Bandi, Vignesh

From: Bill Kingswell [redacted]
Sent: Tuesday, 21 May 2013 10:15 PM
To: Trevor Sadler
Cc: Leanne Geppert; Sharon Kelly
Subject: Re: The efficacy of "Wraparound" services

Trevor
I am sorry you think this is a personal view. I do not pretend to be a Child trained psychiatrist.
You need to persuade your colleagues on the NMHSPF expert ref grp that this is a model that should prevail.
If you can turn the direction of the NMHSPF ERG, it remains my view, that you need to accept that BAC as is, cannot continue for all the reasons I have put before you. A solution (even if an interim solution) must be found found for these children/adolescents and again my view, it must happen quickly.
I wait your board's decision.
Regards Bill K

On 21/05/2013, at 6:26 PM, "Trevor Sadler" [redacted] wrote:

> Hello Bill,
>
> My impression from the last Planning Group meeting was that you considered that the current patients, and those on the waiting list, could be managed alternatively via a wraparound service.
>
> I write this email so that it is clearly on record.
>
> The ECRG was charged with providing an evidenced based model. Wraparound services were considered, but specifically excluded. There is no evidence to support them as a stand alone service. We do however attempt to build in a wraparound component as part of our discharge planning for every adolescent.
>
> Over the weekend I updated my literature search on wraparound services, and reviewed the literature. This term is almost solely used in literature emanating from the USA. Wraparound services arose in the mid 1980's after the collapse of the long stay, psychoanalytically oriented inpatient services which were used to treat inappropriately thousands of US adolescents until the late 1970's. Managed care brought an end to this practice. Wraparound was an appropriate response to the ensuing vacuum for those with moderate disorder, and inappropriate diagnoses and over medication a response to those with more severe disorder.
>
> Wraparound is used as a service for populations of adolescents in child safety systems, juvenile justice and substance use systems and those with "serious emotional disorder" (a term unique to the USA used of young people with a mix of mild to moderate emotional and behavioural disorders).
>
> Although we don't use the term, the concept is found in our own services. Evolve is a prime example. I did training sessions with Maroochydore and Cairns Evolve teams to help them consider specific components of a comprehensive wraparound process. In this case, the wraparound concept is a stand alone service. I did a workshop in Townsville last week to enable them to consider a comprehensive wraparound process as part of their day

program. In this case, the wraparound service on its own would not be sufficient - it needs to be in the context of having a day program facility.

Wraparound is essentially a CSCF Level 4/5 community based service. I had case based discussions as part of these workshops and understood the level of severity, complexity and impairment in adolescents for whom they were providing a service. It is clear that wraparound on its own is not a substitute for a CSCF Level 6 inpatient service.

If it is decided that a stand alone wraparound service will replace the current service as an interim measure, several issues need to be placed on record.

1. It will potentially be very expensive. The experience of Hengeller's MultiSystemic Therapy (MST) trial of MST as an alternative to inpatient admission for young people with acute self harm was that it was as expensive as hospitalisation, and outcomes equivalent. (MST is a very specific form of wraparound.) Their trial's would not have included patients of the severity seen at Barrett. To do so requires a prohibitive amount of support. Hengeller subsequently did not continue this trial, but he has done with a juvenile justice and substance using populations.
2. In 6 - 12 months, funding would be utilised to meet the needs of adolescents with levels of severity and complexity appropriate to wraparound.
3. The more severe ones typically seen at Barrett would have repeated and prolonged admissions to acute inpatient units, with much poorer long term outcomes. Some would die. Many will face significant impairment including long term social exclusion.

Bill, I find it very difficult to reconcile the occupancy figures you supplied to the Planning Group (50% or less - if any one says differently, either they are lying or HBCIS is lying) with figures supplied by the Directorate the next day - 67% for one adolescent unit based in the Greater Brisbane area, 76% for another and s in the 70+% range for the third. If a population of young people with repeated and prolonged admissions were to be placed in these beds, it would necessitate frequent transfer of Brisbane patients to the Gold Coast or Toowoomba or admissions to paediatric or acute adult inpatient beds.

Queensland and New South Wales are the leaders at meeting our obligations to adolescents under the *National Mental Health Plan*.

I am not living in the past about these matters. I live in the current reality of what is clinically possible for adolescents with severe and complex disorder, in the reality of the capacity of CYMHS services and what the implications are for our obligations are under the *National Mental Health Plan*.

Kind regards,

Trevor

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[redacted]