PROJECT EVIDENCE

PROJECT EVIDENCE for Continuing Care of Persons with Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[8] Long-term care

a) Residential services

b) Occupational and ancillary supports

[8 a] Residential services

The process of assessment is described in PE4a. Ordinarily, this will occur with the child in its own family environment, but there are occasions when this is not feasible and must take place in an inpatient setting. However, inpatient management is never isolated but always only a phase of the overall treatment process. Inpatient admission separates the child from usual attachments and is a temporary abnormal situation that should only be undertaken for specifiable goals in a setting that is best able to meet those goals.

At all times an essential requirement is for children in residential services is to be safe, free from physical, emotional and sexual abuse. As part of the process to implement such safety there needs to be an independent authority for children and/or their families or carers to be able take complaints and have these heard, assessed and for any appropriate action to be taken to keep them safe.

An additional issue of children's rights to appropriate residential services has been addressed in the 2015 Senate submission by the Australian Psychological Society, regarding the adequacy of residential arrangements for children and young people with severe physical, intellectual and /or mental disabilities. This submission notes the variability of existing arrangements in 2015 and makes recommendations for age appropriate interpersonal relations, personal development, self-determination and social inclusion as well as promoting good quality of life and wellbeing,

Acute management in a child psychiatric inpatient unit was described in PE 6b. However, there is a range of other residential treatment services that may be needed for young persons with mental health disorders whose treatment may not be possible within their families. The range includes child protection, disruptive behaviour disorders, juvenile justice detention and major psychiatric disorders such as psychotic illness.

A properly constituted residential treatment centre should offer a full-time program with treatment by qualified mental health staff and facilities including a high quality school program and recreational activities in addition to the appropriate therapies. The desirable features and method of working is well described in Lewis, M., Summerville, J.W., and Graffagnino, P.N. "Residential Treatment" in Child and Adolescent Psychiatry, (Ed) Melvin Lewis, 3rdEd. (2002), Lippincott, Williams & Wilkins, pp.1095-1100.

In general, it is thought that centres should be in locations readily accessible by families, should be open institutions whenever possible and as similar to normal life settings as practicable. It is recognized that other factors, such as the need for juvenile justice containment, will have a modifying influence on the characteristics of centres. Facilities should be small, seldom exceeding 60 in capacity with 100 a maximum limit and should make provision for children to live in small groups. Private or shared bedrooms, separate showers and bath facilities for boys and girls, communal living rooms and dining rooms, safe and easy access to recreational facilities and classrooms, and therapists' offices close to the group living area are some of the requirements. Units serving specific age groups are preferred.

Success in therapy depends largely by what happens among the professional staff members. Group cohesiveness among the staff improves performance. This is achieved by measures such as: meetings to discuss team process

issues; acquisition of leadership skills; clear lines of authority and role expectations; training programs; total team participation in decisions; and prompt expressions of support, concern, and empathy by the leadership. Resolving communication problems, sharing perceptions and experiences, clarifying transference and countertransference issues, and providing a means by which staff can receive feedback on how well they are doing are matters that are as important for the staff as they are for the children.

The components of the treatment and its duration should be determined by the Case Management Plan at the outset, although revisions of the plan may become necessary for family and administrative (legal) reasons. A fundamental goal of all residential treatment programs is successful rehabilitation of the young person to community living.

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