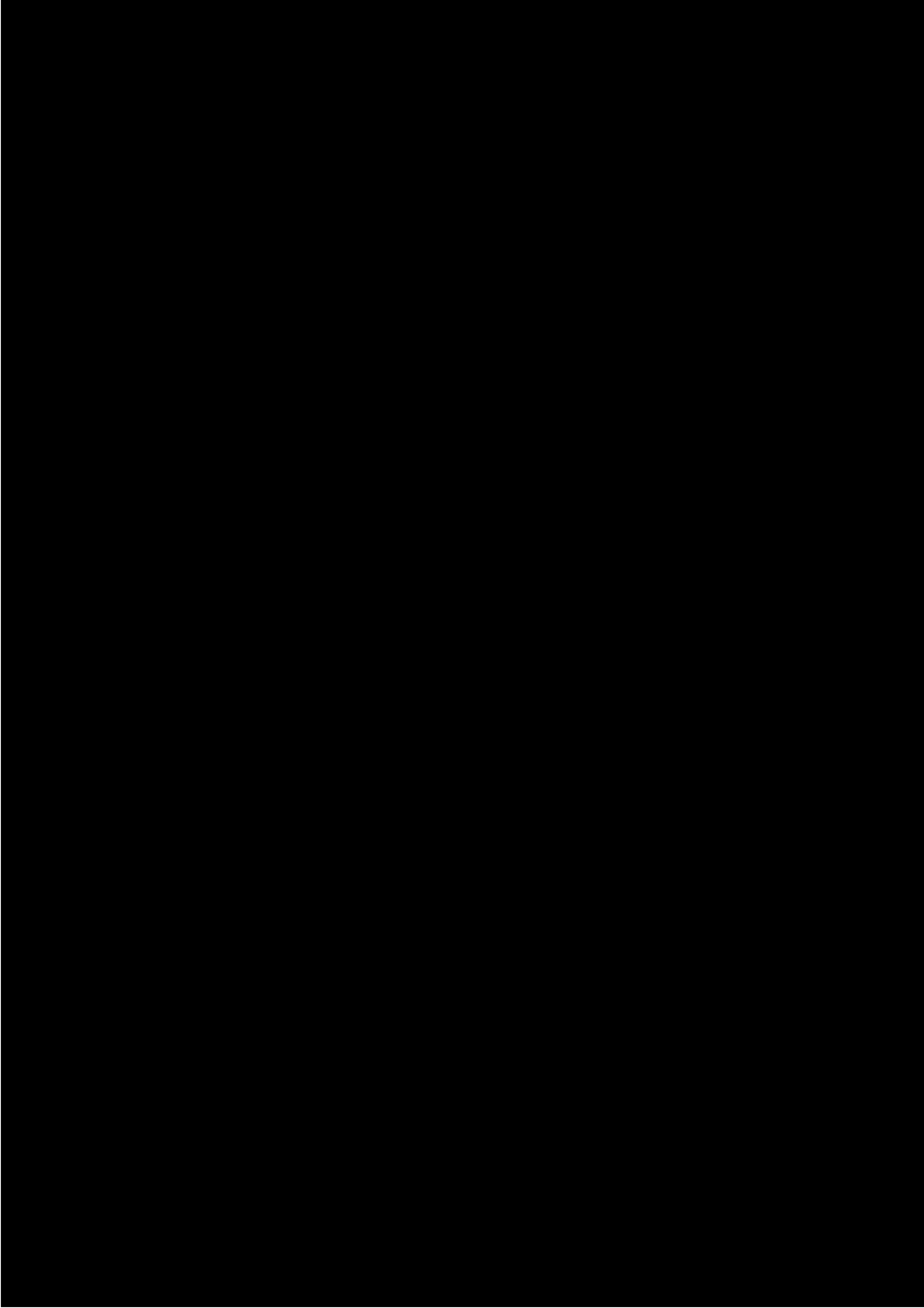


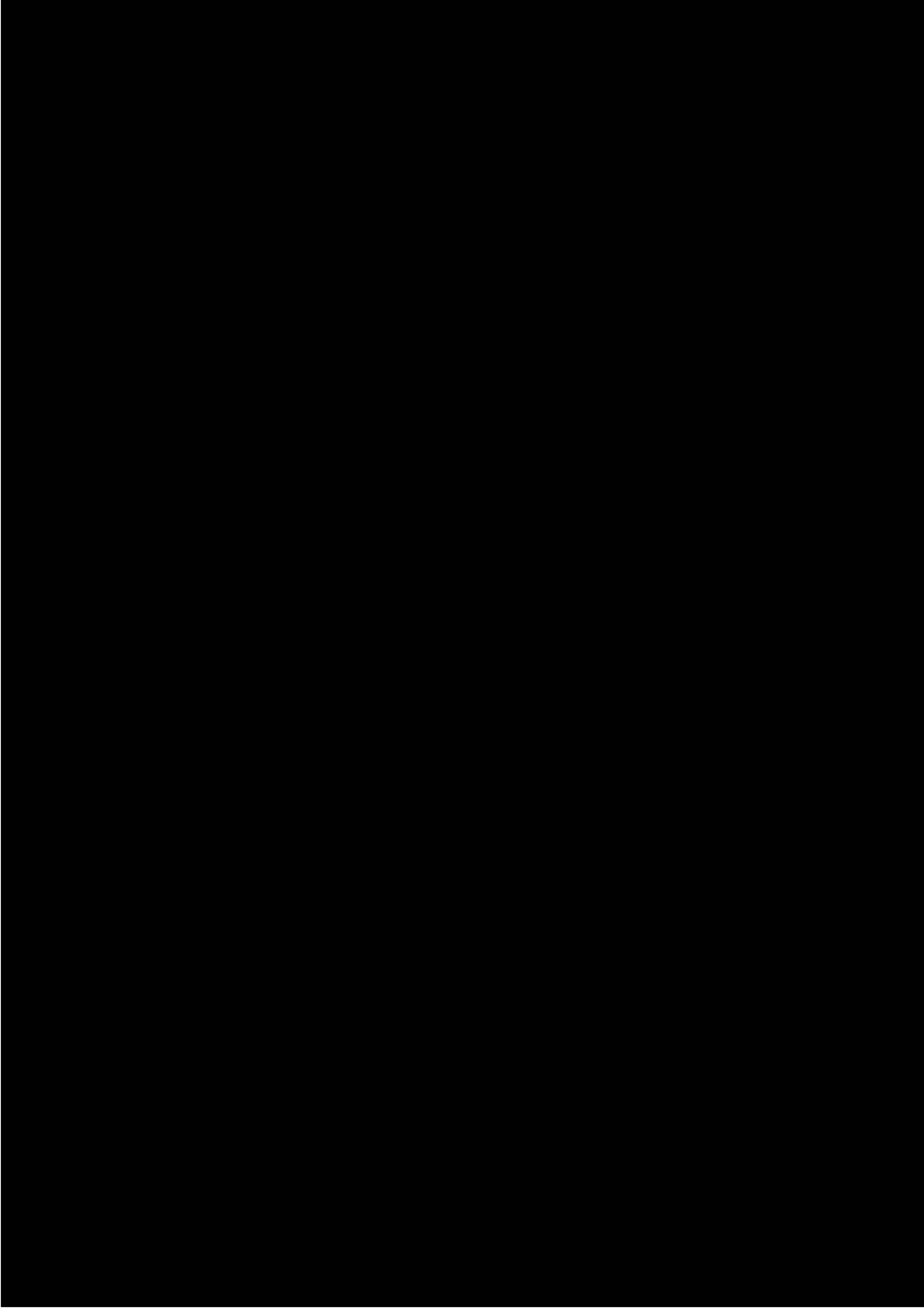


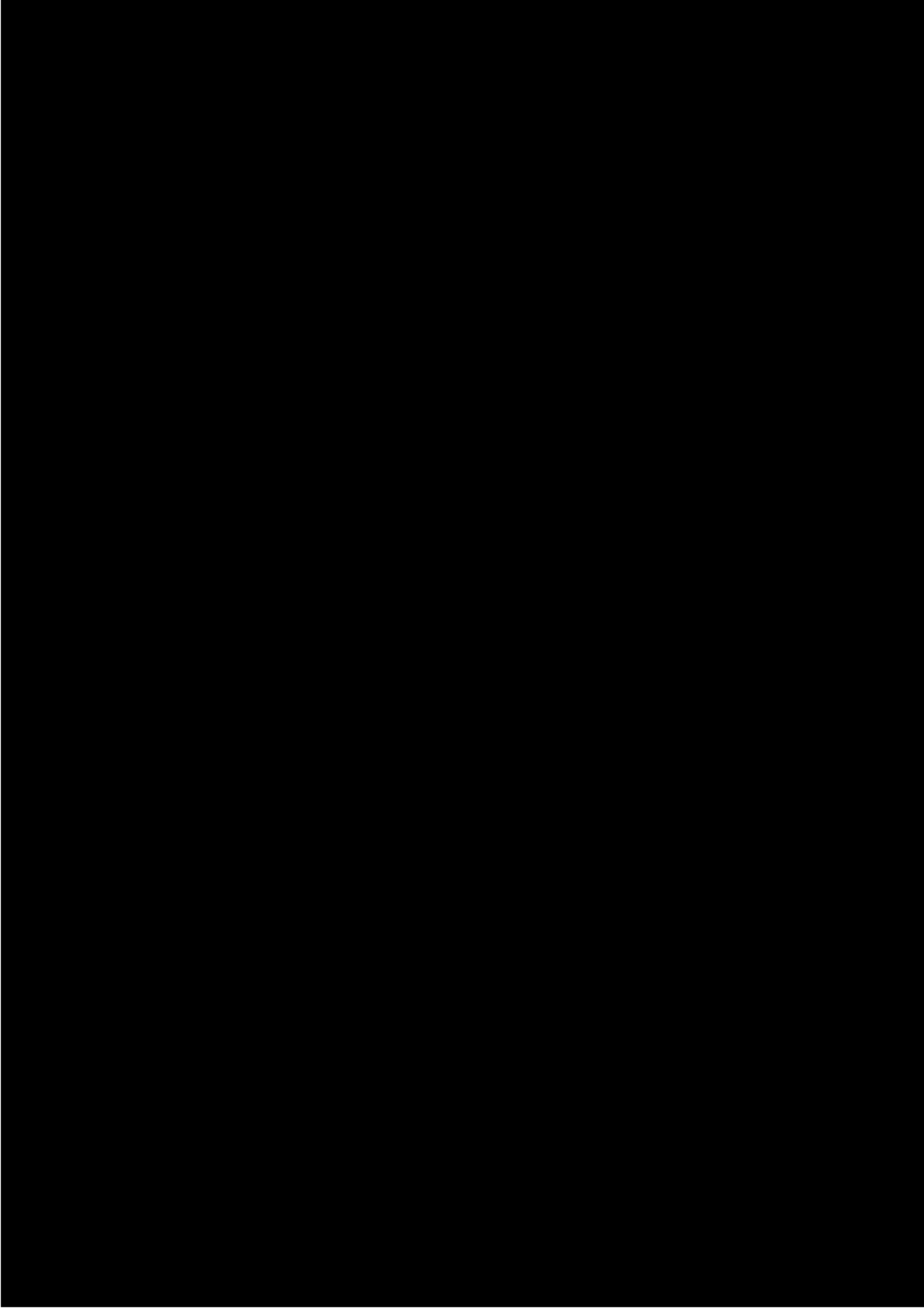


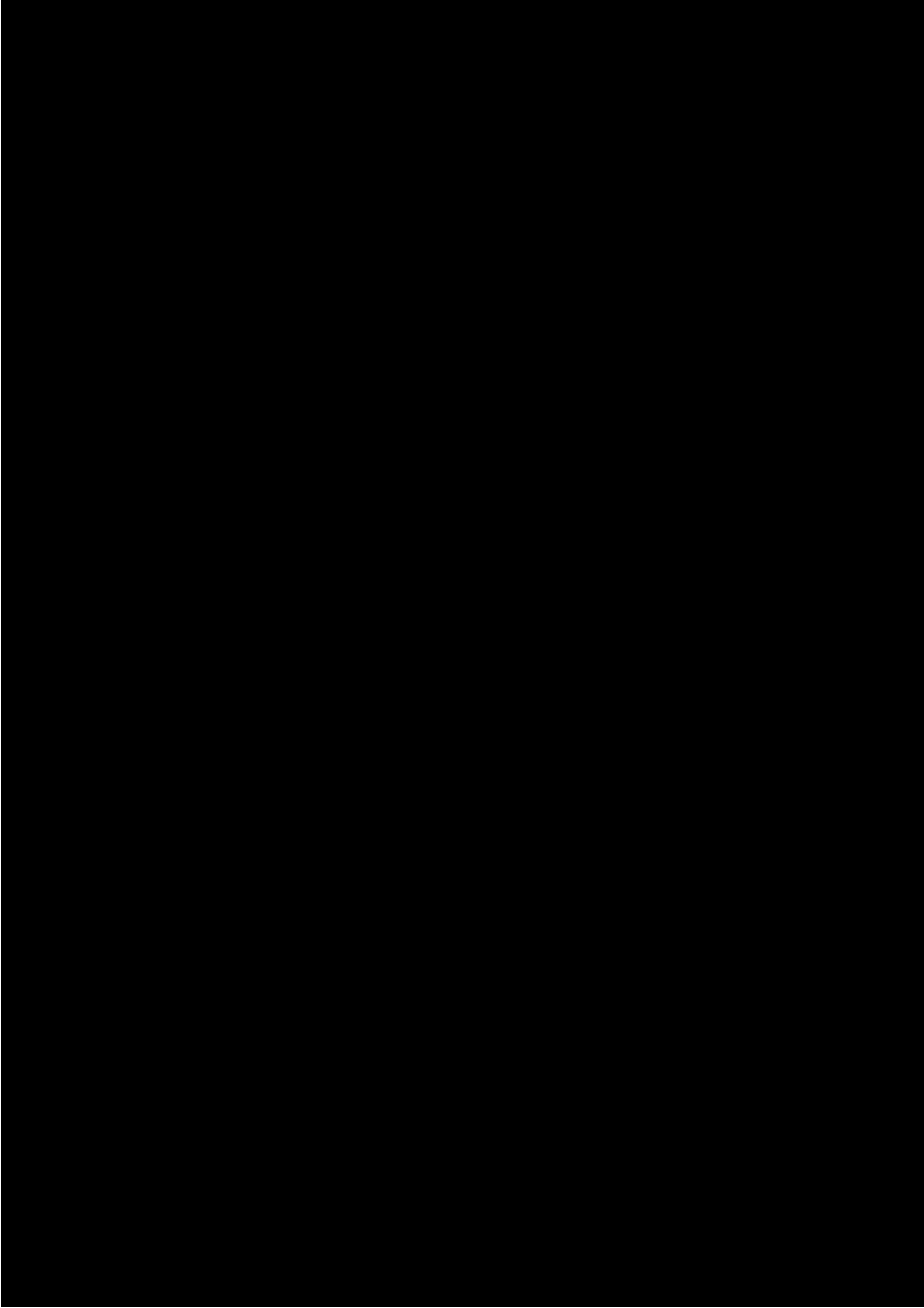


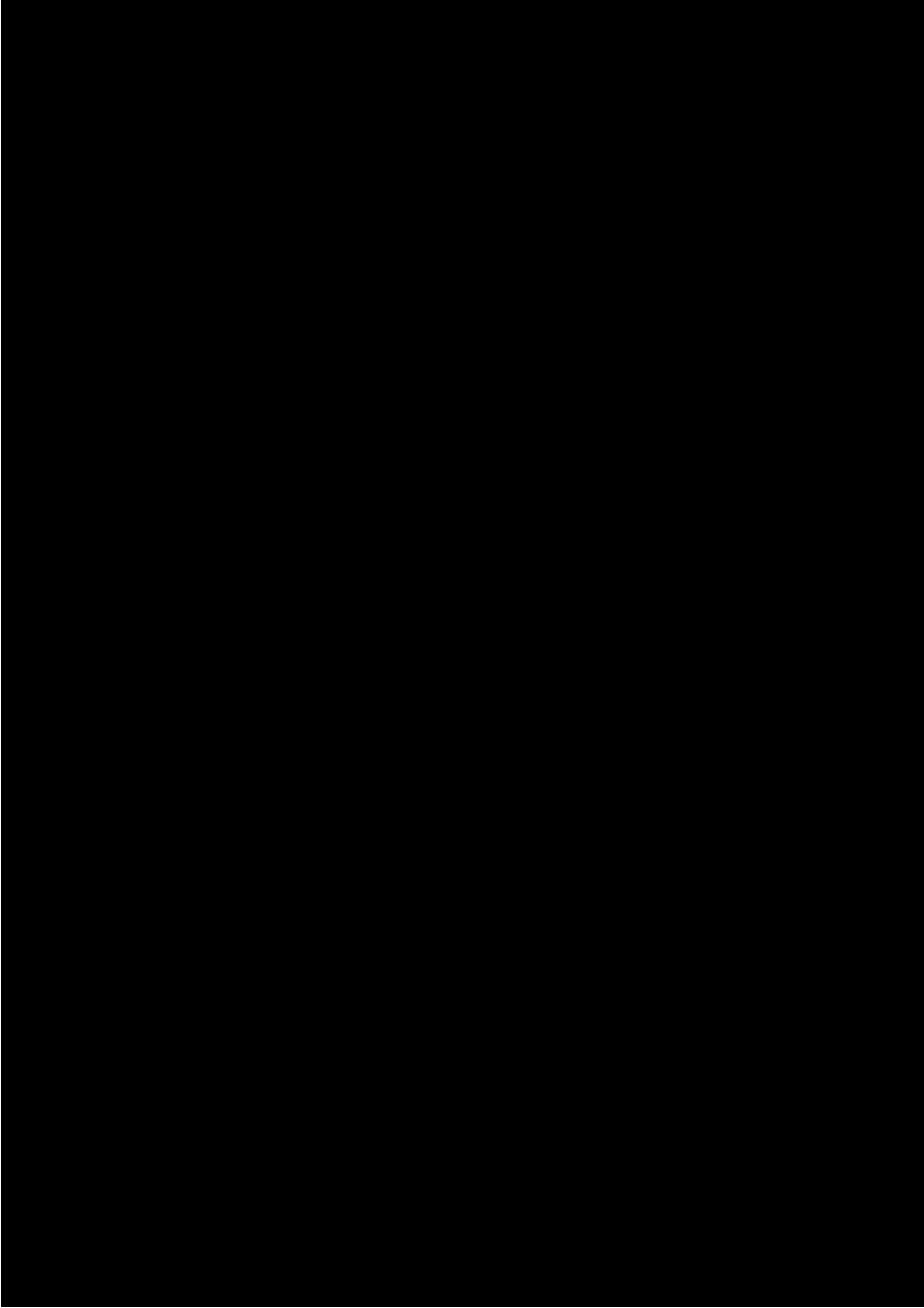


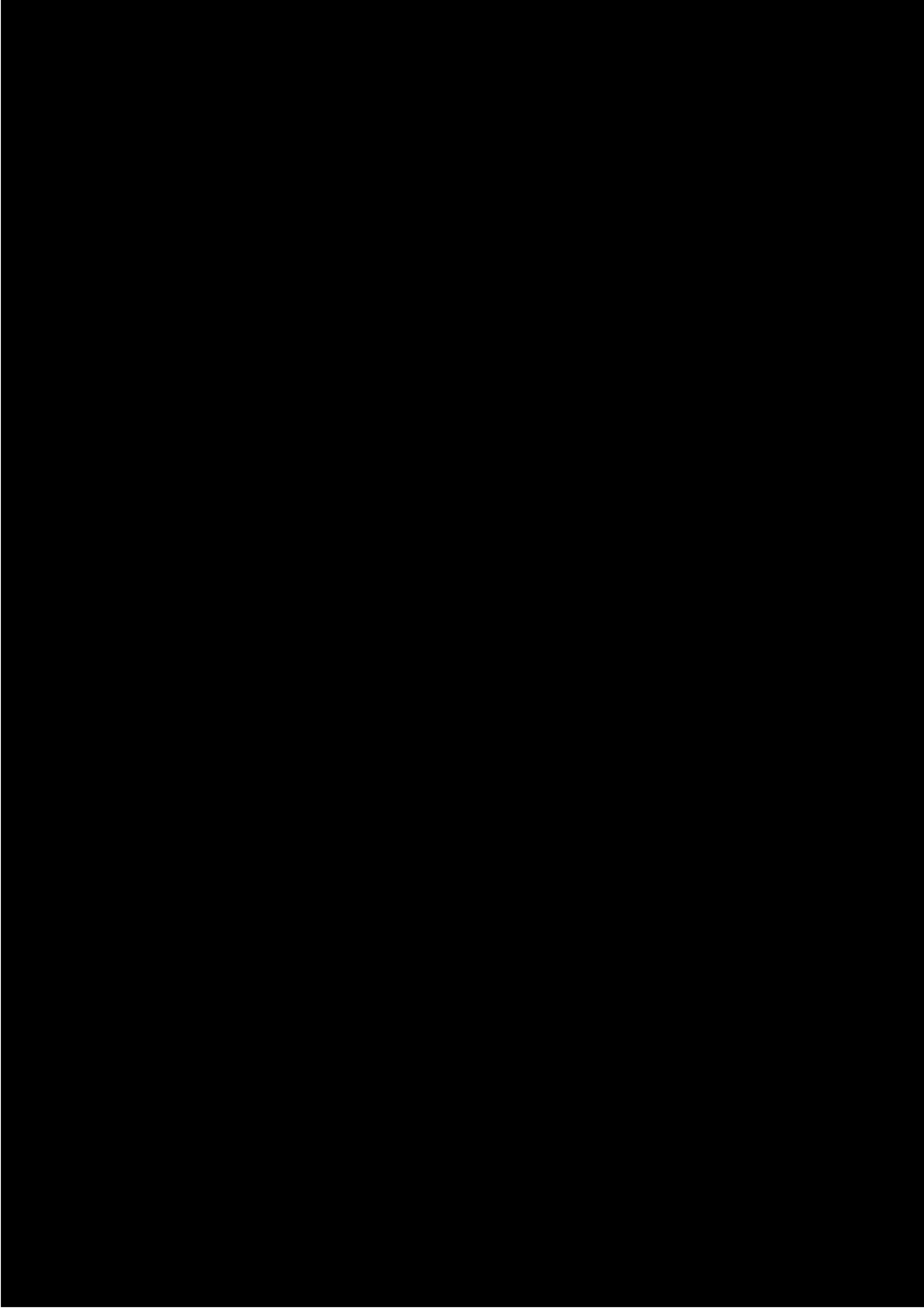


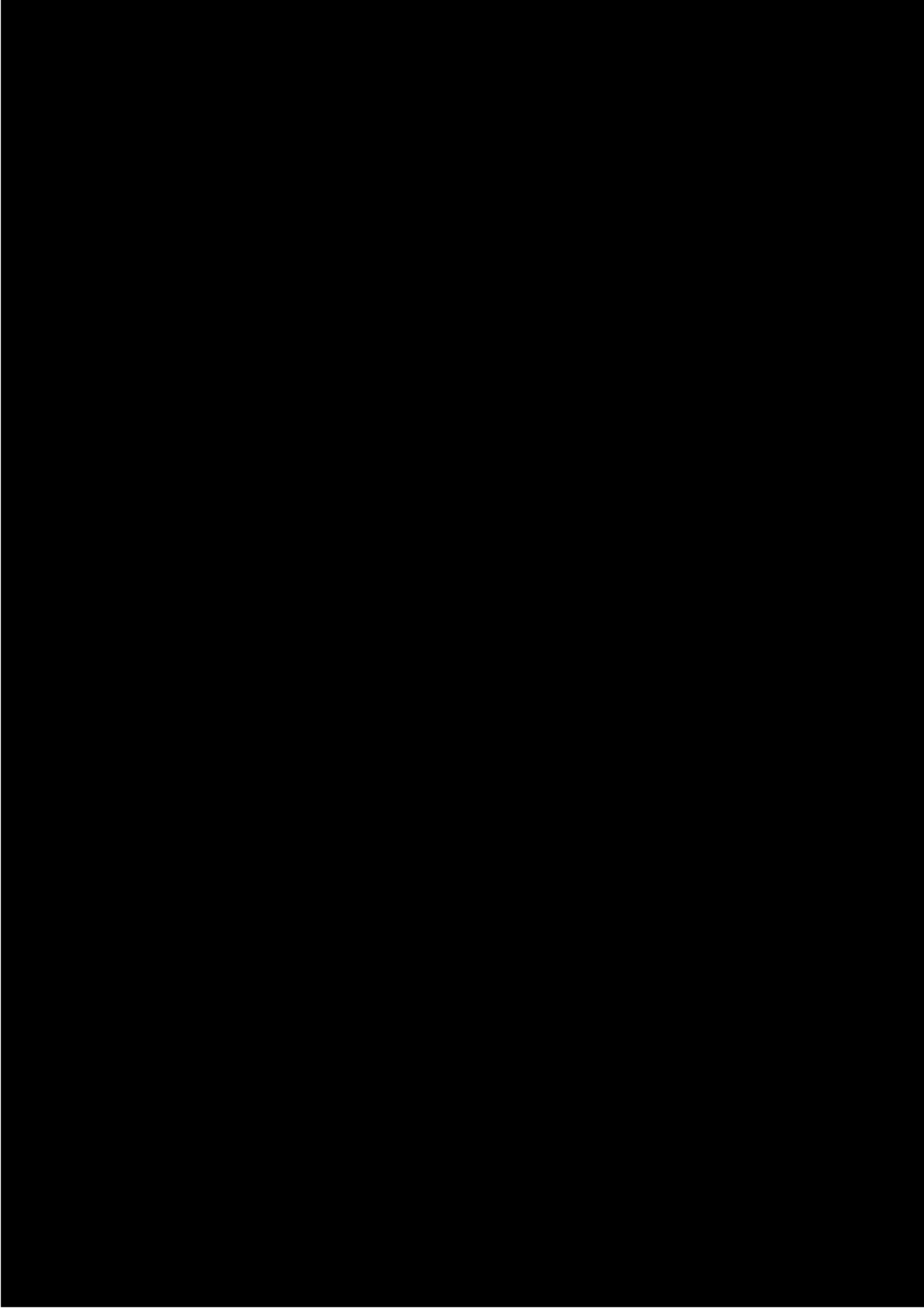


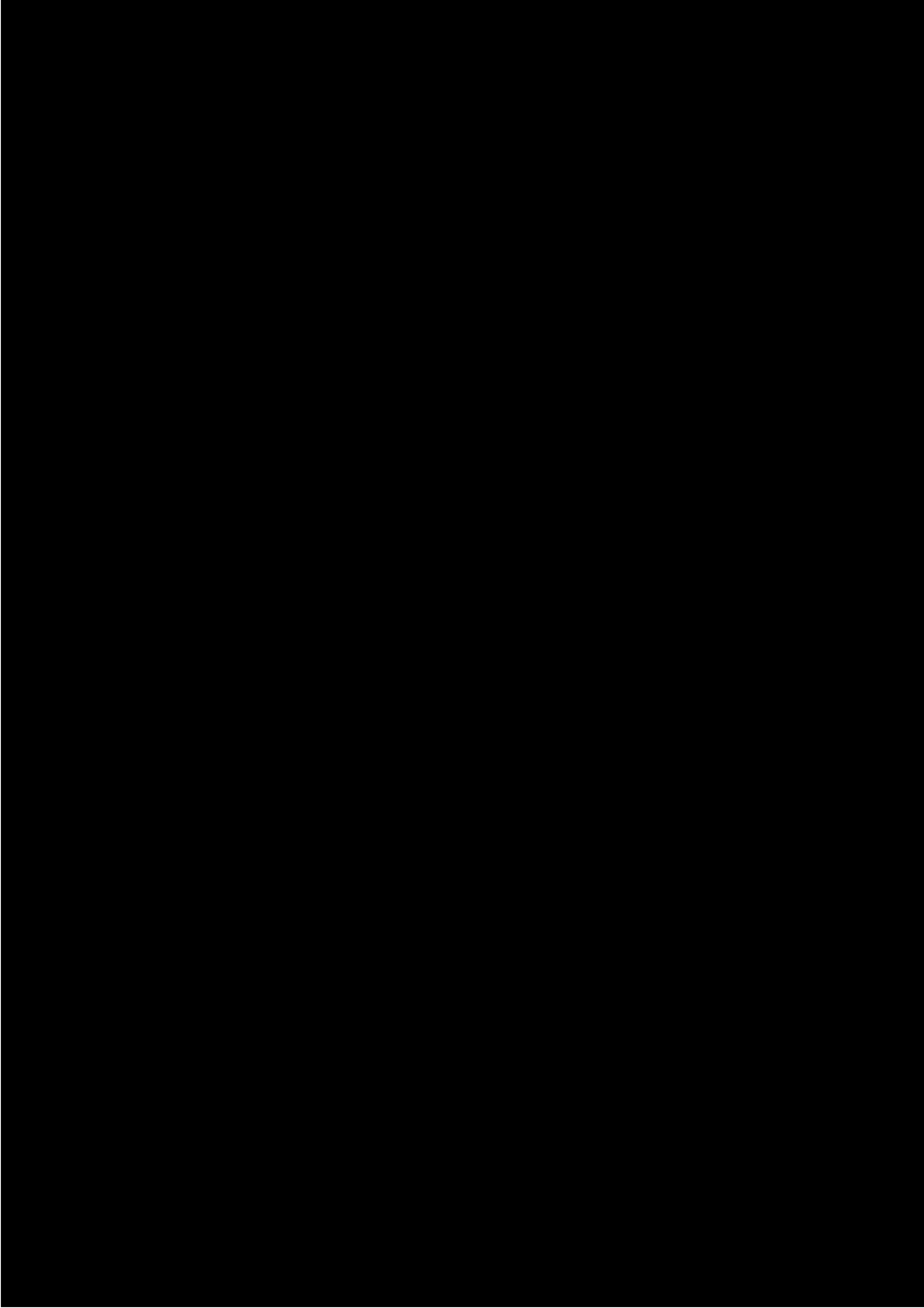


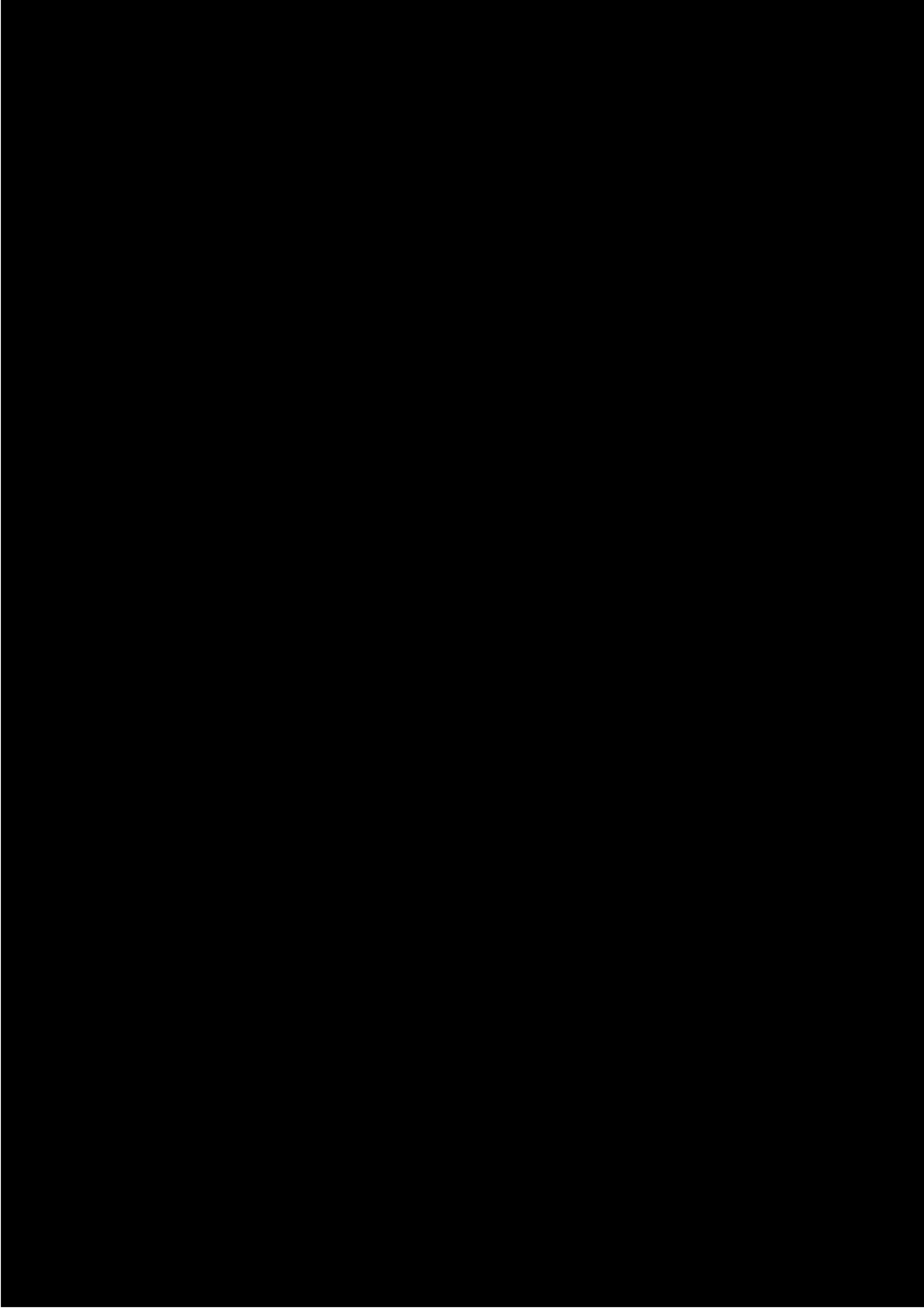


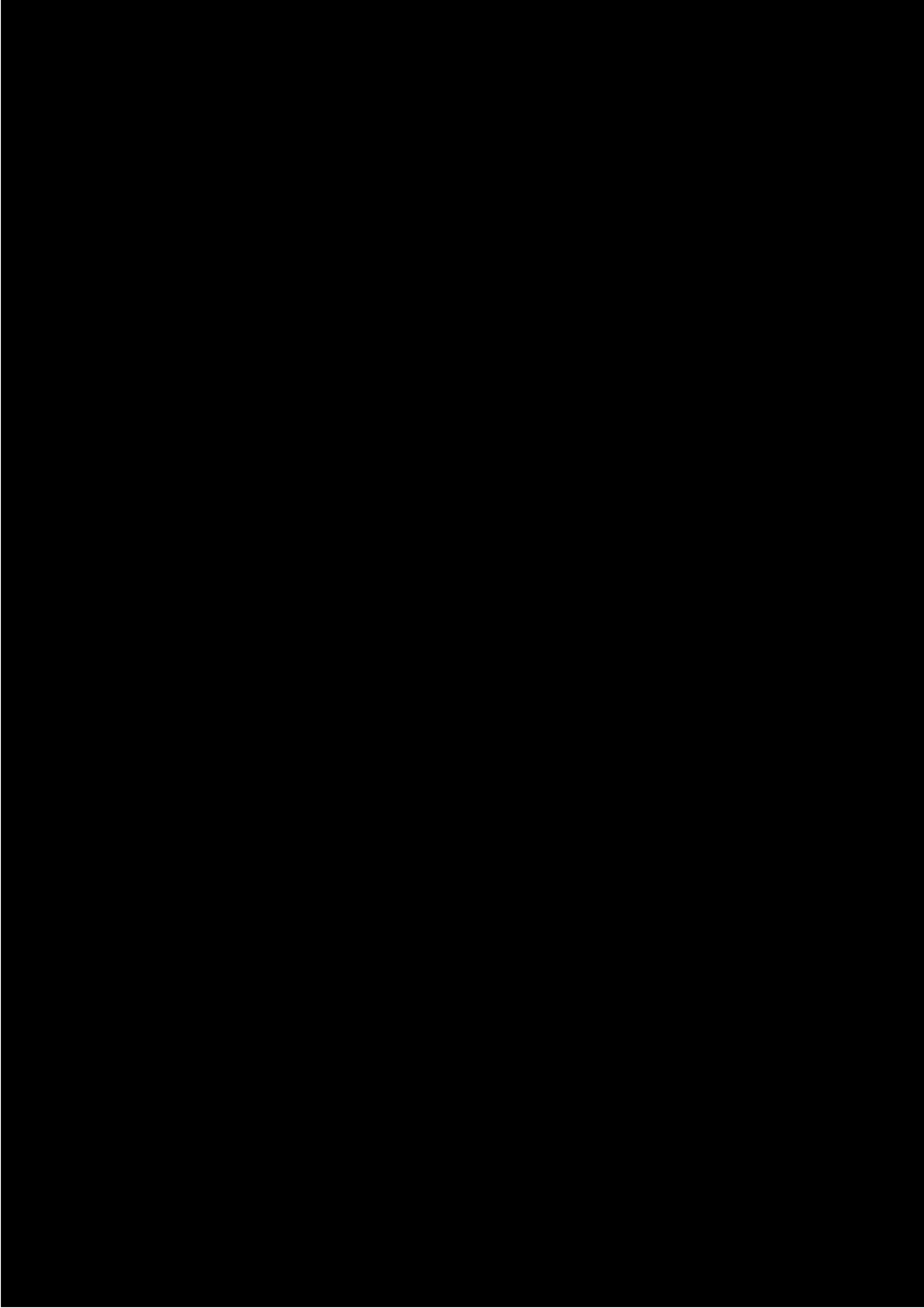


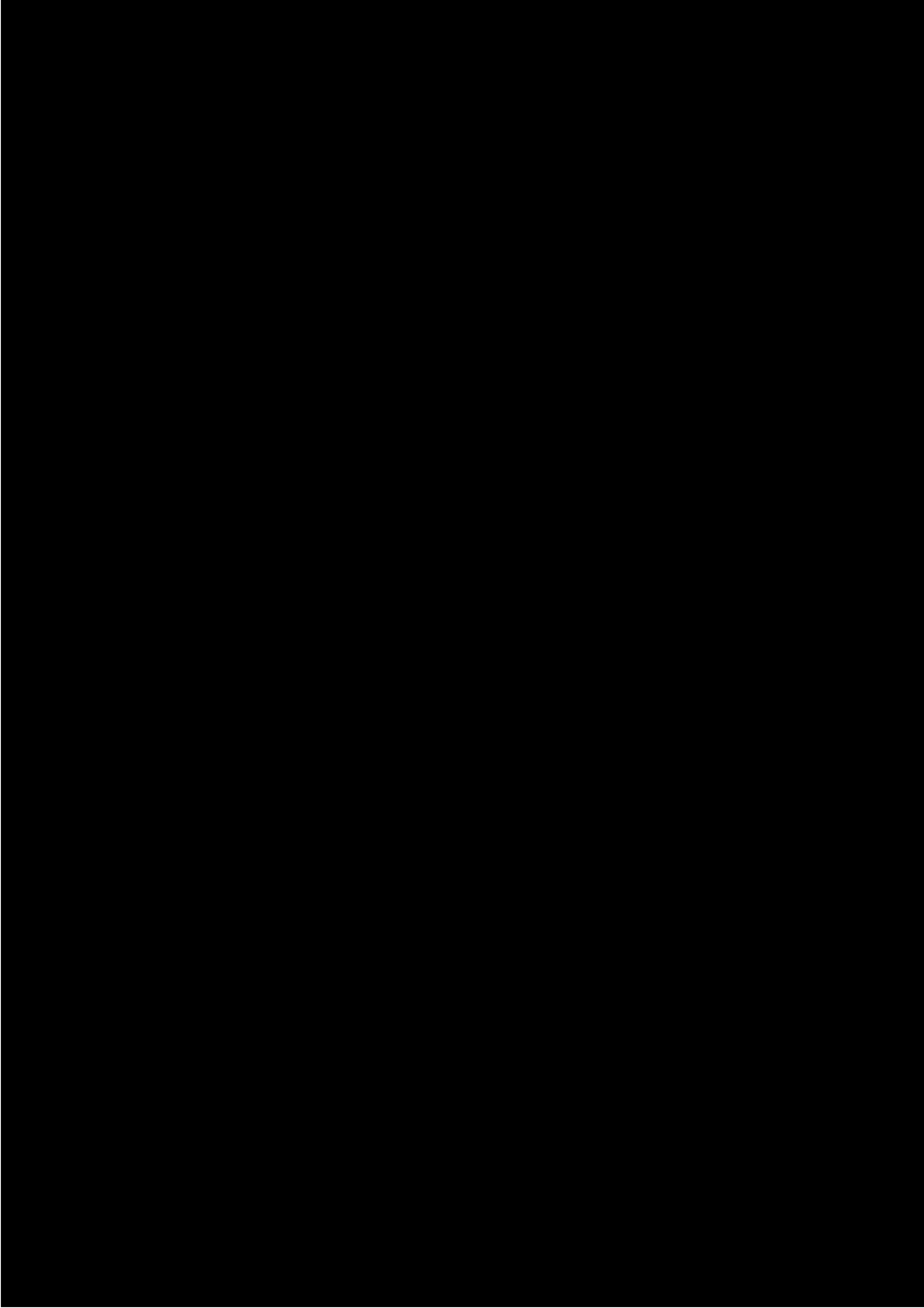


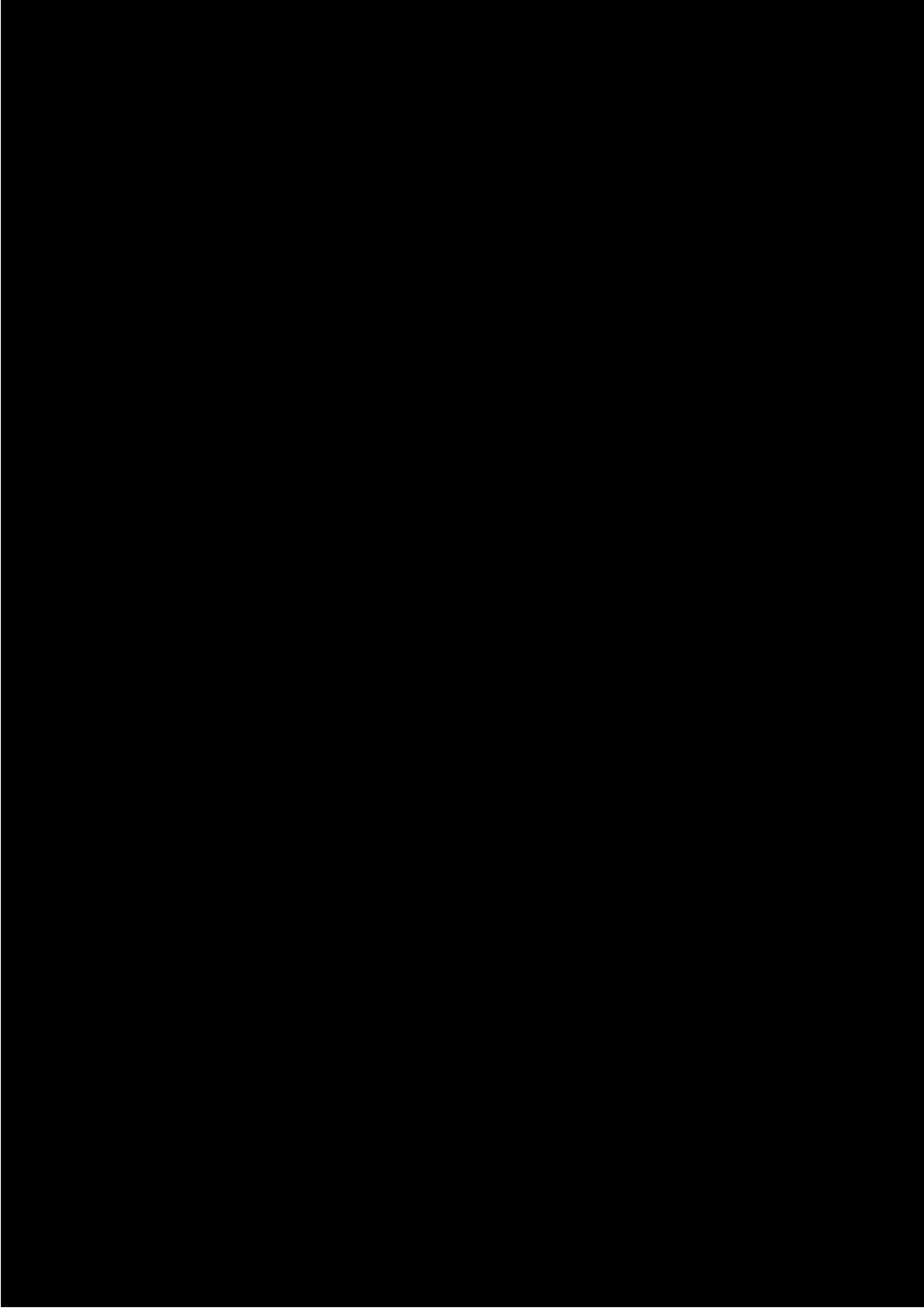


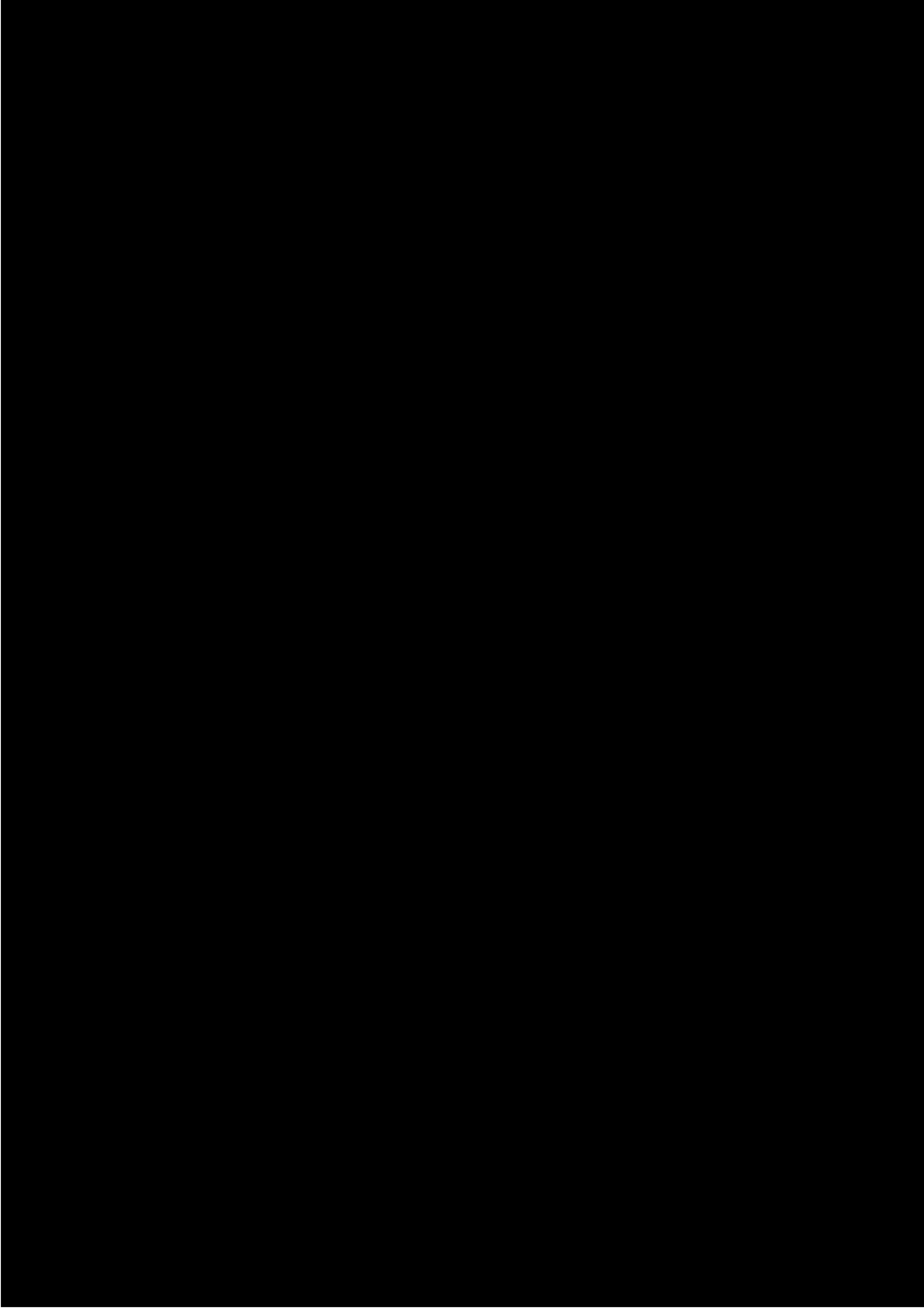


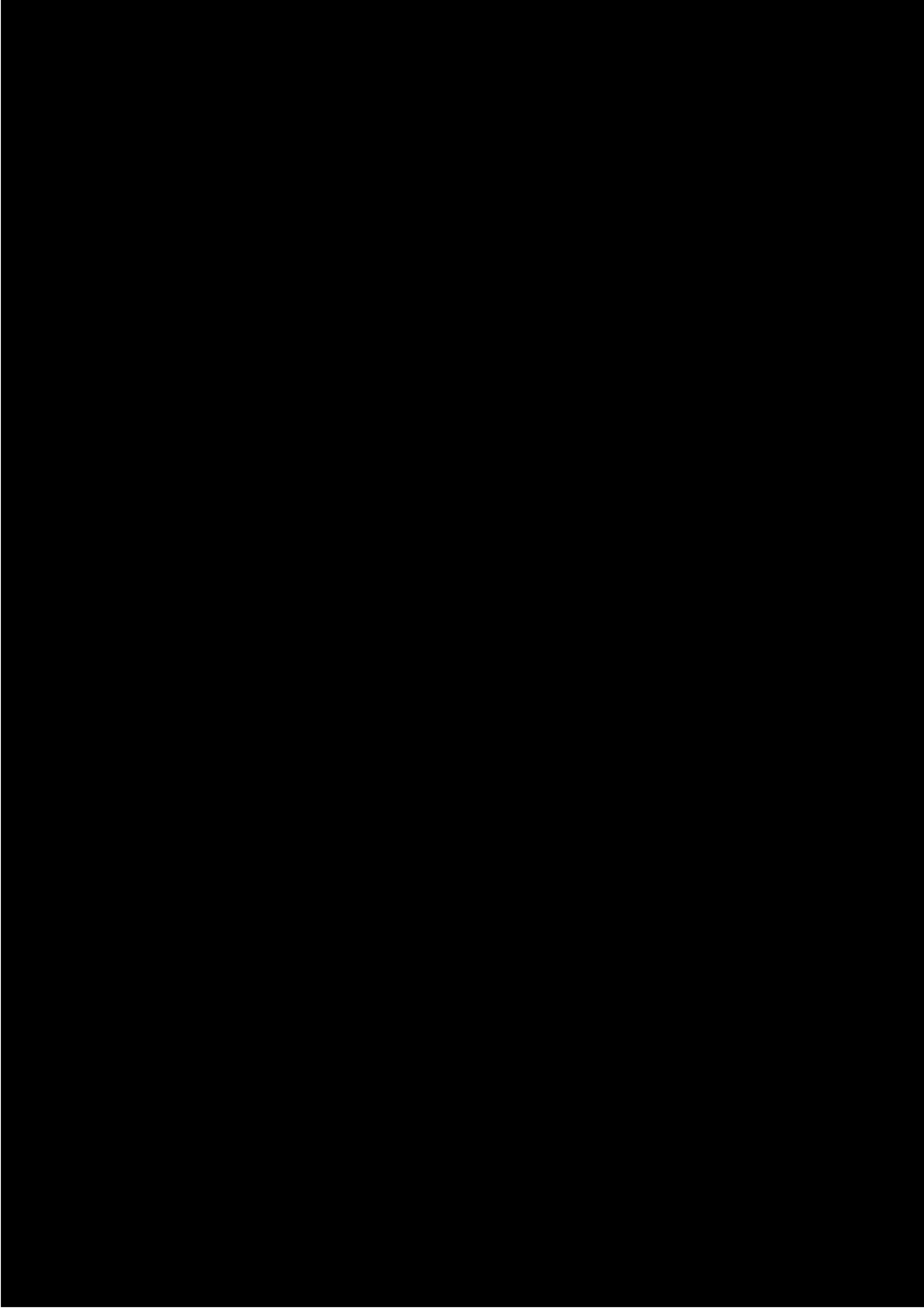


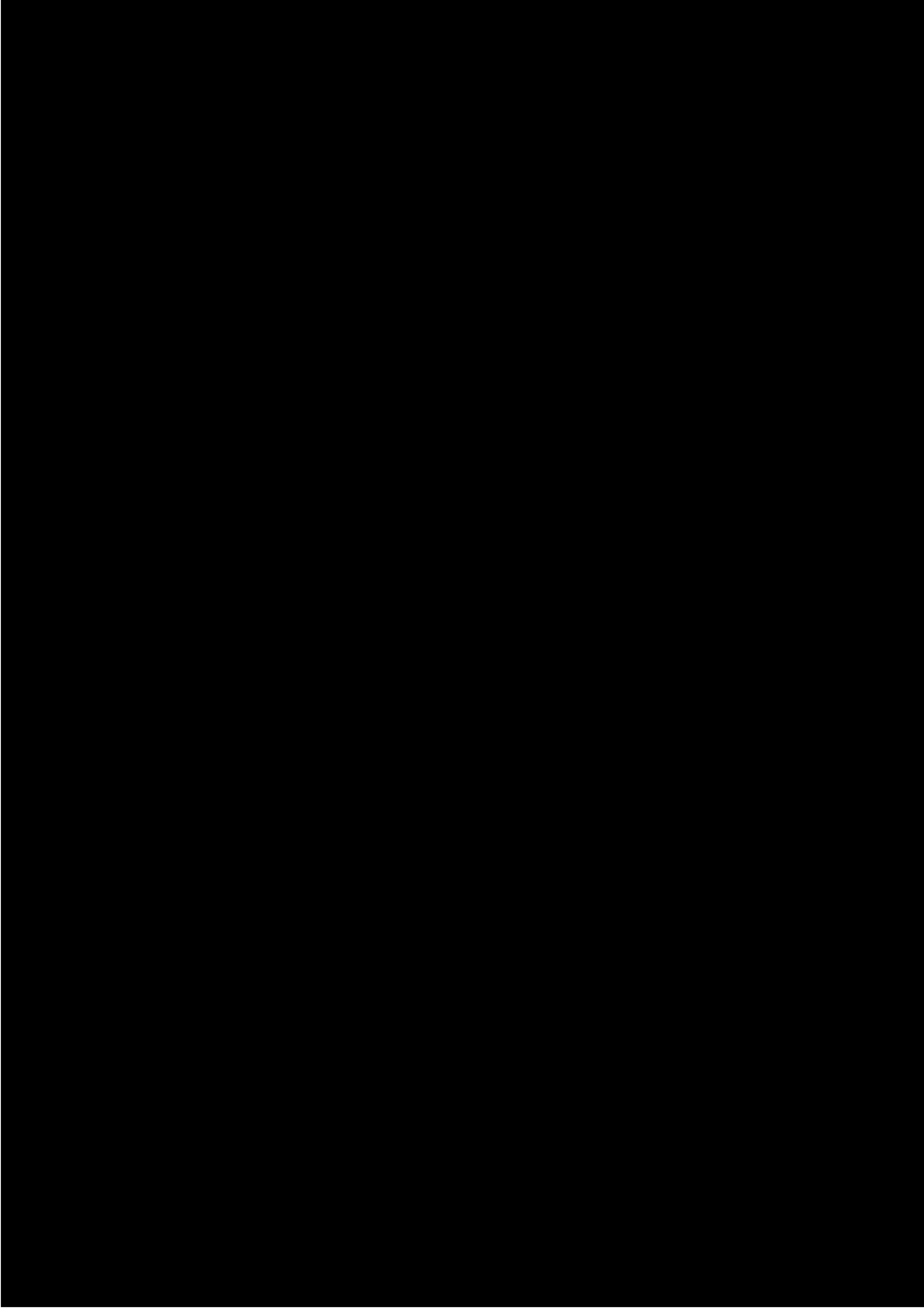


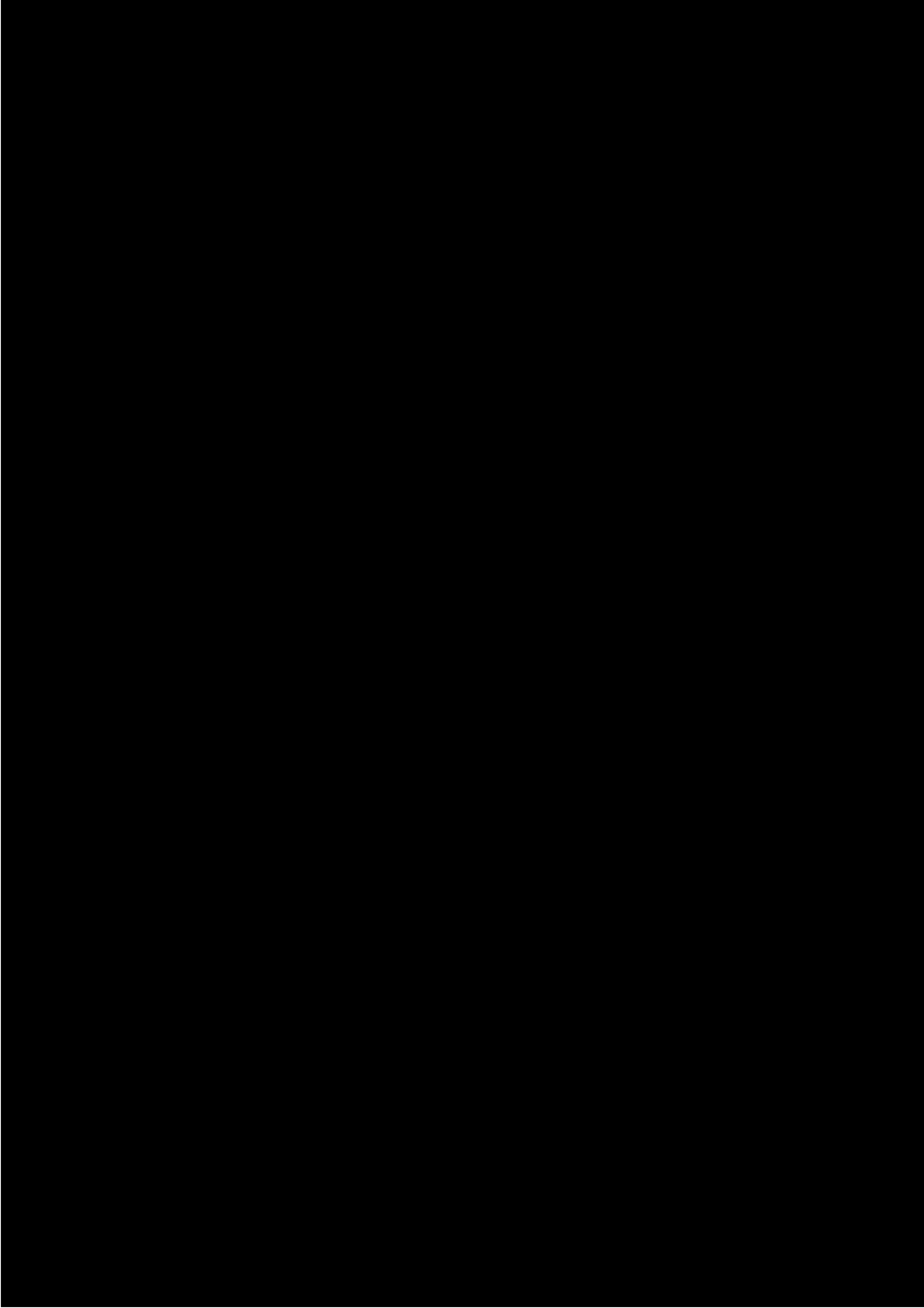


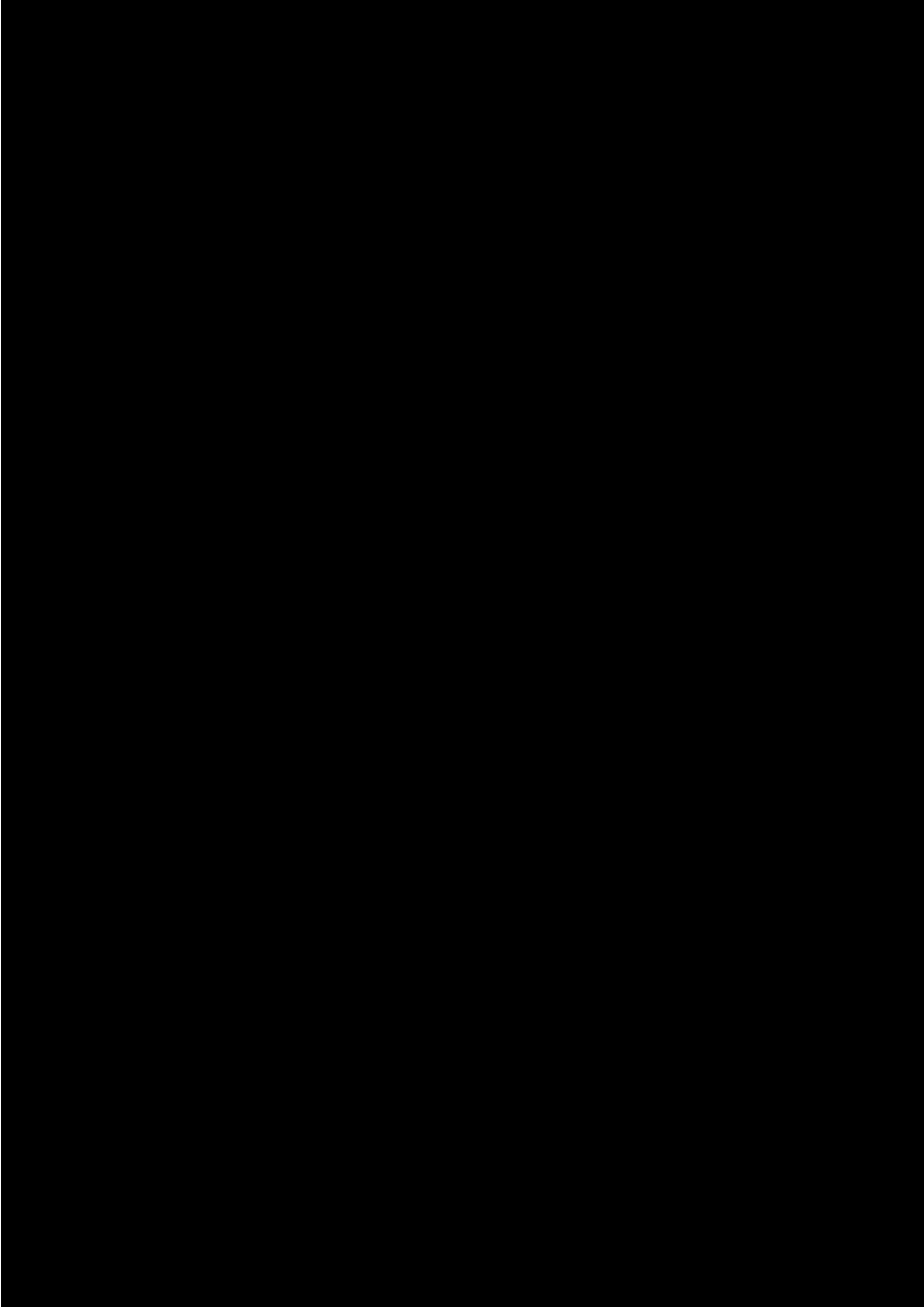


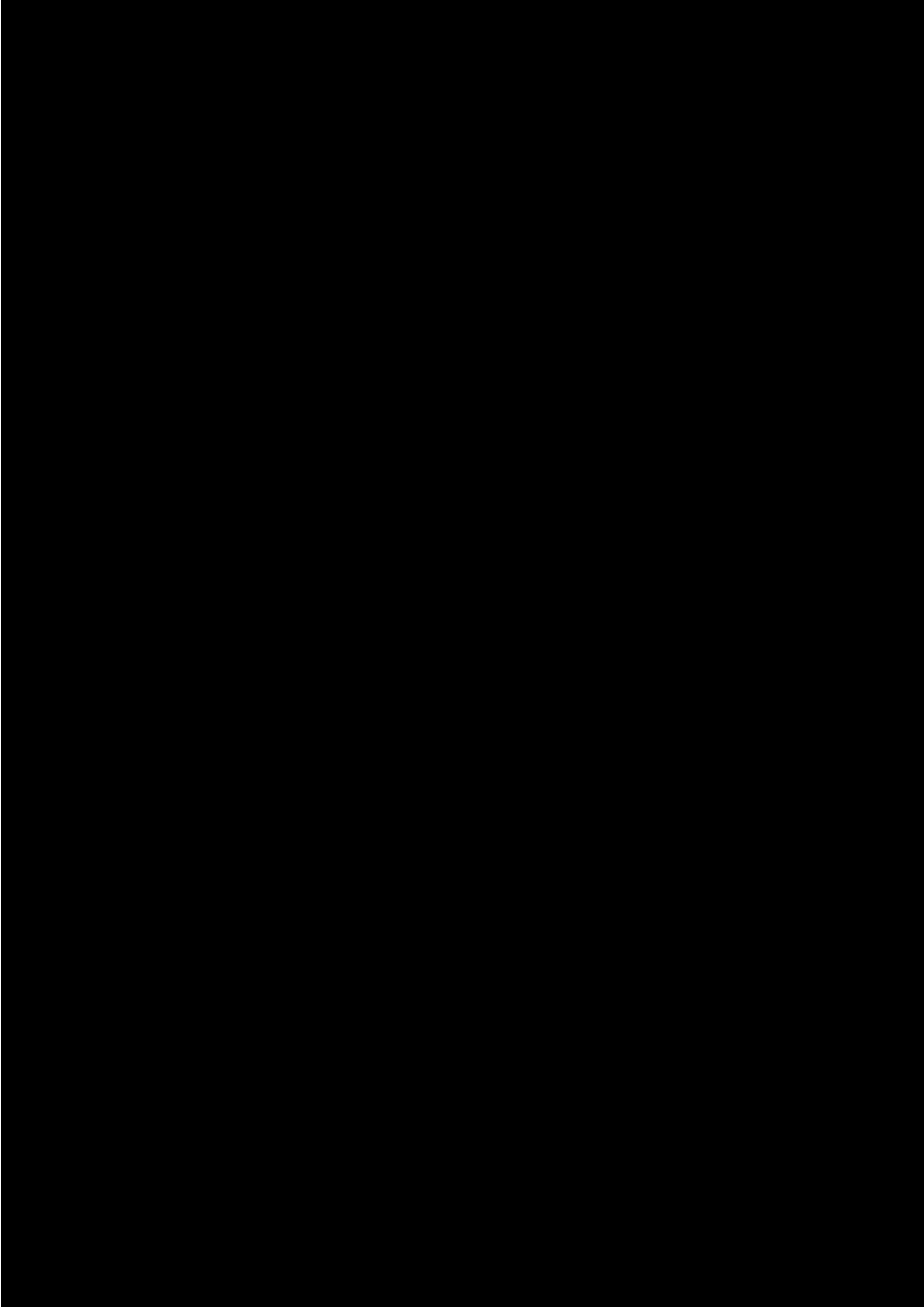


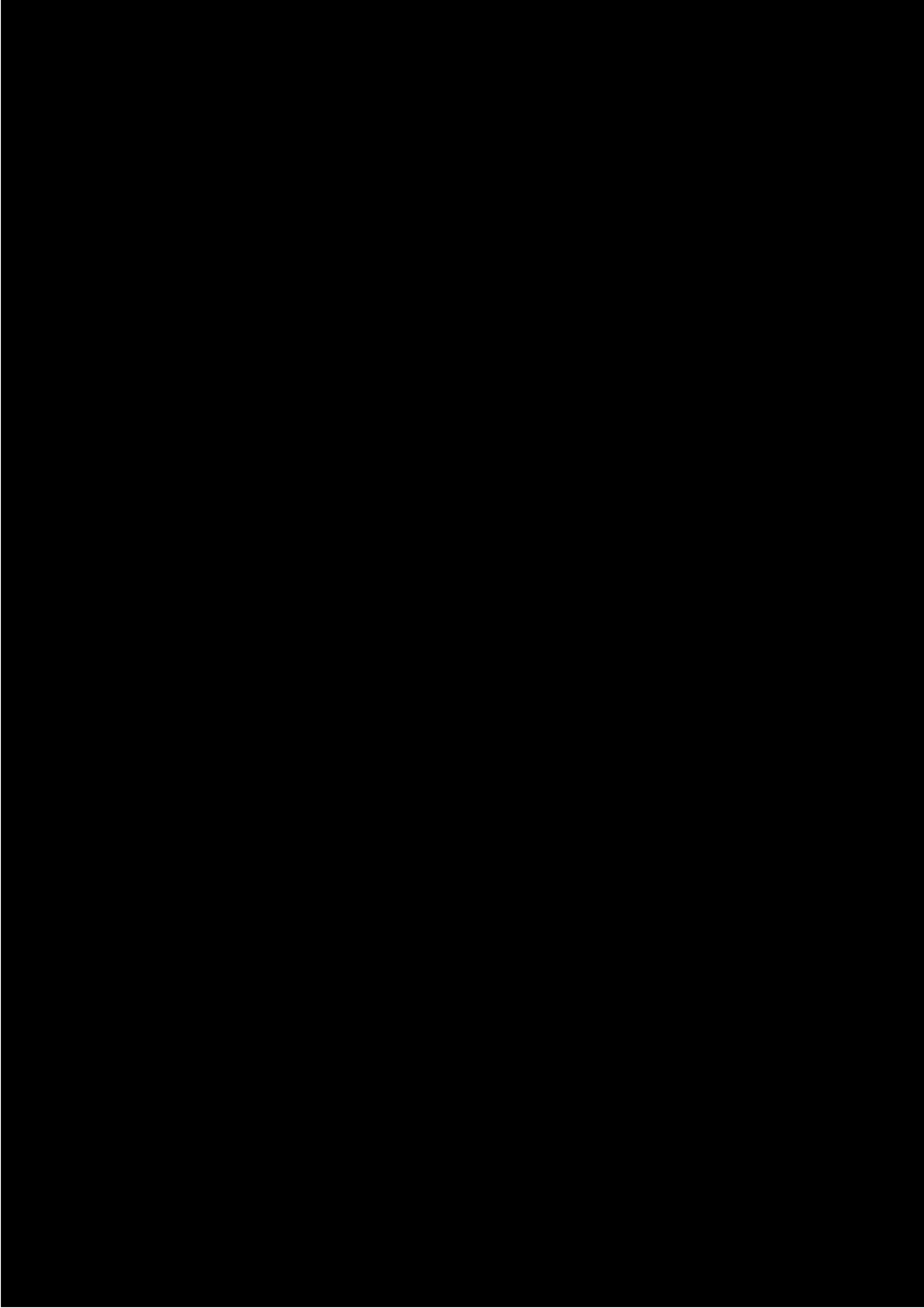


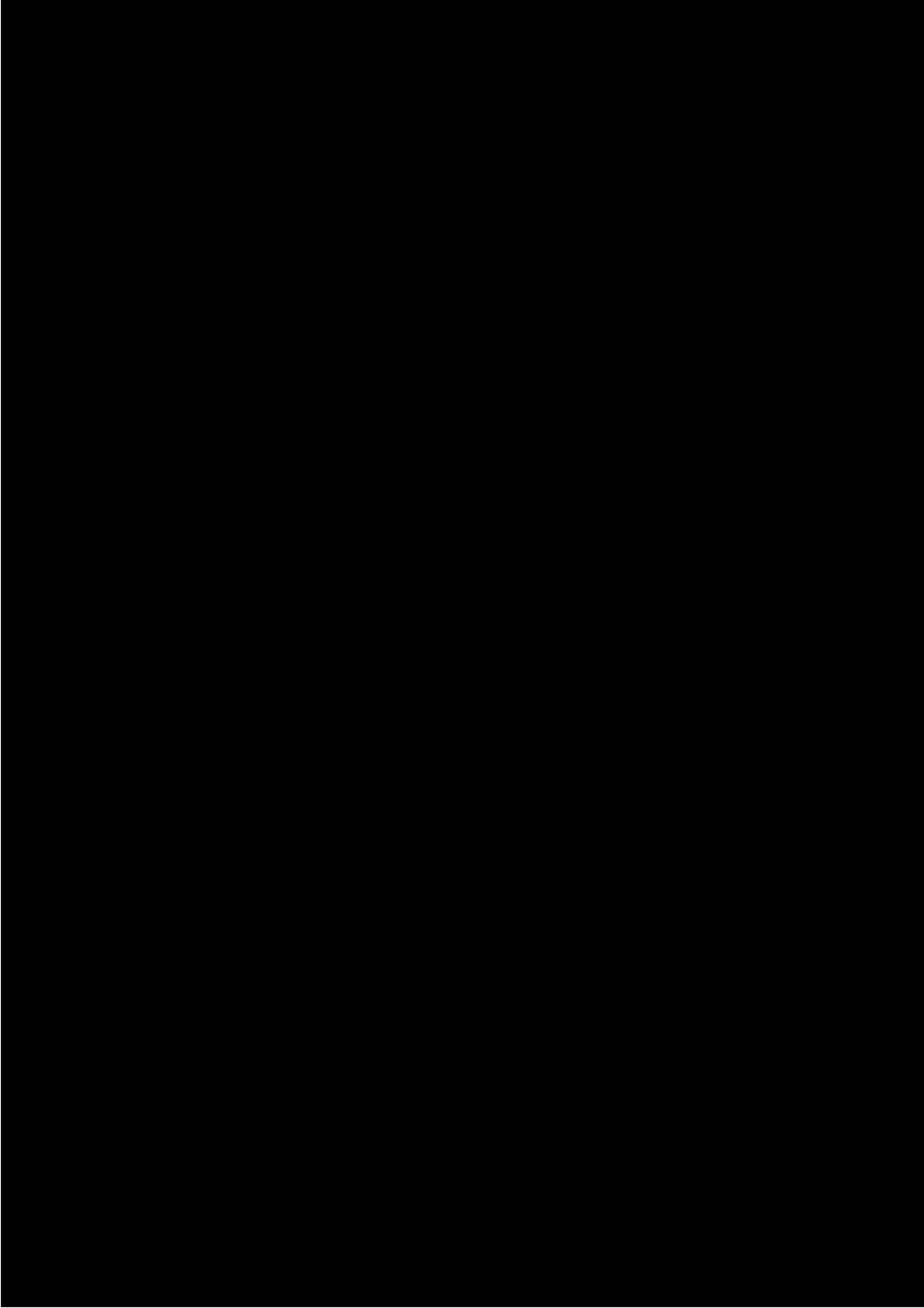


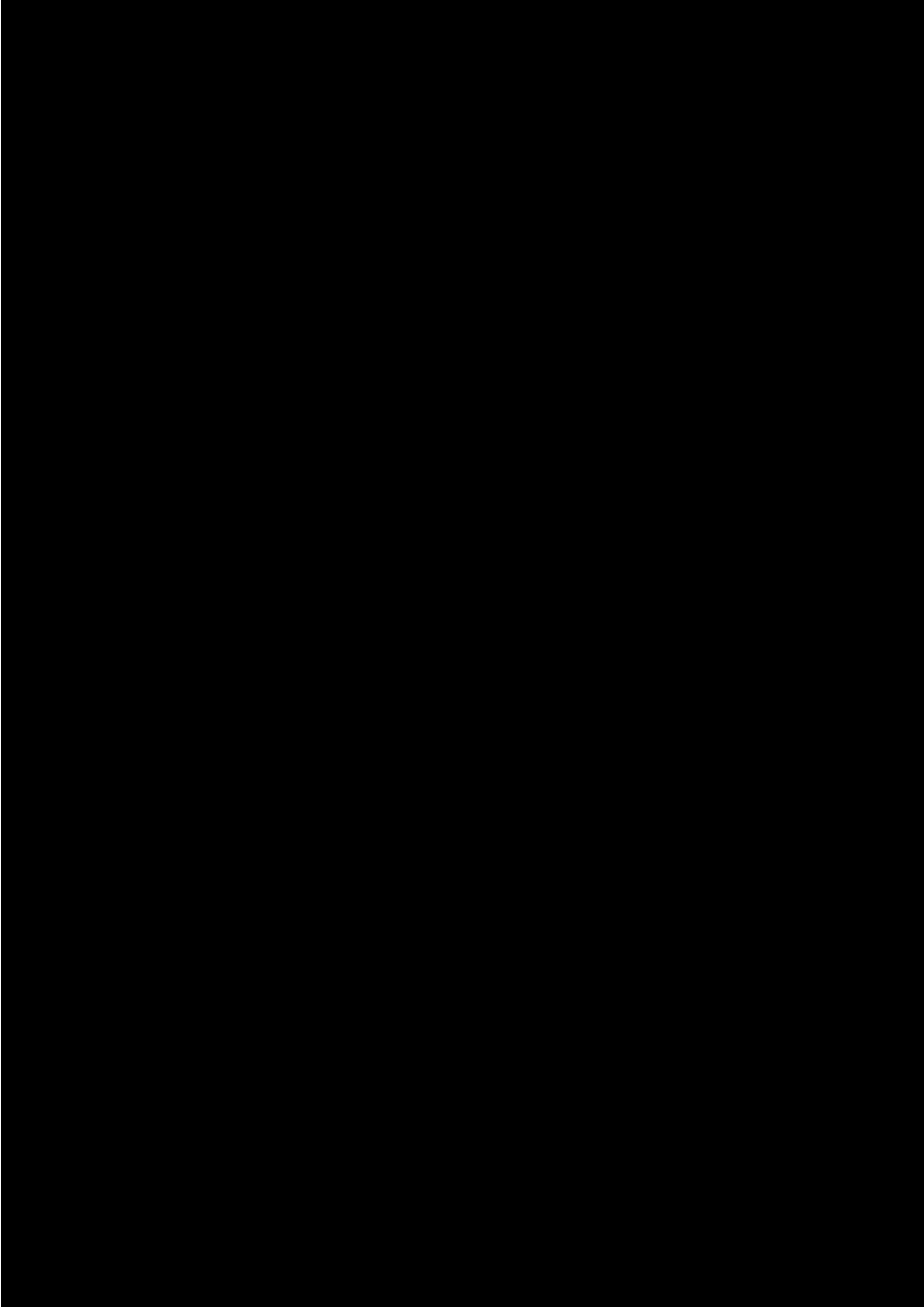


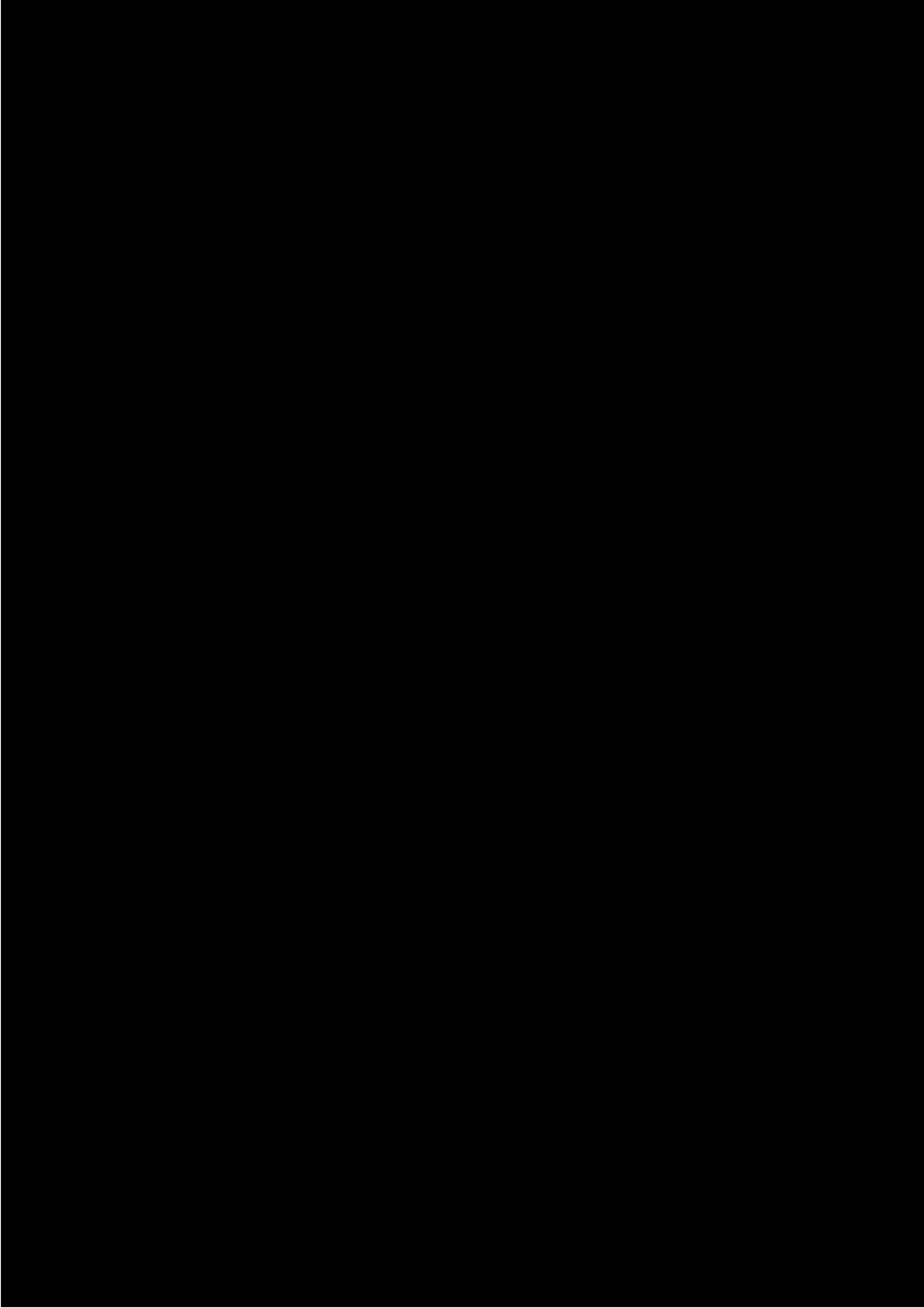


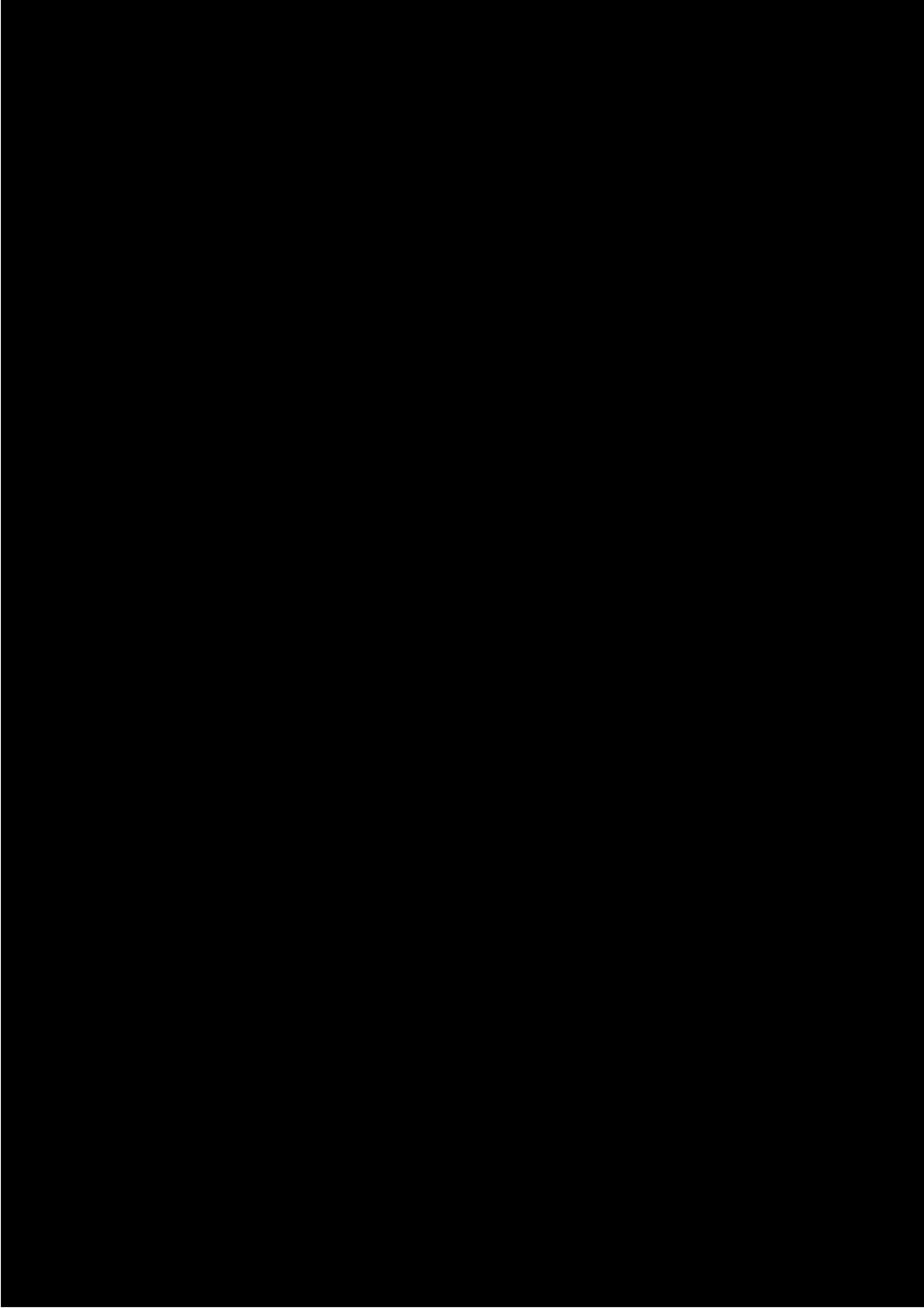


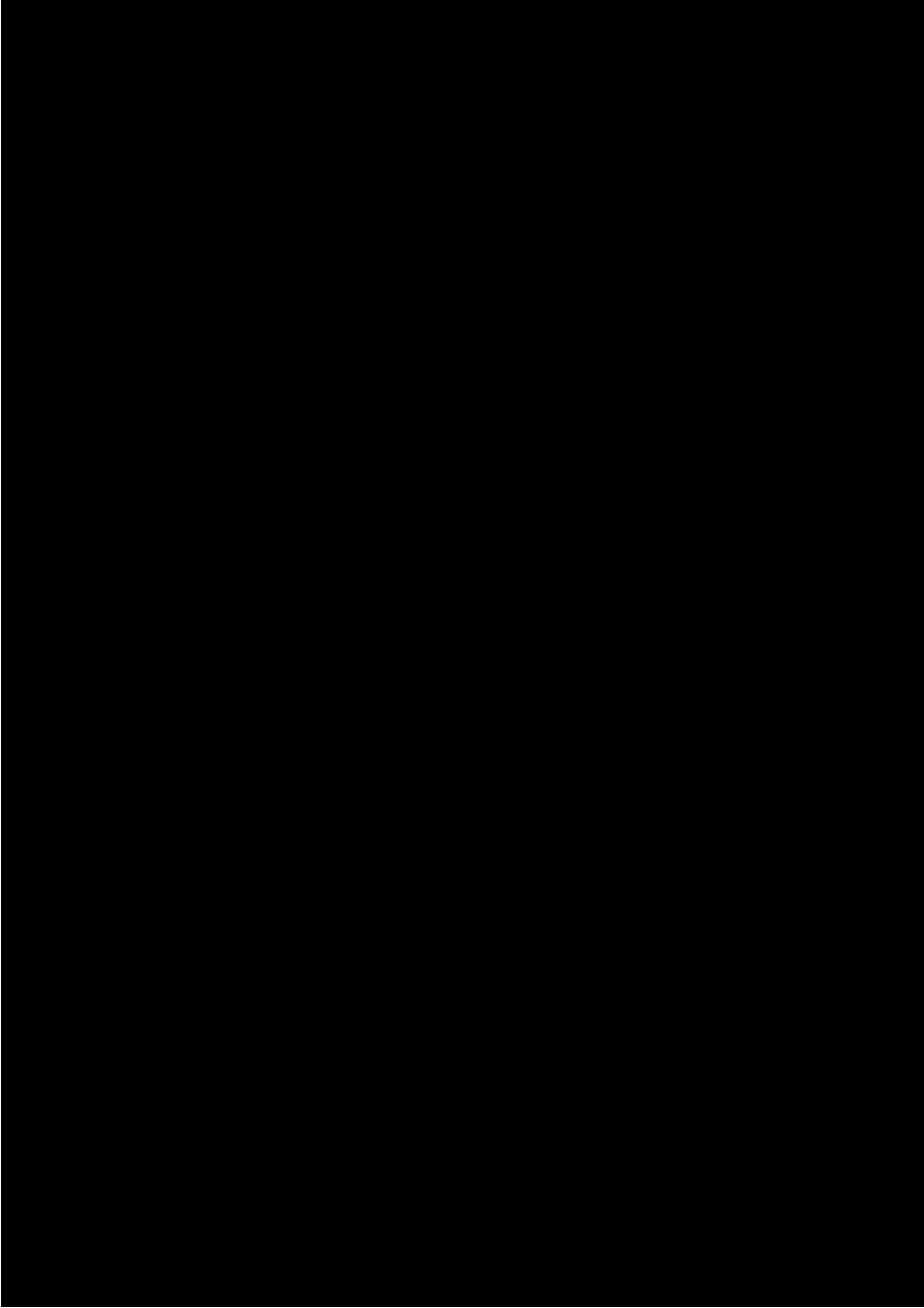


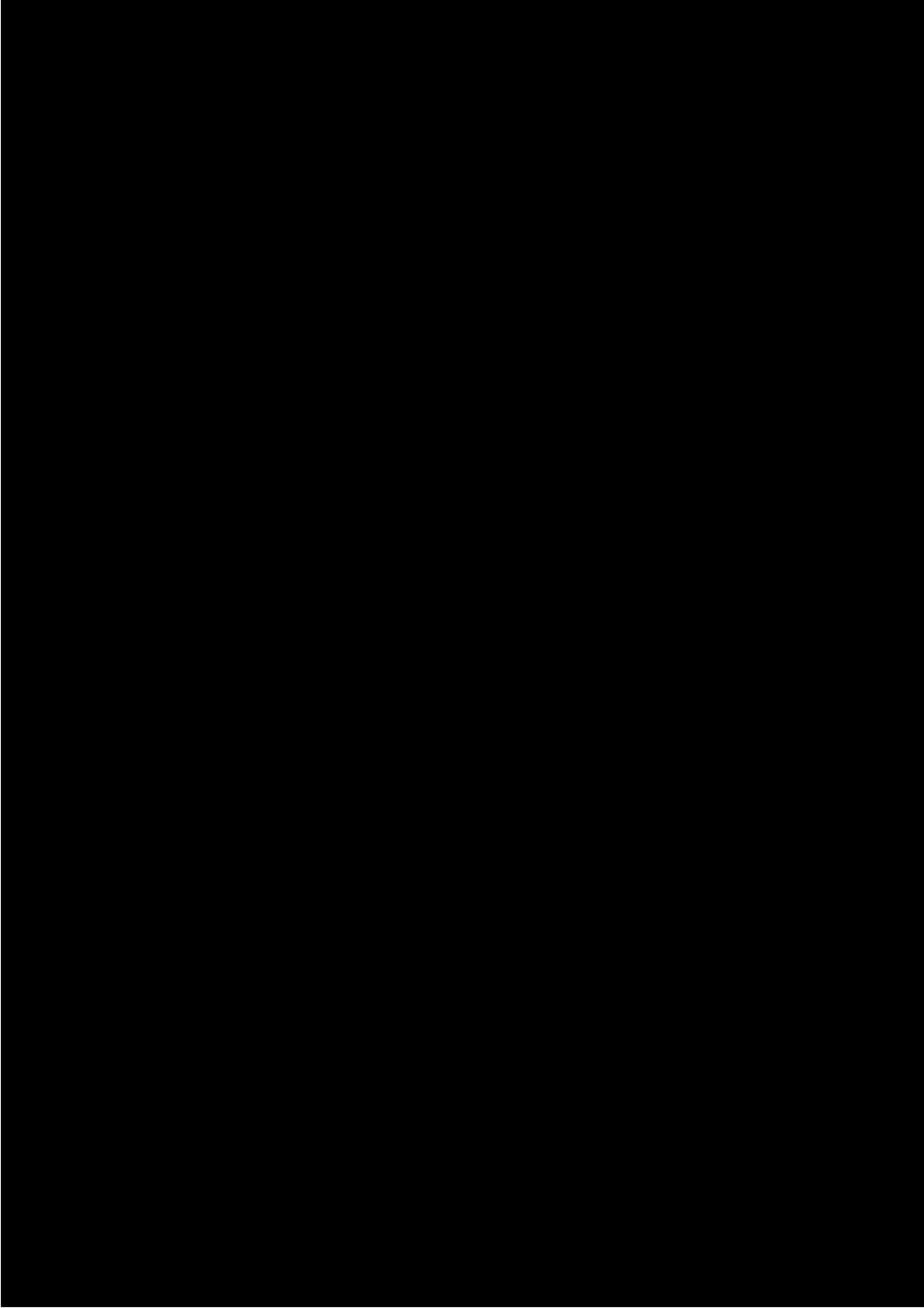


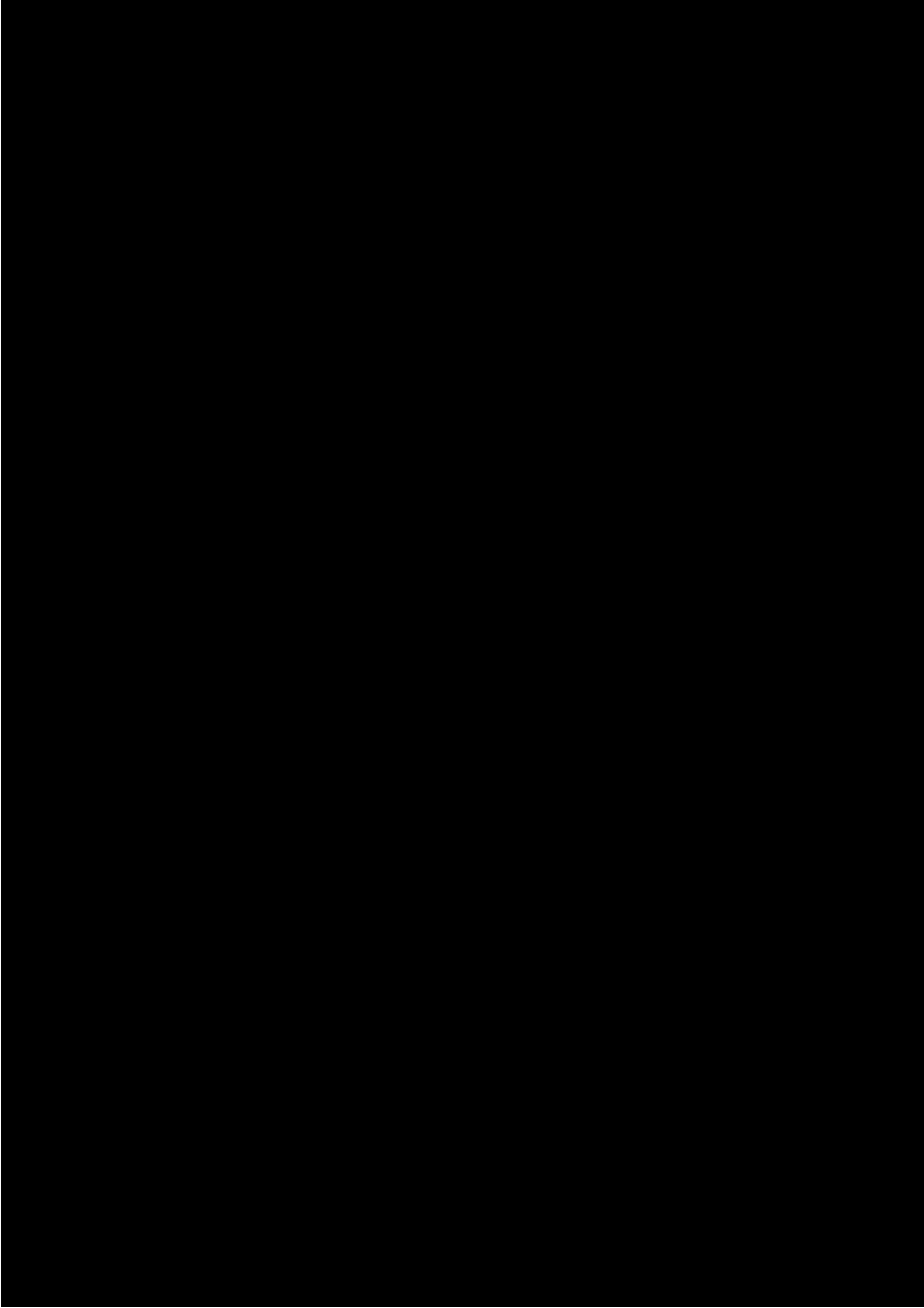


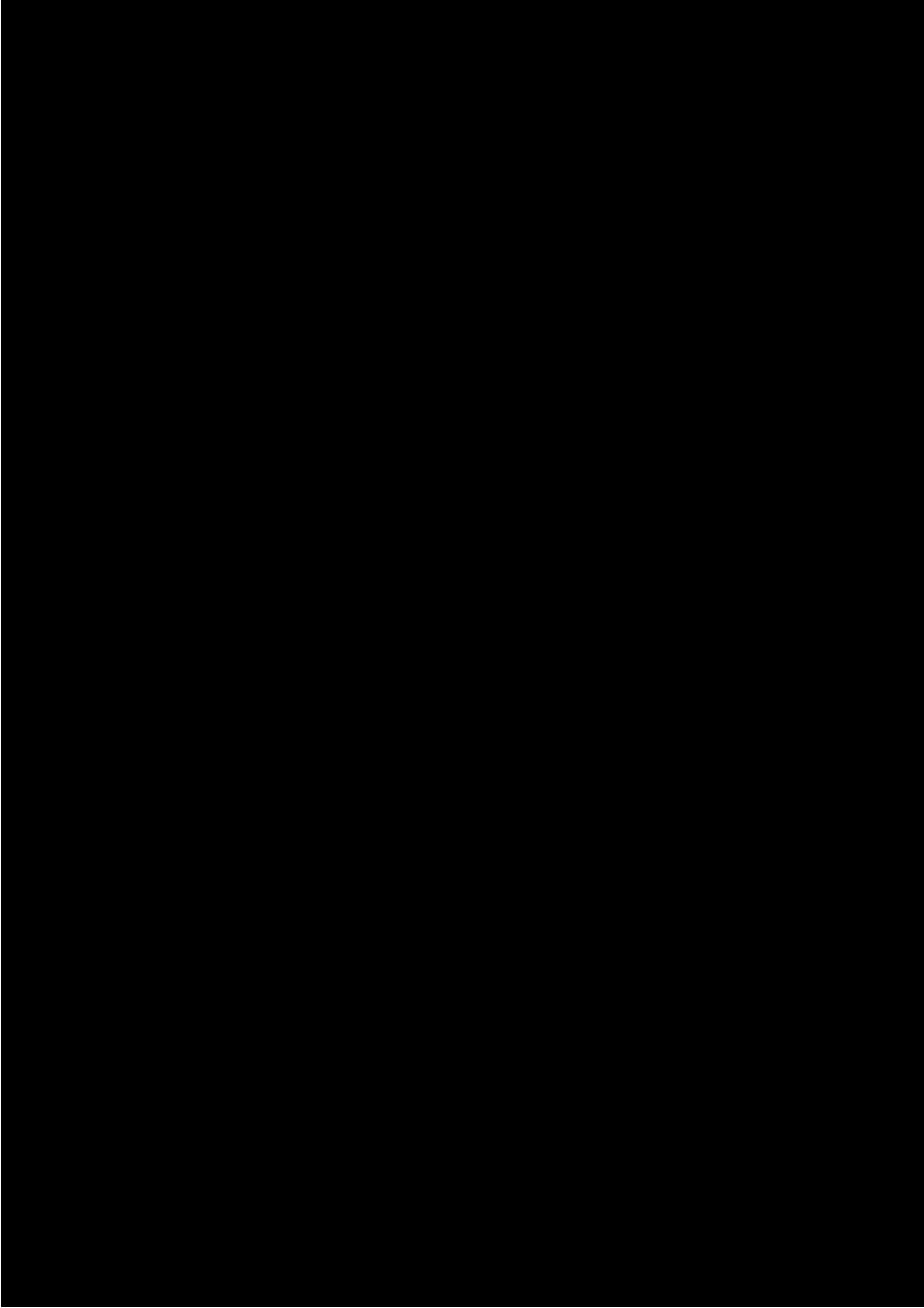


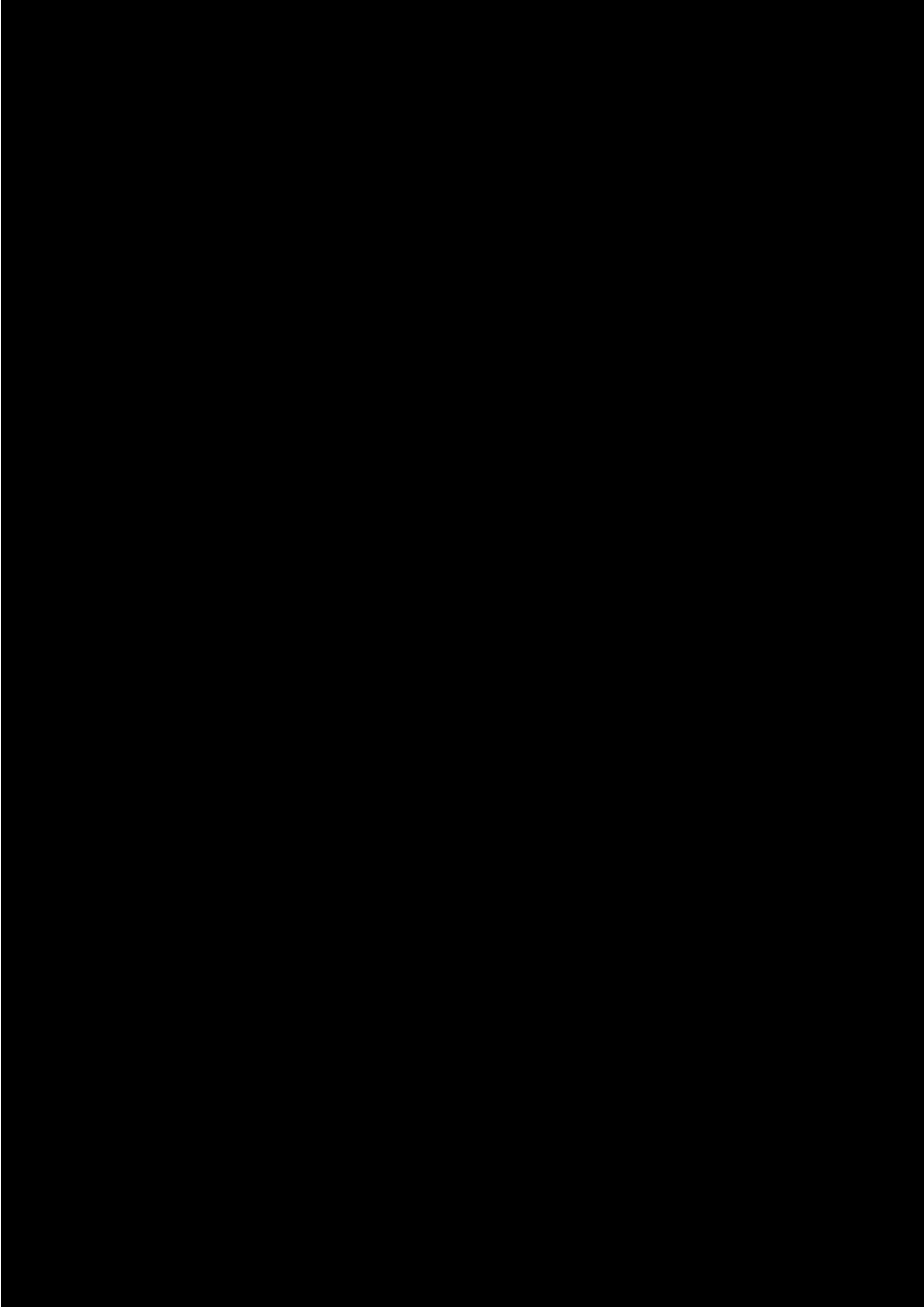


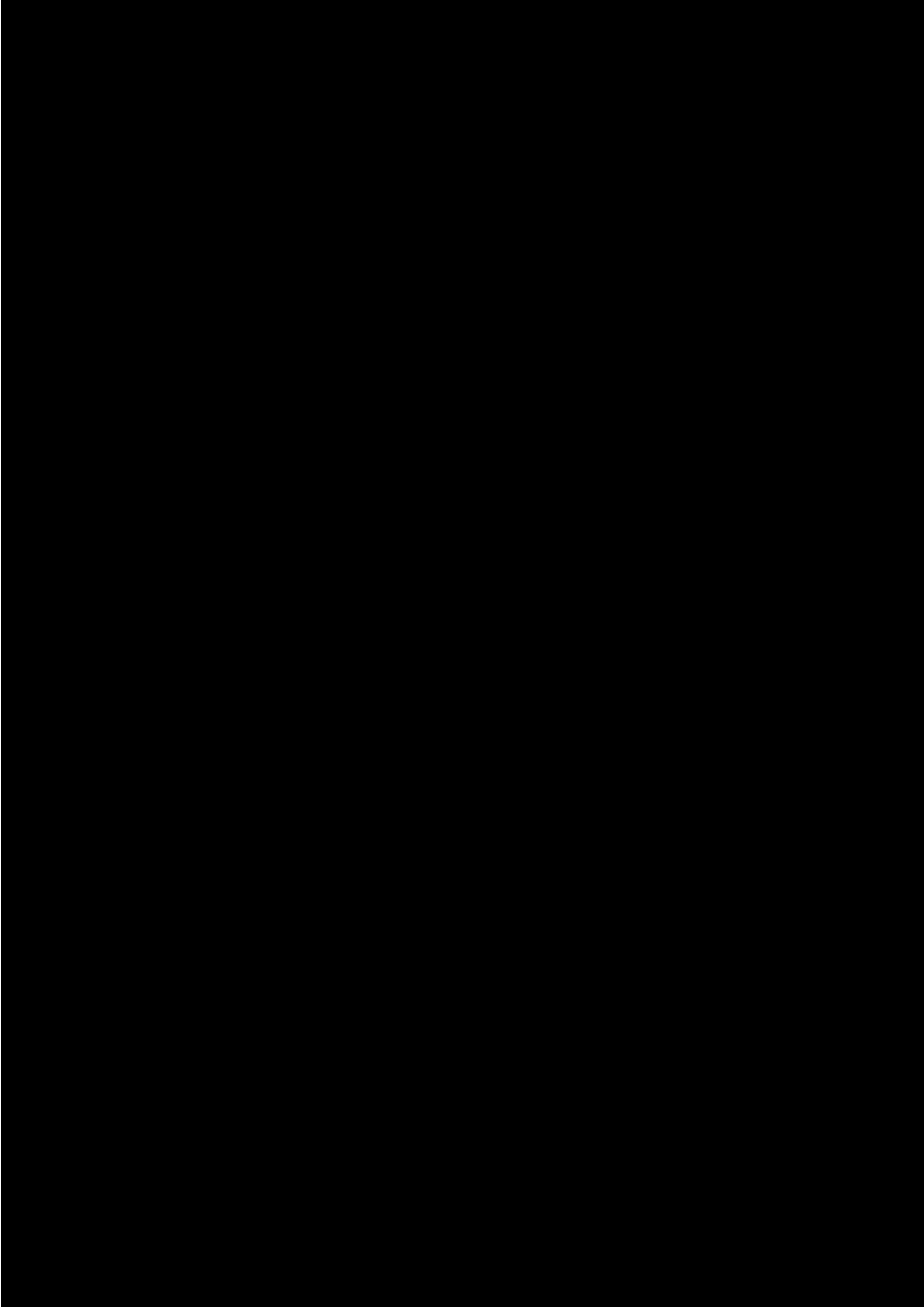


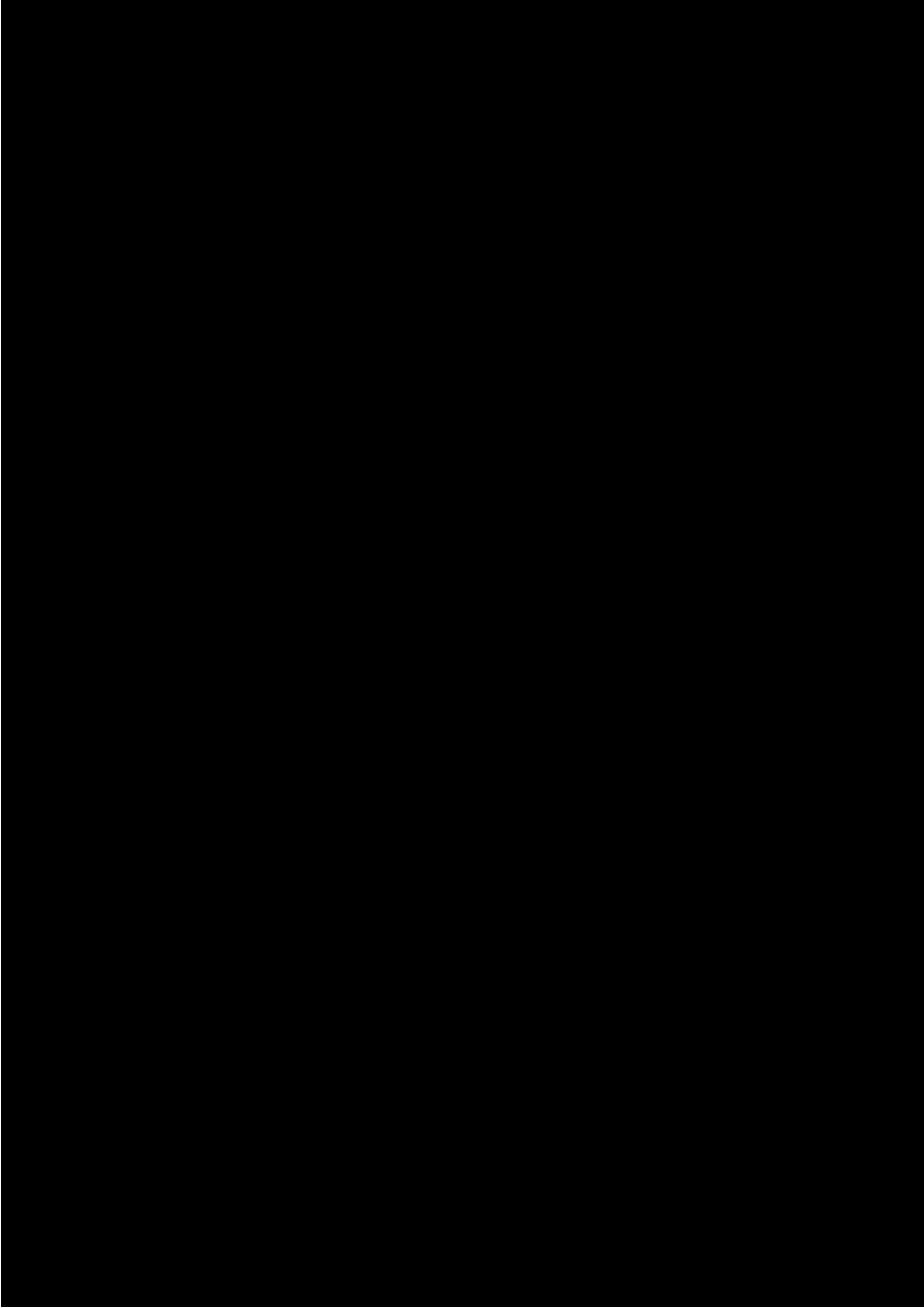


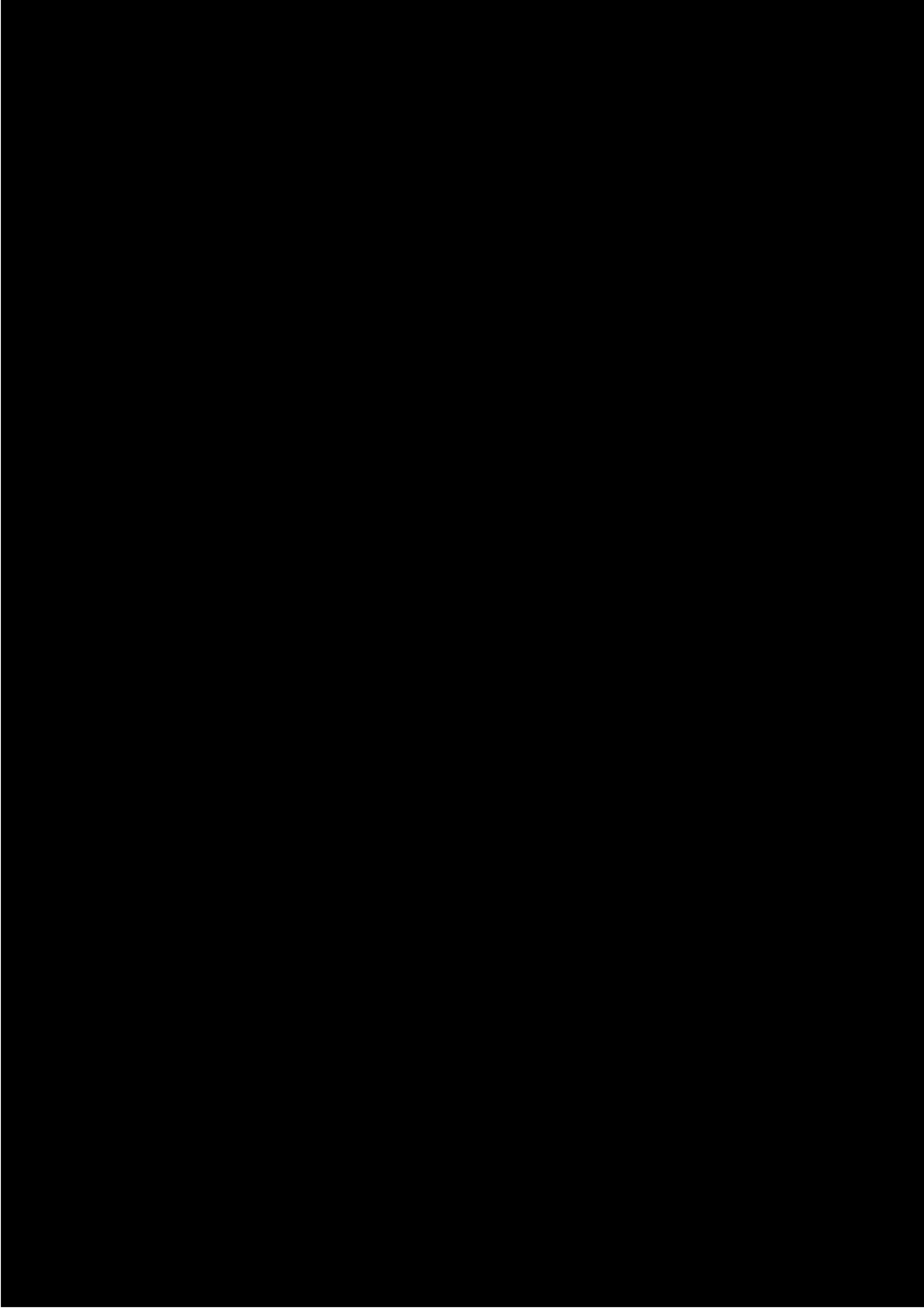


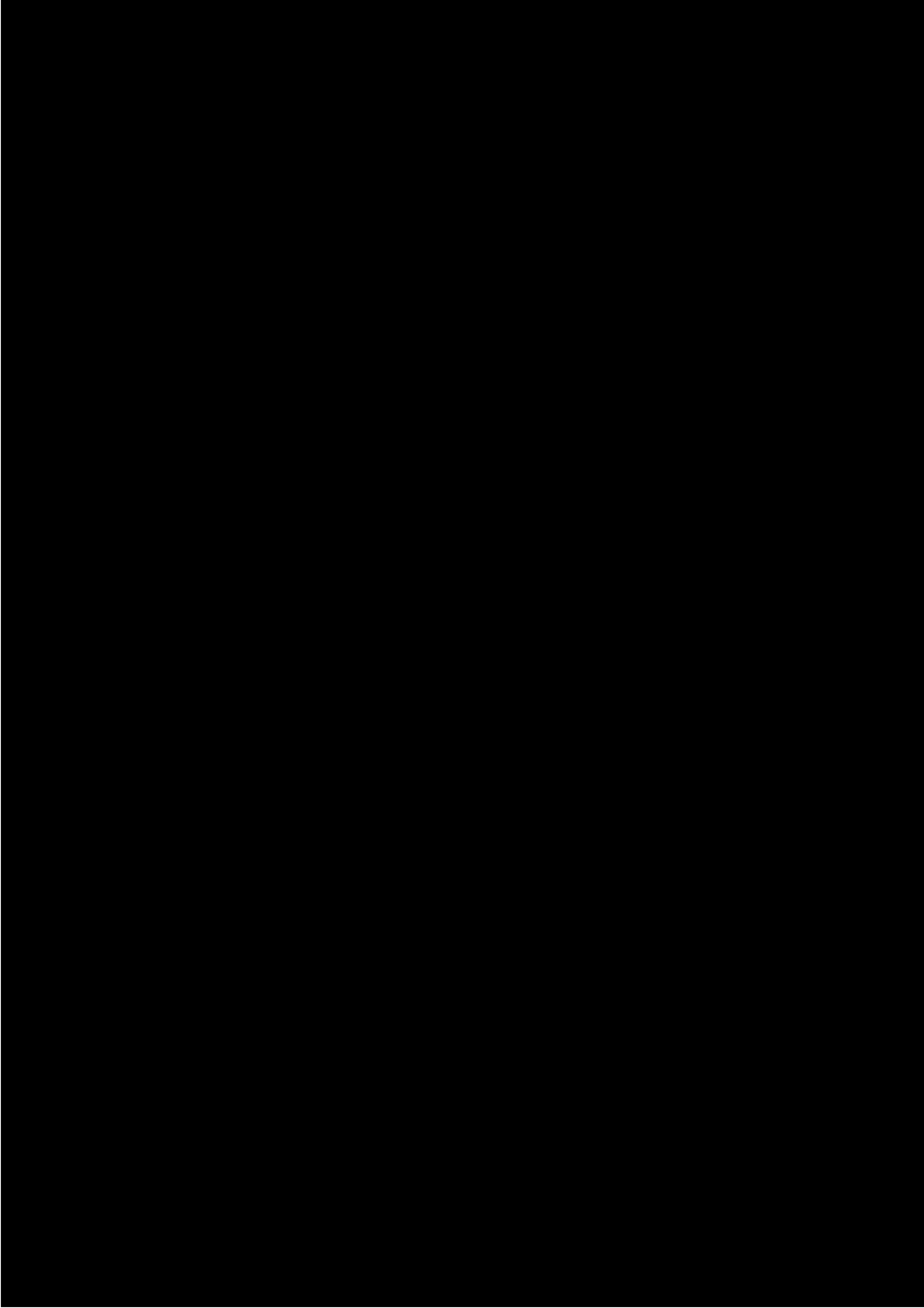


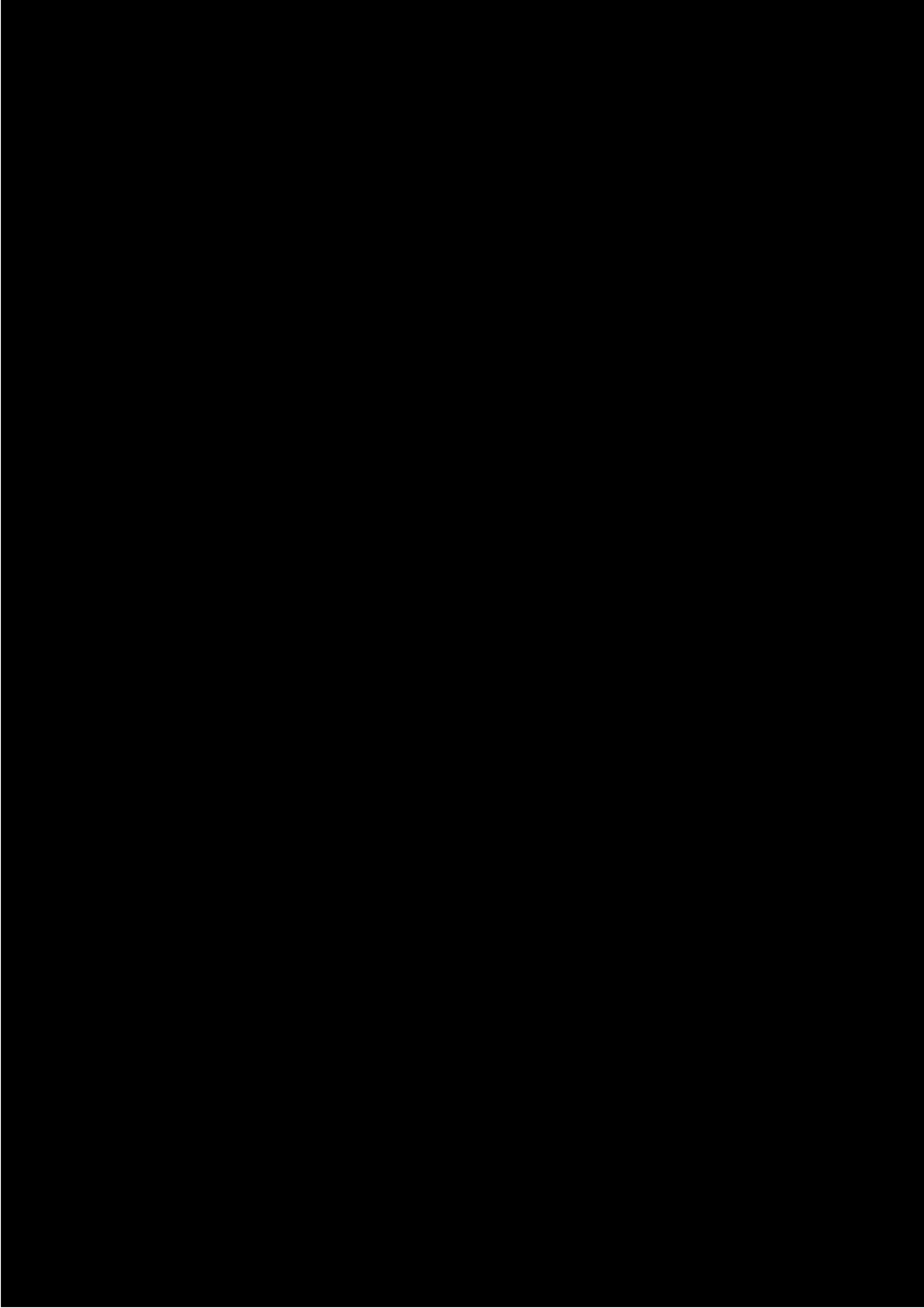


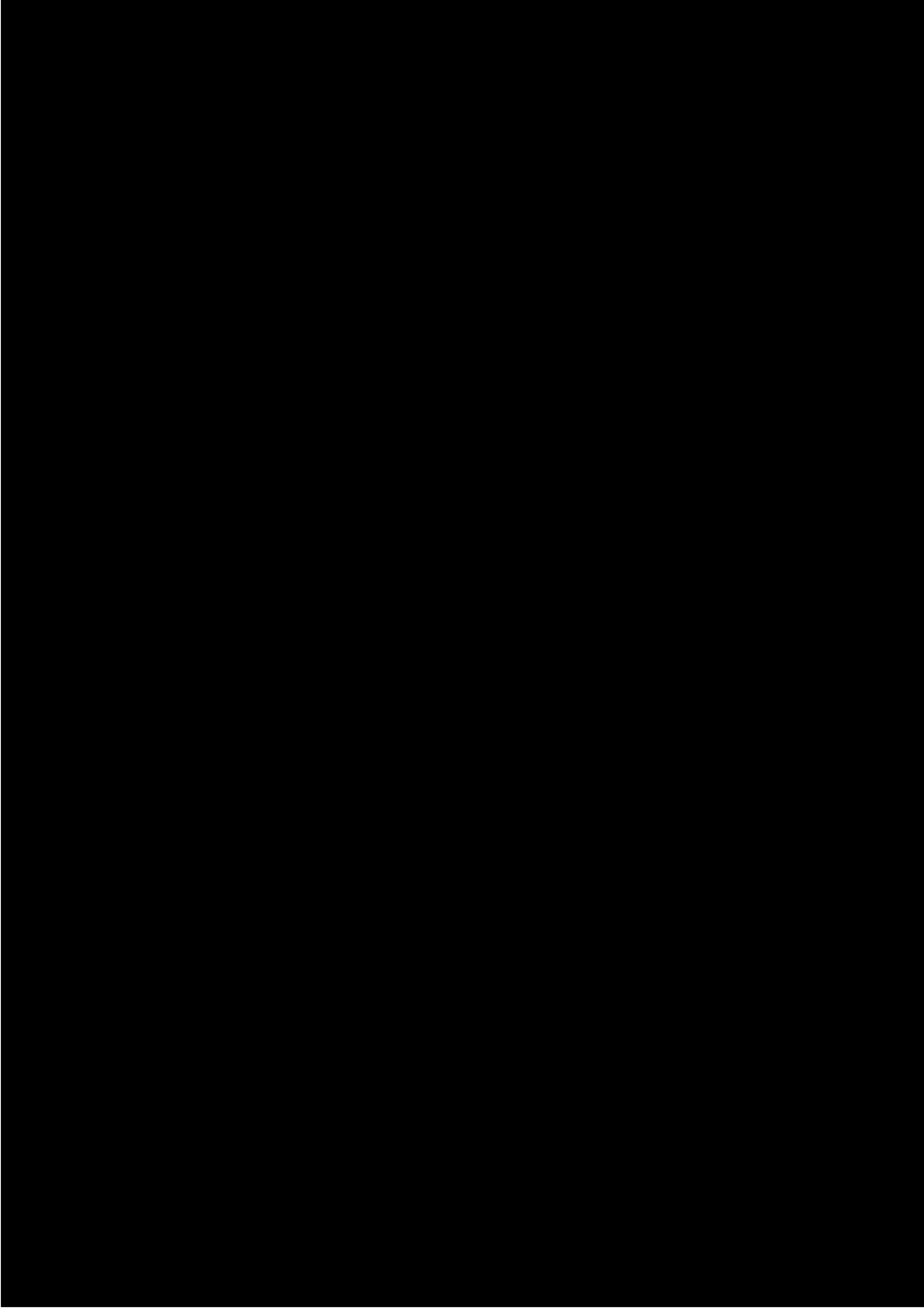


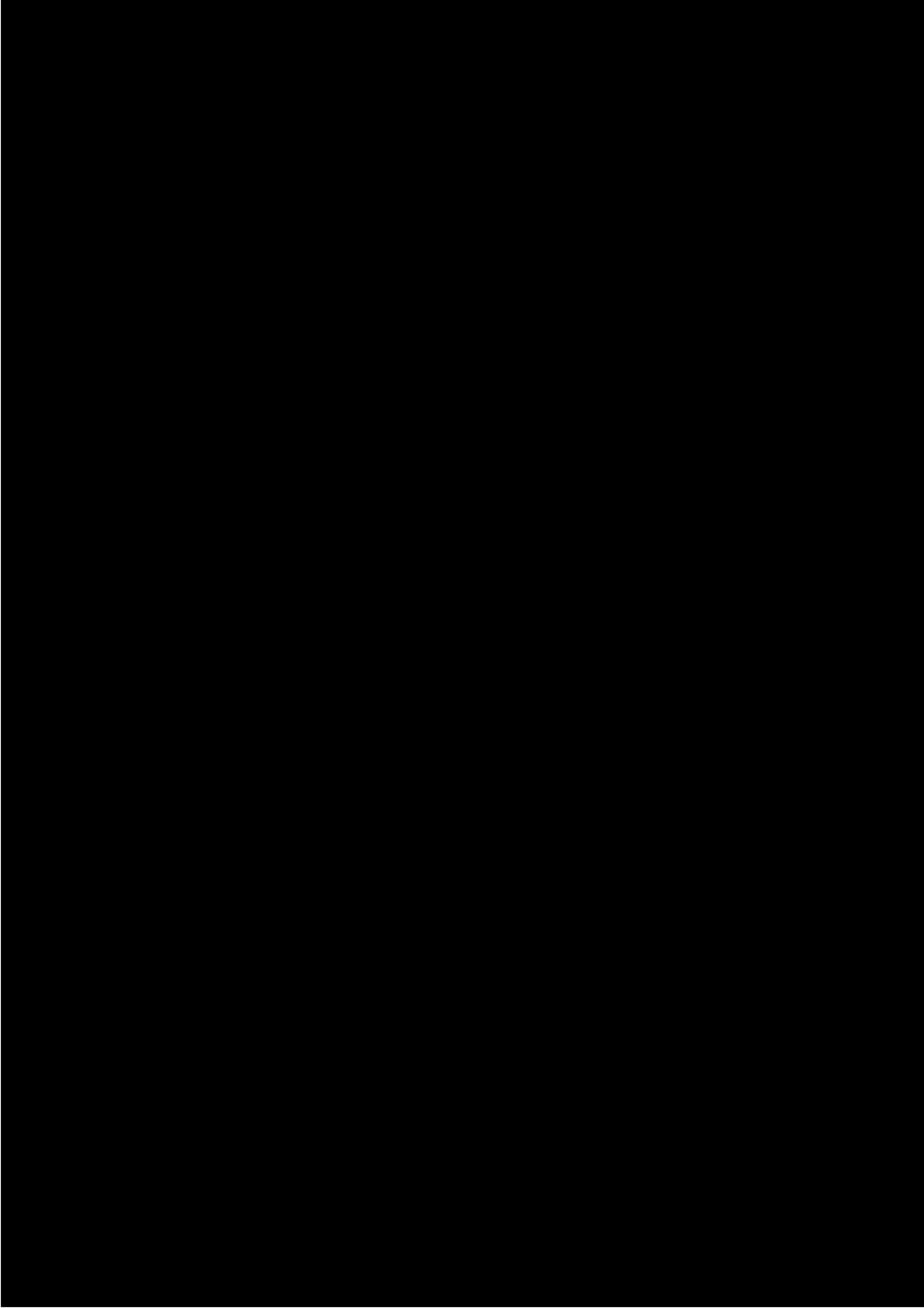


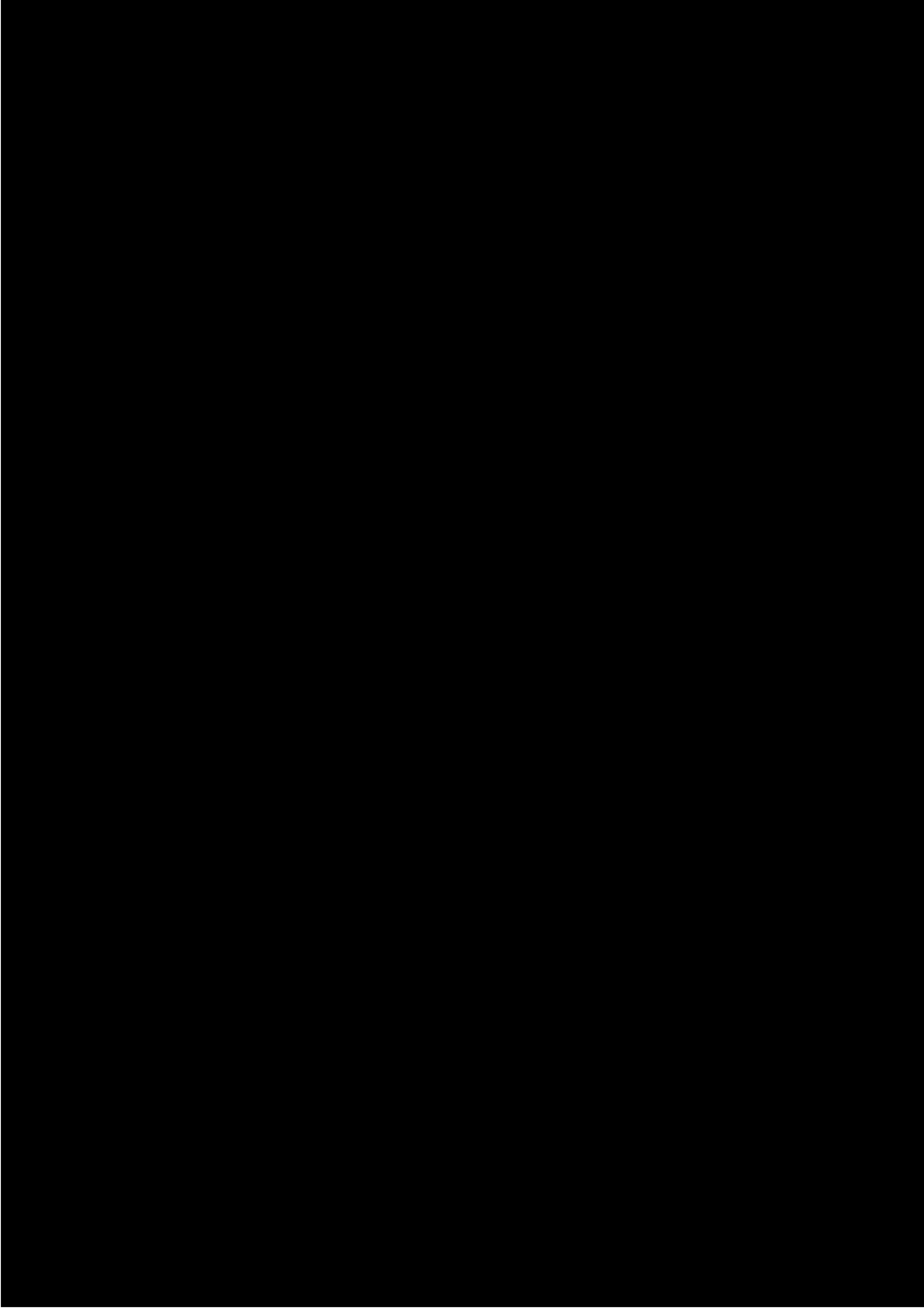


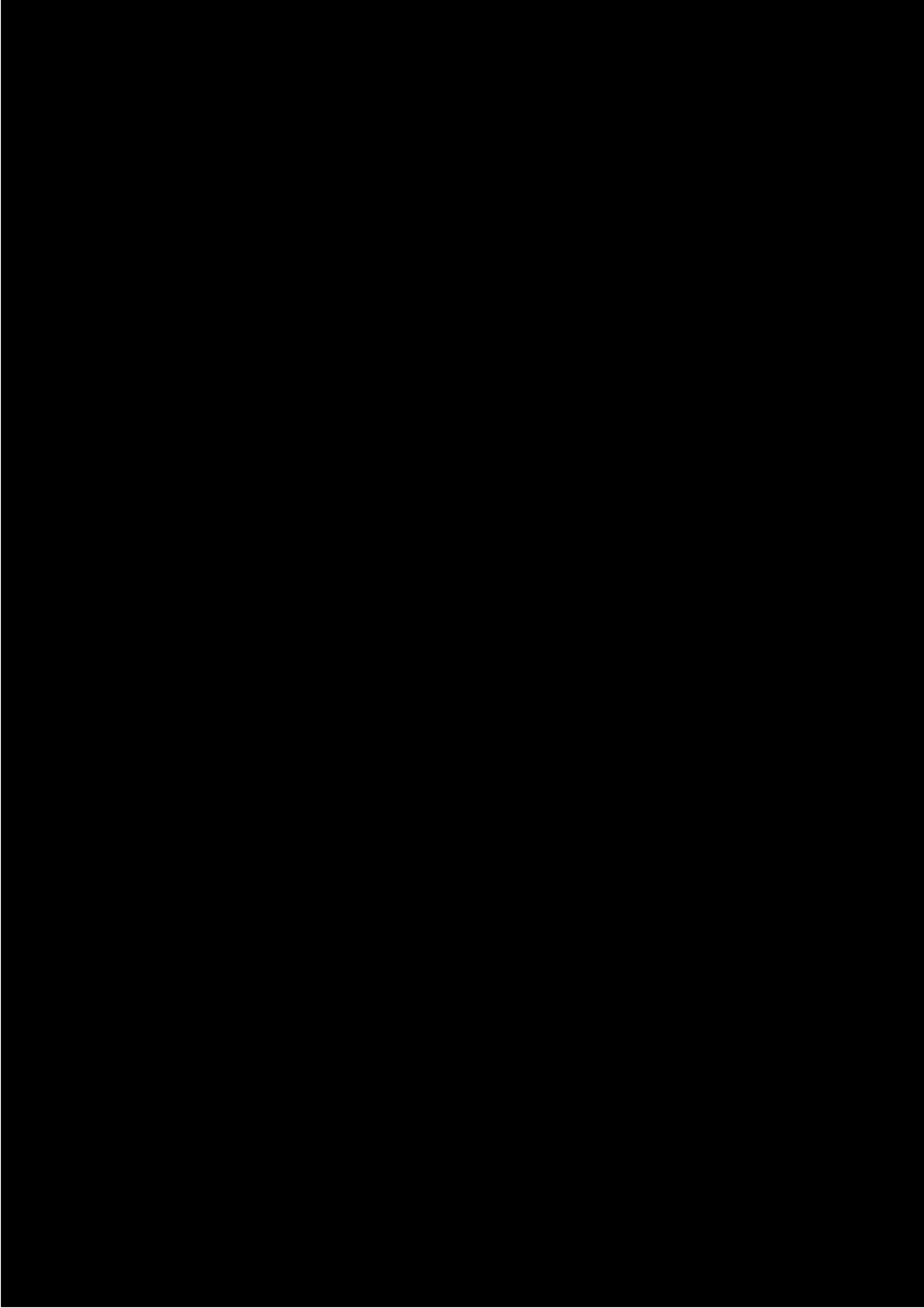


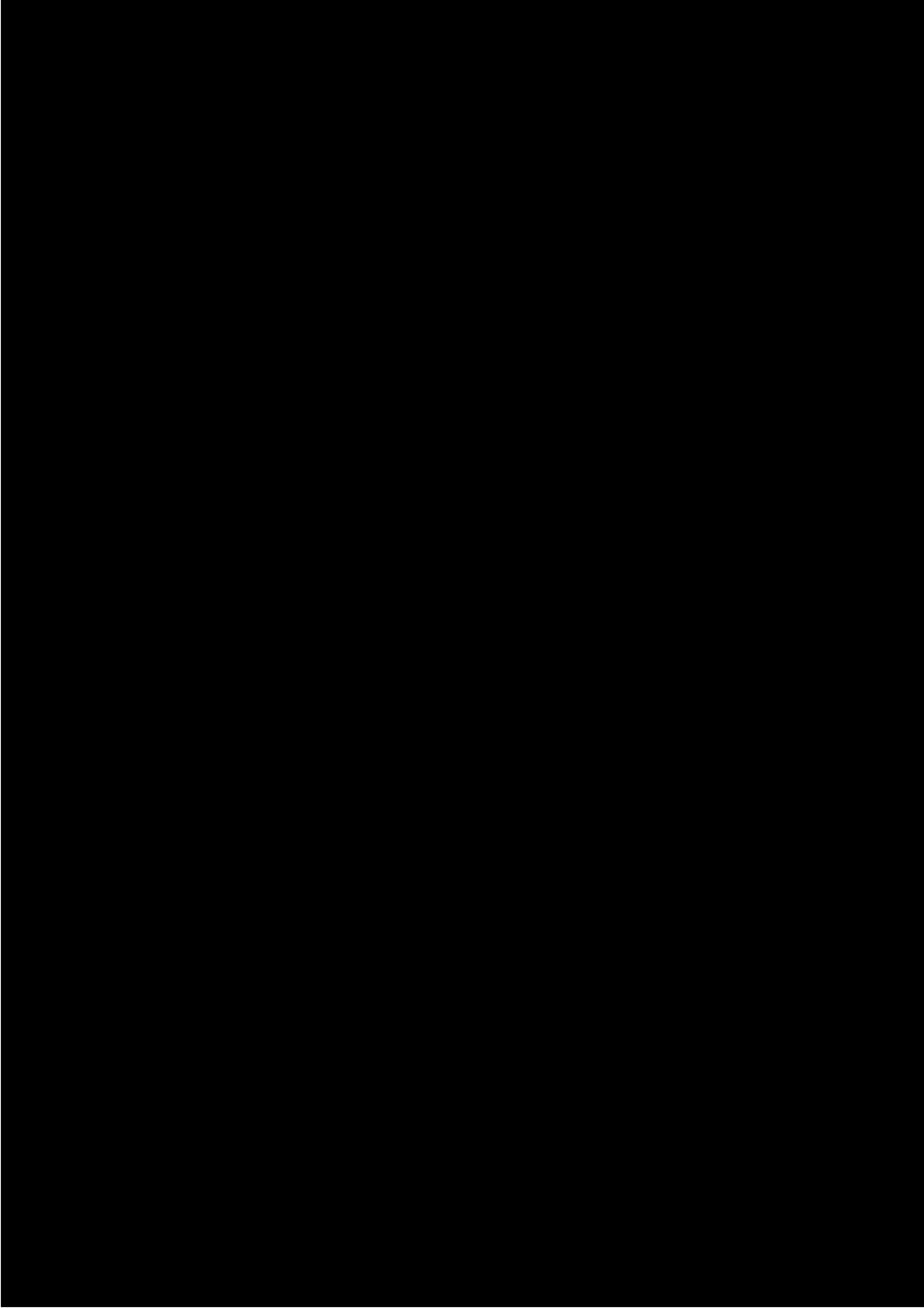


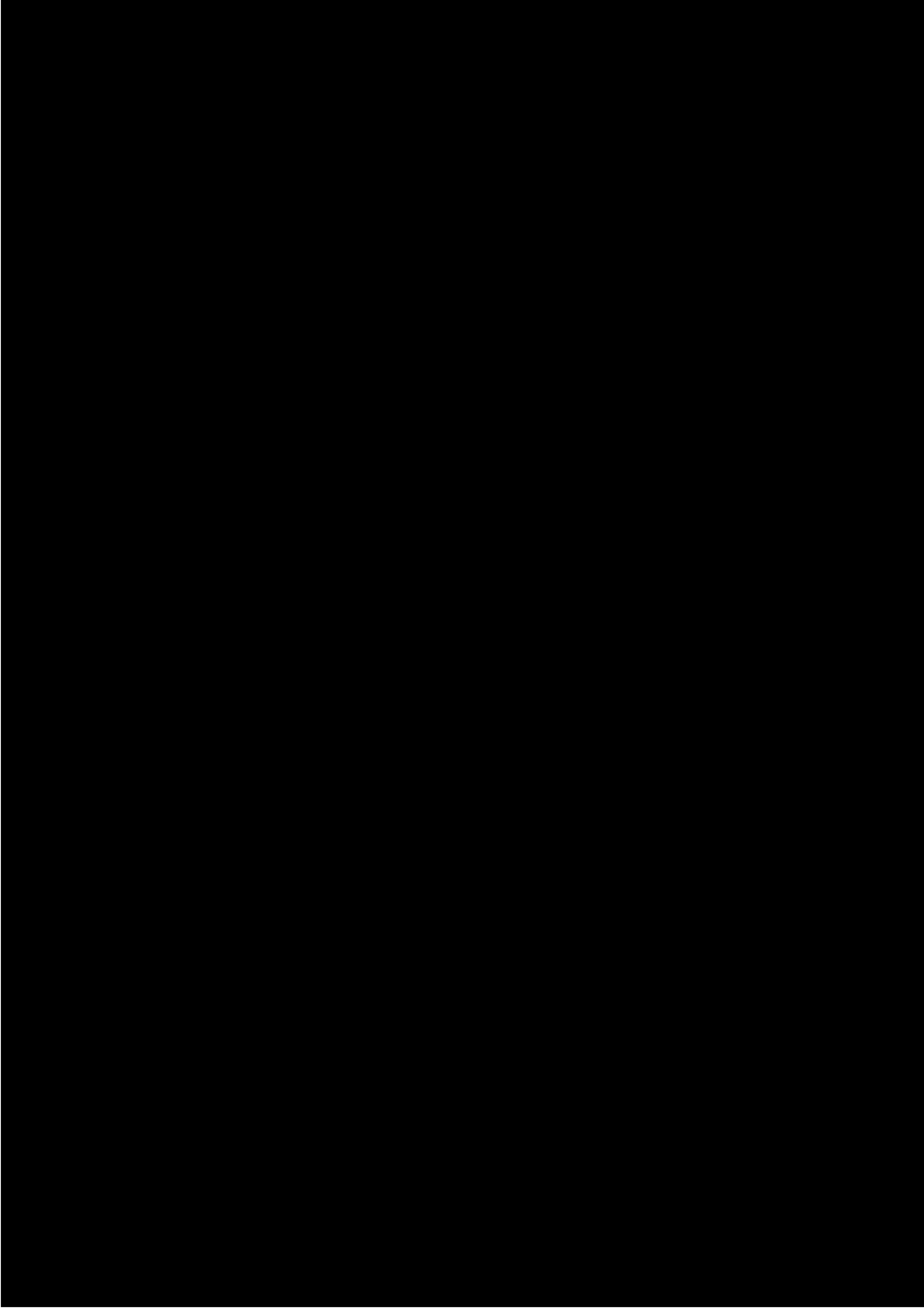


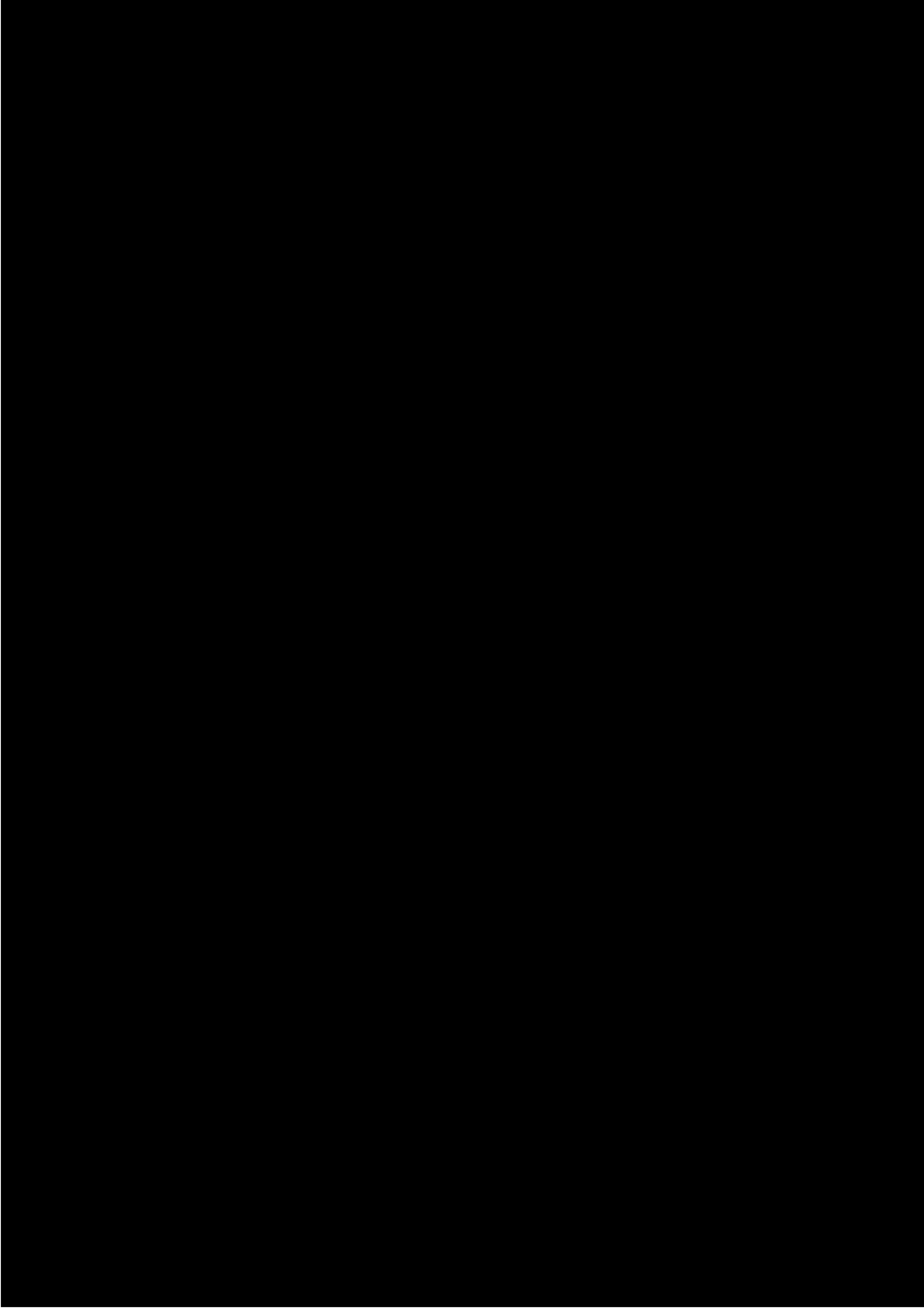


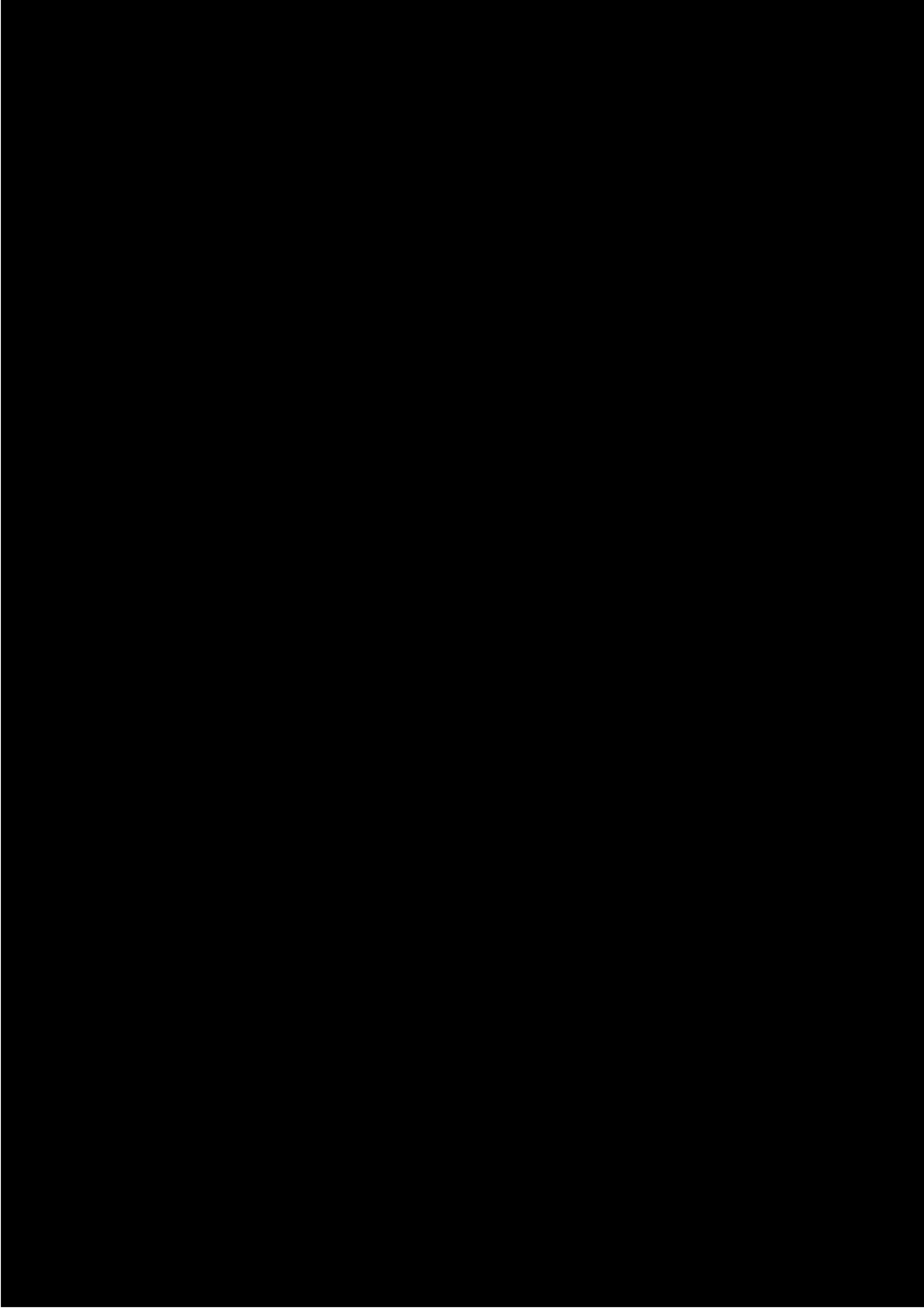


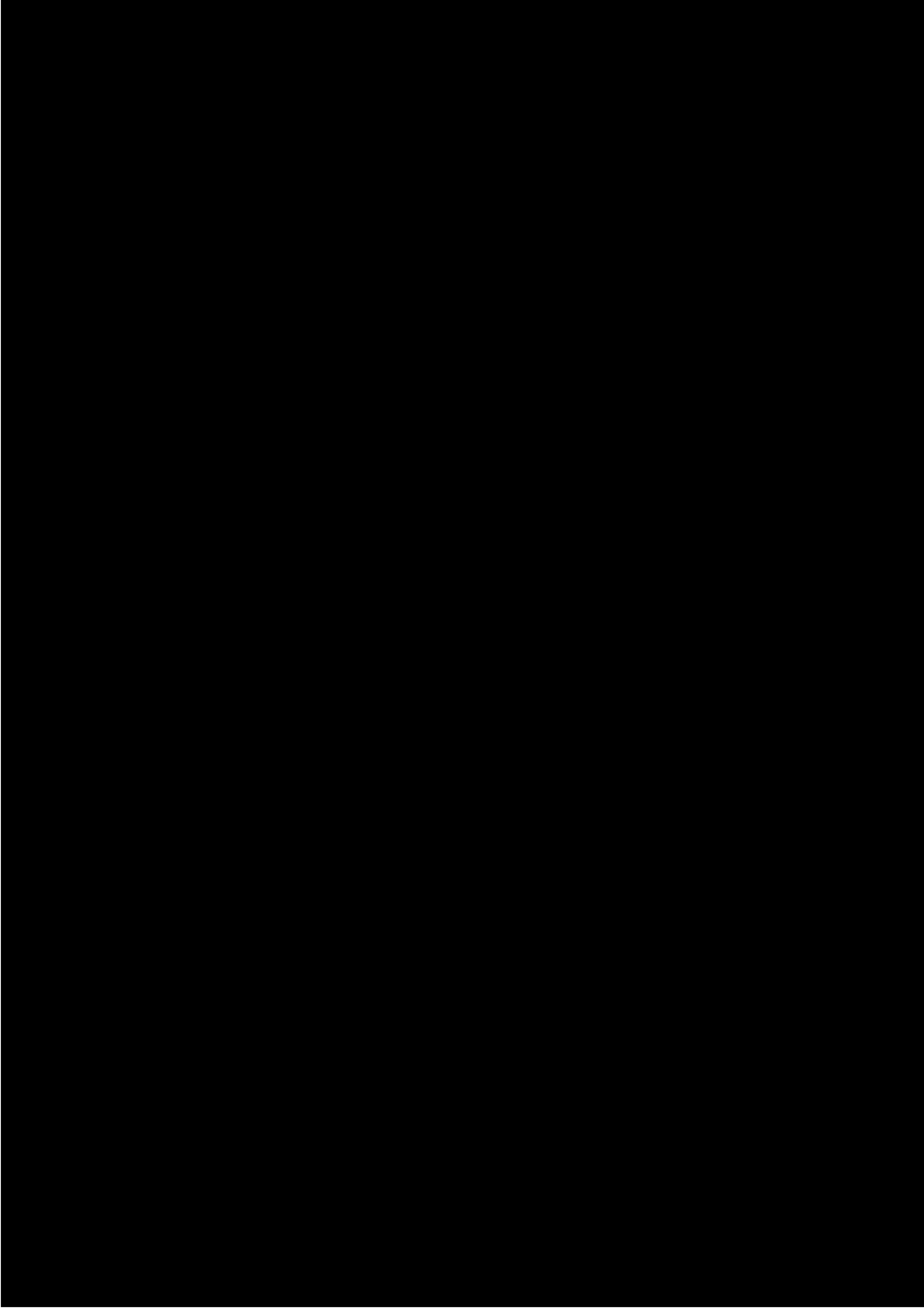


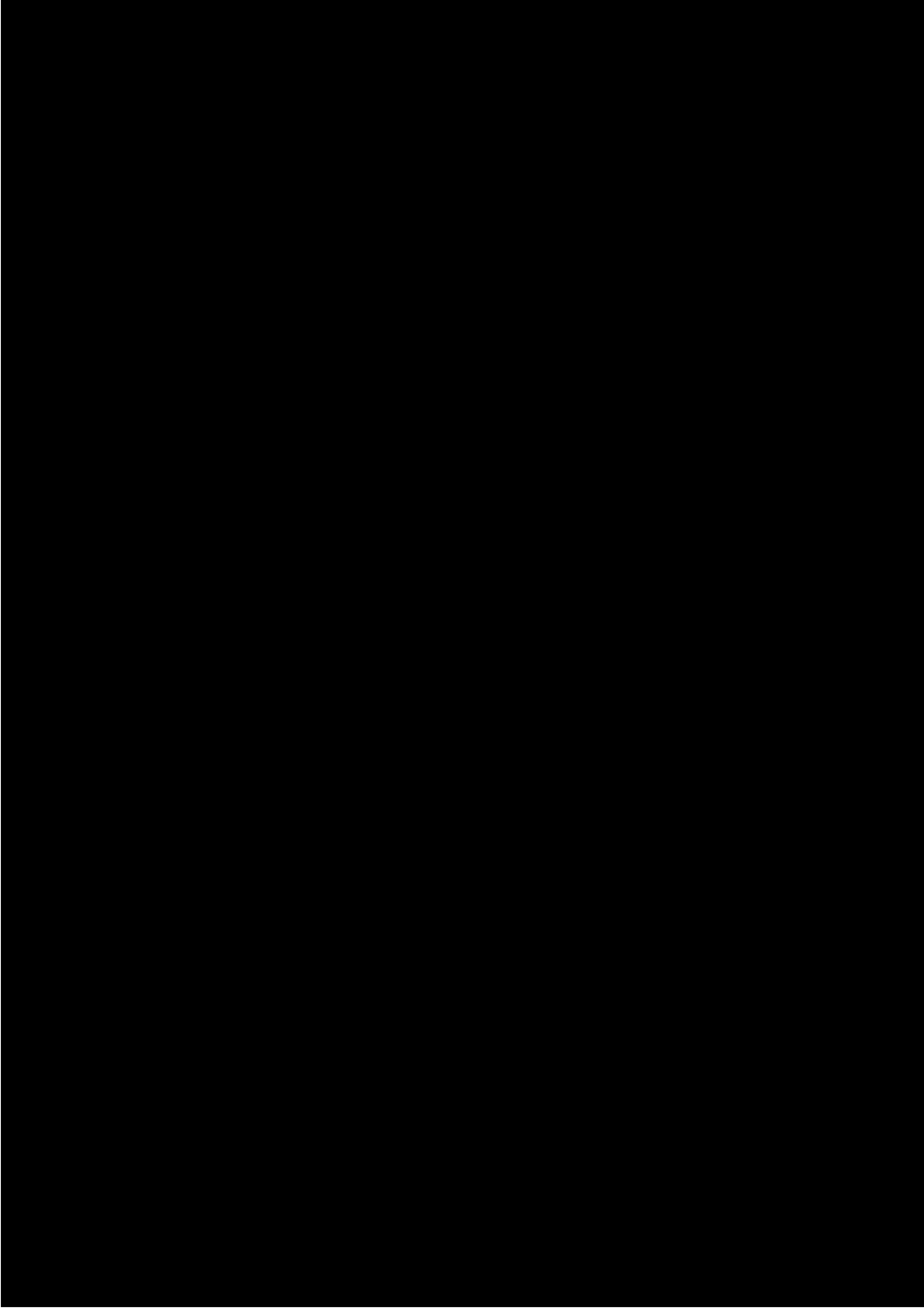


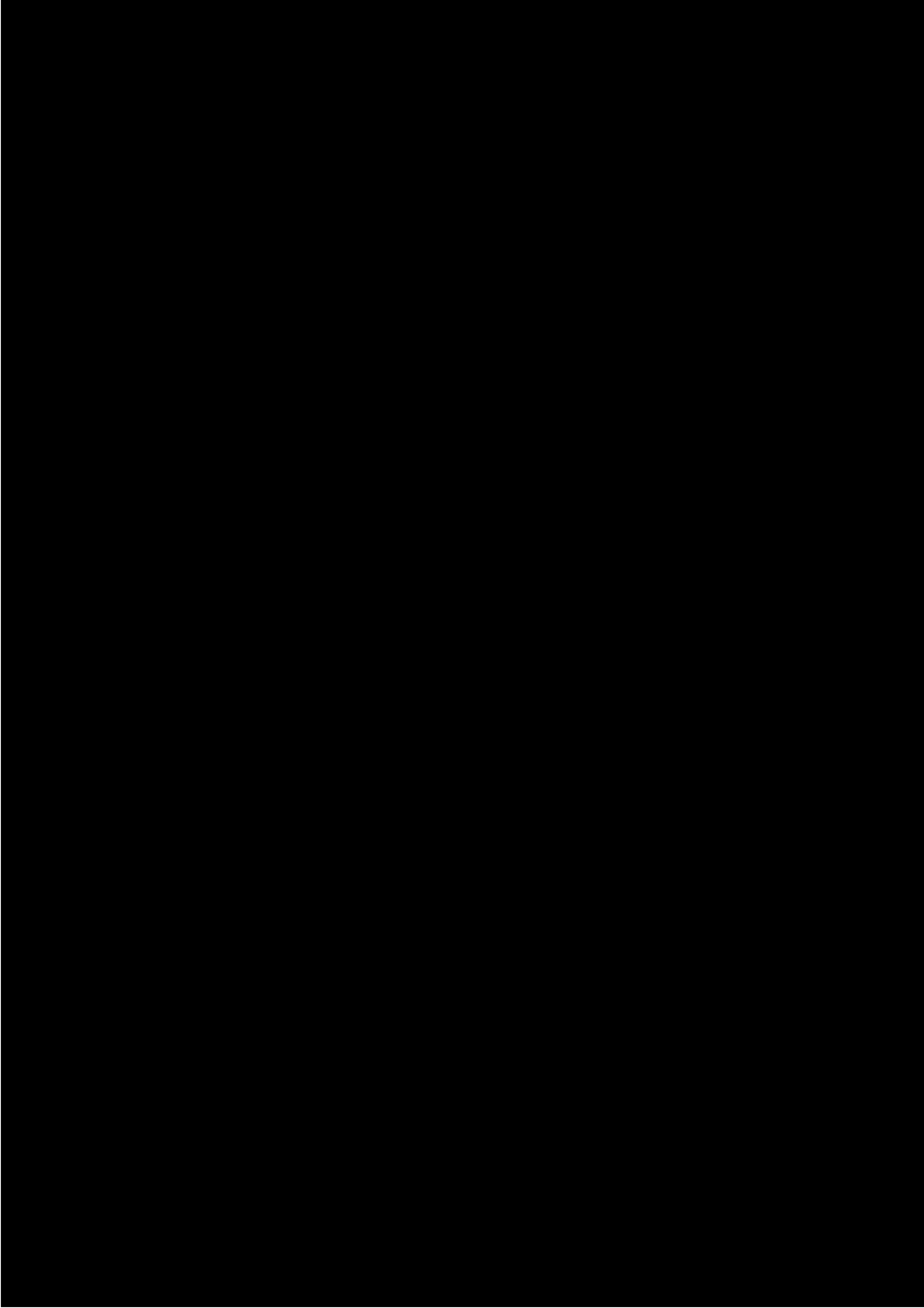


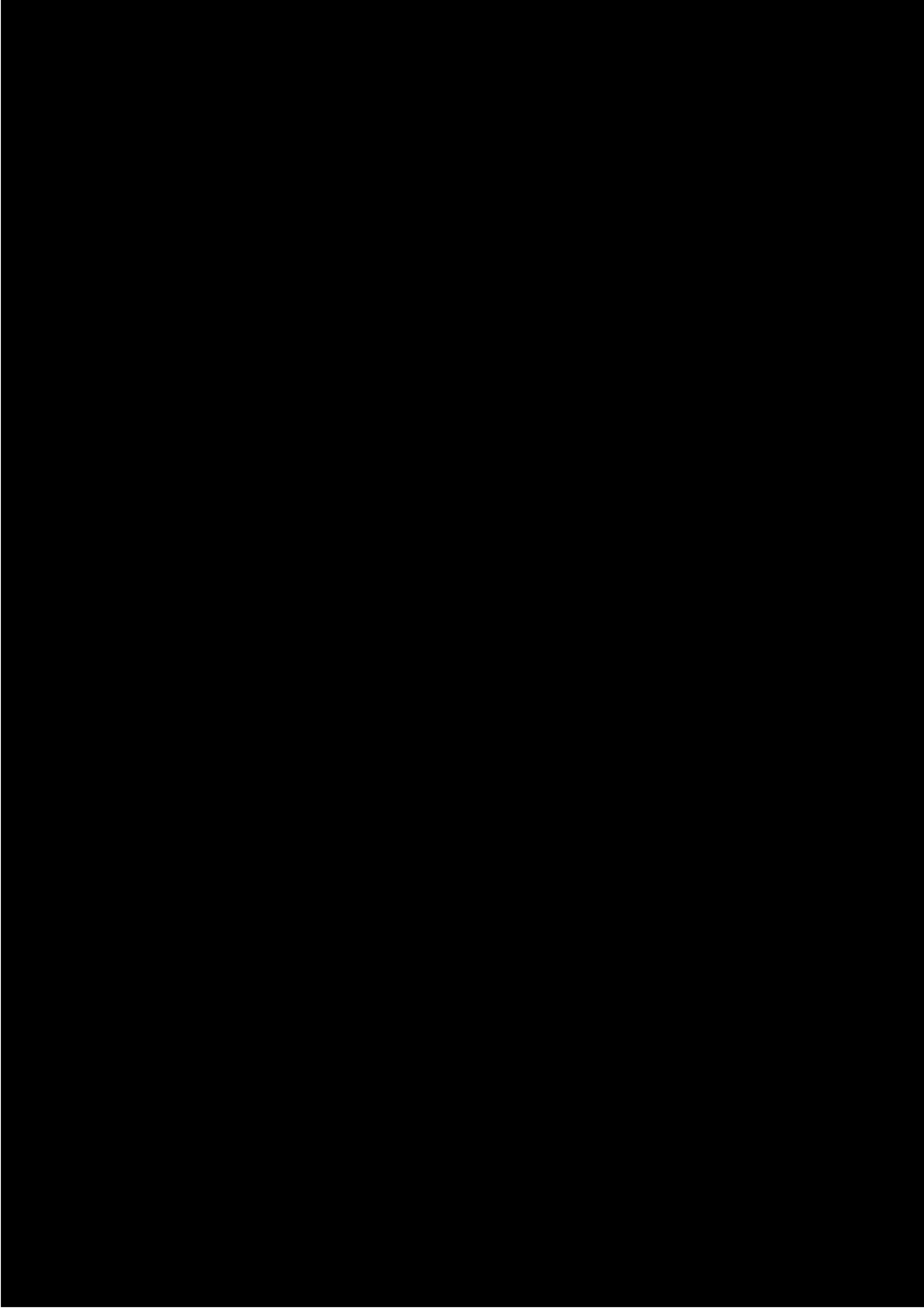


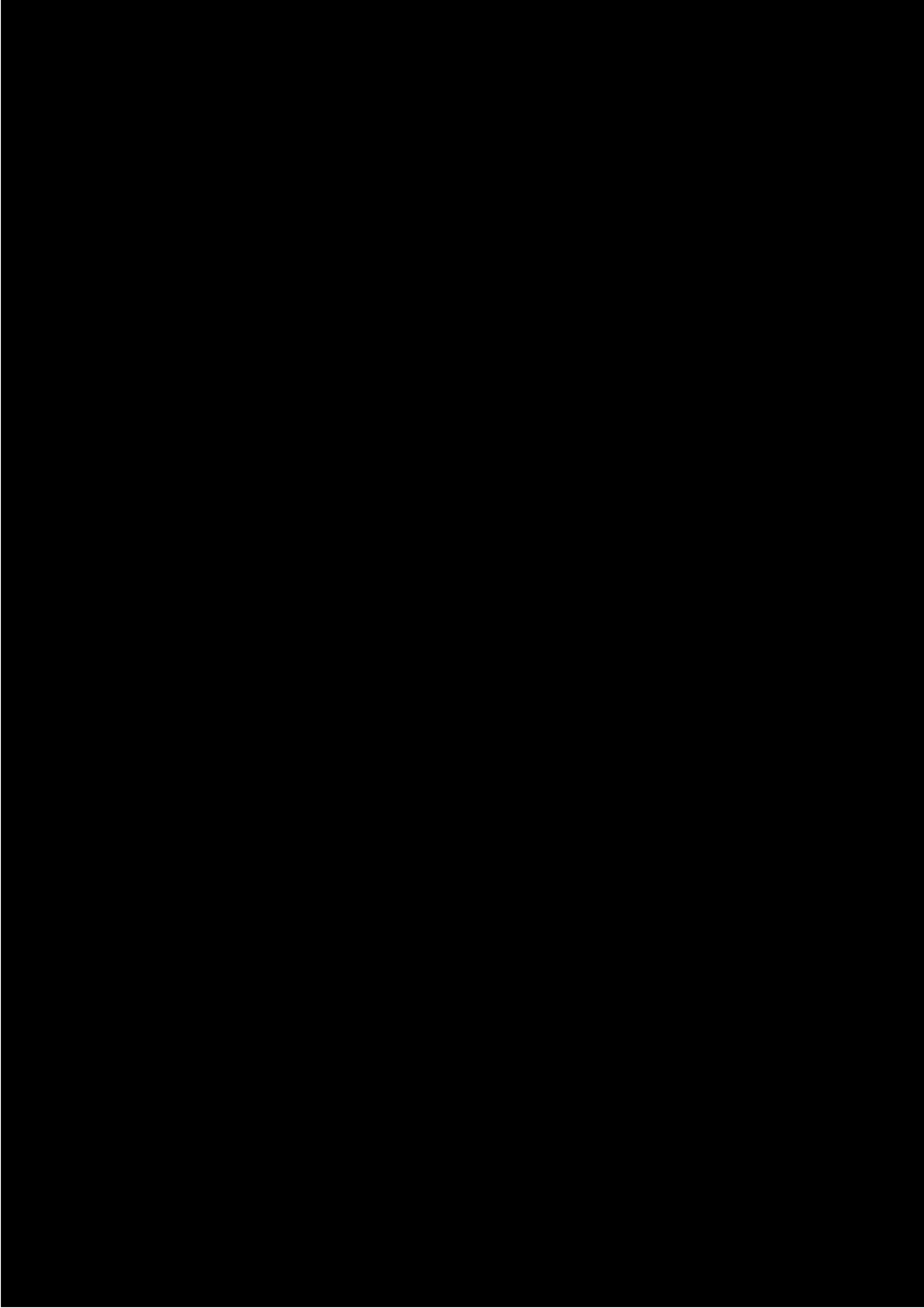


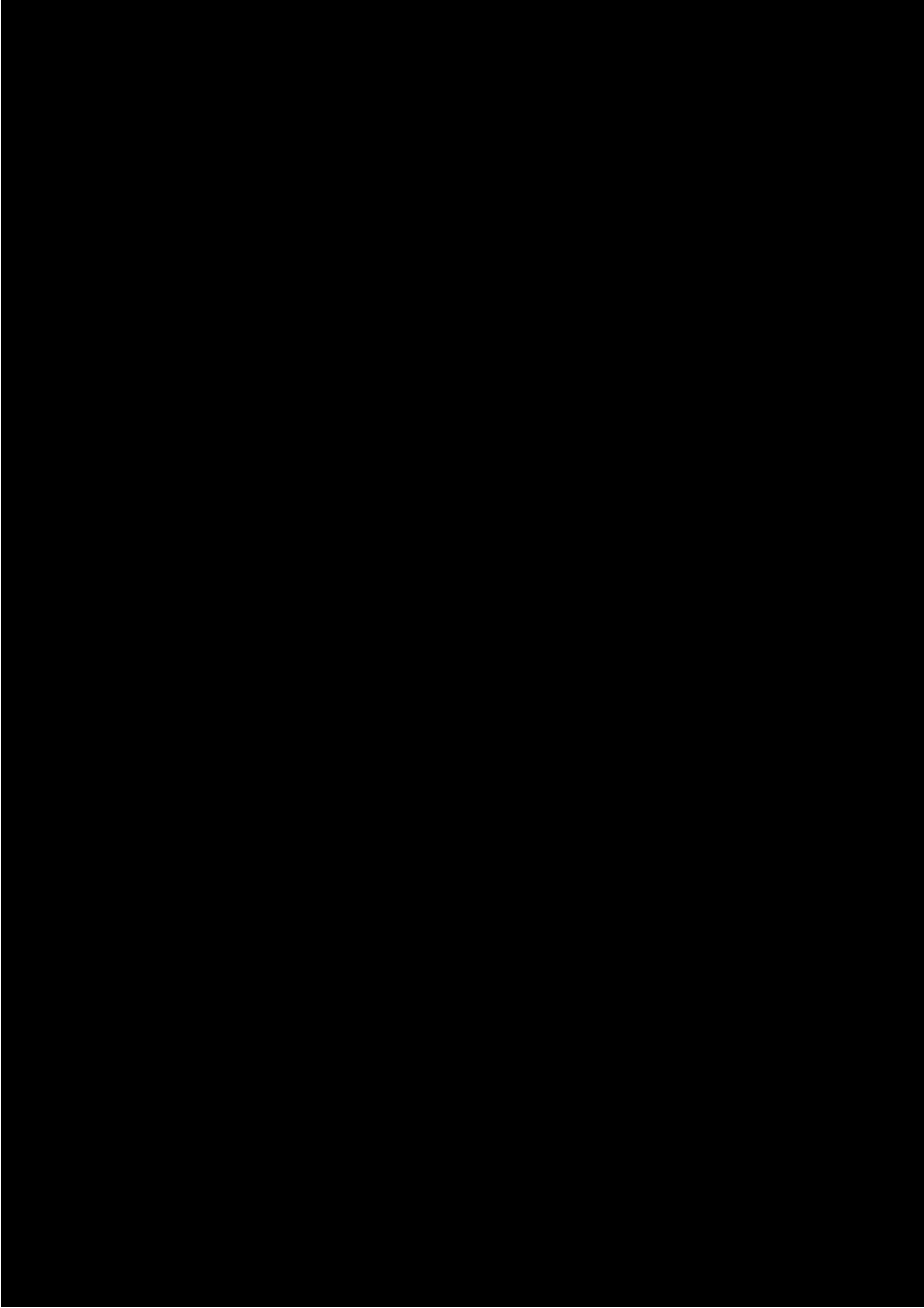


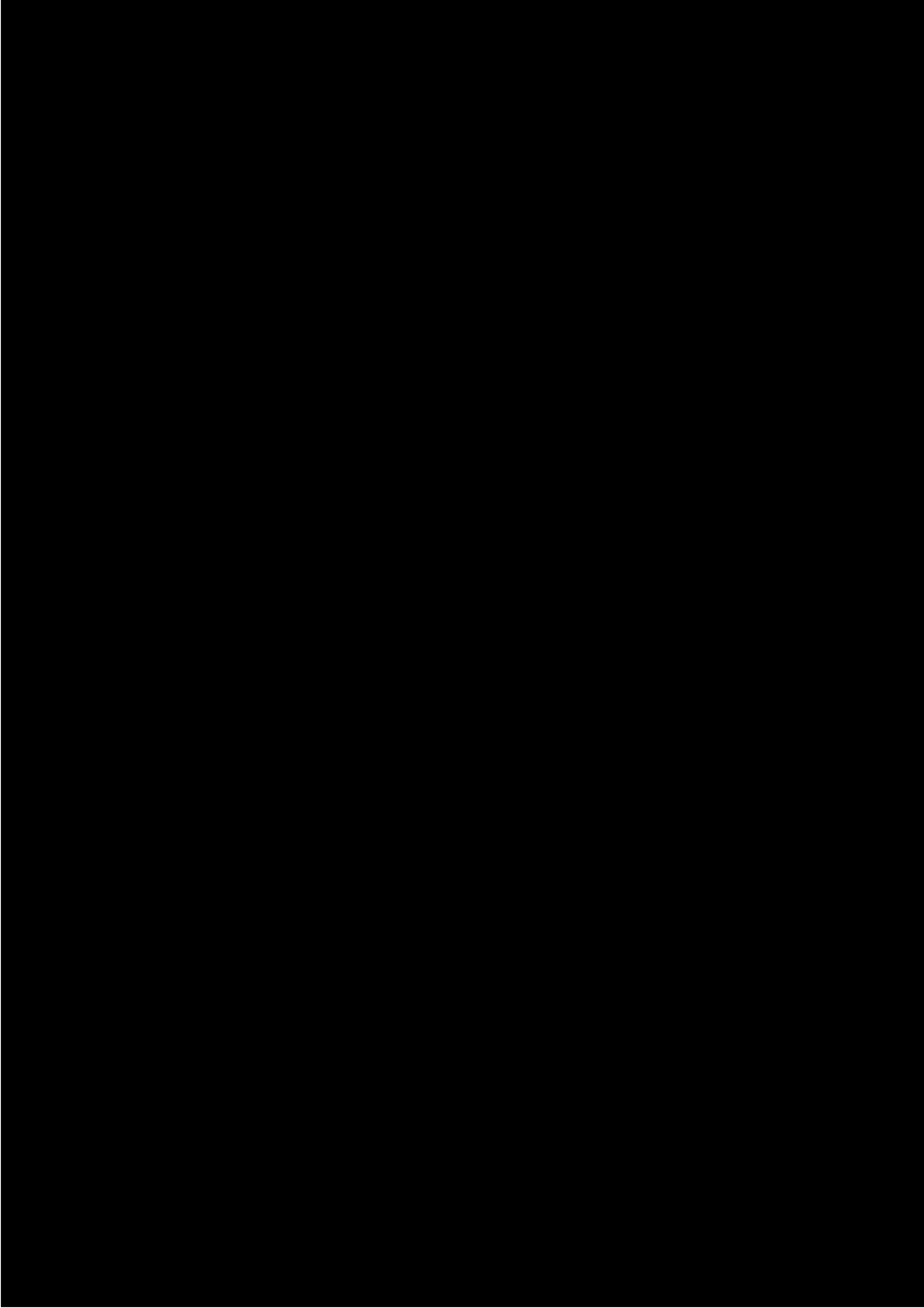


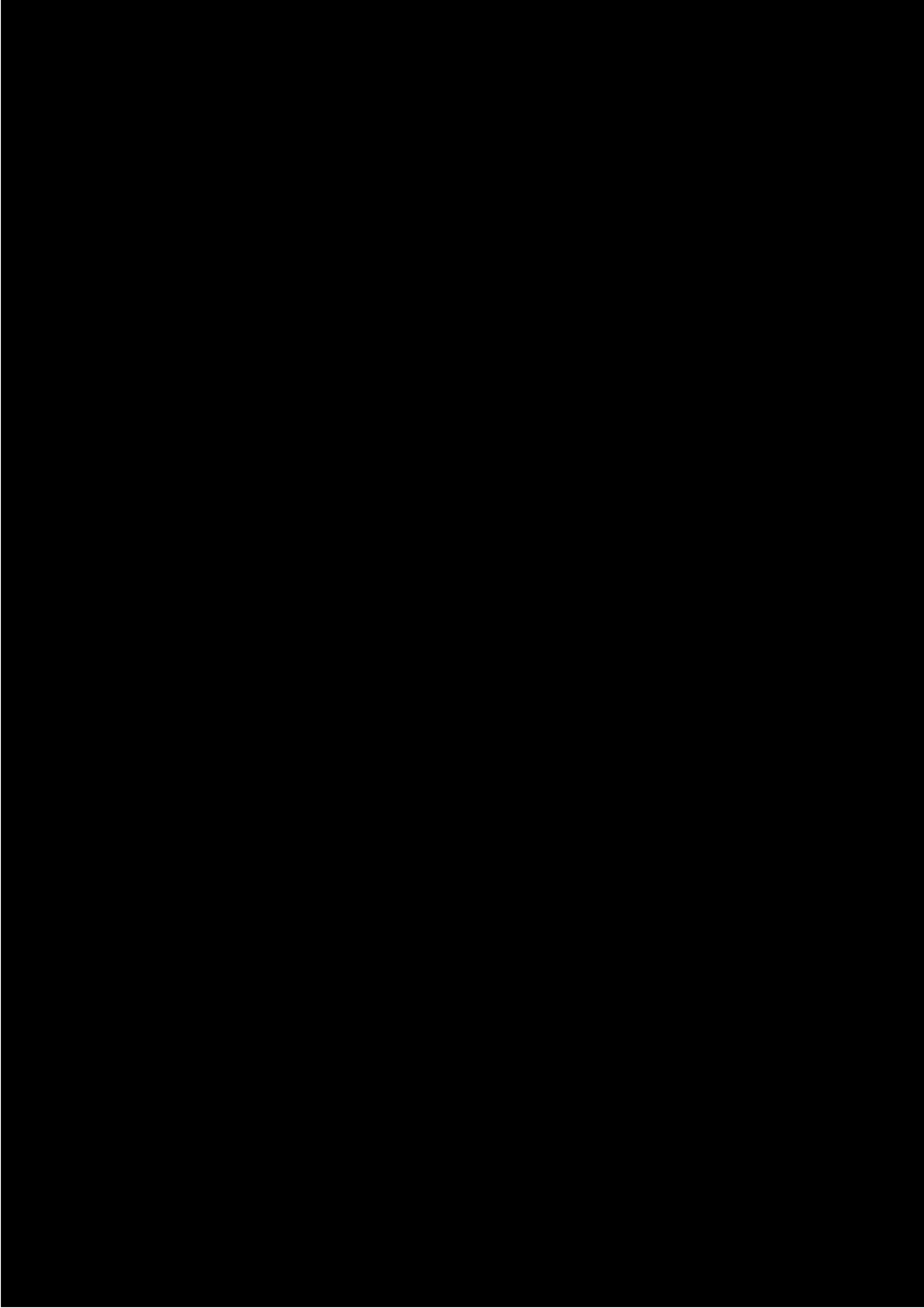


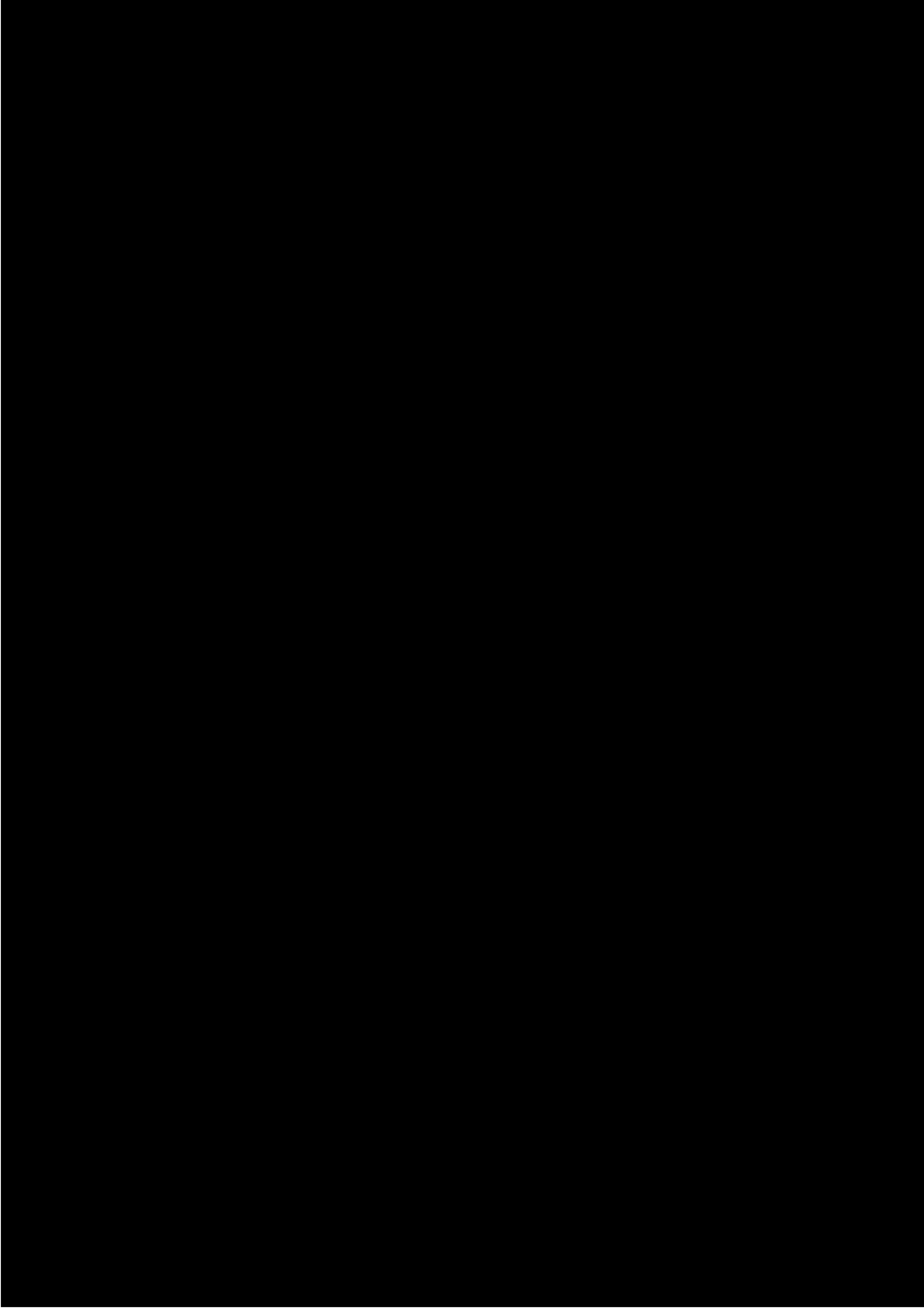


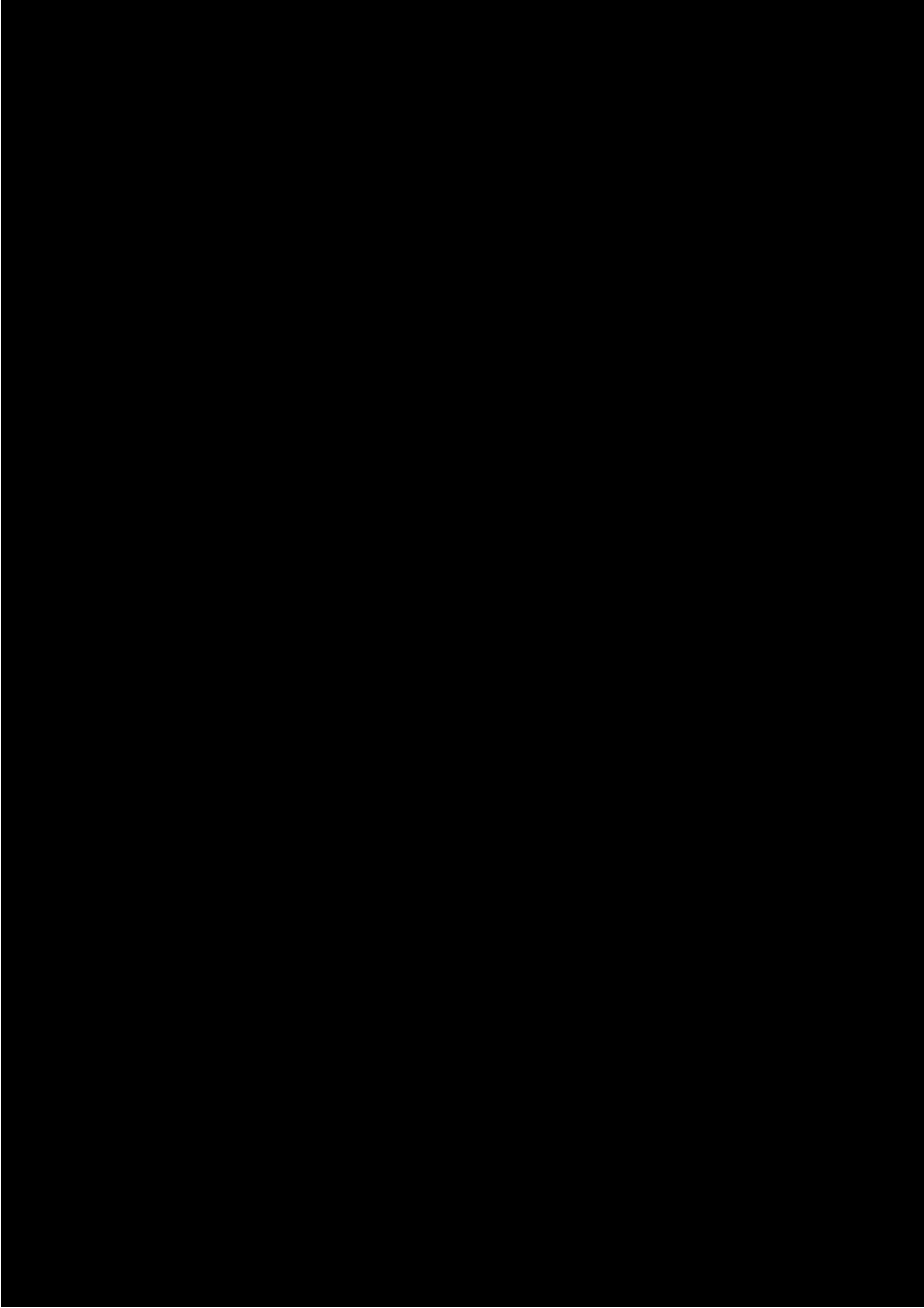


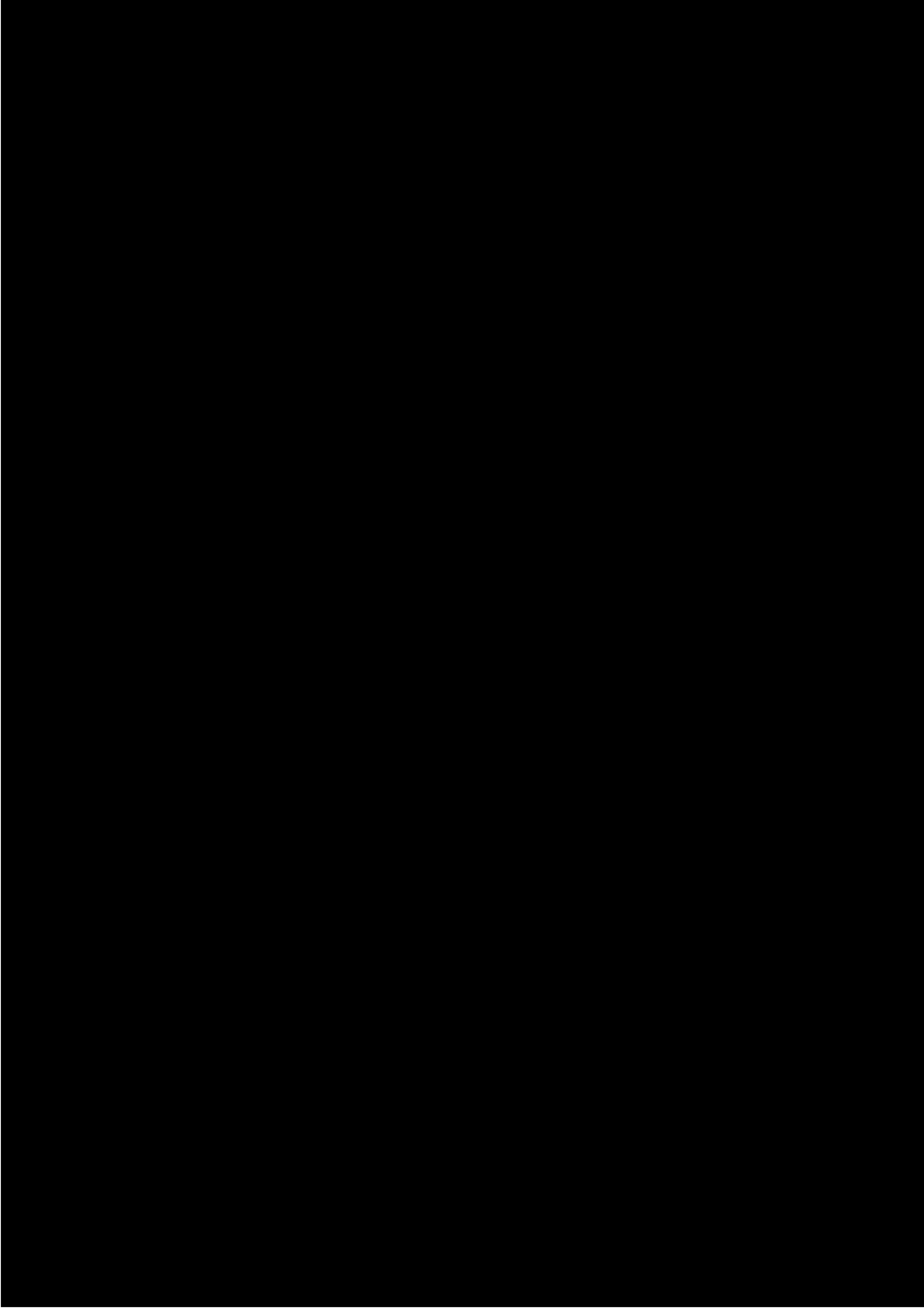


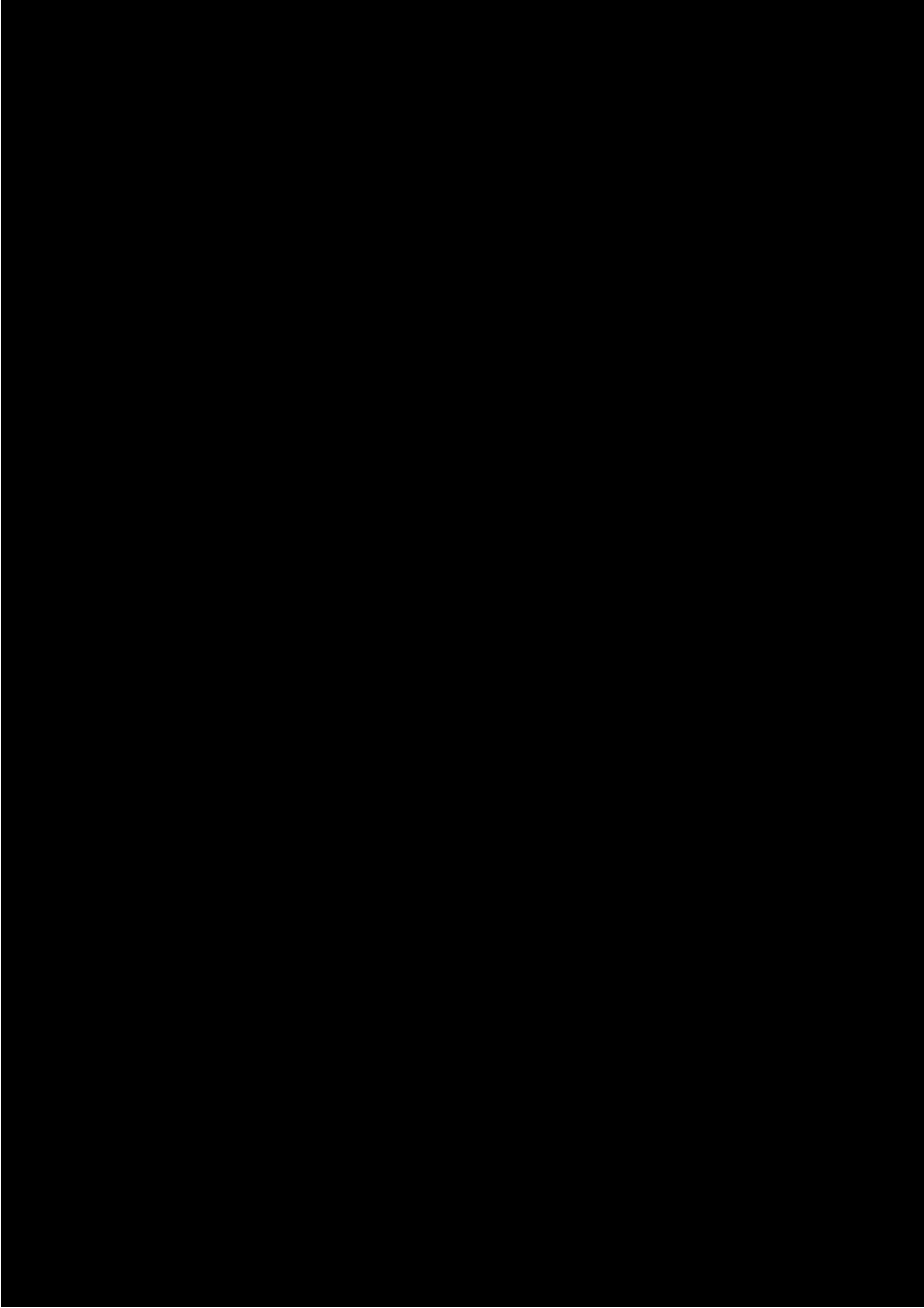


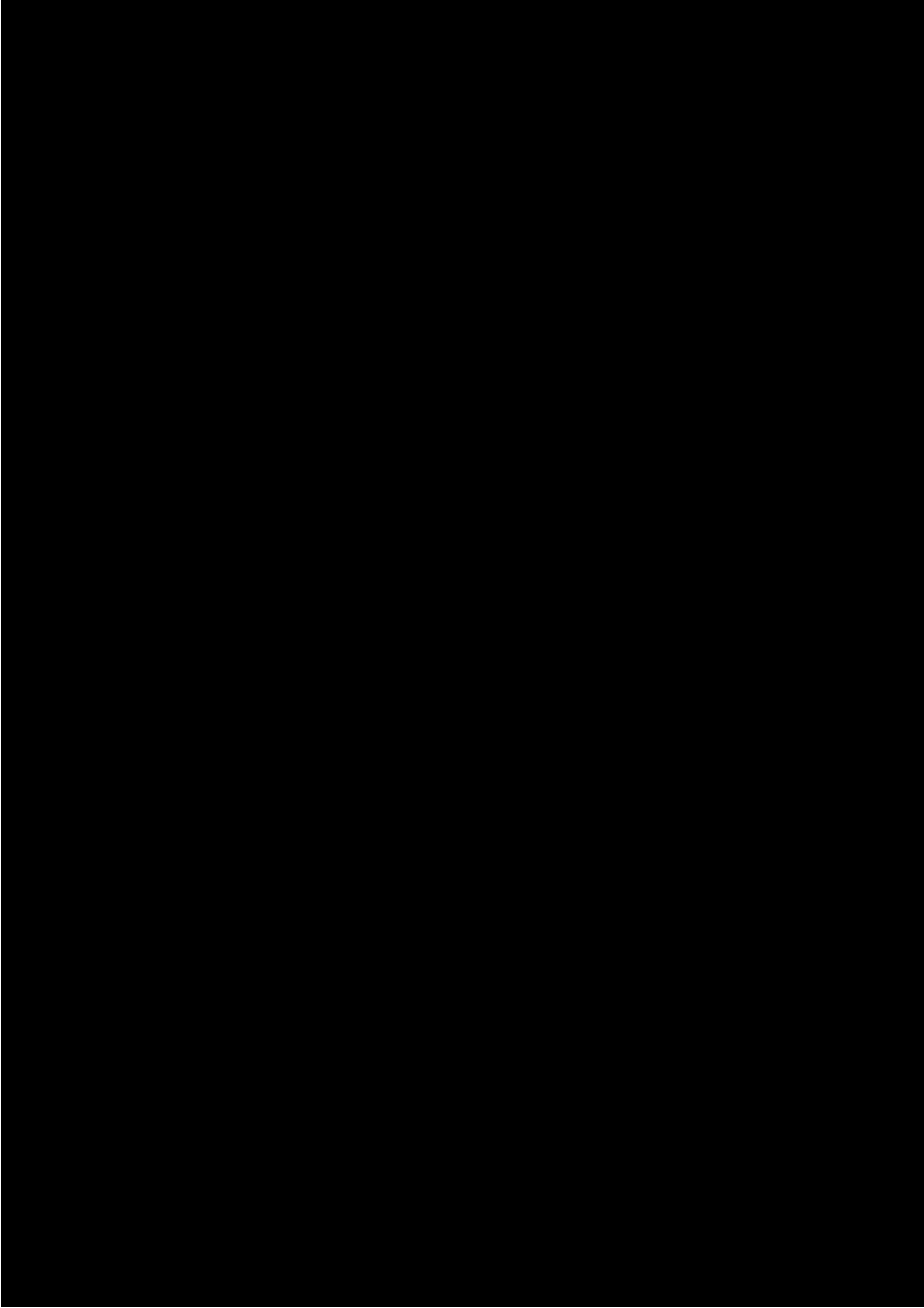


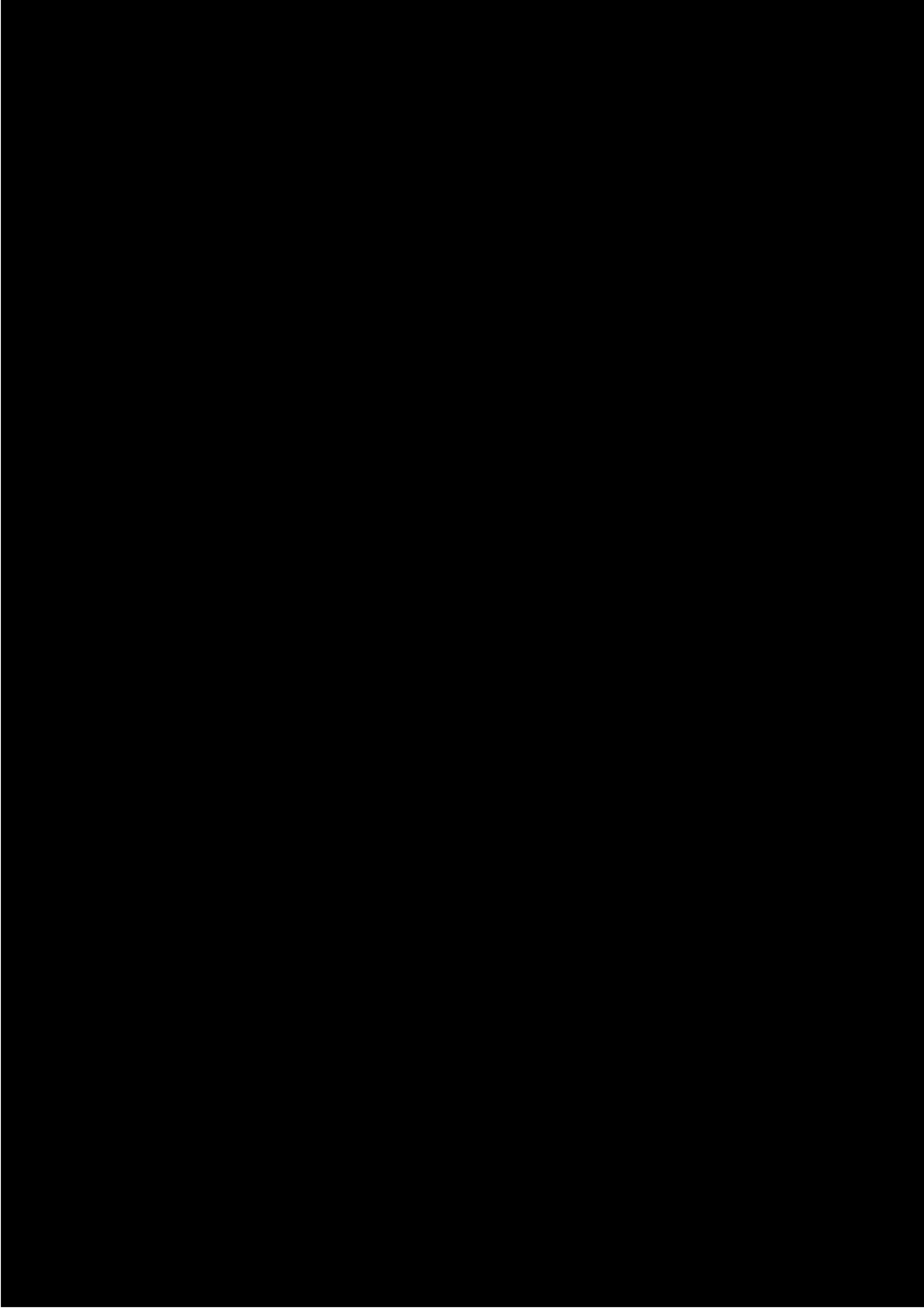


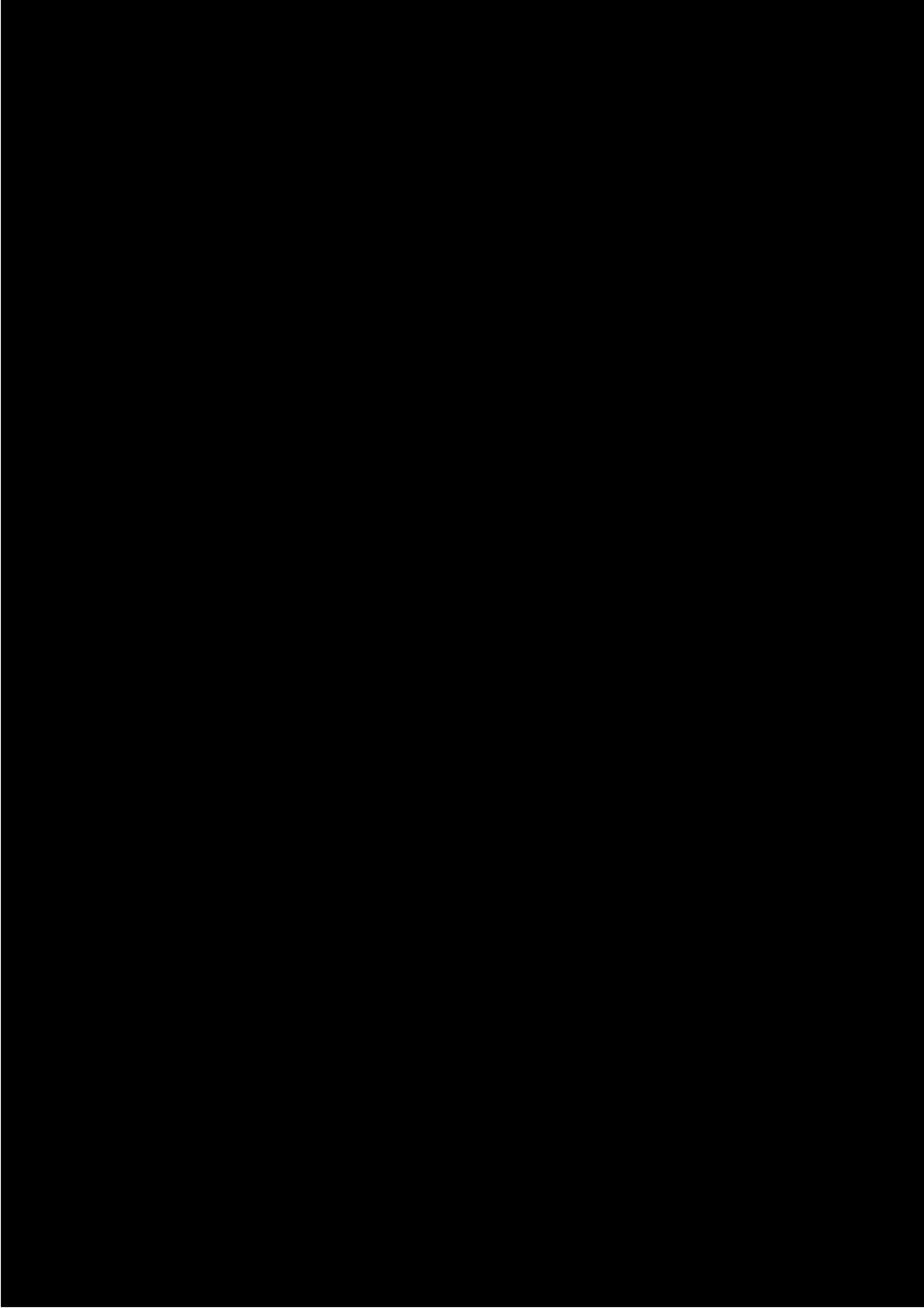


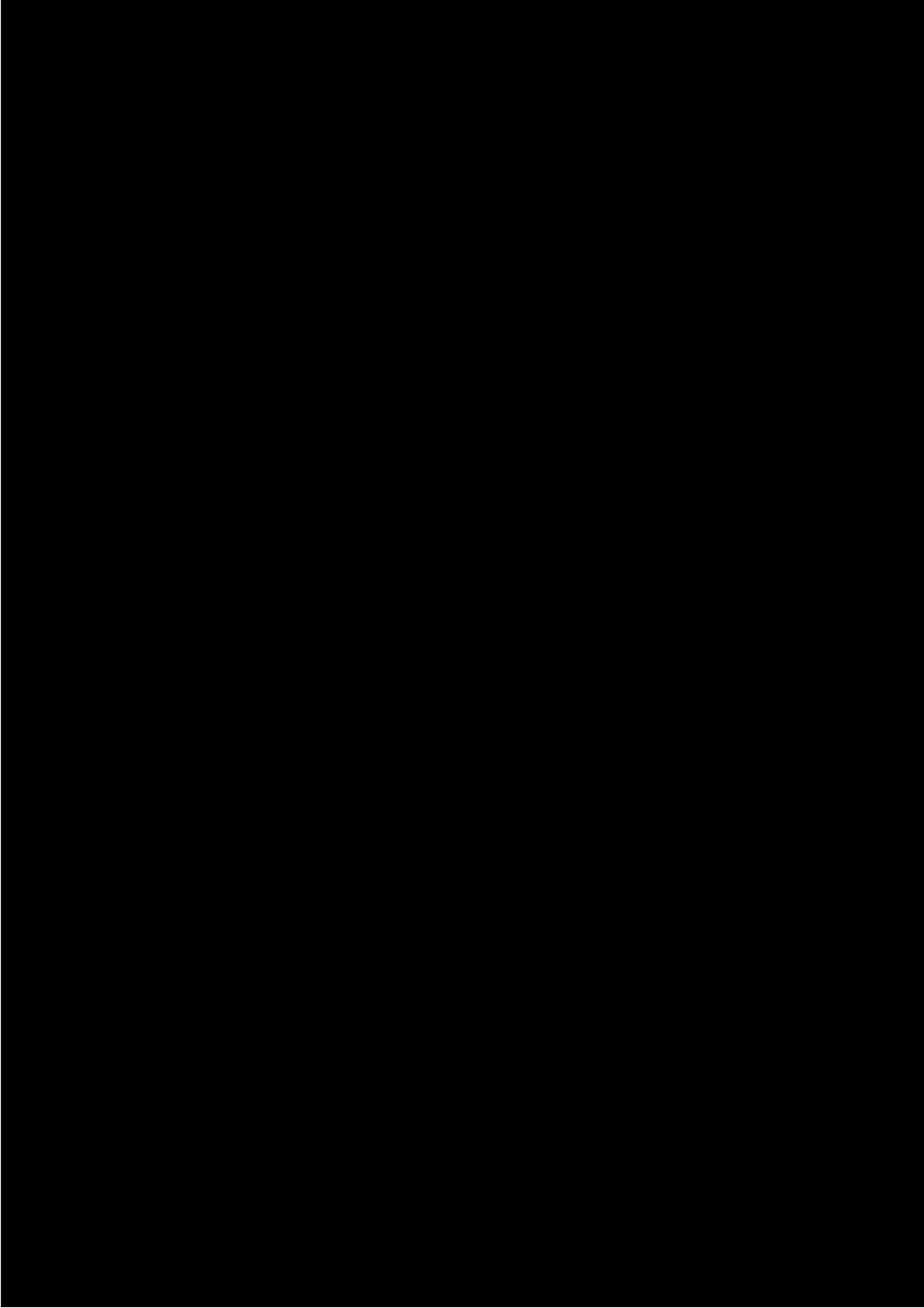


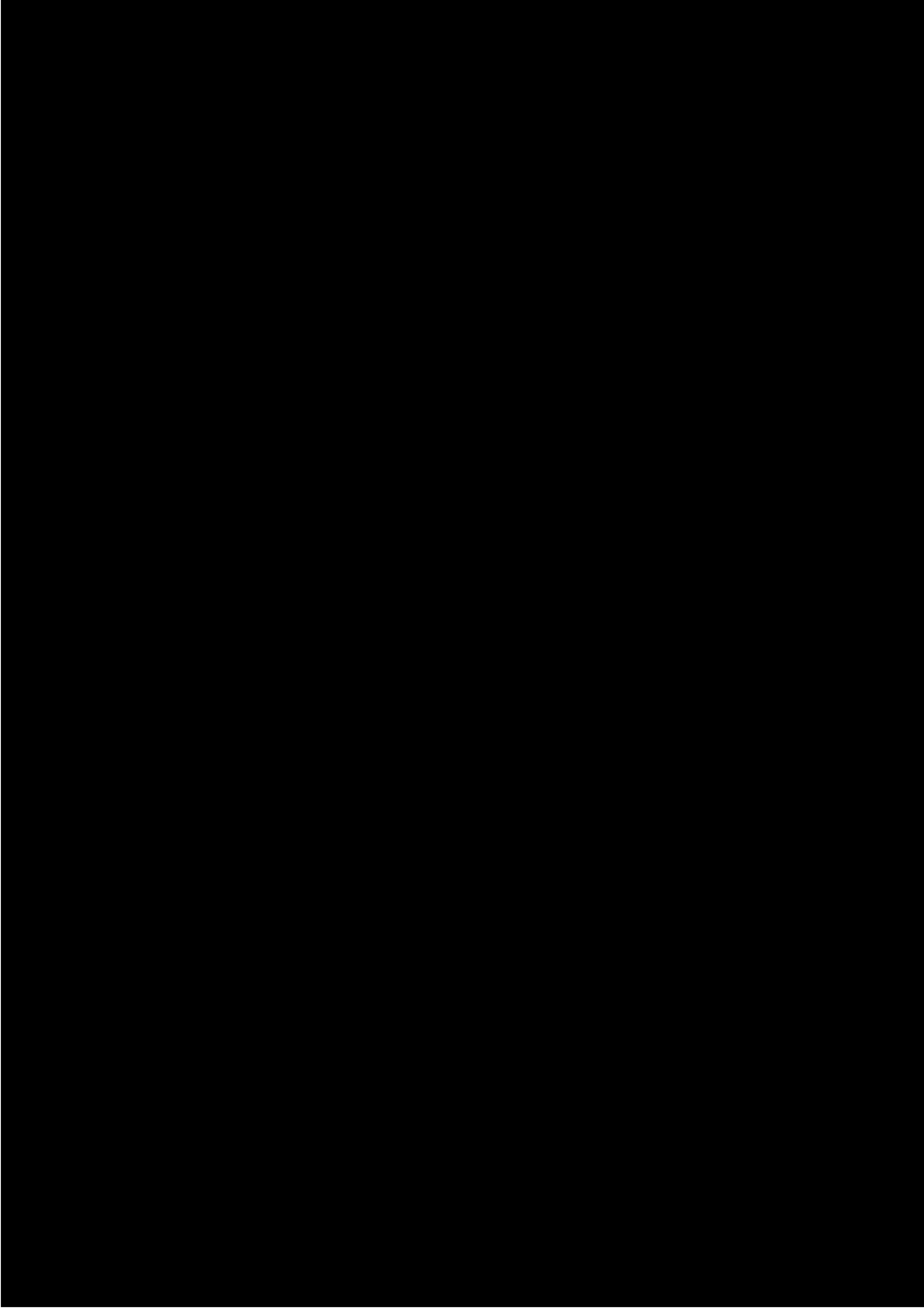


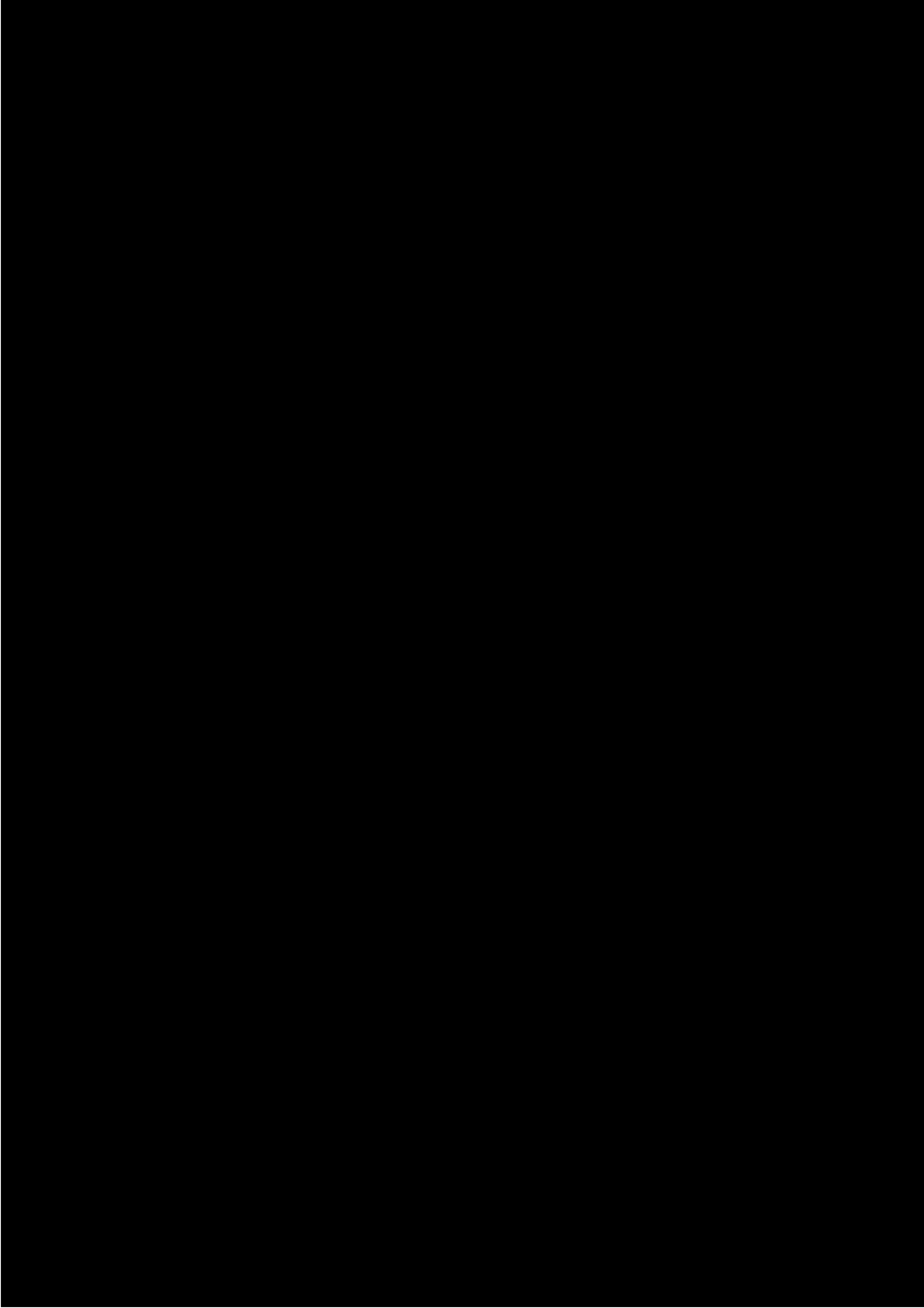


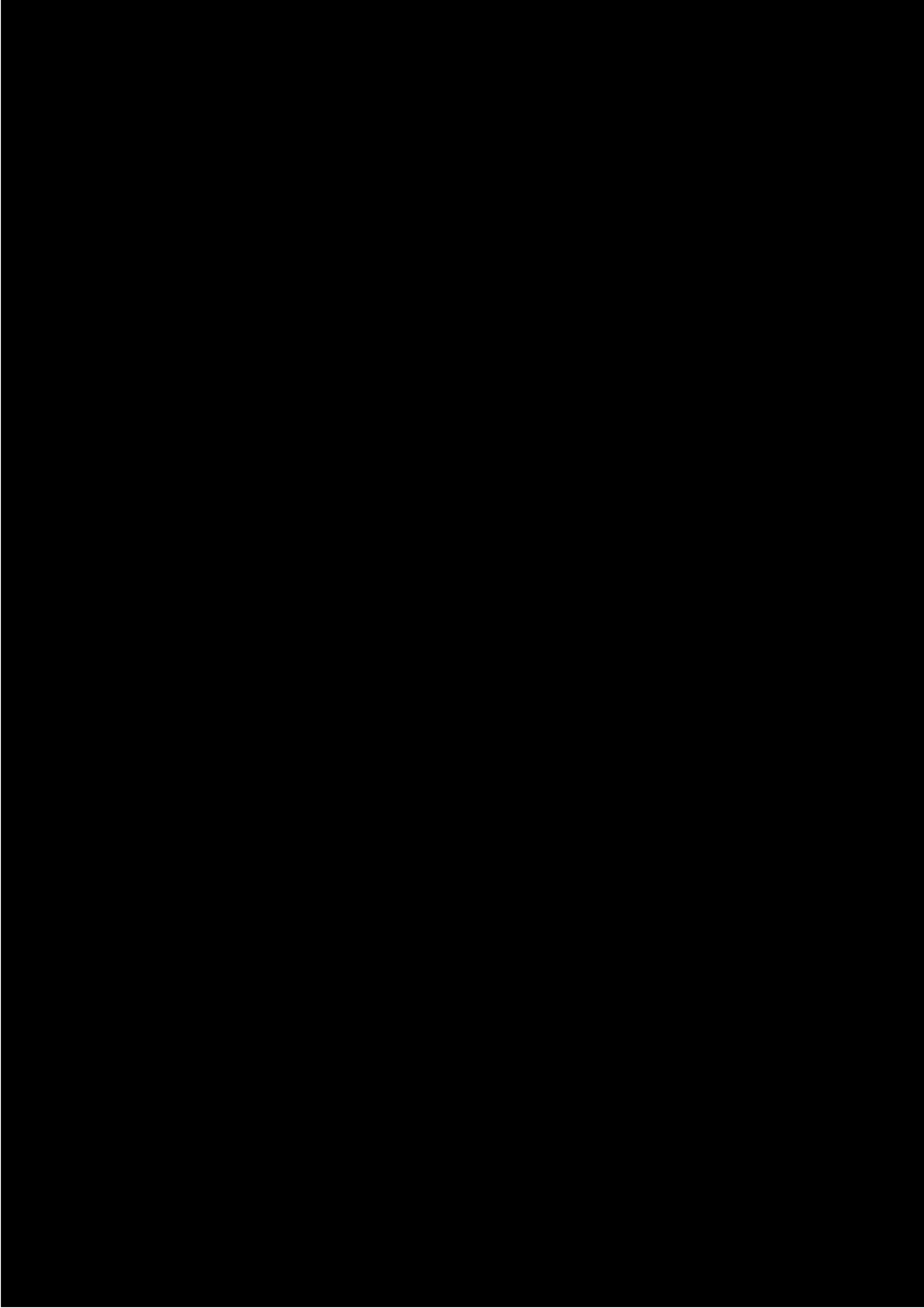


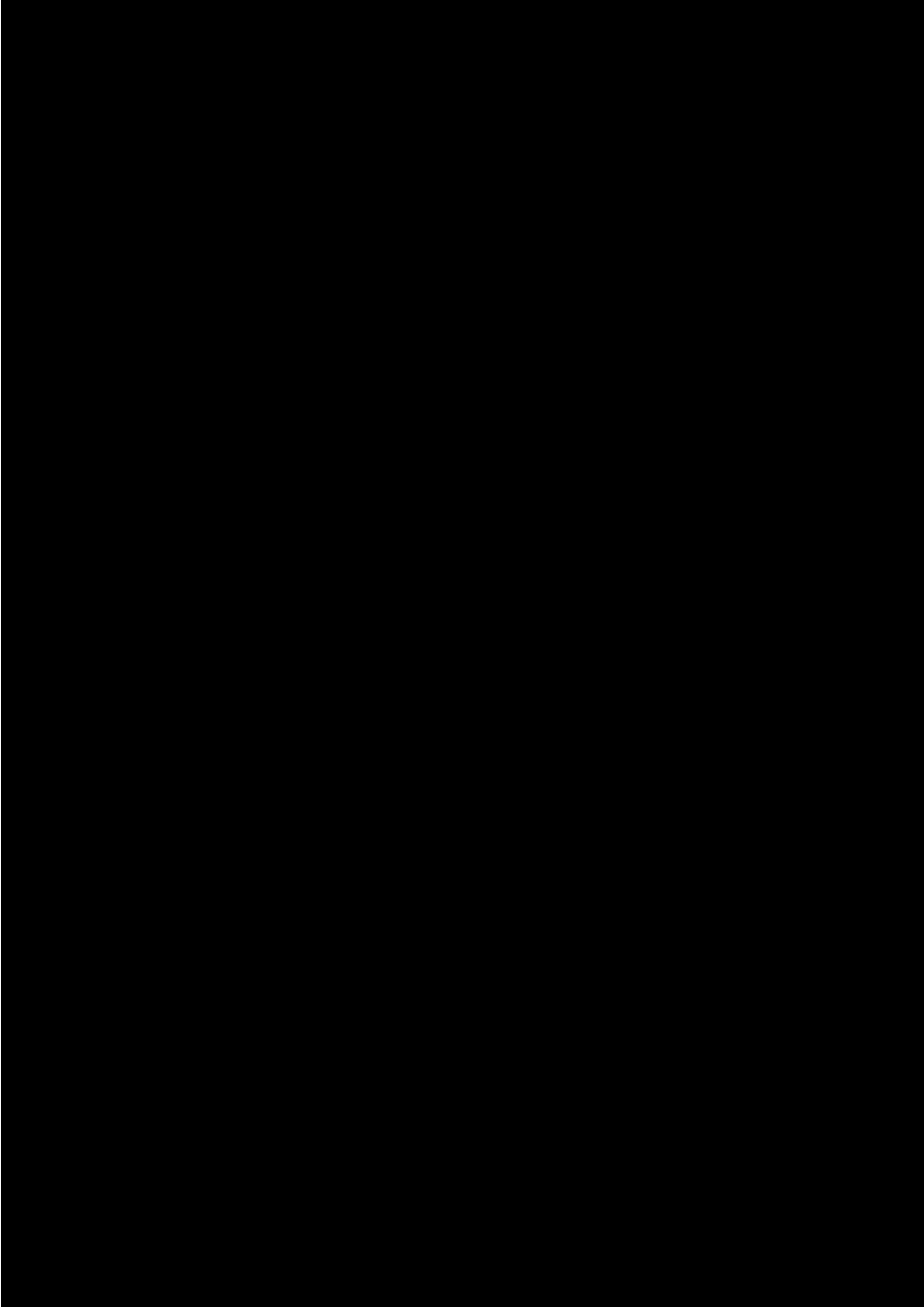


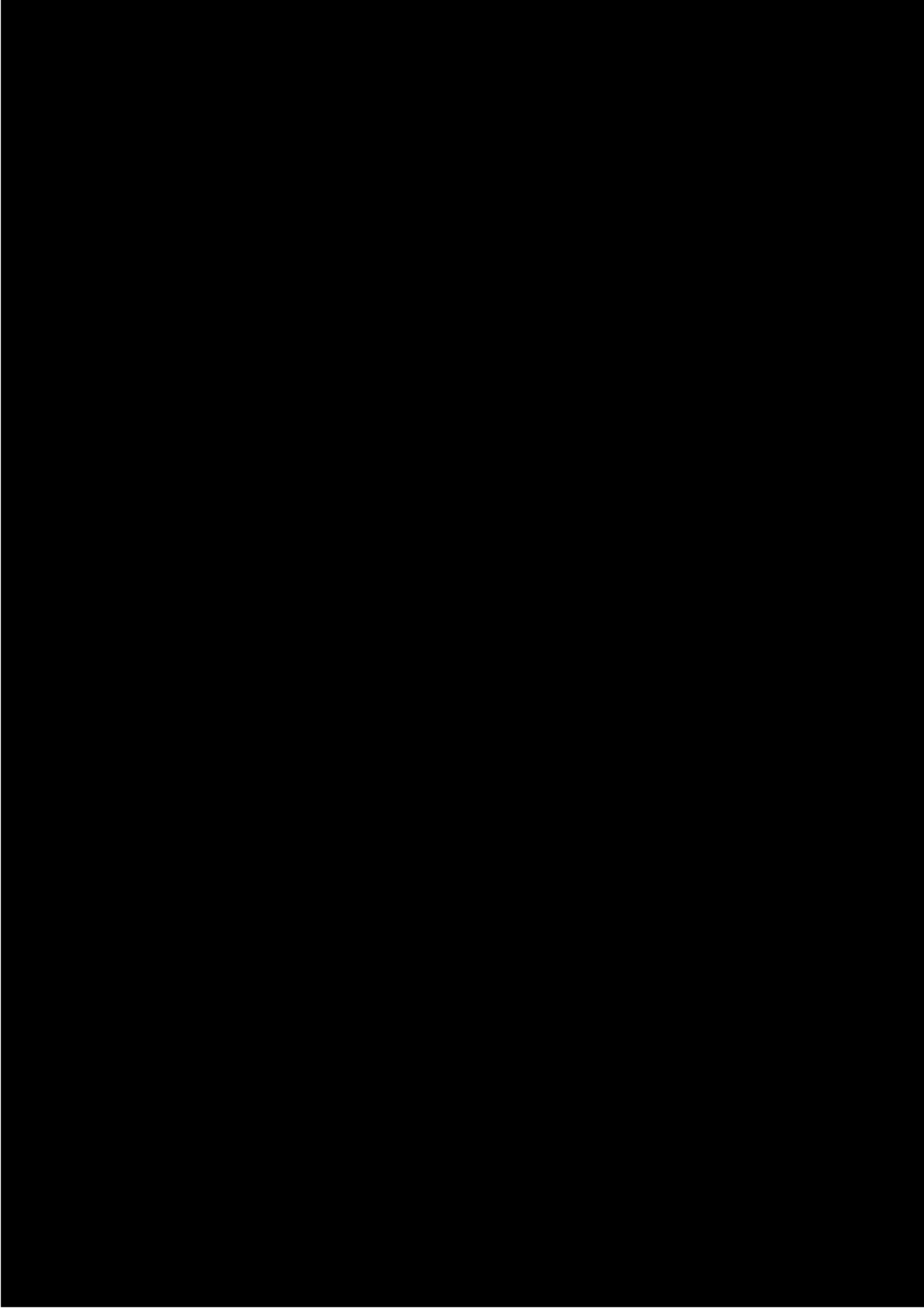


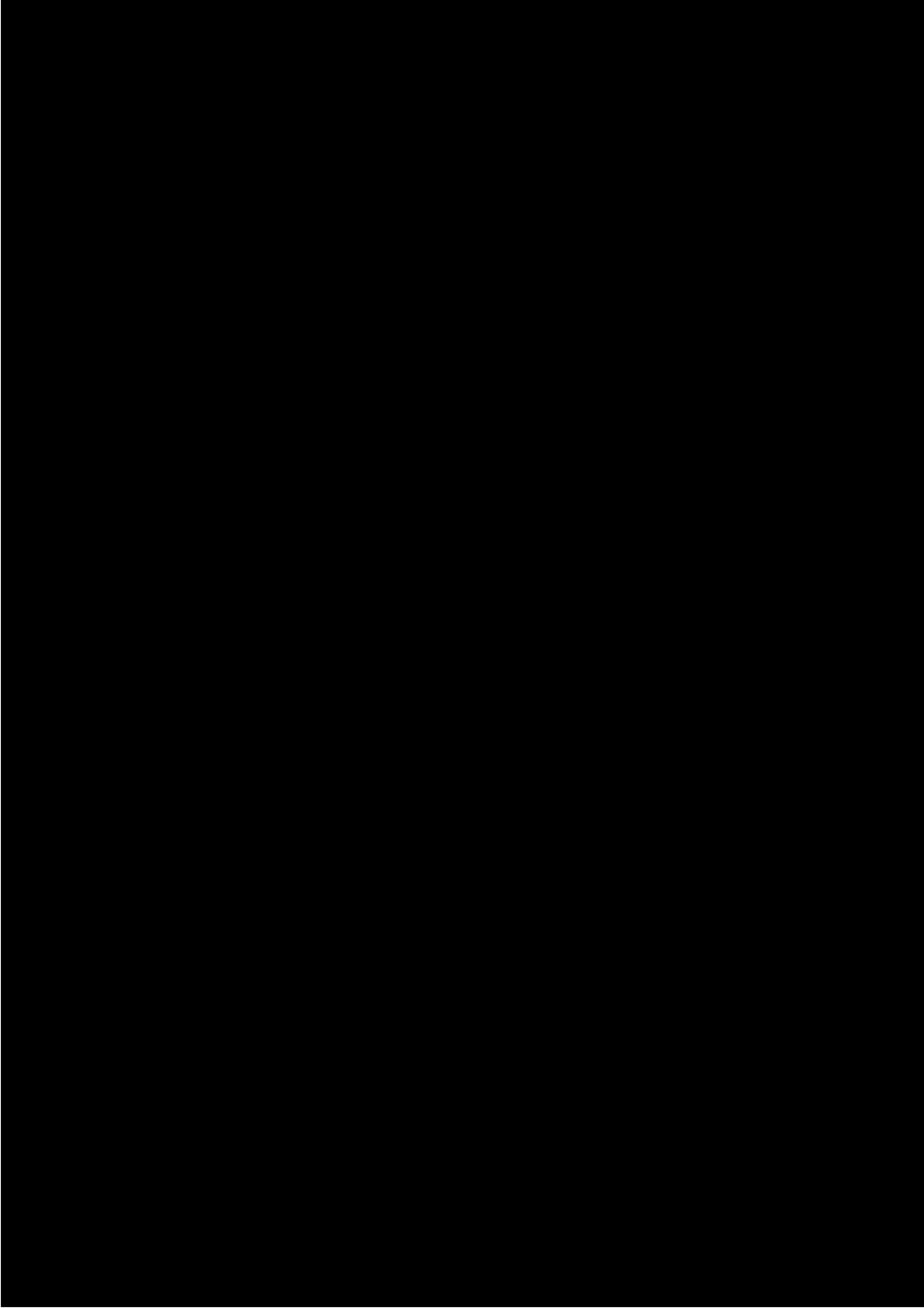


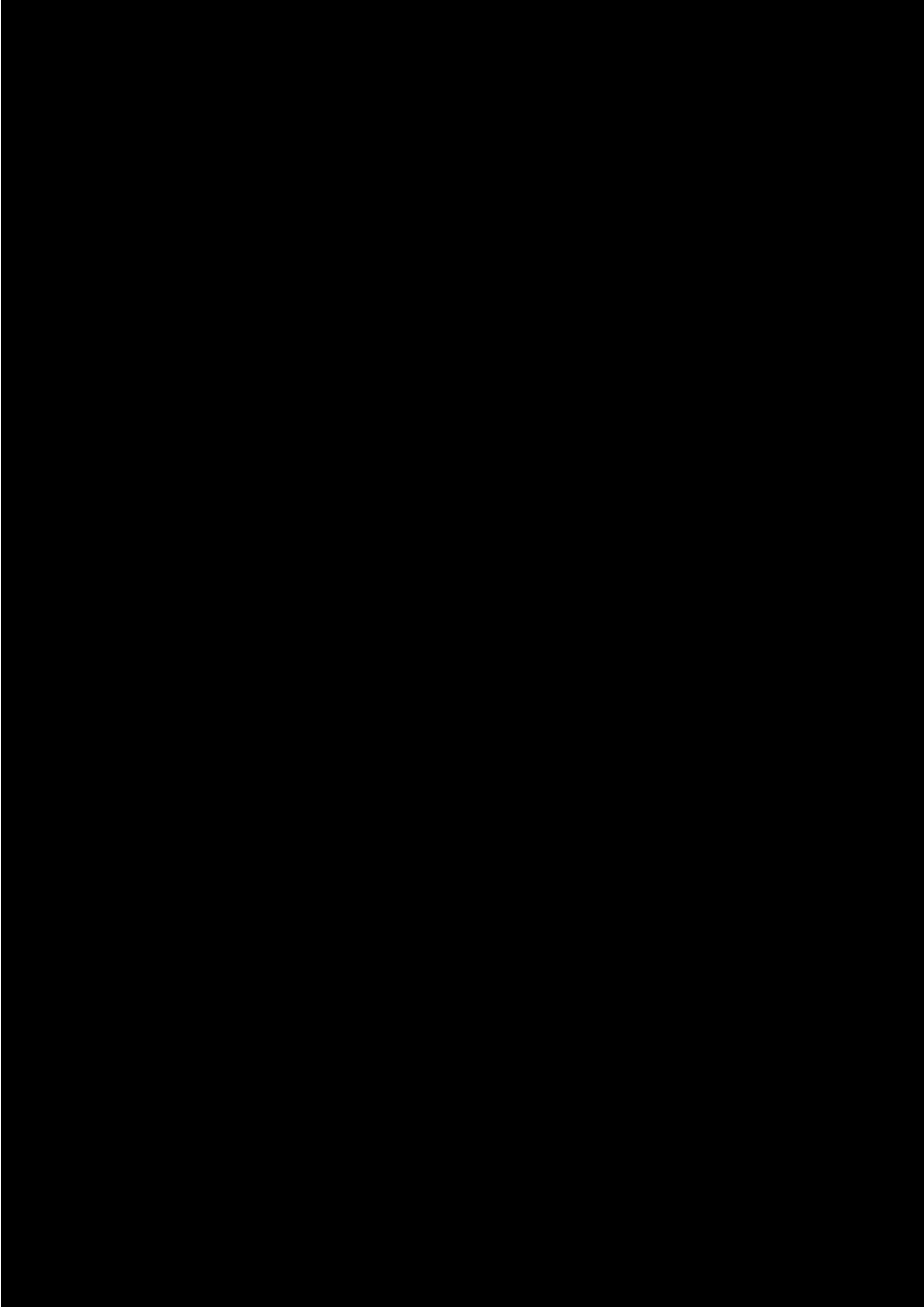


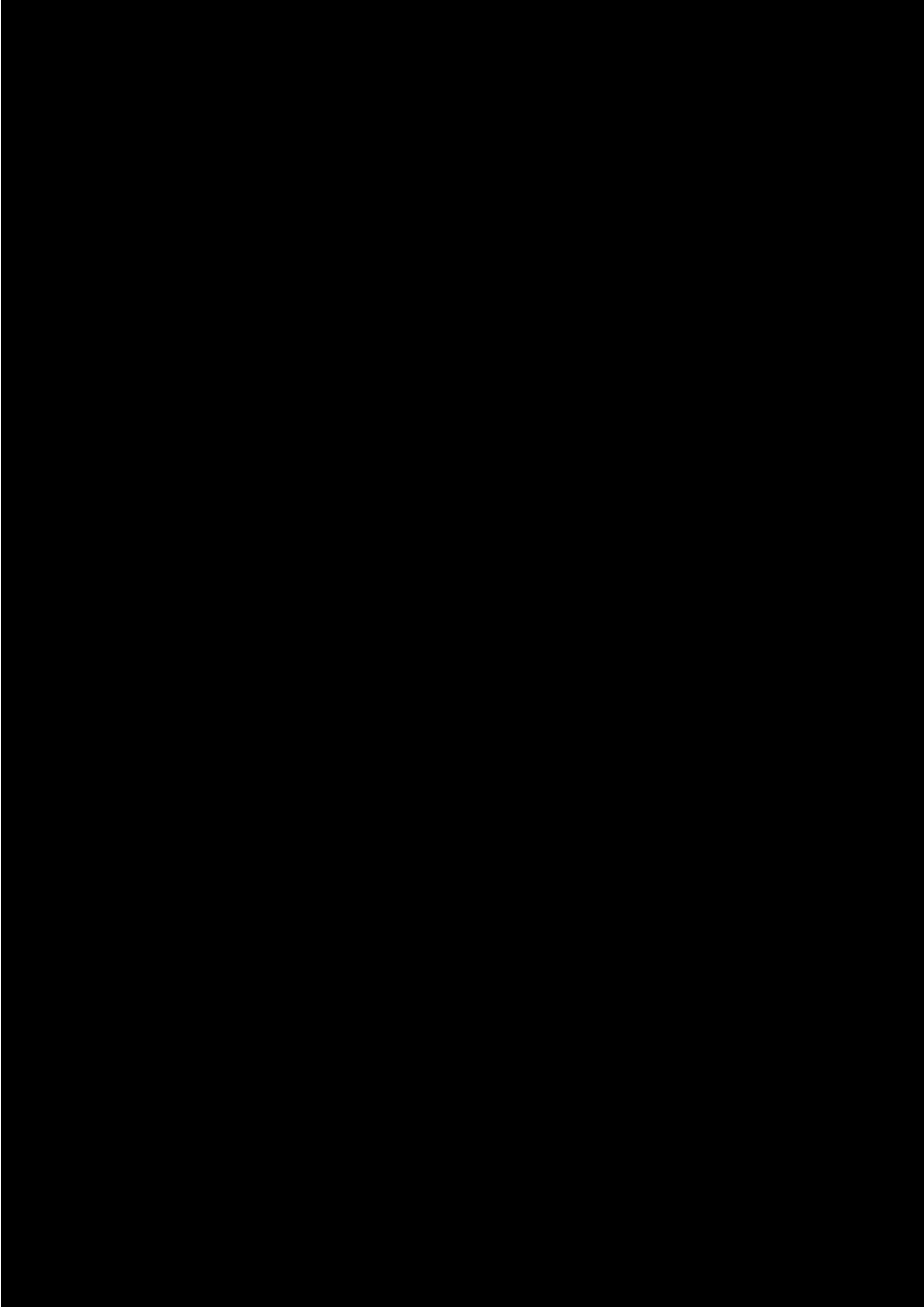


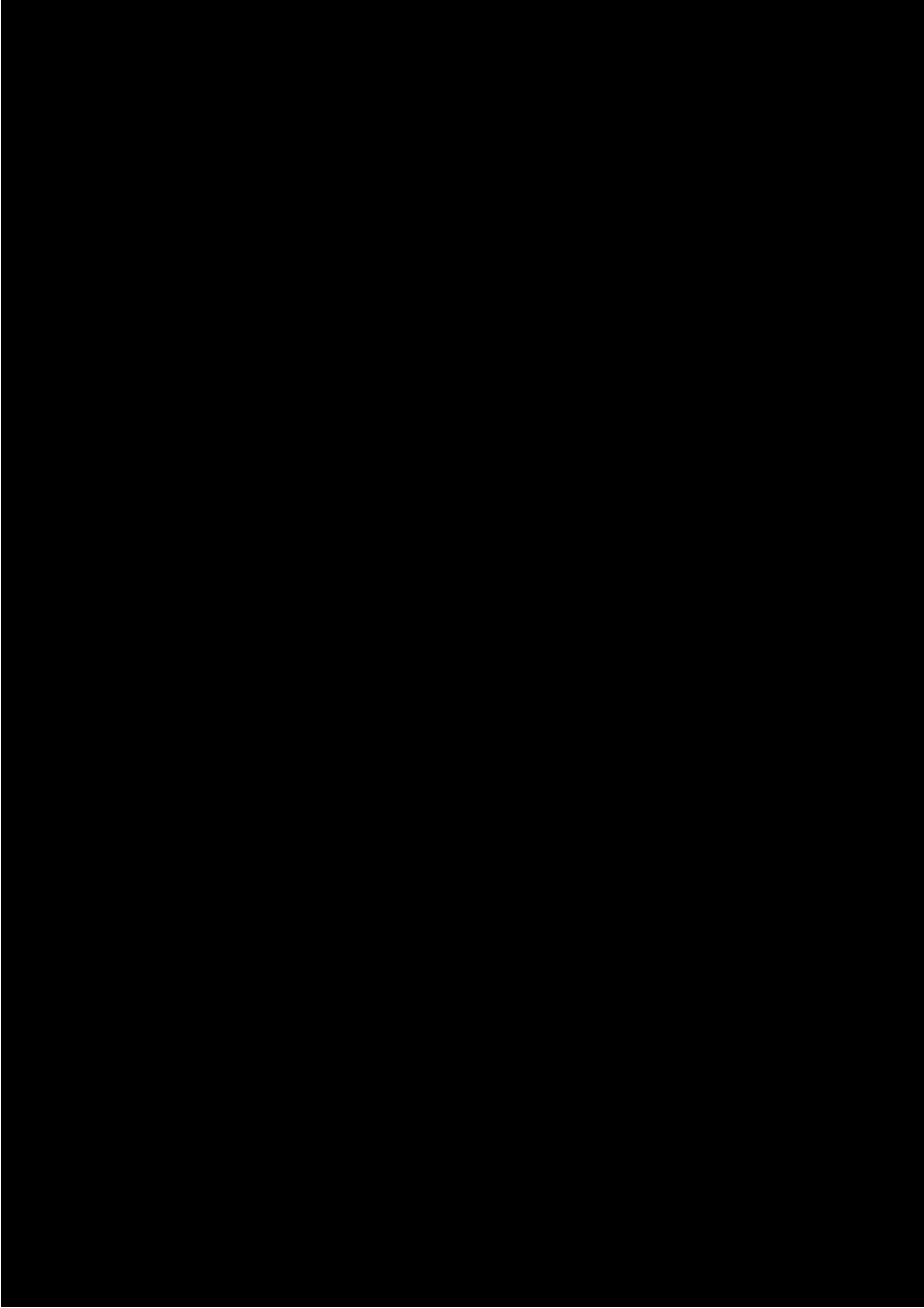


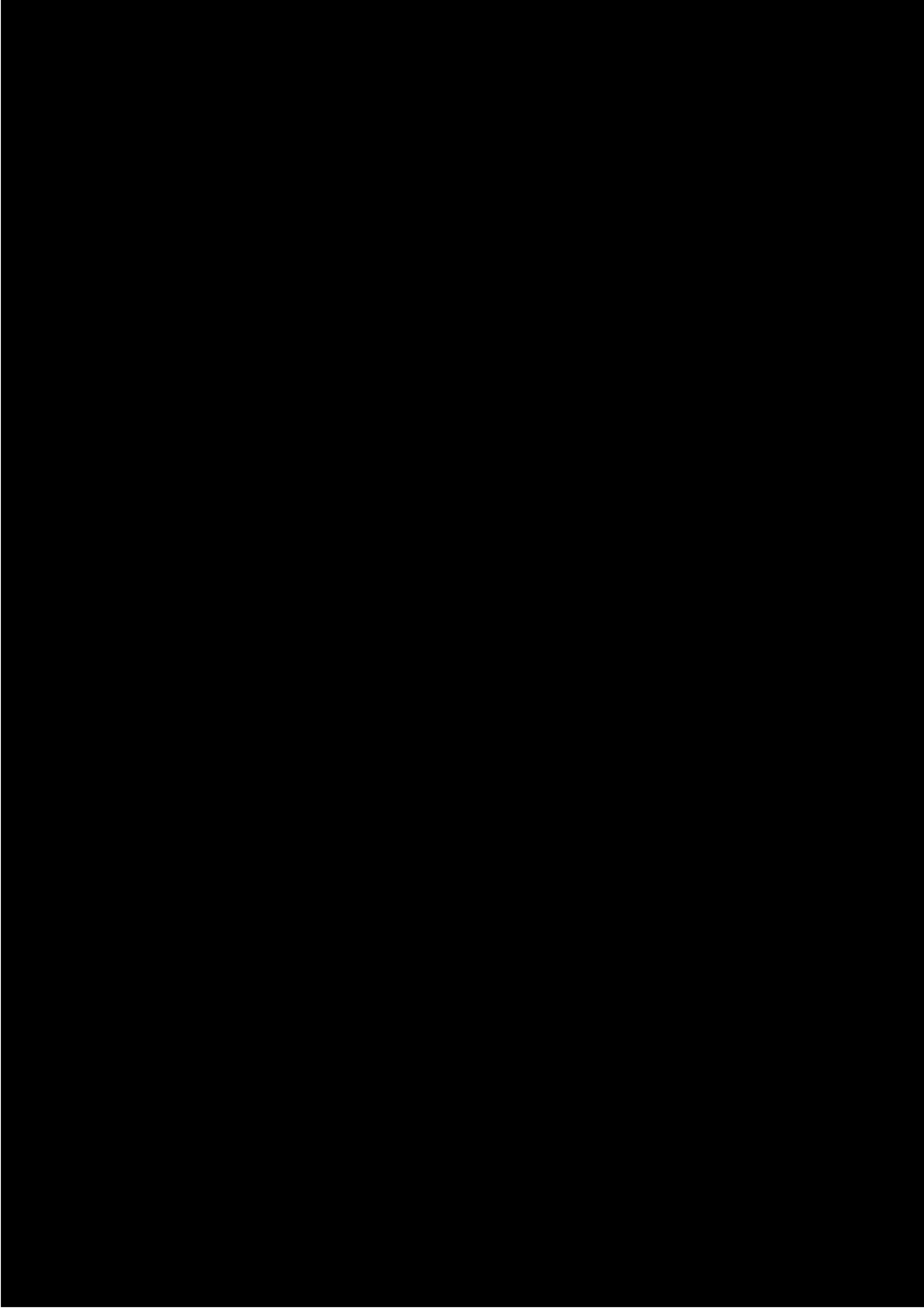


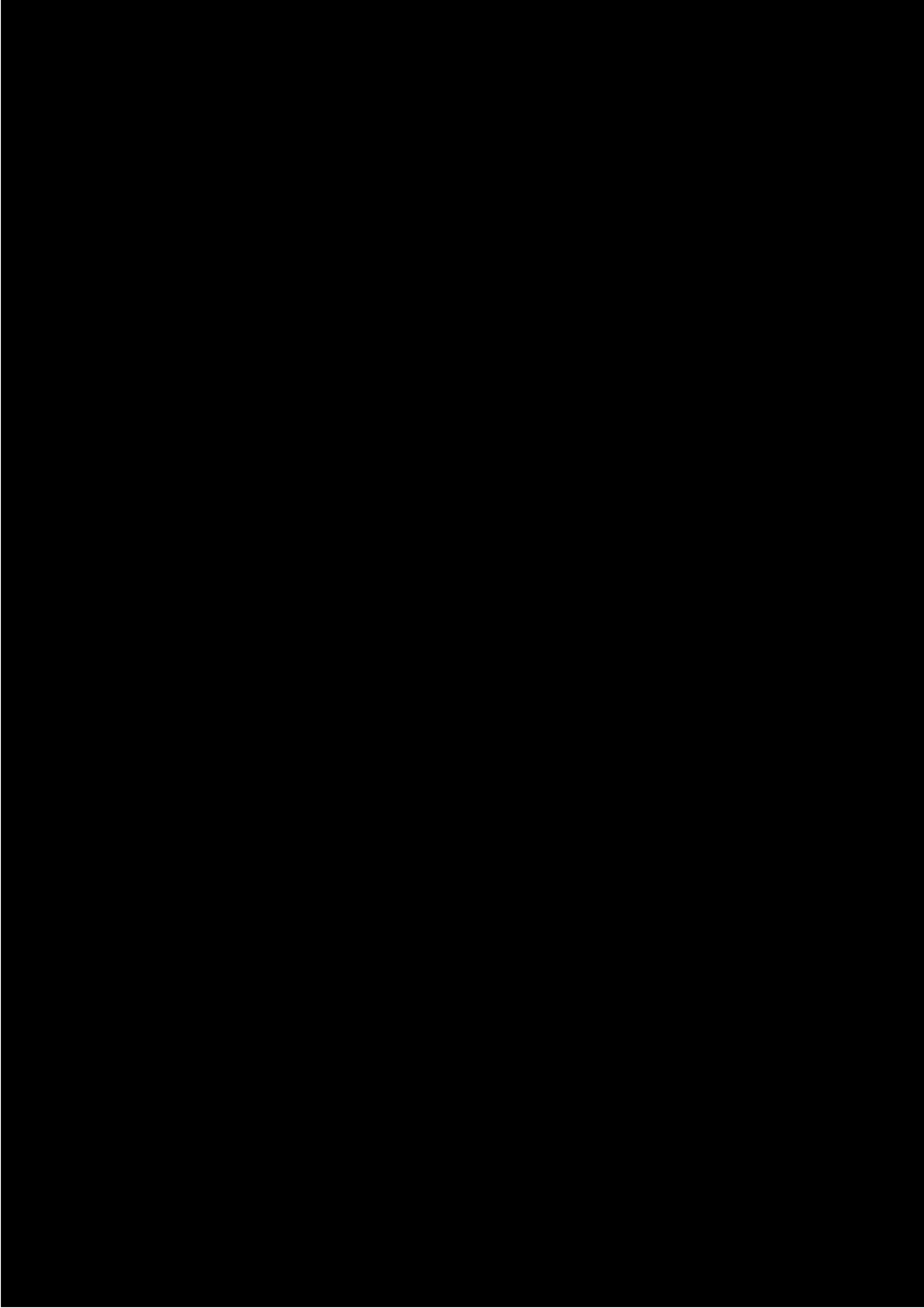


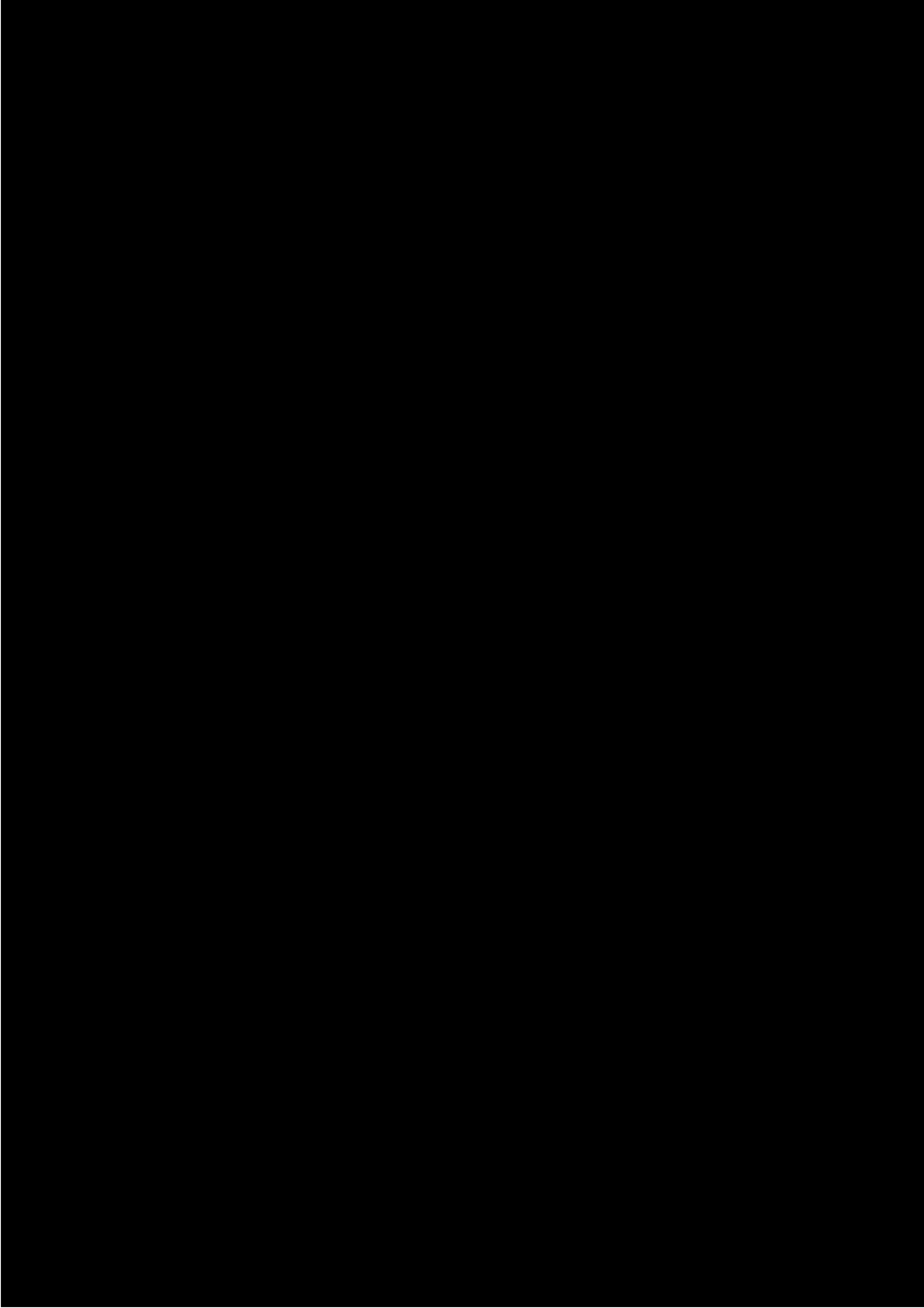


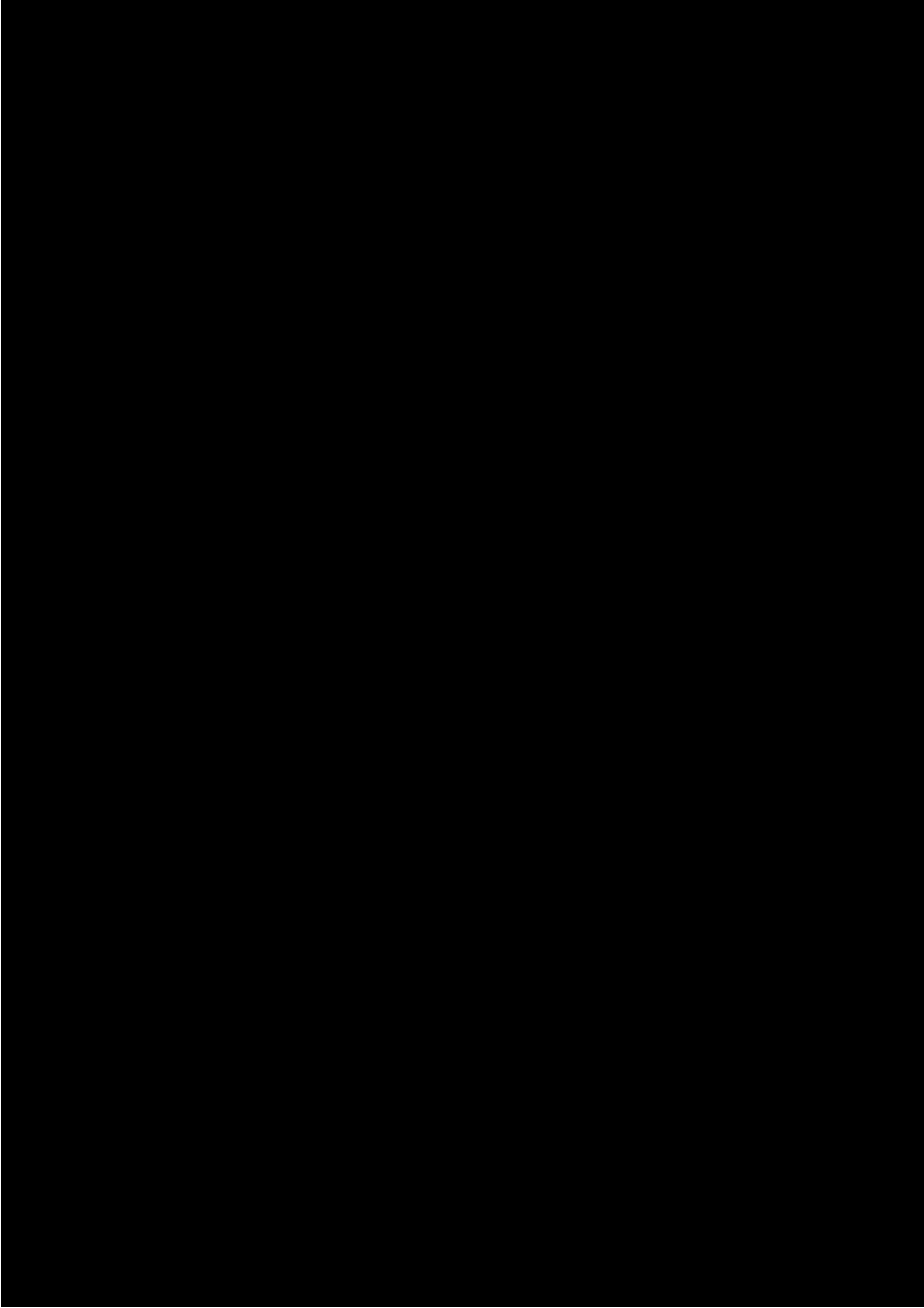


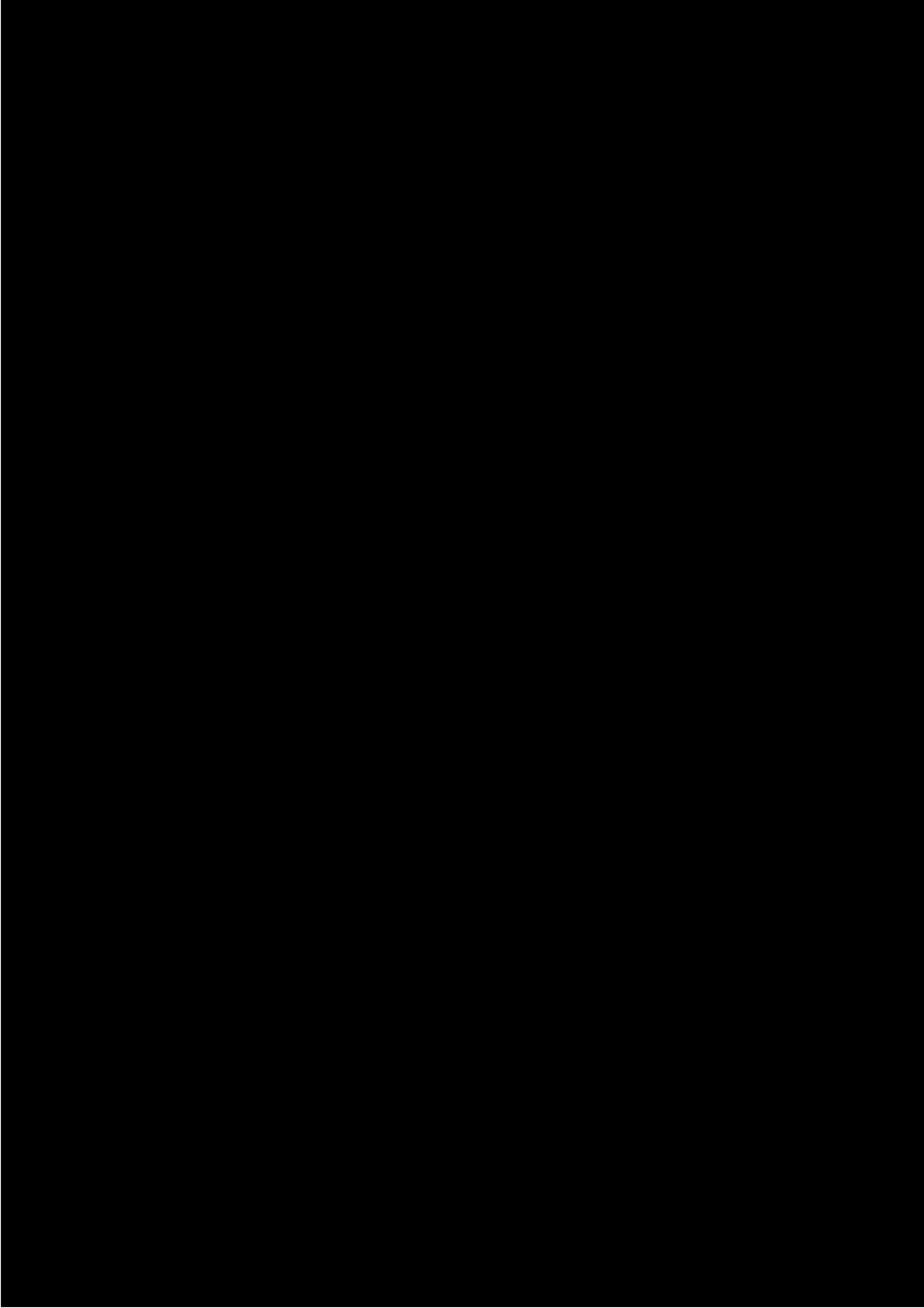


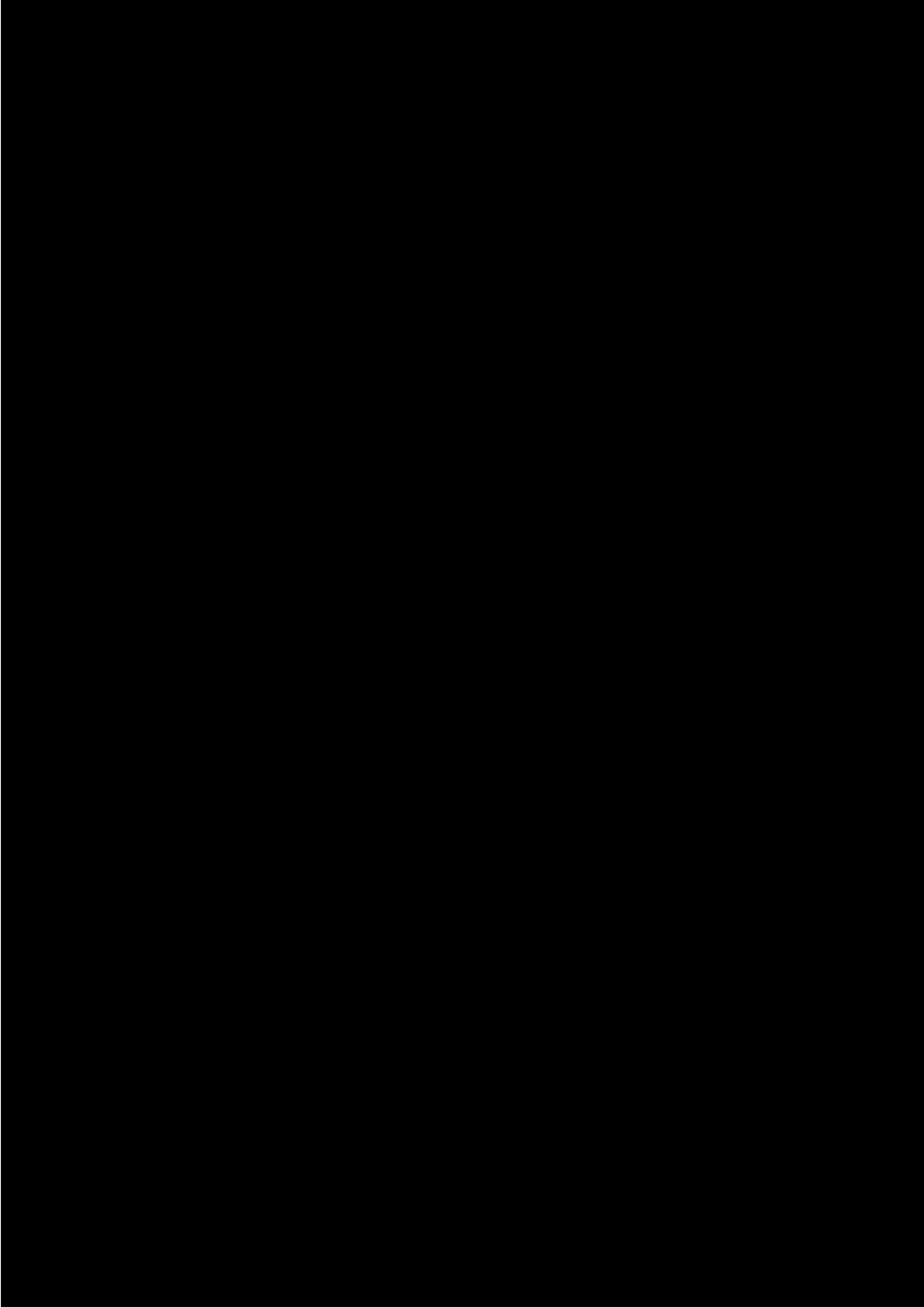


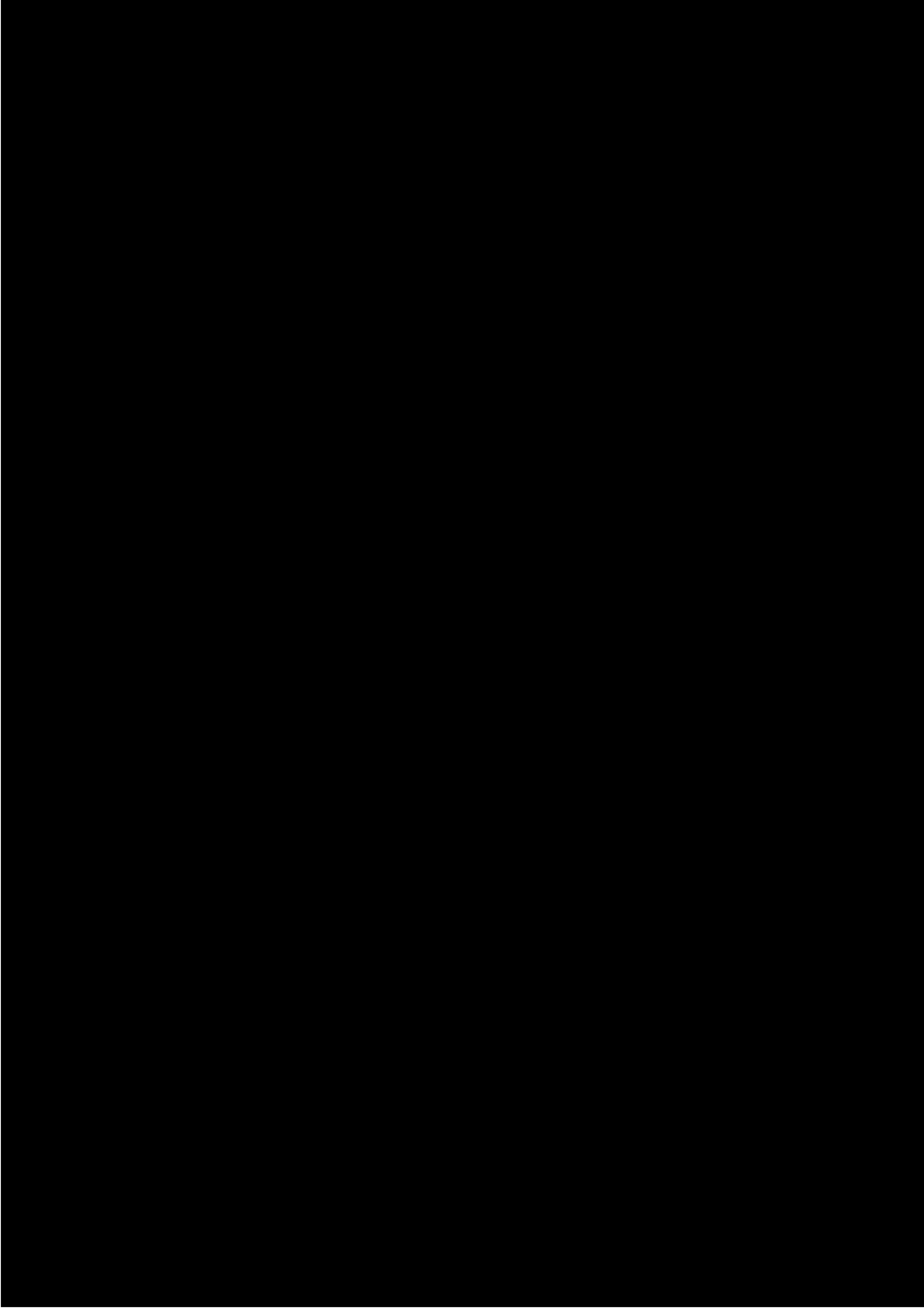


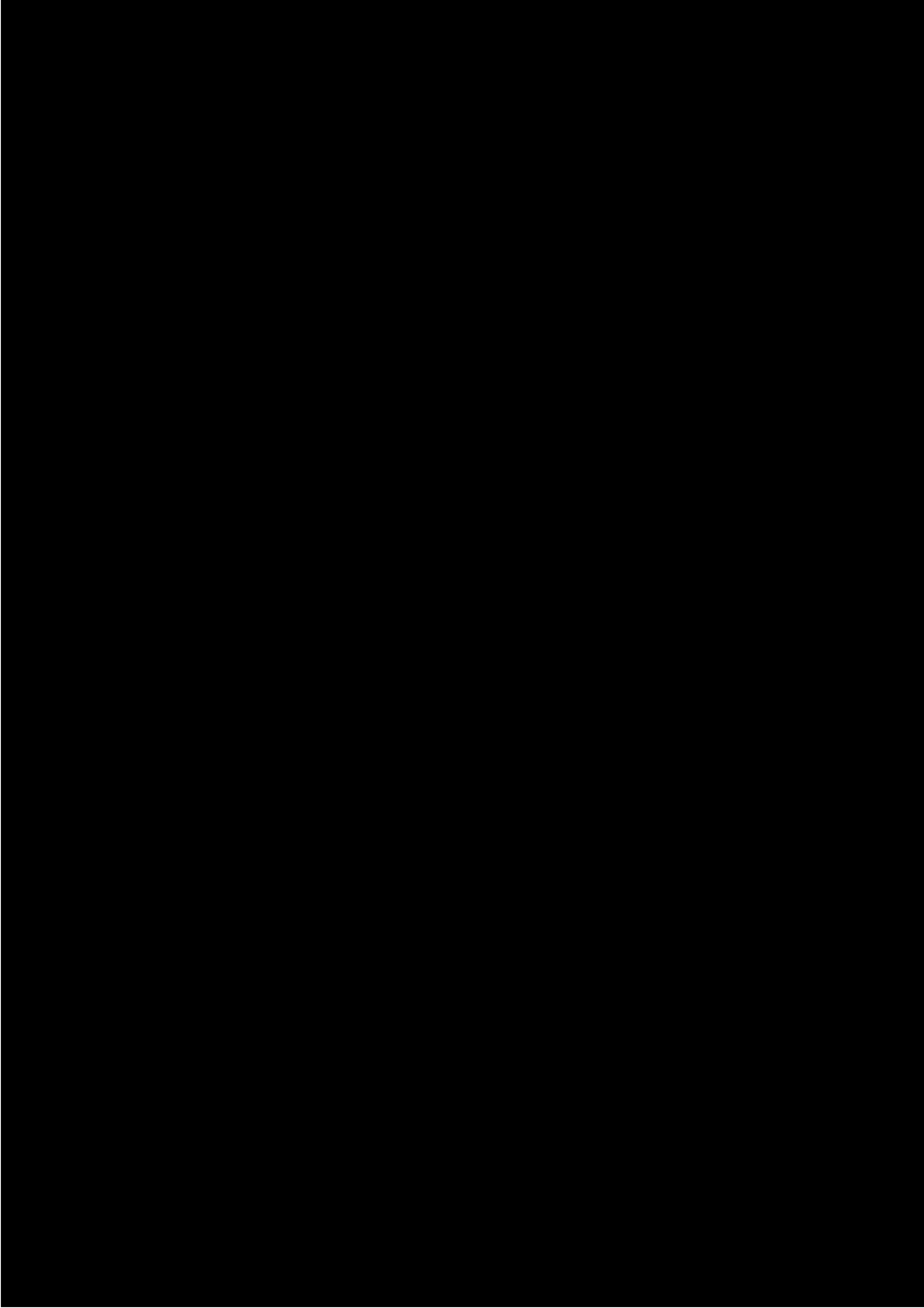


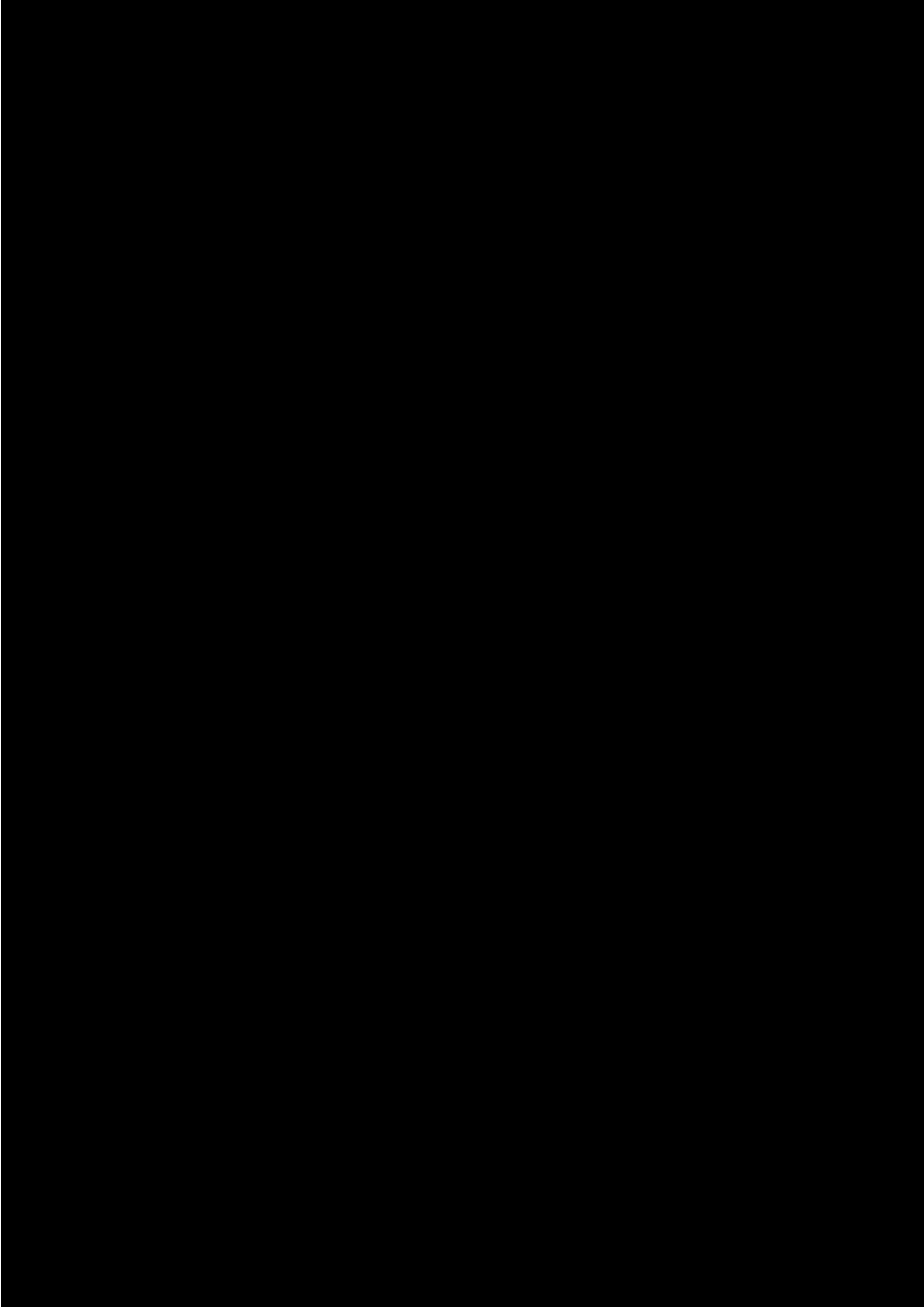


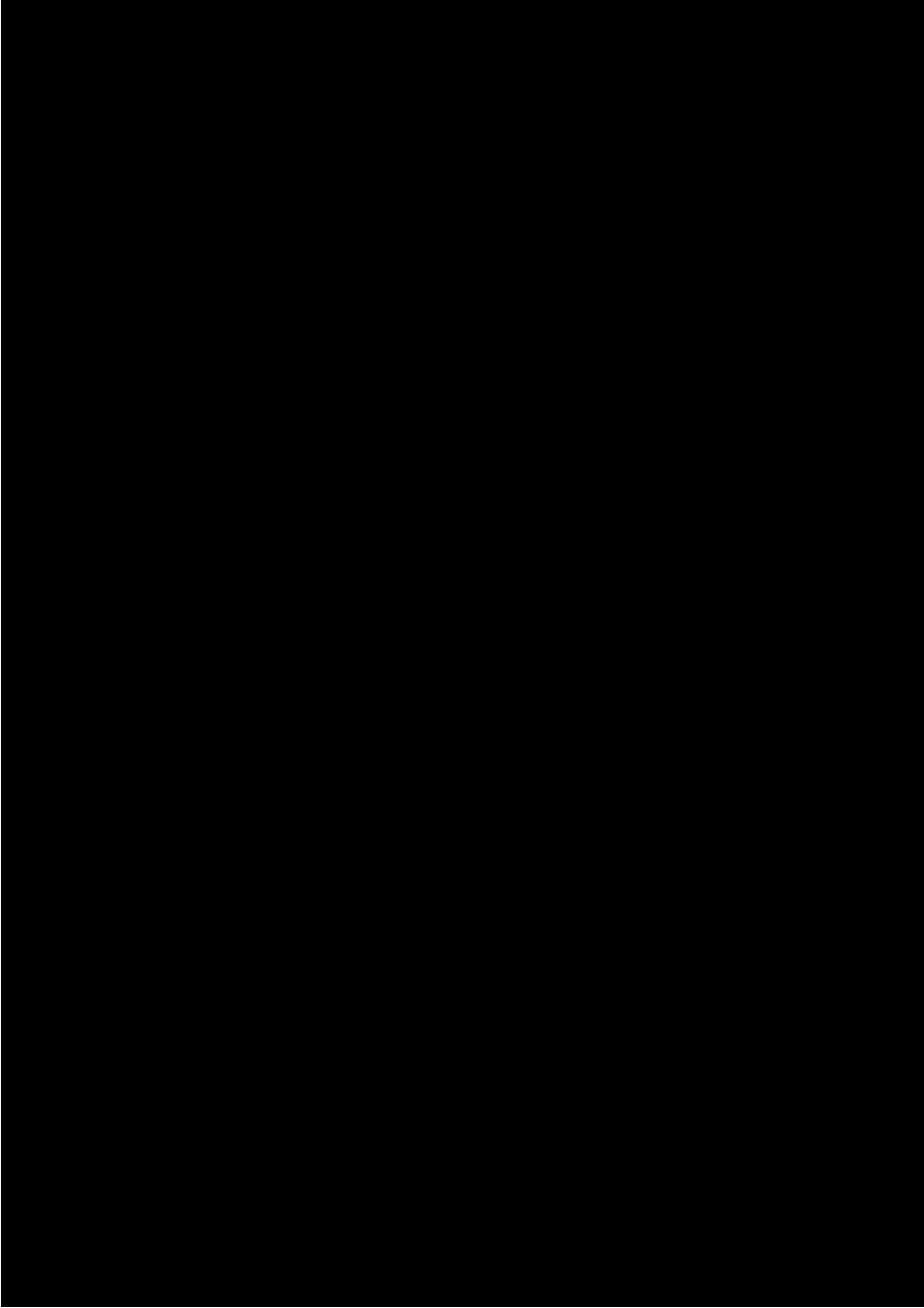


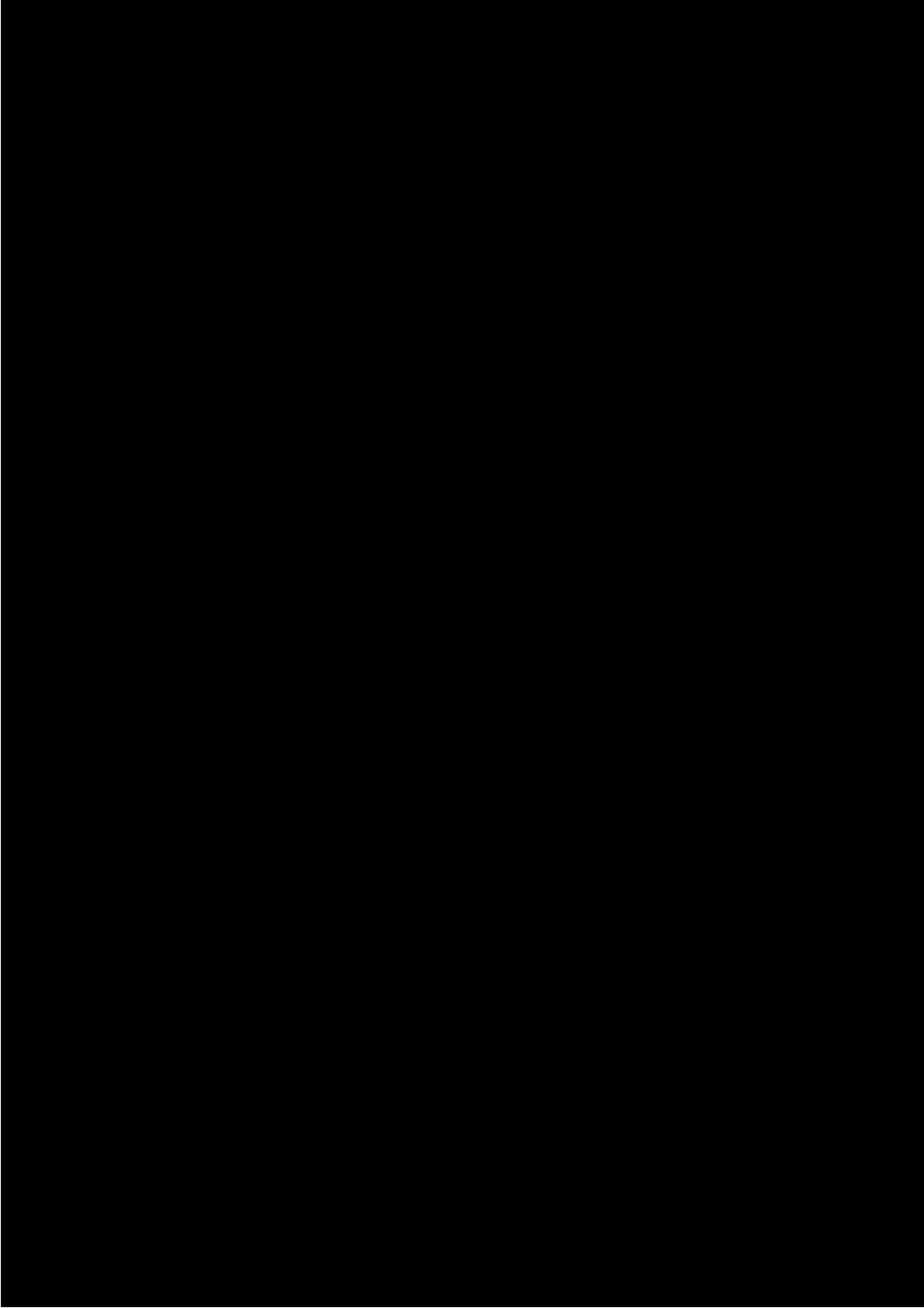


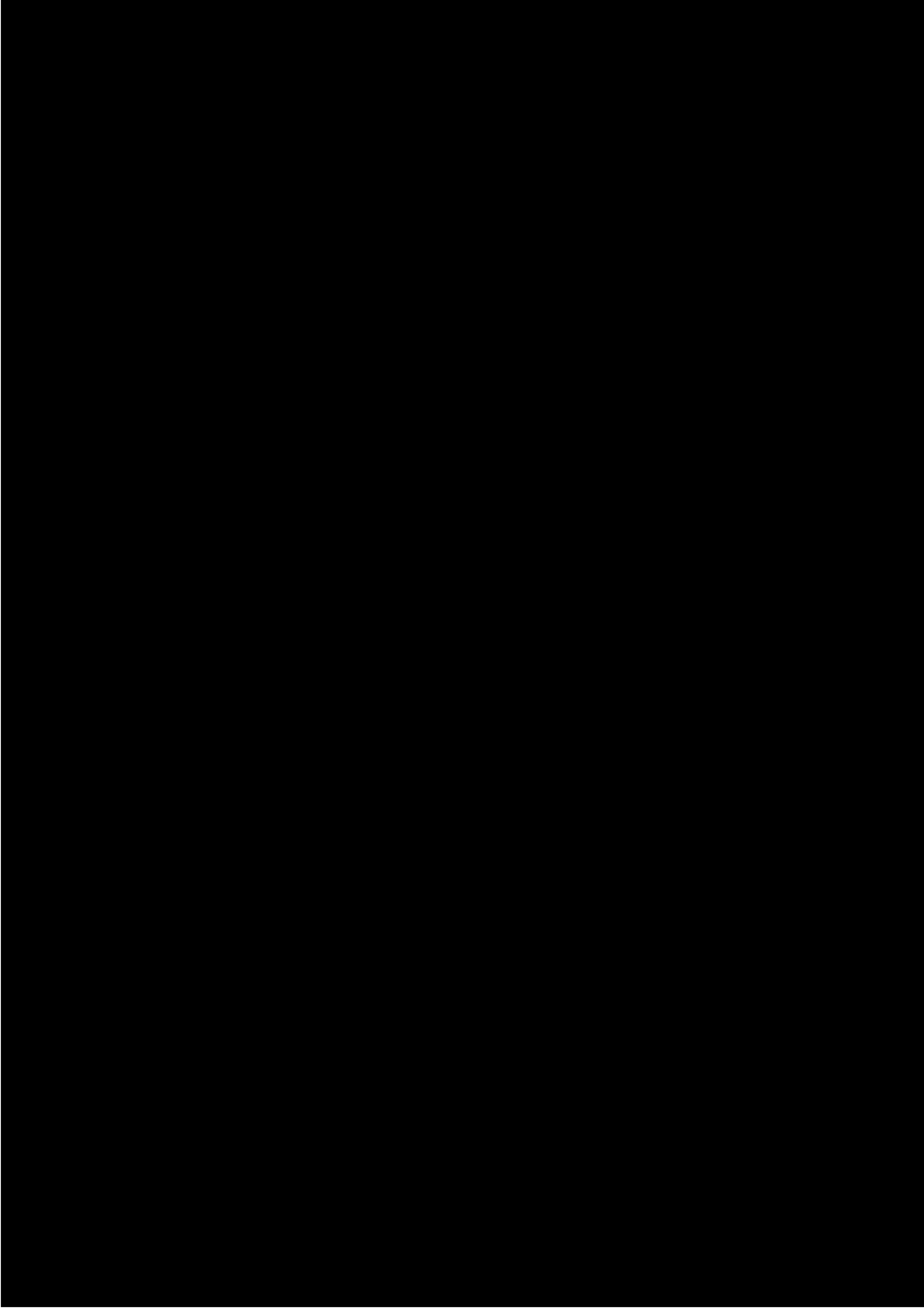


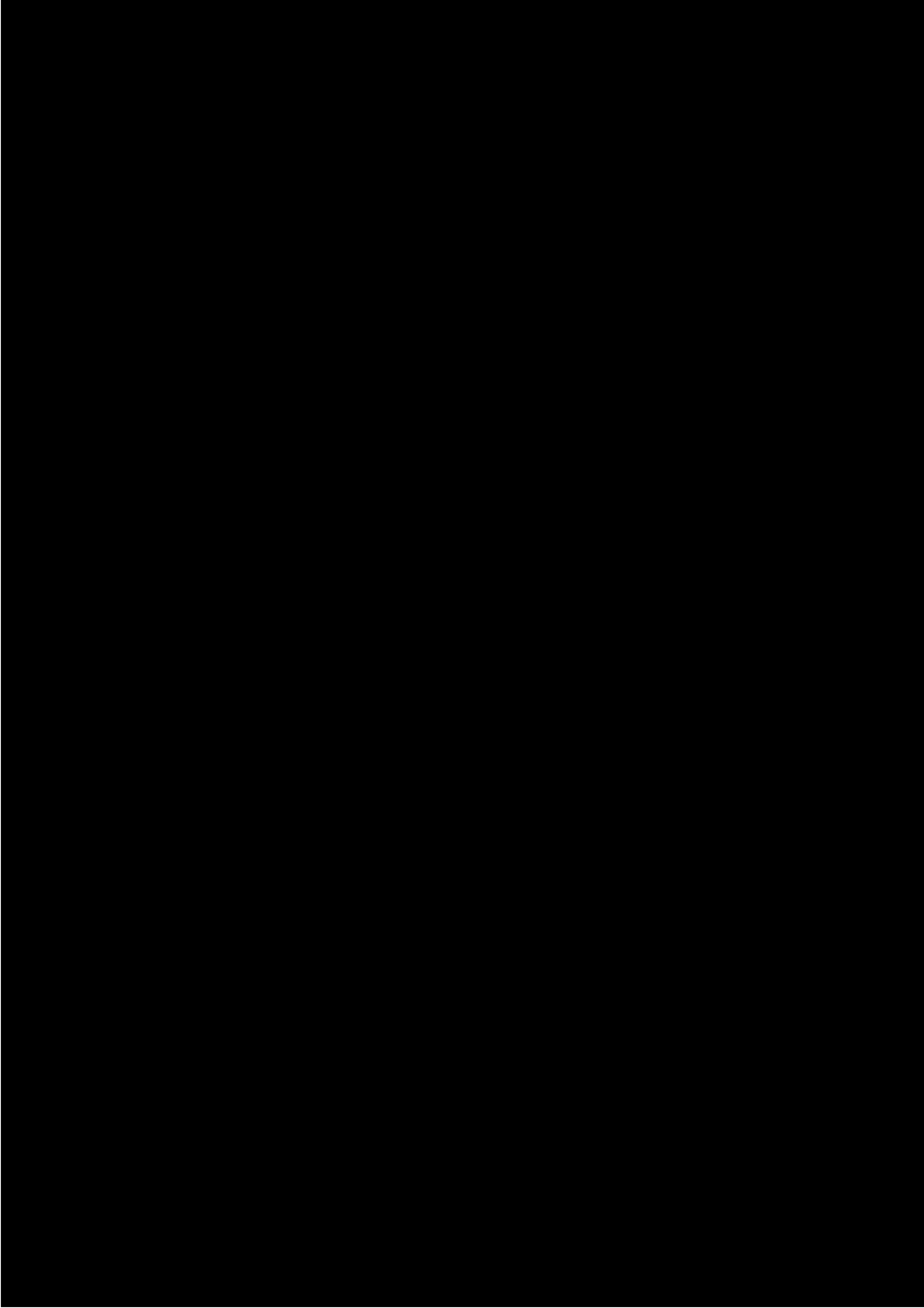


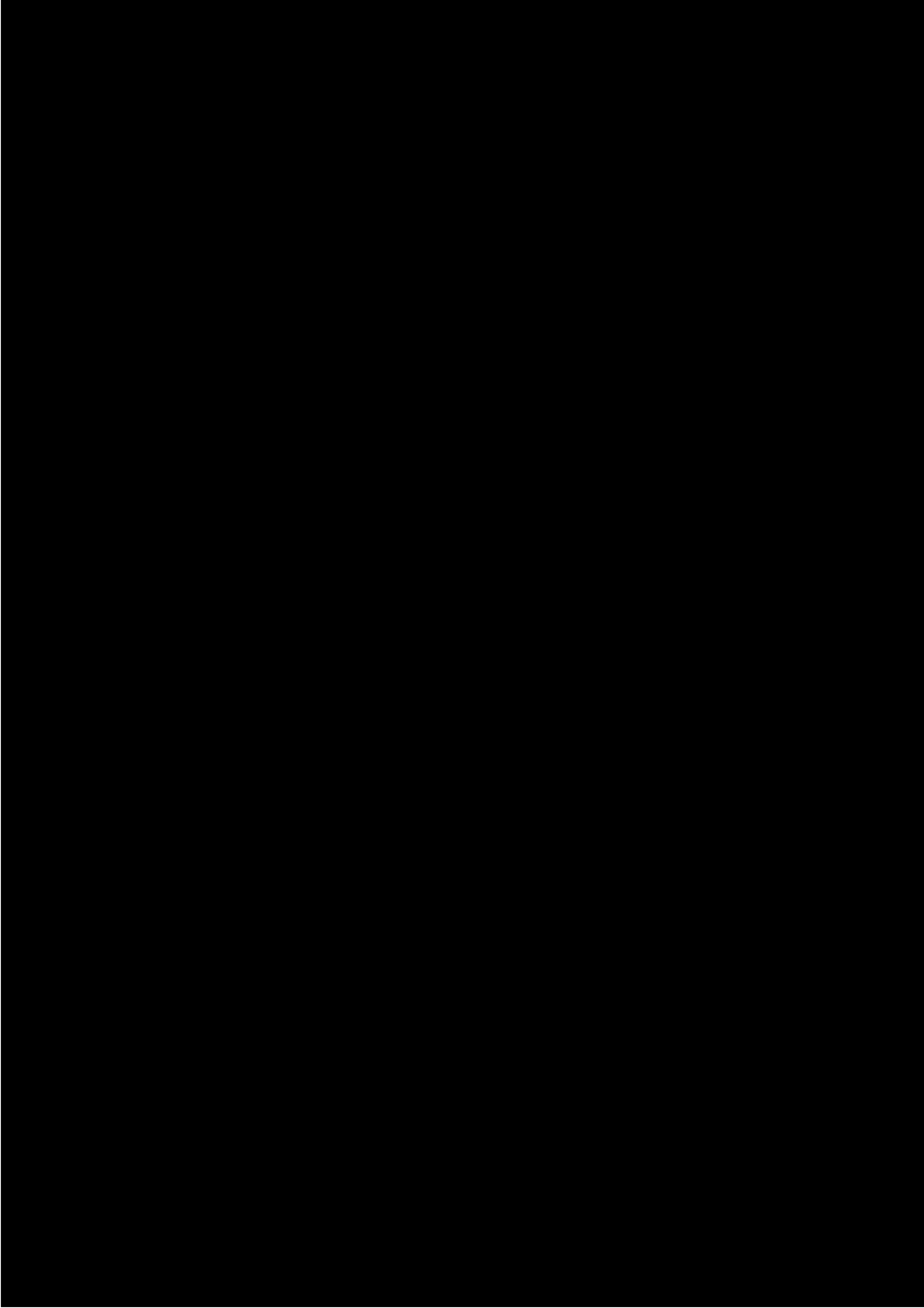


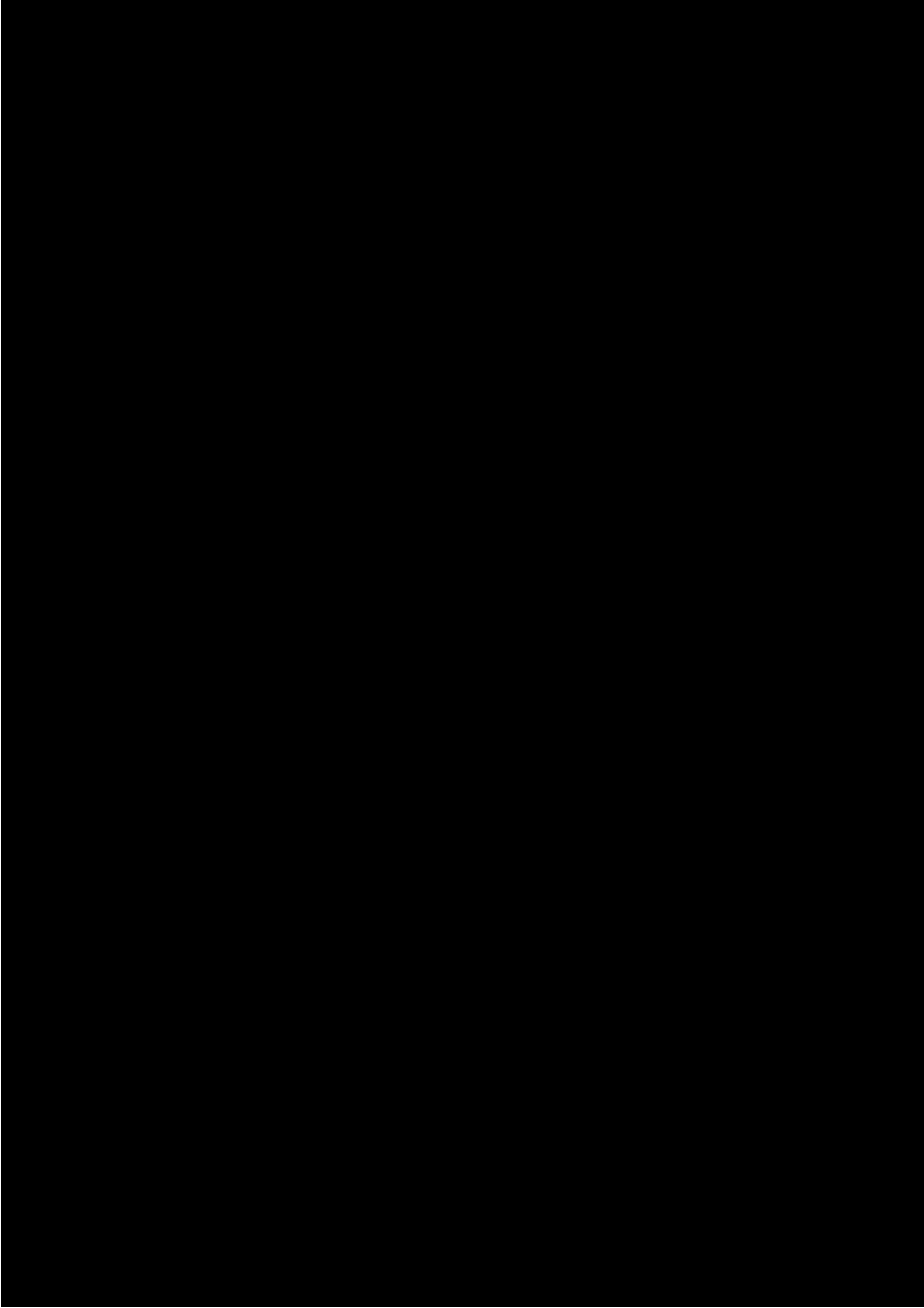


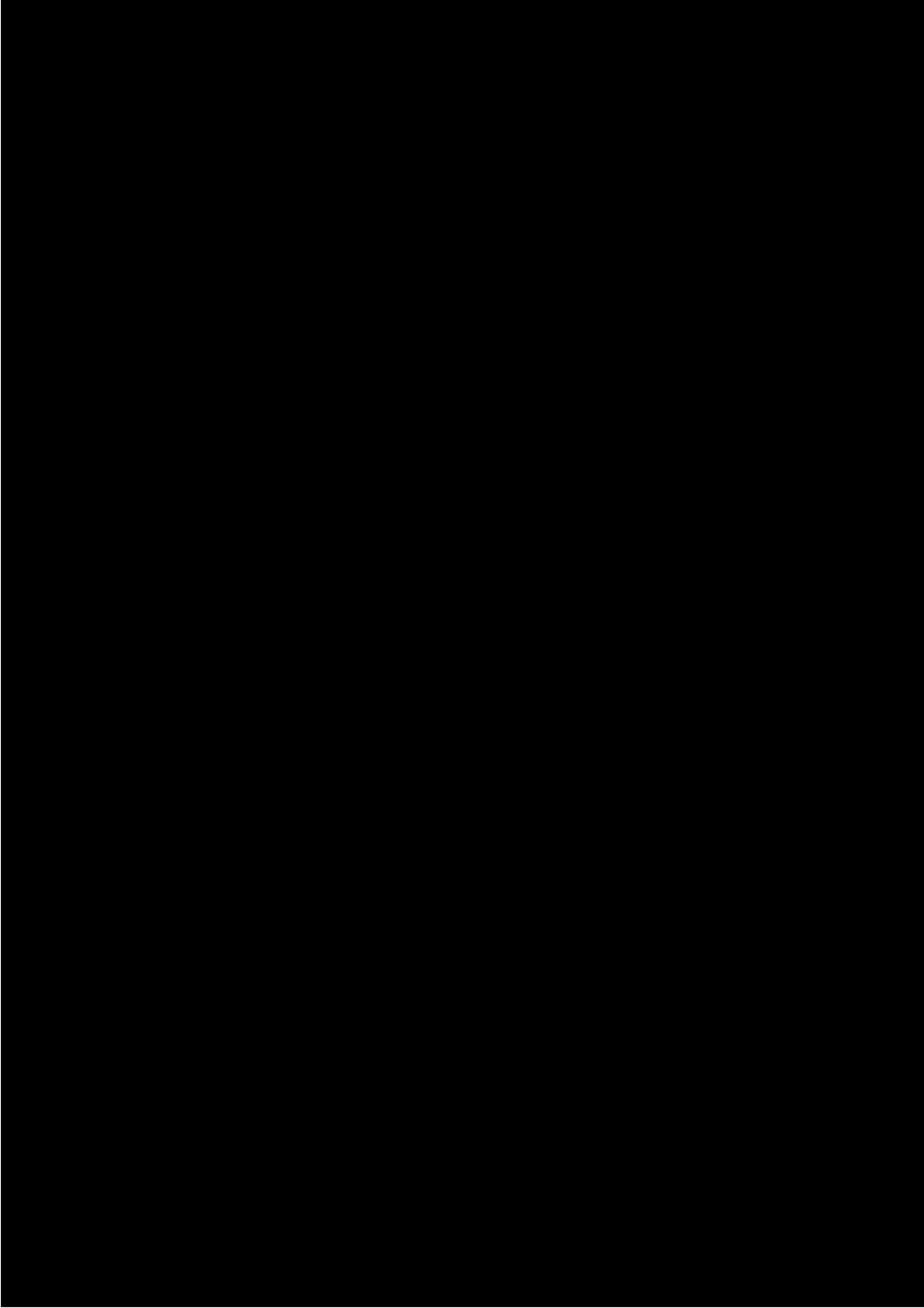


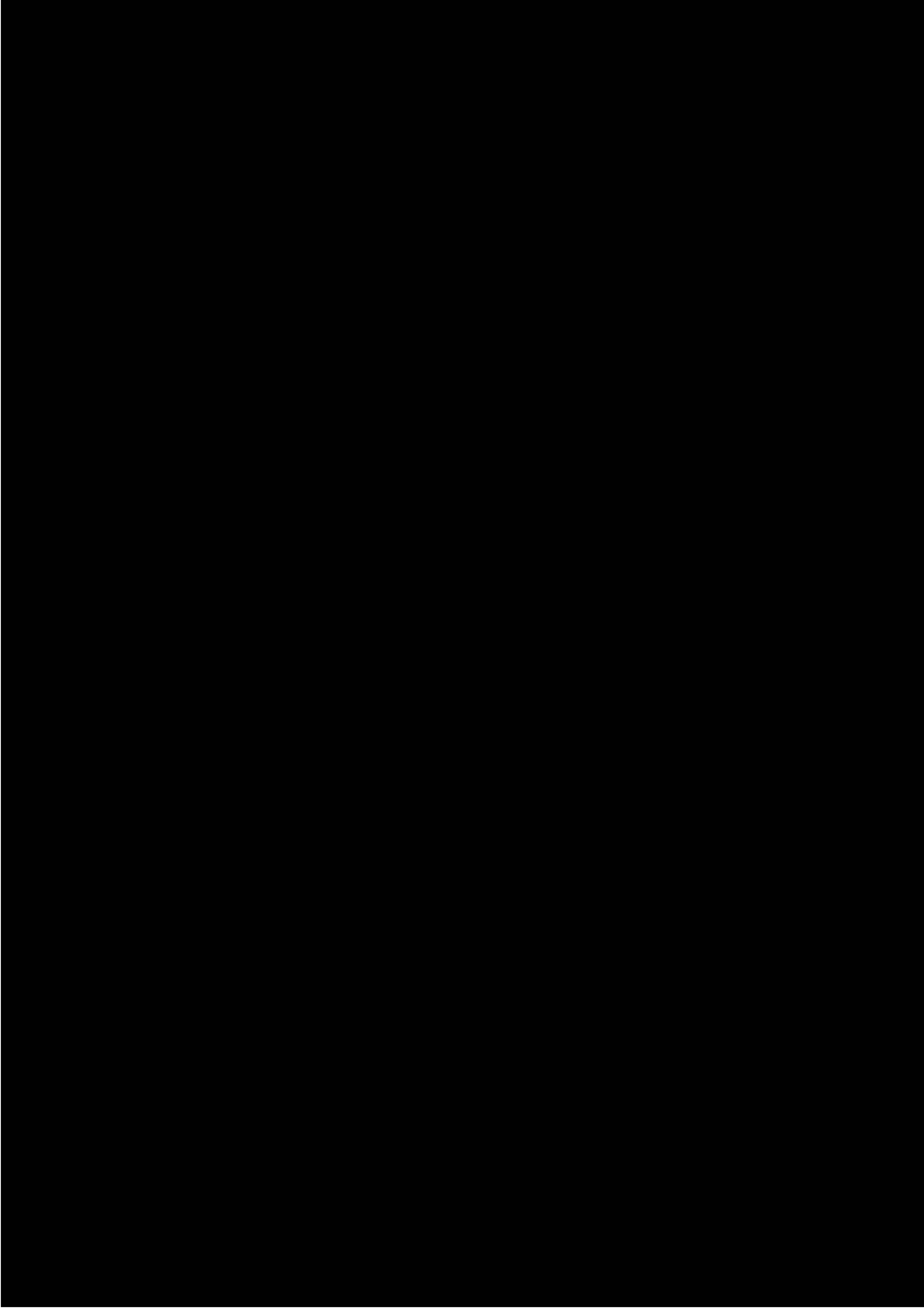


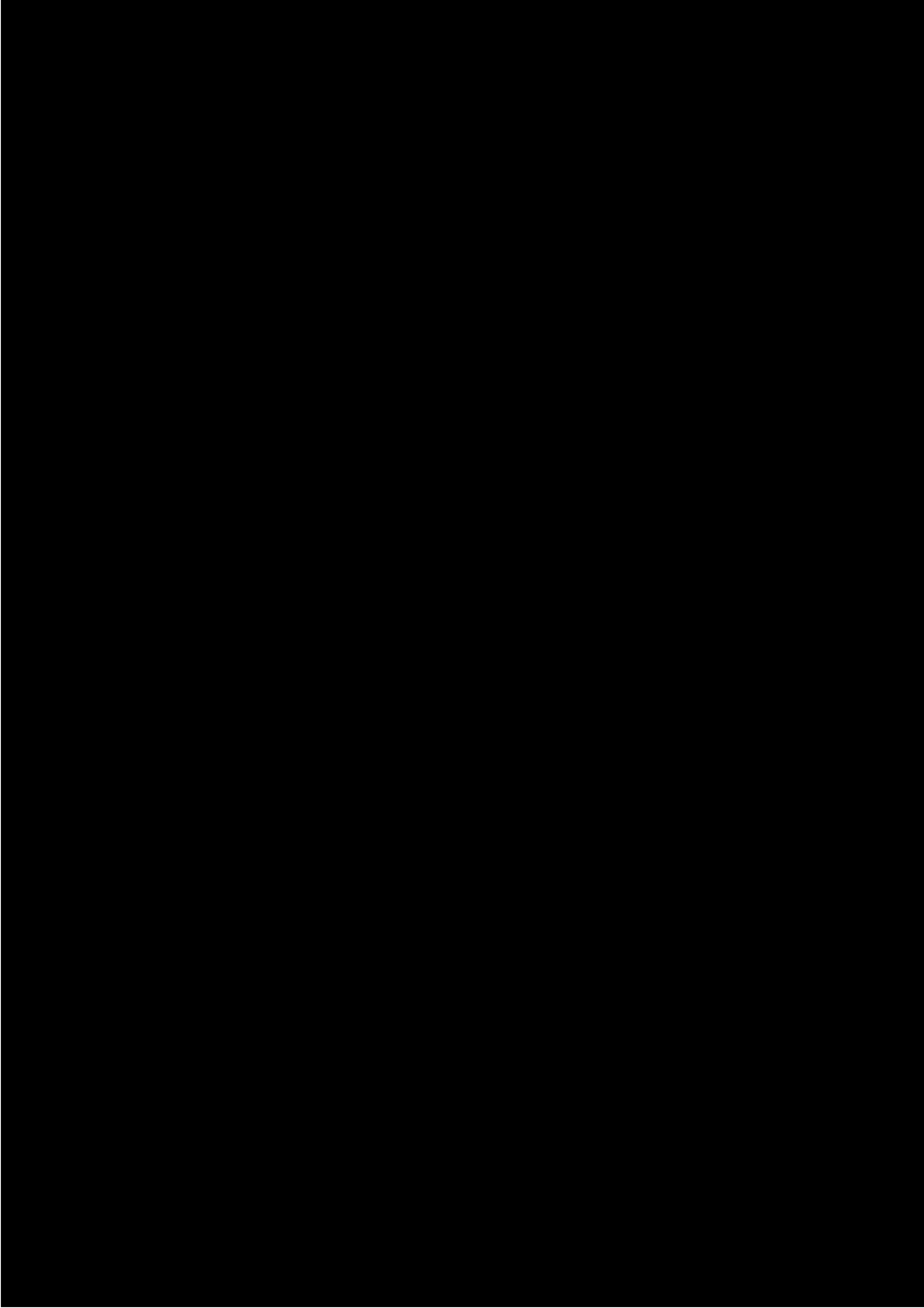


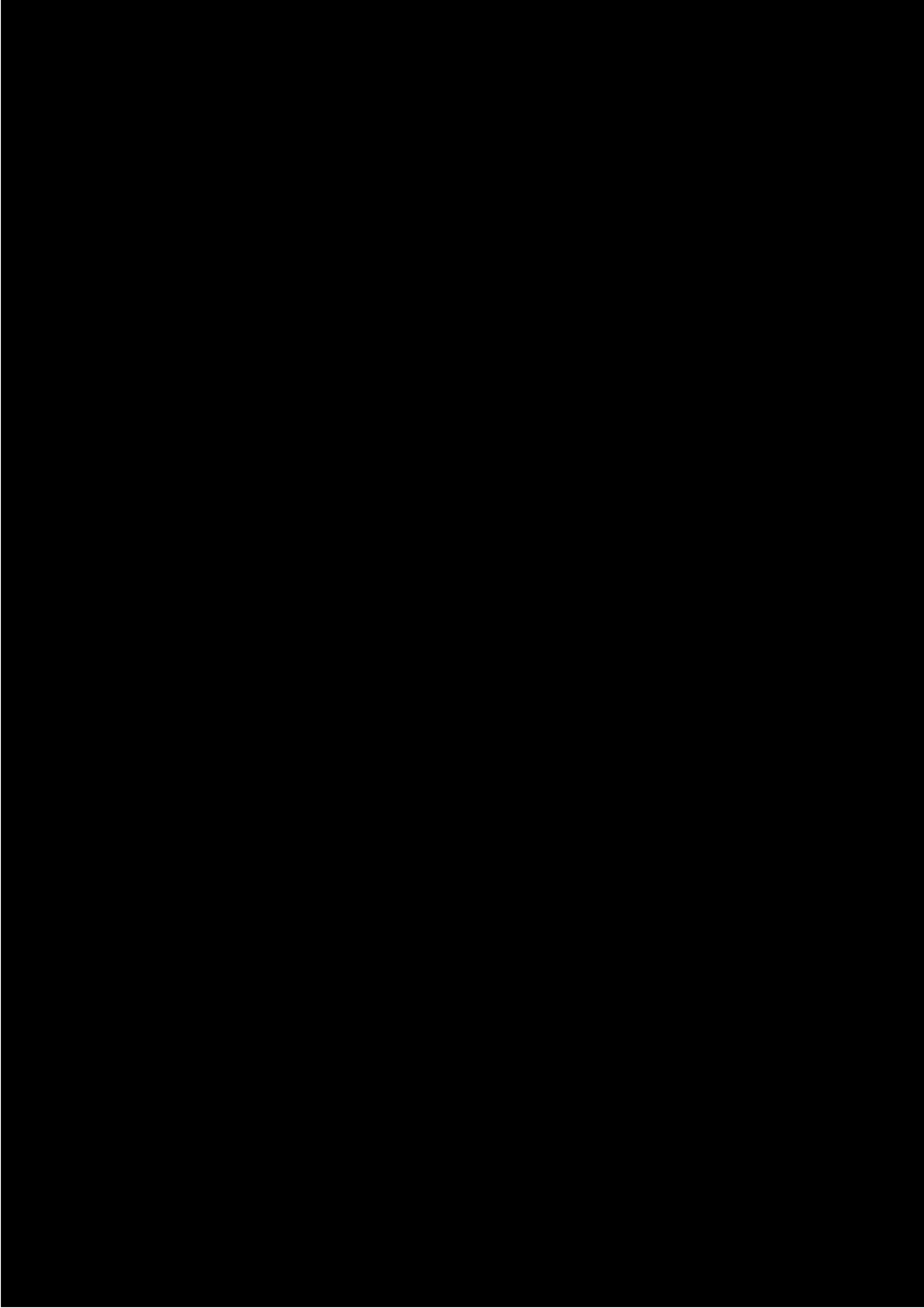


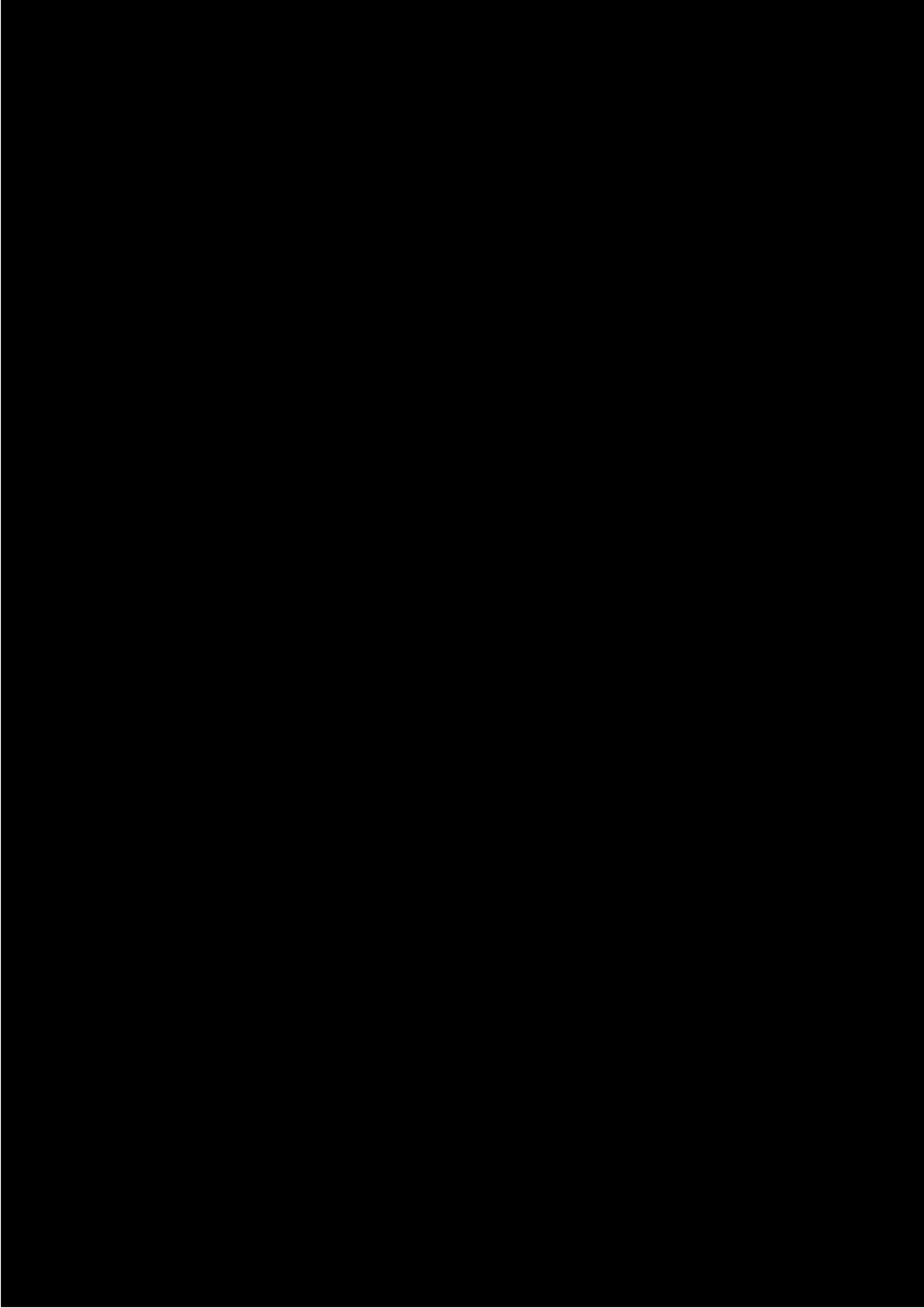


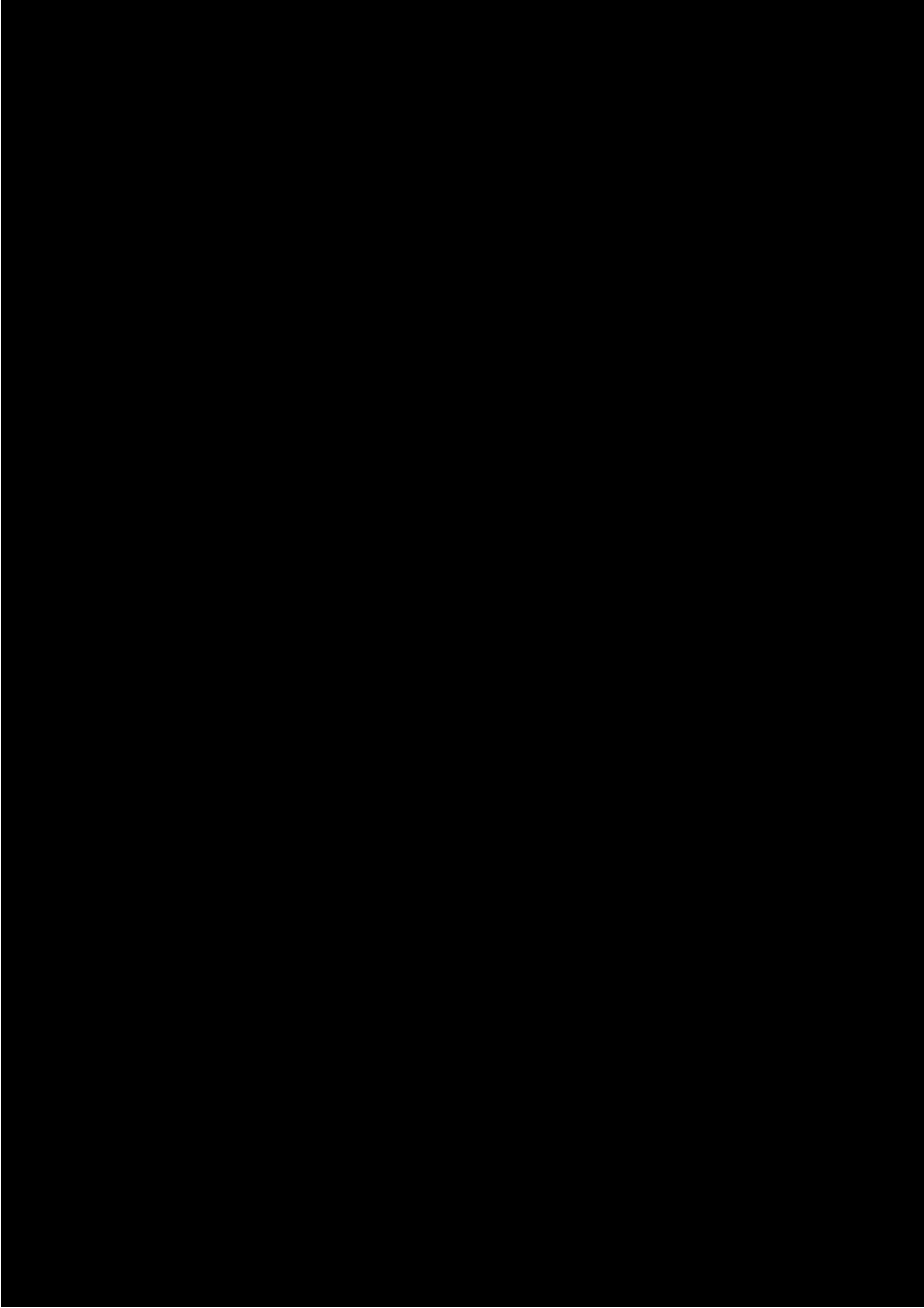


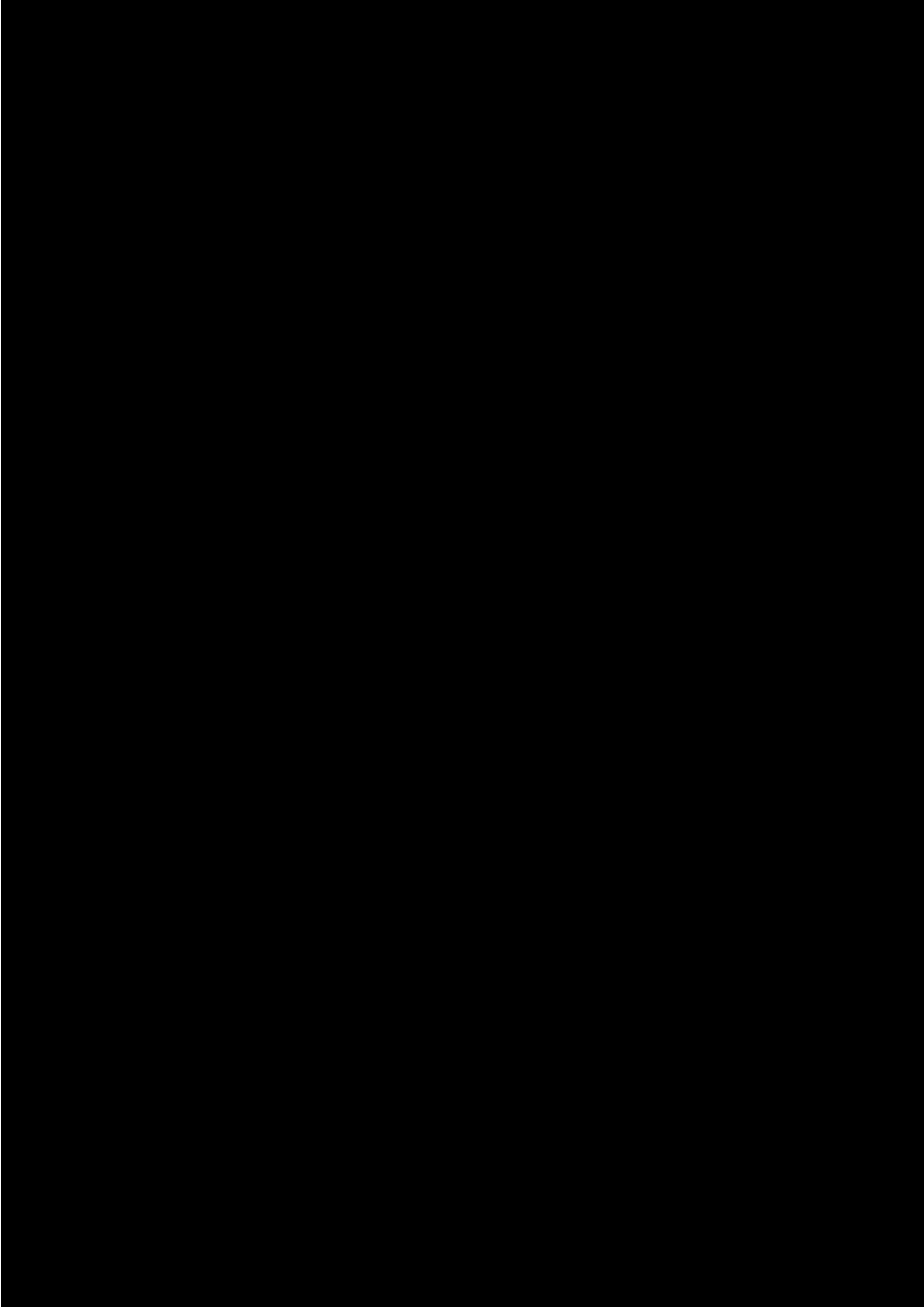


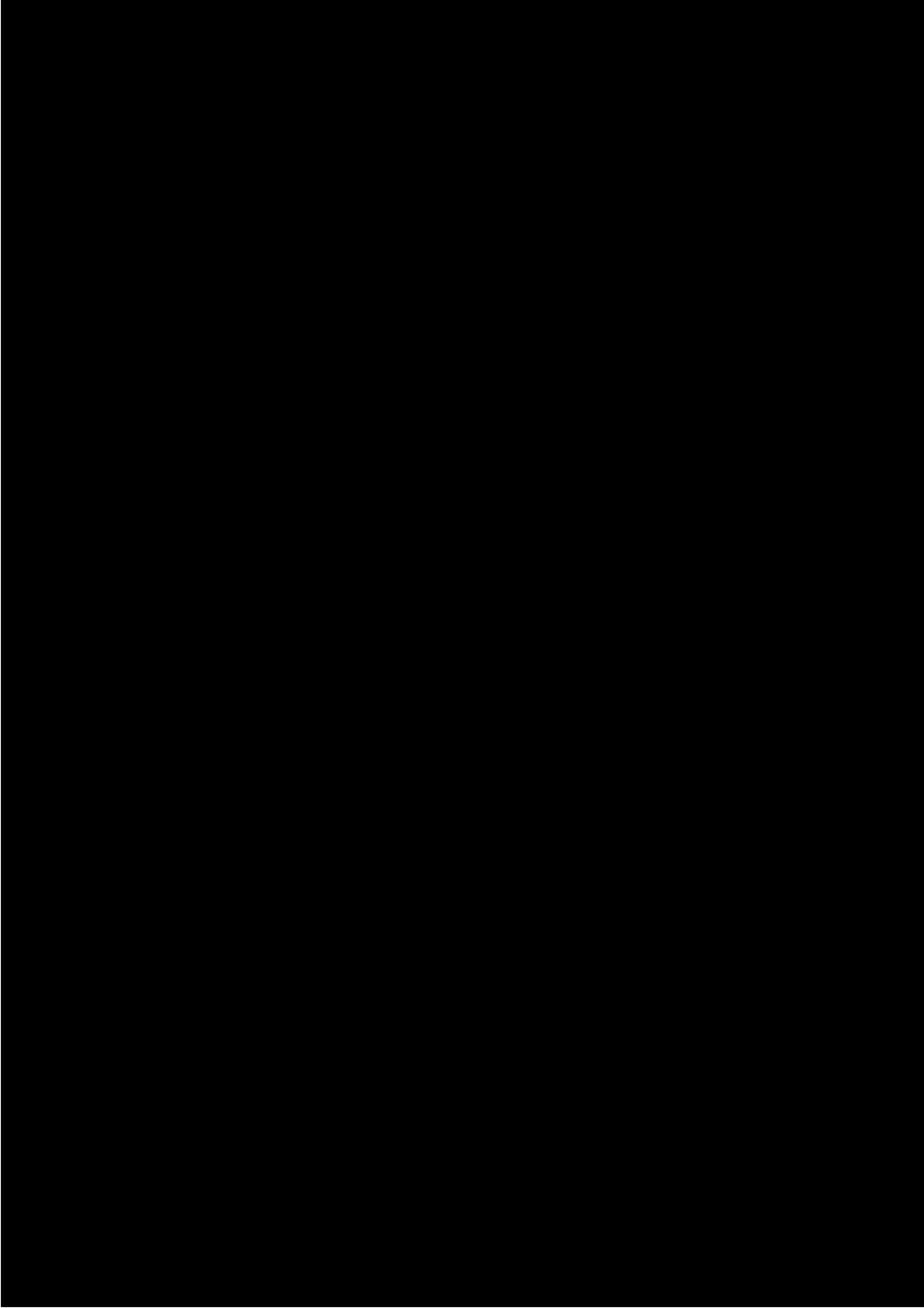


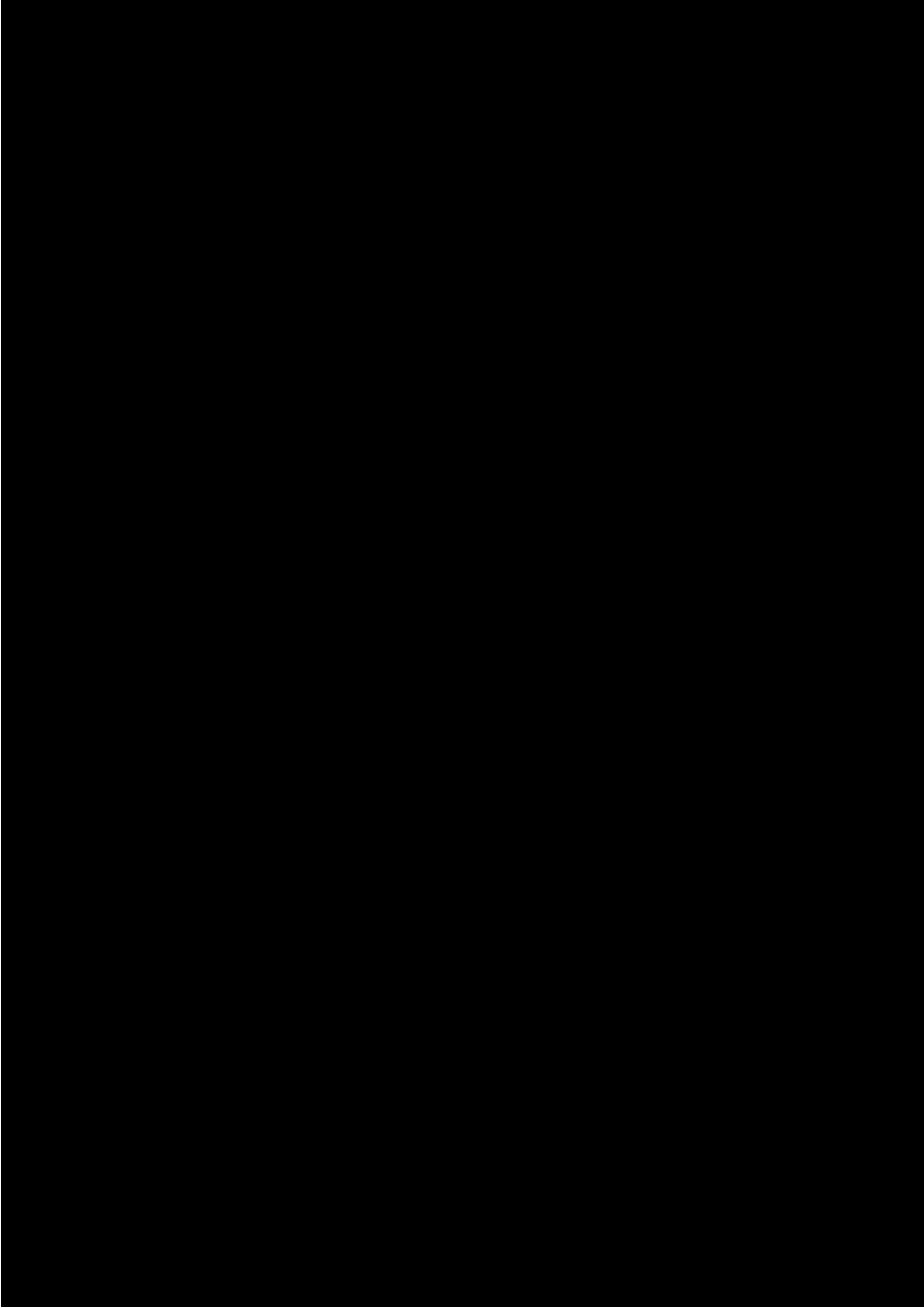


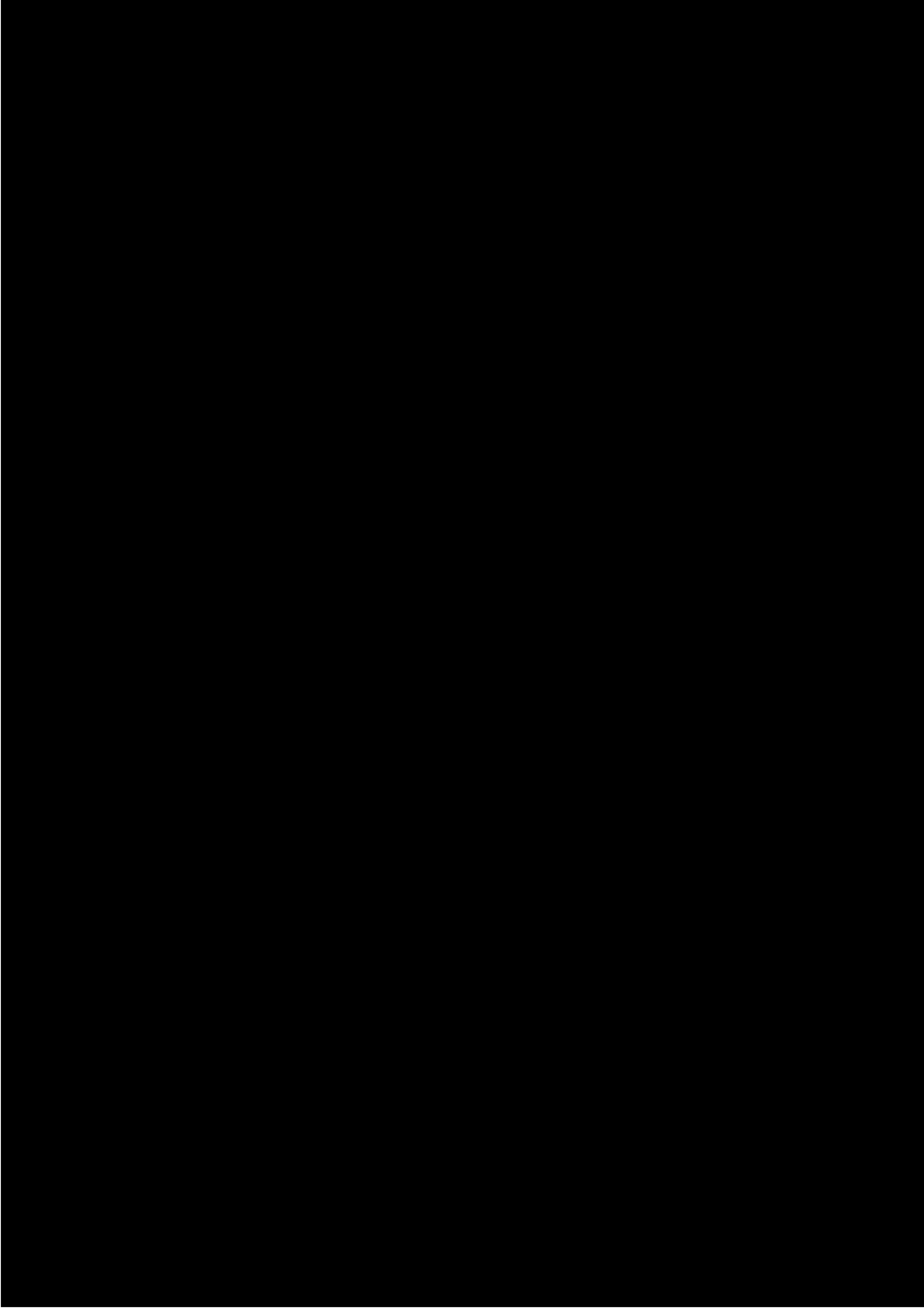


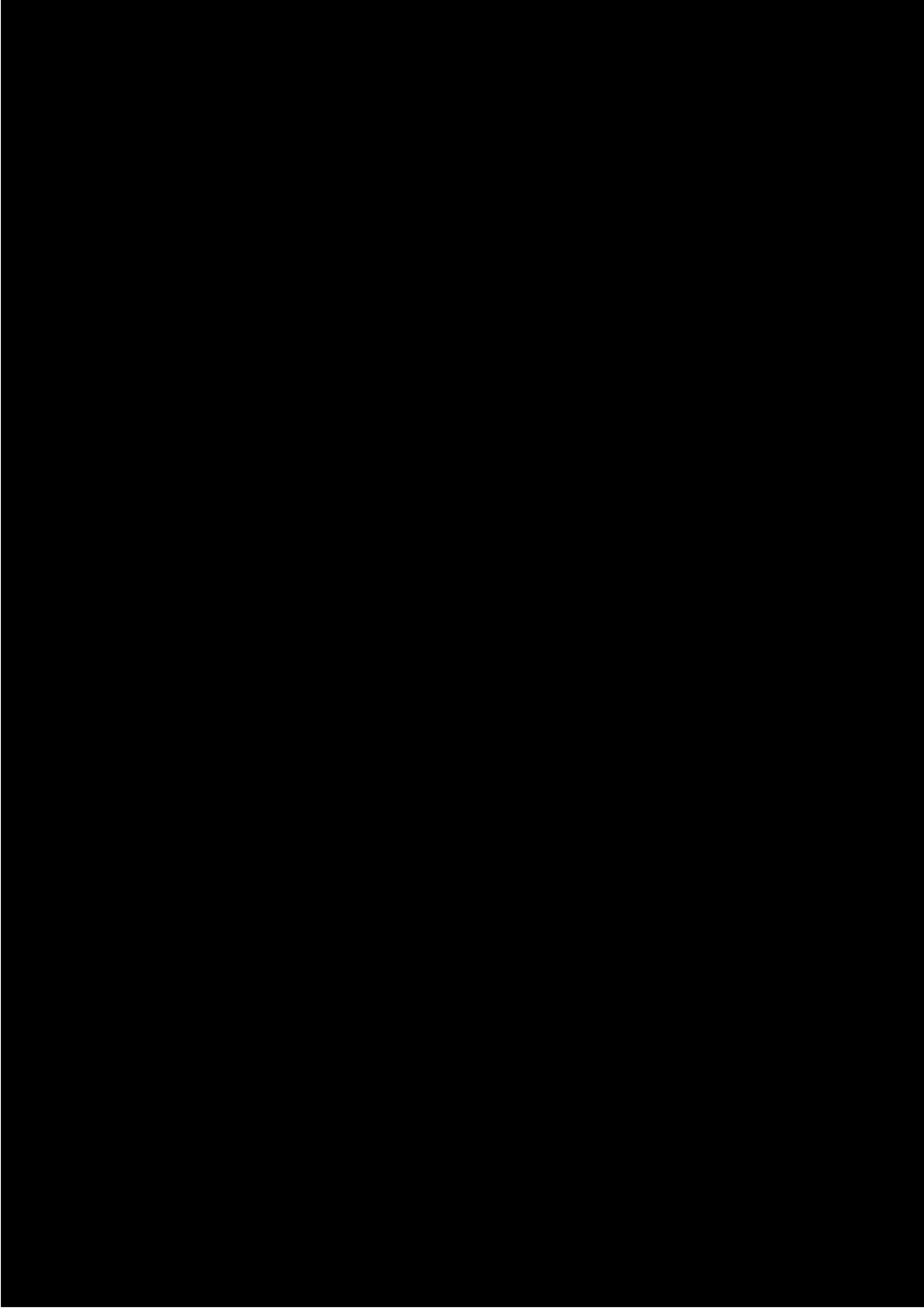


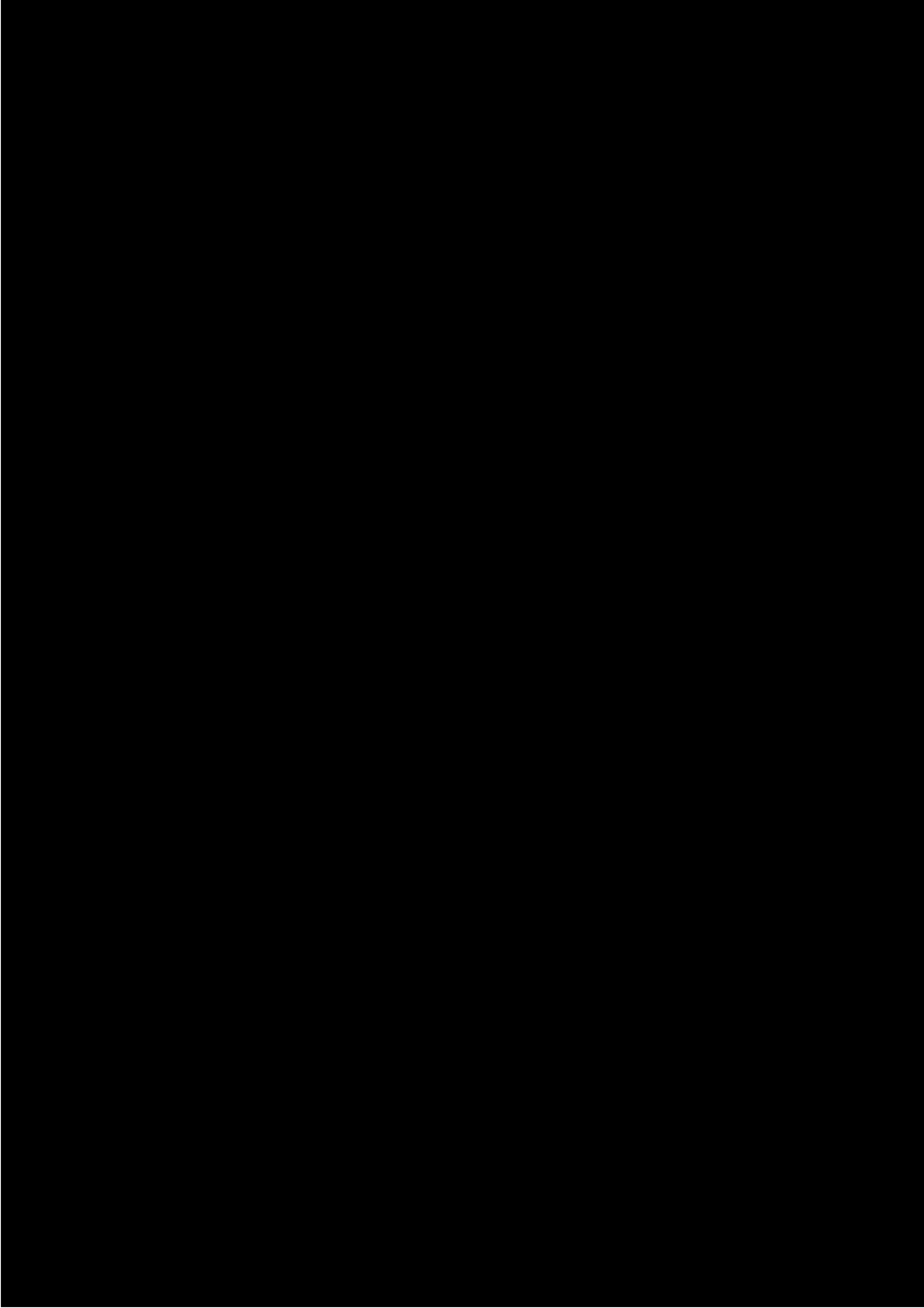


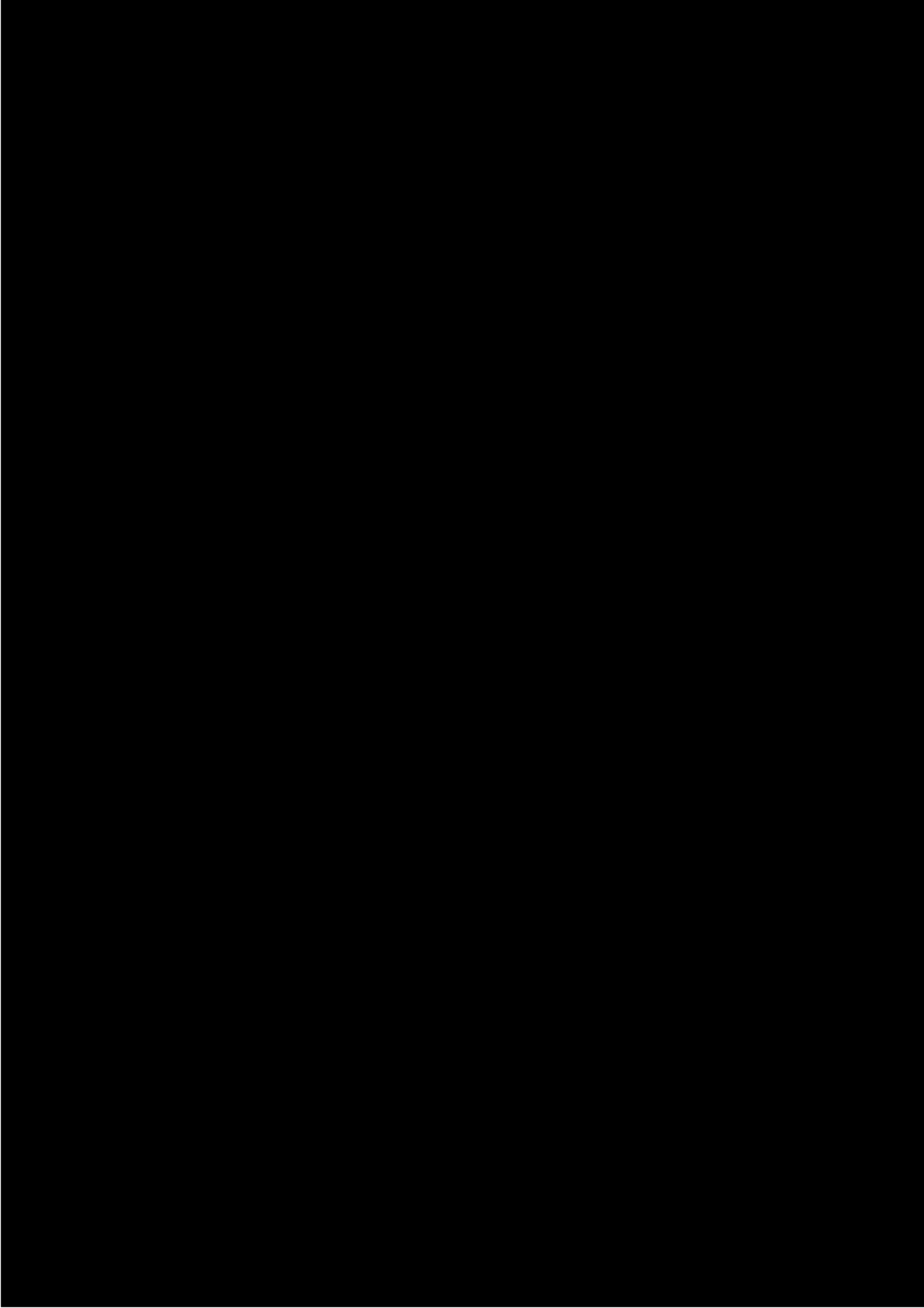


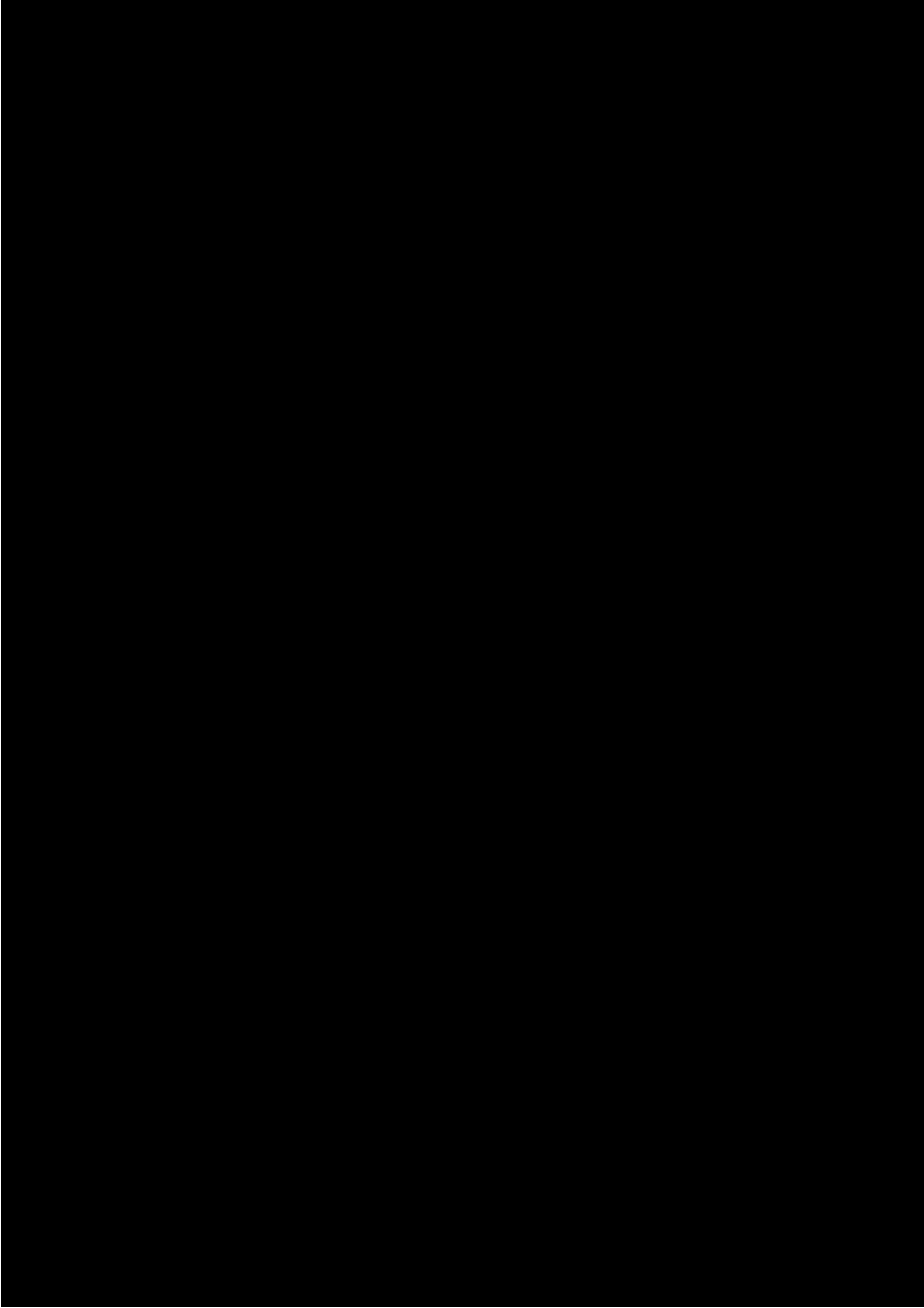


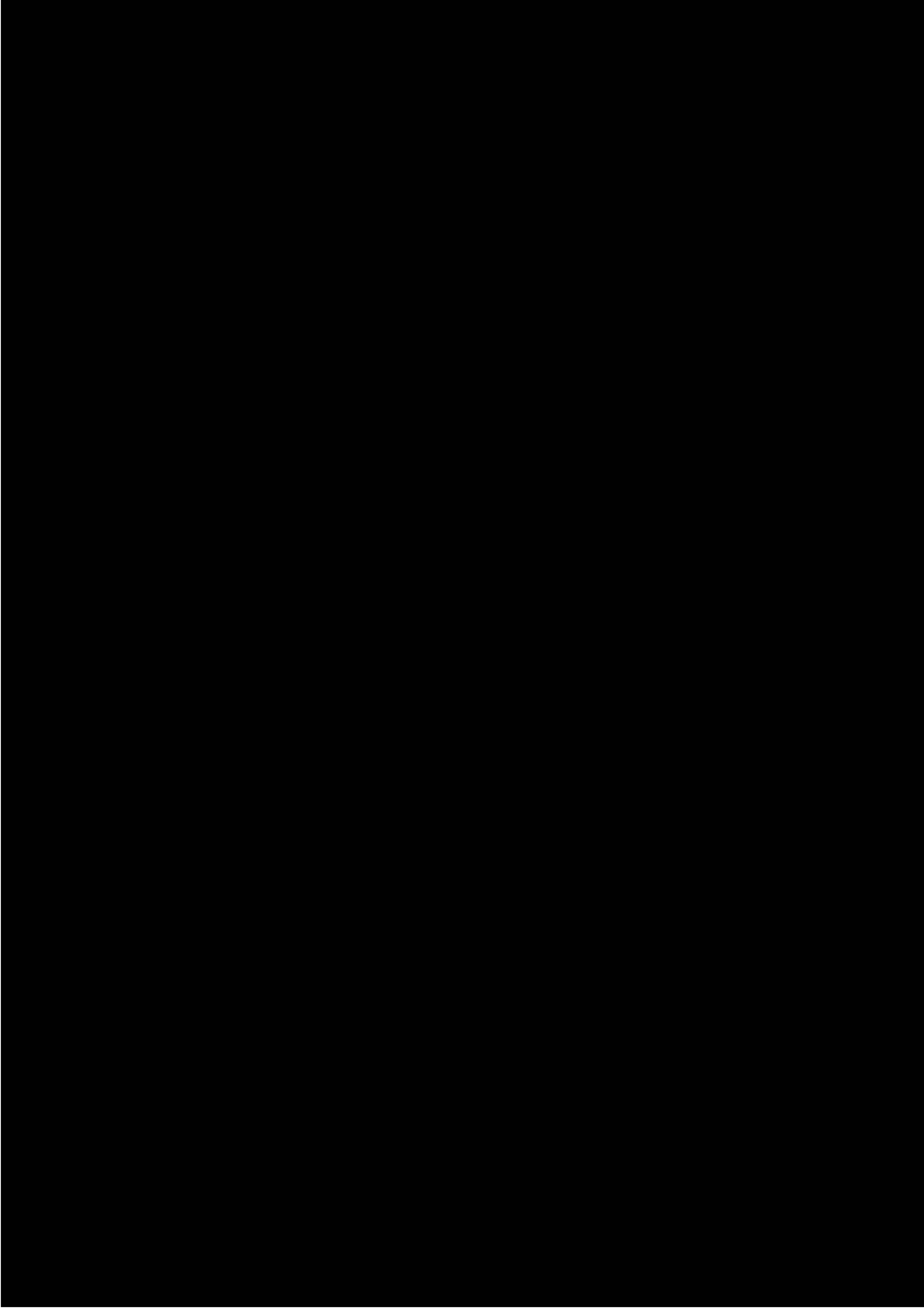


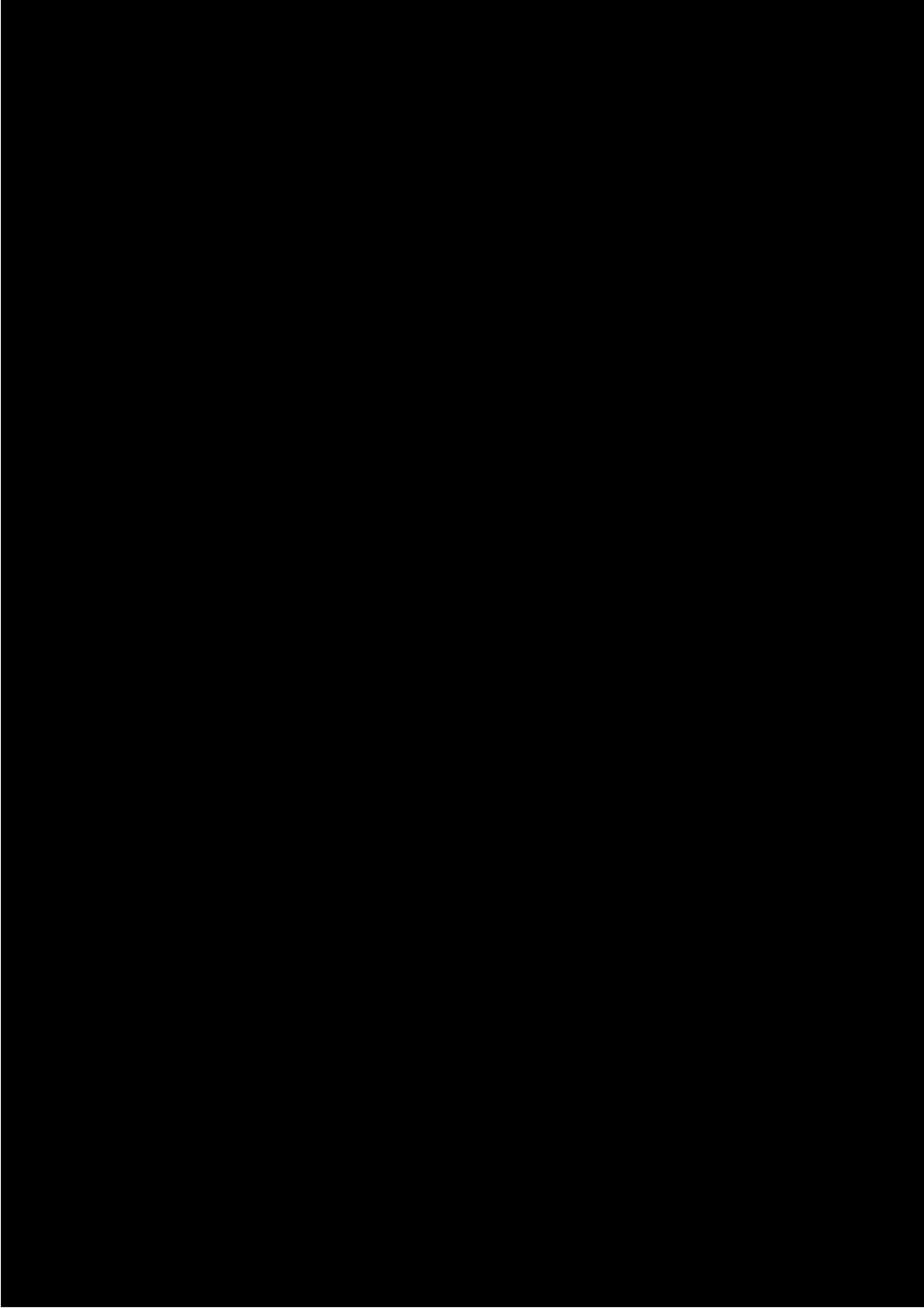


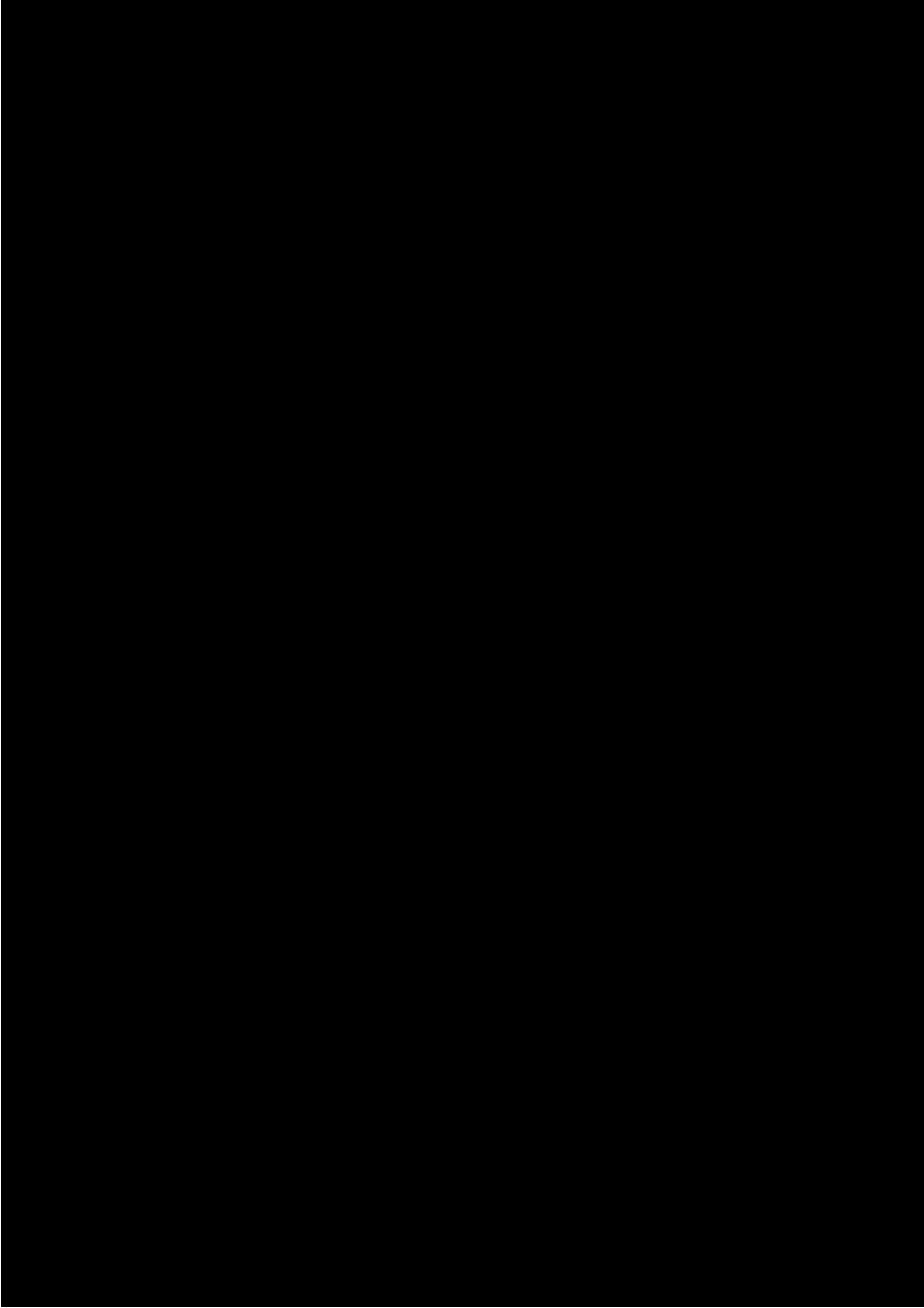


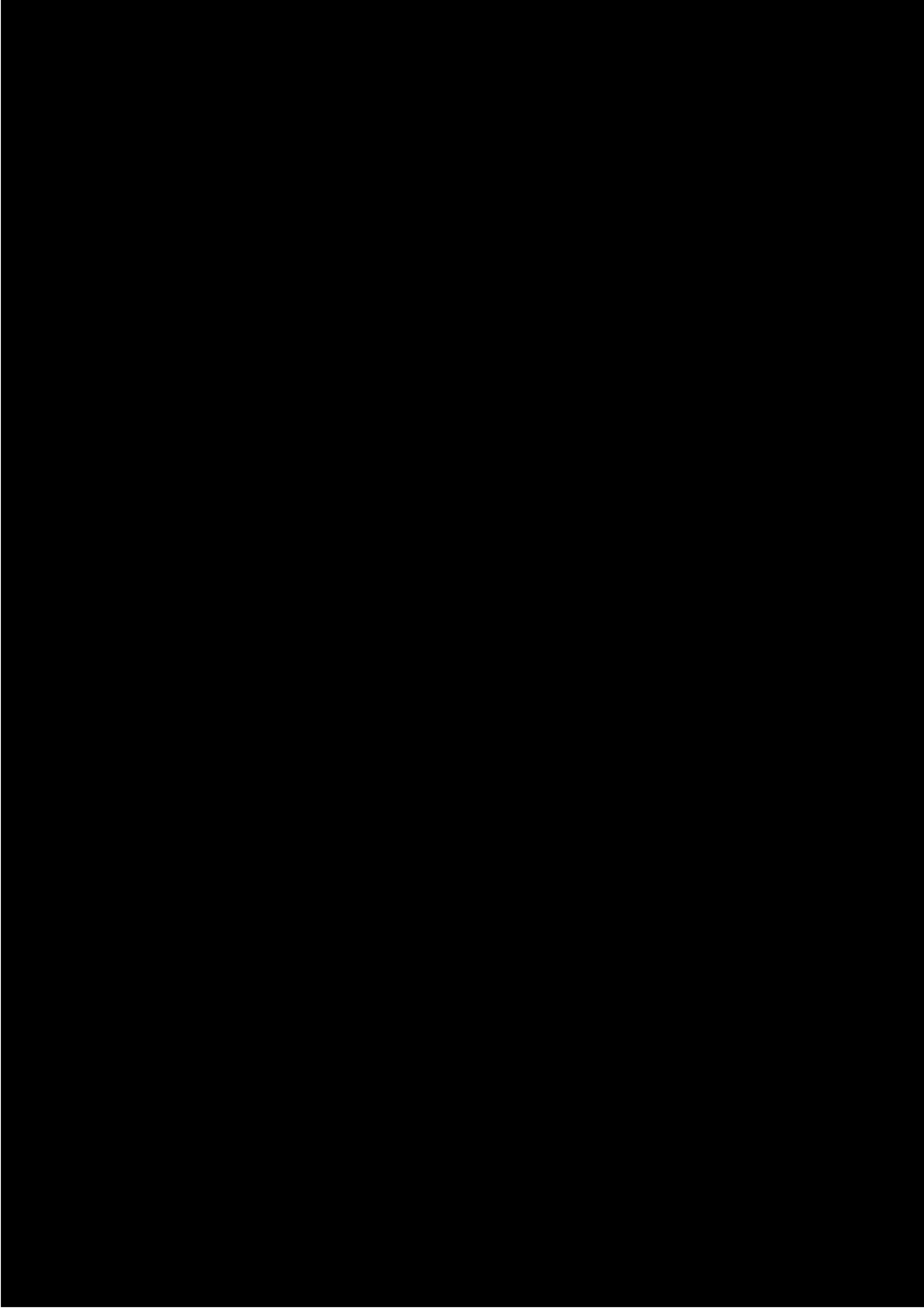


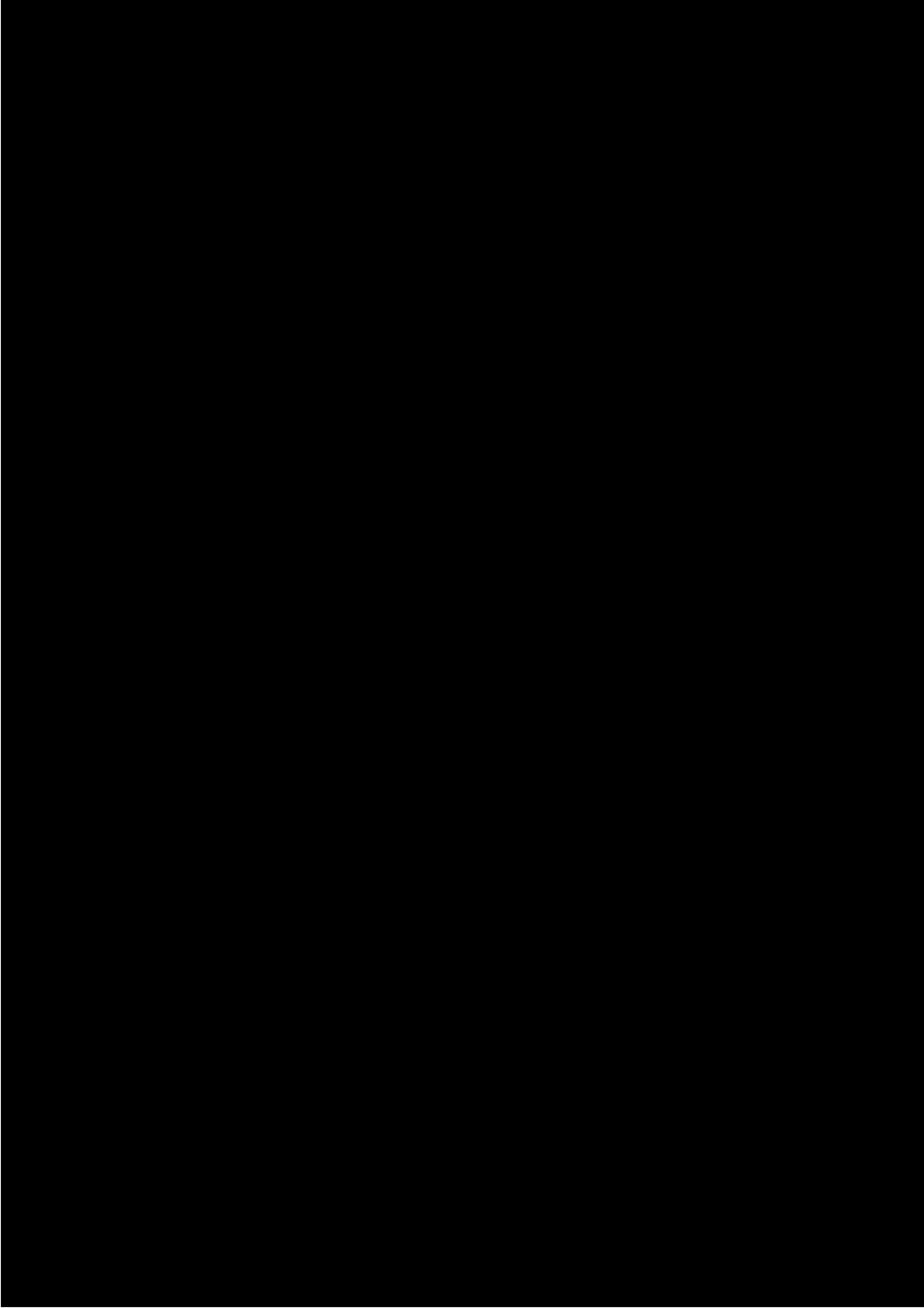


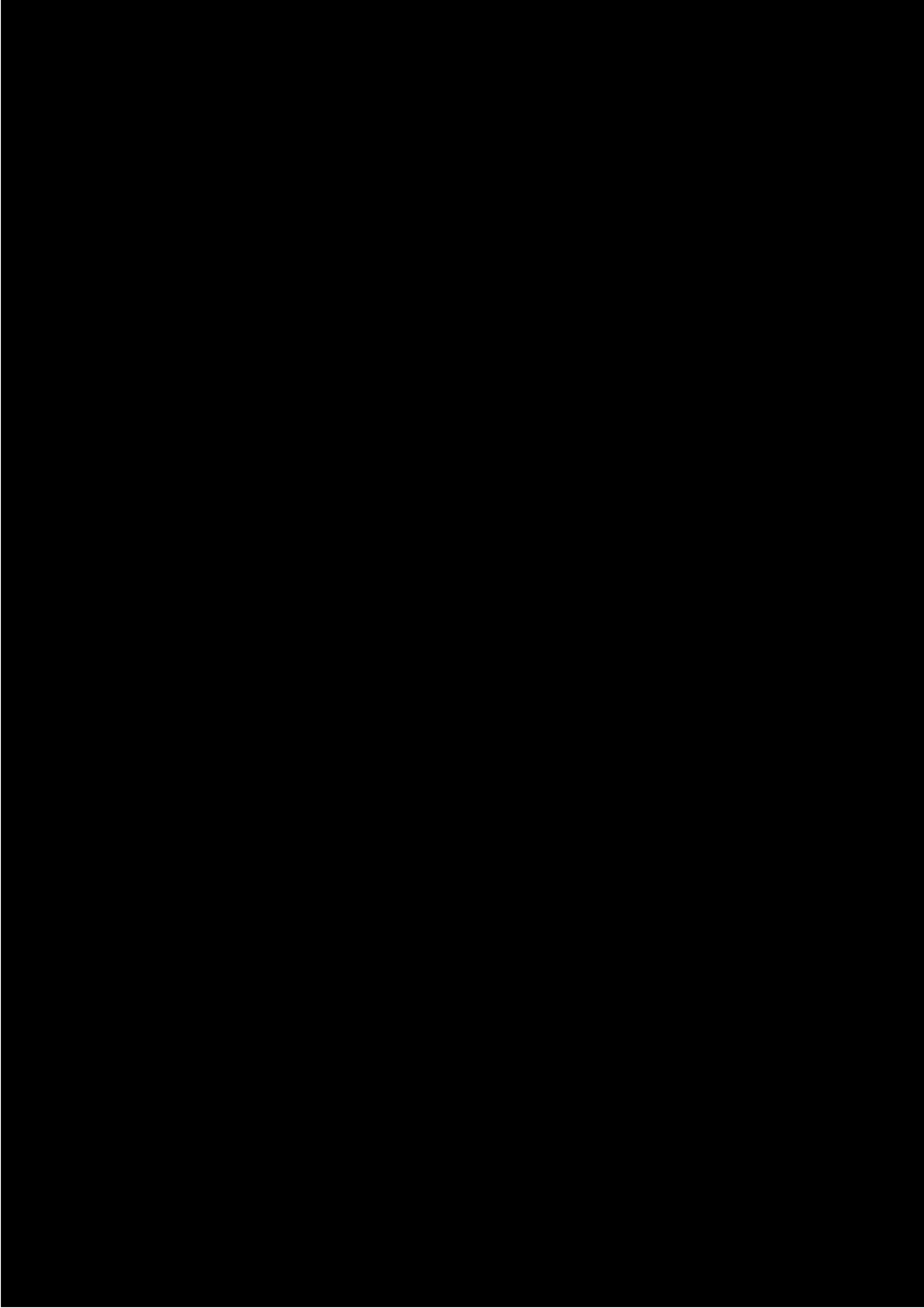


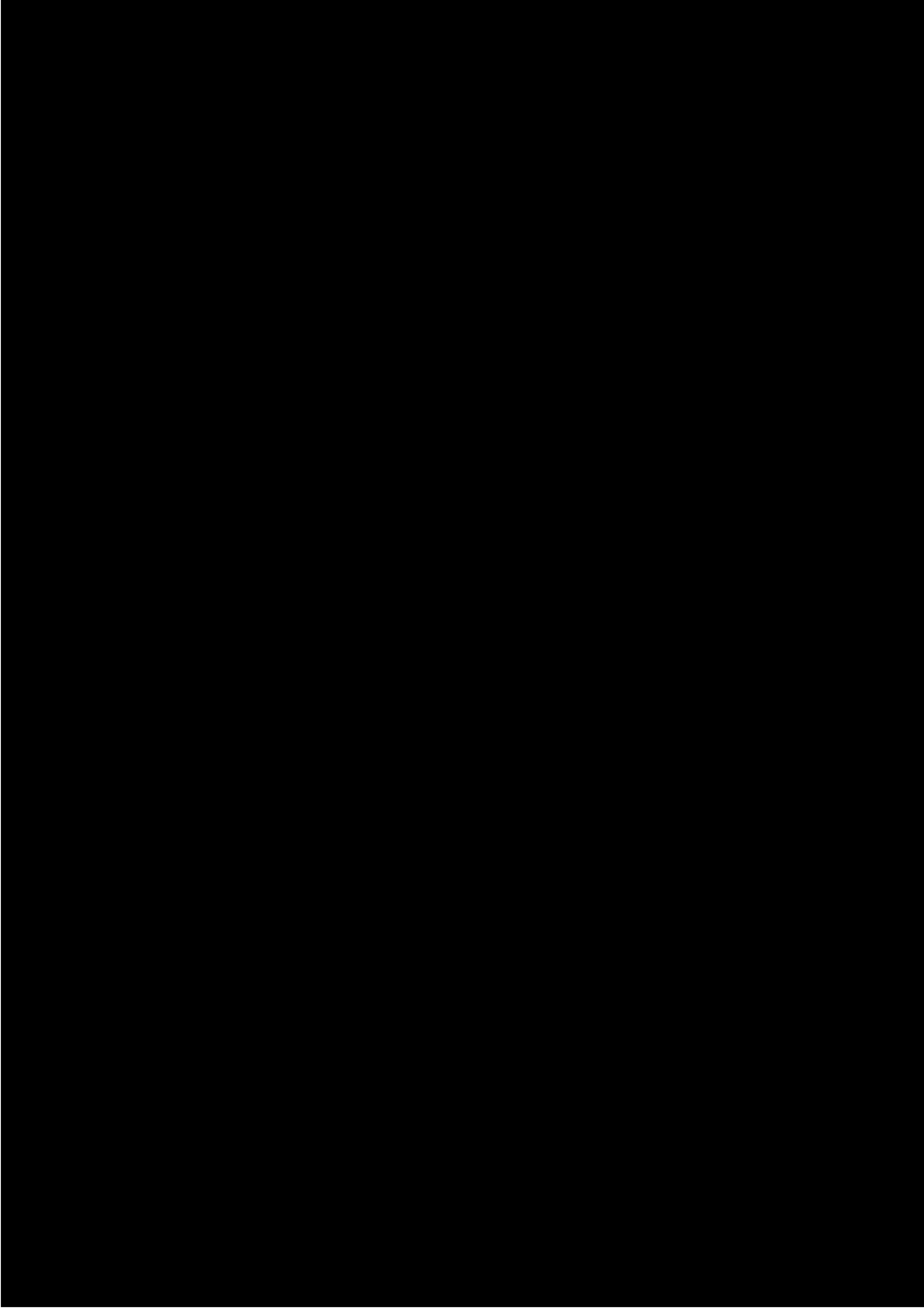


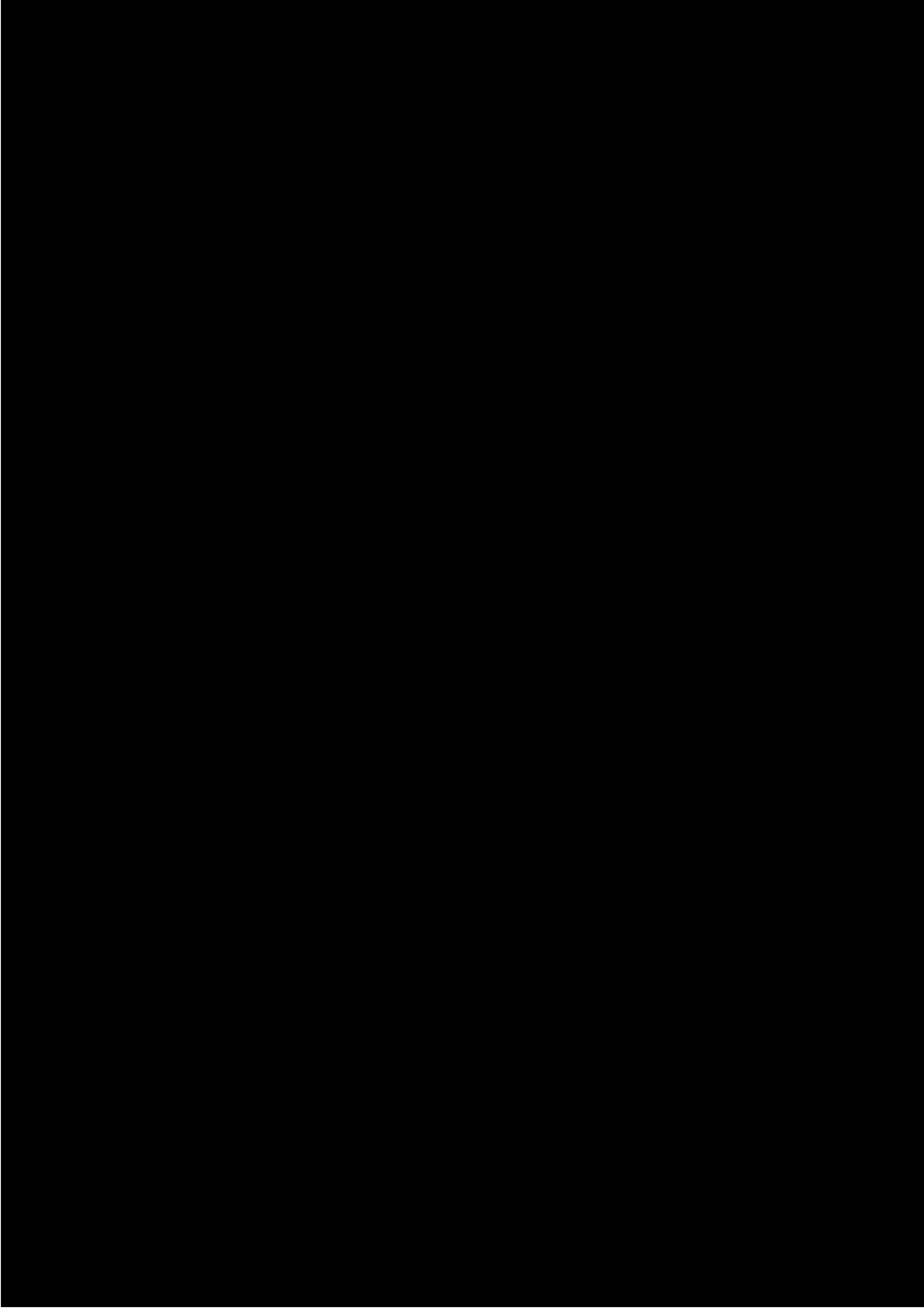


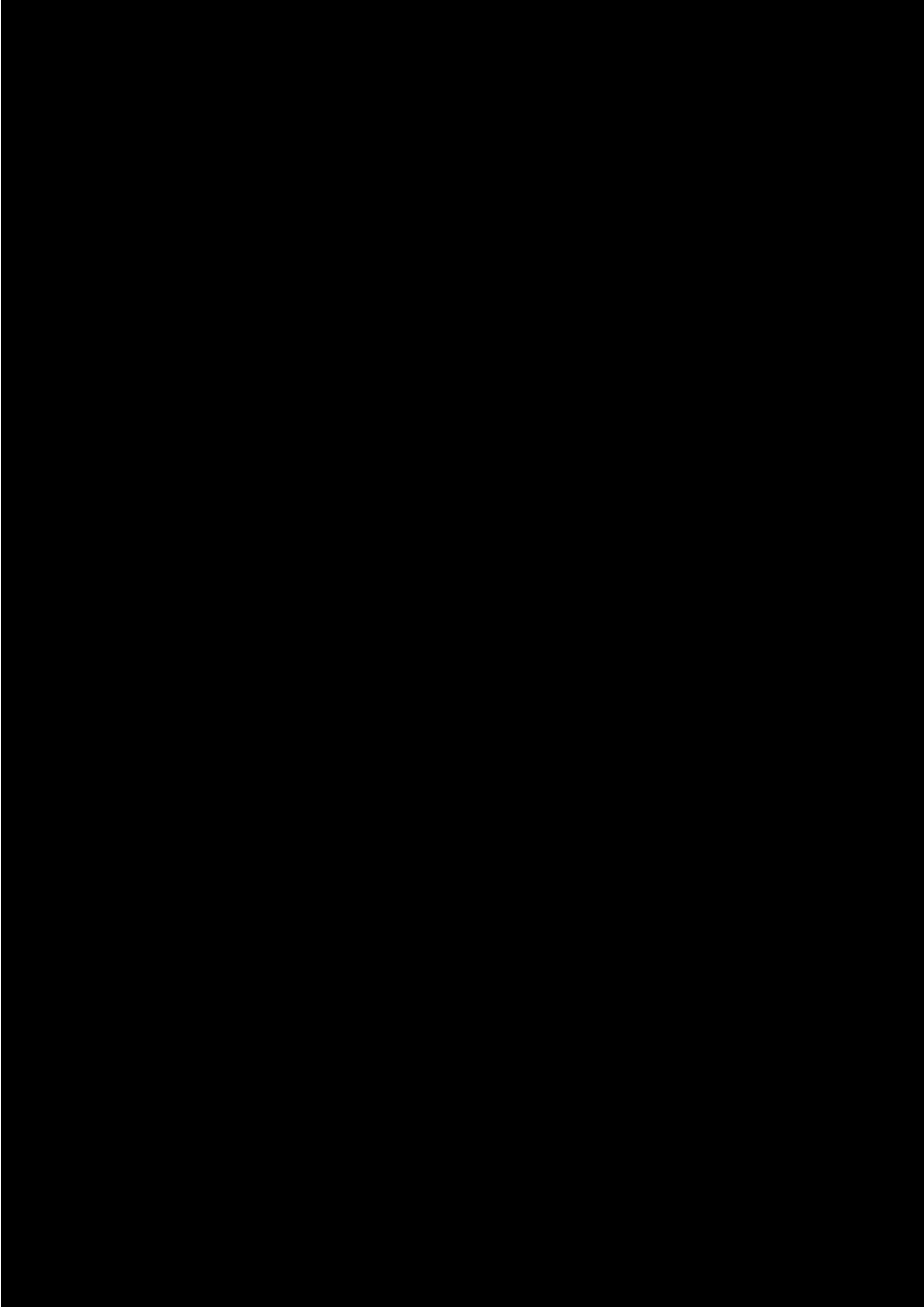


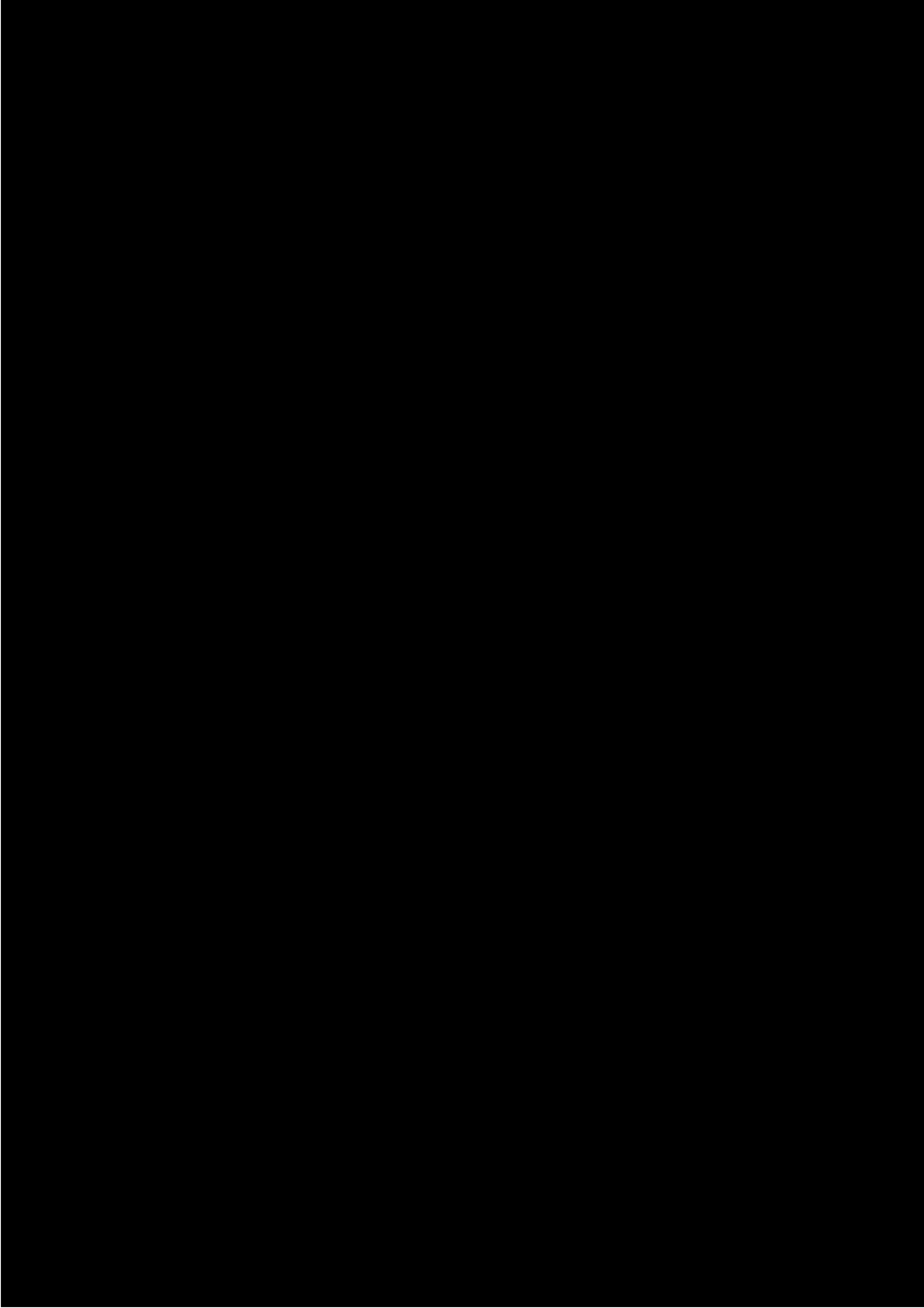


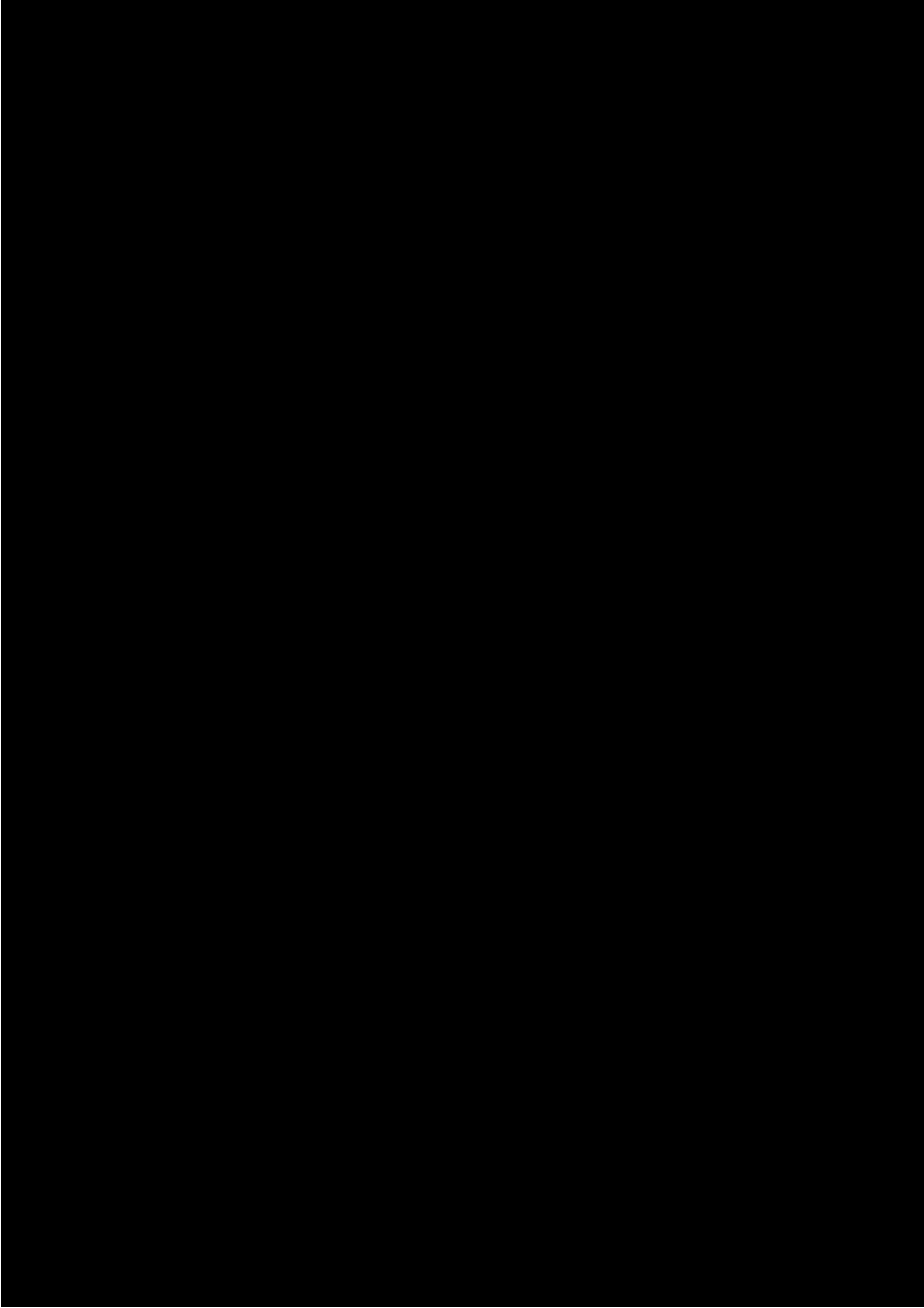


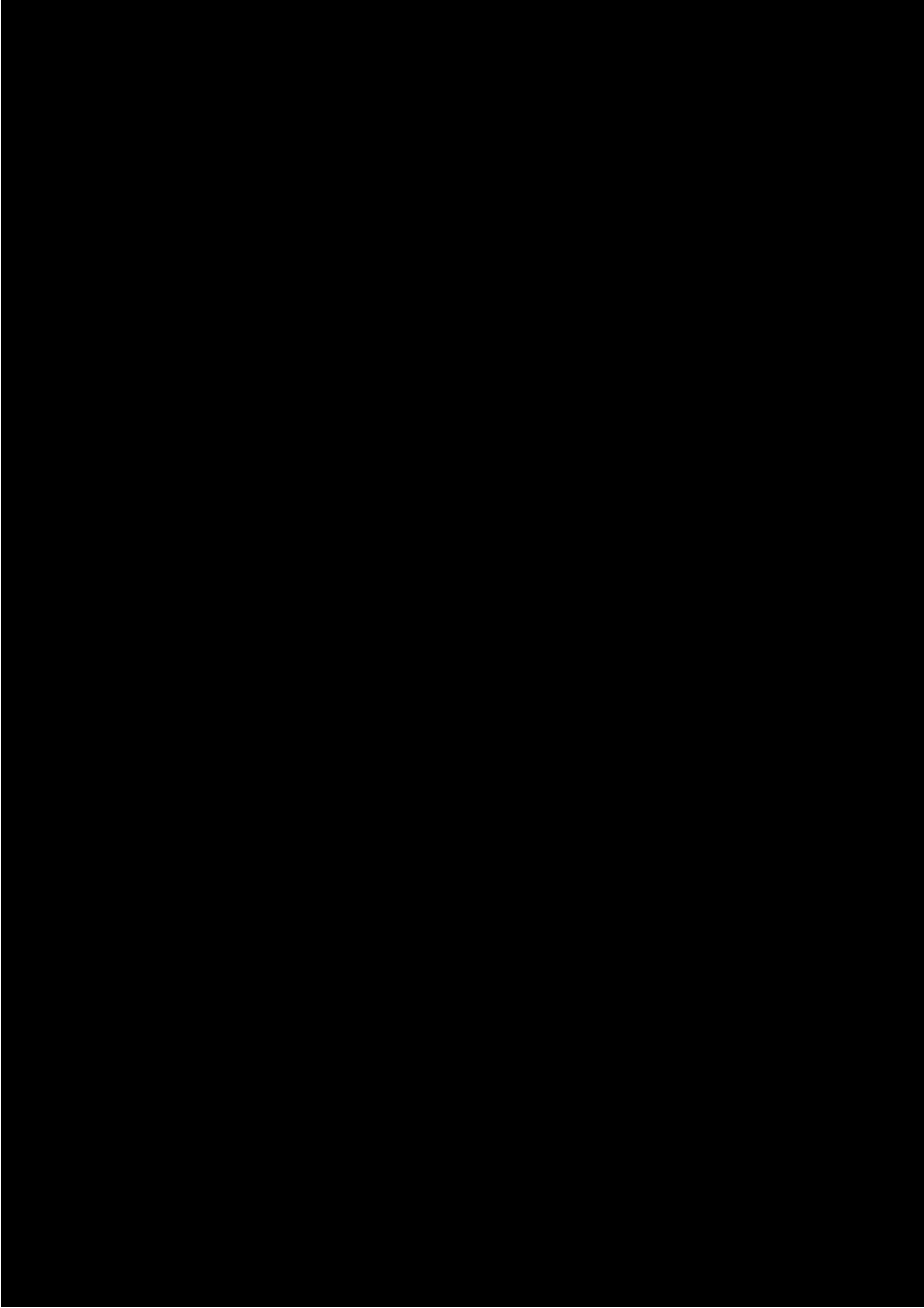


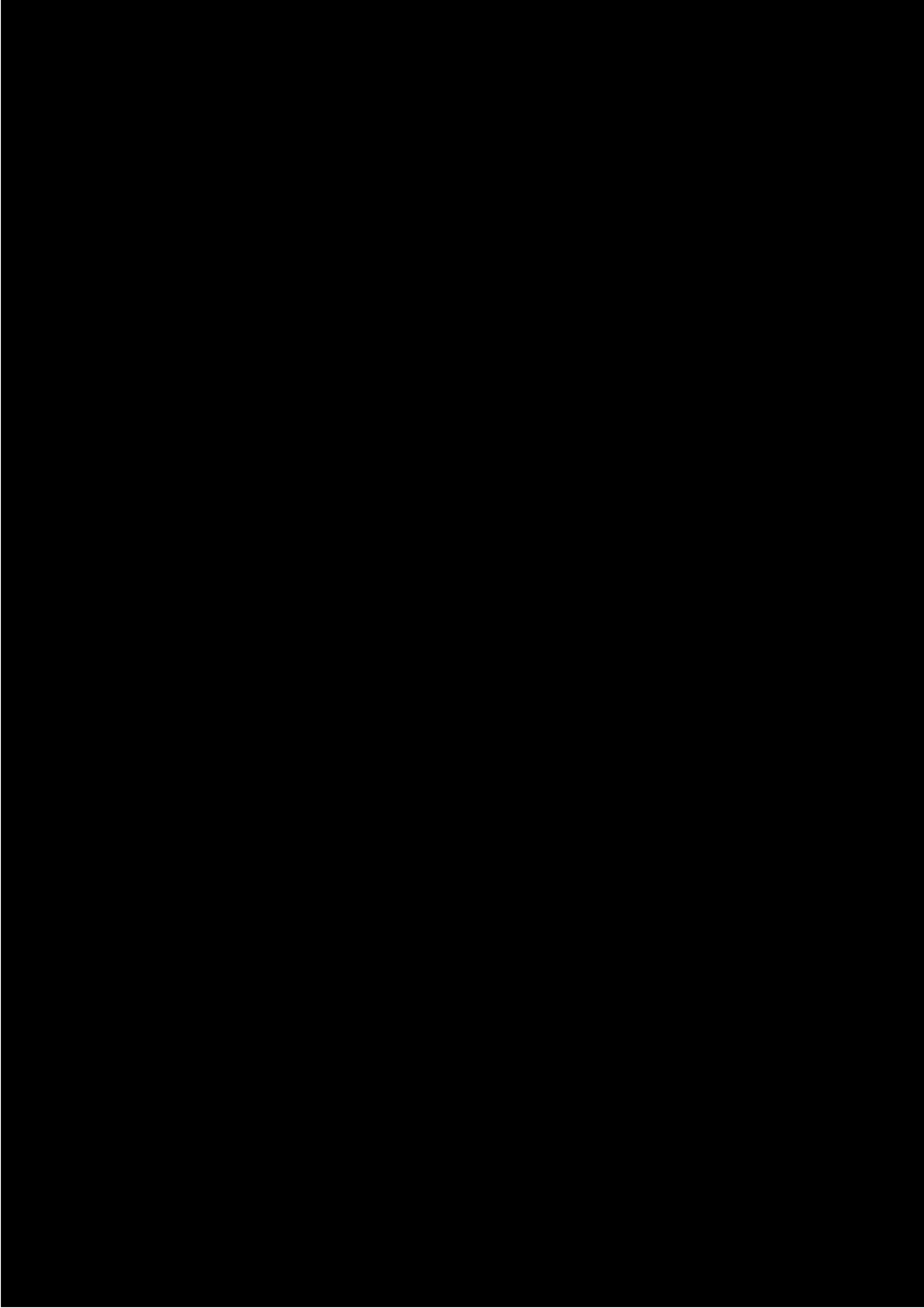


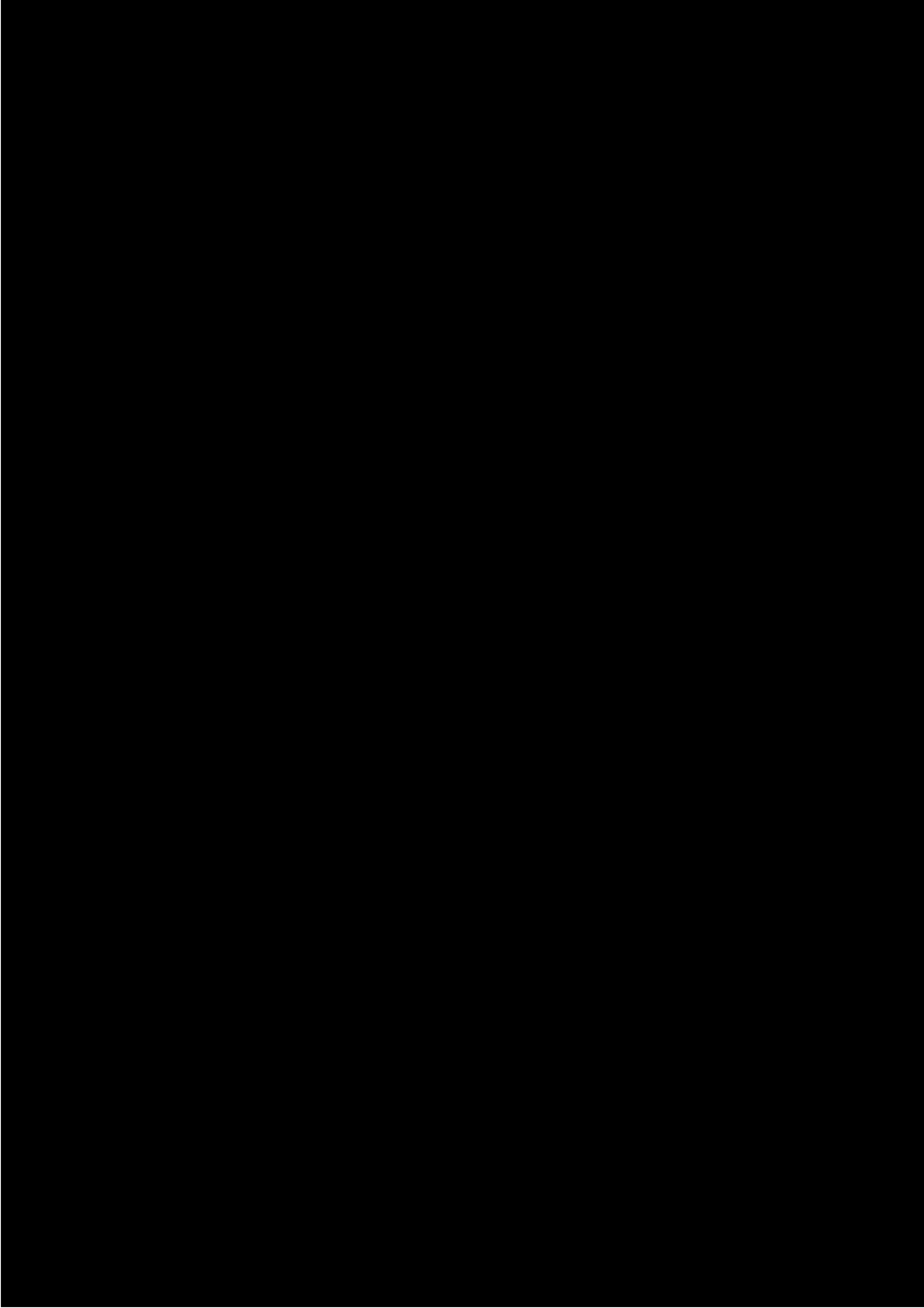


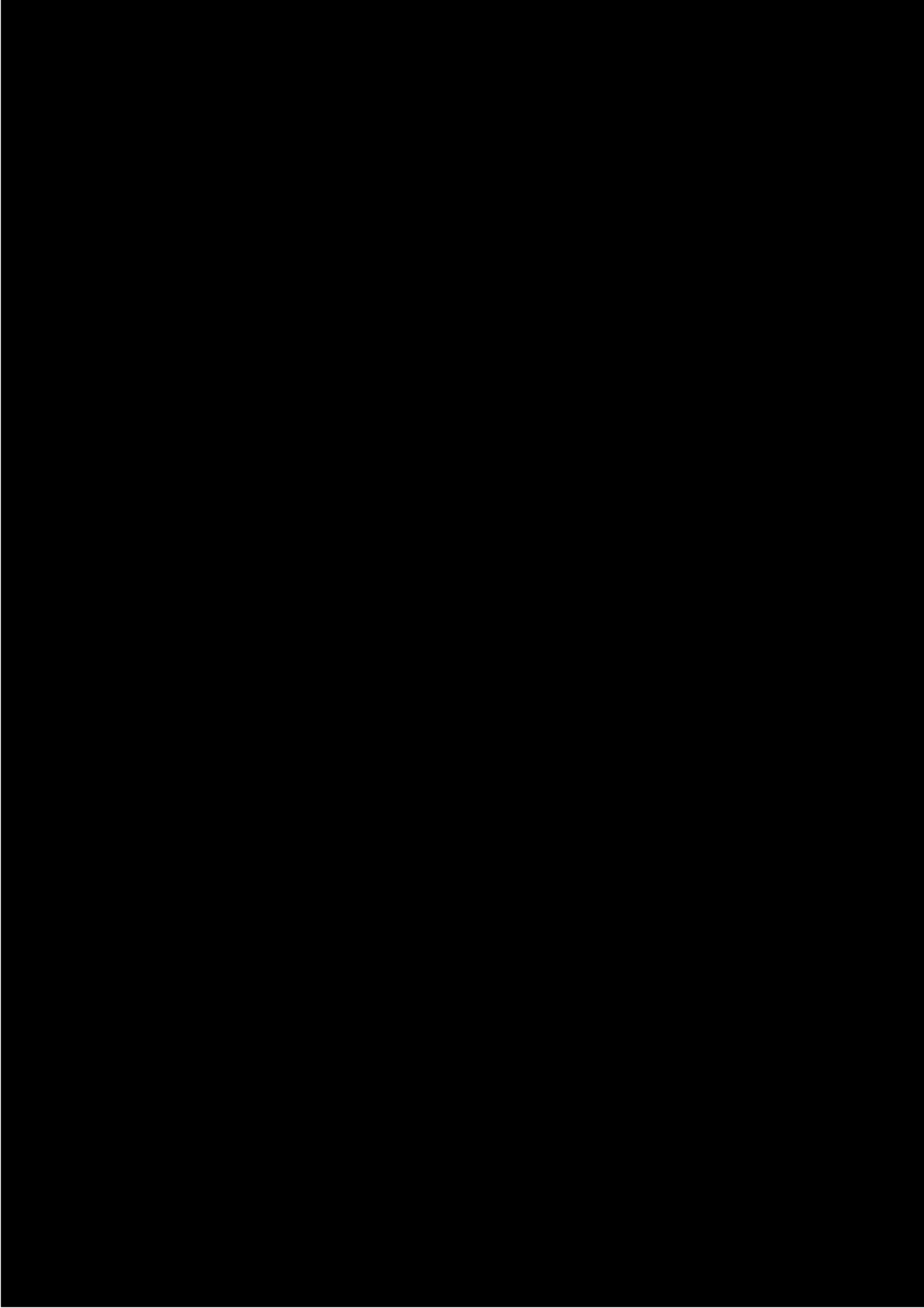


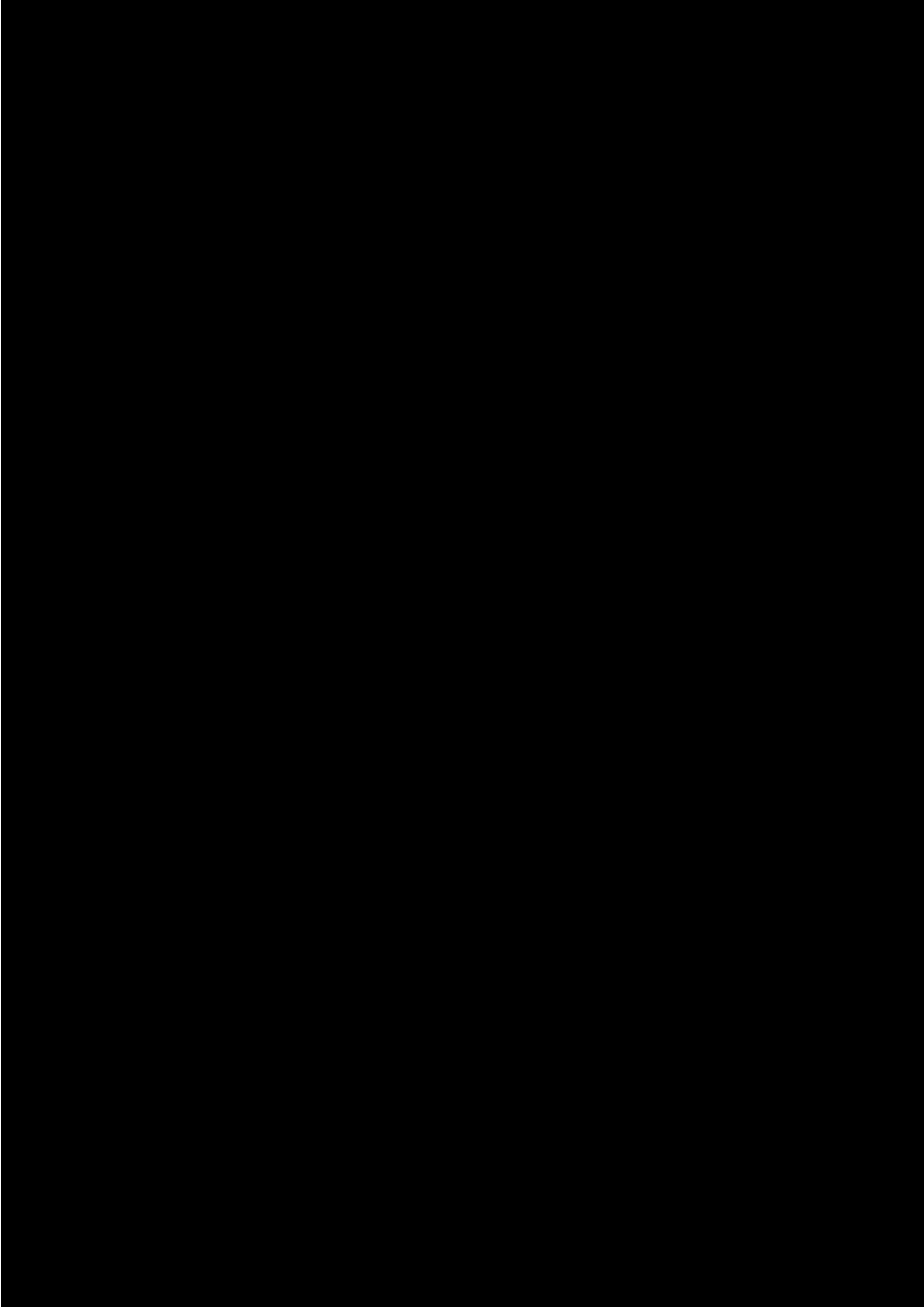


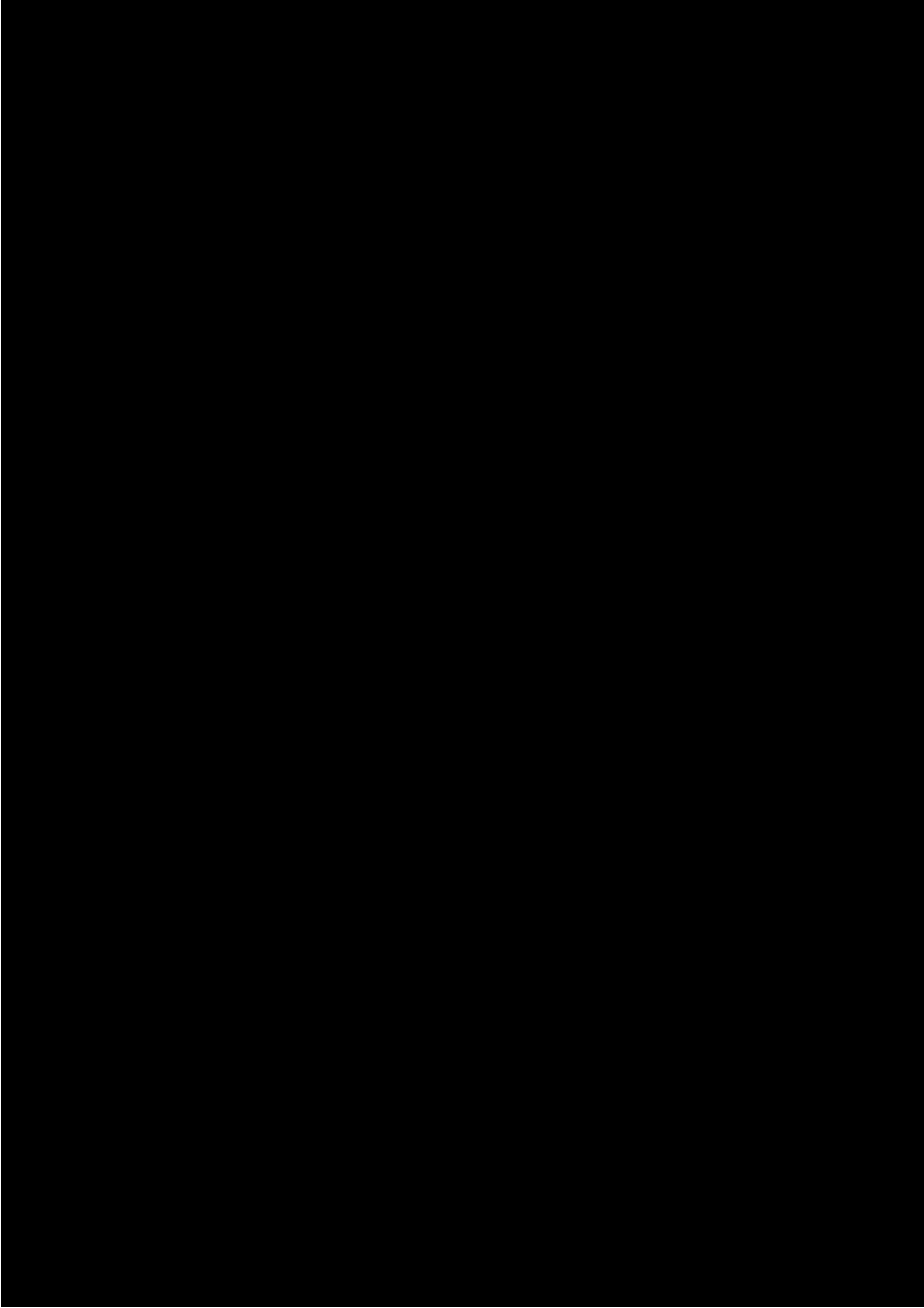


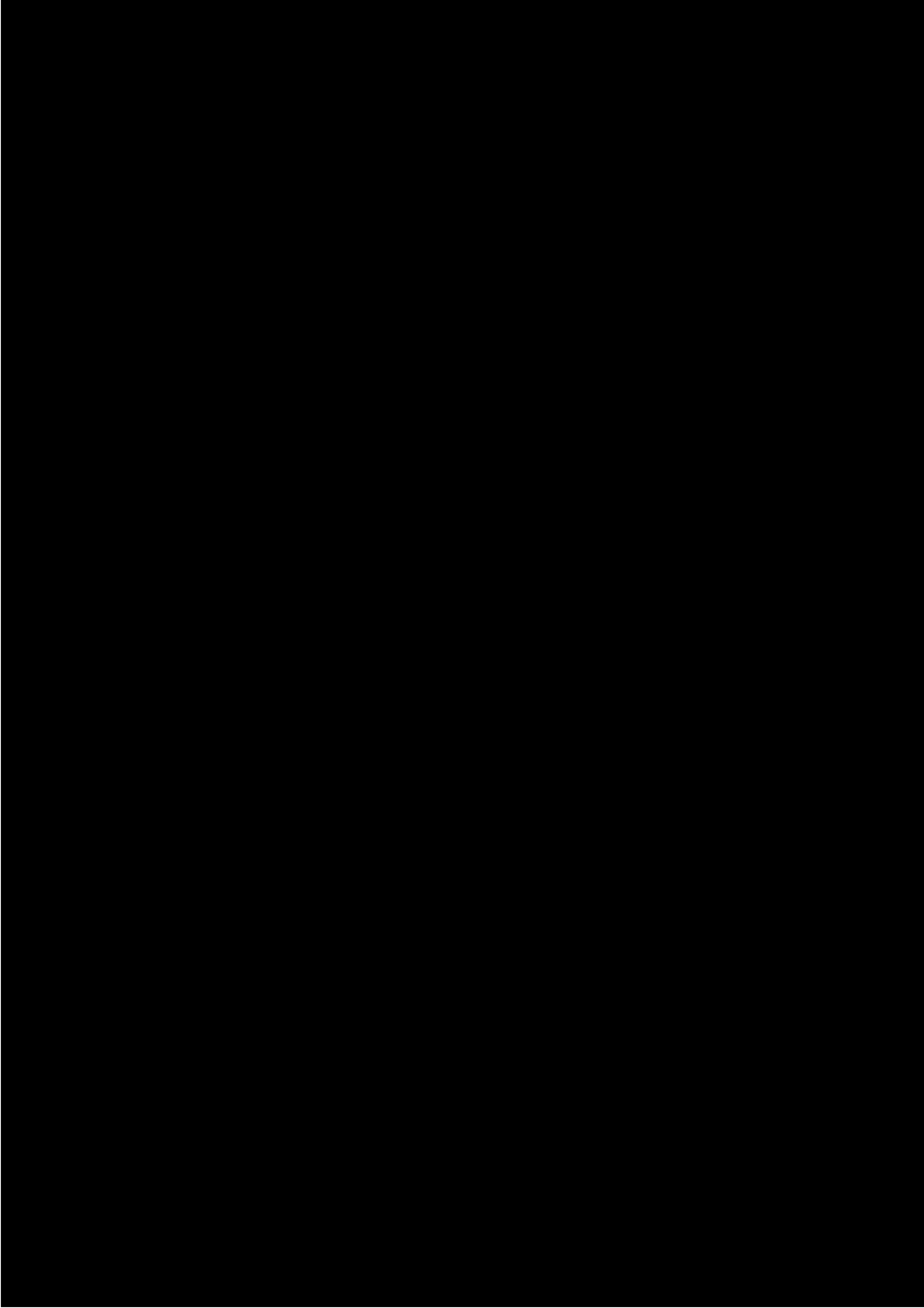


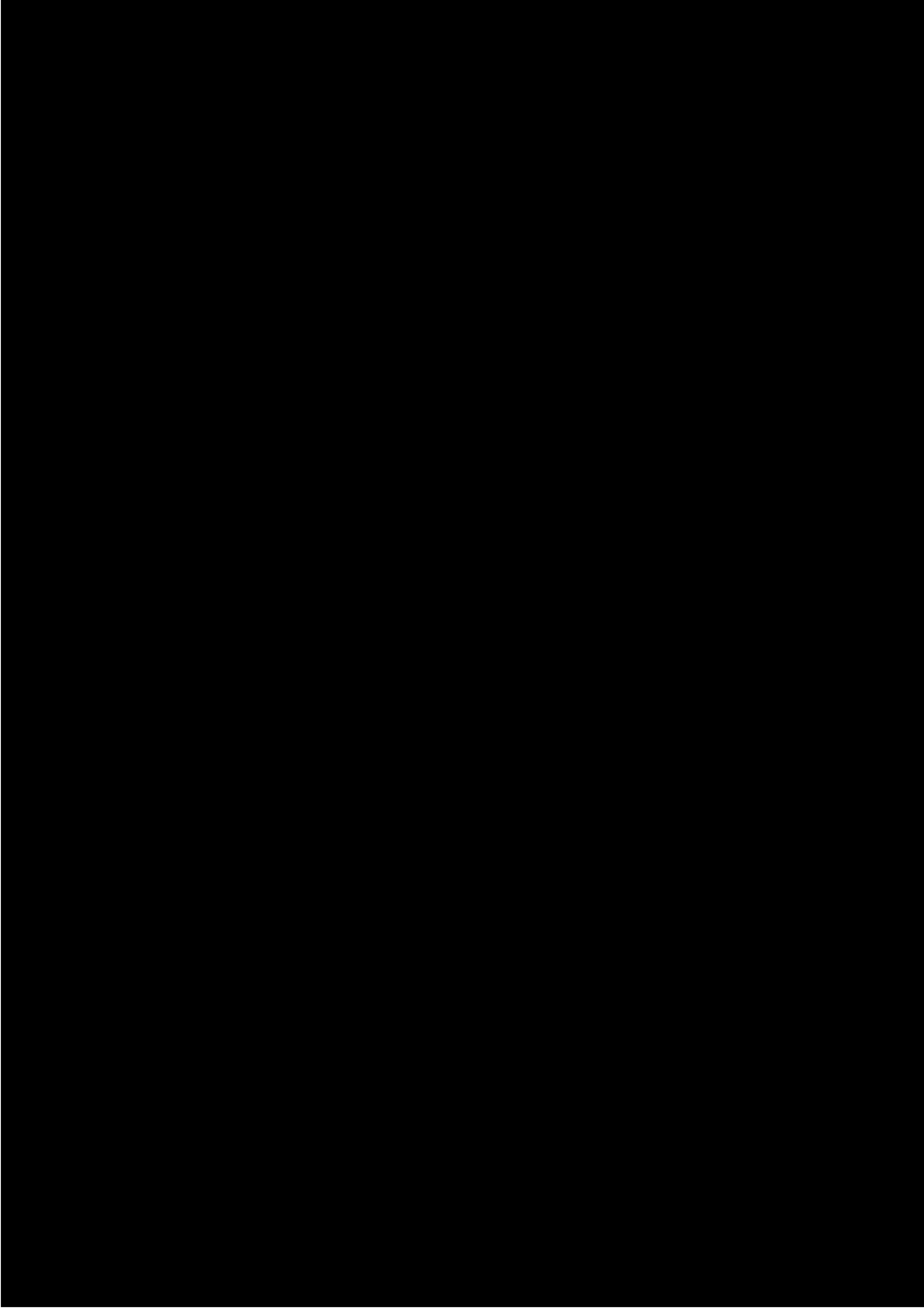


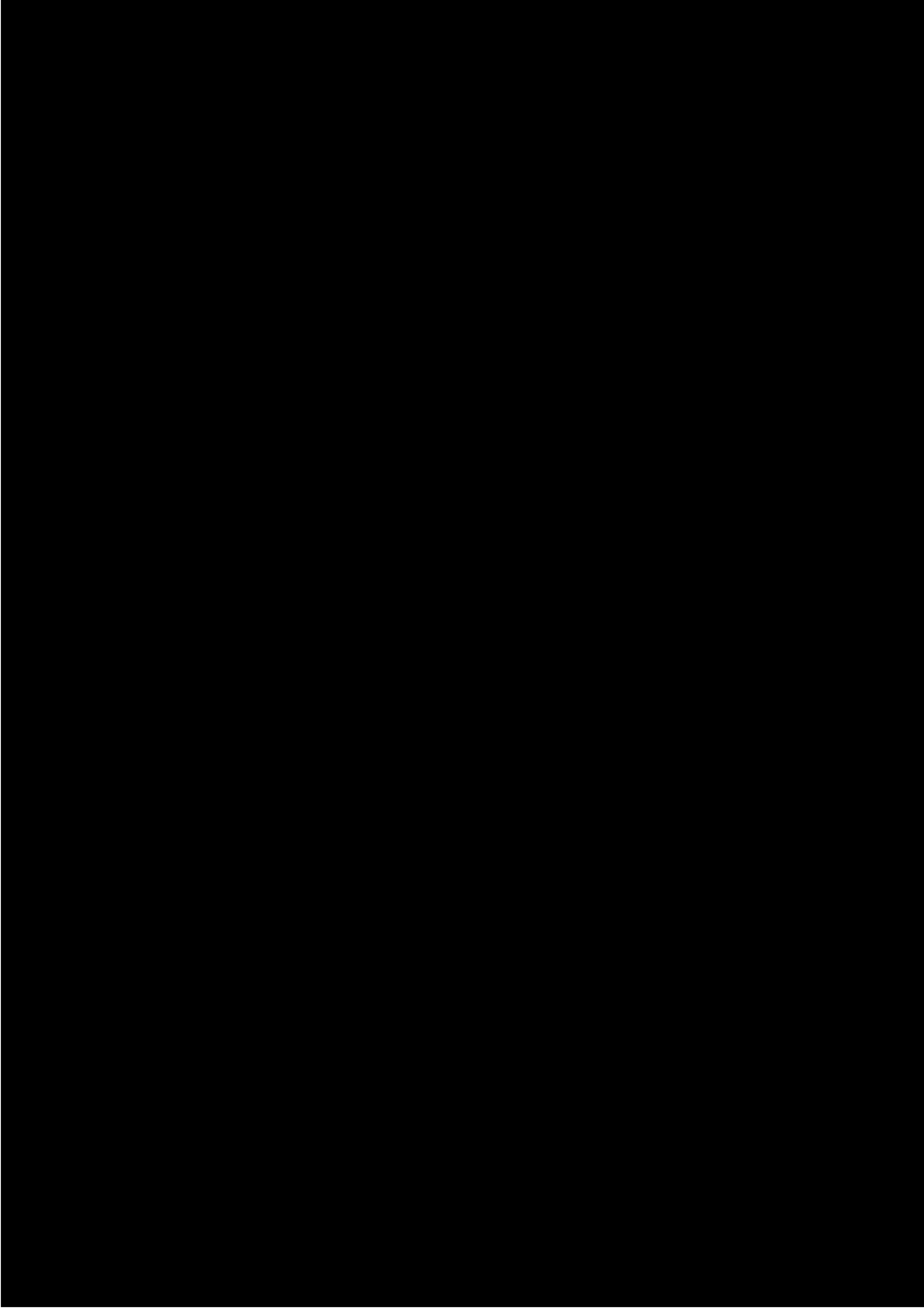


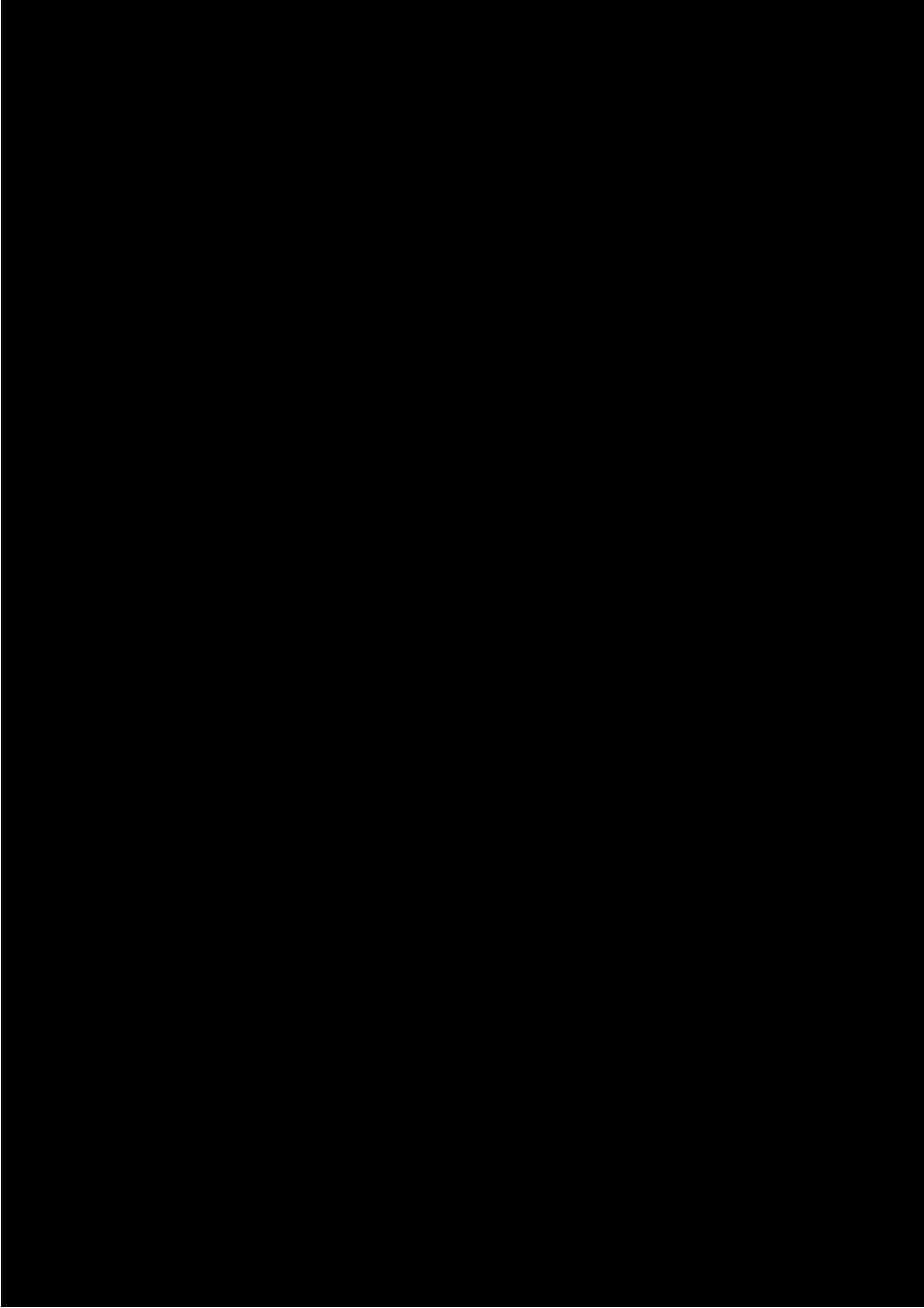


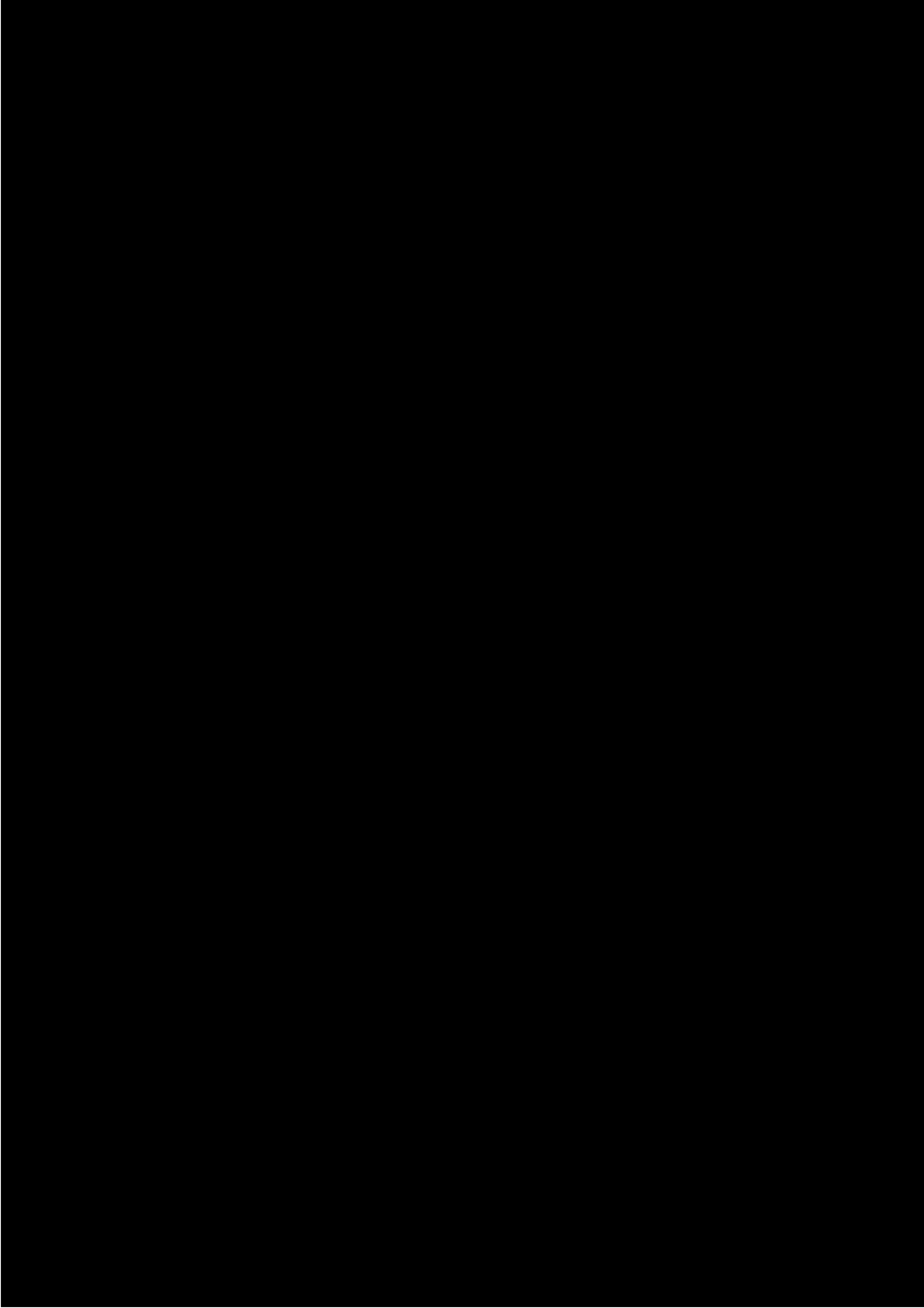


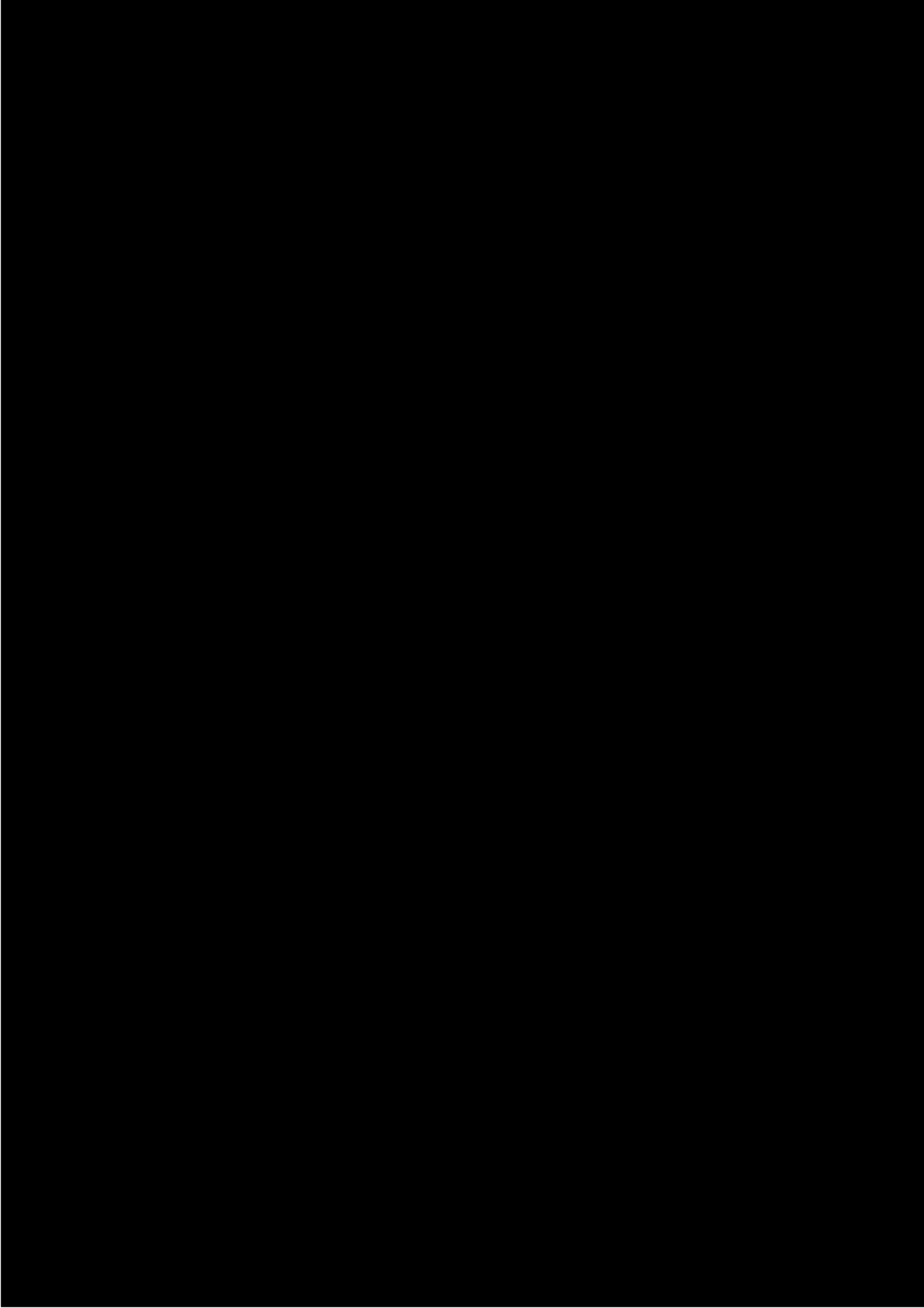


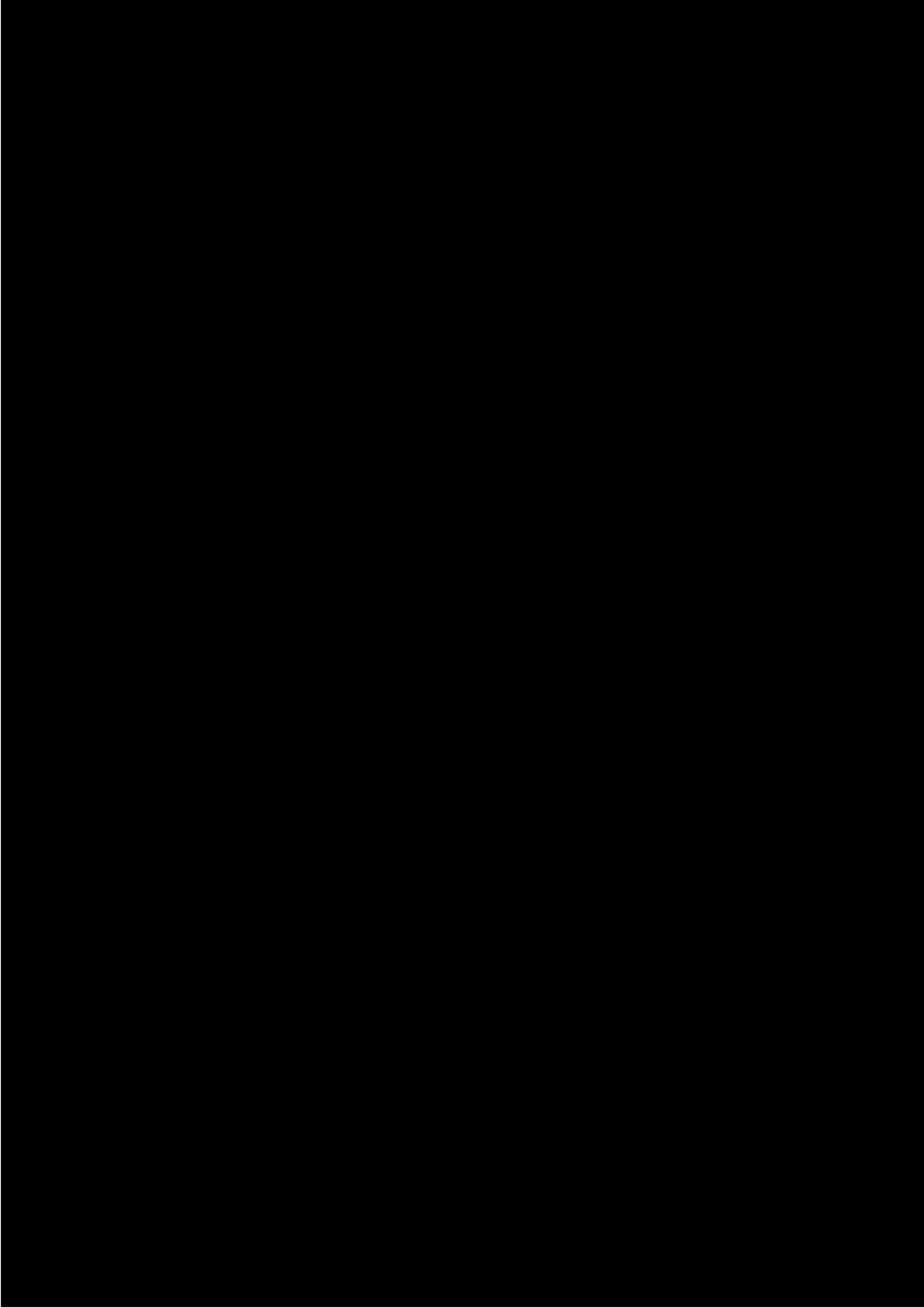


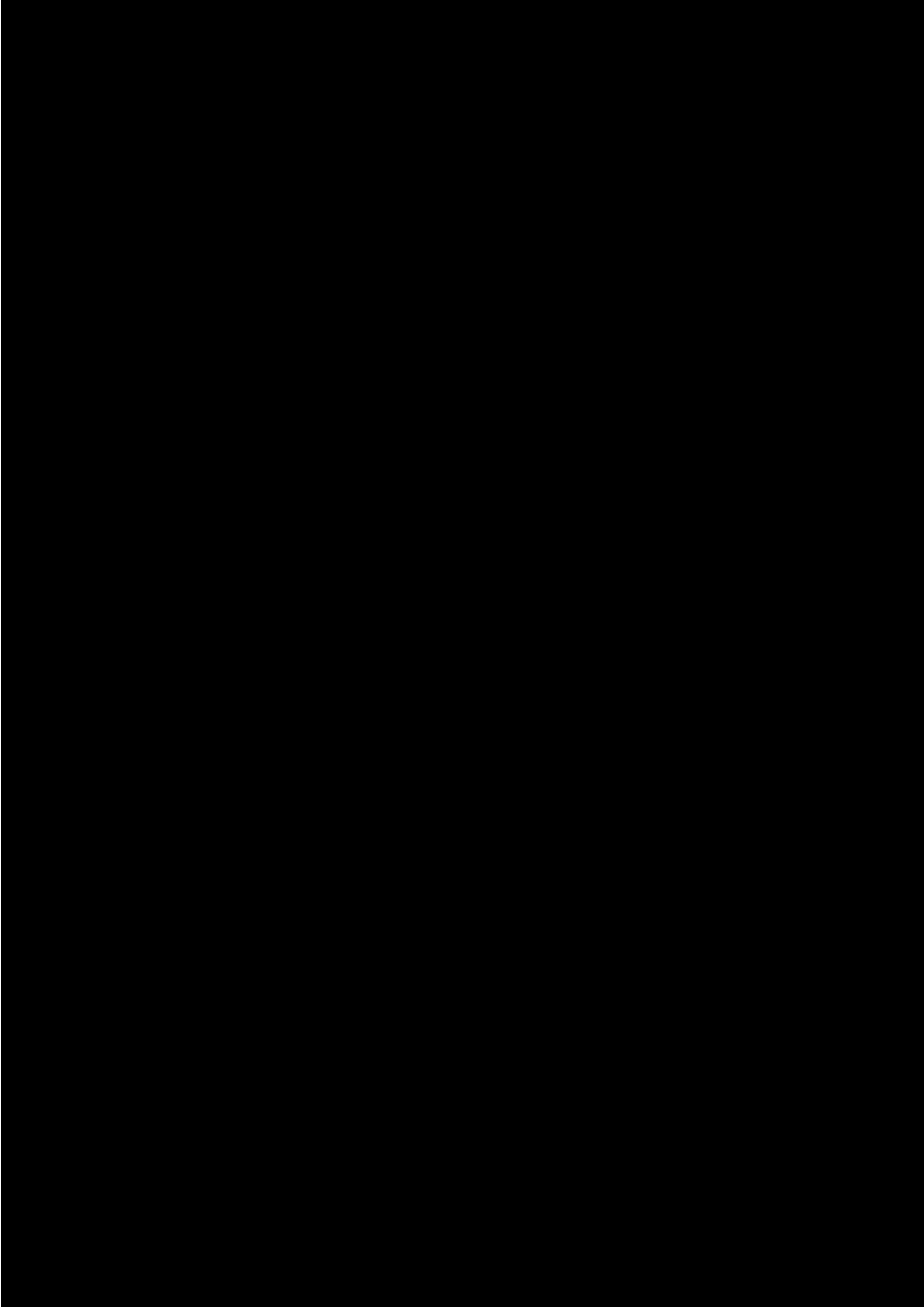


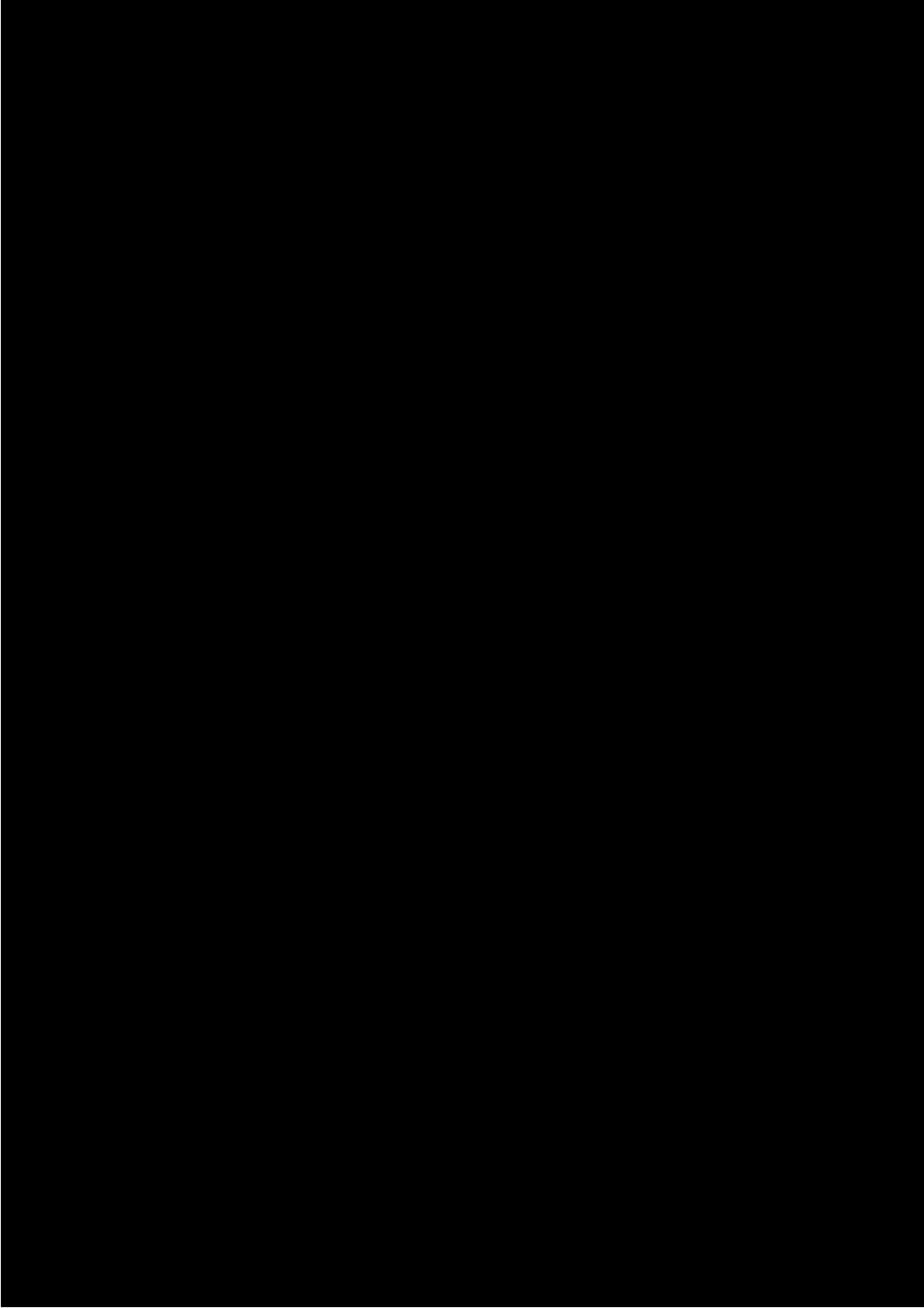


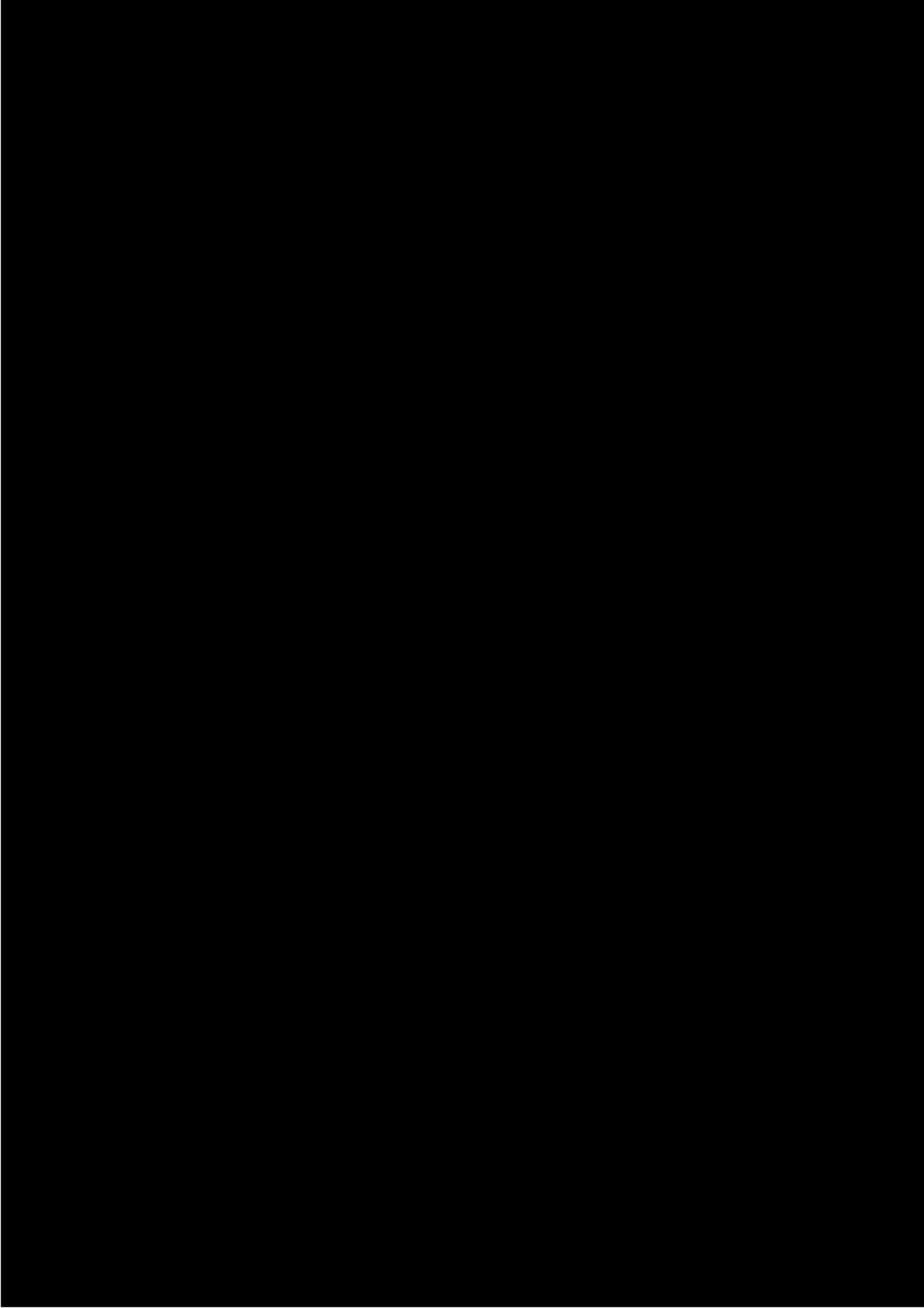


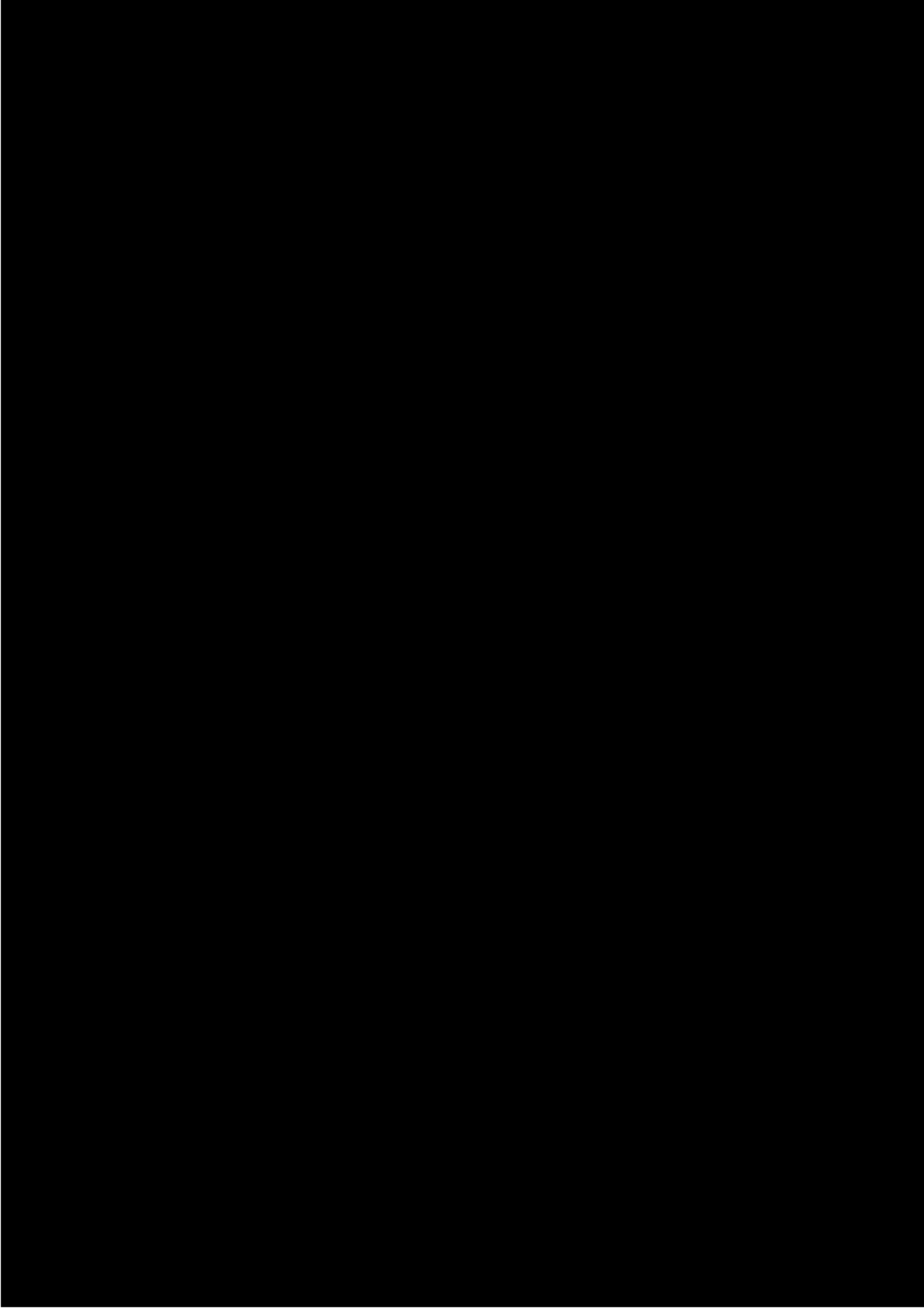


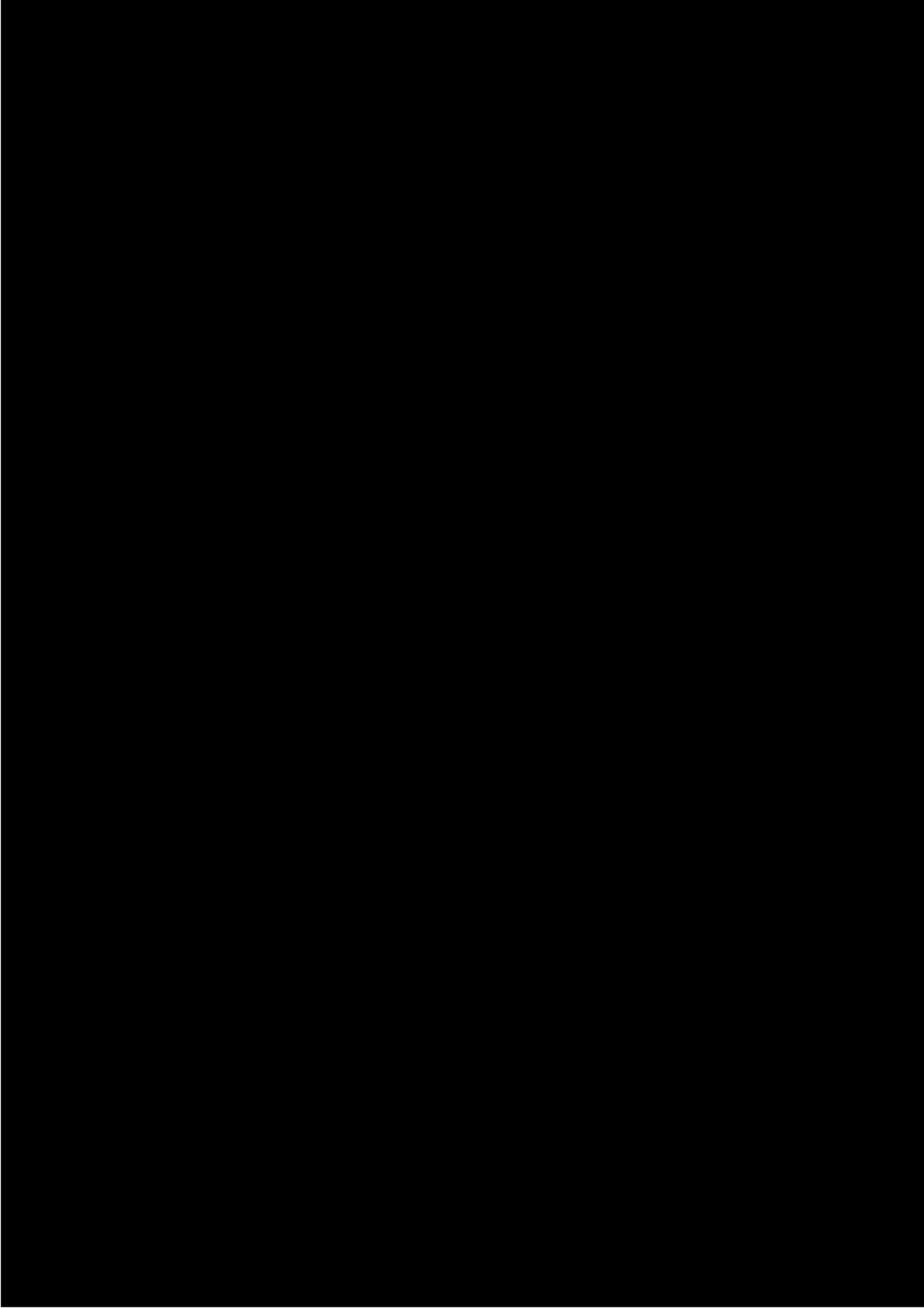


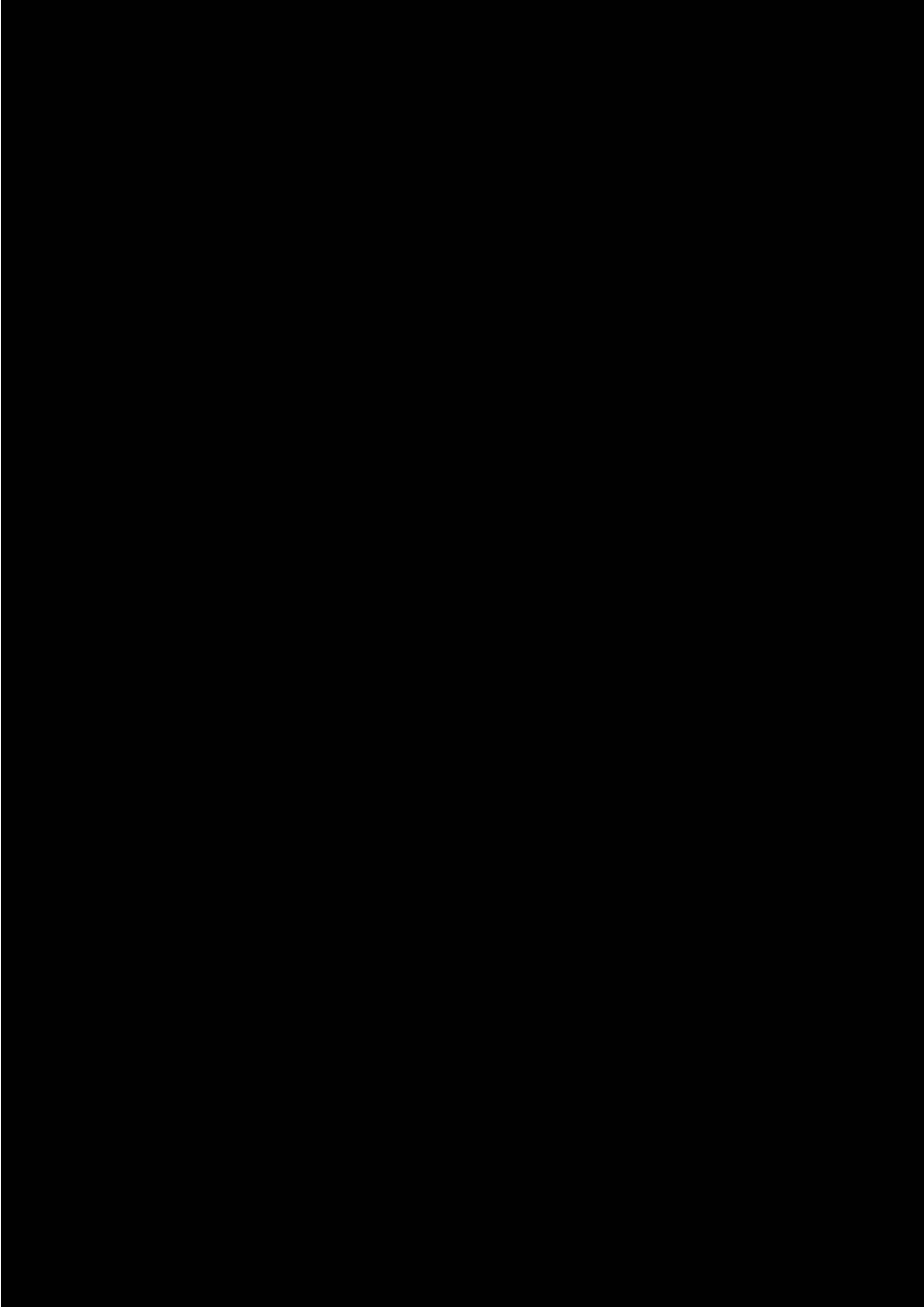


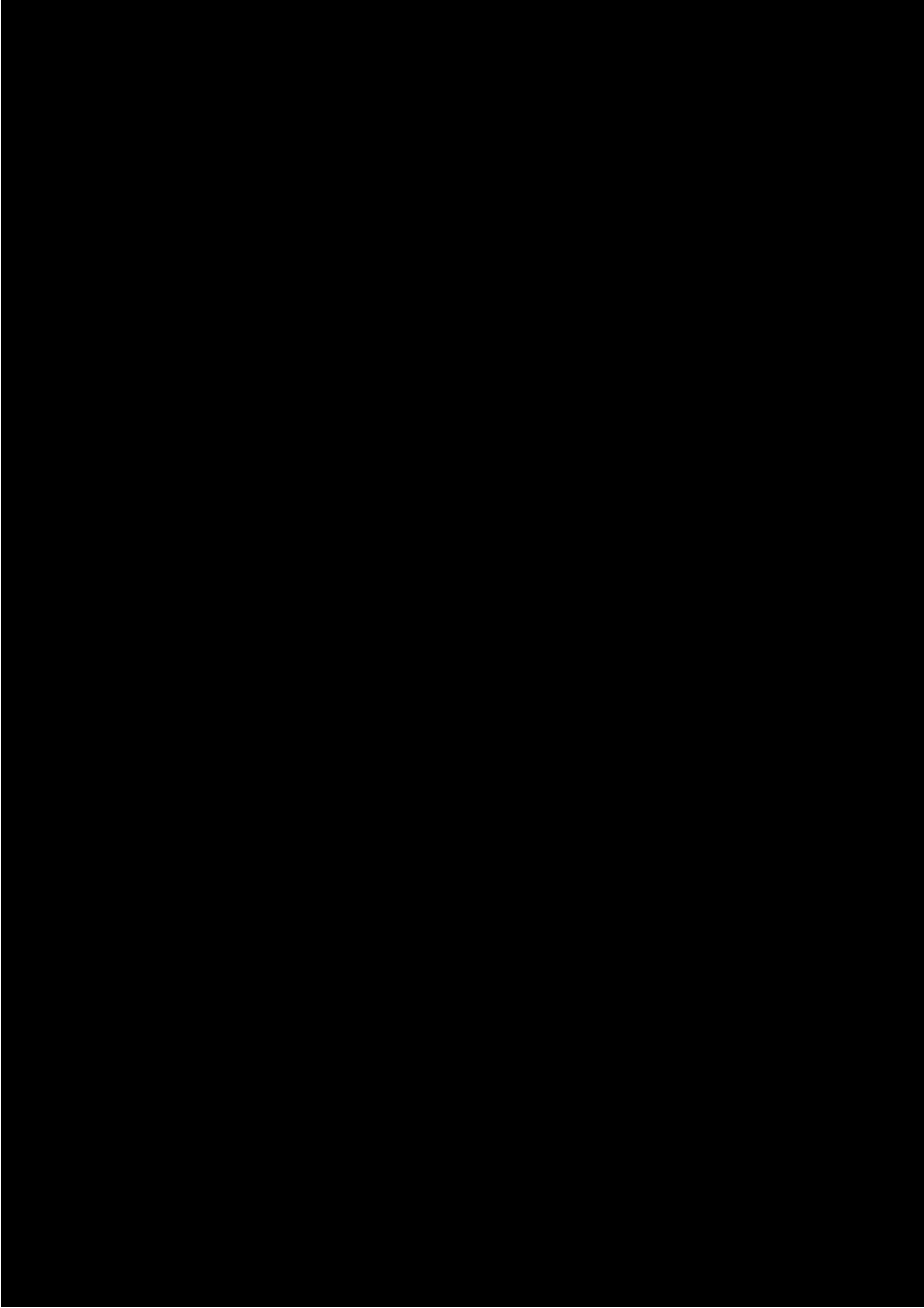


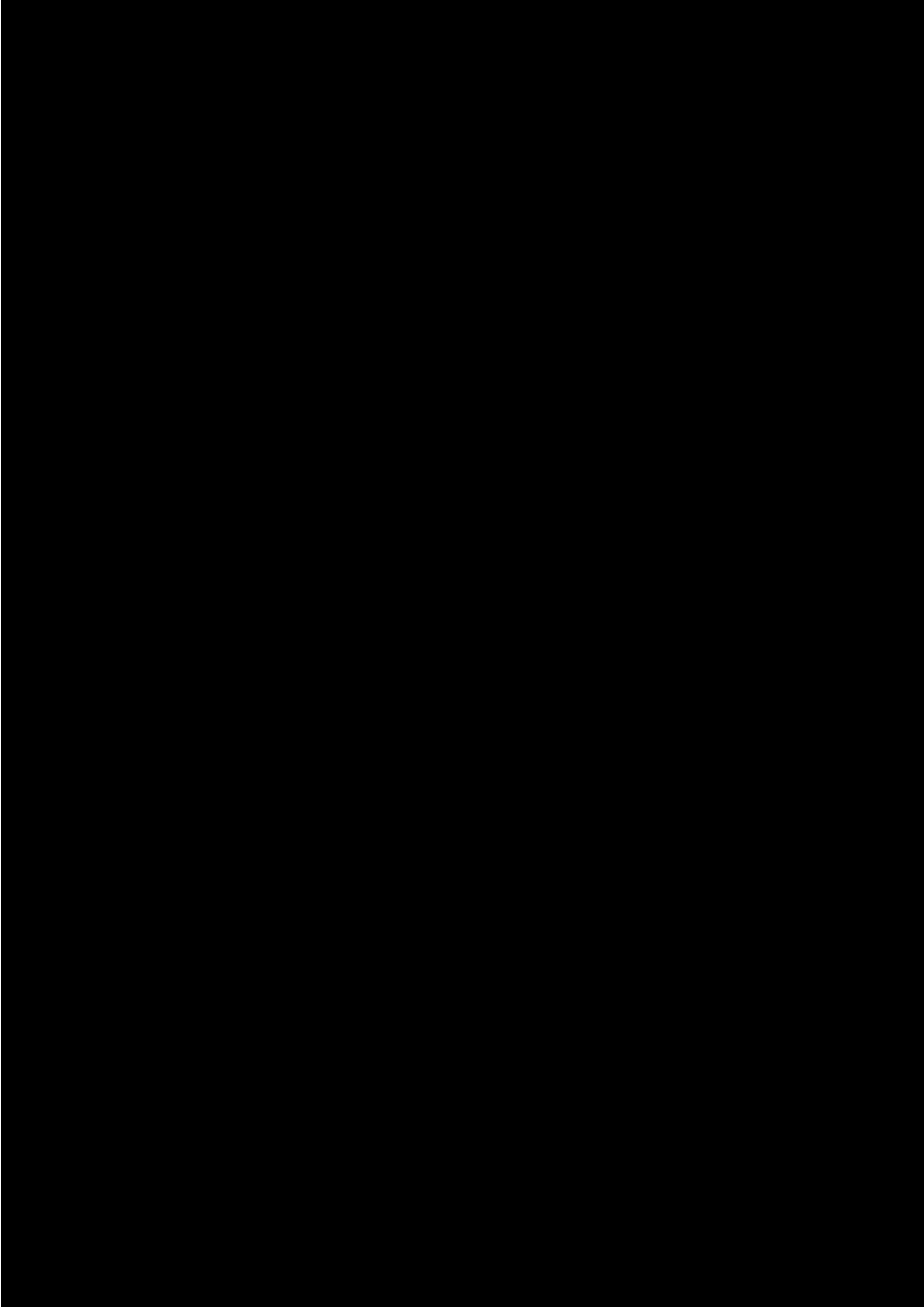


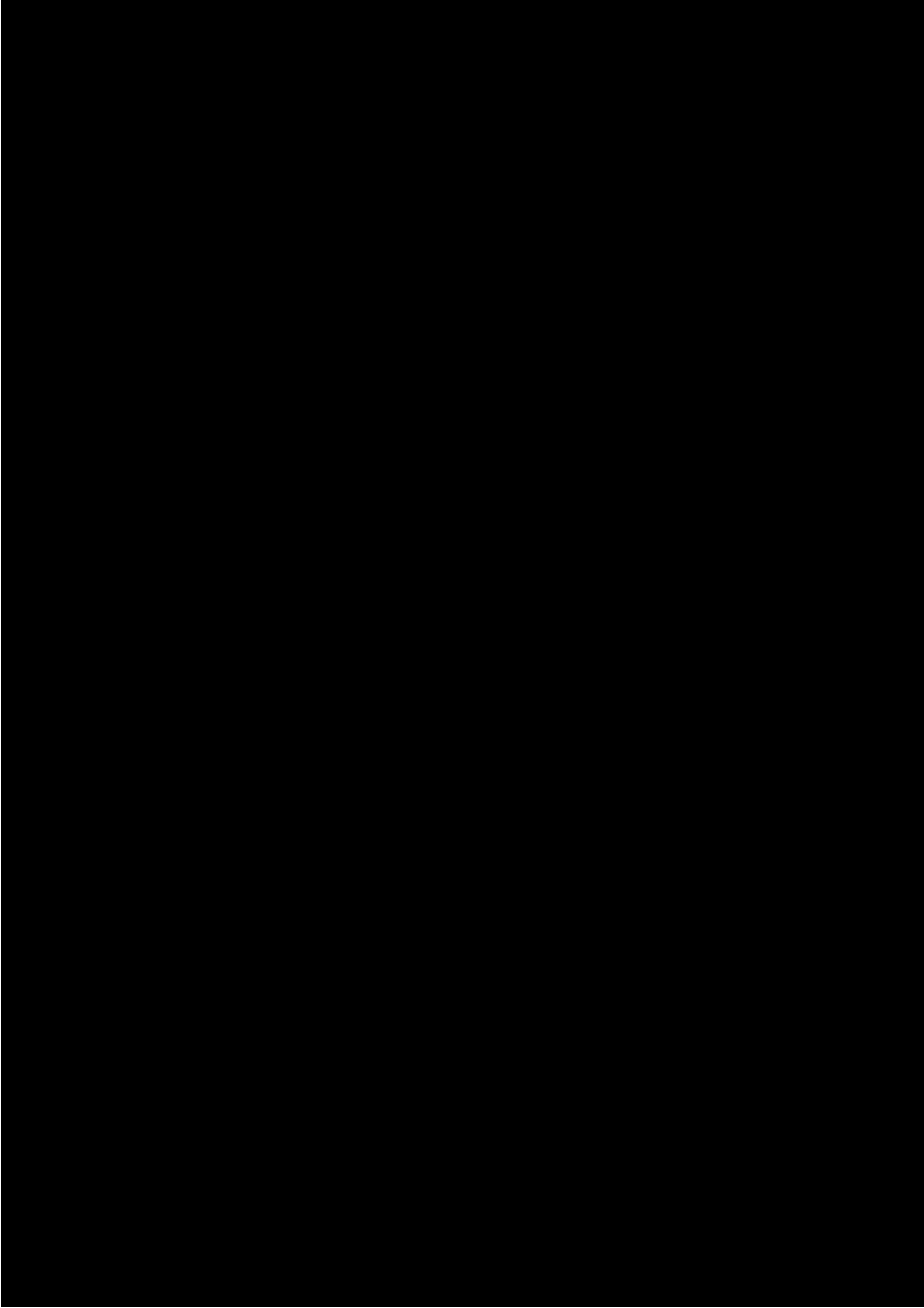


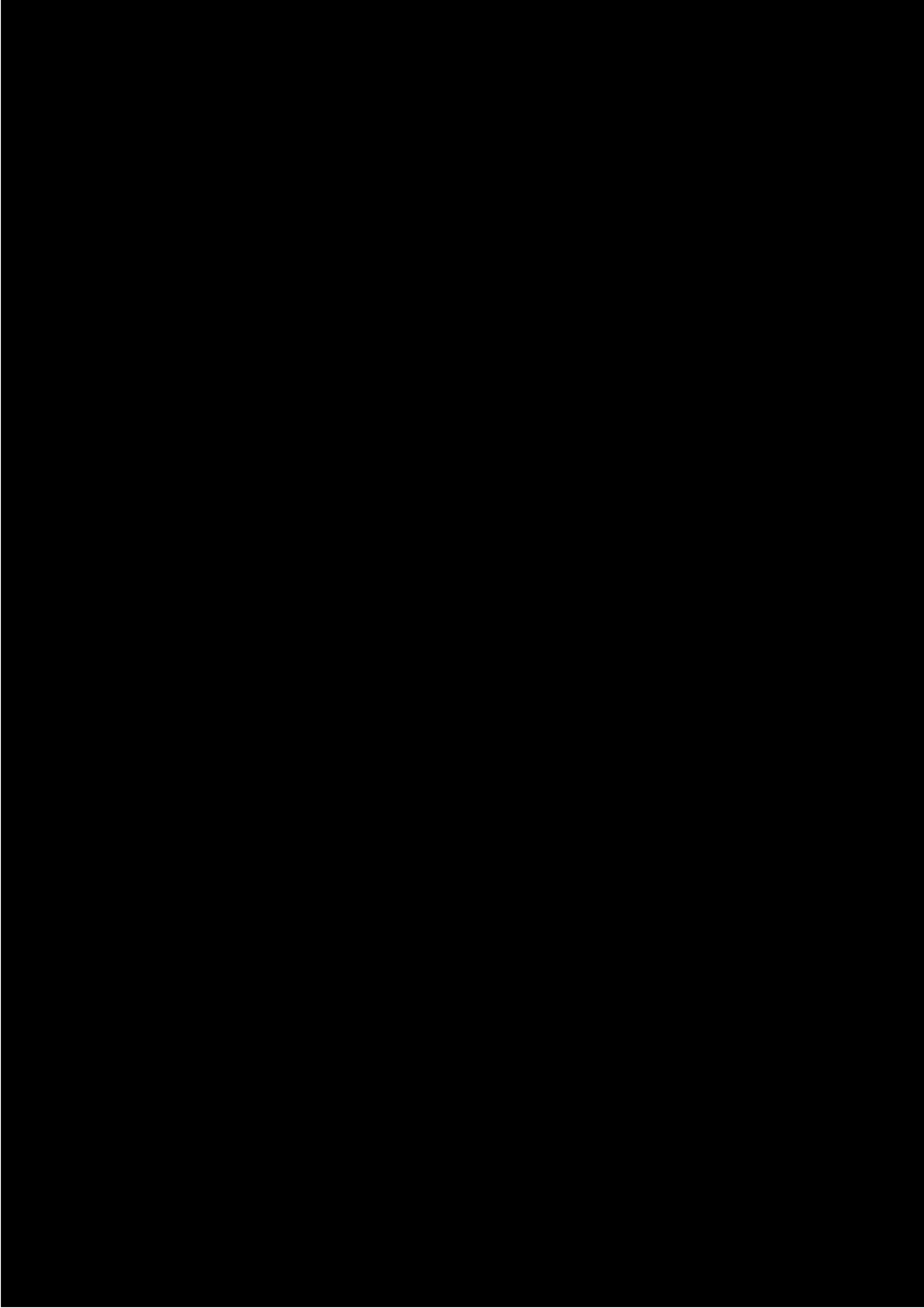


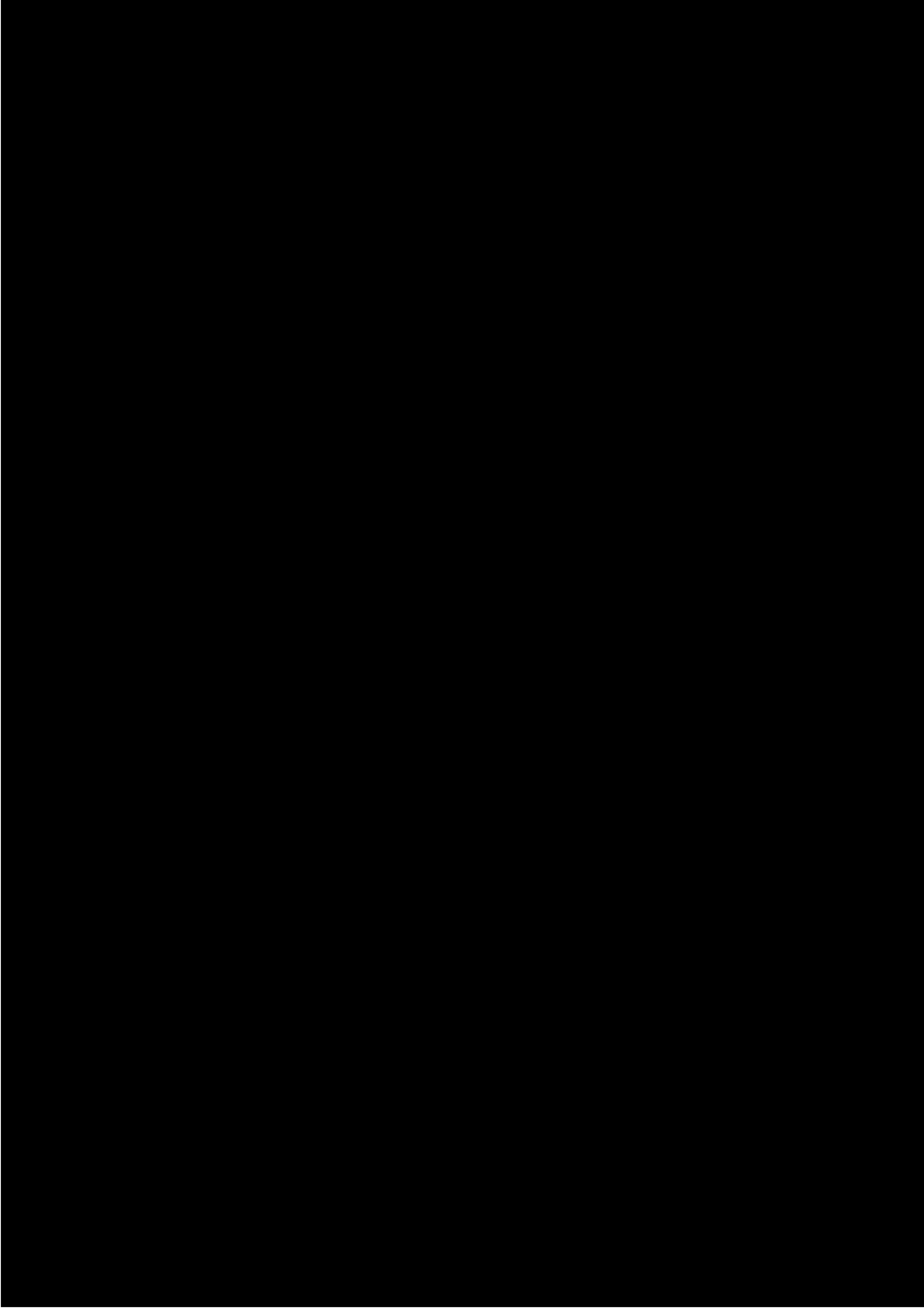


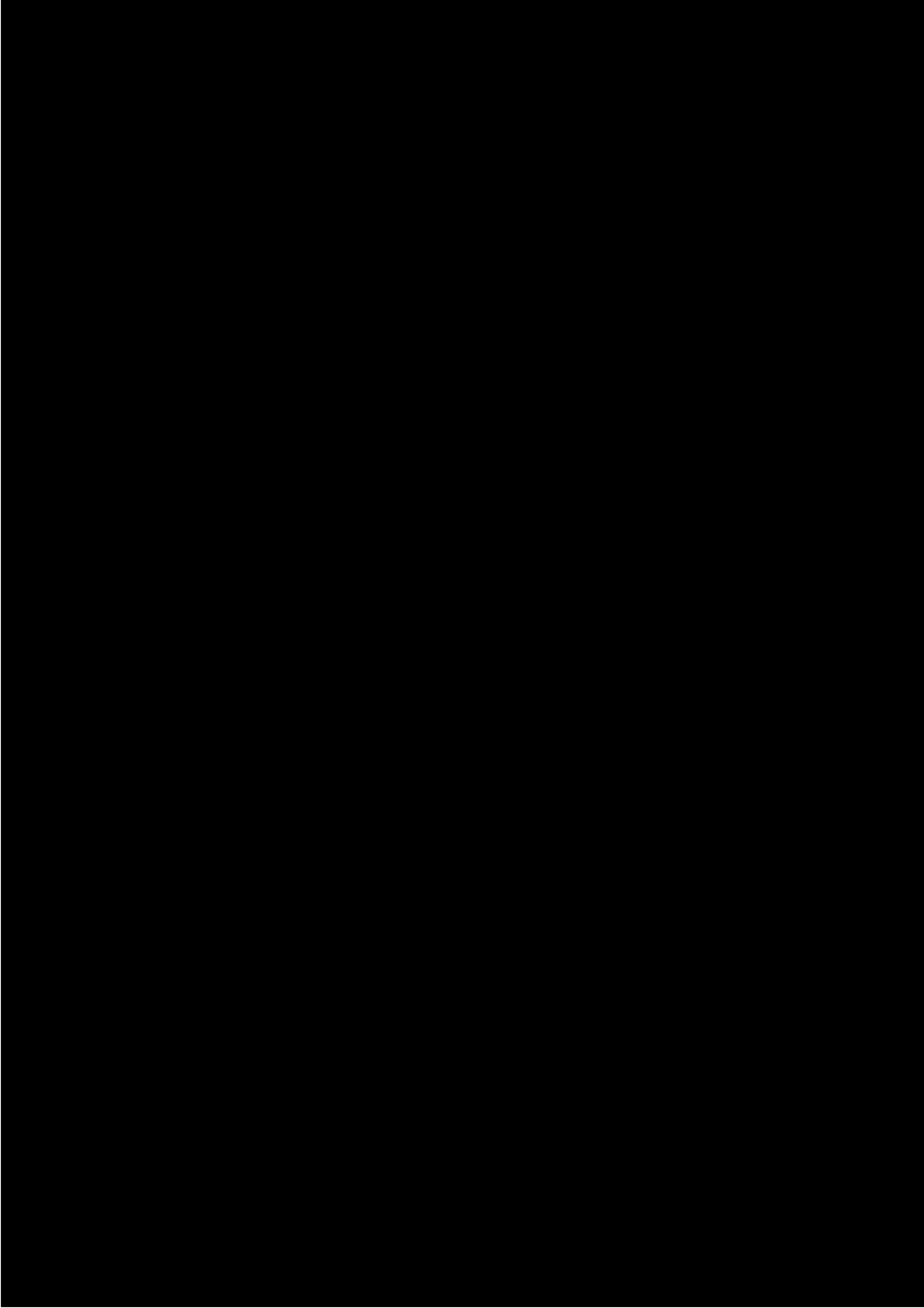


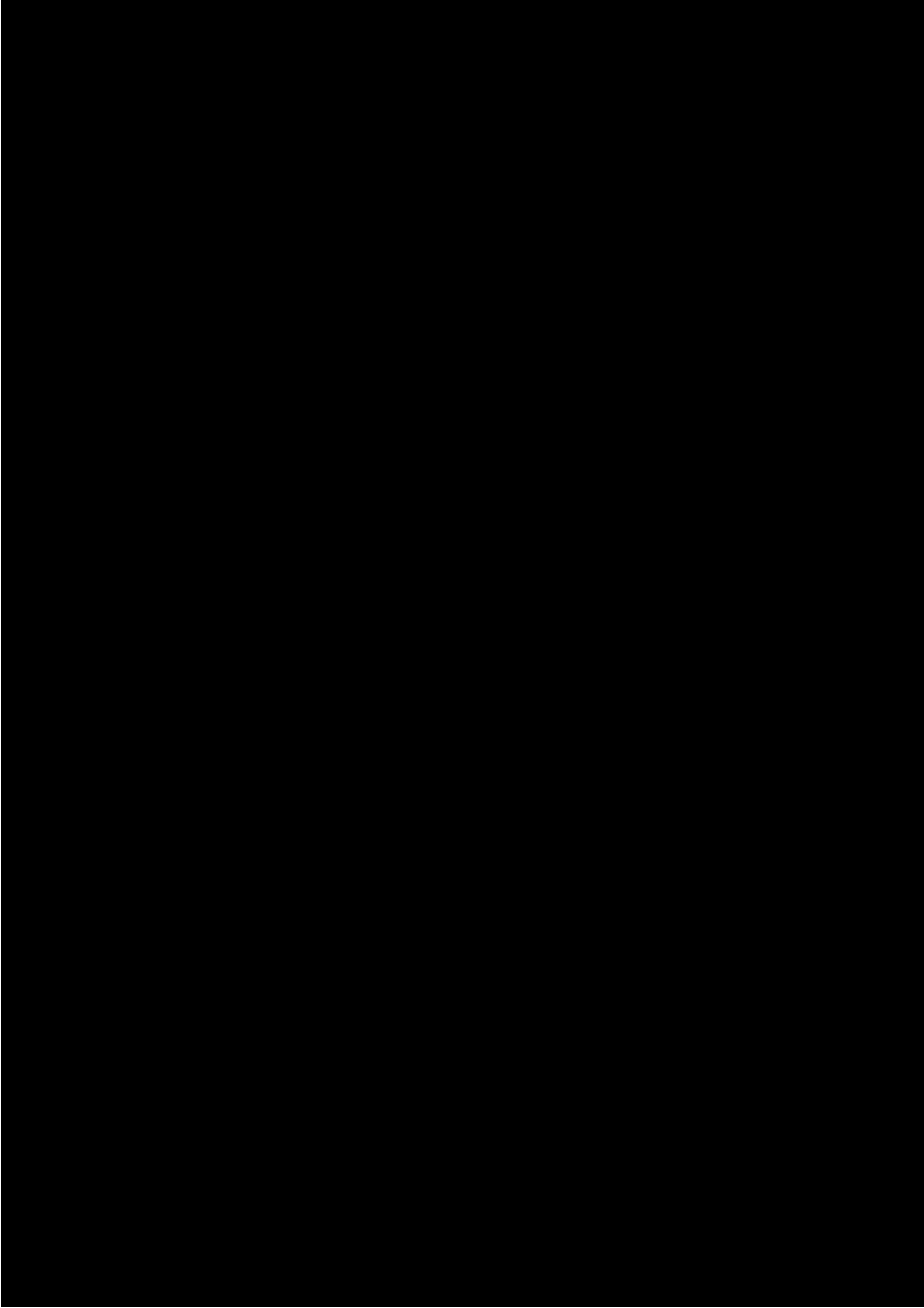


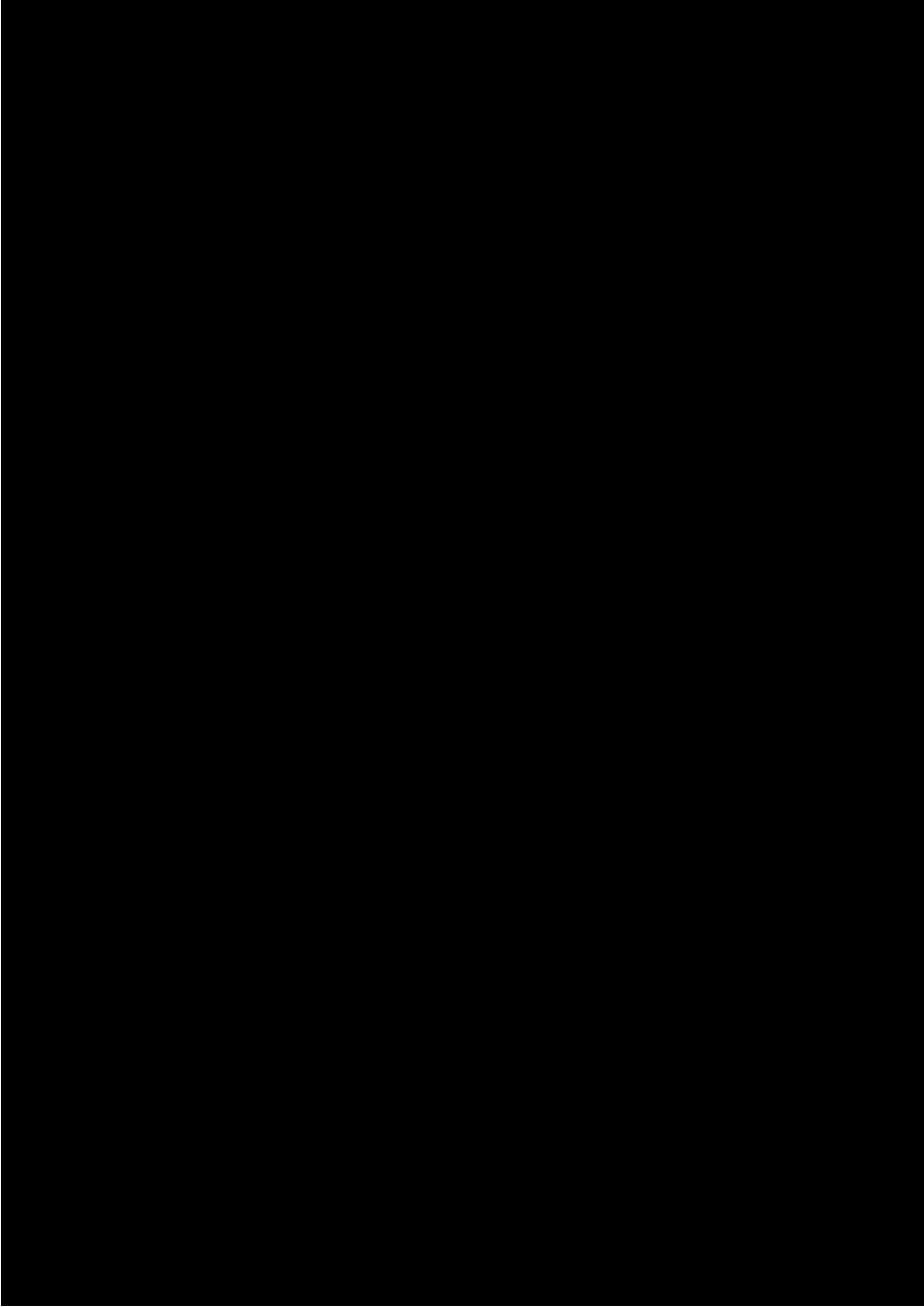


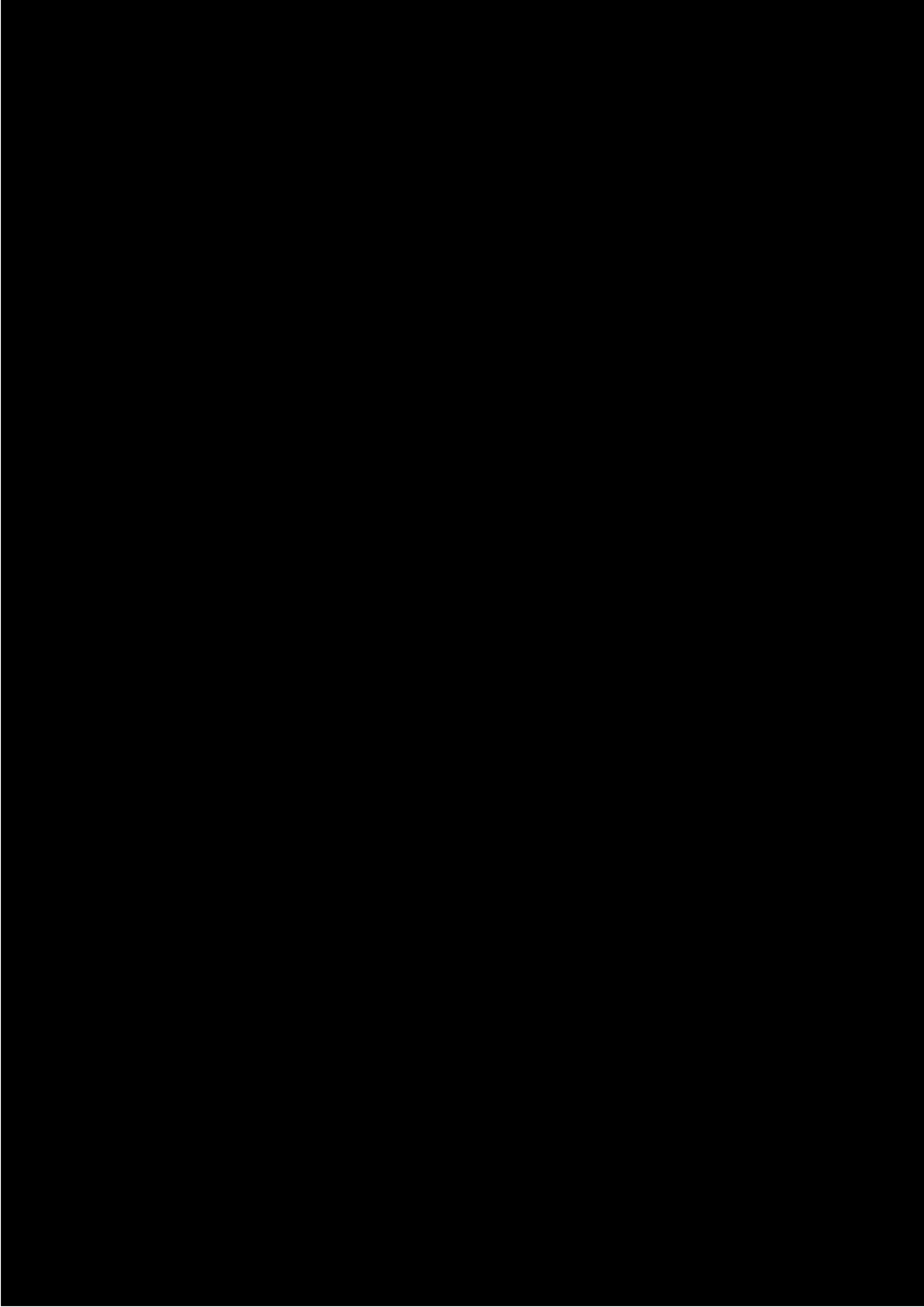


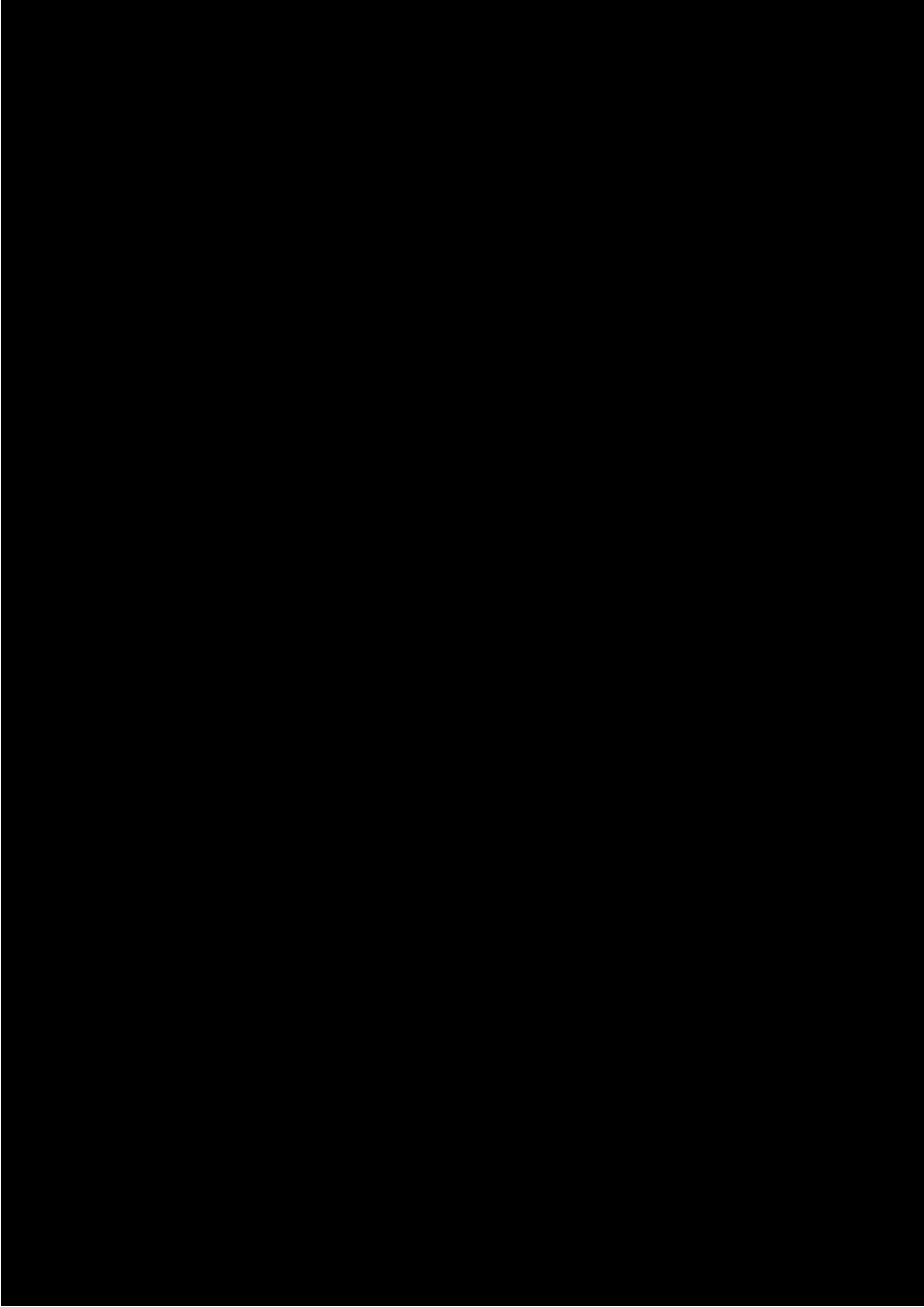


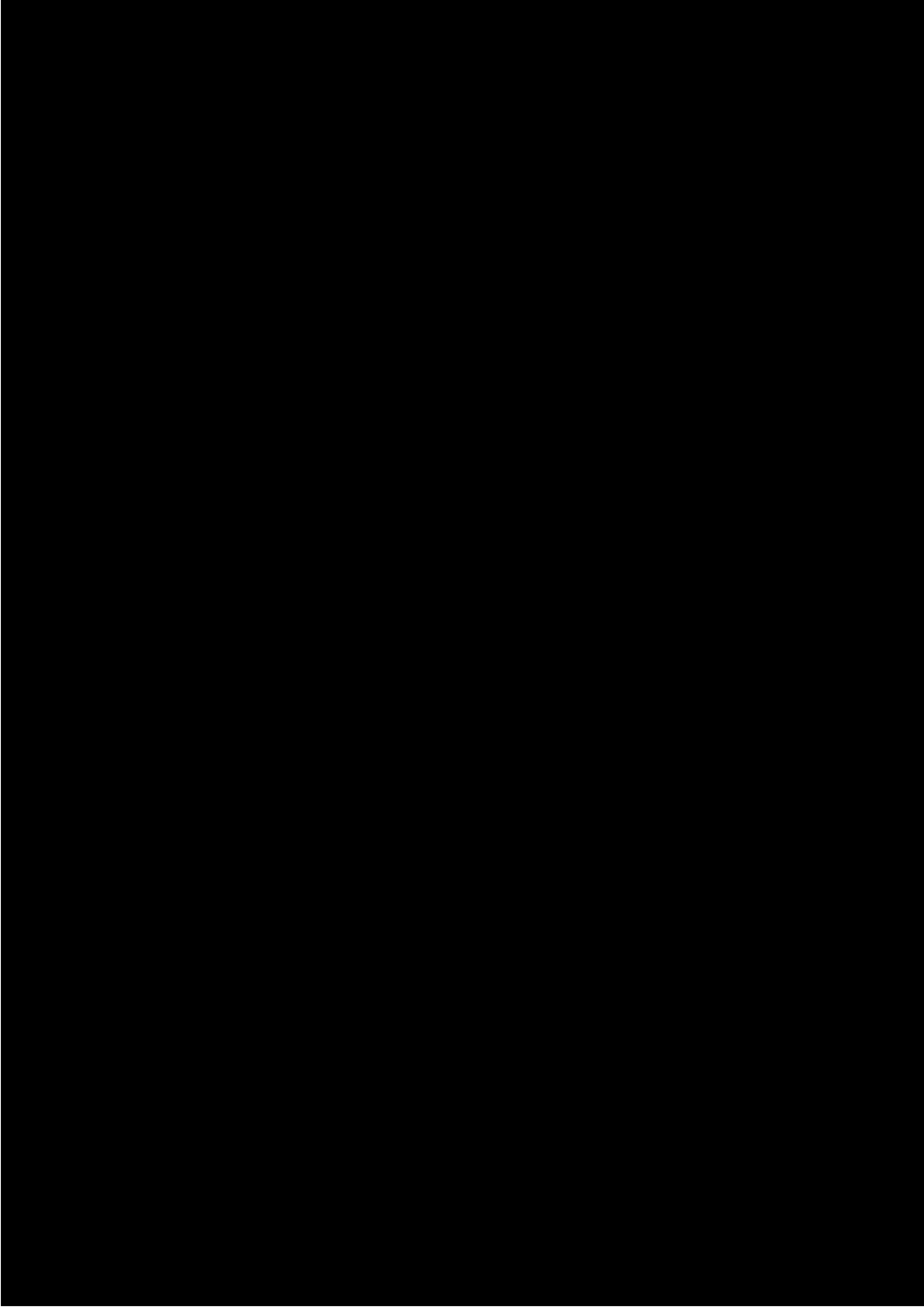


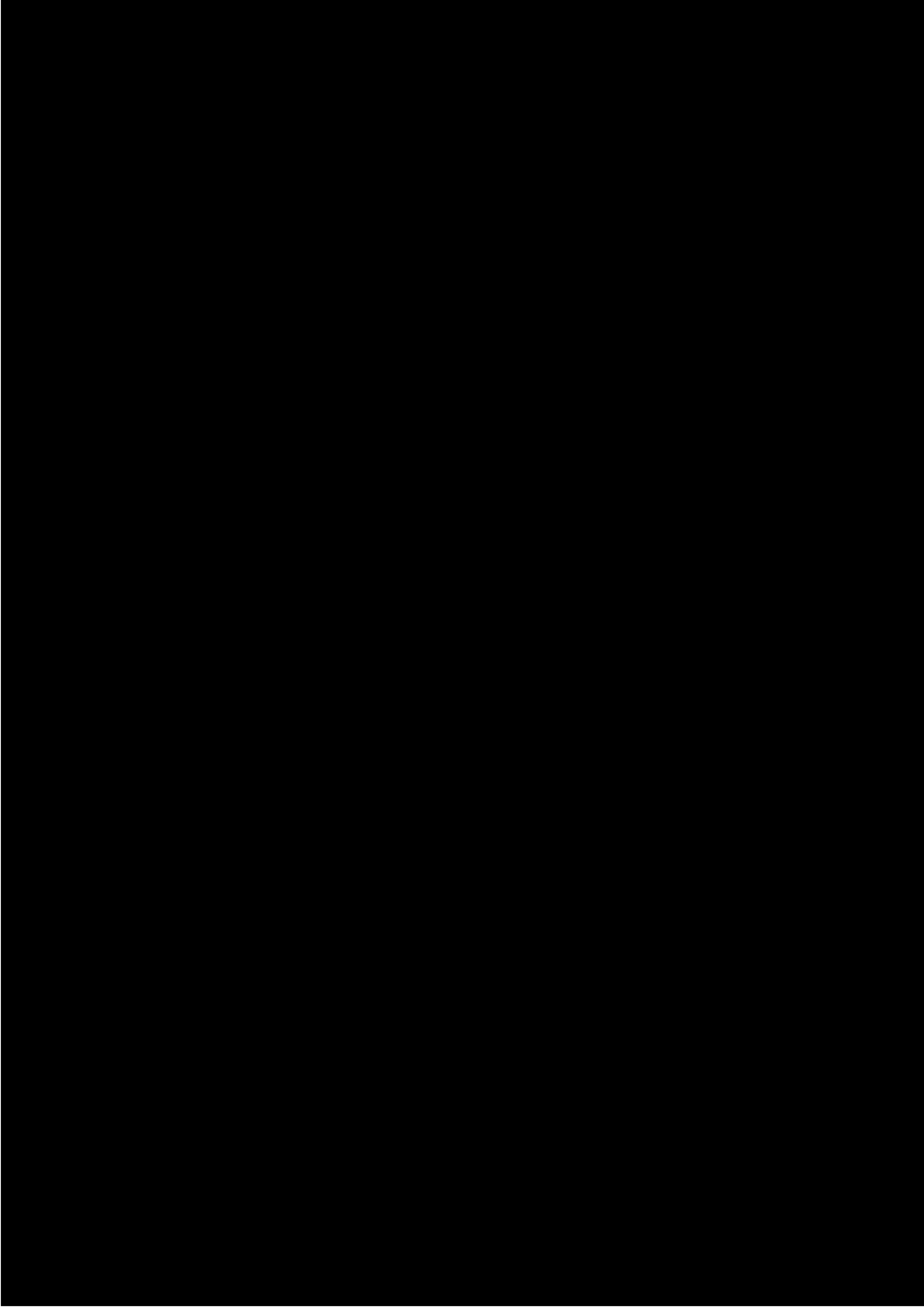


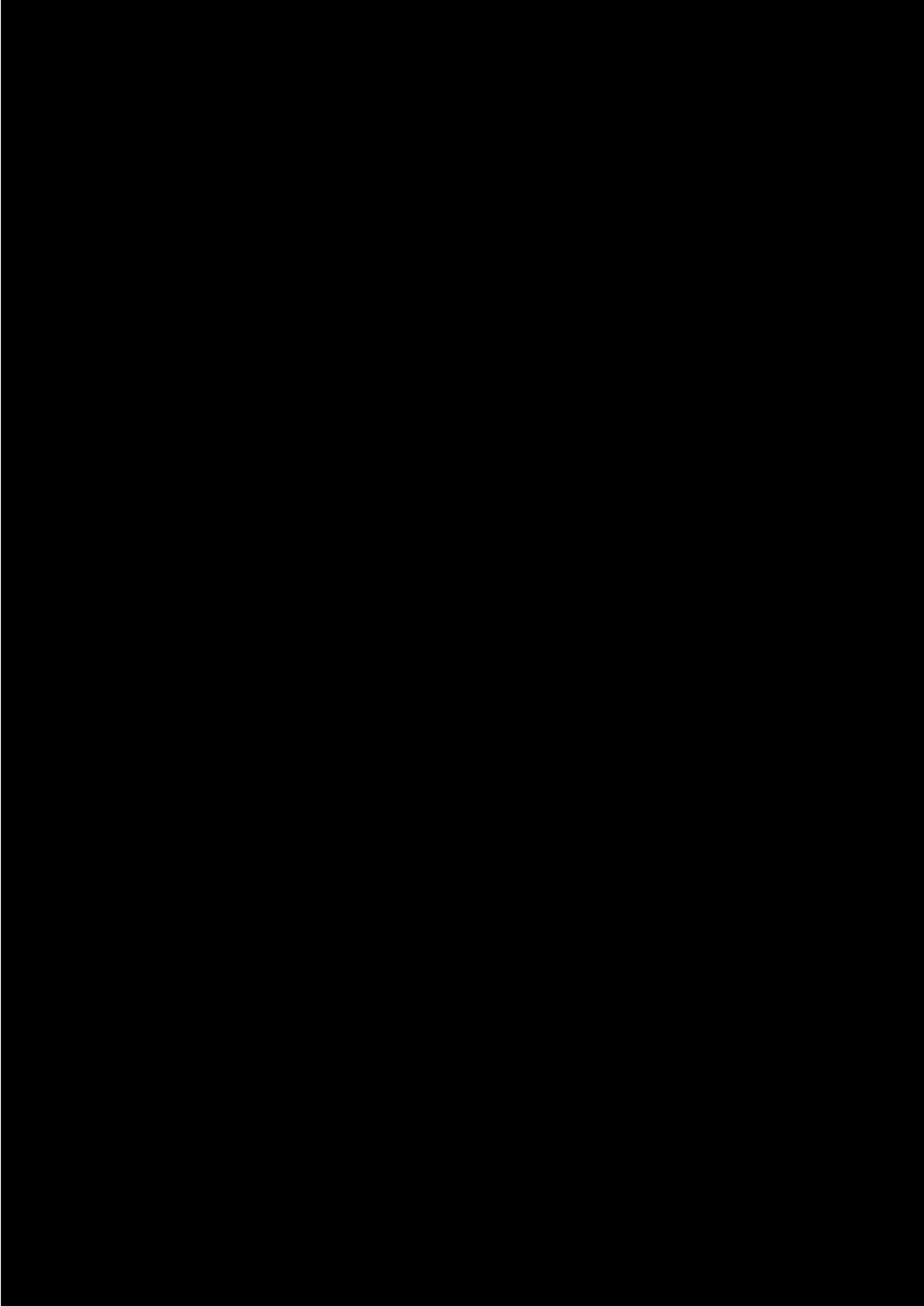


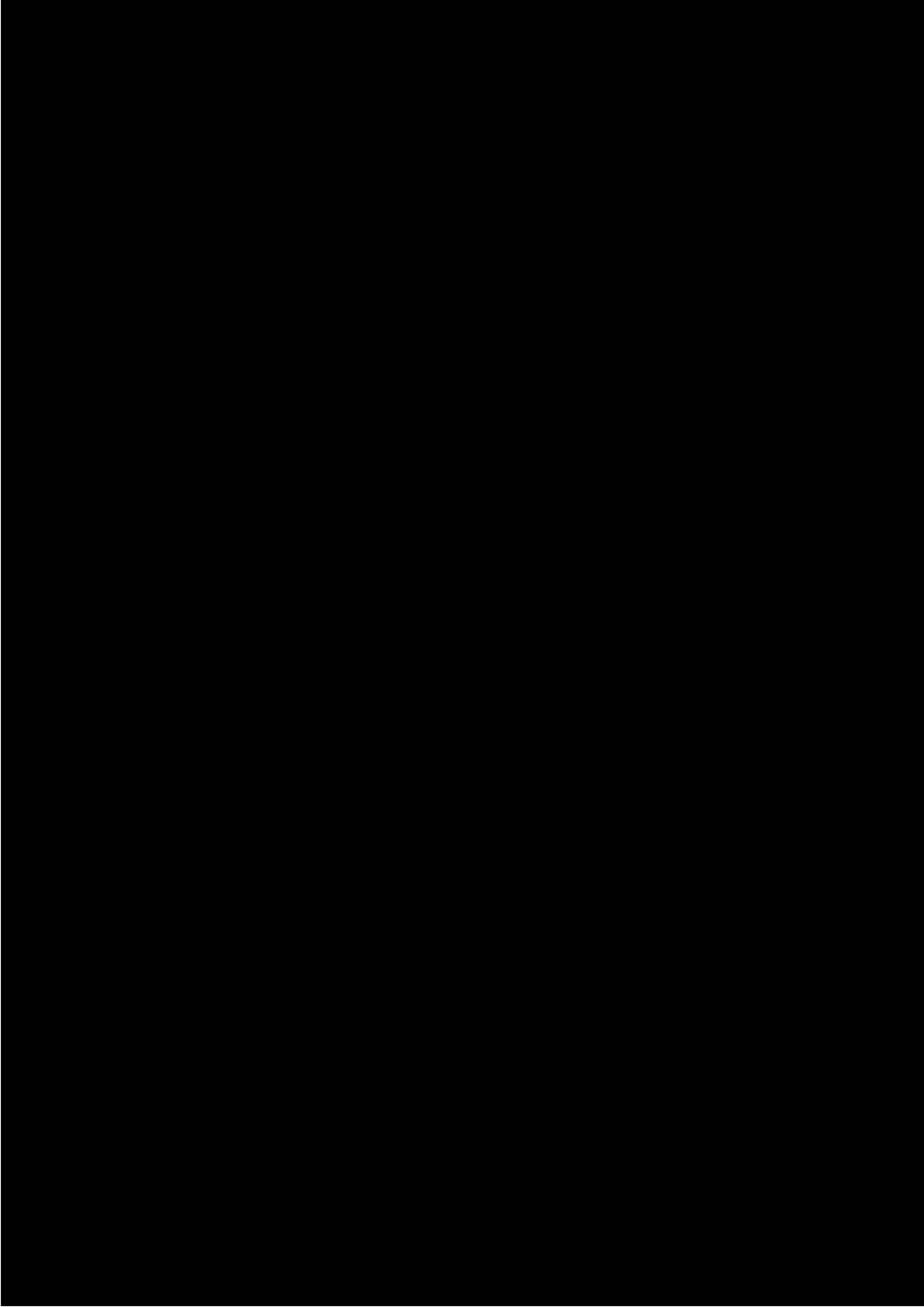


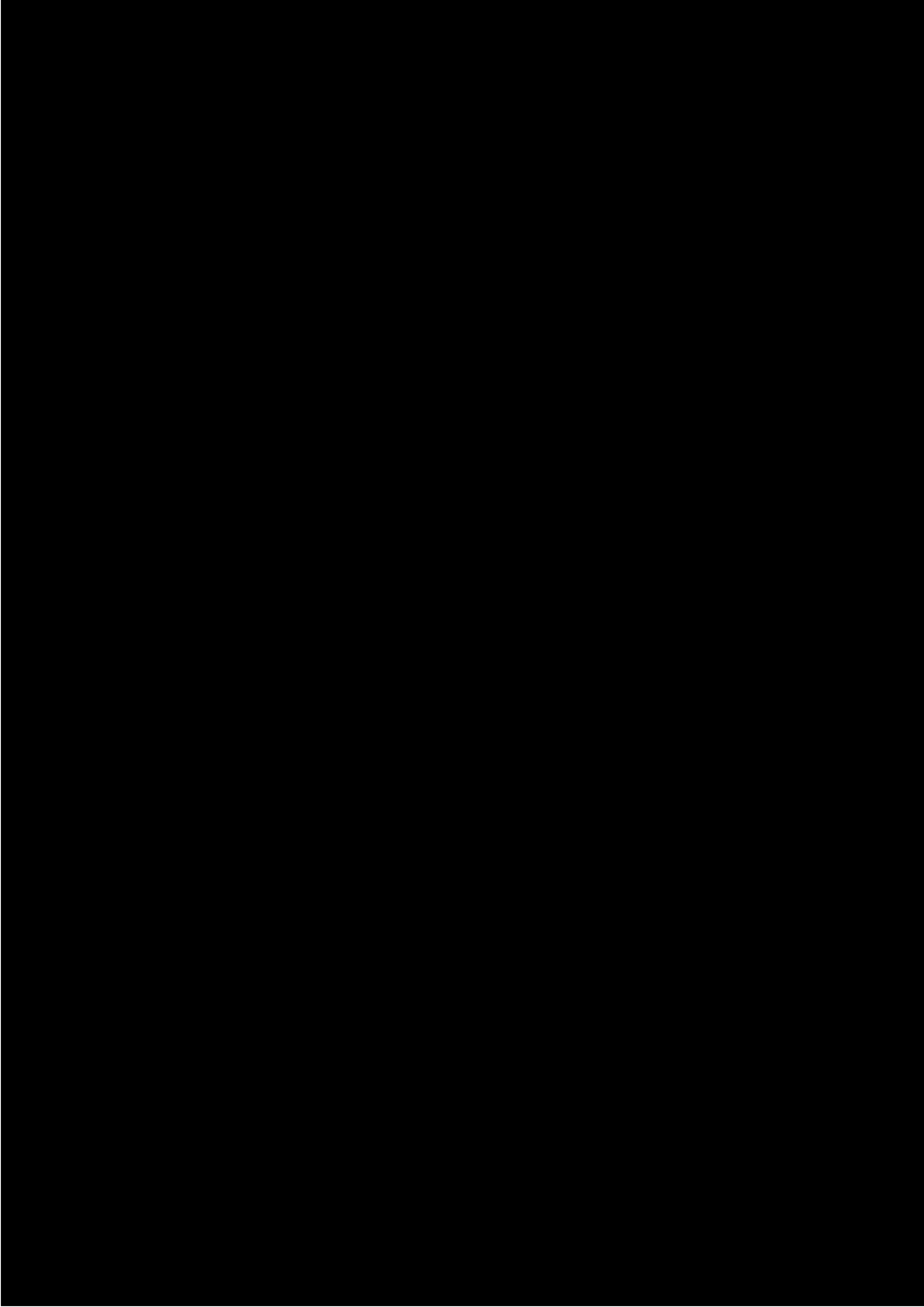


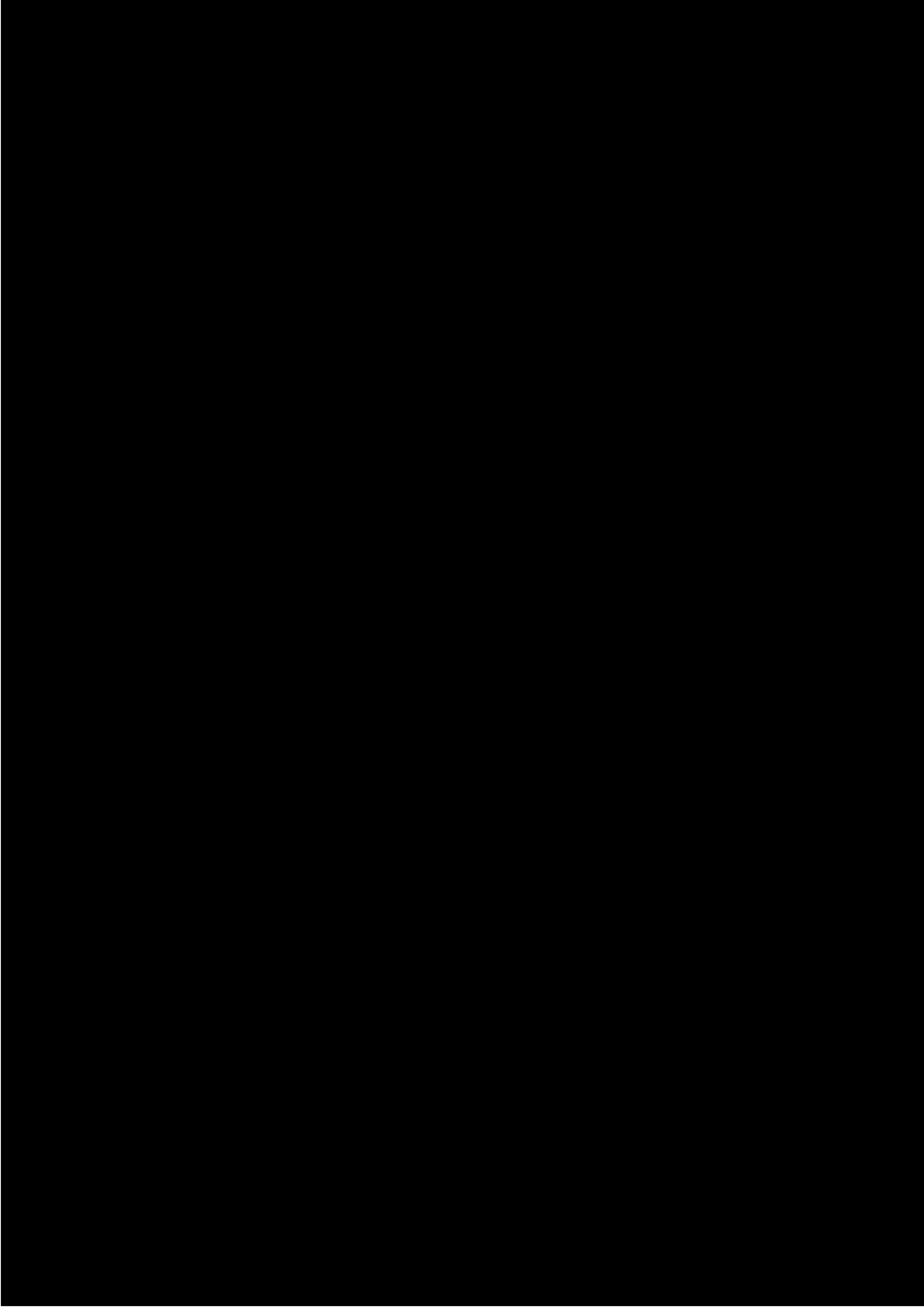


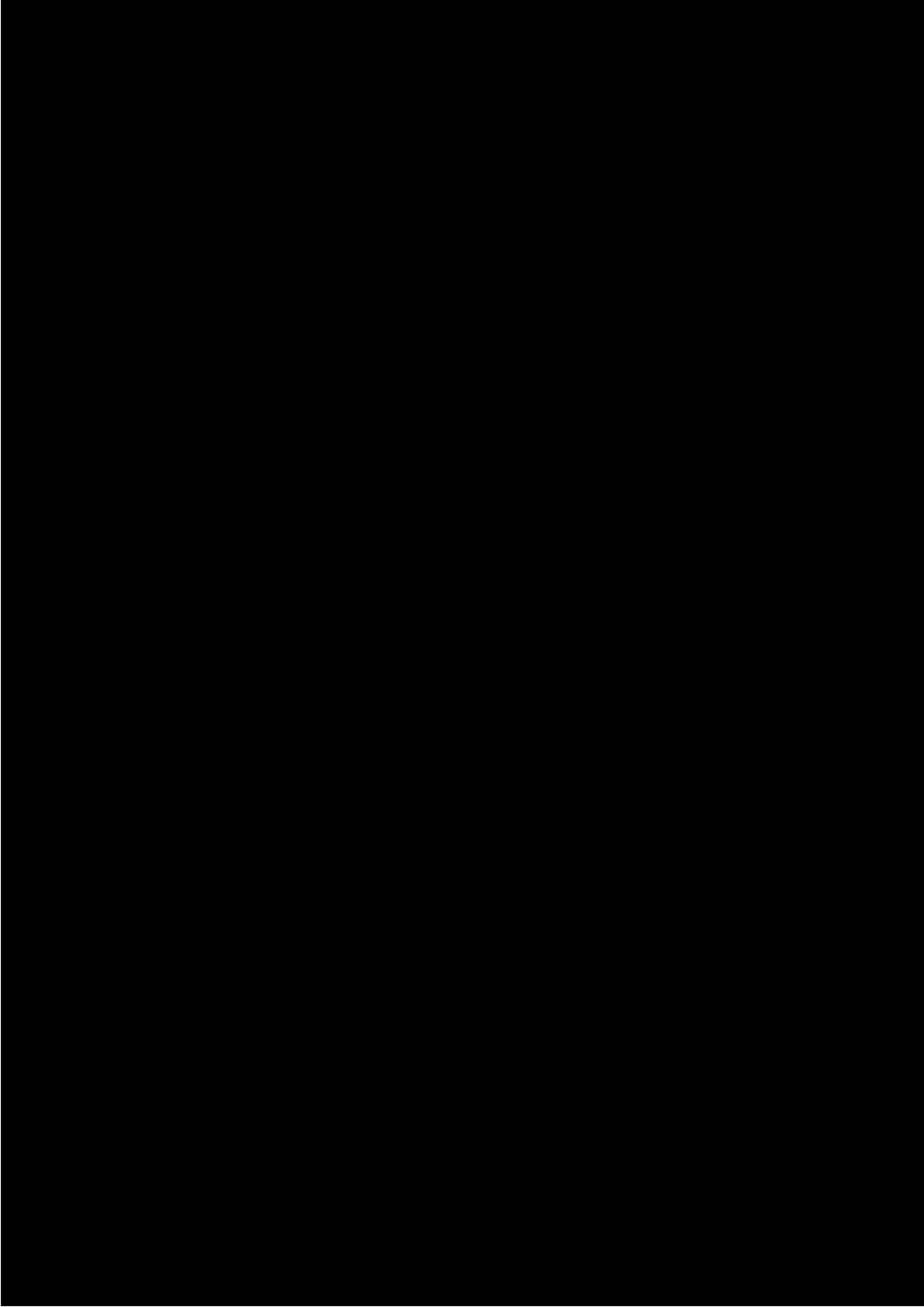


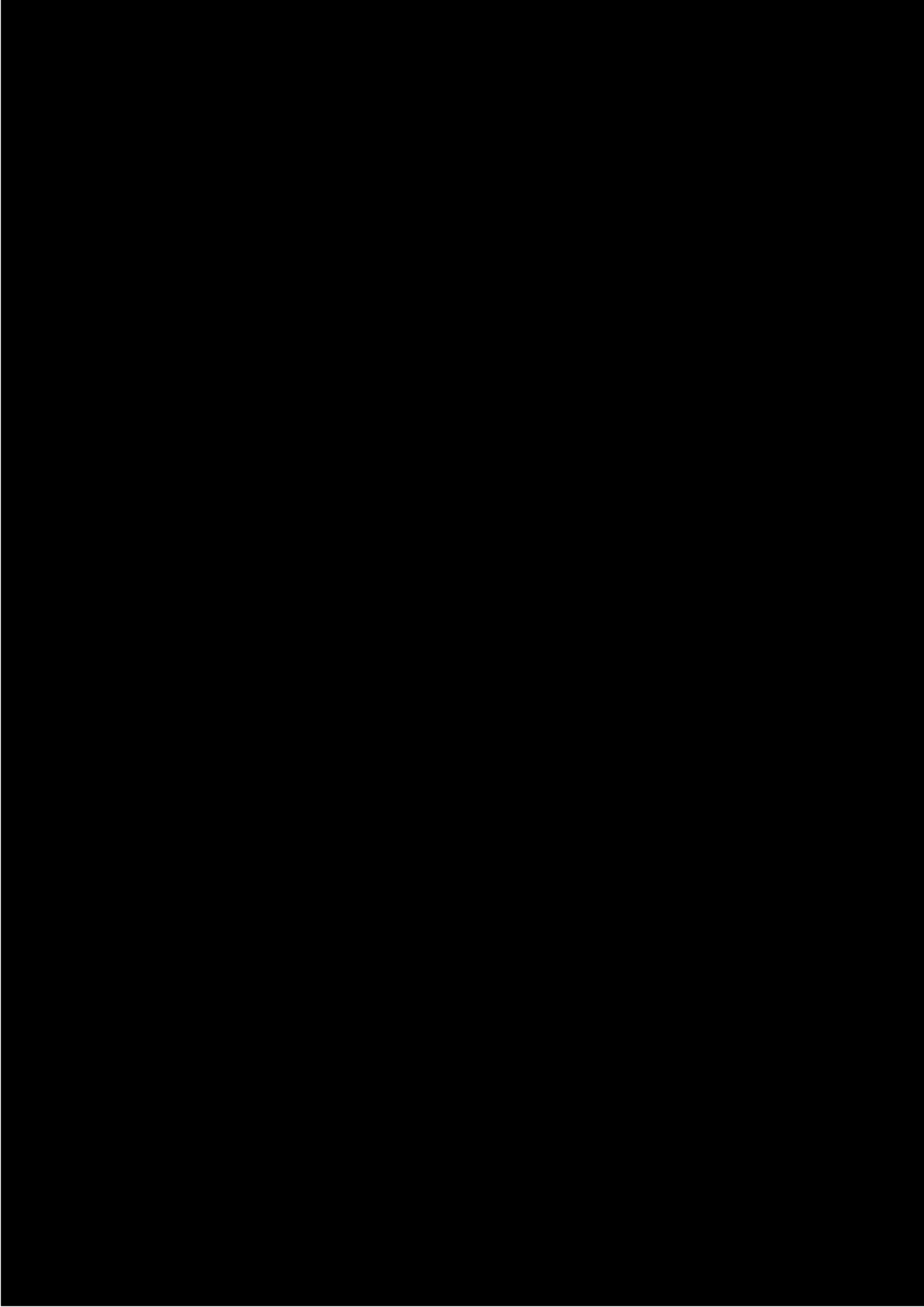


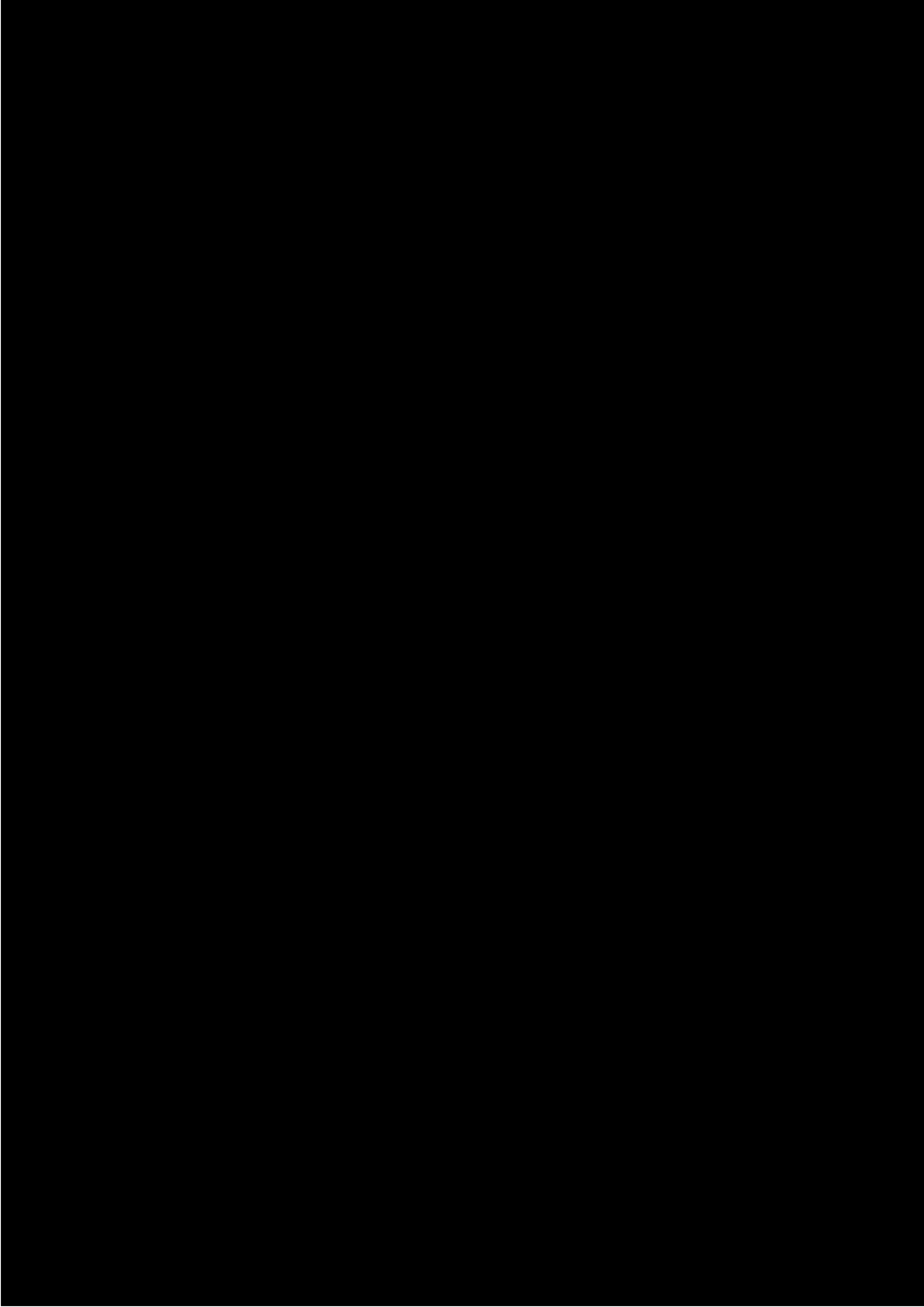


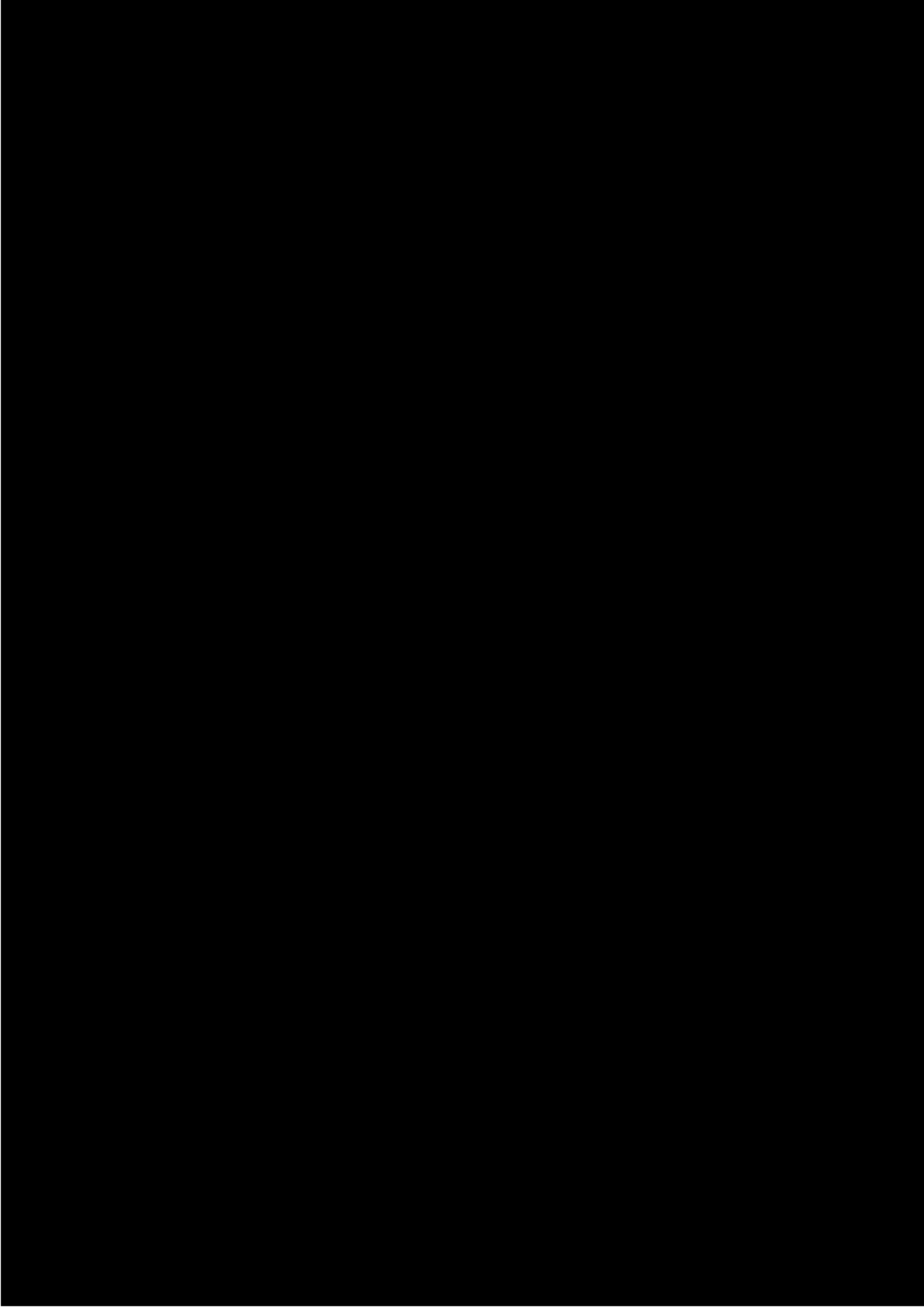


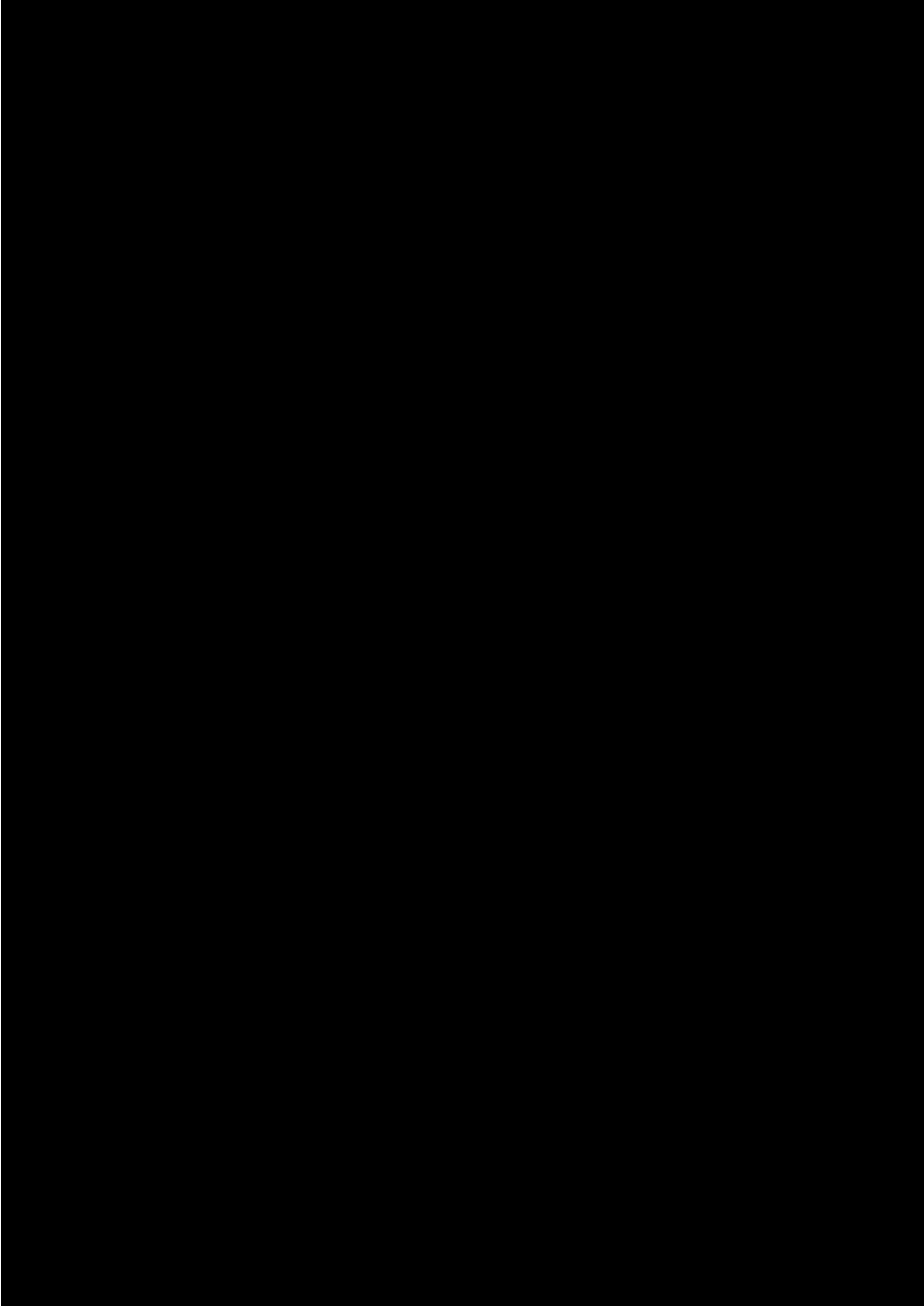


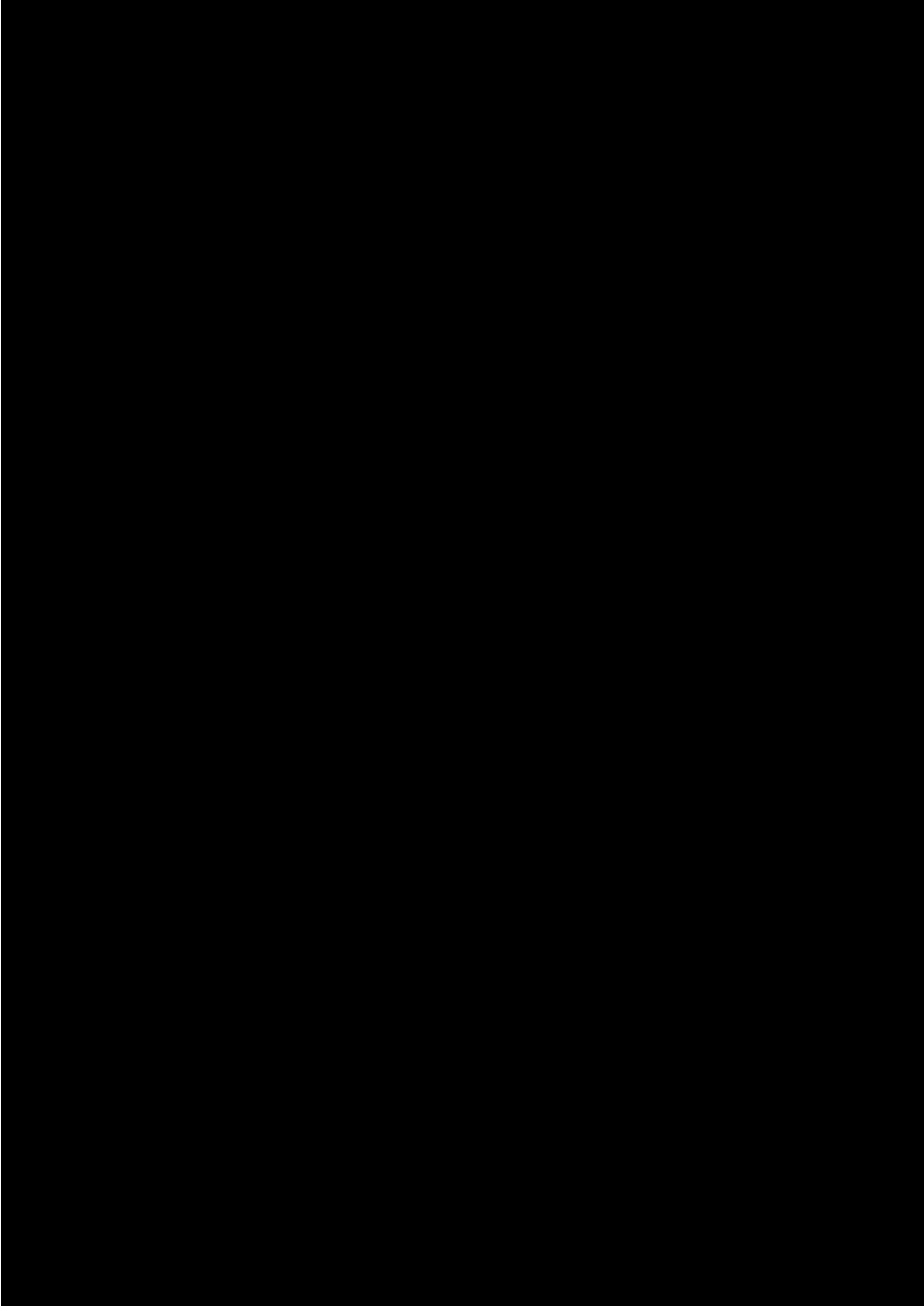


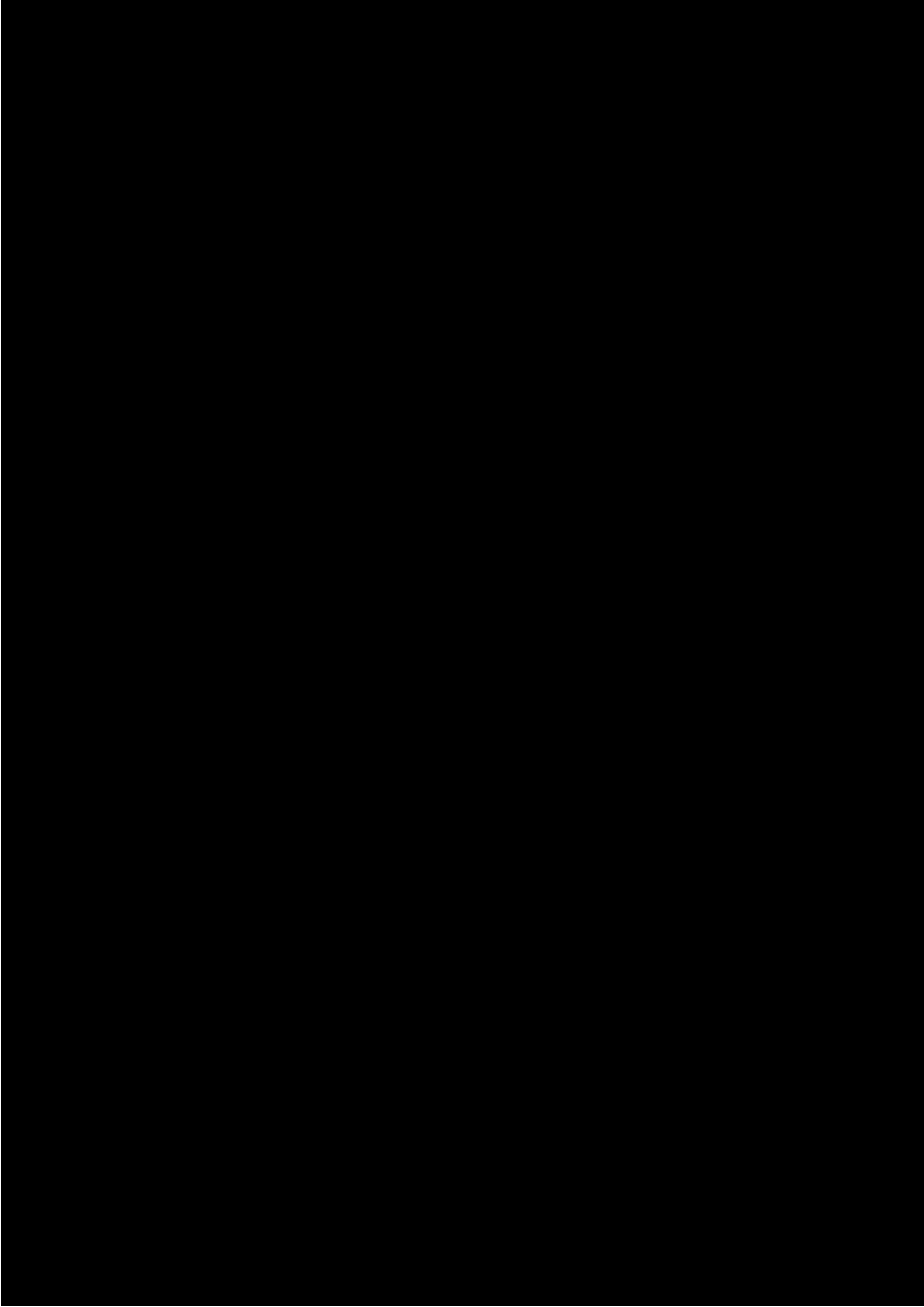


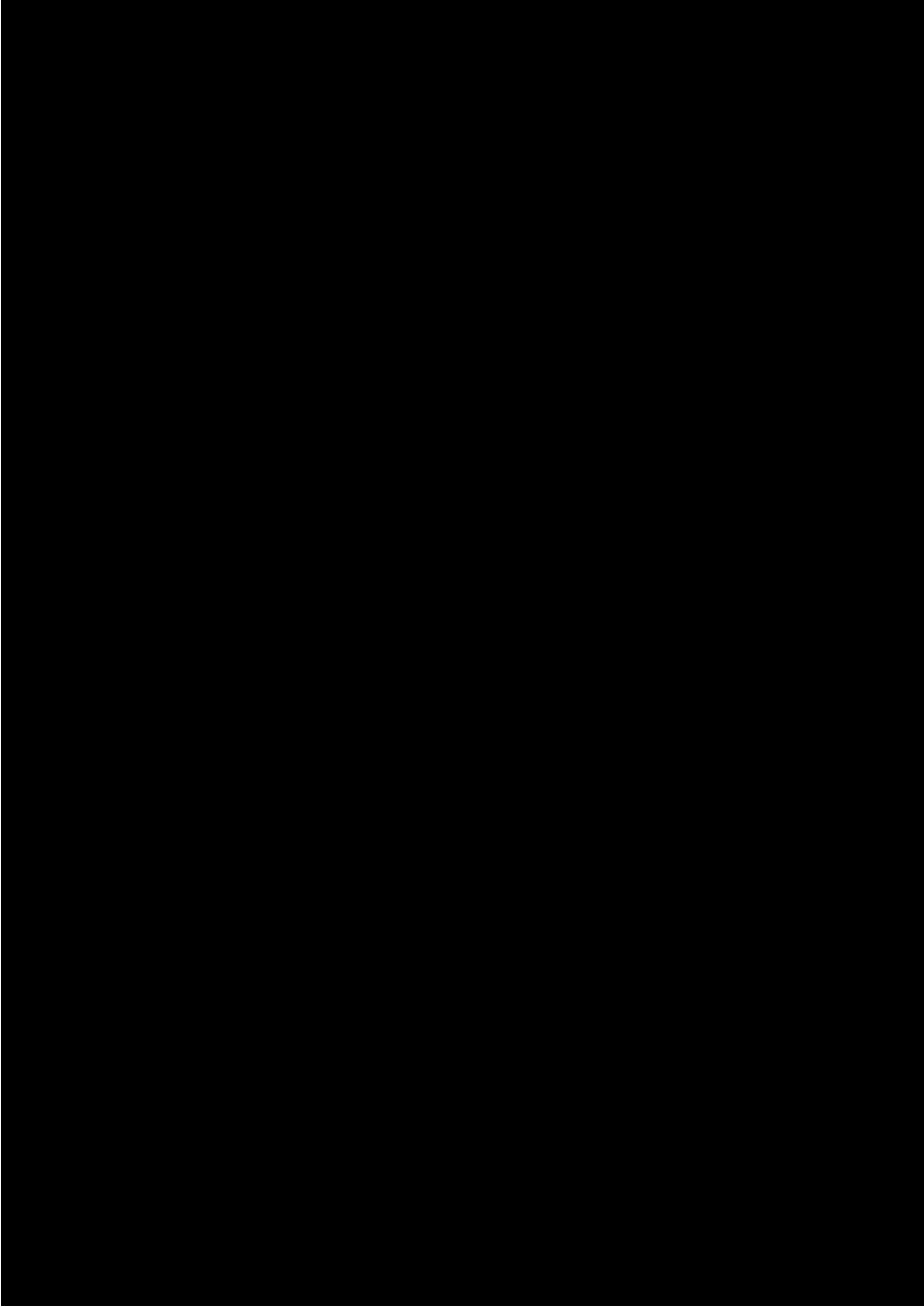


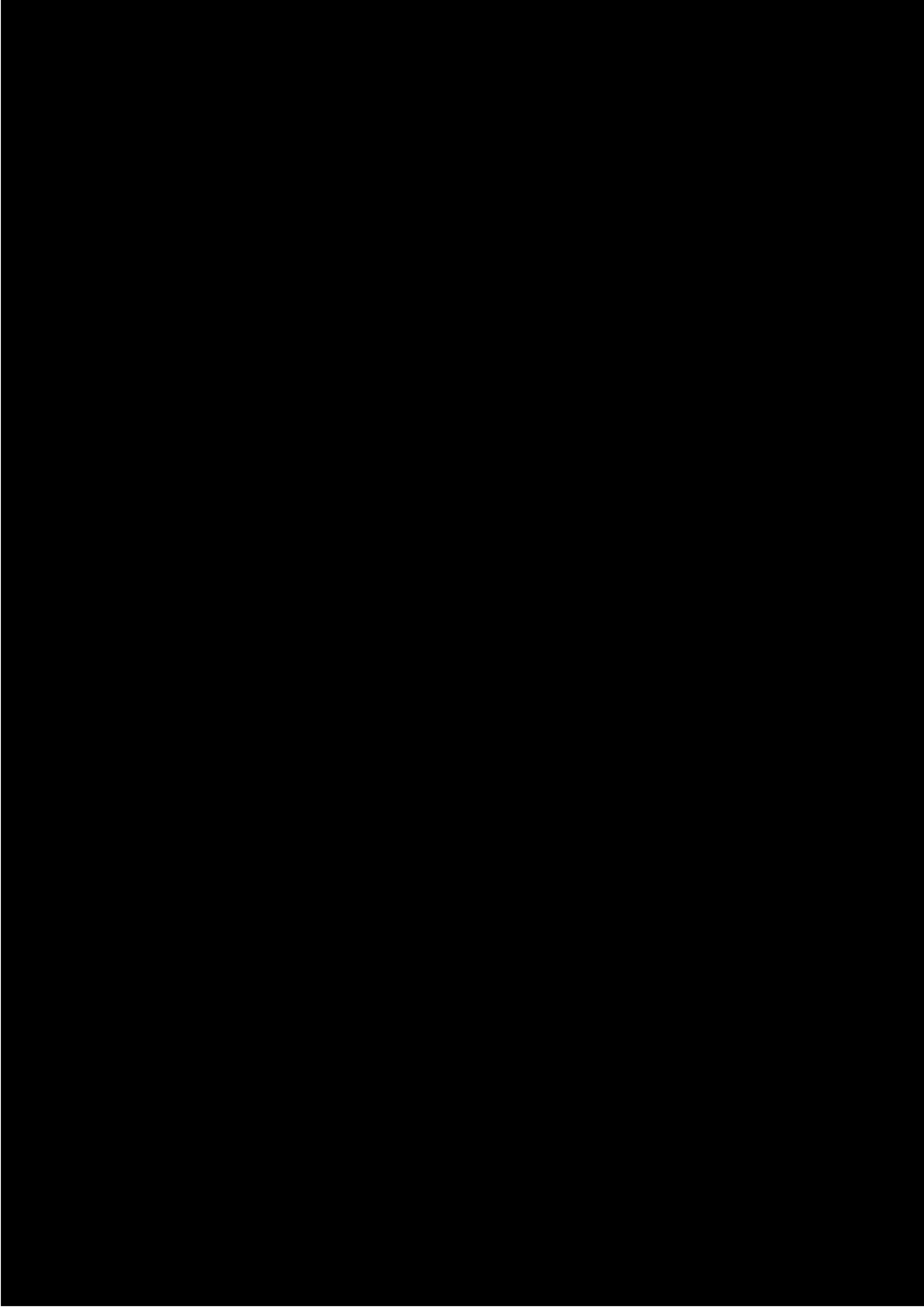


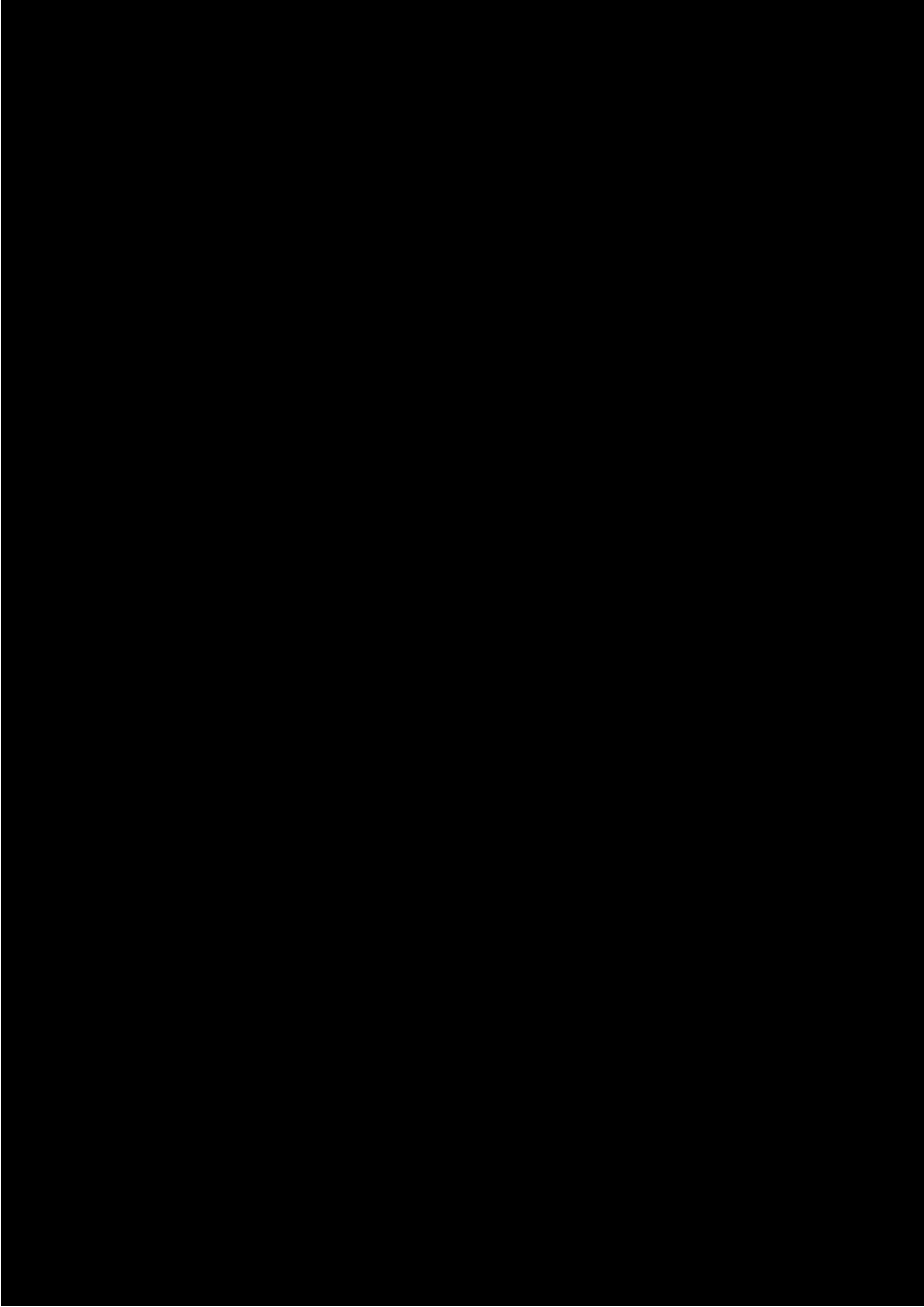


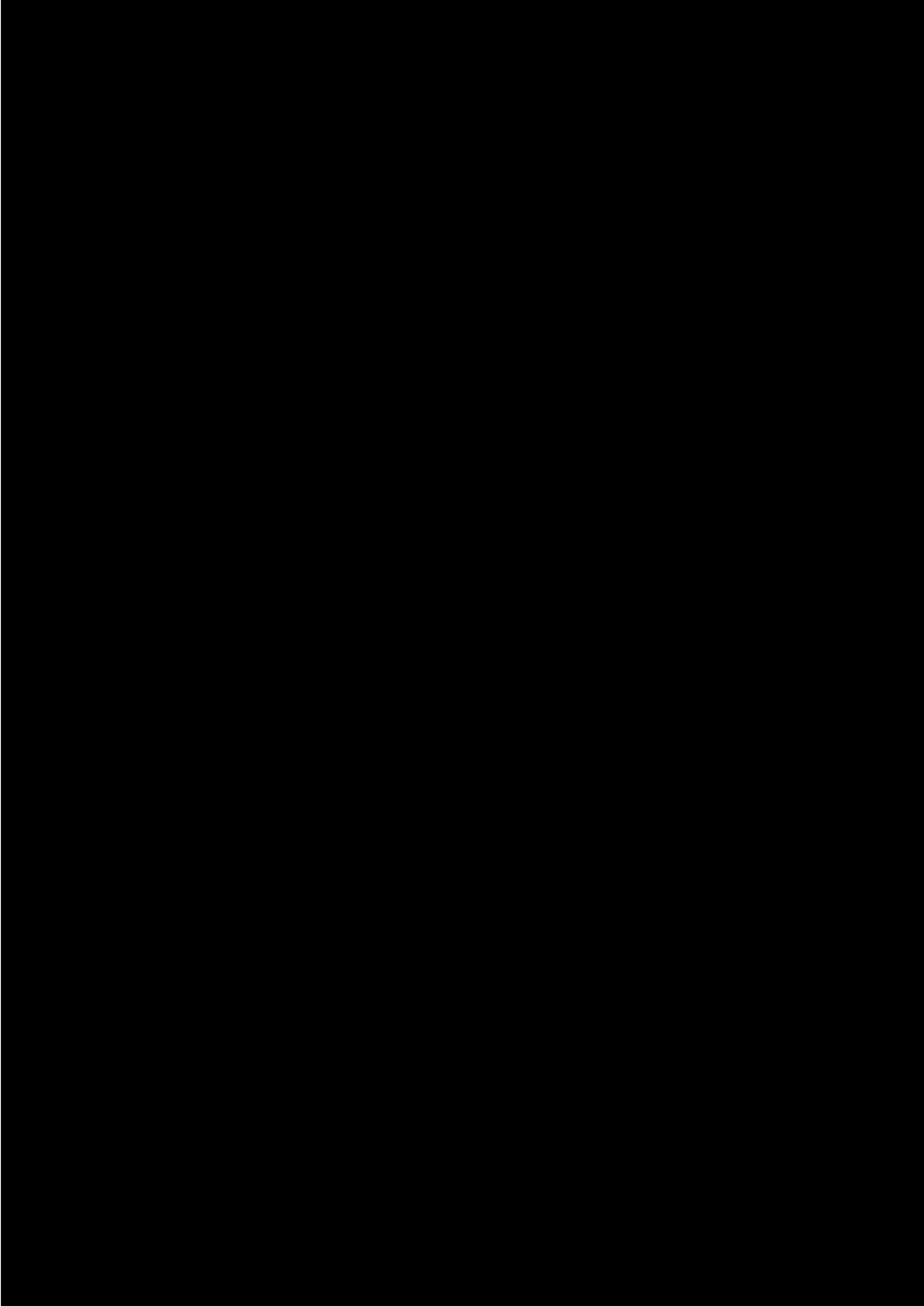


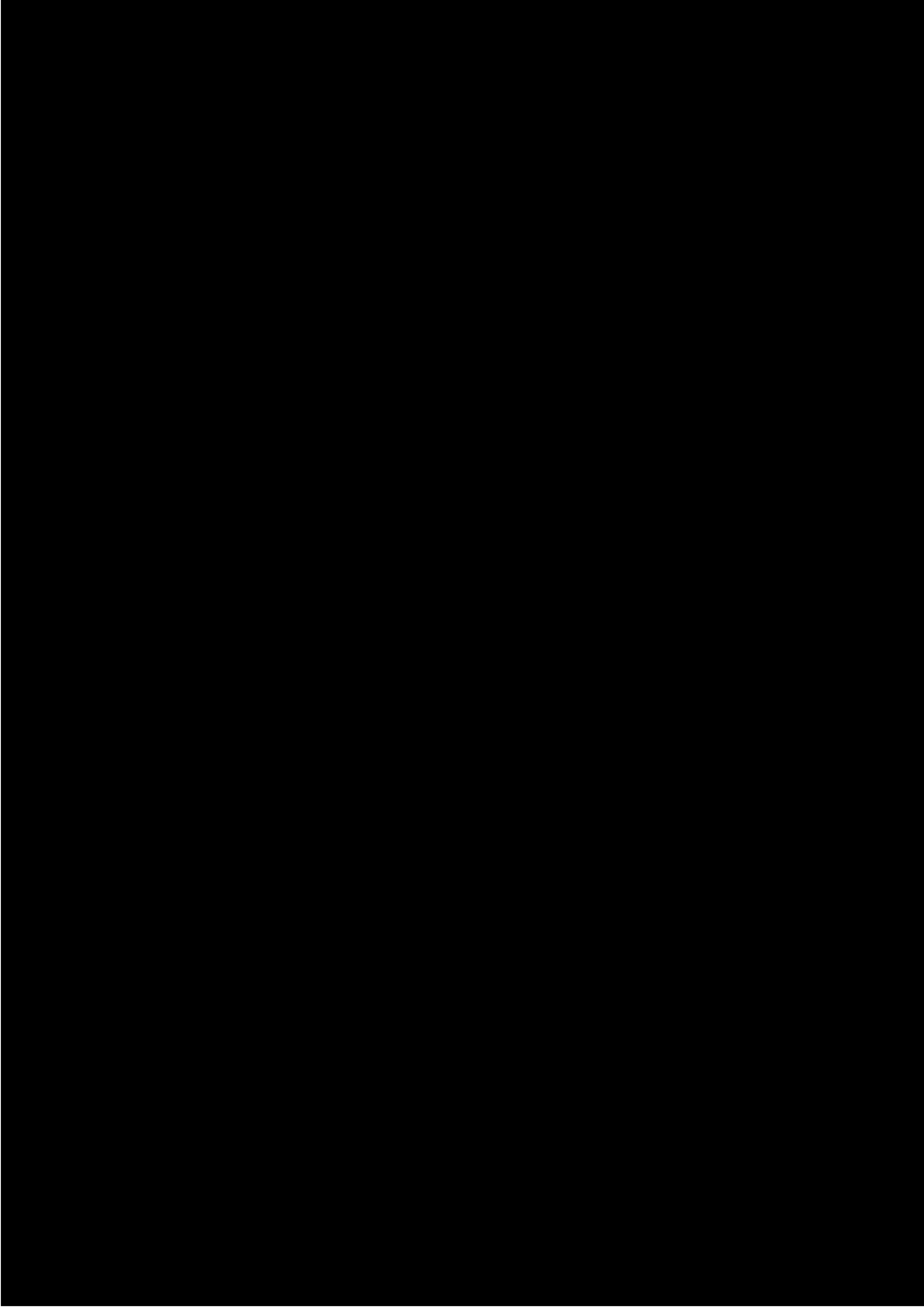


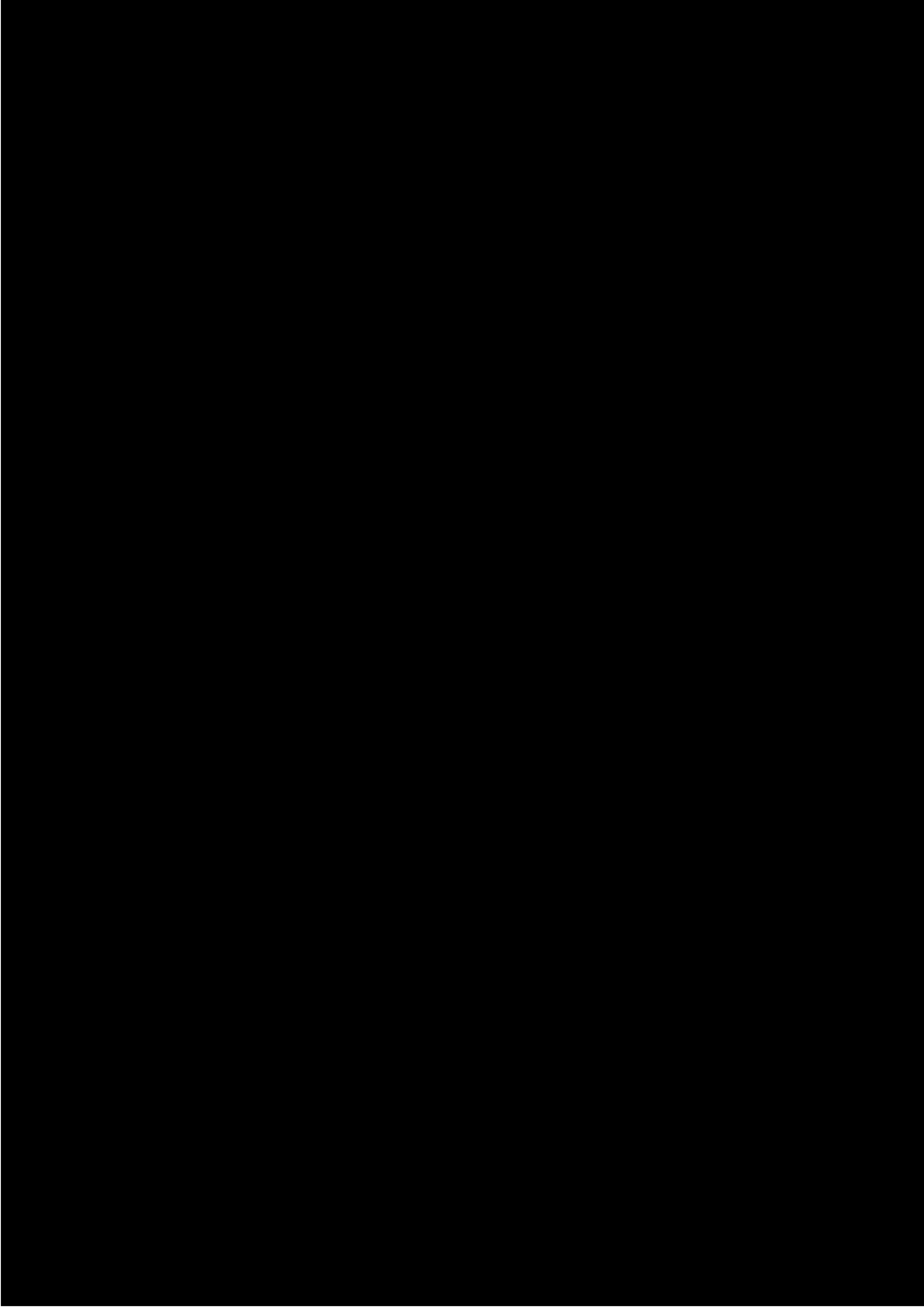


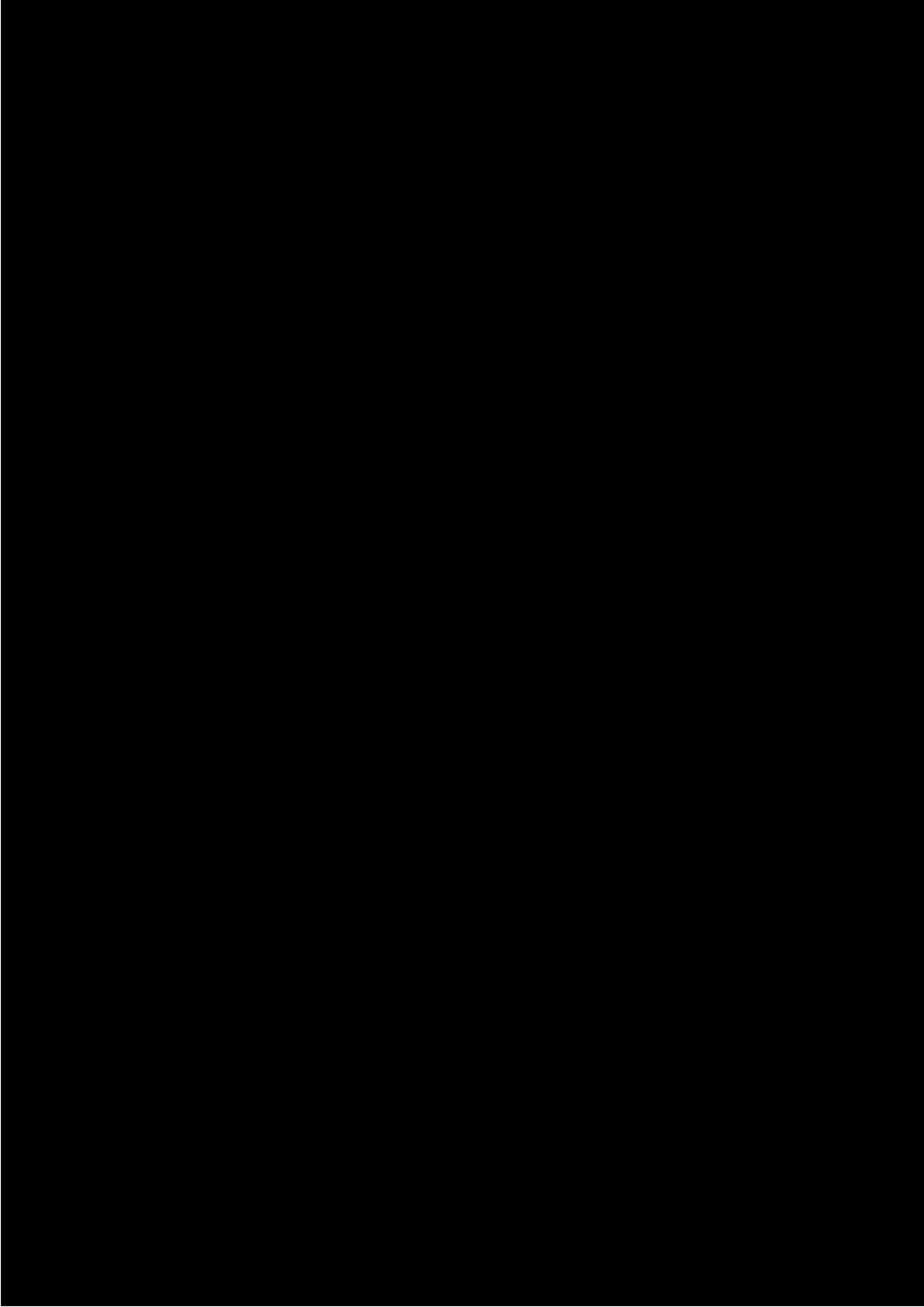


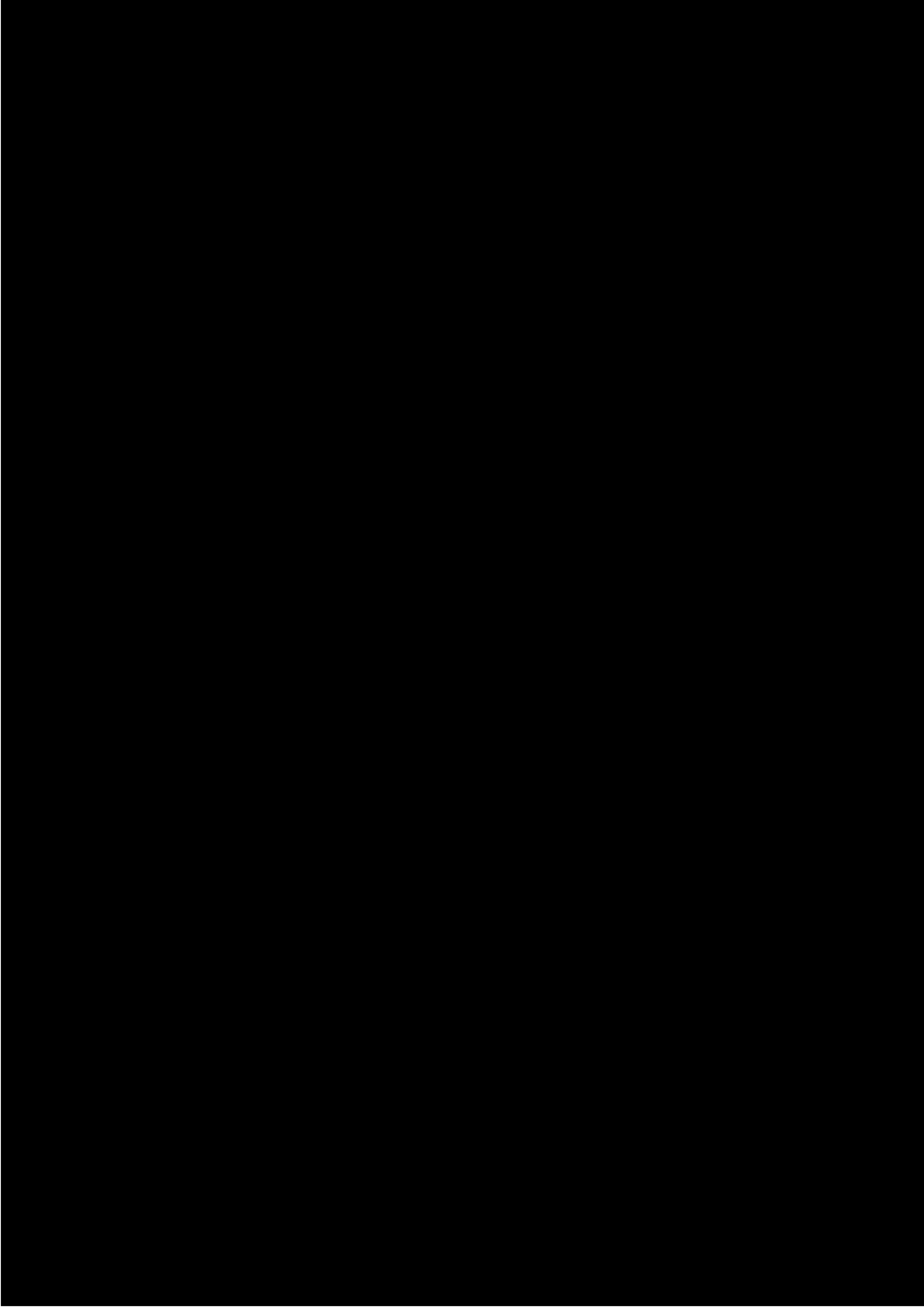


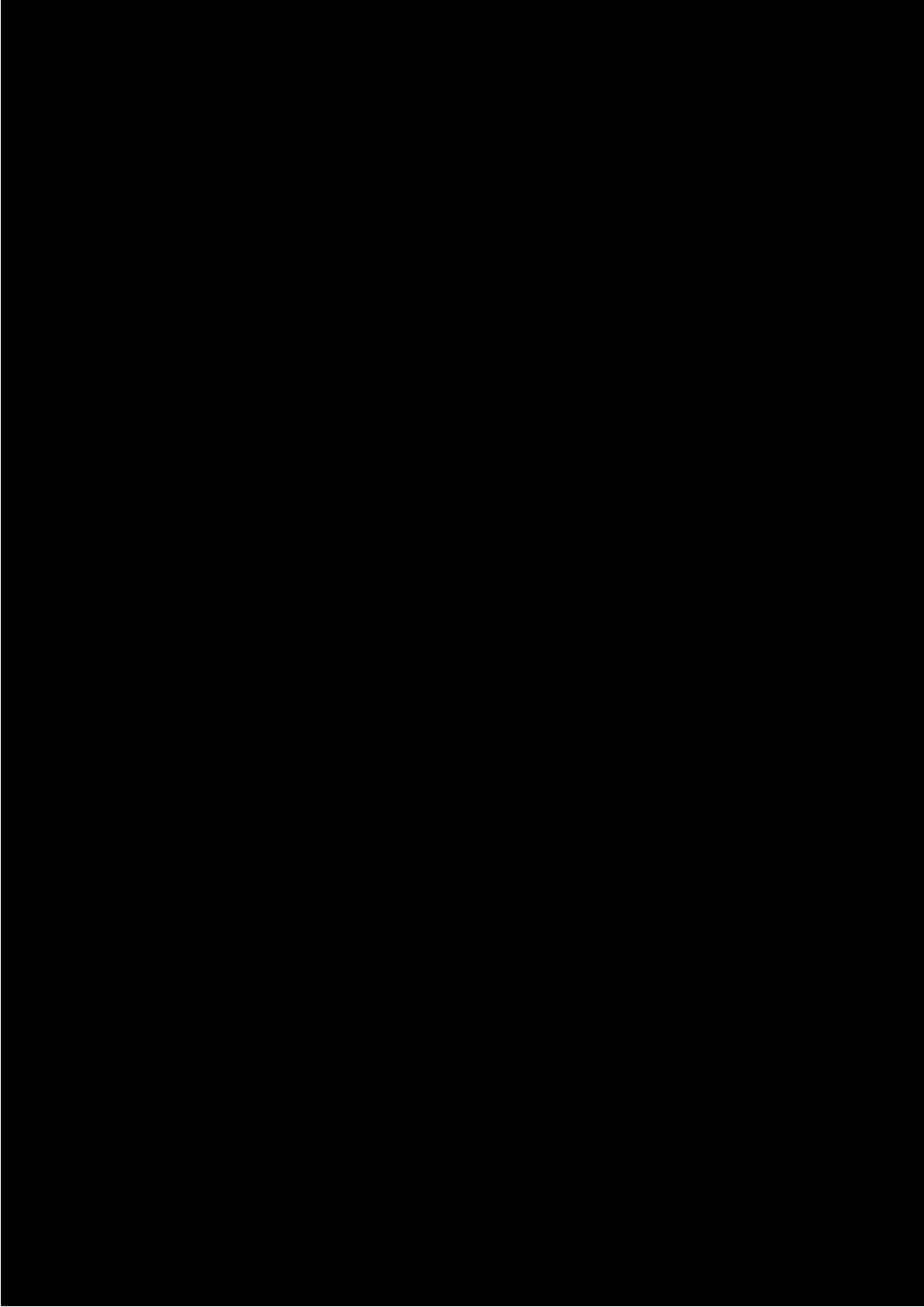


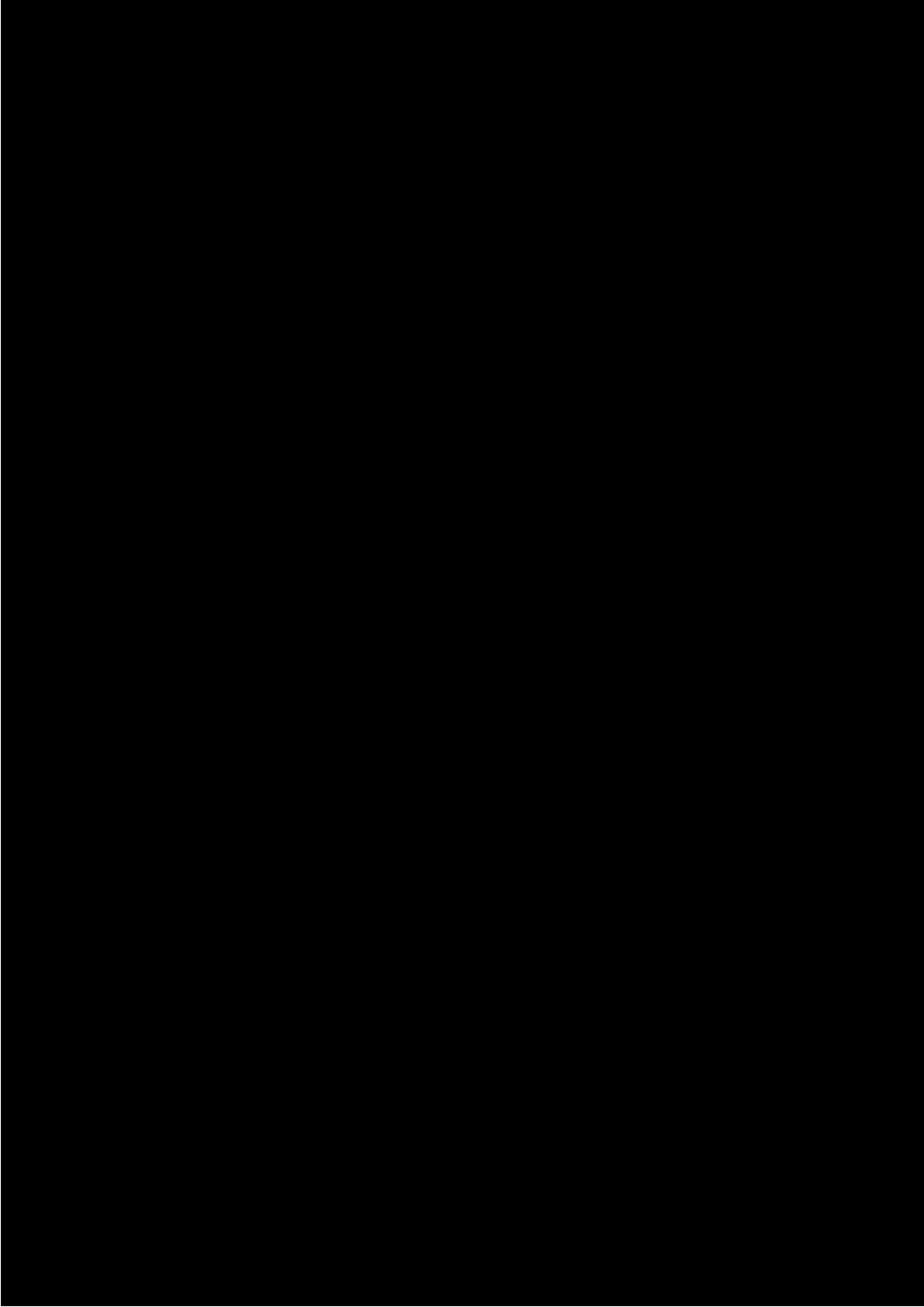


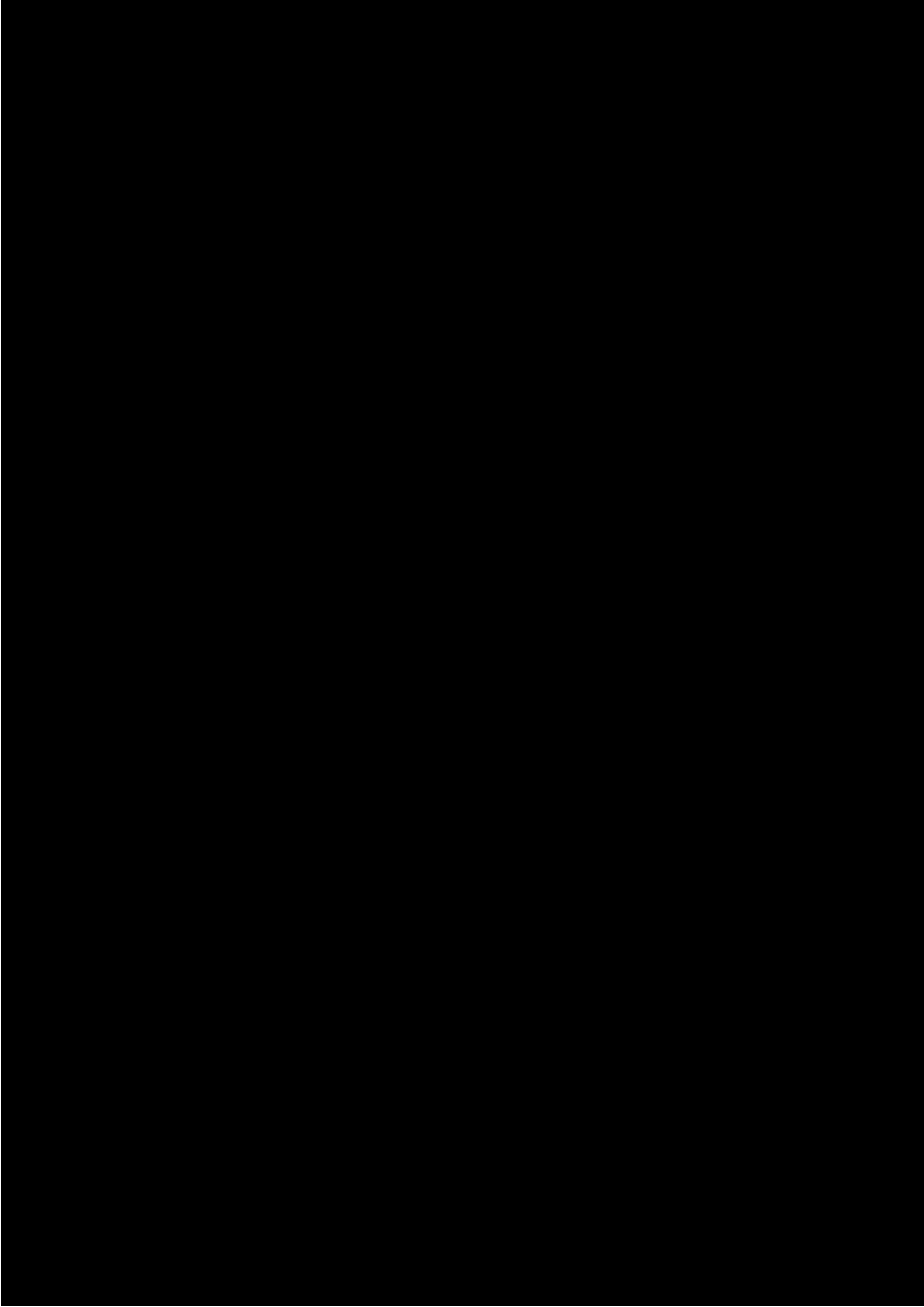


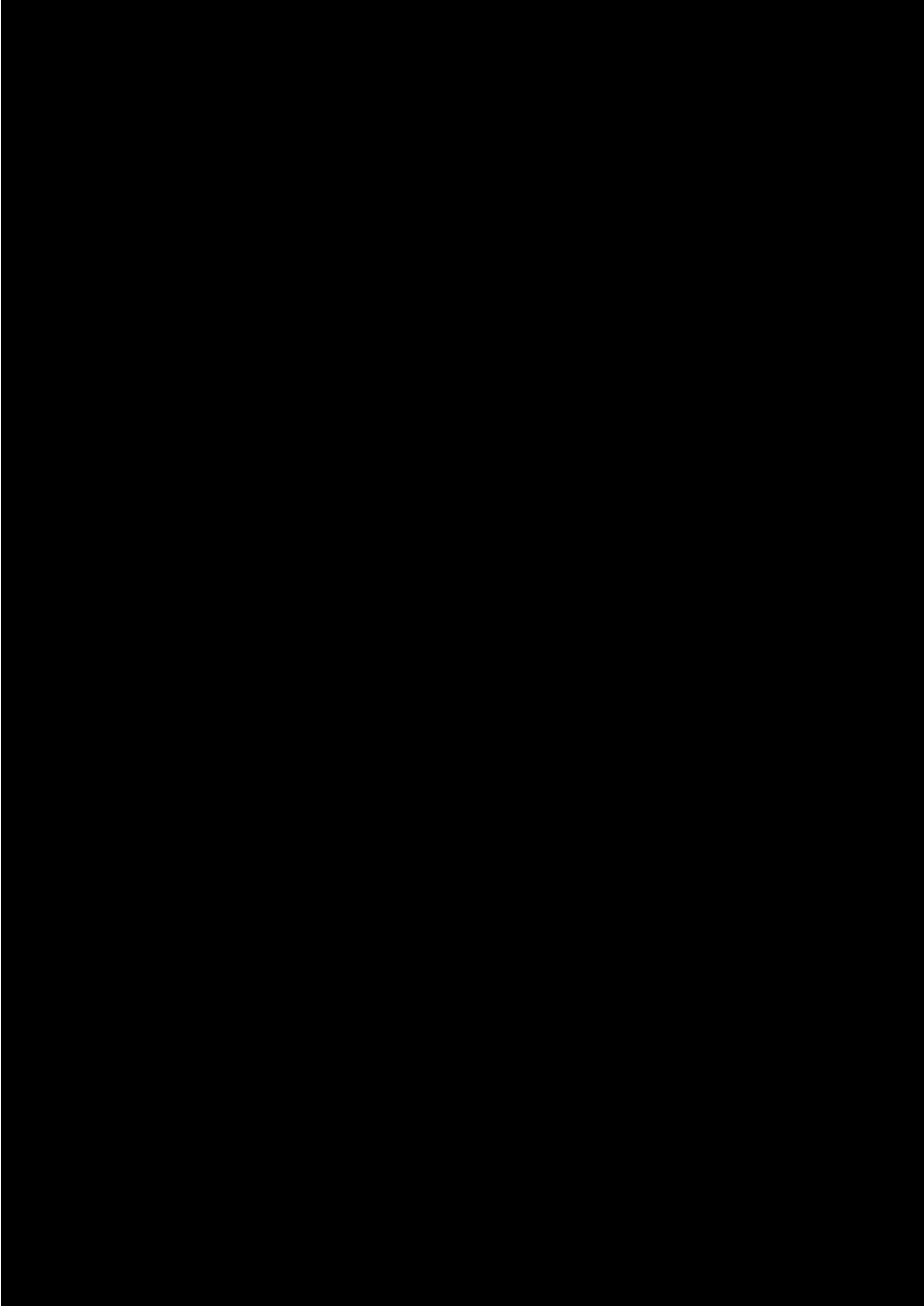


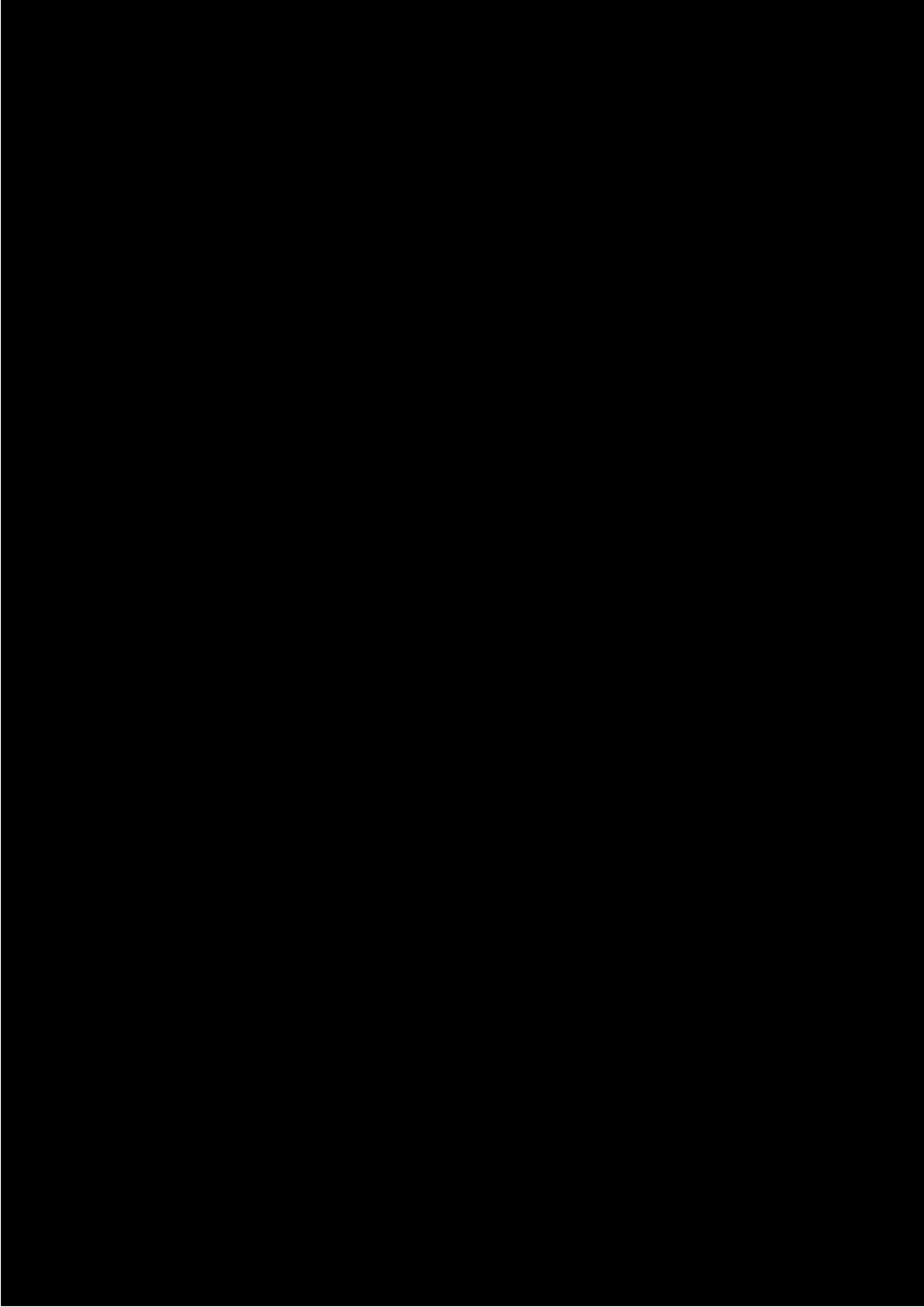


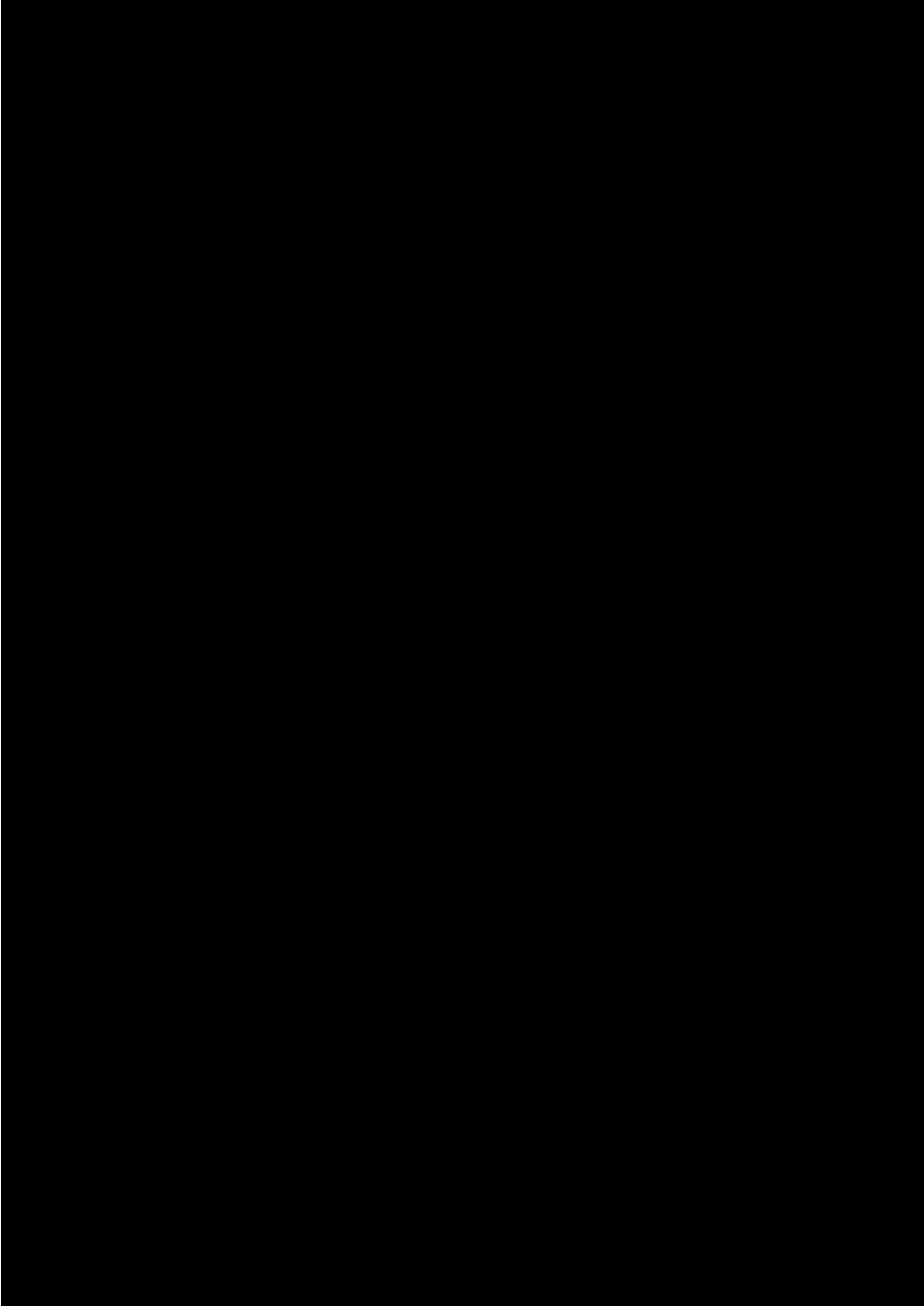


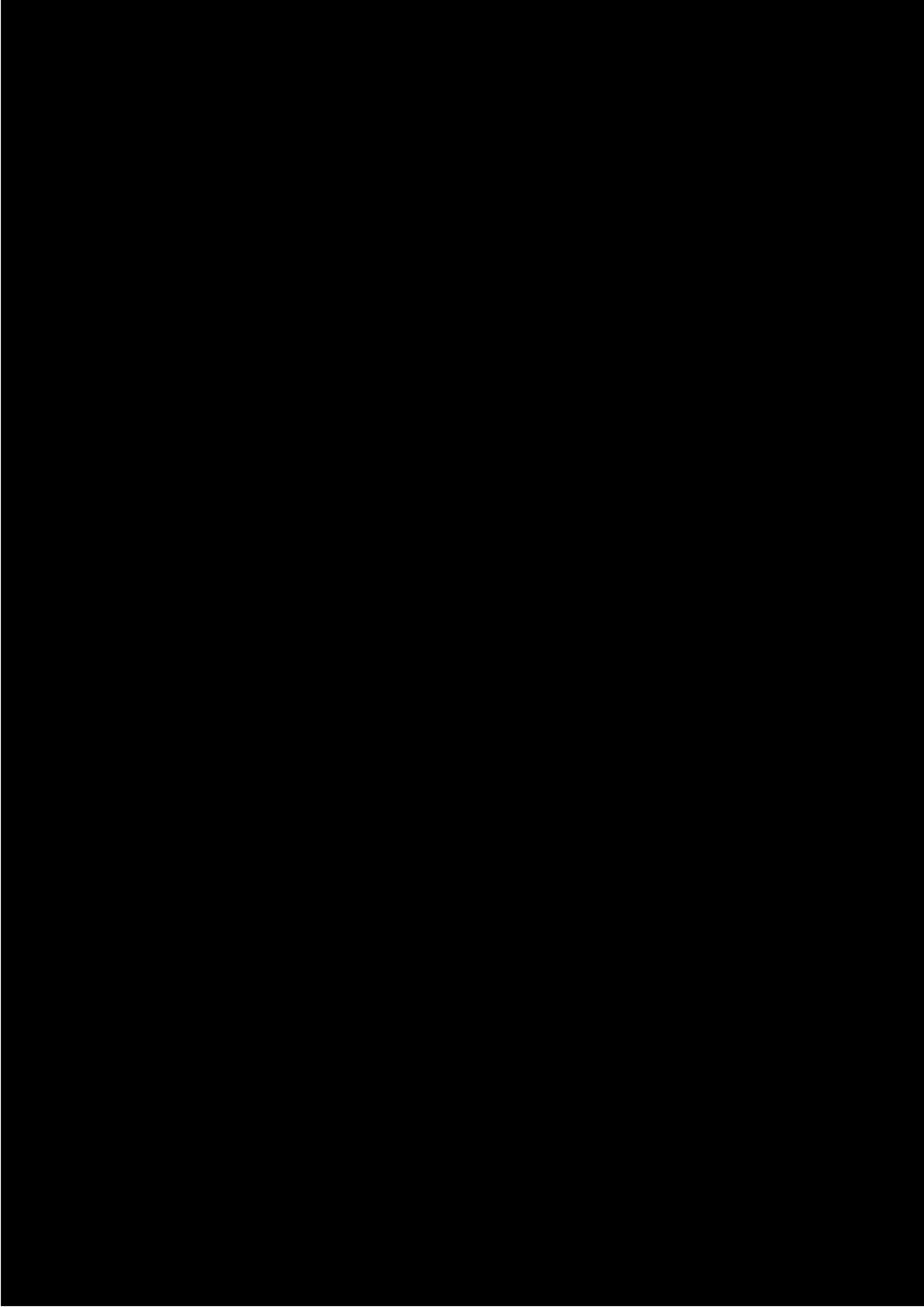


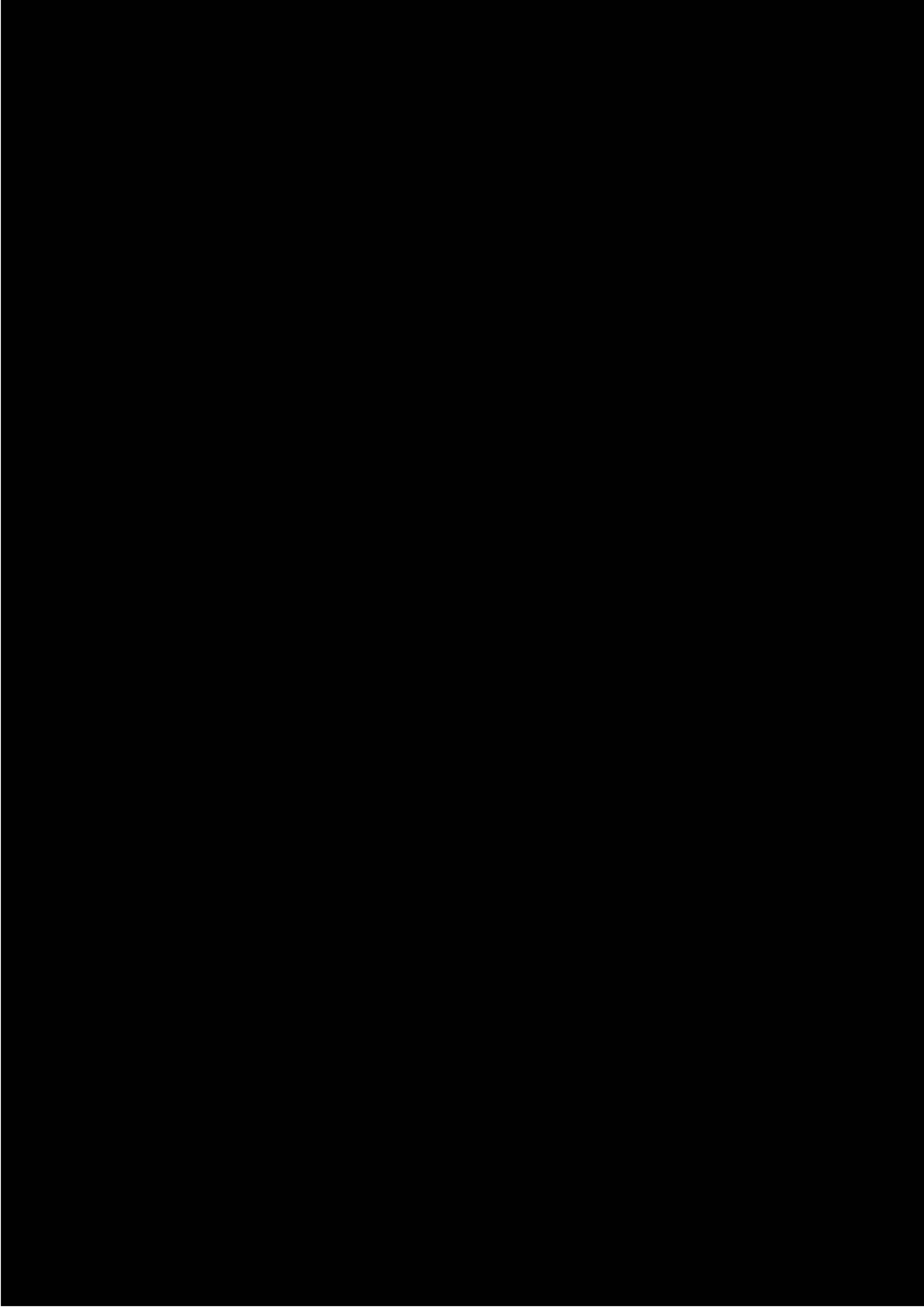


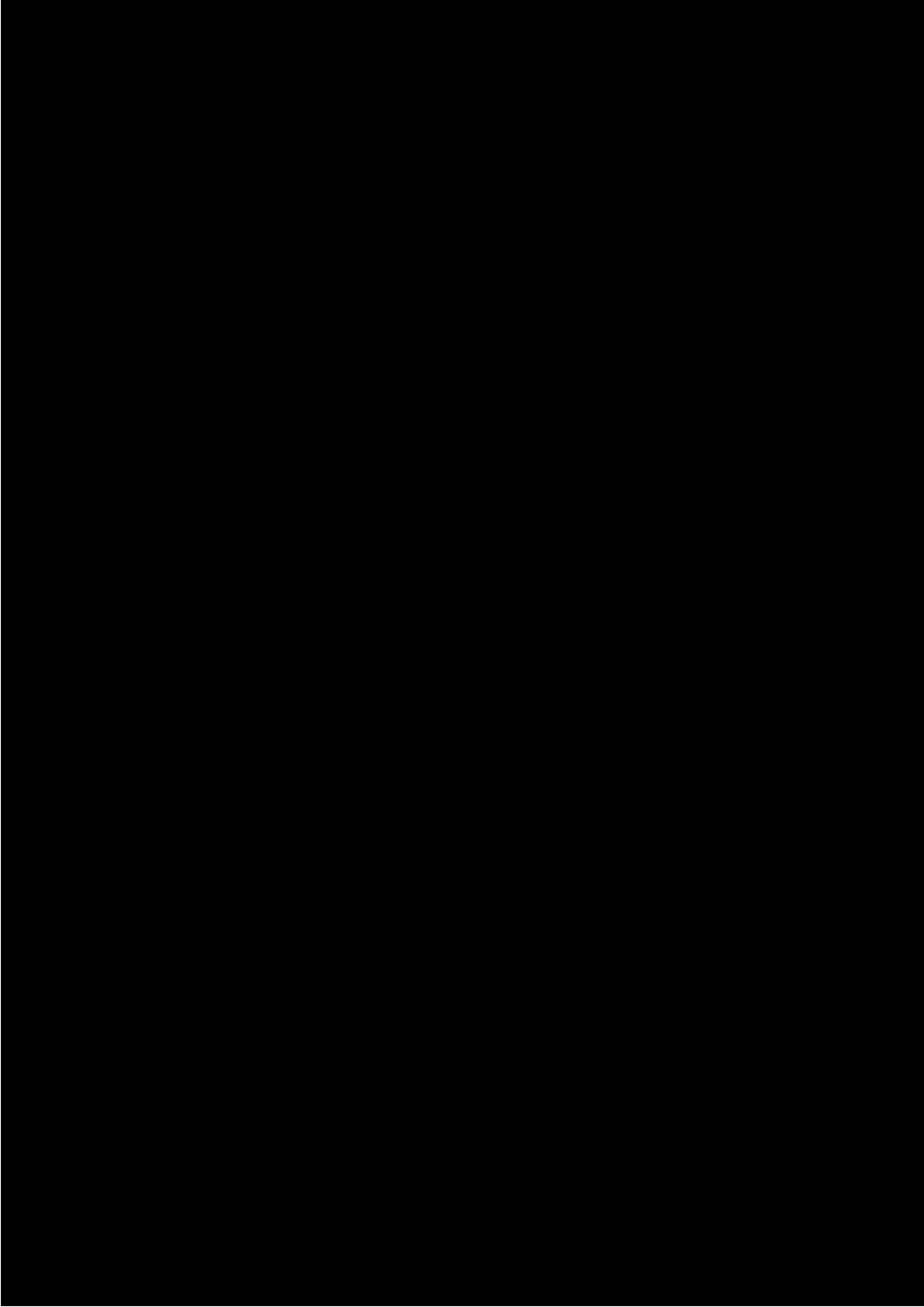


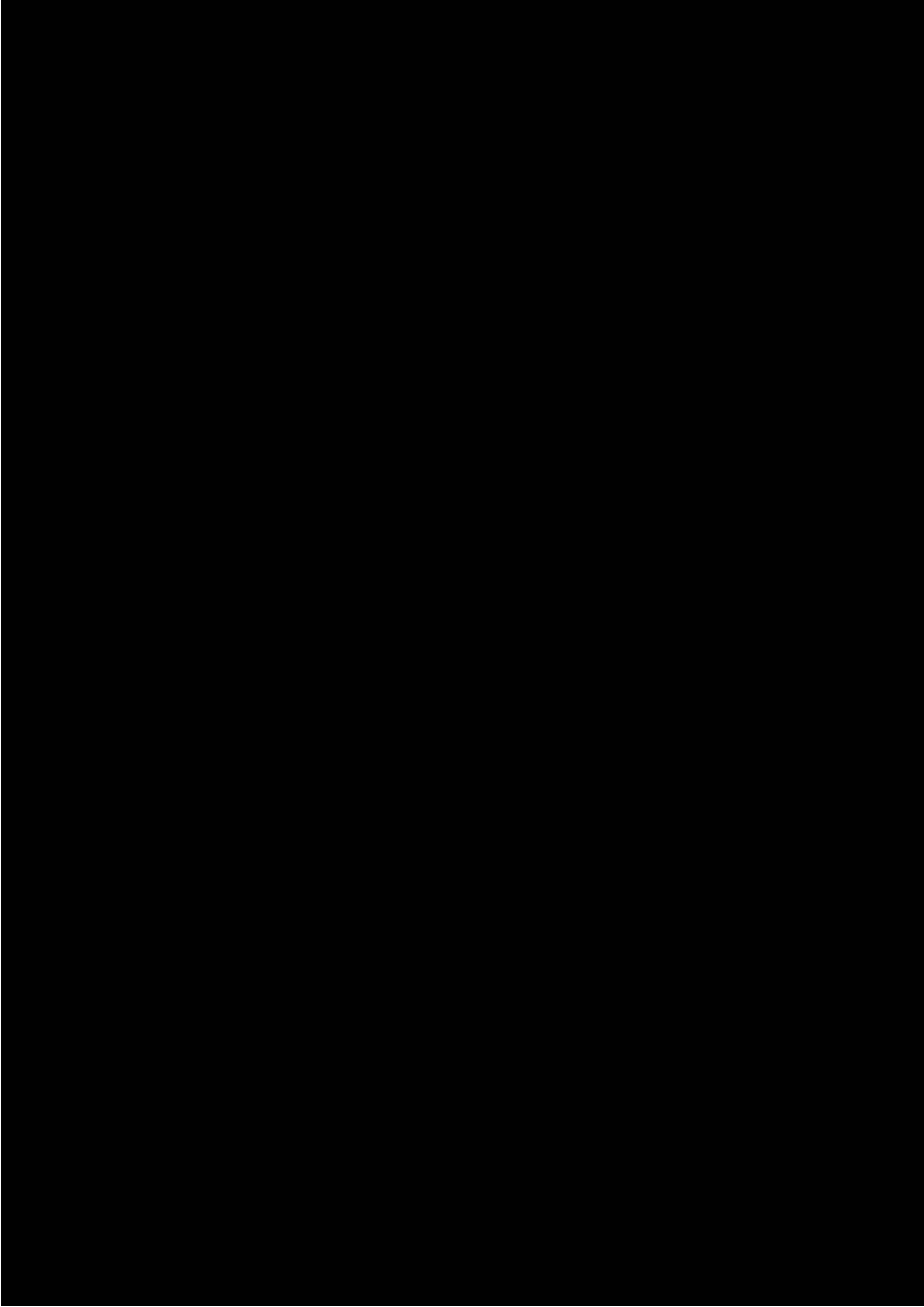


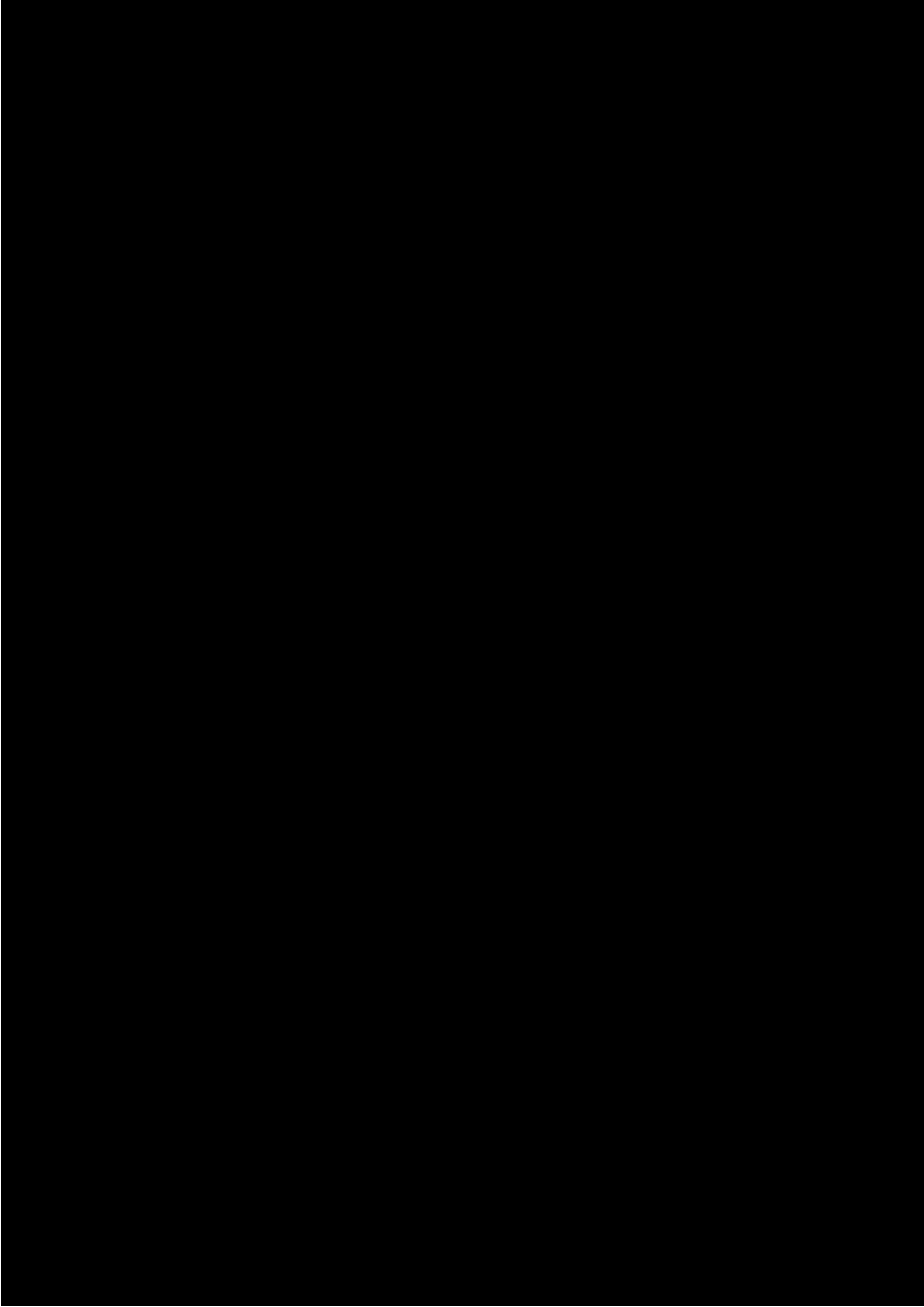


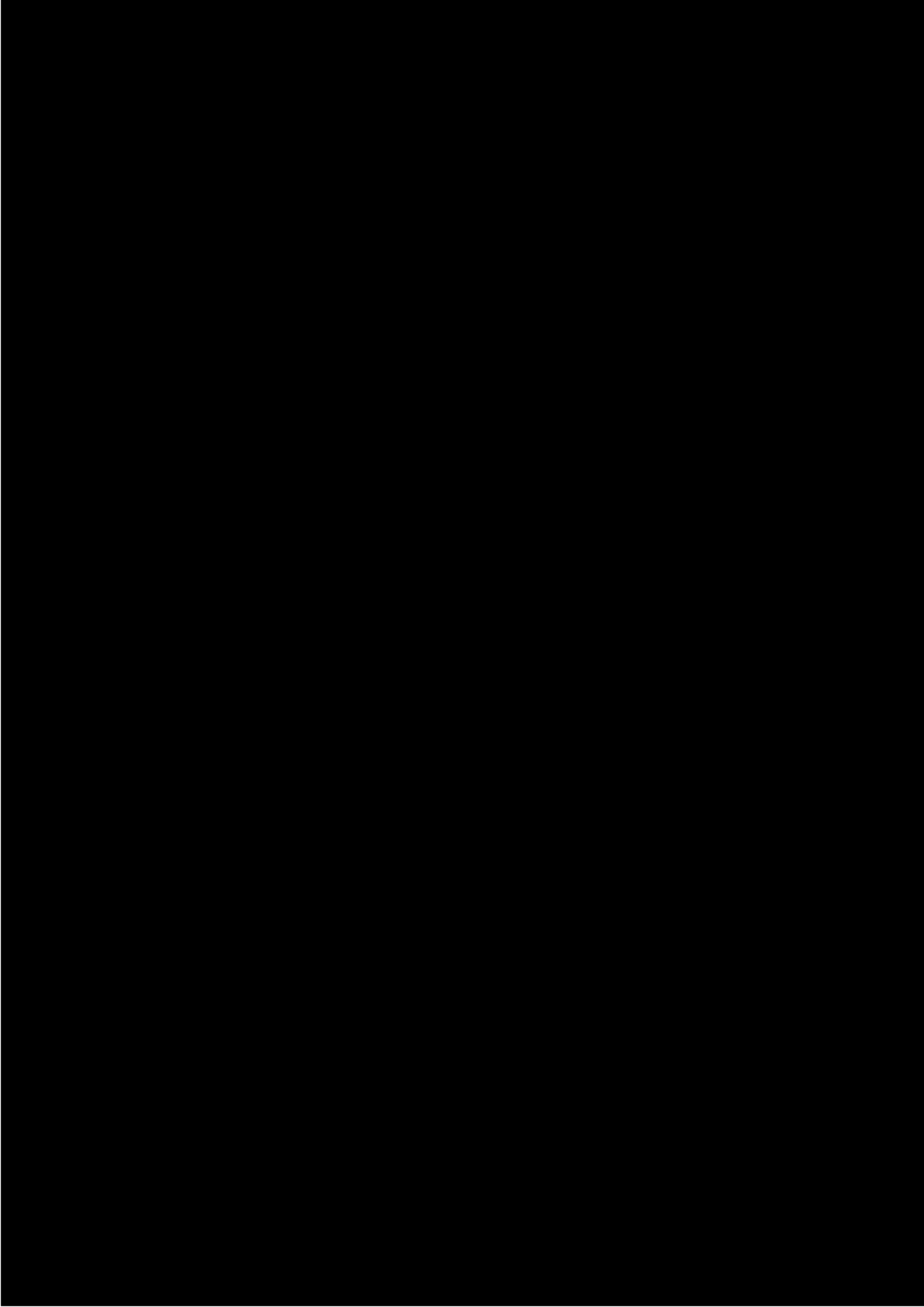


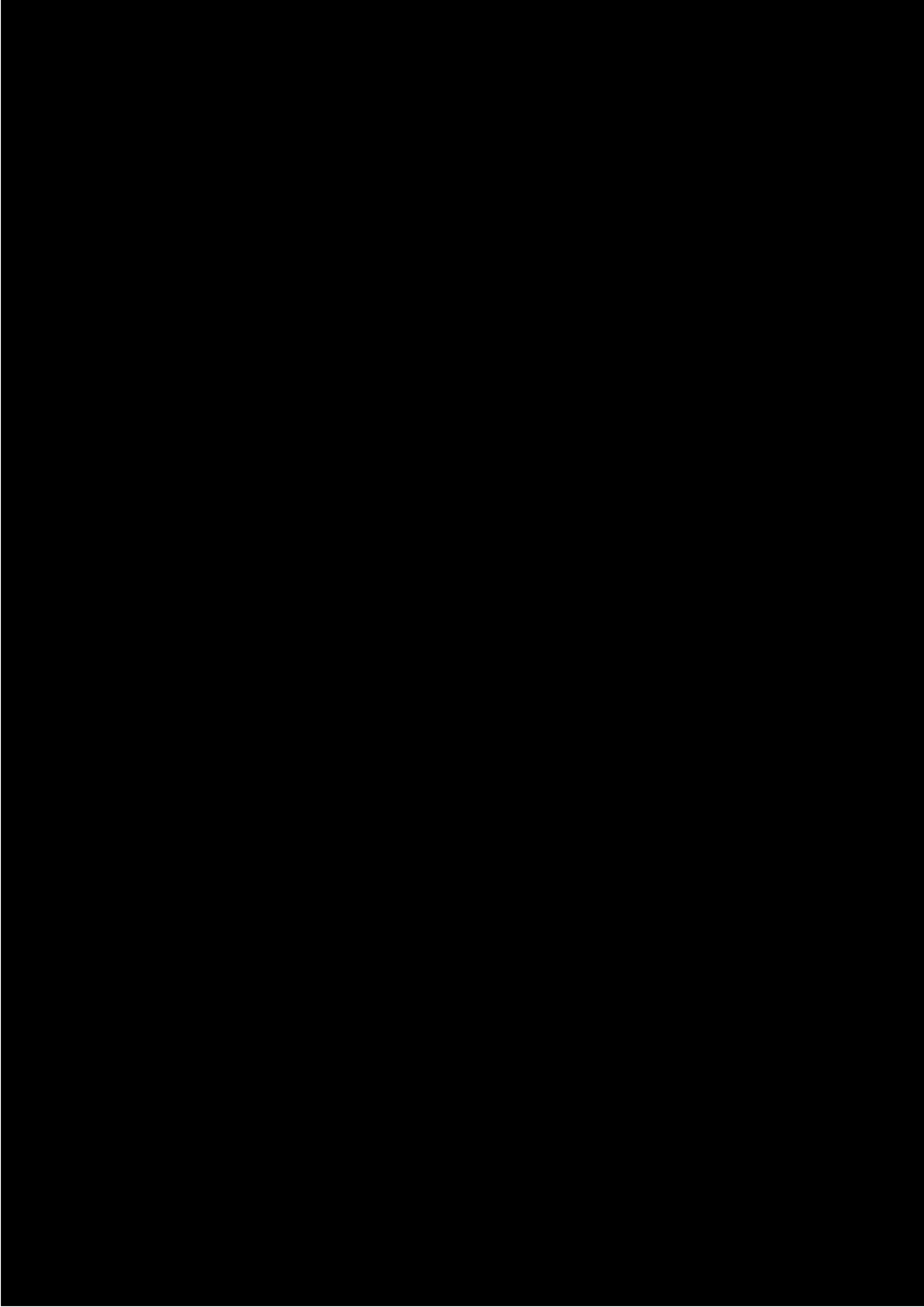


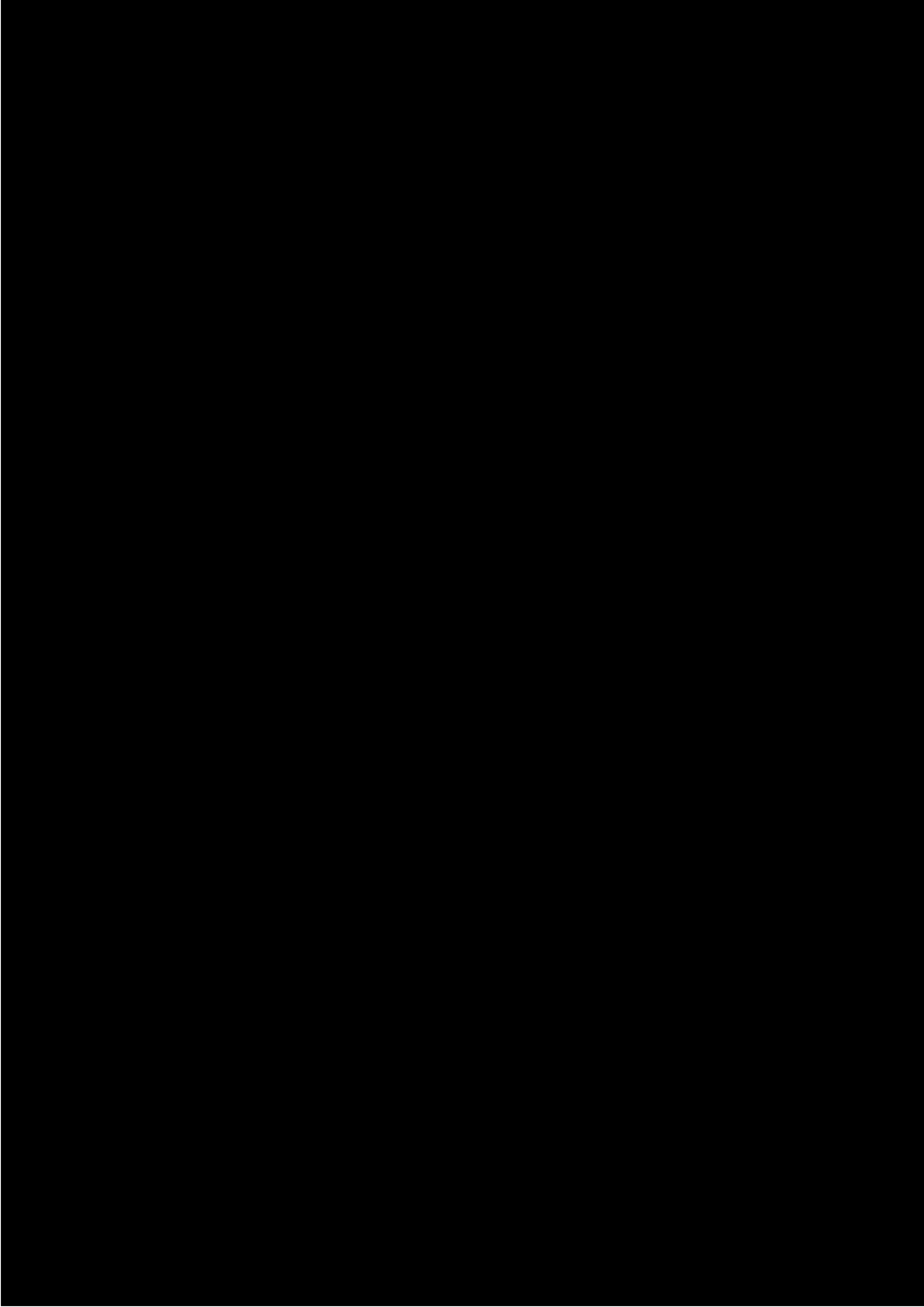












Mental Health, Justice Health and Alcohol & Drug Services

Secure Mental Health Unit Model of Care

Final Version

May 2014

Abbreviations

AMHU	Adult Mental Health Unit
ACT	Australian Capital Territory
ACTAS	ACT Ambulance Service
ACTCS	ACT Corrective Services
ADS	Alcohol and Drug Service
AFP	Australian Federal Police
AMC	Alexander Maconochie Centre
BYJC	Bimberi Youth Justice Centre
CALD	Culturally and Linguistically Diverse
CH&HS	Canberra Hospital and Health Services
FMH	Forensic Mental Health
FMHS	Forensic Mental Health Services
FTO	Forensic Treatment Order
MDT	Multidisciplinary Team
MHAU	Mental Health Assessment Unit
MHJHADS	Mental Health, Justice Health and Alcohol and Drug Services
MoC	Model of Care
PDC	Periodic Detention Centre
PTO	Psychiatric Treatment Order
SMHU	Secure Mental Health Unit
UCPH	University of Canberra Public Hospital

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Introduction

The ACT Government is embarking on a new health infrastructure project to build a Secure Mental Health Unit (SMHU). This facility will respond to the needs of mental health consumers who are or are likely to become involved with the criminal justice system (forensic) and for those civil consumers who cannot be treated in a less restrictive environment. The SMHU will form part of an integrated care pathway for those who need care and treatment as a result of their mental illness and associated co-morbidity.

This facility will provide a safe clinical and therapeutic environment for people who may be characterised as complex, often difficult to treat and are of serious ongoing risk to themselves or others.

The care and treatment provided will be based on assessed need and mental health recovery principles.

This document outlines the Model of Care (MoC) for the SMHU. It seeks to ensure that the approach to care, treatment, recovery, security and a person's requirements for privacy and dignity are considered within the guiding principles of *the ACT Human Rights Act 2004* and the *Mental Health (Treatment and Care) Act 1994*. ACT mental health legislation aims to protect, promote and improve the lives and overall mental health and wellbeing of ACT citizens. It requires that treatment and care should be provided in the least restrictive environment. The MoC promotes care, security and treatment that is lawful, reasonable and proportionate. These principles guide the core components of this MoC.

It should also be noted that the *Mental Health (Treatment and Care) Act 1994* is currently under review. This review, undertaken by the ACT Health Directorate and the Justice and Community Safety Directorate, aims to ensure the ACT Mental Health Act will meet the needs of our community and bring Canberra's legislation into line with important mental health reforms happening here and in other Australian states and globally. The MoC will reflect the new principles and amendments of the ACT Mental Health Act.

Key Motivators for the Building of a Secure Mental Health Unit

There has been a long term demand for secure mental health care in the ACT to supplement existing forensic and non forensic (civil) mental health services. People detained within the justice system who are acutely mentally ill currently have limited access to facilities for their treatment. There is also a narrow capacity to manage the higher risk of those who have been found to be not guilty by reason of mental impairment (due to mental illness) who require rehabilitative care.

The term mental impairment as it is and applied within the justice system has in recent years raised issues as to the perceived need for a secure mental health service and has been the subject of comment in Annual Reports within the criminal justice and health systems as well as the ACT Human Rights Commission.

As well as secure mental health care there is also need to provide low secure and longer term inpatient care for people who have unremitting and severe symptoms of mental illness or disorder and associated behaviour disturbance and are unable to be safely or adequately treated in less restrictive settings.

There are a number of additional guiding documents that have motivated the need for the building of a SMHU. These include:

- The first annual Report Card of the National Mental Health Commission 2012 with key recommendations including: *Increase access to timely and appropriate mental health services and support*
- Human Rights Audit on the Operation of ACT Correctional Facilities under *Corrections Management Act 2007* with key recommendations for the delivery of mental health services in correctional centres
- ACT Human Rights Commission 2011-2012 Annual Report – concerns raised regarding no forensic mental health facility
- The ACT Adult Corrections Health Service Plan 2008-2012 outlines clear strategies and outcomes for individuals with mental illness involved in the justice system. The Plan is based on a comprehensive study of the forensic mental health needs in the ACT

- Health Infrastructure Program initiatives for a secure mental health inpatient unit as identified in the ACT Mental Health Services Plan 2009-2014
- Review of Options for ACT Secure Mental Health Unit April 2012, Prepared by Victorian Institute of Forensic Mental Health
- ACT Comorbidity (Mental Health and Alcohol, Tobacco or Other Drug Problems) Strategy 2012-2014
- National Statement of Principles for Forensic Mental Health 2006
- National Mental Health Standards 2010 (see ***Appendix 1***)
- 1991 Royal Commission into Aboriginal Deaths in Custody
- The Report of the National Enquiry into the Human Rights of People with Mental Illness (Burdekin) 1993

Secure Mental Health Model of Care Project Assumptions

The ACT Government's Review of *the Mental Health (Treatment and Care) Act 1994* is well advanced, with a Bill expected to be finalised in 2014. The SMHU MoC is based on the assumption that key amendments as documented in the second exposure draft of the *Mental Health (Treatment and Care) Act 1994* will be in effect when the SMHU is operational.

Another key assumption of this document is that where detainees are transferred from a correction facility to the SMHU, the Chief Psychiatrist will assume legal custody to detain that person within the SMHU. Where the person continues to be subject to a warrant of imprisonment or a warrant of remand in custody, they will be returned to the custody of the Justice and Community Safety Director-General under the *Corrections Management Act 2007* when they no longer require inpatient care at the SMHU.

Currently, people who require a mental health assessment pursuant to Section 309 of the *Crimes Act 1900* are transferred to the Mental Health Assessment Unit (MHAU). This procedure will not change with the building of the SMHU.

The final assumption relates to the provision of high secure mental health treatment and care. The SMHU will provide care and treatment for those requiring medium to low secure care. People

requiring mental health treatment in a high secure environment will be transferred to an interstate facility where that care can be provided.

1. Diversity and Cultural Awareness

Each person is an individual with rights to respect, dignity and privacy. Cultural and gender sensitivity is required for people who identify with various cultural and/or ethic groups or have diverse family and social networks, educational backgrounds, religion, belief systems or socio-political views. Establishing a positive therapeutic relationship between the person, staff and the facility is more likely when the person feels their beliefs, values and practices are understood and respected by those caring for them.

Aboriginal and Torres Strait Islander People and the Secure Mental Health Unit

The historical and contemporary context and conditions, within which Aboriginal people live, including the loss of country, have made it difficult to attain and sustain good health and wellbeing for many. Aboriginal and Torres Strait Islander peoples regard social and emotional well-being holistically, therefore the interplay of psychological, environmental, economic, biological and social factors that influence mental wellness and illness are considerable for Aboriginal and Torres Strait Islander people. Over-representation in the ACT justice system place Aboriginal ACT residents at much higher risk of health disadvantage and social strain than non-Aboriginal ACT residents.

Culturally and Linguistically Diverse (CALD) People and the Secure Mental Health Unit

It is generally accepted that people from CALD backgrounds can experience a range of complex issues. Some of these issues include discrimination, social isolation, keeping a sense of cultural identity with the culture of origin and difficulties assimilating within the broader Australian culture. In the ACT, the percentage of people who speak a language other than English at home is 15.2%. The ACT's most common countries of origin for migrants are Britain, China, India, New Zealand and Vietnam.

Refugees who migrate to Australia as a result of persecution in their country of origin may also be suffering from untreated psychological trauma. The complex interplay of these factors can impact a person's involvement with the criminal justice system. The ten foremost places of birth for humanitarian arrivals to Australia are: Sudan, Bosnia, Serbia, Croatia, Afghanistan, Iraq, Vietnam, China, Burma, and Myanmar.

There is a whole-of-government commitment to implementing policies that will provide a better future for all Canberrans. ACT Government policies embrace, amongst other themes, the concept of having a community which is socially inclusive. The SMHU will meet the objectives of the key focus areas of the *ACT Multicultural Strategy 2010-2013* that are relevant to its service provision. The 6 focus areas are:

- Languages
- Children and Young People
- Older People and Aged Care
- Women
- Refugees, Asylum Seekers and Humanitarian Entrants
- Intercultural Harmony and Religious Acceptance.

Culturally Sensitive Practice

The SMHU will ensure that it has capacity to meet cultural, gender and spiritual needs of individuals. Examples of culturally sensitive practice will include:

- Training on cultural diversity is part of the Mental Health Justice Health and Alcohol and Drug Services (MHJHADS) Education Program, and includes cultural awareness in regard to health service delivery to people from CALD and Aboriginal and Torres Strait Islander backgrounds. Additional training may need to be developed for the SMHU
- Delivery of services that are sensitive to the social and cultural beliefs, values and practices of Aboriginal and Torres Strait Islander people and those from CALD backgrounds
- With the person's consent, referral of Aboriginal and Torres Strait Islander person to the Aboriginal Liaison Officer (ALO).
- The SMHU will work in partnership with Aboriginal agencies and organisations in the community such as Winnunga Nimmityjah, Gugan Gulwan, Aboriginal Justice Centre and the Ngunnawal Bush Healing Farm (when operational)
- Communication with consumers and carers will be in a language that they can understand, free from medical jargon with use of interpreters where required
- Recognition of and privacy for cultural and spiritual practice. This might be an outdoor space e.g. a garden or the opportunity to use a multi-functional space within the unit for spiritual practice

- Space for Aboriginal and Torres Strait Islander people to communicate and share e.g. a yarning circle/yarning pit
- Recognition of traditional Aboriginal and Torres Strait Islander family structures and elder mentoring
- Recognition of non-traditional family structures.

Lesbian, Gay, Bisexual, Transgender, Sexual and Intersex and Queer (LGBTIQ) People and the Secure Mental Health Unit

People of diverse sexuality, sex and gender have significantly poorer mental health and higher rates of suicide than other Australians. Sexuality, sex and gender diversity is in itself not a causal factor for mental illness however the discrimination and exclusion that LGBTIQ people experience relates to higher rates of depression, suicidality, substance misuse, and psychological distress in this community.

The SMHU will provide safe and supportive care for LGBTIQ people. The clinical team will strive to be one that is sensitive to issues of sexuality, sex and gender diversity. Individualised care plans will take into consideration a person's sexuality, sex and gender diversity and address specific issues that have a high prevalence amongst LGBTIQ people such as bullying, abuse and violence; marginalisation, exclusion and social isolation; self stigma and shame; trauma, anxiety and depression, substance misuse and eating disorders. The SMHU team will consider sexuality, sex and gender diversity when conducting suicide risk assessments. Clinical and support considerations will be made to promote inclusive language and practice, cultural competency and staff education, and optimum clinical outcomes and recovery for LGBTIQ people in the SMHU.

2. Service Scope and Description

The SMHU will be a purpose built, secure mental health facility located at Symonston. This site was chosen after extensive site investigations to determine the most appropriate location. The SMHU will be an integral part of ACT Health services provided by the ACT Health Directorate. As part of Canberra Hospital and Health Services (CH&HS), the SMHU will be managed by the Justice Health Services program as part of the MHJHADS Division.

Justice Health Services incorporates Primary Health and Forensic Mental Health. Primary Health provides health care services at the Alexander Maconochie Centre (AMC), the Periodic Detention Centre (PDC) and the Bimberi Youth Justice Centre (BYJC). Forensic Mental Health is a specialist area

that primarily focuses on providing clinical services, which includes the effective assessment, treatment and management of forensic consumers and people with a mental illness who have offended or are at risk of offending.

The SMHU will further enhance existing Mental Health services provided in the ACT. The unit will have 25 beds and care for people with low to medium secure needs. The 25 beds will be configured into an acute wing and a rehabilitative wing. 10 beds will cater for those who are acutely mentally unwell and 15 beds will be for rehabilitative care. The beds will be configured so as to allow the flexibility required to meet the diverse range of need. The aim of acute care will be short term care for assessment and stabilisation. The aim of the rehabilitative care will be phased community re-integration. The rehabilitation program will provide medium to longer term care. It should be noted that because this is a secure specialist service, the beds of the SMHU will not be included as general mental health beds for bed management purposes.

This facility will provide a safe clinical and therapeutic environment for people with a mental illness who may be characterised as complex, often difficult to treat and are of serious risk to others. People treated in the SMHU will be unable to be safely or adequately treated in a less restrictive setting. This also includes people with a mental illness who cannot be adequately assessed and treated in a correctional setting.

All people accessing the SMHU will be involuntary, assessed as requiring secure care and treatment and require as part of their treatment and care, varying levels of containment and supervision.

The key functions of the SMHU are the:

- Provision of secure mental health inpatient services 24 hours, 7 days a week in a specialised treatment and care environment, for people who are unable to be provided with clinical services in a less restrictive setting. This includes care for both forensic and civil consumers;
- Provision of contemporary, multi-disciplinary secure mental health rehabilitation services to assist people to recover from mental illness and to gain skills needed to live in a less restrictive setting.

The SMHU functions will support a person’s treatment, care and recovery by:

- Assisting people to maintain hope and to support people’s efforts in their recovery from mental illness

- Providing a safe and structured therapeutic environment for persons with persistent and disabling symptoms of mental illness
- Managing clinical risk and implementing behaviour management interventions
- Supporting individuals and their families and carers across the broad continuum of care, including facilitating a smooth transition of care to other teams/services.

The SMHU will:

- Provide specialist forensic psychiatric care, mental health care, alcohol and drug treatment and primary health care
- Provide specialist behaviour management interventions to assist people to manage their needs in a safe and therapeutic environment
- Provide well co-ordinated intensive individual and group rehabilitation services that maintain and develop a person's ability to adapt and function in the environment, minimising the ill effects of long term care, and promote return to community living
- Provide a highly supervised supportive environment for the development of individual vocational skills and requirements
- Actively engage and develop partnerships with ACT community services and community groups
- Support people to address social determinants of health and assist people to harness the resources and means needed to be healthy
- Provide information, education and support for families, carers and significant others
- Provide a site for specialty forensic mental health training to occur for clinicians in the ACT.

Who will the SMHU provide services for?

The SMHU will provide a safe and structured environment with 24 hour clinical support for people with acute or persistent and severe mental illness with associated functional and behavioural difficulties. This will include both forensic consumers and consumers of general mental health services (civil). In exceptional circumstances, services may be provided, following specific consideration by the Chief Psychiatrist, to a young person aged 16 years of age or older who cannot be safely managed in a less restrictive environment. In the rare event that a young person might require admission to the SMHU, a multi-agency review will take place before admission to consider all available treatment and care options for the young person.

People admitted to the SMHU will have moderate to severe mental illness. Most commonly the diagnoses will be schizophrenia and mood disorders with related psychosis. Individuals may also have complex presentations including mental illness and serious behavioural issues associated with personality disorder. Presentations often feature co-occurring conditions such as drug and alcohol disorders, complex trauma and clinically significant impacts on psychosocial functioning.

More specifically, the SMHU is intended to focus on people with complex needs who are unable to be adequately treated in less restrictive settings or correctional settings, due to their mental illness and associated issues of behaviour and risk. This can include:

- Severely disorganised behaviour leading to difficulty in managing the activities of daily living
- Poor impulse control and judgement
- Ongoing risk of aggression and violence
- Serious risk of self harm and/or harm to others.

3. Care Delivery

The pathway into and out of the SMHU will be clear and explicit to all individuals, carers, mental health staff at all levels, the community sector the judicial system and other Government departments.

3.1 Access & Entry

SMHU Admission Panel

The SMHU will operate on the premise that all referrals for admission will be managed so as to promote consistency of peoples' eligibility and priority of need, whilst also maintaining appropriate flexibility to be responsive to individual requests from service areas. There will be an Admission Panel each for acute care and rehabilitation. The SMHU Admission Panels will review all referrals for admission to the SMHU to ensure that people with the greatest need for SMHU care receive the highest priority.

The SMHU Admission Panel will take the following into consideration for all admissions:

- A diagnosis of mental illness
- Assessment of the level of risk to self and others. Risk management will consider environmental and contextual factors in the individual situation, historical factors, cultural

factors, personal vulnerability, factors impacting on the individual's control over behaviour and protective factors and strengths which may moderate risk.

- The mix of people currently admitted to the SMHU
- The triaged need of those already awaiting admission
- The capacity of the individual for rehabilitation: this may not be able to be fully assessed due to presenting issues including, but not limited to, acuity, substance abuse, homelessness or disorganised behaviour. As a consequence, referral may be accepted with a view to further assessment developing a rehabilitation plan once these presenting issues have been managed in the initial period of the admission
- Alternative options for care and treatment within the ACT.

Referral of civil consumers will usually follow an appropriate trial of less restrictive options including high dependency care within the Adult Mental Health Unit (AMHU).

SMHU Admission Panel Members

The Admission Panel reviewing referrals to the rehabilitation program will comprise of:

- SMHU Staff Specialist Forensic Psychiatrist
- SMHU Nurse Manager
- Forensic Mental Health Services Team Leader
- SMHU Senior Therapies Manager (Allied Health)
- Any other relevant person upon invitation.

The Admission Panel reviewing referrals to acute care will comprise of:

- SMHU Staff Specialist Forensic Psychiatrist
- SMHU Nurse Manager
- Forensic Mental Health Services Team Leader
- Any other relevant person upon invitation.

Accompanying Information – Rehabilitation Program

Where relevant and available, information regarding the person's potential benefit from rehabilitation in a structured environment will accompany the written referral documentation. Examples of relevant information may be a range of multi-disciplinary assessments including, but not

limited to, Occupational Therapy functional assessment, neuropsychology assessment and a psychosocial assessment.

It is expected that referrals to participate in the rehabilitation program will include: an up to date recovery plan; a recent case review; legal status, recent risk assessment, completed outcome measures and a recent suicide risk assessment.

Responsibilities of the Admission Panel

The SMHU Admission Panels will meet in a timely manner and on an as required basis. The SMHU Admission Panels will be responsible for completing a clinical report summarising discussion points and outcomes.

Should the referral be accepted, the SMHU team and the referring team will liaise regarding the transition to admission. Should a placement not be immediately available, the referral will be placed on a waiting list, and strategies for meeting the person's needs and managing any risks in the interim will be developed collaboratively.

Should the referral not be accepted, the SMHU team will provide specific feedback to the referring team about the decision and also offer strategies for managing risk and promoting recovery in alternative settings.

Where the Admission Panel cannot reach agreement on suitability or appropriateness, the matter will be escalated to Clinical Director, with oversight from the Chief Psychiatrist and if required the Executive Director of MHJHADS.

Referral Pathways to the SMHU

Referrals for acute care will come from the Alexander Maconochie Centre (AMC) Forensic Mental Health Service (FMHS), AMHU or interstate. Referrals for the rehabilitation program may come from any part of MHJHADS.

A person detained under Section 309 of the *Crimes Act 1900* for immediate assessment, will continue to be sent to the Mental Health Assessment Unit (MHAU) at Canberra Hospital.

Referral Pathway – Acute Care

Individual in AMC or AMHU is identified as requiring acute assessment and care at the SMHU.

AMC FMHS or AMHU psychiatrist contacts SMHU Manager to discuss potential referral. Referral is made in electronic medical record

SMHU Admission Panel review referral. Referral is reviewed against admission criteria.

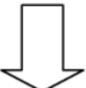
Referral accepted – plan for transition

Referral not accepted – Feedback provided to referrer including strategies for management

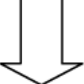
Referral Pathway - Rehabilitative Care

Individual is identified as requiring structured secure rehabilitative care at the SMHU. Discussed as part of MDT clinical meeting.

Referring team contacts SMHU Manager to discuss referral



Referring team completes referral form on electronic medical record



Admission Panel review referral. Referral is reviewed against admission criteria.

Referral accepted – plan for transition

Referral not accepted – Feedback provided to referrer including strategies for management

3.2 Assessment and Review

Admission Criteria

Under the *Mental Health Treatment and Care Act 1994* the SMHU will admit "correctional patients" who can consent to treatment and involuntary consumers.

A person who is detained at the AMC can consent to mental health treatment. The Chief Psychiatrist can make a recommendation regarding a correctional patient to the Director General, Justice and Community Safety Directorate to transfer the consumer to a mental health facility. The Director General, Justice and Community Safety Directorate can then order the transfer to the mental health facility.

Admission criteria for involuntary treatment will reflect the amendments to the *Mental Health Treatment and Care Act 1994*, specifically, the section that applies to a forensic psychiatric treatment order.

A person will be admitted to the SMHU if they meet all of the following:

- The person has a mental illness
- Because of the mental illness the person –
  - is doing, or is likely to do serious harm to himself or herself; or
  - is suffering, or is likely to suffer, serious mental or physical deterioration; and
- Because of the mental illness, the person has seriously endangered, is seriously endangering, or is likely to endanger, public safety; and
- That psychiatric treatment, care, or support in the SMHU is likely to –
  - reduce the harm, deterioration or endangerment, or the likelihood of harm, deterioration or endangerment
  - result in an improvement in the person's psychiatric condition; and
- The treatment, care or support cannot be adequately be provided in a way that would involve less restriction of the freedom of the choice and movement of the person

As per Mock-up MH(T&C) Act 1994: Division 7.1.4: paragraphs ***97 (2) (a) to (f).***

See ***Appendix 2*** for the definition of mental illness as per the Mental Health Treatment and Care Act 1994.

The admission criteria and the admission considerations outlined in the section *SMHU Admission Panel*, will guide all admissions to the SMHU.

Guiding Principles of Admission

- Admission to the SMHU will be based on a number of factors including the diagnosis of a mental illness, the person's level of risk, their suitability for a medium secure environment and the person's treatability.
- Young people under the age of 18 years will be considered on a case by case basis taking into consideration their developmental needs and needs for treatment and care
- All consumers will be treated either under a forensic treatment order or a psychiatric treatment order

The SMHU will implement appropriate processes for considering monitoring and managing referrals and facilitating smooth transitions between service areas. Processes need to ensure that people with the greatest need for SMHU receive the highest priority.

Once the decision to admit is made, the person will be made aware to the extent possible and in terms they understand that the admission is to occur and the reasons for the decision. Admission goals will be identified as part of the pre-admission decision making process.

The admission process will maintain the individual and family's rights to privacy and dignity. Where families, carers and significant others are involved, they will be informed, with the consumer's consent, of the decision to admit. It is important that for escort security purposes, whilst the decision to admit is communicated with family, the date of transfer for correctional patients must not be disclosed until after the person has arrived at the SMHU.

Once admitted a full range of assessments will take place. These will include:

- A full mental state examination
- Psychiatric, psychosocial, forensic (including general behaviour in custody, incidents, risks, legal status), cultural and collateral history
- Assessments to determine mental state, physical and medical conditions and presenting risk factors
- A range of multidisciplinary assessments that provide information on the person's functional difficulties and ability to benefit from an admission to the SMHU.

A formal review will be undertaken with the multidisciplinary team (MDT) and the individual. Regular reviews will be conducted within a recovery focused framework that ensures that progress is made towards the goals identified for admission and those prioritised by the person. Individuals will have regular mental state examinations and risk assessments and will be encouraged to attend and participate in suitable programs.

People admitted to the rehabilitation program will be offered a support person present at the time of assessment. Interpreters will also be offered as required. Aboriginal and Torres Strait Islander people will be offered to have an ALO present at assessment.

3.3 Treatment

Acute Care

Acute care will focus on stabilisation, assessment and early intervention. All new referrals to the SMHU will be assessed and admitted to the acute unit. People suitable for the rehabilitation program will also be admitted to the acute wing for an initial period before a decision is made to transfer them to the rehabilitation wing. This will allow for a period of observation and assessment.

People referred from the criminal justice system, including all those transferred from the AMC who are in need of extensive psychiatric assessment and/or acute care and treatment will be admitted to the acute unit.

Acute admissions from general mental health services to the SMHU will also occur in circumstances where the person is not able to be treated in a less restrictive setting. Staffing of the acute wing will reflect the immediate and critical needs of these consumers.

Rehabilitative Care

The aim of the rehabilitation program will be an individual's reintegration into the community and the acquisition of meaningful roles. The rehabilitation program will provide programs and interventions to assist people to gain and maintain an optimal level of functioning. The program will engage people using a strengths-based approach that promotes hope, good health and creates opportunities to grow and develop resilience and life skills. The programs and facilities will be structured so as to take into consideration longer admissions that are required for rehabilitative care.

People will be supported to undertake training and employment. For most people occupational and vocational training programs will be commenced on-site of the SMHU. The vocational training programs will be provided by non-government or training organisations.

A person's progress in the rehabilitation program will be monitored through outcome measures, ongoing assessments and the attainment of goals.

The outcomes of the rehabilitation program for an individual may be:

- Clarification of diagnosis and formulation of treatment
- Seamless transition to living in the community
- Reduction or removal of psychotic symptoms
- Reduction of risk to self or others
- Improved interpersonal functioning
- Increased social inclusion, post-discharge
- Development of a Keeping Well and Relapse Prevention plan
- Development of mindfulness, resilience and illness management skills
- Identification and recruitment of supports needed for successful transition to community living
- Vocational skills
- Knowledge of reasons for previous offending and strategies to reduce the likelihood of re-offending.
- Improved insight and need for compliance with medication

Care Model

Integrated care pathways will be treatment and recovery-focused, person-centred, based on the person's hopes, goals, their assessed needs, criminogenic issues and risk. The care pathways will be developed with the input of the person and the multidisciplinary team to form an integrated plan. The literature identifies key areas of care which can be termed the 5 Pillars of Care:

- Physical Health
- Mental Health
- Tobacco, Alcohol and other Drug Recovery
- Problem Behaviour
- Psychosocial and Occupational Rehabilitation.

These Pillars can be used to coordinate the many and varied therapies, interventions vocational and occupational activities across a care pathway. Not all Pillars would or could be addressed concurrently but rather they help develop a map to stabilisation and reintegration into the community. The Pillars are central to the principle of recovery where strengths can be identified and holistic care can be delivered.

Pillar 1 – Physical Health

The high level of physical ill health experienced by many people with a severe and enduring mental illness has a direct impact on their life expectancy and quality of life. Often the conditions are unremitting and complex.

Anti-psychotics are associated with weight gain. People will be assessed and a tailored exercise program will be developed for all individuals as required. There will be facility provision for all-weather, day/night, individual and team sports.

Primary health and women's health needs will be met by sessional in-reach services provided by the Justice Health Services – Primary Health. When needed, a medical officer will refer people for specialist or oral health services if that service cannot be provided on-site. This will include inpatient care that cannot be provided on site. A medical officer will also be available on call.

Where individuals are not able to access leave to attend health clinics, services will be provided at the SMHU. These may include: nutrition, physiotherapy, podiatry services amongst others.

Nurse led clinics will be established for the early intervention and management of patients with chronic disease e.g. diabetes, cardiovascular disease and blood borne viruses.

Discussions will be sought with Winnunga Nimmityjah Aboriginal Health Service and MHJHADS Aboriginal Liaison Officers on how best to provide for the health and family needs of Aboriginal and Torres Strait Islander people that may be admitted to the SMHU.

Pillar 2 – Mental Health

This will be a program specifically focusing on mental health and recovery. Pharmacotherapy, individual therapy, and group programs will all be adapted to a person's needs to improve their mental health. Programs may include learning to live with mental illness, living with voices; Keeping Well Planning and cognitive behaviour therapy. Everyone will receive a tailored assessment and

formulation of their needs. This will inform the care they receive, both in individual and group settings.

Exercise improves mental health by reducing anxiety, depression, and negative mood and by improving self-esteem and cognitive function. The benefits of physical activity on mental health include distraction, self-efficacy, and social interaction. Aerobic exercises, including jogging, swimming, cycling, walking, gardening, and dancing, can reduce anxiety and depression.

Pillar 3 – Tobacco, Alcohol and other Drug Recovery

This will address smoking cessation by offering counselling, support and nicotine replacement therapy. The program will use group work, cognitive behavioural therapy and motivational interviewing to direct behaviour change. The SMHU will also provide an Opioid Treatment Service pharmacotherapy program to provide opiate substitution treatment. Nurses will work together with individuals to form a treatment plan and to assist people utilizing harm reduction strategies to manage opiate and other drug use. The program will not provide acute alcohol or drug withdrawal. People requiring acute withdrawal services will be transferred to the Canberra Hospital.

Pillar 4 - Problem Behaviour

This will address a spectrum of challenging and at times dangerous behaviour including extremes of violence and self-harming behaviour. A key focus for interventions will be risk management and behavioural change. The program will seek to develop a person's insight into antisocial behaviour leading to social disorder. The program will develop a formulation of a person's behaviour so that vulnerabilities, high risk situations, thoughts, moods and strategies to avoid future dangerous behaviour are explored. Relapse prevention planning will be undertaken to ensure that the progress made in therapy is maintained in the future.

Pillar 5 – Psychosocial and Occupational Rehabilitation

Recovery Programs

Creating opportunities for occupational engagement, as part of, as well as outside, the structured program and mitigating the risk of occupational deprivation is essential. Not only do people have the right to high quality treatment and rehabilitation services as would occur in less secure settings but people must also have opportunities to develop skills and interests that can play an important part in recovery during a person's time in the unit and after discharge. Reducing the amount of time

where people have nothing to do also reduces the likelihood of people getting bored, acting out, disengaging, becoming deskilled and depressed.

In both acute care and rehabilitative care there will be opportunities for people to participate in meaningful group and individual activities to enhance psychosocial health and wellbeing. Work will be done with individuals and groups to develop leisure, recreational and vocational interests and opportunities. These activities will aim to engage, motivate, activate, develop skills, and improve outlook and hope rather than just occupy time. Diversional therapies and activities may include:

- Gardening
- Exercise, including team sport
- Leisure and recreational activities
- Personal development activities
- Social activities
- Pre-vocational, vocational and academic activities
- Spiritual, religious and cultural activities
- Arts
- Music
- Hobbies and personal interests.

Family Focused Intervention

Many people will benefit from treatment that involves their family. Family interventions will be facilitated that allow a person's needs and personal challenges to be shared and managed by both the person and with the support of their families or other supports. The interventions will aim to increase the understanding of the person's illness within a family setting, and to empower all those involved.

Vocational Rehabilitation

Vocational issues will be addressed at the earliest opportunity in a person's rehabilitation program. The SMHU will work with community agencies that assist people in gaining vocational skills. Individuals will be assisted to apply for vocational and tertiary training programs. For most people, vocational training will commence on-site of the SMHU. People may choose to enrol in an on-line training course or learn new practical skills e.g. gardening and basic mechanical repairs.

A person's access to the phone and the internet will be based on risk assessment and progress through the various stages.

3.3.1 Additional Clinical Treatment Location Requirements

Sensory Modulation Area

A sensory modulation room will be provided as a place that encourages and promotes self-regulation, self-nurturing, resilience and recovery. Key aims of the sensory modulation room will be to:

- Help people learn to relax and self-regulate.
- Learn what environmental factors and activities are helpful for the person.

This room is intended to be where staff actively engages the person in the exploration of sensory modulation techniques by offering different items in the room as a method of improving the patient's emotions, overall mood and/or social interactions. The items in the room cover all the different sensory systems.

The room can be used as an intervention to reduce arousal levels and may be incorporated into a person's treatment plan. It will also be used for planned sensory based interventions by occupational therapists in the unit.

De-escalation and Seclusion Suite

The purpose of de-escalation and seclusion is to manage a highly agitated and emotionally disturbed or high-risk person away from the main ward area in a room that may be locked. De-escalation spaces and seclusion rooms will be co-located. The de-escalation room or area will provide a quiet, low stimulus space for people experiencing high levels of arousal who may not require a period of seclusion. It can also be used as part of the therapeutic process when people are moving out of seclusion and back into the main ward area. The de-escalation space will be a single purpose area.

A seclusion room is a single-function space with an en-suite and specifically designed to be low stimulus and to ensure the safety and physical wellbeing of the person. All fixtures, furniture and fittings substantially limit the risk and ability of a person to harm themselves or others. Seclusion is the subject of strict protocols, is a last resort and only to be used when approved by a medical officer when other less restrictive interventions have failed.

Outdoor Space

There is a clear, positive relationship between physical and mental health and the proximity and use of green spaces. The availability of natural environments of the SMHU will allow people to distance themselves from routine activities, concentrate better and reduce stress levels. Access to varied and large outdoor space will give staff and consumers options to re-direct activity and behaviour as required.

Large outdoor areas are important to traditional Aboriginal and Torres Strait Islander spiritual practice. The outdoor spaces will help to facilitate mindfulness, spiritual practice, relaxation, activities, exercise and group discussion e.g. yarning circle.

The outdoor spaces will be large enough so that the view of perimeter of the facility is minimised.

3.4 Discharge and Transfer

People will remain in the SMHU until they are able to be discharged back to a correctional facility, the AMHU, University of Canberra Public Hospital (UCPH) Adult Mental Health Rehabilitation Unit or the community. Discharge will be dependent on the full implementation of the legal and medical requirements under the *Mental Health (Treatment and Care) Act 1994.* Clinical improvement and reduction in assessed risk directly inform decisions associated with discharge and transfer

Discharge planning will not be solely dependent on clinical factors as there will be legal implications that need to be considered as part of the discharge process. Discharge planning will take place in conjunction with the processes of the ACT Civil and Administrative Tribunal (ACAT). Where the person is from the AMC or Community Corrections, discharge will take place in conjunction with the processes of ACT Corrective Services (ACTCS). Some people may still have some symptoms at the point of discharge but be well enough to move into a less intensive form of care. There may be some people whose sentence is completed whilst they are at the SMHU and may be discharged from their custodial order to the community. Others may still require their community treatment and care to be provided under the provisions of the mental health legislation.

People in the rehabilitation program will have multiple trials of graduated leave before discharge. A leave bed will not be considered an available bed for a new admission.

Planning for discharge and support after inpatient care will commence at the time of admission. Discharge planning will incorporate collaborative partnerships with families, carers and other

nominated supports along with other appropriate services or organisations, including supported accommodation and disability services. Discharge will always be to the care of a MHJHADS team that will assume responsibility for further recovery planning, treatment and care for the person.

Where a person has ongoing criminal or civil matters, there will be facilitated access to legal assistance/representation e.g. Legal Aid ACT outreach service.

ACT Civil and Administrative Tribunal

The ACAT is an independent body established to protect the rights of people placed on involuntary orders for mental illness. It provides an independent review, and makes decisions about whether the involuntary order will continue or not. There will be a process for external review by the ACAT for people in the SMHU.

Responsibilities of the ACAT in regards to Forensic Treatment Orders and Psychiatric Treatments Orders will explained in the *Mental Health (Treatment and Care) Amendment Bill 2014* which has not been enacted by the ACT Legislative Assembly at the time of the development of this model of care.

The SMHU will communicate with ACTCS and Youth Justice where relevant, to ensure that legal requirements are met, that transfer and discharge planning is completed in a timely and cohesive manner, and that the Affected Persons Register obligations are met.

4. Safety and Security Requirements

The approach taken to safety and security requirements is to adopt a three layered approach to physical, procedural and relational security. Each element will be developed in relation to the other two. Physical security alone will not provide safety and cannot operate without appropriate relational and procedural security. Increases in relational and procedural security cannot be used to counterbalance weaknesses in physical security.

A balance has to be maintained between the degree of intrusiveness of any security system and the degree of containment that is required, the level of safety for staff and others working or visiting the facility and the safety of consumers and the general community. The security system in place will enable effective treatment, by providing the structure within which clinical care can be safely provided and privacy of consumers maintained.

The objectives of the security system are to:

- Prevent unlawful departure from the facility and maintain community safety
- Alert staff to incidents and emergency situations
- Protect people who are at risk of causing harm to themselves or others
- Prevent access to illegal and illicit substances and technologies
- Prevent illegal entry of people and contraband
- Provide safety for visitors and other consumers
- Keep staff safe
- Maintain a safe responsive environment
- Allow staff to provide care, treatment and rehabilitation
- Control access and egress
- Provide gender and vulnerable person safety.

4.1.1 Physical Security

Physical security is the provision, maintenance and correct application of appropriate infrastructure, physical barriers, equipment and technology by appropriately trained staff. It is important but should not be the sole element of the security provided. In the SMHU, physical security will address the following:

- Security provided will be such that it protects the privacy and dignity of people
- It will reduce the opportunity of others passing or bringing contraband items into the facility, making unlawful departure and substance abuse difficult
- People will not be locked in their bedrooms, although for therapeutic reasons they may need to have access restricted to their own en-suite bathrooms
- People will be able to secure their rooms when they are not occupying them, or wanting to feel safe from others. Staff will be able to override locks used in consumer areas
- Only under very strict protocols of observation and formal reporting will people be confined to other spaces for reasons of self-protection and behavioural management e.g. seclusion and de-escalation
- Good spatial layout with unobstructed sight lines will be provided
- Provision of adjoining single rooms with a shared, lockable door, to cater for kinship ties (as per the 1991 Royal Commission into Aboriginal Deaths in Custody)
- The building material will be robust and damage resistant

- Access will be strictly controlled at designated security points that include the use of metal detectors
- The duress alarm system will include voice and phone functions
- The facility will have an electronic and grandmaster keying system
- Physical security will be enhanced by a positive physical environment that ensures adequacy of amenity to avoid discontent or a focus on unlawful departure.

The Secure Perimeter

The SMHU will have a secure perimeter. The design, construction and operation of the secure perimeter needs to provide the community and the staff with the confidence that the level of physical security matches the risks associated with assessed risk of those being treated. Good practice dictates that physical barriers to unlawful departure from the facility will not physically injure a person who might try to overcome them e.g. razor wire and electrification of fences. The objective of the secure perimeter will be to:

- **Deter**: provide an obvious barrier for passage into or out of the facility, and reduces the opportunity of contraband entering the facility
- **Detect**: provide some method of reliably detecting a person attempting to depart or enter the facility unlawfully
- **Delay**: provides some method of delaying a person attempting to depart or enter the facility unlawfully until such time as staff arrive.

There will be a planned maintenance programme in relation to the perimeter and other physical security provisions.

4.1.2 Procedural Security

Procedural security is the proper application of policies, standard operating procedures, routines and checking. Establishing a comprehensive range of effective procedures across the service establishes clear boundaries within the facility and anchors the application of therapeutic activity to structure and routine.

The safety and security systems in clinical areas will be managed by clinical staff. All incidents of aggression or violence will be managed by clinical staff. Staff will be trained in the prevention and

management of aggression and violence. All staff will be trained by a team of skilled trainers who will also provide regular refresher courses.

A facility wide personal duress alarm system and telephony will ensure that staff are able to request assistance in an emergency. Hardwired duress, medical emergency and fire alarms will also be located in required locations around the unit to ensure easy staff access under all situations.

Where clinical staff are not able to safely manage a person who is violent and aggressive, ACT Policing will be called to give immediate assistance.

Staff will utilise standard operating procedures to ensure that any restrictions on a person's freedom and any derogation of a person's dignity and self-respect are kept to the minimum necessary for the proper care and protection and safety of the person, other consumers and the protection of the public.

Policies and procedures will be consistent with ACT Health and Divisional policies and procedures. There will also be SMHU specific policies and procedures including:

- Personal and environmental searches
- Visitor management
- Consumer leave management
- Consumer management during emergency incidents
- Controlled access to facilities and buildings

As part of ensuring the safety of staff and consumers, there will be clear and effective systems for clinical governance, communication, handover and clinical decision making within staff teams. There will be regular multi-disciplinary team meetings for clinical matters and administration, and the team will be consulted on relevant management decisions such as developing and reviewing operational policy.

Leave

People admitted to the secure unit will receive all of their care and treatment within the secure perimeter unless authorised to do otherwise under the *Mental Health (Treatment and Care) Act 1994* or by the courts. Consumers on the rehabilitation program will be able to apply for leave or day release from the SMHU in order to participate in activities that progress their recovery and community re-integration. The Chief Psychiatrist or the ACAT will have the authority to grant leave.

A ‘consumer leave’ protocol will be established to give a proper process and maintain security. This protocol will be based on clinical presentation and risk assessments as well as external approving body requirements (e.g. court requirements). The leave protocol will clearly specify the circumstances under which leave can be given, the duration of the leave, requirements for staff escorted leave, family escorted leave and unescorted leave. Before a person is granted leave they will be required to demonstrate cooperation with their management plan and demonstrate the absence of disruptive behaviours.

4.1.3 Relational Security

Relational security is the formation of a therapeutic alliance between staff and consumers, centred on continuing assessment and management of risk. Relational security is concerned with developing good interpersonal and sound professional relationships between consumers and the clinical team so that there is a build up of trust that will enable staff to get to know and understand the person and, where necessary, provide interventions before major problems develop or lead to incidents. Relational security is also concerned with staff to patient ratios.

The 4 key areas that help staff maintain relational security are:

- The whole care team e.g. establishing boundaries and therapeutic relationships
- Other consumers on the unit e.g. consumer mix and dynamics
- The milieu experienced by the consumer e.g. physical environment and personal world
- The connections the consumer has to the outside world e.g. visitors and outward connections.

Cultural Safety

In a clinical context, 'cultural safety' is defined as a health professional’s understanding of his or her own personal culture and how these personal cultural values may impact on the provision of care to the person, regardless of race or ethnicity.

Cultural safety incorporates cultural awareness and cultural sensitivity and is underpinned by good communication, recognition of the diversity of views nationally and internationally between ethnic groups. The SMHU will provide education and promote awareness of cultural safety and diversity, and how this may affect the services which are provided.

4.2 Secure Entry Zone and Emergency Entry and Exit

A controlled entry point will be used for vehicles to enter the perimeter of secure facilities. People transported to the SMHU will enter through the secure entry zone and be taken to an adjacent secure admissions area. Deliveries of goods will also be made through the secure entry zone. Emergency services including fire brigade and ambulance will also access through the secure entry zone.

Staff and visitors will enter the facility through an adjacent controlled access point where they can leave prohibited items in provided lockers. Where required, consumers, staff, visitors and contractors will be electronically scanned for unauthorized items.

4.2.1 Reception

- The reception area will be adjacent to the secure entry zone and will be staffed during business hours, 7 days a week, to register visitors and for the control of contraband entering the unit
- The reception area will provide access for people with a disability.

The reception area will include:

- Visible signage identifying the list of contraband not permitted into the unit
- Secure lockers to store visitors' possessions whilst they are visiting the unit
- A police gun safe that complies with the relevant firearms legislation operated by police to deposit firearms and sprays when they are in attendance at the unit is required

4.2.2 Contraband

Contraband is identified as any item which is illegal or may be a threat to the safety and security of consumers, visitors or staff.

Contraband will include the following:

- Illegal drugs
- Tobacco
- Alcohol
- Weapons including knives and firearms
- Explosive devices
- Unauthorised tools

- Chemicals
- Offensive material
- Mobile phones and accessories including SIM cards
- Camera, video recorders
- Lap top computers, tablets, computer soft ware, floppy discs, USB memory sticks
- Sharps such as scissors, razors, needles
- Unsealed plastic or glass bottles containing liquid
- Glass bottles
- Plastic bags
- Aerosol cans
- Lighters and matches
- Medication
- Any other item deemed to be contraband by the Director-General.

4.3 Emergency Preparedness

Emergency preparedness is a comprehensive system that requires a continuous commitment to staff and resources to ensure a systematic approach to responding to emergencies. A range of multi-agency planning to assist in emergency preparedness will be required. This multi-agency planning will be required for situations such as:

- Evacuation
- Fire and Flood (internal and external)
- Unlawful departure
- Failure to return from leave
- Hostage
- Riot and disorder
- Barricade
- Roof top occupancy
- Critical infrastructure failure e.g. power or water outage, communications system failure.

4.4 Women and Vulnerable Persons

Evidence indicates that there are a significant number of people accessing inpatient mental health services who have experienced some form of sexual violence in their lives. The SMHU will provide an environment that ensures individuals are safe from experiencing further physical, sexual and psychological trauma. The safety of all persons raises organisational issues as well as building design challenges.

An assessment of vulnerability e.g. young people, elderly people, people with intellectual or physical disability, will be undertaken for each person as soon as is practicable following admission. This assessment will include information gained during the mental health assessment, including risk assessment, where relevant. The collection of such information will be in accordance with National Privacy Principles. Assessments of vulnerability will be reviewed at regular intervals for all consumers during their admission to the SMHU.

Written guidelines which outline the arrangements to ensure the safety of all persons, will be available to staff, consumers and visitors. Wherever possible, people will be offered a choice of either a male or female clinician. Staff will ensure that there is appropriate observation of all women consumers and vulnerable persons. Similarly, individuals who are regarded as a risk to others will be appropriately supervised. Women and vulnerable persons will sleep separately and have appropriate levels of staff supervision at night.

Sexual Safety

Sexual safety is a state in which physical and psychological boundaries of individuals are maintained and respected.

The SMHU will have systems that promote sexual safety. Operational policies and procedures will:

- Support the right to physical and psychological safety
- Encourage and educate regarding monitoring of professional boundaries
- Support professional development
- Respond quickly and appropriately to breaches in personal boundaries.

Assessment and identification of persons as being at risk of potential to harm, or of increased vulnerability to sexual assault are also important to the promotion of sexual safety. Identification of risk will be made at initial assessment and regularly reviewed.

The SMHU will have single bedroom accommodation with access to ensuites. A number of rooms will be able to be arranged into clusters which will be capable of being separated to provide safe and secure space for both males and females.

5. Care Delivery Team

Recruiting for the SMHU will actively include and recruit Aboriginal and Torres Strait Islander workers in all categories. This is in accordance with ACT Health's commitment to a combined effort to close the gap in Aboriginal and Torres Strait Islander Health as laid out in the *Health Directorate Reconciliation Action Plan 2012 – 2015.*

The SMHU will undertake evidence based recruitment and retention strategies such as providing clinical placements for undergraduate students and encouraging rotations through the unit with staff from other areas.

The effectiveness of the secure unit is dependent upon an adequate number of appropriately skilled and qualified clinical and non-clinical staff. The staffing profile will be comprised of a mix of multidisciplinary clinical and nonclinical staff providing treatment and care to consumers.

The clinical team will include:

- Forensic Psychiatrists
- Psychiatry Registrars
- Nurses
- Psychologists
- Occupational therapists
- Social workers

Visiting primary health care staff will include:

- Primary health physician
- Chronic Disease Nurse
- Aboriginal and Torres Strait Islander health care clinician
- Allied Health staff
- Pharmacist

The non clinical staff will include a mix of:

- Administration and support staff
- Diversional or Recreational/Art/Music therapist
- Mental Health Support Workers *(role and term yet to be confirmed)*

Additional support will be provided through food services, maintenance and cleaning staff who will assist with the day to day operations of the unit.

Workforce Development

The complexity of persons admitted to secure mental health units means that there is a need to provide staff with continuing and targeted education programs, clinical supervision and mentoring, skills training and research opportunities. The SMHU will have a workforce plan that will be reviewed at specific intervals. The workforce plan will include staffing and skill mix that reflect the complexity of consumer needs and the risks associated. The workforce plan will also include a training and development strategy, which will specify the requirement to provide security training and training to implement a range of code responses to emergencies.

ACT Health will provide appropriate education and training opportunities so that people who are admitted to the SMHU receive care from staff who are highly skilled in meeting their needs. This will be achieved by training and developing the skills of staff already working in the specialist Forensic Mental Health team in evidence-based interventions, as well as providing opportunities for mental health staff of the SMHU to develop skills and experience to equip them to work within the forensic mental health field.

A Workforce Profile and Workforce Plan for the SMHU will be developed as separate documents to the MoC.

6. Service Partners and Supports

6.1 The Consumer

People will be informed of their rights and responsibilities and how they can access support or advice external to the SMHU. People will be supported in their own journey of recovery (to the degree they are able) through:

- Self-management of their mental illness
- Active participation in the daily program
- The activities of daily living including personal care, domestic, social, vocational and recreational aspects of their lives
- Development of a recovery plan inclusive of aspirations, risks. goals and milestones
- Regular review of progress

6.2 Clinical Mental Health Staff

Clinical staff will provide clinical assessment and therapeutic interventions aimed at effective management of a range of complex psychological conditions to minimise and reduce impairment and disability associated with mental illness. This will include the use of medication, psychological therapies and clinical rehabilitation interventions with a focus on risk management and behavioural change.

More specifically, clinical staff will be responsible for:

- Providing planned clinical mental health treatment and support
- Discharge and transfer planning
- Care Coordination - one clinician will be allocated to coordinate a person's care
- Documenting assessment and care
- Responding to needs for medication and physical health related issues
- Undertaking clinical assessments, risk assessments, mental state examinations and outcome measures
- Supporting consumers in behavioural change management
- Carrying out and reporting against legislative requirements e.g *Mental Health (Treatment and Care Act) 1994.*

6.3 Non-Clinical Staff

Non-clinical support staff will provide support to people within the framework of the multi-disciplinary team to enhance the quality of the therapeutic program. They will do this by:

- Providing individually planned recovery and psychosocial support services on a daily basis with a focus on building independent living skills and community engagement (such as support personal care, shopping, home care, cleaning, etc). This will include support at all phases of the rehabilitation continuum.
- Supporting clinical staff

6.3 Families and Carers

SMHU staff will work to ensure that family members and carers identified by the consumer are involved in their care. This will be done in a way that is respectful of the person's wishes and in accordance with the *Mental Health (Treatment and Care Act) 1994* and the ACT Charter of Rights for People who experience Mental Health Issues*.*

Identified caregivers, family members and ALO's will be invited to attend clinical reviews as appropriate. As part of the approach to service delivery, staff will provide education to families and carers, supporting them to address their needs, and suggesting links with supports, whenever appropriate.

There will be a dedicated space for individuals to meet with their family. Family visits will be co-ordinated and time limited. Depending on the assessed risk, staff will supervise visits and children will be allowed to visit.

6.4 Non-Government Psychosocial Rehabilitation and Support Services

Effective links between the SMHU and non-government educational, vocational and rehabilitative agencies will be particularly important. It is anticipated that community based agencies will work internally with the SMHU program providing a range of services.

6.5. Statutory Bodies

Mental Health Official Visitors

Mental Health Official Visitors are appointed by the Minister for Health and independent of MHJHADS. Their role is to assess inpatient mental health facilities in the ACT to ensure they are providing the best possible care. Official visitors will arrange to attend the SMHU and consumers and carers will have the opportunity to talk with and receive assistance from the Official Visitors.

Public Advocate of the ACT

The Public Advocate (PA) undertakes a range of advocacy functions on behalf of children, young people and adults with a mental health issue who are in need of protection from abuse, exploitation or neglect. The PA ACT is an independent Government service which is separate from hospital services, MHJHADS, the ACAT and the Police. The PA ACT aims to support people who come into contact with the Mental Health system to have their views and concerns listened to. Consumers and their carers of the SMHU will be able to contact the PA office if requiring support.

ACT Human Rights Commission

The ACT Human Rights Commission is an independent statutory agency. The ACT Health Services Commissioner is one of three Commissioners within the ACT Human Rights Commission. The Commissioner's mandate is to consider complaints about the provision of health services and services for older people, and complaints about contraventions of the privacy principles or of a consumer's right of access to his or her health records under *the Health Records (Privacy and Access) Act 1997.* If a consumer of the SMHU has a complaint about their care, provision will be made to facilitate their contact with the ACT Human Rights Commission.

Legal Aid ACT

The Legal Aid Commission (ACT) is an independent statutory authority established under the *Legal Aid Act 1977*. The Commission's function is to provide legal assistance in the ACT. Legal assistance includes legal information and advice, duty lawyer services, and grants of financial assistance. Legal Aid ACT helps people with their legal problems, especially people who are socially or economically disadvantaged. Legal Aid ACT can help in criminal law, family law and some civil law matters. If a consumer of the SMHU has any legal problems, provision will be made to facilitate their contact with Legal Aid ACT.

7. Information and Communications Technology (ICT)

Consumers will have vetted access to computers and the internet. For example a computer and the internet will be made available for individuals who might be studying. People will have access to a private space to take phone calls. Access to make outgoing calls will be restricted and staff will vet access.

7.1 Information Technology (IT)

Resources that are to be provided for the unit are reflective of requirements in other units on the Canberra Hospital campus.

The computer hardware to support clinical operations includes multiple standard computer terminals located in designated work zones. The E-Health & Clinical Records Mobile Device Strategy (draft) expects that under the Health Infrastructure Program (HIP) mobile devices will become the primary channel for accessing clinical systems and information. The requirements for fixed computers and workstations in new buildings will decrease.

Operational software requirements (in addition to standard government software provisions) will required to all relevant clinical and administration systems.

Shared Services ICT will be engaged in the operational commissioning process with installation costs included in the building works program. Lease arrangements will be established for all assets supplied.

All ICT hardware is required to meet identified occupational health and safety, infection control and injury prevention standards for clinical service areas. These include cleanable items as keyboards and mice, adjustable height screens, and space saving mountings to enable maximum access to work zones.

7.2 Communication Technology

Communications systems are reflective of requirements in other units on the Canberra Hospital campus. The communication hardware to support the clinical operations of the SMHU includes Voice over the Internet Protocol (VOIP) phones at each designated workstation. There will be access to STD calling function at the main staff station.

There will also be provision for video-conferencing and telehealth capabilities.

A disaster response phone will be provided and located at the main staff station to support disaster response, and enable access to communication technology in the event of disruption to standard VOIP phone services.

The units VOIP phones are also to be equipped with the standard Malicious Caller ID support via the use of the MIC button available on the main screen functions. Docking portable phones will be available for consumers to make local calls.

7.3 Facility Systems

Equipment Tracking and Monitoring

Tracking systems will be available throughout the SMHU to assist in the location and tracking of items. The two options are radio frequency identification (RFID) and location based services.

Safety and Security

There will be a significant requirement for technology to assist with providing a safe and secure environment for consumers, staff and visitors to the SMHU. The following services have significant technology requirements and these will be required to be documented to inform the design of the technology infrastructure. The systems are nurse call, staff duress alarms, CCTV, mobile staff security and auxiliary/back-up power for the unit. Perimeter security requirements will also be developed.

7.4 Data Management Systems

Patient Administration System

The Patient Administration System (PAS) at ACT Health is known as ACTPAS. The function of this software program is to store patient related information and activities for access by clinicians and support staff. Examples include patient name, contact details, General Practitioner (GP) details, locations and episodes of care. In patient areas Ward Clerks will be responsible for entering data into specified fields within this program.

Members from Information Management and Information Technology department will be engaged in the operational commissioning process to ensure the SMHU design meets requirements and to ensure the delivery of services.

7.5 Electronic Mental Health Record

The Electronic Mental Health Record has complete coverage of all aspects of mental health management to ensure accuracy and consistency of the assessments, outcome measures and clinical documentation, and has a direct feed from ACTPAS with patient demographics, bed and ward allocation and allows staff to enter activity data for reporting.

SMHU staff will undertake training and be given passwords and logon details to access this information and then are able to view “real time” activity within the data base

Appendix 1

National Mental Health Standards

NMHS	Title	Descriptor
1	**Rights and Responsibilities**	The rights and responsibilities of people affected by mental health problems and / or mental illness will be upheld by the Secure Mental Health Unit and are documented, prominently displayed, applied and promoted throughout all phases of care.
2	**Safety**	The activities and environment of the Secure Mental Health Facility will be safe for consumers, carers, families, visitors, staff and its community.
3	**Consumer and Carer Participation**	Consumers and carers will be actively involved in the development, planning, delivery and evaluation of care.
4	**Diversity Responsiveness**	The Secure Mental Health Unit will deliver care that takes into account the cultural and social diversity of its consumers and to meet their needs and those of their carers and community throughout all phases of care.
5	**Promotion and Prevention**	The Secure Mental Health Unit will work in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness
6	**Consumers**	Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.
7	**Carers**	The Secure Mental Health Unit will recognise, respect, value and support the importance of carers to the wellbeing, treatment, and recovery of people with a

		mental illness.
8	**Governance, Leadership and Management**	The Secure Mental Health Unit will be governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.
9	**Integration**	The Secure Mental Health Unit will collaborate with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.
10	**Delivery of Care**	10.1 Supporting Recovery The Secure Mental Health Unit will incorporate recovery principles and provides consumers with access or referral to a range of support programs aimed at supporting their recovery. 10.2 Access The Secure Mental Health Unit will be accessible to the individual who requires specialist care and will meet the needs of its community in a timely manner. 10.3 Entry The entry process to the Secure Mental Health Unit will meet the needs of its community and facilitate timeliness of entry and ongoing assessment. 10.4 Assessment and Review Consumers will receive a comprehensive, timely and accurate assessment and a regular review of progress will be provided to the consumer and their carer(s). 10.5 Treatment and Support

		The Secure Mental Health Unit will provide access to a range of evidence based treatments and facilitate access to rehabilitation and support programs which address the specific needs of its consumers and promote their recovery. 10.6 Exit and Re-Entry The Secure Mental Health Unit will assist consumers to exit the service and ensures re-entry to mental health services according to the consumer's needs.

Appendix 2

The meaning of mental illness for the admission is also the same as the Mental Health Treatment and Care Act 1994.

Mental Illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in 1 or more areas of thought, mood, volition, perception, orientation or memory, and is characterised by:

- The presence of at least 1 of the following symptoms:
  - Delusions
  - Hallucinations
  - Serious disorders of streams of thought
  - Serious disorders of thought form
  - Serious disturbance of mood

Or

- Sustained or repeated irrational behaviour that may be taken to indicate the presence of at least 1 of the symptoms mentioned above

A person will **not** be regarded as having a mental illness because of any of the following:

- The person expresses or refuses to express, or has expressed or has refused or failed to express, a particular:
  - political opinion or belief
  - religious opinion or belief
  - philosophy
  - sexual preference or orientation
  - political activity

- The person engages in or has engaged in:
  - sexual promiscuity
  - immoral conduct
  - illegal conduct
  - antisocial behaviour

- The person takes or has taken alcohol or any other drug

As per Mock-up MH(T&C) Act 1994: Chapter 2; ***10 (a) to (b); 11 (a) to (k)***

Canberra Hospital and Health Services Operational Procedure

Dhulwa Mental Health Unit (DMHU) - Referral, Admission and Transfer of Care

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Purpose

The purpose of this procedure is to provide staff with information regarding processes for referral and admission to the Dhulwa Mental Health Unit (DMHU) for both acute or rehabilitative care and transfer of care from the DMHU.

Scope

This procedure pertains to people who are being referred or admitted to the DMHU.

This document applies to all staff working with people who are being considered for referral to the DMHU. It also applies to staff involved in admission processes for newly admitted consumers or DMHU consumers whose care is being transferred to other health services.

This can include:
- DMHU Clinical staff
- DMHU Administrative staff
- DMHU Security staff
- Division of Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) staff who may refer people to the DMHU

Section 1 – Referral Processes for the Dhulwa Mental Health Unit

A consumer will access the DMHU by referral to the Assessment and Admissions Panel (AAP) to facilitate an assessment for consideration of admission. Given the limited resource of the DMHU, there will be no process for bypassing this important "gate-keeping function" of the AAP. Although the source of referrals can vary, it is anticipated that the majority will be from one of the following categories:
- Sentenced or remand detainees who require ongoing mental health care and treatment and who due to legal status, require this to be delivered within conditions of a secure mental health unit.
- Criminal Courts following assessment by mental health staff, including private psychiatrists and made subject to provisions of the forensic sections of the *Mental Health Act 2015*.
- People in Adult Mental Health Services e.g. high dependency units who require admission to secure care.

The referral to the DMHU will be initiated by completing the "*MDTR ISBAR Clinical Handover referral template*" on the clinical record (MDTR - Multidisciplinary Team Review and ISBAR – Introduction, Situation, Background, Assessment and Recommendation). A sample of the content required can be seen in Attachment 4. For any queries regarding the completion of

the Referral form or of the AAP process please contact the Clinical Director of Forensic Mental Health Services.

An access assessment cannot be undertaken without the MDTR ISBAR Clinical Handover referral template being fully completed, unless the urgency of the referral cannot allow for this to be completed. If the referral is urgent, please contact the Clinical Director of Forensic Mental Health Services so that an urgent AAP review can be arranged.

1.1 Assessment and Admission Panel (AAP)
The panel will meet to review applications for assessment and admission, as well as appeals, from a referring team.

The panel members will include the following (or delegates):
- Forensic Mental Health Services Clinical Director
- DMHU Assistant Director of Nursing (ADON)
- DMHU Therapy Manager
- Forensic Mental Health Services Senior Manager
- DMHU Consultant Psychiatrist (non-treating)

The AAP will ensure that the DMHU remains true to its core purpose and that this is reinforced through the referrals it accepts for admission. It is acknowledged that the DMHU is a low volume and high cost service and as such, a robust and transparent process will govern the admission of all people to the service. The AAP will ensure the appropriate use of the DMHU and that people are placed in the least restrictive care environment, appropriate to their identified risk, whilst considering the need for public safety. The AAP will serve as a single point of access but will not only serve to determine if a referred consumer requires care under conditions of security, but will also serve to consider and inform decisions about moving existing people through mental health services.

The AAP will use the Dangerousness Understanding, Recovery and Urgency Manual Quartet (DUNDRUM) which is a four part, validated structured professional judgment instrument for admission triage, urgency, treatment completion and recovery assessments. The DUNDRUM is recognised for its consistency and transparency in decision making in a secure mental health setting.

The purpose of the triage security items (DUNDRUM 1) is to structure the decision making process when deciding what the appropriate level of therapeutic security might be for a consumer. The purpose of the urgency items (DUNDRUM 2) is to provide a structure for deciding who on a waiting list for admission to a given level of security is the most urgent. The purpose of program completion (DUNDRUM 3) is to rate progress in relation to treatment programs. Recovery items (DUNDRUM 4) assists decision making when reviewing levels of therapeutic security along the recovery pathway.

The AAP will review the Access Assessment report and rank each item of DUNDRUM 1 – Triage security items and DUNDRUM 2 – Urgency Items. DUNDRUM 3 – Program completion and DUNDRUM 4 – Recovery items should also be ranked by the AAP.

As the DUNDRUM is not intended to be a guide to the risk of future violence it will be used in conjunction with the Historical Clinical Risk Management-20 (HCR-20^{v3}), a comprehensive set of professional guidelines for the assessment and management of violence risk.

The AAP will review the Access Assessment report and consider:

- Whether the admission criteria have been met;
- Whether the consumer should be admitted to the DMHU or whether a less restrictive option should be attempted;
- What level of security is required;
- How urgent the admission is;
- What are the initial assessment and treatment needs;
- The mix of people currently admitted to the DMHU;
- The triaged need of those already awaiting admission;
- The capacity for rehabilitation of the individual: this may not be able to be fully assessed due to presenting issues including, but not limited to, acuity, substance abuse, homelessness or disorganised behaviour.

As a consequence, referral may be accepted with a view to further assessment developing a rehabilitation plan once these presenting issues have been managed in the initial period of the admission. Alternative options for care and treatment within the ACT – this may include making recommendations to the current treating team around alternative or additional interventions.

Please refer to the following attachments for flowcharts of the Referral Pathways:

- Attachment 1 – Referral Pathway – Acute Care – Lomandra
- Attachment 2 – Referral Pathway – Rehabilitative Care – Cassia and Malee

1.2 Acceptance Criteria for Referrals to the DMHU

Individuals will be considered for admission on the following criteria (refer to Attachment 3 for the Acceptance Criteria Decision tree):

a) Experiences a mental illness as defined in the *Mental Health Act 2015* which is of a nature and/or degree warranting involuntary admission to hospital under the *Mental Health Act 2015* **OR** requires assessment to determine the presence of a mental illness
AND
b) Requires secure care as a current detainee of a correctional facility **OR** requires a period of secure care following being found Not Guilty by reason of Mental Illness (NGMI) for a serious indictable offence **OR** presents a risk of significant and likely harm to others such that the management of the risk requires secure inpatient care, specialist risk management procedures and specialist treatment interventions
AND
c) Requires a high level of physical, procedural and or therapeutic relational security to manage their risk of harm to others (includes public safety) **OR** the consumer cannot be

safely managed in conditions of lesser restrictions **OR** the consumer may present a significant risk of escape from an alternative facility that could be expected to lead to an increased risk of harm.

AND

d) Has the potential to benefit from the treatment/assessment provided **OR** the treatment provided is likely to prevent deterioration that could be expected to lead to an increased risk of harm.

1.3 Exclusion Criteria for Referrals to the DMHU

Individuals will not be considered for admission based on the following criteria:

- Individuals at risk of harm to others but who do not experience a moderate to severe mental illness requiring inpatient care;
- Individuals with mental illness who are unlikely to pose a risk of significant harm to others in the context of appropriate treatment in a less restrictive environment, except where the consumer is subject to Conditions of Release following a finding of NGMI;
- Individuals who present with disturbed or challenging behaviour involving violent and aggressive behaviours (as distinct from dangerous behaviour) during acute episodes of mental illness, which are likely to be relatively brief and/or responsive to generic intensive mental health treatment;
- If the predominant risk is of self-harm, except in the case of consumers with a correctional status who may not be able to be treated in a less restrictive environment due to security requirements.

1.4 Timeframe for the Referral process

For urgent referrals, the following time frame can be anticipated:

- An initial verbal response regarding appropriateness of the referral should be made within 24 hours of receipt;
- An access assessment should be conducted within seven days;
- The outcome should be verbally notified within 24 hours of the assessment;
- A formal written assessment should follow within seven working days;
- Although it is likely to be the exception, in some cases where there is overwhelming evidence, within the referral and associated documents, that the individual requires urgent admission under conditions of security, but where it is not possible to conduct a timely face-to-face assessment. In these circumstances the access assessment may be conducted using the available clinical information.

For non-urgent referrals, the following time frame can be anticipated:

- Initial response on whether a multidisciplinary access assessment is appropriate within seven working days;
- Access Assessment conducted within two weeks;
- Formal written advice, including recommendations for alternative management in the event that an admission to DMHU is not supported, within two weeks post-assessment

Note:
All correspondence regarding progress or outcome of a referral will be conducted by a member of the AAP.

1.5 Access Assessment and Report Requirements

Completed referrals will in the first instance be reviewed by the AAP. Following this, an assessment team comprising of a DMHU Psychiatrist (or psychiatry registrar) and a DMHU allied health clinician will be allocated to carry out an Access Assessment. Within the principles of "nothing about me without me", the Access Assessment will seek to put the consumer at the centre of their care. The consumer and, if they have one, their nominated person should be made aware by their current treating team that an Access Assessment has been requested from the DMHU.

The Access Assessment team will endeavour to give the consumer (and nominated person and/or guardian, if relevant) appropriate advance notice of their assessment visit, including explaining the purpose of the assessment. Once the assessment has been completed, the Access Assessment team may communicate an initial opinion to the consumer. However, the final decision can only be made by the AAP and the assessing team will inform the consumer when the decision is likely to be made and how that decision will be communicated to them. The Access Assessment team will endeavour to seek the views of carers, nominated persons, and family during the assessment process.

The process of access assessment will ensure:

- A single point of access to co-ordinate the referrals and associated paperwork;
- Multi-disciplinary involvement in the access assessment;
- A standardised assessment process;
- An opportunity for the referrer to participate in the AAP meeting, if required;
- Transparency around decision-making;
- A quick response to referrals to ensure that assessments and potential admission can occur in a timely manner;
- The transparency of waiting lists for admission based on the Dangerousness Understanding, Recovery and Urgency Manual (DUNDRUM) structured professional judgement instruments for admission triage and urgency.

The Access Assessment team will provide a comprehensive report to the AAP and the referrer. The assessment report will contain as a minimum, details relating to:

- Consumer demographics
- Current clinical presentation
- Legal status
- Relevant personal, family and developmental history
- Relevant medical and past psychiatric history
- Current medication
- Substance misuse history
- Antecedent offending history
- Current risk issues

- Identified care and treatment needs
- Clear recommendation of the least restrictive care environment
- Proposed care and treatment plan
- Timescale for admission (if applicable)
- Any further recommendations if admission is not supported

The Access Assessment will seek to answer four key questions:

1. **Should the consumer be admitted to hospital?**
    a. Does the consumer meet the statutory requirements of the *Mental Health Act 2015*?
    b. What are the (provisional) diagnoses?
    c. Can these illnesses be treated effectively and safely in the current setting?
    d. Is there more effective treatment available in the DMHU?
    e. Is that treatment likely to be effective for this particular consumer and are they likely to engage?
    f. Will there be any potential increase in risks to the individual associated with admission to the DMHU?
2. **What level of security is required?**
    a. RECENT RISK BEHAVIOURS
        a. Violence
            1. Seriousness
                - Risk of serious harm
                - Use of weapons
                - Evidence of planning/premeditation/revenge
                - Evidence of excessive violence/sadism/torture
            2. Imminence, including whether mental state and situation now are the same as at the time of previous violence
        b. Fire setting
            1. Seriousness
            2. Imminence
        c. Sexually inappropriate behaviour
            1. Contact/non-contact
            2. Relationship to mental health
        d. Self harm
            1. Seriousness
            2. Imminence
    b. PAST RISK BEHAVIOURS
        i. Violence
        ii. Sexual violence
        iii. Subversive behaviour
        iv. Absconding/escaping
        v. Drug use
        vi. Fire setting
        vii. Self harm
        viii. Self neglect
        ix. Coercive behaviour

Note: The AAP will review Riskman clinical incident reports and clinical documentation regarding past risk behaviours of the consumer.

c. VICTIM ISSUES
    i. Note any individuals at risk, or types of individuals at risk
    ii. What is the immediacy of risk to these individuals (in the event of escape for example)
d. PUBLICITY/PUBLIC CONFIDENCE ISSUES
    i. Media profile of individual or nature of (alleged) offence
e. LEGAL STATUS
    i. Remand or sentenced
    ii. Prospective release date
    iii. Current Mental Health Act Status
    iv. Current charge(s) or offence(s)

The assessment will in particular consider the frequency of each behaviour, the relationship of behaviour to mental health and the setting in which each has occurred, especially noting previous periods of hospitalisation at a specified security level.

3. How urgent is the admission?

i. Severity of current mental illness
ii. Stability of current mental illness
iii. Degree of treatability in current setting
iv. Immediacy of risk any significant risk of harm to self or others
v. Risk of absconding or escape from current placement
vi. Current physical health, including dietary intake
vii. Legal requirements (release date approaching, court order already in place)

4. What are the initial assessment / treatment needs?

i. Overall initial objective of admission, immediate needs and initial treatment pathway plan;
ii. Initial pharmacological treatment needs;
iii. Initial nursing observations and supervision needs;
iv. Other specific initial risk management measures;
v. Security needs;
vi. Adult protection/vulnerable adult issues;
vii. Child protection issues;
viii. Initial visitors to be approved (or specifically excluded);
ix. Any necessary restrictions on telephone/internet use;
x. Communication needs;
xi. Cultural / Faith / Diversity needs;
xii. Dietary needs;
xiii. Physical health needs;

xiv. Consumer's choice about the geographical location of hospital e.g. close to home (when possible);
xv. Potential discharge/transfer of care routes.

It is acknowledged that each referral is unique and the receiving clinical team at the DMHU will determine the urgency of the referral on receipt. Discussions between the referrer, assessing clinicians and case managers may be required.

1.6 Appeals Process

It is anticipated that there may be occasions when the referring team does not agree with the decision of the AAP. An appeals process will be followed to ensure that consideration has been given to the needs of all. As with any appeals process, local resolution should first be sought in all cases, initially by contacting the Clinical Director of Forensic Mental Health Services by phone or email.

To enable this process the DMHU assessing team should provide a detailed assessment and treatment options. The referring team should discuss the assessment and options suggested with the AAP. Any differences at this stage should be managed by case review and inter-team discussion on care and treatment issues. If following the appeal process the parties agree to the admission, the AAP will advise the referring team and admission should progress as usual.

If disagreement regarding admission remains then the AAP will formally offer the appeals process:

- If the AAP offers the appeals process, the AAP must notify the Clinical Director of Forensic Mental Health Services and the Operational Director of Justice Health Services in writing, with copies of all reports.
- The Clinical Director of Forensic Mental Health Services and the Operational Director of Justice Health Services may invite another assessing team to provide an assessment (with or without treatment advice).
- This second assessment will be discussed between all involved, usually at a case conference. If agreement is given for admission to the DMHU then the admission will progress as normal.
- If the second assessment team also do not agree with the need for admission to the DMHU, then that will be the end of the process and the consumer will not be admitted to DMHU. There will be a joint meeting held to ensure that lessons can be learnt in terms of developing better process control chaired by the Operational Director Justice Health Services.
- If the referring team remains concerned, the concerns can be referred to the Chief Psychiatrist for arbitration.

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Section 2 – Admission

All admissions to the DMHU will be planned and as such, all admissions should take place in the mornings when the greatest numbers of staff are available. No admission should be accepted after 1530 hours (unless the urgency of the admission dictates that this must happen on the grounds of risk and clinical need). Admissions should ideally take place at the beginning rather than the end of the week. This provides access to more Multidisciplinary Team (MDT) staff and the first week of admission assessments can be conducted. It also allows access to services that are only open weekdays such as Centrelink, housing services, etc.

Based on the Access Assessment the formulation of the initial risk management plan (Treatment, Placement, Restrictions, Implementation, Monitoring and Review - TPRIM) for the first 48 hours including Security Classification and Leave Entitlement (SCALE) will be completed by the Primary Nurse in consultation with the MDT and the consumer where possible. This will be documented in the clinical record and communicated through handover to the MDT prior to the admission.

Following a decision to admit by the AAP, admission to the DMHU will be arranged with the referring team and the consumer notified of the plan to admit them to DMHU. With the consumer's consent, any family/ carer should be notified of the plan (note that the date and time of admission may be withheld for security reasons on a case by case basis).

Fagerstrom test will be conducted by the referring agency where possible, and Nicotine Replacement Therapy (NRT) will be commenced, where applicable as per the MHJHADS Clinical Guideline for Managing Nicotine Dependence.

Where possible, the consumer will be provided with a Welcome to DMHU handbook and other resources that contain the following information:

- A clear description of the aims of the DMHU
- admission goals to be achieved prior to transfer of care
- The current programs and types of treatment/interventions available
- Written information on the consumer's rights and responsibilities
- Visiting arrangements
- Personal safety on the unit
- Unit facilities including use of the personal entertainment system
- A list of items deemed to be contraband or restricted requiring approval on the unit
- A list of practical items that may be needed within the unit that may be brought with them
- The Recovery Planning process
- The feedback process
- Legal information regarding the *Mental Health Act 2015*, ACT Civil and Administrative Tribunal (ACAT), the courts, etc

This information will form part of the orientation to the unit after admission assessments and security requirements are completed.

2.1 Day of Admission

Prior to the arrival of the consumer, admitting staff should have read and familiarised themselves with the Access Assessment and any recommendations made by the AAP. Security staff will be notified in advance of the expected arrival time by the ADON and the identity of the consumer to be admitted.

All new admissions will be expected to be attended by a clinician from the referring team.

On arrival at the DMHU and once satisfied the escort is legitimate, security officers will permit the vehicle entry to the Secure Vehicle Entry (SVE). Thus all new admissions will arrive and be brought onto the unit via the SVE. The SVE must be fully closed before the consumer can be permitted to exit the transporting vehicle. Security will immediately advise the Clinical Escort Team (comprising of five control and restraint trained clinicians) of the arrival of the consumer being admitted and the Clinical Escort Team will attend. If necessary, additional clinical and/or security staff may be requested to assist with the admission and escort onto the unit. If the consumer is a consumer with correctional status, please refer to the DMHU Transfer of Custody procedure.

Prior to entry to the unit the following processes will be followed:

- Property search
- Biometric scanning registration
- A personal search will be conducted prior to the consumer entering the common areas of the unit;

In rare circumstances, it is anticipated that the clinical needs of the consumer might prevent the relevant registration being completed at the time of admission, for example in the case of extreme behavioural disturbance. In such cases, the registration must be completed as soon as possible after arrival.

2.1.1 Clinical Handover

Clinical Handover will be provided by a representative of the referring team at admission, if possible, this should be confirmed prior to admission. The handover will follow the ISBAR (Introduction, Situation, Background, Assessment and Recommendation) format as per the MHJHADS Clinical Handover Procedure. The handover should be done in person, by the person accompanying the consumer and should be documented in the clinical record. If possible, the consumer should be involved in the handover.

2.1.2 Admission Assessment

Following a consumer's arrival to the DMHU the following will be completed:

- Standardised clinical handover (ISBAR) from the referring team to the DMHU treating team, involving the consumer as appropriate
- An interim Risk Management Plan (TPRIM) will be developed prior to the admission during the Access Assessment

- Initial assessments are to be done by the Psychiatric Registrar and the primary nurse, in consultation with the Clinical Nurse Consultant (CNC). The following assessments are required within the first 24 hours:
  - Physical Health assessment including blood investigations, urine drug screen, electrocardiogram (ECG) and midstream urine screen.
  - Formulation of the initial individual care plans for the first 48 hours such as the Nursing Assessment
  - Security Category and Leave Entitlement (SCALE) (refer to DMHU Leave procedure)
  - Physical Appearance
  - Observation Requirements
  - Suicide vulnerability assessment tool (SVAT)
  - Short Term Assessment of Treatability and Risk (START)
  - Personal safety planning
  - Aboriginal and Torres Strait Islander Assessment
  - Cultural Assessment

2.1.3 Orientation and Arrival on the unit

Clinical staff will escort the consumer into the DMHU, and will assume responsibility for the orientation of the consumer onto the DMHU. In the case of a consumer with a correctional status, the DMHU will assume legal custody of the individual on signature of the Transfer of custody section of the Request to Transfer a consumer between a correctional facility or place of detention and DMHU Form (s. 144A *Mental Health Act 2015*—Transfer of Custody—Secure Mental Health Unit). See Transfer of Custody Procedure. Once the consumer has exited the SVE and is within the secure area of the DMHU, security staff may allow the vehicle to depart the SVE.

In the case of a consumer identifying as Aboriginal and Torres Strait Islander the consumer will be given the option of having the DMHU Aboriginal Liaison Officer (ALO) participating in their orientation to the unit.

Note: The orientation will usually occur after the admission assessment and security requirements are completed such as registration on the biometric scanning system photo taken for identification purposes search etc.

2.2 Assessment – Within one week of Admission

The Admission to the unit requires comprehensive assessment by the MDT in collaboration with the consumer and carer, if relevant.

The following assessments are considered necessary within the first week of admission:

- National Outcome and Casemix Collection tools (NOCC)
  - Basis 32 and the Health of the Nation Outcome Scale (HoNOS) Secure – by the Primary Nurse
- Interests assessment
  - Camberwell Assessment for Need Forensic Version (CANFOR) – by the Occupational Therapist

- Psychosocial needs assessment
    - By the Social Worker/Allied Health Clinician
- Schedule of Family/Carer Contact/Welcome Meeting
- DUNDRUM 3, if not already completed by AAP.

2.3 Comprehensive Multidisciplinary Assessment

The comprehensive multidisciplinary assessment is to be presented at the consumer's first individual case review. Individual Case Reviews will then be conducted every three months.

The time frame for an initial Individual Case Review for consumers admitted for rehabilitation will be within six to eight weeks of admission and within two weeks for consumers admitted for acute care only and not expected to be transferred to a rehabilitation ward. Carers, families and nominated persons should be encouraged to attend case reviews.

The multidisciplinary assessments required for the Initial Individual Case Review will aim to include the following:

- Review of Individual Care Plan, including TPRIM
- Review of Personal Safety Plan
- Nursing Summary
- Physical Health investigation summary
- Clinical Risk Assessment and Management (CRAM) review
- DUNDRUM review
- SCALE review
- Occupational Therapy Assessment and any occupational therapy assessments or intervention plans
- Psychology Assessment and any psychological assessment or intervention plans
- Social Work Assessment and any social work assessments or intervention plans.
- Any other relevant assessments (e.g., neuropsychology, art therapy, education etc.)
- Mandatory Outcome scores or progress graphs (Basis-32, HONOS-Secure)
- Recovery Plan
- Preliminary Discharge/Transfer of Care Plan

2.4 MDT Ward Rounds

The care and treatment of each consumer will be based on a multidisciplinary approach and all multidisciplinary activity will be recorded in the clinical record and reviewed each week at the MDT Ward Round, to which the consumer will be invited and encouraged to attend at the time when their case is being discussed. A selection of consumers will be reviewed each week at these meetings. A record of the clinical discussion will be documented in the relevant clinical record.

The purpose of the weekly MDT Ward Round shall include, but is not limited to:

- A review of the current treatment – Biological, Psychological and Social
- Review of TPRIM including current bio psycho social treatment and medication regime
- A review of the consumer's mental state and recent behaviour

- Update on legal proceedings, where applicable
- Review of the consumer's strengths, skills and area/s of need (i.e. physical needs, functional capacity, activities of daily living, interpersonal supports, co-morbidities and psychological assessment)
- Reviewing and updating nursing care plans (part of the TPRIM)
- A review of any physical health needs
- Updates on consumer engagement and progress
- Proposed leave submissions to the DMHU Leave Panel, progress of approved leave and review of leave taken
- Planning for how a consumer's goals might be addressed during the admission (e.g. develop skills in activities of daily living, establish social supports and networks, skills to manage any physical co-morbidity, develop coping skills and resilience)
- Reviewing and updating any risk issues on the risk management plan, including identification and review of triggers, early warning signs and personal safety planning.
- Initial planning for the consumer's discharge/transfer of care

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Section 3 – Discharge Planning

3.1 Discharge Planning

Effective discharge planning from the DMHU, including return to a correctional facility, aims to promote continuity of care and a seamless transition for the consumer within the health system and across services.

Discharge planning will start from the time the consumer is first admitted into the DMHU and will be routinely discussed throughout the recovery planning and the case review process. It is expected that the receiving/post discharge team is identified as early as possible along the treatment pathway and the attendance of a representative at the three monthly case review meetings for each consumer will be encouraged. This serves not only to inform the receiving team of the consumer's progress, but also serves to develop rapport between the consumer and their primary team and to instil in the consumer a sense of working towards a discharge plan from early on in their admission.

Discharge planning will require regular liaison with the consumer, their primary mental health clinician, transition clinician, family, carer and nominated person, General Practitioners (GP) and medical specialists, community sector agencies and other relevant supports. As part of discharge planning, the expectations and required outcomes in order to achieve discharge should be negotiated with the consumer, their families and carers, and any other support services or networks.

Prior to discharge, the consumer will be involved in discharge meetings, held with all relevant stakeholders to facilitate transition into the community and other services. A clear plan will be formulated with the consumer, outlining the role of each of the services engaged. A written plan for discharge with relevant supports and contacts will be documented.

Therapeutic leave to the post-discharge accommodation and supported transition arrangements will assist people to discharge safely and successfully from the DMHU.

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Section 4 – Transfer of Care to other services

4.1 Transfer of Care

Transfer of care is a structured, standardised process for ensuring the safe, efficient and effective transition of people with a mental illness between inpatient settings and from hospital to the community or from hospital to a correctional facility. Transfer of care is part of the continuum of care that starts with the consumer's admission to the DMHU.

The following steps should be followed for all consumer types. When following these generic steps there may be additional specific requirements for particular consumer groups depending on their legal status or identified risks:

- The MDT should ensure that the consumer and his/her family and/or carer and/or nominated person are involved in transfer planning and are kept informed of the consumer's expected transfer of care dates and times (if appropriate)
- The MDT must conduct regular reviews of the consumer and document those reviews and outcomes in the clinical record.
- Identify and contact the health facility and community support providers, for example, a consultant psychiatrist from the Adult Mental Health Unit, Forensic Mental Health Senior Manager, Clinical Manager, GP, or Non-Government Organisation (NGO) care provider.

In collaboration with the receiving health service, the consumer, their legal guardian and, where appropriate family and/or carers and/or nominated persons, the MDT must develop a transfer of care plan detailing:

- management plan (including wellness strategies),
- key referral services and programs (e.g. Detention Exit Community Outreach - DECO, Housing and Accommodation Support Initiative - HASI),
- medical and community or other support follow-up arrangements,
- emergency contact numbers,
- contingency and relapse response plans and
- security considerations.

If the consumer was homeless prior to their admission to DMHU or the consumer would otherwise be homeless on release from the DMHU, then the Primary Nurse must consult with the DMHU social worker. This needs to be identified and actioned on admission. A consumer who has been detained involuntarily in the DMHU must have appropriate and stable accommodation arranged prior to release to the community.

4.2 Transfer of care from the DMHU to an ACT Mental Health Facility

Note: For consumer transfer to an ACT Health Facility due to Emergency or Planned Medical Treatment, please refer to the DMHU Leave Procedure.

The transfer of a consumer to another ACT Mental Health Facility can be a daunting experience for the consumer and every effort must be made to ease this process.

Transfer of care from the DMHU to another ACT Health Mental Health facility may occur when the consumer requires ongoing inpatient treatment, but is no longer deemed to require secure care and can be effectively managed in conditions of less restriction. In this case, the ADON or Consultant Psychiatrist of the DMHU liaises with the ADON, or equivalent, of the receiving unit to negotiate a date and time for transfer.

The transfer of a consumer with forensic mental health orders from the DMHU to another ACT Mental Health Facility will require an appropriate order from the relevant authority approved to authorise the transfer. In most cases, this will be the ACAT or the Chief Psychiatrist dependent on who made the initial order for the consumer to be detained, as per the *Mental Health Act 2015*.

The transfer of a consumer with correctional status from the DMHU to another ACT Mental Health Facility may be required in exceptional circumstances. In this case, the Forensic Mental Health Clinical Director is required to seek approval from the Director General of ACT Corrective Services (ACTCS), or delegate, or the Director General Children and Young People (CYP), in the case of a young person in addition to any negotiation with the receiving unit. ACTCS or Bimberi Youth Justice Centre (BYJC) Youth Workers will assume custody of the consumer upon the consumer leaving the DMHU and will maintain custody whilst the consumer remains at the receiving inpatient unit.

The decision to transfer a consumer to another ACT Mental Health Facility will be agreed at a MDT Ward Round/Case Review Meeting by the MDT. Following this, an application will be made to the AAP. Where appropriate, family and/or carers and/or nominated persons should be made aware of the plan to transfer and invited to attend the MDT Ward Round /Case Review meeting. The MDT must consider in its decision-making the type of facility to which the consumer could be transferred and the level of supervision or security that would be appropriate to manage the consumer's level of risk in that setting.

In the case of a consumer on a forensic mental health order (FMHO), and regardless of any legal obligation requiring approval for transfer from the ACAT, following approval by the AAP of a request to transfer, the MDT will prepare a report for the ACAT detailing the reason for the transfer and include a comprehensive risk assessment and management plan in the planned placement. In the case of a consumer detained by the ACAT, approval from the ACAT must occur before the consumer can be transferred.

Following approval by the AAP (and ACAT in the case of a consumer on a FMHO), transfer planning commences, including:

- MDTR ISBAR Clinical Handover referral template completed and message sent to team that the consumer is being referred and transferred to on the clinical record, however, if the facility is not a mental health facility then the relevant referral form should be used for the ACT Health facility.
- Negotiating the date and time of transfer with the receiving unit and in consultation with the Alexander Maconochie Centre (AMC) or BYJC where appropriate (see above).
- Advising the consumer of the planned transfer and of the likely date (except in the case of consumers with custodial status).
- Inventory of consumer's property and arrangements for transfer of property to the receiving unit or to a nominated person if required.
- Transfer of any funds in DMHU trust to the consumer's private account.
- The consumer's family, carer and nominated person are also informed and provided with contact details for the receiving unit.

In the case of a consumer with correctional status, a *Request to Transfer a Correctional Detainee to Hospital* and *ACT Health Brief Risk Assessment* form must be completed by the Nurse in Charge (NIC) and submitted to the ACTCS or CYP Director General (or delegate). The Director General, ACTCS or CYP, reserves the right to refuse any request to transfer a consumer with correctional status to a hospital (*s. 54 Corrections Management Act 2007 or s.109 Children and Young People Act 2008*).

On the day of transfer, it is the responsibility of the NIC to ensure that the transfer checklist is completed, that all relevant requests and approvals have been submitted, and that appropriate liaison with the receiving team has occurred. The number of security officers or clinical staff required (as per SCALE rating) to transport the consumer will have been determined in advance by the AAP. Regardless of this, the consumer's Primary Nurse or another key nurse allocated by the NIC will be expected to accompany the consumer being transferred to the receiving unit to conduct the appropriate clinical handover. In the case of consumer with correctional status, the Primary Nurse will be expected to meet the transporting AMC or BYJC staff at the unit and provide liaison between AMC/BYJC and ACT Mental Health staff at the unit. (Refer to DMHU Transfer of Custody procedure)

Visits by members of the receiving team to the consumer at the DMHU will be encouraged prior to transfer and, where appropriate, a visit, or series of visits, by the consumer to the receiving unit will be made to introduce the consumer to the new treating team and allow for any questions either party may have.

4.3 Transfer of care to a Community Mental Health Service

The transfer of a consumer to the community and under the care of a community mental health team can be a daunting experience for the consumer and every effort must be made to ease this process.

In most cases, transfer of care from the DMHU will be to the Forensic Community Mental Health team when the consumer no longer requires ongoing inpatient treatment.

The transfer of a consumer on a FMHO from the DMHU to the community will require an appropriate order from the relevant authority approved to authorise the transfer. In most cases, this will be the ACAT or the Chief Psychiatrist dependent on who made the initial order for the consumer to be detained, as per the *Mental Health Act 2015*.

The decision to transfer a consumer to a community mental health service will be agreed at a MDT Ward Round /Case Review Meeting by the MDT and following this an application made to the AAP. Where appropriate, family and/or carers and/or nominated person should be made aware of the plan to transfer and invited to attend the MDT Ward Round /Case Review meeting. The MDT must consider in its decision-making the context to which the consumer could be transferred and the level of supervision or monitoring and restrictions that would be appropriate to manage the consumer's level of risk in that setting.

In the case of a consumer of forensic mental health orders, and regardless of any legal obligation requiring approval for transfer from the ACAT, following approval by the AAP of a request to transfer, the MDT will prepare a report for the ACAT detailing the reason for the transfer and including a comprehensive risk assessment and management plan in the planned placement. In the case of a consumer detained by the ACAT, approval from the ACAT must occur before the consumer can be discharged.

Following approval by the AAP (and ACAT in the case of a Forensic consumer), transfer planning commences, including;

- MDTR ISBAR Clinical Handover referral template completed and message sent to team that the consumer is being referred and transferred to on the clinical record
- Negotiating the date and time of discharge with the community mental health team and in consultation with ACTCS/CYP where appropriate (for example, bail or parole).
- Inviting the Community Mental Health team to participate in discharge planning (refer to Section 3.1)
- Advising the consumer of the planned discharge and of the likely date
- Inventory of consumer's property and arrangements for transfer of property to the consumer or to a nominated person if required.
- Transfer of any funds in DMHU trust to the consumer's private account.
- The consumer's family and carer and nominated person are also informed and provided with contact details for the community team.

On the day of transfer, it is the responsibility of the NIC to ensure that the transfer checklist is completed, that all relevant requests and approvals have been submitted, and that appropriate liaison with the receiving team has occurred.

In some cases, the MDT and AAP may choose to reserve a bed at the DMHU for a determined period of time for the consumer, in case of readmission to DMHU.

Visits by members of the community mental health team to the consumer at the DMHU will be encouraged prior to transfer and, where appropriate, a visit, or series of visits, by the consumer to the community team will be made to introduce the consumer to the new treating team and allow for any questions either party may have. The primary nurse would

also attend the community mental health team case reviews, following discharge from the DMHU for a mutually agreed time period with the clinical teams and the consumer.

4.4 Transfer of care to Alexander Maconochie Centre (AMC) or Bimberi Youth Justice Centre (BYJC)

The return of a consumer to a correctional facility, or place of detention, can be a daunting experience for the consumer and every effort must be made to ease this process. Prior to returning a consumer to custody, the mental health service within the custodial setting should be contacted and invited to attend a transfer meeting where all aspects of the consumers care and treatment will be discussed.

The Corrections Case Manager or Bimberi Youth Worker will also be invited to attend this transfer meeting in order to allow the consumer to familiarise themself with people they will encounter when transferred. It is hoped that this will mitigate some of the difficulties with the transfer. At this meeting, a transfer date should be discussed and if possible finalised. The corrections facility or place of detention must be notified using the *Intention to Discharge a Person to a Detention Facility or Place of Detention Form,* at least 24 hours before the planned discharge to allow them time to make the relevant arrangements to receive the person.

Decisions to transfer consumers from the DMHU to the AMC or BYJC are made by the MDT with approval by the AAP.

Transport arrangements must be made in accordance with the DMHU Transfer of Custody Procedure.

Where the AAP agrees to transfer a consumer with correctional status back to custody the ADON, in consultation with the clinical lead at FMHS AMC and FMHS BYJC must:

- discuss this as soon as possible with the appropriate staff at AMC or BYJC who will determine the placement and transport arrangements,
- provide AMC/BYJC with at least 24 hours notice, using the *Intention to Discharge a Person to a Detention Facility or Place of Detention Form,* of the planned return of the person, and
- negotiate the transfer of care date and time, in accordance with s. 144A(4) *Mental Health Act 2015—Transfer of Custody—Dhulwa Mental Health Unit*).

On the day of transfer, it is the responsibility of the NIC to ensure that the transfer/discharge checklist is completed, that all relevant requests and approvals have been submitted, and that appropriate liaison with the receiving team has occurred.

The family or carer or nominated person is also to be informed of the transfer only after the consumer has arrived at the correctional facility.

4.5 Expiry of a consumer's sentence or release during admission

A consumer admitted to the DMHU, who is on a warrant of remand or imprisonment, may be released directly from DMHU as a result of:

- the expiry of the consumer's sentence during the admission to DMHU,

- the release of the consumer on parole,
- an order of the ACAT or the Court, or
- the release of the consumer on bail.

Transfer in the case of the points above will usually be able to be planned in accordance with Section 4.2 and 4.3. Prior to the expiry of a consumer's sentence or the date of parole, the MDT and AAP must consider whether, following the expiry of the sentence, the consumer is likely to continue to require treatment as an inpatient either voluntarily or involuntarily.

If the consumer is likely to require treatment as an inpatient then review with the MDT and AAP is required to continue admission to DMHU or Section 4.2 is required to be followed if transfer to another ACT Health inpatient facility is required.

4.6 Transition between Acute and Rehabilitation Wards of the DMHU

It is the responsibility of the MDT, on the basis of the individual consumer's clinical need to determine the most appropriate placement of the consumer within the DMHU. Before deciding on moving a consumer between accommodations, a discussion about this must take place at the MDT meeting and then for decision by the AAP.

Any transfer will be arranged involving clear guidance on the time and date. Both accommodation areas will be involved and in agreement and it is likely that the receiving ward will seek to carry out its own evaluation prior to transfer. In particular the receiving rehabilitation ward might seek a gradual and staged transfer with the consumer initially undertaking day visits to the rehabilitation ward as part of a settling in and familiarisation process prior to a full transfer. The receiving rehabilitation ward must formulate a socialisation care plan, which must be transparent to the consumer and the referring team. Any problems encountered during socialisation visits will be discussed in the next MDT meeting.

4.7 Transfer to Interstate Services

If a consumer is being transferred interstate then the following should be followed:

- Refer to section 4.2 for a transfer to an interstate health facility
- Refer to Section 4.3 for a transfer to an interstate community mental health service.

As the consumer will not be accessing ACT mental health services at this time, please refer to MHJHADS Episode of Care Closure procedure.

4.8 Documentation requirements when transferring to another service

The following information is required to be made available to the receiving team when transferring a consumer to another service:

- Cover Letter
- ISBAR as per the MHJHADS Clinical Handover Procedure. If the transfer is between ACT Mental health services an ISBAR file note would be completed, for external to ACT Health transfers a letter would be completed.
- Discharge Summary, including discharge medication information
- ACAT reports for the last 12 months

- Updated Clinical Risk Assessment Management Plan (TPRIM) relevant to the new placement
- Any other relevant assessments (for example, Neuropsychology, Occupational Therapy, risk assessment, etc).

The following documents are to be provided to the consumer, and with consent to their family/ carers/nominated person, and any other relevant supports.

- Discharge plan and discharge summary

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Implementation

The contents of this procedure will be communicated through the following means to DMHU staff and other relevant teams where the procedure applies.

- Education
- Orientation documentation and sessions
- Leadership and governance expectations regarding adherence to policy, procedure and legislation.
- Structured Case review and MDT Ward Rounds that reflect the procedure
- Assessment and Admission Panel Terms of Reference.
- Performance Management plans

Related Policies, Procedures, Guidelines, Frameworks, Standards and Legislation

Policies
ACT Health Work Health and Safety Policy
ACT Health Work Health and Safety Management System
ACT Health Incident Management Policy
ACT Health Consumer and Carer Participation Policy

Procedures
ACT Health Incident Management Procedure
ACT Health Significant Incident Procedure
CHHS Admission/Discharge Procedure – Adults, Pregnant and Neonates
CHHS Clinical Handover Procedure
CHHS Discharge Summary Completion Procedure
CHHS Medication Handling Policy
MHJHADS Assessment and Intervention for People Vulnerable to Suicide Procedure
MHJHADS Clinical Handover Procedure
MHJHADS Clinical Management for Mental Health Services Procedure
MHJHADS Confidentiality, Privacy and Access to MHJHADS Clinical Records
MHJHADS Daily Clinical Meetings in Community Mental Health Settings Procedure

MHJHADS Director on Call Roles and Responsibilities Procedure
MHJHADS Episode of Care Closure Procedure
MHJHADS Patient Outcome Measures
MHJHADS Significant Incidents Reporting Procedure
DMHU Search Clinical Procedure
DMHU Transfer of Custody Procedure
DMHU Clinical Risk Assessment and Management Procedure

Frameworks
DMHU Security Procedural Framework
ACT Health Waste Management Plan

Standards
Australian Charter of Healthcare Rights
National Standards for Mental Health Services 2010
National Safety and Quality Health Service Standards 2012

Legislation
Mental Health Act 2015
Mental Health (Secure Facilities) Act 2016
Children and Young People Act 2008
Public Advocate Act 2005
Human Rights Act 2004
Carers Recognition Act 2010
Health Records (Privacy & Access) Act 1997
Guardianship and Management of Property Act 1991
Crimes Act 1900
Privacy Act 1988
Discrimination Act 1991
Work Health and Safety Act 2011
Corrections Management Act 2007
Official Visitor Act 2012
Territory Records Act 2002
Working with Vulnerable People (Background Checking) Act 2011
Health Act 1993
Workplace Privacy Act 2011
Security Industry Act 2003
Court Procedures Act 2004

Definition of Terms

AAP – Admission and Assessment Panel
ACAT – ACT Civil and Administrative Tribunal
ACTCS – ACT Corrective Services
ADON – Assistant Director of Nursing

ALO – Aboriginal Liaison Officer
AMC – Alexander Maconochie Centre
BYJC – Bimberi Youth Justice Centre
CANFOR - Camberwell Assessment for Need Forensic Version
CNC – Clinical Nurse Consultant
Consumer with a correctional status – refers to people subject to a warrant of remand or imprisonment
CRAM – Clinical Risk Assessment and Management
CYP – Children and Young People
DECO – Detention Exit Community Outreach
DUNDRUM - Dangerousness Understanding, Recovery and Urgency Manual
DMHU – Dhulwa Mental Health Unit
ECG – electrocardiogram
FMHO – Forensic Mental Health Order
GP – General Practitioner
HASI – Housing and Accommodation Support Initiative
HCR-20^{v3} – Historical Clinical Risk
HoNOS Secure – Health of the Nation Outcome Scale Secure
ISBAR - Introduction, Situation, Background, Assessment and Recommendation
MDT – Multidisciplinary Team
NGMI – Not Guilty by reason of Mental Illness
NGO – Non Government Organisation
NIC – Nurse in Charge
NOCC – National Outcome and Casemix Collection Tools
NRT – Nicotine Replacement Therapy
MHJHADS – Mental Health, Justice Health and Alcohol and Drug Services
SCALE - Security Category and Leave Entitlement
START - Short Term Assessment of Treatability and Risk
SVAT - Suicide vulnerability assessment tool
SVE – Secure Vehicle Entry
TPRIM - Treatment, Placement, Restrictions, Implementation, Monitoring and Review

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Search Terms

Admission, Referral, Transfer of Care, Continuity of Care, DMHU, discharge planning, corrections patient, Forensic Mental Health, Dhulwa Mental Health Unit

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Attachments

Attachment 1 – Referral Pathway – Acute Admission
Attachment 2 – Referral Pathway – Rehabilitative Care Admissions through Lomandra
Attachment 3 – Acceptance Criteria – Decision Tree
Attachment 4 – Sample Referral Form

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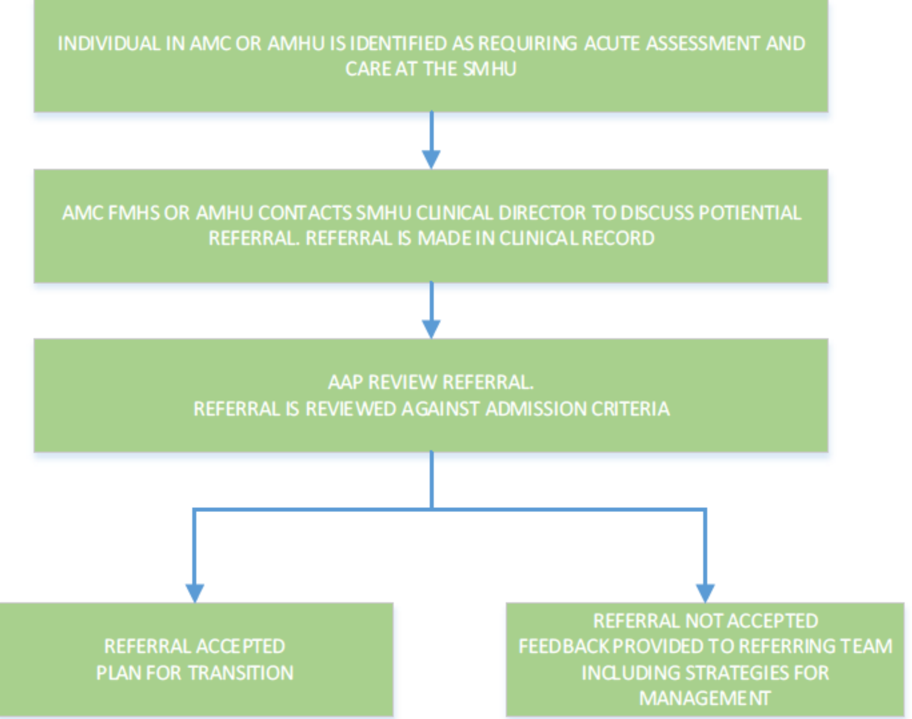
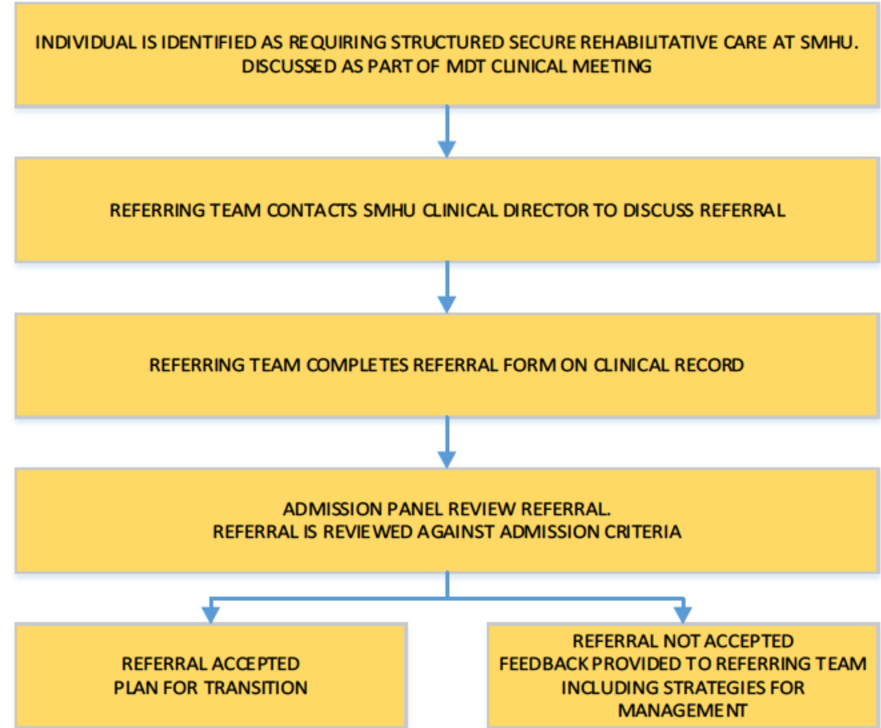
Date Amended	Section Amended	Approved By
Eg: 17 August 2014	*Section 1*	*ED/CHHSPC Chair*

Attachment 1 – Referral Pathway – Acute Admission



Attachment 2 – Referral Pathway – Rehabilitative Care Admissions through Lomandra



Attachment 3 – Acceptance Criteria – Decision Tree

SEVERE MENTAL ILLNESS

- Experiences a mental illness (which is of a nature and/or degree warranting involuntary admission to hospital under the *Mental Health Act 2015*). Mental illness is defined as per the *Mental Health Act 2015; or*
- *Requires assessment to determine the presence of a mental illness;*

AND

FORENSIC NEED

- Requires secure care as a current detainee of a Correctional facility; or
- Requires a period of secure care following being found Not Guilty by reason of Mental Illness (NGMI) for a serious indictable offence; or
- Presents a risk of significant and likely harm to others such that the management of the risk requires secure inpatient care, specialist risk management procedures, and specialist treatment interventions;

RISK ASSESSMENT AND SECURITY NEED (Therapeutic Security)

- Requires a high level of physical, procedural and or relational security to manage their risk of harm to others (includes public safety); or
- The individual cannot be safely managed in conditions of lesser restrictions; or
- The individual may present a significant risk of escape from an alternative facility that could be expected to lead to an increased risk of harm.

TREATABILITY

- Has the potential to benefit from the treatment/assessment provided; or
- The treatment provided is likely to prevent deterioration that could be expected to lead to an increased risk of harm.

An answer must be YES to at least one criteria from each level.
If at any level there are no applicable criteria do not continue further.

Attachment 4 – Sample Referral Form

URN:
Surname: Red Riding Hood
Given name: Little
DOB: 21/06/1979
Gender: Male

MDTR ISBAR Clinical Handover
Multi-Disciplinary Team Review (MDTR) - Referral for your' follow-up as described in plan below.
Introduction:
Age,
Diagnosis
History
Legal status,
known to MHJHADS
Situation:
Current placement
Reason a more restrictive environment is being considered.
Current restrictions in place
Restrictions required
Background:
Relevant history, timescales of note (eg expected release date, PTO expiry date, etc)
Antecedent offending history
Most serious violent offence
Substance use history
Physical obs
Medications
Program completion – briefly comment on group or individual therapy/ interventions and engagement:
Physical Health
Mental Health
Drugs and Alcohol
Problem Behaviours
Self Care and ADLs
Education, Occupation and Creativity
Family and Social Networks
Inpatient incidents/Institutional violence: Dates/summary of incidents.
Assessment:
Mental State Examination
Risk Issues
Recommendation:
Reason for referral/presenting problems
Any other relevant information
Current treatment and Management Plan