Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

The *Queensland Health Nursing Model of Care – Toolkit for Nurses* (2003) notes that while this model may useful in situations where there is a staffing crisis or that it may be more efficient for certain care, its weaknesses include depersonalised care, ritualised and repetitive tasks, and reduced job satisfaction.

FACTS: Barrett Adolescent Centre for many years utilises the Primary Nurse Model with components of the Case Management Model. This would have been clear to the Reviewers with multiple entries in the clinical records they had at their disposal marked "Care Coordinator" and signed by the relevant staff member with RN besides the name. In addition one of the Reviewers worked for several years at BAC in this model. They were very proficient in the role of Primary Care Nurse, did Case Management and should have been well aware of these roles. In addition the other two Reviewers attended a section of the Recovery Intensive where the Nursing Model was presented, and ways in which it could be generalised to community settings discussed.

These models are used in combination to facilitate a supportive environment and high standard of care for adolescents in longer term care with a stable core of staff. Adolescent and staff needs can be addressed on a shift basis. According to the *Queensland Health Nursing Model of care – Toolkit for Nurses (2003)* the strengths of the Primary Nursing Model are:

- Continuity of care, better discharge planning
- Improved patient satisfaction
- Professional satisfaction – more sophisticated nursing skills developed
- Works well in mental health etc.

The potential weaknesses (with comments in the Barrett environment in parentheses) are:

- Needs full time staff to work well *(Generally stable staffing at BAC with average lengths of stay in excess of two years. This may have not been as evident to the reviewers as a number of longer term staff had resigned in the preceding twelve months.)*
- Assumes longer length of stay *(therefore applicable to BAC)*
- Resource intensive – all RN workforce with high level of skill *(therefore applicable to BAC)*
- Lack of variety –care of same patients/long inpatient stay *(because of the active rehabilitation/treatment environment, the reverse is true – it enhances professional satisfaction)*
- Medical staff may resist due to perceived loss of control *(the reverse is true – the Director perceives the value to enhanced patient outcomes by having a skilled nursing staff whose professionalism is stimulated by the role)*

Aspects of the Case Management Model relate to continuity of care into the community and when the adolescent is on trial leave, or changes status from full inpatient to either partial hospitalisation or day patient. According to the *Queensland Health Nursing Model of care – Toolkit for Nurses (2003)* the strengths of the Case Management Model are:

- Patient centred
- Better for chronic illness
- Better transition to the community
- Improved quality of care for the patients
- Early intervention – prevent readmission

The potential weaknesses (with comments in the Barrett environment in parentheses) are:

- Attachment of nurse, patient and patient dependence on nurse. *(Adolescents have inputs from a number of staff besides the care co-ordinator. This minimises the risks of attachment to an individual. On the other hand, where an adolescent has experienced disrupted attachments over a considerable period, the Primary Nurse Model and Case Management Model enables*

stability and the opportunity to work through issues pertaining to the qualities of parenting they have experienced.

Each patient is assigned a Case Coordinator (CC), a Registered nurse, who is responsible for the Coordination of care from the time of admission until discharge. It is felt that this model is best for continuity of care, consistency, development of a therapeutic alliance with the patient and allows for ongoing contact with the patient following discharge. In addition it helps to streamline communication with the multidisciplinary team, primarily through the weekly Case Conference meetings and the bi-monthly Intensive Case Workups. On a shift-by-shift basis the Case Coordinator or associate (registered nurse, enrolled nurse) is the main contact for the patient and at times when they are not on shift the Clinical Nurse acts as 'surrogate CC'. When the CC is on leave a detailed handover is given to an acting CC who fills the role in their absence. Care co-ordination is a means of advocating for the adolescent, providing personalised care and adds to job satisfaction.

The allocation of tasks is part of the day to day management of any inpatient nursing environment. Task allocation is seen as the most practical and safe way to effect certain tasks on a daily basis:

- Risk Management. Both continuous and intermittent observations are shared amongst the staff as evenly as possible according to a roster drawn up by the CN at the beginning of each shift. In line with The Park observation policy, staff are not allocated more than two hours continuously (in practice usually one hour); or more than four hours total per shift (usually less) of continuous observation. The same consideration is given to the allocation of intermittent observations.
- A "clinic nurse" assigned to medications, first aid, physical observations etc. This leaves less room for medication error through miscommunication.
- A nurse is assigned by the Clinical Nurse on shift to carry a two way radio to respond to duress alarms
- If a heightened need for consistency is identified, a patient may be assigned an 'allocated nurse' for each shift.

During the visit, some nursing staff identified that it was particularly stressful being allocated to escort duty, during which time the nurse is required to be a continuous escort for consumers attending appointments usually outside BAC. Nurses reported feeling anxious and unsupported having to remain alone with consumers in what is usually an unfamiliar environment.

COMMENTS:

The report accurately reflects the stress placed on nurses who are required to carry out 'continuous escorts' at local hospitals with patients who require medical interventions. This problem has been addressed in the following ways:

- Since 2009 nurses are relieved of escort duty after four hours instead of eight.
- Attempts to collaborate with local hospitals via Consultation Liaison teams with varying success (use: support, meal breaks, review of adolescent's mental state).
- Attempts to negotiate with medical teams to take over responsibility for continuous observation once the patient is admitted to another ward.
- Crisis Intervention Plans/ management plans individualised and made available to escort nurse and hospital.

Patient Journey

The "Report of the Site Options paper for the Development of the Barrett Adolescent Centre" identified a number of issues related to the patient journey of clients admitted to BAC. These included:

- The need for acute medical management at a local general hospital at regular intervals;
- Occasional need for more intensive acute psychiatric care;
- The need for intensive discharge planning at point of referral;
- Integration of BAC with services at the local community of origin;
- Partial hospitalisation as a method of transition from BAC to community management;

- The remoteness of referring services, making the above patients difficult to manage;
- Out of home care for increasingly older adolescents and young people who cannot return to their family of origin;
- Transitioning to suitable adult mental health services if the adolescent requires long term treatment and has reached an age where this transition is necessary.

The management or the difficulties in managing these issues has created some significant problems for BAC. The reviewers were advised that:

- Admissions to BAC are increasingly severe and complex;
- There is a perception that BAC has a limited choice over whom it accepts;
- There are referrals on from the CAMHS Acute Units if there is no obvious community placement option and that BAC becomes a treatment option of "last resort";
- A number of clients who are accepted are homeless;
- A number of clients are referred from very remote parts of Queensland – often by NGOs with little local CAMHS type support.

FACTS: It is unclear from where this information came.

- All patients are accepted on the basis of clinical need and evidence of response to the program at Barrett. At times, as clinical expertise has increased, we have extended admission to an adolescent who may have appeared on the borderline of what would be suitable. At times this has been to the benefit of the adolescent, at other times not.
- All community CYMHS are advised on referral as to the potential suitability of the referral. We are included in the orientation program for new CYMHS clinicians, so they are aware of the Centre, the adolescents we take and appropriate referrals. We rarely have referrals simply as there are no community placement options.
- The Comment about taking a number of adolescents who may be homeless is perplexing. Admission is on the basis of clinical need whether or not the

adolescent is homeless. This is in line with the UN Charter on the treatment of the mentally ill.

- In the past decade, there has been only one referral a town where there was only one CYMHS clinician, and four from towns where there were three or fewer CYMHS clinicians. These all had previous acute adolescent inpatient referrals as well as support from larger community teams which recommended the admission.

The concept of continuity of care is based around the notion of seamless transitions between treatment episodes, and this does not appear to be the case at BAC.

FACTS: Continuity of care has been an important principle for more than a decade. There is strong documentary evidence in the clinical records available to the Reviewers of ensuring seamless transitions where acute medical care is needed by letters of referral, direct communication between medical and nursing staff of the Centre and medical ward, liaison with clinical-liaison staff and often supply of nursing staff. There is clear evidence from two of the records of continued involvement of the referring agencies in bi-monthly intensive case workups which review progress and develop the care plan for the next two months, and email correspondence in the interim. In addition, there is other evidence that in the months prior to discharge, where the referring agency is longer be involved of planning to engage another service which can continue with the care of the young person on discharge to ensure a seamless transition.

While some of these issues will be addressed when the unit is relocated to a site adjacent to an acute hospital, there appear to be significant problems with all of: referral to the unit, waiting time to admission for accepted patients, length of stay, and discharge planning and discharge placement.

The BAC has 15 inpatient beds gazetted for use of adolescents with challenging mental health problems requiring medium to long term treatment. At the time of the visit, there were 9 inpatients. The nursing staff on duty were unable to clarify how the remaining beds were being utilised. [One of the clinical nurses performs the role of Clinical Liaison Officer, coordinating the intake activities of the service. The clinical liaison nurse informed the reviewing team that BAC has developed exclusion criteria

that include: conduct disorder, predatory behaviour, criminal behaviour, aggression, substance misuse and moderate-severe intellectual impairment.]

COMMENTS: The Management Group of The Park – Centre for Mental Health were informed via the Business Unit Meeting of BAC that patient numbers would be low in January/February 2009 because:

- The high acuity of some of the adolescents meant that resources were stretched in managing their care
- A number of adolescents were actively supported by staff in being integrated back to their local schools as part of their transition planning.
- A number of experienced staff had resigned, and the unit needed to mentor new staff.
- We were running the Recovery Intensive (a workshop for CYMHS clinicians from throughout Queensland to consider aspects of managing adolescents with severe and complex disorders) in the February of the Review which involved many of the senior nursing staff.

An obvious indicator of this constellation of problems is the increasing age of the clients. At the time of the review, one third of the inpatients (3 out of 9) were over the age of 18 years. Those 3 individuals had admission dates of November 2007, August 2006 and April 2005, meaning length of stay for them was approaching 2, 3 and 4 years respectively.

Thus, consumers are not necessarily discharged at 18 years of age and there appears to be a lack of clearly understood or communicated process to transition these young people to adult services.

FACTS: There is active debate in the Australian literature regarding the best models for transitions of services for young people. Traditionally CYMHS services have gone up to 18, and arranged transition to adult services. The Headspace model which is also endorsed[16], recommends treatment from 16 – 25 years. Indeed the Robina Adolescent Inpatient Unit envisaged treatment in co-located adolescent and young adult wards up until the age of 25.

---

[16] Whiteford H. Groves A. (2009) Policy implications of the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry. 43:644-51*

The Barrett approach is very clear. If an adolescent is likely to require long term treatment and support for several years for a mental illness in which adult services have expertise, the transition process begins well before their 18th birthday, if the adult service will accept the referral. Even so there can be a considerable delay, even when high level representations are made. On the other hand, if an adolescent is well engaged in treatment, and likely to respond more positively for a while in Barrett compared to transfer to an adult MHS at that stage, a decision it made to continue their admission beyond their 18th birthday. The transition is made when treatment is substantially completed or when they are sufficiently stabilised to benefit from the more limited treatments available in the relevant Adult MHS. This is more in line with the "Headspace model" than the "CYMHS model".

An assertively managed approach to admission and discharge will need to be adopted by BAC wherever it is located. The following recommendations can define the parameters of this approach.

FACTS: While many of the recommendations have merit (particularly 3, 4, 5, 10, 13, and 14), Recommendation 12 is part of current processes, Recommendation 6 has not identified the many problems the Centre has had to date with transitions, and minimises the complexities in establishing mechanisms to ensure they happen, Recommendations 7 and 11 have no evidence base, Recommendation 8 is contrary to evidence available to the Reviewers that the MHS service on discharge can be predicted – eg change of address, need to move from CYMHS to Adult MHS, and Recommendation 9 is contrary to the UN charter on the rights of the mentally ill.

***Recommendations*:**

1. *That referral forms for referring agencies be updated.*
2. *That service level agreements, Memoranda of Understanding or shared protocols be used as the basis of agreement for the transfer or sharing of care between BAC and other units. These would include but not be restricted to:*
3. *Agreements with local Acute Hospitals for assistance in the management of the physical sequelae of self harm.*
4. *Agreements with local Acute Hospitals for assistance in the management of the physical complications of eating disorders.*

5. *Agreements with local Acute Mental Health Facilities for assistance in the management of acute and extreme behavioural disturbances.*
6. *Agreements with local Acute Mental Health Facilities with regard to the transition of older adolescents from care at BAC to care in Adult Mental Health Services.*
7. *That the length of admission, and planned discharge date, for prospective admissions, be agreed upon by referrer and BAC staff prior to admission.*
8. *That there is firm agreement, prior to admission, about which service will have an ongoing role in the patient's management upon discharge (failure to agree on this will result in the patient not being admitted to BAC).*
9. *That homelessness in the absence of an identified and agreed upon strategy for accommodation at discharge be an exclusion criteria for admission to BAC.*
10. *That the concept of step up/step down facilities and halfway houses, possibly managed by NGOs, be explored as methods of transitioning clients back to the community, especially those clients who will require out of home care.*
11. *That a target for Length of Stay be set for BAC – this can be aspirational, but should be no more than 12 months. Any client that exceeds this target on clinical grounds should be identified and intensively managed to find alternative clinical placement including, for older clients, placement with Adult Mental Health Services.*
12. *That planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission.*
13. *That regular (eg twice yearly) meetings of BAC staff with key referring agencies occur to improve the referral, treatment and discharge processes.*
14. *That data regarding referrals, wait times, lengths of admission etc be reviewed regularly and in different forums (eg at meetings of senior BAC staff and Park Hospital and Qld Mental Health)*

Treatment evaluation

There appears to have been negligible evaluation of treatments delivered by BAC.

FACTS:

1. BAC was one of the first CYMHS in Queensland to implement evaluation, using the HoNOSCA and CGAS since 2000.[17]
2. Throughout the clinical records available to the Reviewers, there were hard copy records of evaluation measures (HoNOSCA, CGAS, FIHS, SDQ) used in the regular bi-monthly care planning reviews. These are collectively scored by clinicians with contact with the adolescent at the intensive case workup so that they can be entered in to CIMHA.
3. Since the migration of OIS to CIMHA, we have been unable to access cumulative reports to understand changes in these evaluation measures. To do so is beyond our current resources.
4. A range of assessments are described in Appendix 2. A number of these form the basis of individual evaluation of change by a particular discipline. This is then reported to the treating team at the Intensive Case Workup.

Recommendations:

1. *Regular use of patient and parent/carer satisfaction surveys.*
2. *Affiliation with an academic unit to facilitate treatment evaluation.*
3. *Introduction of a regular meeting to specifically address the process of outcome measurement at BAC and the (outcome) results obtained for patients.*

Clinical leadership

One of the major problems of BAC relates to leadership and leadership structure. While several staff (e.g. psychiatrist, NUM, liaison nurse, senior allied staff) have considerable experience, there does not appear to be a clear Executive structure nor forum for the Executive to meet.

FACTS: All nursing staff are accountable to the Nurse Unit Manager who in turn is accountable to the Assistant Director of Nursing. All staff are accountable to the

[17] Harnett PH. Loxton NJ. Sadler T. Hides L. Baldwin A. (2005) The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. *Australian & New Zealand Journal of Psychiatry. 39:129-35*

position, the role of Clinical Nurse Consultant remained, while the roles of a Nurse Unit Manager was performed by a senior nurse for both BAC and the High Secure Unit. Gradually the CNC assumed more of the role of the NUM until it was impossible to perform CNC duties. The loss of the CNC position has taken away an important avenue for supervision for nurses.

Recommendations:

1. *The use of professional development funds by nursing staff should not be compromised by budgetary constraints. The provision of the money to undertake development activities is an award condition.*
2. *Nursing staff would benefit from regular and relevant in-service, and a program or calendar of such in-service could be developed and then facilitated through rostering. There appears to be generous blocks of time that could be regularly quarantined for staff development during the time the young people are attending school.*
3. *Structures for group clinical supervision should be reviewed and strengthened by sourcing a clinical supervisor not currently working at BAC.*

Finally, while staff may understandably be unsettled by the prospect of significant changes as recommended in this report, the proposed rebuilding of the facility at a new location constitutes an unprecedented opportunity to reflect on BAC's purpose, mission, systems and work practices. With a motivated leadership team employing good change management skills, BAC and key stakeholders can seize this chance to review the service and maintain BAC's commendably long record of service provision to young people in Queensland.

APPENDIX 1 – DEVELOPING OBJECTIVE CRITERIA FOR REVIEWS

The Royal College of Psychiatrists (RCPsych) in the earlier part of this century set out to review the number and functions of child and adolescent inpatient units in the United Kingdom[18,19,20]. The Quality Network for Inpatient CAMHS (QNIC) developed out of this process. It is a multidisciplinary network funded by the RCPsych to support and monitor standards in inpatient CAMHS. QNIC hosts an internet discussion forum (of which staff from BAC have contributed), hosts yearly meetings to discuss issues relating to inpatient CAMHS.

It has developed, from extensive literature reviews, consultations with clinicians and Government guidelines, a set of standards. The fifth edition has just been published. It is anticipated that each inpatient unit will supply staff for a minimum of three site visits to other inpatient units to assess a unit against the standards. Participation is voluntary, but a high percentage of inpatient units are part of this process. Each unit has an annual review. The purpose is two-fold – to provide feedback to clinicians regarding their service, and to provide feedback to the local NHS Trust about resourcing issues. I have not been able to find a comparable process which is specific to CYMHS/CAMHS inpatient units in New Zealand, Canada, the USA, France or Switzerland.

I have reviewed the performance of Barrett Adolescent Centre against the 4th edition of these Standards[21], not only because were these the Standards in place at the time of the Review, but also because a subsequent Report[22] has been released which gives figures for the level of compliance with the Standards. Our performance is shown in the Table below, together with a measure of the QNIC average level of compliance.

Two factors emerge. Our level of compliance is comparable to QNIC rated adolescent inpatient units in five domains. It is clearly below in two – Staffing and Training and Access, Admission and Discharge

---

[18] O'Herlihy, A., Worrall, A., Banerjee, S., Jaffa, T., Hill, P., Mears, A., Brook, H., Scott, A., White, R., Nikolaou, V. & Lelliott, P. (2001) National Inpatient Child and Adolescent Psychiatry Study (NICAPS). *Final Report to the Department of Health. London: Royal College of Psychiatrists' Research Unit*

[19] O'Herlihy A, Worrall A, Lelliott P, Jaffa T, Hill P, Banerjee S (2003) Distribution and characteristics of in-patient child and adolescent mental health services in England and Wales *The British Journal of Psychiatry 183: 547 - 551*

[20] McDougall T, Worrall-Davies A, Hewson L, Richardson G, Cotgrove A (2008) Tier 4 Child and Adolescent Mental Health Services (CAMHS) - Inpatient Care, Day Services and Alternatives: An Overview of Tier 4 CAMHS Provision in the UK *Child and adolescent Mental Health 13:173 – 180*

[21] Davies G, Thompson P, Landon G (Eds) (2007) Quality Network for Inpatient CAMHS 4th Edition Royal College of Pyschiatrists

[22] Solomon J, Thompson P (2010) QNIC A Quality Network for In-patient CAMHS Annual Report Review Cycle 7: 2007 – 2008

STANDARD	ESSENTIAL/ DESIRABLE	MET	NOT MET	N/R	% MET	QNIC %
1. Environment and Facilities	Essential	24	4	0	83%	85%
	Desirable	15	4			
2. Staffing and Training	Essential	47	11	3	74%	85%
	Desirable	13	10			
3. Access, Admission, Discharge	Essential	13	3	6	76%	85%
	Desirable	3	2			
4. Care and Treatment	Essential	37%	4%	1	87%	88%
	Desirable	15%	4%			
5. Information, consent confidentiality	Essential	24	2	2	89%	88%
	Desirable	25	3			
6. Young People's Rights	Essential	20	1	10	96%	92%
	Desirable	1	0			
7. Clinical Governance	Essential	17	1	15	84%	83%
	Desirable	11	4			
8. Location within a Public Health Context	Essential	7	0	16	N/A	N/A
	Desirable	9	6			

Below is are the criteria we failed to meet for Staffing and Training
Training

- Formal knowledge of aetiology, symptoms and a range of relevant conditions
- The nature and development of the therapeutic environment for children and young people and understanding of psychodynamic processes
- Managing relationships and boundaries between young people and staff, including appropriate touch
- The role of other services and the range of local services and activities
- Members of the nursing team including all newly appointed senior nurse managers, have undertaken further training in child and adolescent mental health
- Working with young people with learning disabilities alongside mental health problems
- Working with young people whom have visual impairment, hearing problems, physical disability and physical illness
- Working with young people with co-morbid substance abuse and mental health problems
- Audit and research skills
- Unit managers have had further training in management and team leadership
- All staff, including temporary staff, have a comprehensive induction which covers key aspects of care (e.g. observation, child protection) before they can have unsupervised access to the young people
- There is commitment and financial support to conduct service relevant research and academic activity, and to disseminate the findings and implications of studies widely
- Supervision is included in the job description of every member of the MDT
- The team have regular designated time to meet as a group to reflect upon the process and the impact of working with young people

- Units have a dedicated Human Resources contact who understands the nature of the service
- There is a minimum of two registered nurses, that have appropriate child and young people training, per day shift and one at night
- There is a minimum of two registered nurses, that have appropriate child and young people training, per day shift and one at night
- 0.5 WTE Psychotherapist input is provided in a typical 10-12 bed unit
- A written review of staffing needs is completed at defined intervals and when there are changes in service provision
- The team has off-site and informal 'away days' to facilitate team building and service development
- Training needs are informed through the skills needed within the unit, staff appraisal and individual development plans and support and supervision systems - all have been assessed in the last year

Some of these can be addressed immediately. Some should be noted as part of the redevelopment, so that they can be incorporated into staff training.

Below are the criteria we failed to meet for Access, Admission and Discharge.

- Young people do not experience delay in treatment that leads to deterioration in health
- Interpreters used by Specialist CAMHS have received training or guidance about mental health matters and recognise the importance of full and accurate translation
- Children's units have access to nearby facilities for parents to stay overnight when appropriate
- Young people have a named worker from the referring agency throughout their stay in the unit, who attends all CPA reviews and discharge planning meetings. The worker is the care coordinator unless the unit take on this role
- Young people and parents know the names of workers involved in follow-up after their discharge and have met them prior to discharge
- There is an agreement with the referring teams, regarding aftercare pathways, before admission

Although it should be possible to meet most of these, most relate to issues beyond the control of the Barrett Adolescent Centre. For example, one local Adult MHS will not accept a referral until a patient is discharged. This makes it difficult to meet a clinician prior to discharge.

Overall these Standards are an example of a valid reference point against which the unit can be measured. They do not prescribe a particular Model of Service Delivery, but ensure a set of basic Standards which should apply to all units. Most are highly relevant, although some Standards could not be translated to a Queensland Health context, and others needed to be adapted to suit our context.

Evaluation of an adolescent inpatient service against these standards could apply at local, State or National levels. One value of the QNIC process is the experience of staff visiting other services to review the other service. I am sure this has bi-directional effects.

APPENDIX 2 – EVALUATION AND INTERVENTIONS

On admission to BAC, adolescents are given a comprehensive range of assessments (if they have not been given them recently) to enable a complete formulation of the issues and develop a management plan. Each discipline brings a range of assessment and observational skills. Each discipline conducts an initial interview as an integral part of the assessment before commencing discipline specific assessments.

The first section lists the range of standardised assessments and a limited number of non-standardised assessments. Standardised assessments are of two broad types. The first ascertains abilities and characteristics which are unlikely to change (e.g. intelligence), but which must be accommodated in a rehabilitation program. The second type of standardised assessment allows for testing after a period of time or on discharge as part of an evaluation of treatment and rehabilitation. These are marked with an *.

As the primary purpose of this Appendix is to outline additional areas of evaluation, a number of unstructured assessments (family, parent assessments, peer interactions, general behaviour etc.) are not described. These are nevertheless an important component of the formulation.

The second section describes a range of interventions which had been utilised in the twelve months preceding the Review. Literature referring to the evidence base for these interventions is included. It is noted in passing that the evidence base for interventions with many disorders in adolescents is limited.

SECTION 1: ASSESSMENTS

1. Psychology Assessments

Core psychological tests are administered following admission. The following are the most commonly used psychometric tests at BAC, shown to have good validity and reliability.

- *The Reynolds Adolescent Depression Scale, Second Edition (RADS-2)
- *The Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2)
- *The Adolescent Anger Rating Scale (AARS)
- *The Eating Disorder Inventory-2 (EDI-2)
- *The Childhood Trauma Questionnaire (CTQ)

Where there is a direct concern surrounding cognitive and academic ability and a referral is made, the following measures may be used:

- *Intelligence* - The WISC-IV
- *Achievement/Academic* - The WIAT-II
- *Memory* – The Children's Memory Scale

A neuropsychology referral is made if necessary, to further assess attention and concentration, memory and executive functioning, or to determine capacity or decision-making competency.

2. Occupational Therapy Assessments

Adolescent

- *Activity Configuration (how adolescents occupy a 24 hour period)
- *Adaptive Behaviour Assessment System (ABAS - II)
- Adolescent/Adult Sensory Profile
- The Handwriting Speed Test (HST)
- Beery-Buktenica Developmental Test of Visual-Motor Integration
- *Canadian Occupational Performance Measure (COMP)
- *Living Skills Checklist
- *Interest Checklist
- *Barriers to Leisure and Leisure Hopes Checklist

Parent

- *Living skills Information – Initial Parent /Carer Interview
- (Adaptive Behaviour Assessment System (ABAS - II)
- Adolescent/Adult Sensory Profile
- *Living Skills Checklist

Ongoing Assessments

- Cooking assessment
- Vocational Education Interest Form
- Adventure Therapy Assessment

3. Speech Pathology Assessments

Specialist communication assessments.

- Test of Adolescent and Adult Language (TOAL -3/4)
- Children's Evaluation of Language Function – Revised (CELF-4)
- *Test of Problem Solving (TOPS)
- The Test of Auditory Processing Skills – 3rd Edition
- Test of Language Competence – Expanded edition (TLC-E)
- Language Processing Test – Revised edition
- The Children's Communication Checklist – second edition
- Test of Word Knowledge, Literacy Tests

4. Dietetic Assessments

All adolescents undergo an initial nutrition screening process[23] which may consist of one or more of the following:

- Medical and psychosocial History - reason for admission, medical history & medications, psychosocial history, socioeconomic status & history
- *Growth and development – height, weight, BMI plotted on CDC 2000 growth charts, weight and height history
- *Dietary intake, physical activity - meal and snacking patterns, appetite, food likes, dislikes, food allergies/intolerances, special dietary practices, nutrition supplement use, food security, alcohol consumption. physical activity levels
- Physical parameters – blood pressure, pulse, lipids, iron studies (females)

[23] Modified from Stang J, Story M (eds) Guidelines for Adolescent Nutrition Services (2005).

As well there may be indications for an in-depth nutrition assessment

- Medical and psychosocial history - medications known to have drug-nutrient interactions, depression or dysthymia, diagnosed eating disorder (AN, BN, EDNOS), at risk of re-feeding syndrome, disordered/fussy eating, ASD, developmental delay, chronic disease i.e. diabetes
- Growth and development - underweight, overweight, at-risk of overweight, short stature
- Dietary intake and physical activity - history of food insecurity, meal skipping, inadequate micronutrient intake, excessive intake of total or saturated fat, food allergy or intolerance, vegetarian diet, dieting, fasting, alcohol consumption, minimal/excessive sport/physical activity
- Physical observations and biochemistry – hypertension, hyperlipidaemia, iron deficiency anaemia

SECTION 2: INTERVENTIONS

Clinicians providing interventions at the time of the Review were contacted and asked to provide a list of:

- The range of interventions they provided at the time of the Review
- The evidence base for these interventions (including any reviews since the Review)

These interventions are listed in three categories

- Interventions Specific to a Disorder
- Treatment Interventions across Disorders
- Rehabilitation Interventions to Address Impairments across Disorders

1. Interventions Specific to a Disorder

School Refusal/Social Anxiety Disorder and Co-morbid Anxiety Disorders

- Behavioural Interventions – exposure individually or via groups

  Evidence Base

  Beidel DC, Turner SM, Morris TL. (2000) Behavioral treatment of childhood social phobia. *Journal of Consulting & Clinical Psychology 68:1072-1080*

  Borgeat F, Stankovic M, Khazaal Y, Rouget BW, Baumann MC, Riquier F, O'Connor K, Jermann F, Zullino D, Bondolfi G, (2009) Does the form or the amount of exposure make a difference in the cognitive-behavioral therapy treatment of social phobia? *Journal of Nervous and Mental Disease. 197:507-13,*

  Silverman WK, Pina AA, Viswesvaran C. (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents *Journal of Clinical Child and Adolescent Psychology. 37:105-30*

  Storch EA, Larson M, Adkins J, Geffken GR, Murphy TK, Goodman WK. (2008). Evidence-based treatment of pediatric obsessive-compulsive disorder. In: Handbook of evidence-based therapies for children and adolescents: Bridging science and practice. *Steele RG. (Ed.); Elkin TD (Ed.), Roberts MC. (Ed.); New York, NY, US: Springer Science + Business Media, 2008. pp. 103-120.*

- Social Skills Enhancement

  Evidence Base

  Beidel DC, Turner SM, Young BJ. (2006) Social effectiveness therapy for children: five years later. *Behavior Therapy 37:416-25*

  Cook CR. Gresham FM, Kern L, Barreras RB, Thornton S, Crews SD, (2008). Social skills training for secondary students with emotional and/or behavioral disorders: A review and

analysis of the meta-analytic literature. *Journal of Emotional and Behavioral Disorders 16:131-144.*

Herbert JD, Gaudiano BA, Rheingold AA, Myers VH, Dalrymple K Nolan, E M. (2005) Social Skills Training Augments the Effectiveness of Cognitive Behavioral Group Therapy for Social Anxiety Disorder. *Behavior Therapy. 36:125-138.*

Spence SH, Donovan C, Brechman-Toussaint M (2000) The treatment of childhood social phobia: The effectiveness of a SST-based cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology and Psychiatry 41:713-726*

- Cognitive Therapies

  Evidence Base

  King NJ, Heyne D, Ollendick TH (2005) Cognitive-behavioral treatments for anxiety and phobic disorders in children and adolescents: A review. *Behavioral Disorders. 30:241-257.*

  Layne AE. Bernstein GA. Egan EA. Kushner MG. (2003) Predictors of treatment response in anxious-depressed adolescents with school refusal. *Journal of the American Academy of Child & Adolescent Psychiatry 42:319-26*

- Family Therapy

  Evidence Base

  Kendall PC. Hudson JL. Gosch E. Flannery-Schroeder E. Suveg C (2008) Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. *Journal of Consulting & Clinical Psychology. 76:282-97*

  Siqueland L, Rynn M, Diamond GS. (2005) Cognitive behavioral and attachment based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders. 19:361-81*

Depression, Dissociation and PTSD

- Trauma Focussed Cognitive Behaviour Therapy and Stress Inoculation Therapy

  Evidence Base

  Forbes D, Creamer M, Phelps A, Bryant R, McFarlane A, Devilly GJ, Matthews L, Raphael B, Doran C, Merlin T, Newton S. (2007) Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder *Australian & New Zealand Journal of Psychiatry* 41:637-648

  Cohen JA, Deblinger E, Mannarino AP, Steer R. (2004) A multisite, randomized controlled trial for children with sexual abuse related PTSD symptoms. *Journal of the American Academy of Child Adolescent Psychiatry. 43:393-402*

  Foa EB, Chrestman KR, Gilboa-Schechtman E, (2009). Prolonged exposure therapy for adolescents with PTSD: Emotional processing of traumatic experiences: Therapist guide.; *New York, NY, US: Oxford University Press, 2009. xii, 206 pp*

  Hembree EA, Foa EB (2003) Interventions for trauma-related emotional disturbances in adult victims of crime *Journal of Traumatic Stress 16:187-199.*

  Hembree EA, Foa EB Dorfan NM, Street GP, Kowalski J, Tu X (2003) Do patients drop out prematurely from exposure therapy for PTSD? *Journal of Traumatic Stress. 16: 555-562*

  Jonsson PV (2009) Complex trauma, impact on development and possible solutions on an adolescent intensive care unit *Clinical Child Psychology & Psychiatry. 14:437-54*

  King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH (2000). Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial. *Journal of the American Academy of Child Adolescent Psychiatry. 39: 1347-1355.*

  Lewis C, Simons A, Silva S, Rohde P, Small D, Murakami J, High R, March J. 2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology. 77:422-428.*

  Rauch SA, Cahill SP (2003) Treatment and Prevention of Posttraumatic Stress Disorder. Primary Psychiatry. 10:60-65.

  Trowell J, Kolvin I, Weeramamthri T, Sadoski H, Berelowitz M, Glasser D Leitch I (2002) Psychotherapy for sexually abused girls: psychopathological outcome findings and patterns of change. *British Journal of Psychiatry160:234-247.*

Saunders BE, Berliner L, Hanson RF, eds. *Child Physical and Sexual Abuse: Guidelines for Treatment.* Revised Report: April 26, 2004. National Crime Victims Research and Treatment Center.

Spermon D, Gibney P, Darlington Y. (2009) Complex trauma, dissociation, and the use of symbolism in therapy. *Journal of Trauma & Dissociation. 10:436-50*

Weber S (2009) Treatment of trauma- and abuse-related dissociative symptom disorders in children and adolescents *Journal of Child & Adolescent Psychiatric Nursing. 22:2-6*

In addition, expressive therapies (art, sandplay) facilitate the expression of emotions and expression of traumatic events related to trauma focussed therapy.

Eating Disorders

- Integrated Management Program

  Evidence Base

  Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*

  National Collaborating Centre for Mental Health (2004) Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders *National Institute for Clinical Excellence Clinical Guideline*

- Dietetic Management

  Evidence Base

  Dietetic Management of Adolescents with Eating Disorders is based on existing guidelines and current literature. Including but not limited to:

  Golden HN. (2003)et al Eating disorders in adolescents: position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health. 33:496-503.*

  Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults http://www.daa.asn.au/index.asp?pageID=2145872887

  American Dietetic Association (2006) Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Anorexia Nervosa, Bulimia Nervosa, and Other Eating Disorders. *Journal of the American Dietetic Association. 106: 2073-2082.*

  ANZAED The Role of Nutritional Management in the Treatment of Eating Disorders Position Paper. (2008) http://www.anzead.org.au/files/nutrition_position_paper.pdf

  Yager J, Devlin MJ, Halmi KA, Herzog DB, Mitchell JE, Powers P, Zerbe KJ, (2006) Practice guideline for the treatment of patients with eating disorders (3rd edition) Arlington *American Psychiatric Association.*

  Eating Disorder Toolkit - a practice-based guide to the inpatient management of adolescents with eating disorders, with special reference to regional and rural areas (2008) *MH-Kids Centre for Eating Disorders*

  Dietetic Association of Australia. Guidelines for paediatric nutrition support in health care facilities. (2001)

  Dietetic Association of Australia. Enteral Feeding Manual for Adults in Health Care Facilities. (2007)

  The Dietetic Association of Australia Eating Disorders Interest Group acknowledges that there is a gap literature regarding practice guidelines for the management of Anorexia Nervosa in Children and Adolescents. This is currently being addressed.

- Psychotherapies (including Motivational Enhancement and CBT-E) and Family Therapies. (Numerous articles up to the present outline[24,25,26] the poor

[24] Gowers S, Bryant-Waugh R. (2004) Management of child and adolescent eating disorders: the current evidence base and future directions. *Journal of Child Psychology and Psychiatry 2004; 45: 63–83.*

[25] Hay PPJ, Bacaltchuk J, Byrnes RT, Claudino AM, Ekmejian AA, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. *Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD003909.*

[26] Treasure J, Claudino AM, Zucker N (2010) Eating disorders *The Lancet 375:583-593*

Evidence Base for therapeutic interventions for anorexia nervosa, although the strongest to date is for the Maudsley Intervention. Where this is not suitable – e.g failure of the intervention already, or the adolescent is in unstable foster care, interventions are planned on a range of interventions described in the literature. These are listed below.)

Bowers W. (2002). Cognitive therapy for anorexia nervosa. *Cognitive and Behavioral Practice. 9:247-253.*

Bowers WA, Ansher LS (2008) The effectiveness of cognitive behavioural therapy on changing eating disorder symptoms and psychopathology of 32 anorexia nervosa patients at hospital discharge and one year follow up. *Annals of Clinical Psychiatry 20:79-86*

Eisler I, Simic, M, Russell GF Dare C (2007) A randomised control trial of two forms of family therapy in adolescent anorexia nervosa: a five year follow up *Journal of Child Psychology and Psychiatry and Allied Disciplines 49:552-60*

Fairburn CG, Cooper Z, Shafran R. (2003) Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. Behavior *Research and Therapy 2003; 41: 509–28.*

Keel PK, Haedt A. Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child Adolescent Psychology 2008; 37: 39–61.*

Pearson, K., (2009). Cognitive behavior therapy and eating disorders. *British Journal of Psychology. 100:804-806.*

Robin AL, Siegel PT, Move AW, Gilroy M, Dennis AB, Sikand A (1999) A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa *Journal of the American Academy of Child and Adolescent Psychiatry 38:1482 – 1489*

Tierney S, Fox JR (2009) Chronic anorexia nervosa: a Delphi study to explore practitioners' views *International Journal of Eating Disorders 42:62-67*

Townsend E. Hawton K. Altman DG. Arensman E. Gunnell D. Hazell P. House A. Van Heeringen K. (2001) The efficacy of problem-solving treatments after deliberate self-harm: meta-analysis of randomized controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine. 31:979-88*

2. Treatment Interventions across Disorders

Individual Therapies

Evidence base

Young JF, Mufson L, Davies M (2006) 'Impact of Comorbid Anxiety in an Effectiveness Study of Interpersonal Psychotherapy for Depressed Adolescents', *Journal of the American Academy for Child and Adolescent Psychiatry 45:904-912.*

Castonguay LG, Beutler LE. (2006). Principles of therapeutic change: A task force on participants, relationships, and techniques factors. *Journal of Clinical Psychology,:631–638.*

Kaslow NJ, Thompson MP (1998) Applying criteria for empirically supported treatments to studies of psychosocial interventions for children and adolescents depression. *Journal of Clinical Child and Adolescent Psychology 27:146-155*

King, R. (1998) Evidence-based practice: where is the evidence? The case of cognitive behaviour therapy and depression. *Australian Psychologist*, 33, 83-88.

Family Therapies

Evidence base

Carr, A. (2009) 'The effectiveness of family therapy and systemic interventions for child-focused problems', *Journal of Family Therapy*, (31) 3-45.

Hayes AM, Laurenceau JP, Feldman G, Strauss JL, Cardaciotto (2007) Change is not always linear: the study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review27:715-723*

Larner, G. (2009) 'Integrating family therapy in adolescent depression: an ethical stance', *Journal of Family Therapy 31: 213-232.*

The following group interventions are adaptations of interventions described in the literature. Each group is described briefly.

Groups – Dialectical Behaviour Therapy

DBT is a therapy approach, with skills that can be used for any individual who has difficulty tolerating distress, regulating emotions and relating effectively with others. Four core skills learned in DBT: mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness. It has been found that DBT is most successfully incorporated into the treatment program by a weekly group of one hour for all adolescent patients at BAC. One DBT skill is addressed each term. Outcomes are measured by evaluation of checklists of attendance, behaviour, participation and progress has generally shown a gradual improvement in group performance over each term. Changes in the cohort tend to alter group dynamics. Increased participation coincides with anonymous group participation and collective group activities.

Evidence base

Dimeff LA, Koerner K (2007). Dialectical behavior therapy in clinical practice: Applications across disorders and settings. *New York, NY, US: Guilford Press, 363 pp.*

James AC, Taylor A, Winmill L, Alfoadari K (2008). A preliminary community study of dialectical behavior therapy (DBT) with adolescent females demonstrating persistent, deliberate self-harm (DSH). *Child and Adolescent Mental Health 13:148-152.*

Bogels SM. Sijbers GFVM. Voncken M (2006) Mindfulness and task concentration training for social phobia: A pilot study *Journal of Cognitive Psychotherapy. 20:33-44.*

Nelson-Gray RO, Keane SP, Hurst RM, Mitchell JT, Warburton JB, Chok JT, Cobb AR. (2006). A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings. *Behaviour Research and Therapy 44:1811-1820.*

Salbach-Andrae H, Bohnekamp I, Pfeiffer E, Lehmkuhl U, Miller AL. (2008). Dialectical behavior therapy of anorexia and bulimia nervosa among adolescents: A case series. *Cognitive and Behavioral Practice 15:415-425.*

Groups – Social Skills and Community Access Groups

Social Skills training - this group has been run in many formats, depending on staffing, consumer and resourcing capabilities. It is focused on developing key verbal and non-verbal communication skills, and interpersonal skills (for example negotiation, problem-solving, assertiveness.

Community Access - to develop skills enabling independence in the community e.g. Public Transport, accessing community facilities, purchasing and consuming meals in public planning leisure-based outings; to encourage development of organisational and planning skills; to improve social skills through participation in group processes; to provide exposure to reduce anxiety around food, socialising, talking to shop assistants and promoting safety whilst in public spaces; to be able to work well within a group setting.

These groups have both treatment and rehabilitation components.

Evidence Base

Beidel DC, Turner SM, Morris TL. (2000) Behavioral treatment of childhood social phobia. *Journal of Consulting & Clinical Psychology 68:1072-1080*

Davies S (2004) A group-work approach to addressing friendship issues in the treatment of adolescents with eating disorders *Clinical Child Psychology and Psychiatry 94:519-531*

Dirks MA, Treat TA, Weersing VR (2007) Integrating theoretical, measurement, and intervention models of youth social competence. *Clinical Psychology Review 27:327-347*

LaGreca AM, Santogrossi DA (1980) Social Skills Training with elementary school students: a behavioral group approach. *Journal of Consulting and Clinical Psychology 48:220-227*

Losel F, Beelman A (2003) Effects of child skills training in preventing antisocial behavior: A systematic review of randomized evaluations. *The Annals of the American Academy of Political and Social Science 587: 84-109*

Rao PA, Beidel DC, Murray MJ (2008) Social skills interventions for children and adolescents with Asperger's Syndrome or High-functioning autism: A review and recommendations. *Journal of Autism and Developmental Disorders 38:535-361*

Silverman WK, Pina AA, Viswesvaran C. (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents *Journal of Clinical Child and Adolescent Psychology. 37:105-30*

Spence SH (2003) Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health 8:84-96*

Webster-Stratton C, Reid J, Hammond M. (2001) Social skills and problem-solving training for children with early-onset conduct problems: Who benefits? *Journal of Child Psychology and Psychiatry 42:943-952*

Groups – Adventure Therapy

Adventure therapy creates an environment of experiential learning where adolescents face challenges which enable them to learn to problem solve to overcome challenges; learn to identify emotions and cognitions associated with challenging situations and implement strategies to moderate. Adventure activities can facilitates experiential learning by providing a tool to enable adolescents to reflect, generalise and apply what they have learnt from an adventure based experience. It utilises communication skills and skills in group participation. The main components are problem solving activities, challenging activities and camping. Observation suggests that individual A-B-A research designs may be more valid than group evaluations because of the heterogeneity of the group and variations.

Evidence Base

Carlson KP, Cook M (2007) Challenge by choice: adventure-based counselling for seriously ill adolescents *Child and Adolescent Psychiatric Clinics of North America 16:909-919*

Cook EC (2008) Residential wilderness programs: the role of social support in influencing seld-evaluations of male adolescents *Adolescence 43:751-774*

Gillan MC, Balkin RS (2006) Adventure counselling as an adjunct to group counselling in hospital and clinical settings *Journal for Specialists in Group Work 31:153-164*

Jelalian E, Mehlenbeck R, Lloyd-Richardson EE, Birmaher V, Wing RR (2006) 'Adventure therapy' combined with cognitive-behavioral treatment for overweight adolescents *International Journal of Obesity 30:31-39*

Kelly VA (2006) Women of courage: a personal account of a wilderness based experiential group for survivors of abuse *Journal for Specialists in Group Work 31:99-111*

3. Rehabilitation Interventions to Address Impairments across Disorders

A range of group and individual interventions are aimed at improving function in adolescents with a range of developmental impairments.

There is a dearth of research into rehabilitation interventions for adolescents with severe and complex mental illness. This suggests either that adolescents with severe and complex mental illness

- do not suffer impairments in function secondary to severe and complex mental illness or
- that any functional impairments resolve on treatment of the disorders or
- that impairments in function are commonly overlooked by clinicians or
- that rehabilitation interventions to address functional impairments are not as easy to address in common research paradigms

The first two possibilities are not supported by clinical observation.

Groups – psycho-education

Psycho-education – delivered in a group process to foster acceptance and tolerance within the ward environment – reducing stigmatisation and bullying. The group enables adolescents to understand differences between people.

Groups – fitness and physical activity

Sporting group, gym group, bike riding group, walking group run in 8- 10 week programs. Most adolescents including those with anorexia nervosa and social anxiety engage in solitary leisure pursuits prior to admission and either solitary or no exercise. Engaging in leisure accounts for 50-57% of most young people's time. Leisure enhances competencies, self efficacy and self worth. Adolescents that feel less competent are more likely to choose solitary activities and use these opportunities to ruminate on their problems. Conversely there is evidence to support non-specific psychological effects of exercise

Evidence Base

Bracegirdle, H. (2002). Developing physical fitness to promote mental health. In J. Creek (Ed.), *Occupational Therapy in Mental health* (3rd ed.). (pp. 209-225). Sydney: Churchill Livingstone.

Davies, S. Parekh K, Etalapaa K, Wood, D, Jaffa T (2008) The inpatient management of physical activity in young people with anorexia nervosa *European Eating Disorders Review 16:334-340*

Henley R, Schweitzer I, De Gara F, Vetter S (2008) How psychosocial and sports programs help youth manage adversity: a review of what we know and what we should research *International Journal of Psychotherapy 12:53-61*

Tokumura M, Yoshiba S, Tanaka T, Nanri S, Watanabe H (2003) Prescribed exercise training improves exercise capacity of convalescent children and adolescents with anorexia nervosa *European Journal of Pediatrics 162:430-431*

Szabo CP, Green K (2002) Hospitalized anorexics and resistance training: impact on body composition and psychological well-being. A preliminary study *Eating and Weight Disorders 7:293 - 297*

Groups – cooking

Cooking groups involve planning balanced and varied meals, growing or purchasing food to preparation, developing simple to complex cooking skills, trialling new foods, and when consuming the meal, learning meal etiquette and socialising during meal time and learning the basics of eating out.

Evidence Base

Hinojosa, J., & Blount, M.L. (2004). *The texture of life; Purposeful activities in occupational therapy* (2nd ed.). Bethesda: AJOT

Zielinski-Grimm, E., Meus, J. S., Brown, C., Exley, M., & Manner, T. (2009). *OTJR: Occupation, Participation and Health.* Meal Preparation: Comparing Treatment Approaches to Increase Acquisition of Skills for Adults With Schizophrenic Disorders. 29:04.

Individual treatment and rehabilitation interventions – healthy eating (Dietitian + Nursing Staff)

The Dietitian meets with adolescents directly to identify priority areas for behaviour change. Graded dietary changes are developed with supportive meal therapy and Motivation Interviewing techniques where change is necessary. Meal plan developed for adolescents with eating disorders and for adolescents with specific dietary requirements that require support from staff for effective implementation. Special dietary requirements can be met by hospital foodservices.

Individual rehabilitation interventions - self care (Occupational Therapist + Nursing Staff)

- Personal care – showering, dressing, sleep patterns, basic first aid etc,
- Community management – road safety, public transport, budgeting etc.

- Vocational readiness – work interests and goals, motivation to find and work, job search resumes, time management etc.
- House management – chores and home duties, planning meals cooking and preparing simple and complex meal etc.
- School – attending school, addressing difficulties, managing work load, time
- Individualised dietary planning

Evidence base

Kopelowicz, A. & Liberman, R. P. (2003). Integration of Care: Integrating Treatment with Rehabilitation for Persons With Major Mental Illness. *Psychiatric Services 54, 1491-1498.*
Lloyd C, Waghorn G (2007) The importance of vocation in recovery for young people with psychiatric disabilities *British Journal of Occupational Therapy 70:50-59*
Loyd, C., Waghorn, G. (2010). The Importance of Vocation in Recovery for Young People with Mental Illness. In Loyd, C. *Vocational Rehabilitation and Mental Health* (pp. 115-151). United Kingdom: Wiley-Blackwell

Individual rehabilitation interventions - leisure activities (Occupational Therapist + Nursing Staff)

- Quiet relaxation – identifying and participating in interests, hobbies etc.
- Active relaxation – sports, outings, travel, exercise, fitness and health
- Socialisation – keeping in touch with family, friends, social participation etc.

Individual rehabilitation interventions – improved communication skills (Speech Pathologist + Nursing Staff)

- individual skills training for social interactions;
- development of self talk for self regulation;
- development and use of language underlying emotional literacy;
- development and use of language underlying for problem solving;
- development and acquisition of vocabulary and sentence construction skills to assist functional communication

APPENDIX 3 – RESEARCH PRESENTATIONS

All of the publications, presentations, current research projects and academic links are based on research conducted at BAC

Publications

Harnett PH. Loxton NJ. Sadler T. Hides L. Baldwin A. (2005) The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample. *Australian & New Zealand Journal of Psychiatry. 39:129-35*

Clarke A, Soady D (2006) Social skills impairment impacts on behaviour in the school setting, Talkabout, Volume 19, 2006 (with Deborah Soady, Logan-Beaudesert CYMHS)

Clarke A (2008) Tourette's Syndrome: A comprehensive review of diagnosis, course, aetiology, assessment and treatment" *Talkabout 21*

Ward, D. (2009) Five messages every adolescent needs to hear, *Psychotherapy in Australia 15:48-54*

Presentations:

Harnett P, Sadler T (2003) Health of the Nations Outcome Scales for Children and Adolescents (HoNOSCA) in an adolescent inpatient centre *Queensland Health Mental Health Research Conference, Brisbane*

Sadler T (2004) Borderline Personality Disorder in Adolescence *Bi-National Grand Rounds, CYMHS Training Centre, Brisbane*

Sadler T (2005) Models of Care in Grief and Trauma *Child and Adolescent Psychiatry Grand Rounds, Brisbane*

Clarke A (2006) Charting a life: analysis of 50 adolescents in a long-stay mental health unit. *Speech Pathology Australia National Conference, Fremantle*

Clarke A (2006) Communication Profiling and masking Behaviours *Department of Child Psychiatry, University of Queensland/Royal Brisbane and Women's Hospital, State-wide Grand Rounds*

Clarke A (2006) Prevalence of Communication Disorders in Mental Health *Queensland Health and Medical Research Conference, Brisbane*

Corbett D, Clarke A (2006) Community Access and Socialisation Group *Australian Allied Health Conference, Hobart*

Sadler T (2006) Adolescent Trauma *Seminar: Trauma in Childhood and Adolescence, Toowoomba*

Clarke A (2006) Communication Profiling and masking Behaviours *Education Queensland, Training and Development Seminar (TADS), Brisbane*

Sadler T (2006) The role of attachment in professional interactions with traumatised adolescents *Brisbane North Interagency Forum, Brisbane*

Clarke A (2006) Charting a life: analysis of 50 adolescents in a long-stay mental health unit. *17th World congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals. Melbourne*

Clarke A, Corbett D (2007) Community Access and Socialisation Group *Mater Kids in Mind Conference, Brisbane*

Clarke A (2007) Communication and Mental Health *Mater Kids in Mind Conference, Brisbane*

Clarke A, Corbett D (2007) Community Access and Socialisation Group *RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference, Port Douglas*
Corbett D, Bruce K (2008) "Food Challenges" Community Access group for Adolescents with Eating Disorders. *RANZCP Faculty of Child & Adolescent Psychiatry Annual Conference, Port Douglas*
Sadler T (2008) Reflections on two decades of adolescent school refusal *Child and Adolescent Psychiatry Grand Rounds, Brisbane*
Corbett D, Ward D (2009) The BAC Community Access and Socialisation Group *Protecting Children Today Conference, Brisbane*
Hayes M, Clarke A (2009) The role of Occupational Therapy and Speech Pathology in managing children with complex trauma *Zonal Directors Statewide Meeting, Department of Child Safety, Brisbane*
Hoang K (2009) Benefits of adventure therapy in a mental health setting. *Victorian Outdoor Education Conference, Melbourne*

Current Research Projects:
Case review study, (first commenced in 2005 and continuing), compares communication disorders and psychiatric diagnoses. Results found common communication profile amongst eating disordered (anorexic) patients; identified the prevalence of communication impairment in the self-harming population. This project is currently being considered by the University of Queensland, Division of Speech Pathology and Audiology, for inclusion in the next round of Honour's and Master's students.
A proposal is currently before RCH Ethics Committee entitled: Communicate: an examination of the interface between self harming populations and communication impaired populations in child and youth mental health services.
Design, trial and evaluation of *BAC Adolescent Developmental Tasks Questionnaire* – a measure of the key adolescent developmental milestones to assess an adolescent's strengths and difficulties to assist care planning in a rehabilitation environment.

Academic Links:
Clarke A, (2005 – 2009) Invited lecturer: Communication profiles in mental health, engagement with adolescents, Specific diagnoses – ADHD, Aspergers, OCD, anxiety, depression *University of Queensland Division of Speech Pathology, School of Rehabilitation Sciences*
Corbett D (2006 – 2009) Invited lecturer: Clinical skills in adolescence *Masters and Doctorate of Clinical Psychology Postgraduate Program, Psychology Department, The University of Queensland*
Corbett D (2006 – 2009) Invited lecturer: The scientist practitioner model in action *Postgraduate Honours Psychology Program, Psychology Department, The University of Queensland*
Sadler T (1993 – 2010) Managing adolescents with severe and complex mental illness (4 sessions per year) *Queensland Advanced Trainee Registrar Program, RANZCP*