4th March 2010

Dr. David Crompton
Executive Director Clinical Services
Metro South Mental Health Service

Dear David

Please find enclosed the draft Model of Service Delivery (MOSD) for the Adolescent Extended Treatment and Rehabilitation Centre (AETRC) formerly known as Barrett Adolescent Unit. As requested by you at the Redland Facility Project Team Meeting on 4th February this document has been reviewed by a working group of the Statewide Mental Health Network Child and Youth Sub Group. This group comprised of Erica Lee, Manager Mater CYMHS, Dr. Brett McDermott, Executive Director Mater CYMHS, Dr. Penny Brassey, Clinical Director, Townsville CYMHS, Dr. Michael Daubney, Clinical Director, Metro South CYMHS, Dr. James Scott, Child Psychiatrist, RCH CYMHS, Fiona Cameron, A/Statewide Principal Project Officer, CYMHS, Dr. Trevor Sadler, Clinical Director, AETRC (who provided input via email as he is currently overseas) and myself. Recommendations have been further reviewed by Denisse Best, Allied Health Leader, Queensland Children's Services.

The group acknowledged that reviewing the MOSD was a complex task which was not conducive to the four week timeframe. The group were able to meet on three occasions with email communication in between sessions.

The emphasis has been on addressing clinical governance issues, positioning AETRC in the integrated CYMHS continuum of care and refining referral, treatment and discharge processes. The group recommended clinical governance of AETRC be incorporated within the QCH (the Mater in the interim period) as this would address some of the key themes identified in the recent reviews. It would facilitate the establishment of clear reporting relationships, address risk management and patient safety issues and enable multidisciplinary staff to link into existing frameworks of clinical supervision, staff development and clinical education and peer support networks. It would also ensure that the national mental health reform agenda is embedded into the operational management of AETRC.

There are a range of recommendations relating to the continuum of care including referrals being reviewed by a multidisciplinary intake panel consisting of key stakeholders, treatment being defined to a six month period in most cases, a suite of evidence based treatments being available which will be tailored to suit the individual's needs and more assertive discharge planning processes being adopted.

In relation to resources required from Redland Hospital it would be envisaged that they would support acute medical emergencies and other medical issues that can be managed

locally. AETRC as an integrated component of the Mater/ QCH would have access to a range of specialists who could provide support.

In relation to the proposed building design of AETRC when it is relocated to Redlands it is recommended that this be reviewed in lieu of the changes to the MOSD. The cottage style of accommodation may not be conducive to the proposed six month treatment model and some components of this may need to be modified. It is noted that not all group members had an appreciation of the current status of the proposed building design for AETRC. It would be recommended that the group have the opportunity to familiarise themselves with this prior to further comment. The group (or part thereof) would like to be involved in any discussions relating to building re-design.

While some significant changes have been made to the original draft MOSD the group would like to emphasise that this document should not be viewed as the final version of the MOSD for AETRC. Further work is required to finalise this document and encapsulate the detail of the above recommendations. The group view it as imperative that we continue to work on this document and are consulted with in relation to any changes that are proposed.

As you were aware Dr. Trevor Sadler, Clinical Director of AETRC, was unable to participate in these group discussions. He has sent us a range of email information in relation to the current treatment programs at AETRC and his observations from visiting other adolescent units overseas. It should be noted that there was not group consensus on all issues. Trevor felt strongly that the model proposed above did not encapsulate the complexity of the AETRC cohort and was simplistic in nature. The group note that Trevor is critical of the 6 month treatment time frame suggesting there is no evidence for this period of care. The group note that there is equally no evidence for a 1-3 year admission and these lengthier periods of care are more costly, block beds and appear developmentally inconsistent with generalising change to the patient's local setting. For your information I have enclosed the information that Trevor forwarded to the group.

Please do not hesitate to contact myself (or any member of the group) in relation to the above information if further clarity or discussion is required.

Kind Regards

Judi Krause
Acting Executive Director
Royal Children’s Hospital
Child and Youth Mental Health Service
Children’s Health Services.

c.c. Shirley Wigan – Executive Director Mental Health Toowoomba MHS
Aaron Groves – Director Mental Health

Model of Service for Mental Health in Queensland

Service Guideline for the ADOLESCENT EXTENDED TREATMENT CENTRE

Service Description and Function:

The Adolescent Extended Treatment Centre provides specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness/es. The majority of consumers present with severe psychosocial impairment as a result of their mental illness/es, and presentations are often complicated by developmental co-morbidities. Many also experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

The centre currently offers various levels of care from 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program. Transition to the community is facilitated by partial hospitalisation with outpatient follow up available if appropriate. The proposed redevelopment of the Centre will include therapeutic residential and step down accommodation and a family stay unit. The service provides multidisciplinary assessment, collaborative integrated treatment and rehabilitation interventions, and discharge planning to young people and their family/carers.

Care focuses on the treatment or stabilisation of the symptoms of severe mental illness and aims to develop tailored rehabilitation interventions (psychosocial, educational and vocational programs) to promote progress in developmental tasks appropriate to the adolescent and their illness. The care and discharge planning delivered by the service is facilitated in collaboration with the consumer, their family/carers and a range of key stakeholders and service providers, so as to enable the young person to build on their strengths and maintain and enhance recovery focused outcomes upon discharge.

The service capability of the Adolescent Extended Treatment Centre is defined in the Child and Youth Non-Acute Inpatient sub module of the *Clinical Services Capability Framework (CSCF)* - *Mental Health Services Module*, which can be found on either the *CSCF* or Mental Health Branch website once endorsement and implementation is complete in early 2010.

Target Population:

The Adolescent Extended Treatment Centre provides specialist multidisciplinary specialist assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age whose level of mental illness and disability persist despite intense interventions in community or acute inpatient settings. All present with co-morbid disorders or developmental delays.

Adolescents may continue treatment past their 18th birthday if there are clinical indications that recovery is more likely if they continue at the Adolescent Extended Treatment Centre rather than transferring to an adult setting. This is conditional on their not posing a risk to the health or safety of others who are minors. Transition to an adult mental health service should involve extensive clinical planning and include the consumer, their family/carers, and all service providers.

The incidence of significant disorders of adolescents admitted 2004 -2009 is provided in Table 1.

Table 1. Adolescent Extended Treatment Centre, Consumer Demographics, 2004-2009

Consumer Demographics[1]	
Mean Age	
Gender	
Indigenous Australian	
Mental Health Legal Status	

Data source: HBISCUS audit of Barrett Adolescent Centre patients

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

The average length of stay for an adolescent admitted to the Adolescent Extended Treatment Centre is 9.5 months with a median of 7.5 months.

Reasons for admission will include severe and persistent eating disorders, social anxiety disorder, persistent severe recurrent self harm with associated depression, anxiety and PTSD and persistent psychotic disorder. There are usually multiple co-morbidities associated with the primary diagnosis including a range of anxiety disorder, oppositional defiant disorder and developmental disorders including language disorders. A majority will be diagnosed with parent-child relational problems. Based on the activity data collected in 2004 - 09, it is anticipated that the diagnostic profile of the consumer group accessing the Adolescent Extended Treatment Centre will be similar to that outlined in Table 2.

[1] Adolescents aged 14 years to less than 18 years.

Table 2. Adolescent Extended Treatment Centre, Diagnostic Profile[2]

	Percentage	ICD-10 Category Code
Social Anxiety Disorders		F20 – F29
OCD and Anxiety Disorders		
Eating Disorders		
Depression and Dysthymic Disorders		
Post Traumatic Symptoms		
Schizophrenia		
Pervasive Developmental Disorders		
Receptive-Expressive Language Disorders		
Other Developmental Disorders		
Oppositional Defiant Disorder		
Substance Abuse		
Disorders with an Organic Origin		
Parent child relational disorders		

Data source: Chart Review of Patients

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Diagnosis is that recorded in the Outcomes Information System at the end of episode (movement to other mental health setting and to no further care).

Service Planning Guidelines:

Key stakeholders associated with the *Queensland Plan for Mental Health 2007 – 2017,* in conjunction with service providers and consumers and carers, are leading the redesign and strategic service planning of the Adolescent Extended Treatment Centre.

There are no recognised guidelines nationally or internationally for the number of beds required for this type of facility.

Legislative Framework:

The Adolescent Extended Treatment Centre is gazetted as an authorised mental health service in accordance with Section 495 of the *Mental Health Act 2000*.

Service Delivery Pathway:

Referral

The Adolescent Extended Treatment Centre accepts and prioritises referrals from other Child and Youth Mental Health Service (CYMHS) facilities from across Queensland (community clinics, acute inpatient or day patient units). Under some circumstances, referrals may be accepted from private mental health practitioners. A comprehensive clinical assessment occurs prior to the

[2] Admitted adolescents (aged 13 – 18 years) in 2004 – 09.

decision to admit in order to assess the adolescent's suitability for admission, their potential interactions with other adolescents, and to orientate the adolescent and their family/carers to the service.

Treatment Overview

Based on available clinical information from the referrer and the assessment interview, the adolescent will be offered an admission as a day patient, a limited admission inpatient (usually two to six weeks) or an open admission inpatient. If there is a wait before admission, the Clinical Liaison Clinical Nurse will communicate with the referrer and the family to assess the levels of acuity and will advise of progress towards admission. Timing of admission is determined by the length of time on the waiting list, the relative acuity of the individual case, and the current mix of adolescents within the unit.

Based on the principles of Recovery, as outlined in the ***Sharing Responsibility for Recovery: creating and sustaining recovery orientated systems of care for mental health*** document, mental health services operate on the premise that most consumers can and do recover[3] from mental illness. Services are directed at helping the consumer (and their family/carers) manage their illness and enhance their capacity for recovery. Importantly, the Adolescent Extended Treatment Centre team considers how the concept of Recovery applies to adolescents and their families/carers. This includes acknowledgement that Recovery should take into account developmental processes, that the concepts of Recovery may also be applied to parents, carers and entire families, and that the mental health field for this consumer group is broader than that for adults (i.e. including prevention and early intervention; a wider range of challenges and disorders, not all of which are mental illnesses; and that the focus should be on promoting the positive potential of all children and adolescents).

An initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission. During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery. Continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other agencies of significance to an adolescent. These plans reflect phases of an adolescent's admission. They incorporate at different times assessment, treatment and rehabilitation and discharge planning.

Treatment is provided in the least restrictive, most appropriate facility for the required level of care that balances the young person's autonomy with their need for observation and treatment in a safe environment.

[3] It is important to note that some disorders (such as intellectual and developmental disorders) may not be associated with the definition of a 'true' recovery, however, mental health services may still have a role in helping these young people to achieve an optimal level of personal functioning and social participation.

Core Service Provision:

1. Clinical Interventions

A multidisciplinary mental health team in conjunction with the Adolescent Extended Treatment Centre School delivers and coordinates a range of integrated therapeutic, rehabilitation and recovery focused interventions. These interventions focus not only on the symptoms and behaviours associated with severe, persistent mental illness, but also on the reciprocal interactions between these symptoms and behaviours on delays and moratoriums in developmental tasks and specific developmental impairments.

Interventions may be individual, group or generic.

Individualised interventions determined by evidenced based practice include:

- Psychological interventions (verbal and non-verbal therapies and education).
- Pharmacotherapy.
- Family therapy and education.
- Individualised behavioural programs.
- Other biological interventions (e.g. Electro Convulsive Therapy [ECT], psychosurgery).

Interventions delivered in groups include:

- Individual education plans delivered by the Extended Treatment Adolescent Inpatient School (staff employed by Education Queensland).
- A range of group based activities which are tailored to meet the needs of any particular group of adolescents, predominantly activity based and aimed at intervening in areas of psychological and developmental need.

Generic interventions include:

- Maintaining a milieu with professional staff so that young people experience an environment consistent with the qualities identified in longitudinal studies of optimal parenting.
- Forming strong positive therapeutic alliances between staff, consumers and families/carers.
- Providing opportunities for activities of daily living, leisure, social interaction and personal privacy
- Encouraging peer support opportunities, where available, for young people and/or families to appropriately engage with past young persons/carers for peer support.

The Adolescent Extended Treatment Centre School addresses delays and moratoriums on a number of developmental tasks including education and vocational preparation. Appropriate educational plans are developed after an assessment of the adolescent's educational strengths and difficulties. If a young person is not currently enrolled in an education program, a decision will be made whether to engage an adolescent in a school readiness program, develop a formal educational program with links to external curricula or develop educational strengths to enhance vocational readiness. The school develops a transitional program towards continuing education or workforce participation as part of the Centre's comprehensive discharge planning.

Increased levels of intervention are sometimes necessary for the management of clinical presentations associated with an acute exacerbation of mental illness and behavioural difficulties that increase the risk to themselves or others. These increased levels of interventions are delivered by qualified staff following a comprehensive risk assessment. They may take a number of forms ranging from specific behavioural, activity based or sensorimotor interventions through to increased visual observation and the use of a designated high dependency area through to the potential use of restraint and seclusion. The use of an increased level of intervention is based on clinical need, in order to ensure the safety of the young person as well as the safety of others. The maintenance of basic human rights such as privacy, dignity, cultural background and confidentiality are recognised, respected and promoted in all clinical interventions.

2. Discharge Planning

Discharge planning is a component of each young person's Recovery Plan. Discharge planning typically will not begin until comprehensive assessments of the adolescent and the functioning of their family is completed, and the particular variables associated with progress have been assessed. Nevertheless, potential discharge goals are usually able to be negotiated with the adolescent in the early stages of admission.

- Young people are most commonly discharged from the Adolescent Extended Treatment Centre back to their home environment or independent living. Adolescents may transition between the various components of the program to assist the transition and facilitate rehabilitation and recovery goals. Considerable support will still be required on discharge for the young person and their family and/or carers.
-

Adolescent Extended Treatment Centre discharge planning and support for young people includes, but is not limited to:

- Continued engagement of the parent or carer throughout the admission where possible and appropriate with the potential for enhanced care on discharge.
- Assessing the capacity of parents or carers to provide safe, appropriate care. Where this is not possible, a notification is made to the Department of Child Safety to receive the adolescent into care. If they do not accept the notification, or if the adolescent is older, they are prepared for independent living in either supported accommodation if available, or to live independently.
- Facilitating extended periods of leave, and transition to partial hospitalisation, step down facility or day program if appropriate.
- Developing a clear educational or vocational plan which is usually negotiated with the adolescent. The transition into the appropriate program commences prior to discharge as part of discharge planning.
- Developing linkages with developmentally appropriate activities in the community where the adolescent will reside.
- The referring CYMHS team or private clinician is involved throughout the term of admission unless the adolescent turns 18 years during the

admission. Follow up will be arranged by negotiation with the adolescent and their family/carers, in addition to the referrer, another specialist service or if appropriate, with the limited outpatient service at the Extended Treatment Adolescent Unit.

- Maintaining collaborative relationships with a wide range of service providers including education providers, extended family and carers, general practitioners, general community health services and/or adult mental health services to meet the needs of the young person and enhance their capacity to effectively manage their mental health care needs in a less intensive environment and continue recovery.

3. Expected Clinical Outcomes

All adolescents requiring extended treatment and rehabilitation have severe persistent mental illness, resulting in severe impairment. For most, extended treatment and rehabilitation is likely to significantly reduce the severity of symptoms of their mental illness and restore considerable functional improvement. Adolescents are admitted with the understanding that there is a reasonable chance of improvement in either or both their symptoms and their function, and that this improvement has some chance of being maintained for a period of time.

Mental health services utilise the *Health of the Nation Outcome Scale for Children and Adolescents* (HoNOSCA) to measure the severity of symptoms and health status of the consumer across 15 broad items. Each item is rated from 0 ("no problem") to 4 ("severe to very severe problem"). These scores can be summed to provide five sub-scales (behaviour problems, impairment, symptomatic problem, social problems and information). Clinicians use this data to record both the complexity of a consumer's episode of illness and to monitor changes in their symptoms and functioning over the period of care. As indicated in Figure 1, CYCMHS consumers will typically present with clinically significant scores in XXX of the sub scales – XXX, XXX, XXX, with an average total score of XXX on admission and XXX on discharge.

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Figure 1. Adolescent Extended Treatment Centre, Average HoNOSCA Subscale Scores, 2007/2008

Data source: Outcomes Information System

NEED TO ADD THIS TABLE.

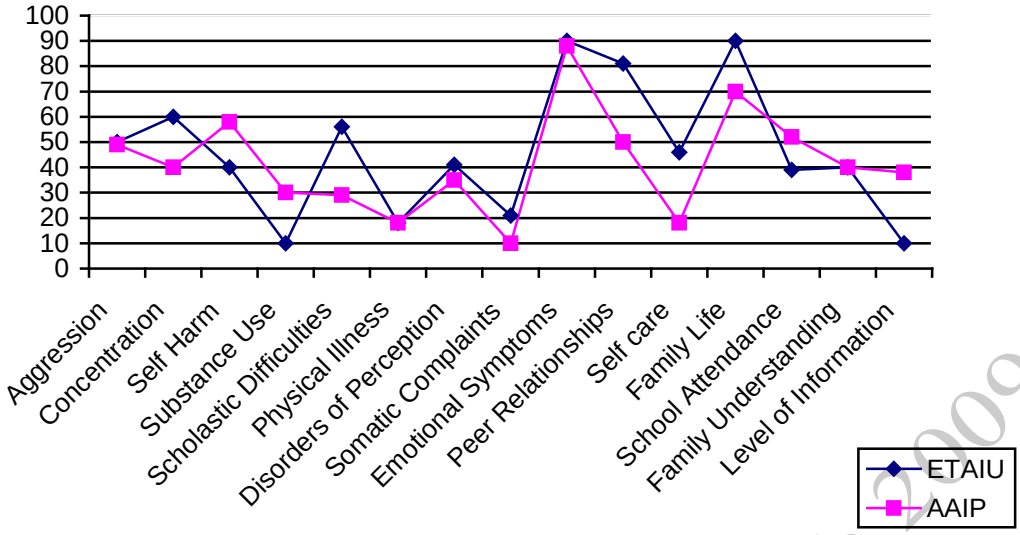
NOTES:

(a) Where an item is scored 7 or 9, for the purpose of this analysis, the score is converted to a zero. However, measures with more than two items, of the first 13 items, rated 7 or 9 are excluded from this analysis. *n* refers to the number of 'valid' collections (that is, measures that have two or less items scored 7 or 9).

(b) 'Max' refers to the maximum possible score for each of the subscales. Caution is required with any graphical representation as the subscales have different denominators and are therefore not strictly comparable.

Turning now to Figure 2 below, a representation of HoNOSCA scores is provided on the 15 items at admission (new collection), review and end (no further care). Consumers of the Adolescent Extended Treatment Centre will present with clinically significant scores on the majority of items.

Figure 2. Clinically Significant HoNOSCA Items (?date) on Admission.[4]



Data source: Outcomes Information System

NOTES:

(a) Age is calculated based upon first contact with mental health services within the reference period.

(b) Percentage is calculated for each individual item, but only when the scores are between 0 and 4. Measures with a 7 or 9 are excluded from this analysis on an item by item basis, therefore the denominator may change between items.

(c) *n* refers to the number of collections with a score between 0 and 4.

Applicable to ALL HoNOSCA Data (in addition to the specifics listed under each item)

- New Collections is a combination of New Referral and Referral from other mental health services.
- Review Collections is a combination of Standard Review and Ad Hoc Reviews.
- End of Episode due to *no further care* refers to consumers who are discharged from the community service for whom no further treatment or care is planned by the mental health network. Consumers who move to a different health service setting in a different mental health network (for example, a consumer of ambulatory services in Metro South admitted to an inpatient unit in the Gold Coast) are included in the *no further care* analysis.
- Community episodes which end due to *movement to another health service setting* refers to consumers who are admitted to acute or extended treatment service in the mental health network.
- All reasons for ending an episode, other than those listed above are excluded from the analysis.

4. Collaborative Care Systems and Service Linkages

Child and Youth Mental Health services operate in a complex, multi-system environment including crucial interactions with Education Queensland,

[4] Adolescents aged 14 to less than 18 years admitted to an Adolescent Extended Treatment Centre (ETAIU) vs an Acute Adolescent Inpatient Unit.

Department of Child Safety, Child Health Services, Juvenile Justice, Disability Services Queensland, Department of Communities, Alcohol Tobacco and Other Drug Services, private providers, non-government organisations disability support providers and others.

Services should be integrated and coordinated, with partnerships and linkages with other agencies for young people and with specialist mental health services, to ensure continuity of care across the service system and through the young person's developmental transitions. Mechanisms for joint planning, developing and coordinating services should be developed.

The Adolescent Extended Treatment Centre will develop service linkages with:

- Acute and ambulatory child and youth mental health services
- Adult mental health services
- Specialist health clinics for the target population e.g. diabetes clinic for children
- Community pharmacies
- Educational providers/schools and Guidance Officers
- GPs and other relevant health service providers
- Private mental health service providers
- Child health and developmental services
- Primary health care providers (including those for Indigenous health)
- Department of Communities (Child Safety Services, Youth Justice and Disability Services)
- Government and non-government community-based youth and family counselling and parent support services

Staffing Structure and Composition:

The Adolescent Extended Treatment Centre is staffed by a multidisciplinary team of clinical and non clinical staff. Treatment and rehabilitation is provided by clinical mental health workers including doctors, nurses and health professionals including occupational therapists, psychologists, social workers and speech pathologists with regular access to a dietitian and exercise physiologist. Additionally, the multidisciplinary team are supported by administrative officers, and catering and security staff who assist with the day to day operations of the unit. Young person and carer consultants and peer support workers should be engaged by the service. *(CSCF Workforce hyperlink).*

The Adolescent Extended Treatment Centre and Education Queensland work collaboratively to ensure the effective provision of resources, enabling a comprehensive and tailored educational program as an essential strategy of rehabilitation.

The effectiveness of the Adolescent Extended Treatment Centre is dependent upon an adequate number of appropriately trained clinical and non clinical staff. The complexity of adolescence mandates the need to provide staff with the opportunity to access continuing education programs, clinical supervision and mentoring and other appropriate staff support mechanisms. The Adolescent Extended Treatment Centre provides clinical placements for

undergraduate students, encouraging rotations through the unit from staff from other areas of the mental health services and supporting education and research opportunities.

A number of roles and duties are generic to all Adolescent Extended Treatment Centre clinical staff. These roles include, but are not limited to:

- Monitoring mental state during activities, monitoring risk and participating in the development of appropriate risk management plans.
- Generalising the gains from a range of individual and group based interventions to assist recovery.
- Engaging and promoting activities which facilitate progress in developmental tasks in conjunction with other staff and service providers.
- Developing individual Recovery Plans in consultation with the other members of the treating team, the adolescent, and the family or carers.
- Undertaking relevant supervision and professional development to ensure contemporary and evidence based practice.
- Evaluating the evidence for individual and group interventions to develop a continuum of evidence based practice.

The role of the consultant psychiatrist, registrars and medical officers includes, but is not limited to:

- Ensuring that a comprehensive assessment is available which includes a detailed history including any relevant collateral history through to specialist medical examinations and diagnostic formulation. A physical assessment is part of the overall assessment process.
- Monitoring mental state and risk in relation to stage of change, current interventions.
- Collating and synthesising information about the impact of multiple therapeutic, developmental and family interventions on progress mental state and stage of change in the recovery process to assist in enhancing the cohesion of the multidisciplinary team.
- Delivering, prescribing and supervising appropriate treatments including biological treatments (pharmacological, ECT) or at times being the prime provider of psychological or family interventions.
- Administering the *MHA 2000* as required under legislation.

The role of nursing staff includes, but is not limited to:

- Providing high quality levels observations of symptom and behavioural changes, risk of harm to self or others, progress in developmental tasks, responses to care, counselling and group interventions, and interactions with parents/carers to formulate appropriate levels of supervision, individual support, medication adjustments, counselling interventions and behavioural management plans.
- Assisting adolescents to identify those factors that enable them to cope and to encourage them to utilise strategies that increase their own mental health and safety.
- Contributing to maintaining an environment that is safe, therapeutic and developmentally and clinically appropriate.
- Implementing and evaluating the effectiveness of nursing interventions as outlined in the Recovery Plan.

- Communicating with parents or carers about issues of leave, progress and areas of support.
- Facilitation and provision of developmental and therapeutic interventions for adolescents to enhance strengths identified in the individual Recovery Plan.
- Engaging adolescents is developmentally appropriate activities of daily living, and provide options to increase social, physical and leisure activity.
- Developing areas of individual expertise to contribute to the range of recovery oriented programs.
- Providing nursing care for general medical conditions in consultation with appropriate medical teams.
- Communicating with community support services to ensure that adolescents have access to the supports they require.

The role of allied health staff includes, but is not limited to:

- Providing discipline specific individual assessment of the young person's development, progress in developmental tasks and symptoms and behaviours of mental illness.
- Develop discipline specific, cross discipline and generic interventions towards treatment and rehabilitation of the mental illness in the context of impairments in developmental tasks associated with both the mental illness and developmental delays.
- Implementing a range of individual and group based adolescent, parent/carer and family therapy utilising verbal, non-verbal and activity based therapies.

The role of consumer and carer workers includes, but is not limited to:

- Effectively engage young people and carers (through appropriate consultation methods) to inform recruitment and selection processes. This may include, but is not limited to, young persons and carers serving as members of recruitment and selection panels or by being involved in staff training where stories of recovery and the consumer/carer lived experience is highlighted.
- Effectively engage with young people and carers to meaningfully participate in the planning, delivery and evaluation of the services provided by the Adolescent Extended Treatment Centre. This should include identifying areas for improvement and what is working well.
- Working collaboratively with clinicians to foster a recovery focused service to enhance a positive outcome for young people and their family/carers.

Performance, Quality and Safety Indicators:

The Adolescent Extended Treatment Centre has not been benchmarked on Key Performance Indicators because of the lack of comparable facilities. The following indicators are adapted from the *Queensland's Mental Health Patient Safety Plan (2008- 2013)* which supports and facilitates the culture of safe practice, continuous improvement and consumer focused outcomes. The following guiding principles are proposed as indicators of performance accountability and quality.

- Service delivery is focused on adolescents and the achievement of positive outcomes.
- Strategies are implemented that promote optimum quality of life for adolescents with mental health problems and mental illness.
- Practice is improved through a framework of assessment, monitoring, planning, evaluation and follow up.
- Comprehensive, coordinated and individualised care that considers all aspects of the adolescent's recovery is provided.
- Decision making by the adolescents about their treatment and care is encouraged and involvement of families, carers and significant others is facilitated where possible.
- Adolescents, family members, carers, referring service providers and the local community of the adolescent are involved in the planning, development, implementation and evaluation of the mental health service.
- The unique physical, emotional, social, cultural and spiritual dimensions of the adolescent or family members are utilised in Recovery Planning, and staff work with them to develop their own supports in their community.
- Strategies such as incident reporting, Root Cause Analysis and reviews of sentinel events are implemented to ensure clinical practices and other processes are evidence based and continually improved to meet best practice requirements.
- Participation in professional development activities and demonstration of learning in daily practices.

This service guideline will be reviewed in line with the evaluation strategy of the *Queensland Plan for Mental Health 2007 – 2017.* The Strategic Policy Unit of the Mental Health Branch is charged with ensuring that the policies and procedures remain relevant and updated.

Key resources:

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*

- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008
- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program
- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

MODEL OF SERVICE DELIVERY FOR THE ADOLESCENT INTEGRATED TREATMENT AND REHABILITATION CENTRE

INTRODUCTION

I started composing this at about 11000 metres above sea level en route to Europe. Normally this is of little relevance, but it has brought to mind an analogy relevant to the Model of Service Delivery for Barrett.

If I was in a city in which I had never been before, I would get a map, get my bearings and find my way around the city. Up here, there is little of anything. The atmosphere is rarified, even clouds are absent. I can see a few stars, but can't see enough of any familiar constellations to get my bearings. There are no recognisable landmarks to see where I am on the map.

I've often had the feeling that this is what it has been like at BAC over the past 23 years. We see adolescents at the extreme end of the spectrum, with complex disorders and family life. We need to negotiate a pathway to their treatment in what is often a unique combination of circumstances that has brought them to that point.

In some ways the Model of Service Delivery (MOSD) is an indication of the navigation tools we use to negotiate that path through treatment and the resources we need to do that. Your task is to assess the validity of the MOSD. I maintain that the lack of reference points creates problems in assessing the validity of the MOSD.

This paper is under the following headings.

Establishing reference points - (What criteria can we use to determine the MOSD for an Adolescent Integrated Treatment and Rehabilitation Unit?) The sub-headings are:

- characteristics of adolescents currently admitted to BAC (it is necessary to understand this patient cohort, and not extrapolate from those seen in other settings e.g. community CYMHS)
- literature reviews with respect to severe disorders in adolescents, functioning of inpatient units, treatments for specific disorders or behaviours, rehabilitation for mental disorders in adolescence
- comparisons with function of equivalent adolescent inpatient units in Australia or overseas
- observations we have made over the years about processes of change

Our current approaches to treatment and rehabilitation

Questions raised

ESTABLISHING REFERENCE POINTS.

Reference Point 1. Characteristics of Adolescents Admitted to BAC

Characteristics of the adolescents admitted to BAC is at once both the most obvious, but also the most easily overlooked reference point.

Adolescents typically are referred with one of three profiles:

- those with severe anorexia who have had extensive treatments and repeated hospitalisations prior to admission
- those with severe school refusal who typically have not been to school for 12 months or more in spite of a range of interventions
- those with recurrent self harm and high suicidality.

A fourth group - those with severe, persistent psychosis, are small and will not be described in detail.

They are likely to have in common:

- high rates of co-morbidities including co-morbid mental illness, and often a range of co-morbid developmental problems.
- high rates of family dysfunction including abuse and neglect
- severe impairments in functioning in a number of areas
- failed responses to treatments for the primary disorder. Paradoxically referrals often come from the more experienced CYMHS clinicians - presumably because they are engaging the more difficult adolescents for longer periods, and can negotiate a referral to BAC.
- difficulties in recognising and expressing emotions
- difficulties in various cognitive functions utilised in cognitive therapies - problem solving, recognising and applying cognitive approaches etc.

Characteristics pertaining to each profile are now outlined

Adolescents with severe, persistent anorexia

- We have treated adolescents with anorexia since at least 1986.
- For the past 13 years (since the opening of the RBH Adolescent Inpatient Unit and subsequently other inpatient units) these have had 15+ months of treatment in both community and acute inpatient settings prior to admission to BAC.
- Most admitted during this period have had BMI's in the 15 - 18 range which is only maintained in this range while in hospital, and physical health becomes impaired within days to a fortnight of discharge.
- have had severe co-morbid Social Anxiety Disorder or Avoidant Personality Disorder. Many had other co-morbid anxiety disorders (e.g. Generalised Anxiety Disorder, OCD etc.). Most have Major Depressive Episodes before and during admission.
- The without severe Social Anxiety Disorder (they had mild to moderate SAD) had which directly contributed to the Anorexia. (Several other adolescents with anorexia also had incidents of abuse which required treatment, but was not as directly related to the Anorexia).
-
- Lengths of stay have increased and outcomes are poorer since naso-gastric feeding has become more routine in this group.
- Typically they are non-contemplative (pre-contemplative) in terms of motivation to change.
- Functional impairments in this group include interrupted schooling, limited or no peer interactions, very constricted leisure activities
- Outcomes for this group have become poorer over the past two decades. Only about

50% do not need admission to hospital within two years post discharge cf about 70% 15 years ago. This reflects the increasing severity of those admitted to BAC, the increased length of time of being quite unwell and the increased complexity of family life in the current group.

Adolescents with severe school refusal

- This group was the main reason for which BAC was initially established.
- Nearly all had severe Social Anxiety Disorder/Avoidant Personality Disorder.
- Many have co-morbid anxiety disorders (e.g. Generalised Anxiety Disorder, Separation Anxiety Disorder, OCD etc.). Some have Major Depressive Episodes before and during admission.
- Typically they have not attended school for >12 months, and have either no contact with peers, contact with one peer or contact with peers via the internet.
- Since the internet became widespread, most adolescents in this group have sleep reversal patterns compared to 20 years ago. This has decreased any secondary gains for parents who are happy to have adolescent company during the day. Consequently they are less likely to convince parents to withdraw them from therapy.
- More families of these adolescents have the capacity to engage in family therapy than other groups. Nevertheless rates of parental mental illness, substance use, neglect and abuse are higher than in the average CYMHS population.
- This group has the shortest length of stay (mean 6 months)
- More adolescents are in the contemplative stage of change compared to the non-contemplative
- Functional impairments in this group include body image disturbances from a variety of factors, poor peer relationships, specific learning disorders in over half, constricted leisure skills, poor self care skills, diminished competencies for independence, poor individuation, poor goal setting or future planning and underdeveloped schemas.
- Short term (up to a year) outcomes are good as measured by improvements in mood, engagement in school or work, contact with peers, improved family life, improved range of leisure for 75% on discharge. However, I am impressed by the severity and chronicity of severe Social Anxiety Disorder. Often they require a range of supports and interventions which is not available in the community.

Adolescents with severe recurrent self harm and high levels of suicidality

- This group has increased over the past 20 years.
- They can broadly be divided into 3 sub-groups
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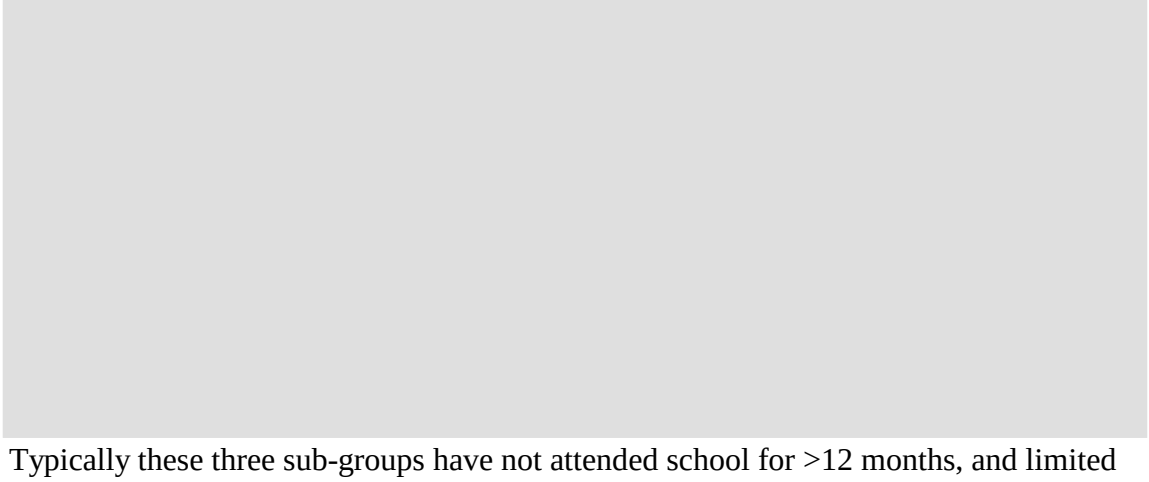
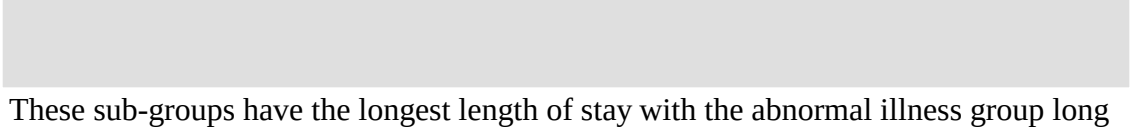
- 
- Typically these three sub-groups have not attended school for >12 months, and limited contact with peers.
- 
- These sub-groups have the longest length of stay with the abnormal illness group long because of lack of community supports and containment, and the internalising group because of clinical reasons.
- Most of these adolescents actively seek help.
- Functional impairments in this group include variable peer relationships, constricted leisure skills, variable competencies for independence, poor individuation, poor goal setting or future planning and underdeveloped schemas.

Reference Point 2. Literature Reviews

These are broad summaries of the published research from literature searches from Medline or Medline +PsychInfo.

2.1 Characteristics of adolescents with more severe illness

I have always wondered as I treat adolescents at BAC: Do we treat adolescents with disorders

which require treatment? If we didn't treat them, would they be any worse off in their adult life?

The AIHW publication "*The Burden of Illness and Disease in Australia 2006" (*available from their website has a chapter on mental illness. This chapter outlines the onset of many mental disorders in adolescence, their persistence into adult life, and the contributions of various disorders to the burden of illness. Patterns of presentation to BAC are consistent with the respective burdens for various mental disorders in this chapter.

Certainly there is a substantial literature which suggests that adolescent depressive disorder is likely to persist, particularly when there is a background of either severe anxiety or abuse. Those eating disorders which persists longer than 2-5 years is likely to persist for 10 years or more. Severe Social Anxiety Disorder is likely to persist for 10- 15 years. Sexual abuse and alcohol abuse are the only factors listed in the WHO burden of disease publications which have an impact on mental illness. Sexual abuse in children is associated with higher rates of substance abuse, more persistent depression, eating disorders, especially bulimia and an earlier onset of panic disorder.

I feel satisfied the evidence is that we are being referred adolescents with an appropriate range of disorders of sufficient severity that their distress and impairment is likely to persist well into adulthood without some attempt at intervention.

2.2 Functioning of adolescent inpatient units

Articles concerning therapeutic interventions focus on single interventions - use of medication, time out and a range of family or group interventions.

Articles on the inpatient treatment of anorexia nervosa cover a range of topics including outcomes (generally positive), descriptions of phenomenology, investigations of various biological parameters, use of medication, family therapy in the inpatient setting, the short term effects of naso-gastric feeding. Only two articles describe integrated approaches in the inpatient setting. The literature does not contain a consensus view of the management of anorexia nervosa in an inpatient unit - articles are simply descriptors of an individual unit. It does not address the management of adolescents with severe and persistent eating disorder.

Articles on affective disorders describe a range of phenomenology, demographic data, co-morbidities, scales, biological markers and family variables. A few describe the use of a particular antidepressant in this population. None descibe psychological therapies in an inpatient unit.

The literature on the treatment of adolescent school refusal is scant, the majority describes the phenomenology of adolescents in inpatient units (consistent with what we see at BAC) and one article describes outcomes. Neither of two literature searches (school refusal and inpatient units) revealed any articles on treatment processes for school refusal in an inpatient unit.

Articles mentioning adolescents with self harm in an inpatient adolescent setting describe diagnosis, contagion effects, associated phenomenology, demographics, behavioural programs, outcomes and staff attitudes. I could not find any dealing with a comprehensive

approach to severe recurrent self harm.

The literature provides no consensus as to the way adolescent inpatient units operate. It is difficult to get an idea from many articles as to characteristics of adolescents they admit. Some units operate for adolescents with conduct or substance abuse issues which we are unlikely to accept. Much of the literature predates 1990, when there were significant changes in the operation of inpatient units in the USA with the impact of managed care. Articles which do describe programs describe interventions for a particular behaviour or issue, but not the context of the comprehensive program into which they fit. Books and chapters of books are certainly written on adolescent inpatient treatment, but these draw on a fairly scant research literature.

2.3 Literature on particular disorders

Some time ago I did a survey of articles in three of the major journals in our field - the *Journal of the American Academy of Child and Adolescent Psychiatrists*, the *Journal of Child Psychology and Psychiatry* and the *Journal of Child and Adolescent Mental Health*. Less than 10% of the articles specifically addressed issues of non-pharmacological treatments of various disorders.

The treatment of anorexia has several components - restoration of weight (e.g. nasogastric re-feeding or behavioural program), establishment of normal eating patterns, psychological therapies for the disorder (e.g. CBT-E, motivational approaches, acceptance-commitment therapy or focal interventions for particular aspects e.g perfectionism or self esteem) and family therapy (e.g. Maudsley). None are strongly evidenced based (although one article cites the Maudsley model as being the most promising). There is no clear evidence for the adoption of any one approach. This literature applies to a general population of adolescents with anorexia. Gowers describes a UK multi-site approach of either general community CAMHS treatment, specialist AN outpatient treatment or inpatient treatment. 12 - 17% did poorly after two years. No comment is made on further interventions for this group, nor have I found an article in the literature which addresses further interventions for those who failed the initial intervention being investigated. Yet this is the group we see at BAC.

I recently reviewed the literature for the past 40 years on school refusal and social anxiety disorder for a keynote address to a Mater CYMHS conference. Most of the literature deals with conceptualising the issue. Articles describing treatment describe treatment at the early intervention and prevention end of the spectrum. No consensus view emerges of the management of school refusal. Similar observations apply to the literature on the management of social anxiety disorder in adolescence, apart interventions at the less severe end of the spectrum e.g. an intervention for those with a sole social phobia e.g. speaking or eating in front of others. A number of CBT approaches are described in the adult literature.

I have done a 20 year literature search as part of my role of clinical leader of the CYMHS self harm collaborative. Definitions of self harm are quite variable, and few articles distinguish between those who self harm 2 or 3 times vs those who may self harm 10+ times (including several serious suicide attempts). Few articles try to contextualise the meaning of self harm for an individual - most regard it as a uniform behaviour with no regard to temperament, associated pscyhopathology etc.

- Most of the treatment literature derives from adult populations.

- Some articles on the efficacy of DBT in adolescents are appearing.
- DBT is one of a number of therapies including Problem Solving Therapy, Emotion-Focussed Therapy, Cognitive-Analytic Therapy (CAT) and some brief psychodynamic therapies.
- DBT does not deal with issues of abuse or help with symptoms of PTSD.
- None of these has a compelling evidence based that they can be used with all populations.
- DBT research generally employed a very unequal control group. The control group offered much less clinical contact, and therapist input was highly variable and unsupervised. Channen from Orygen compared CAT with "Good Clinical Care" which offered the same intensity of contact and therapist supervision. The results were equivalent to DBT and there was no difference between CAT and the control. This and observations in other local settings raises the question as to whether a large component of treatment of these therapies is regular contact with a therapist who is well supervised (and whose own anxieties are contained). This accords with observations from the psychodynamic tradition of workign with victims of abuse. Michael recently drew my attention to some articles reevaluating the place of DBT.
- Although DBT is largely used in the treatment of BPD, I could find no articles on the treatment of adolescents with DSM-III avoidant disorder of childhood who were abused and were subsequently suicidal. The very different (almost polar opposite) psychological functioning of this group vs the BPD group would suggest they require very different treatment approaches.
- The research on management of adolescents who self harm is more complicated in this area than what is often mooted.

General Observations about Research Literature on Treatment of Mental Illness in Adolescents.

- The literature on treatment of various disorders describes a range of therapeutic interventions which could be trialed for a particular disorder or behaviour.
- There is no compelling evidence to utilise a specific approach for any one disorder.
- It is surprising that this literature generally assumes treatment of a mental illness, mental disorder or associated behaviour without any reference to the other characteristics of that person in most cases. If individuals respond differently to different antidepressants, there is even more likelihood of different responses to different psychological and family interventions/
- Research has moved from individual case descriptions in the psychodynamically orientated literature up until the 1970's to trials of interventions for groups of people. Research is often regarded as being more powerful if it involves larger populations. However significant information about individual variation and responses to treatment are lost in this approach. This is a crucial research gap for a centre dealing with disorders at the severe end of the spectrum.
- The literature is silent on interventions which may be further tried for those who do not respond to an intervention.

2.3 Rehabilitation for impairment due to mental illness in adolescence

It has been about 8 months since I looked at my literature review on impairment due to mental illness in adolescence. However, at that time, the literature was scant, with articles describing only the impairments associated with specific disorders, or impairments in

adolescents who had been in a particular treatment setting. No articles addressed the impact on impairments on the treatment of a disorder (e.g. whether a person with depression with severe impairment of function was no more or less responsive to treatment than one with little impairment). No articles described rehabilitation. I presume the assumption is made that if a treatment intervention is made, the impairment will dissipate with no specific rehabilitation necessary.

Reference Point 3. Comparisons with other equivalent adolescent inpatient units

Rivendell until recently was the only other current longer stay adolescent inpatient unit in Australia. A psychiatrist from there said they were forced to become a Monday to Friday unit in the late 1980's because so many adolescents went on leave. They tried admitting adolescents with eating disorders or who were suicidal, but they required transfer to either an adult or a short term adult inpatient unit. The results were disastrous. They concluded that highly suicidal adolescents or those with eating disorders do not function well in a long term inpatient unit. I maintain the discontinuity in treatment setting was crucial to their poor outcome. As fare as I can tell, no UK unit operates similarly to Rivendell.

I am a participant in an email discussion group run by the Royal College of Psychiatrists for adolescent inpatient unit staff as part of their Quality Network for Inpatient CAMHS (QNIC). There are differences in the operation of inpatient services in the UK, and certainly some fundamental differences between the units there and our units in Queensland. I hope to understand more as I visit various units over the next 3 weeks.

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

(Group changed name from Adolescent Integrated Treatment and Rehabilitation Centre to Adolescent Extended Treatment and Rehabilitation Centre AETRC as this better reflected where the service is positioned in the CYMHS continuum of care).

Model of Service

1. What does the Service intend to achieve?

Mental disorders are the most prevalent illnesses in adolescence and they have the potential to carry the greatest burden of illness into adult life.

The Child and Youth Mental Health Service (CYMHS) Adolescent Extended Treatment and rehabilitation Centre (AETRC) is a statewide service providing specialist multidisciplinary assessment and integrated treatment and rehabilitation to adolescents between 13 and 17 years of age with severe, persistent mental illness/es. The majority of consumers present with severe psychosocial impairment as a result of their mental illness/es, and presentations are often complicated by developmental co-morbidities. Many also experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

The AETRC is part of the Statewide CYMHS continuum of care that includes community based treatment teams, Adolescent Day Programs and Acute Child and Adolescent Inpatient units.

The key functions of the AETRC are to:

- build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending AETRC
- provide individually tailored evidence based treatment interventions to alleviate or treat distressing symptoms and promote recovery
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide a 6 month targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community

Treatment programs undertaken by the AETRC will include an extensive range of therapeutic interventions and comprehensive activities to assist in the development and recovery of the consumer. The program will follow structured phases incorporating assessment, establishing a therapeutic alliance and developing realistic therapeutic goals, treatment, and assertive discharge planning to facilitate reintegration back to community based treatment.

Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers
- targeted 6 month treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff

- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

Length of Admission:
- admissions will be individually planned
- in specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review following the initial 6 month admission.

Level of Care:
The level of care is determined by:
- providing care in the least restrictive environment appropriate to the adolescent's developmental stage
- acuity of behaviours associated with the mental illness with respect to safety to self and others
- capacity of the adolescent to undertake daily self care activities
- care systems available for transition to the community
- access to AETRC

2. Who is the Service for?

The AETRC is available for Queensland adolescents;
- aged 13 – 17 years
- eligible to attend high school
- with severe and complex mental illness
- who have impaired development secondary to their mental illness
- who have persisting symptoms and functional impairment despite previous treatment delivered by other components of child and adolescent mental health services including CYMHS community clinics, Evolve, day programs and acute inpatient child and youth mental health services
- who will benefit from a range of clinical interventions
- who may have a range of co-morbidities including developmental delay and intellectual impairment

Severe and complex mental illness in adolescents occurs in a number of disorders. Many adolescents present with a complex array of co-morbidities. AETRC typically treats adolescent that can be characterised as outlined below:

1. Adolescents with persistent depression, usually in the context of childhood abuse. These individuals frequently have concomitant symptoms of trauma eg. PTSD, dissociation, recurrent self harm and dissociative hallucinoses.

2. Adolescents diagnosed with a range of disorders associated with prolonged inability to attend school in spite of active community interventions. These disorders include Social Anxiety Disorder, Avoidant Disorder of Childhood, Separation Anxiety Disorder and Oppositional Defiant Disorder. It does not include individuals with truancy secondary to Conduct Disorder.

3. Adolescents diagnosed with complex post traumatic stress disorder. These individuals can present with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour resistant to treatment within other levels of the service system.

4. Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.

5. Adolescents with a persistent eating disorder such that they are unable to maintain weight for any period in the community. These typically have co-morbid Social Anxiety Disorder. Treatment will have included the input of practitioners with specialist eating disorders experience prior to acceptance at AITRC. Previous hospital admissions for treatment of the eating disorder may have occurred. Any admission to AETRC of an adolescent with an eating disorder will be linked into the Queensland Children's Hospital (QCH) for specialist medical treatment. Adolescents requiring nutritional resuscitation will be referred to QCH. For adolescents over 15 years of age specialist medical treatment may be met by an appropriate adult health facility.

Suitability for admission will be undertaken by an **intake panel** that will consist of:

- the AETRC director/delegated senior clinical staff
- referring specialist and/or Team Leader
- representative from Metro South CYMHS
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders (including local CYMHS as required)

In making a decision the panel will consider the:

- likelihood of the adolescent to experience a positive therapeutic outcome
- potential for treatment at AETRC to assist with developmental progression
- potential adverse impacts on the adolescent of being admitted to the unit (e.g. isolation from existing supports and/or cultural connection; possibility of escalation of self harm behaviour) posed by the adolescent to other inpatients and staff, this includes evidence of inappropriate sexualised behaviour
- potential adverse impacts on other adolescents if they were to be admitted
- possible safety issues

A comprehensive recovery and discharge management plan that includes community reintegration will be in place prior to admission for all adolescents.

Adolescents who reach their 18th birthday during admission will be assessed on a case by case basis by the panel. The panel will consider whether:

- continued admission is likely to produce the greatest clinical outcome in terms of symptom reduction and developmental progression
- admission will pose any risk to the safety of other adolescents in the AETRC

Admission Risks
Some young people may pose considerable risk to others. Admission to AETRC will be decided on an individual case basis by a multidisciplinary review panel.
Admission risks include but are not restricted to:

- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder
- ongoing significant substance abuse

3. What does the Service do?

AETRC will provide a range of evidence based treatments tailored to meet the individual's mental health needs. Interventions will be delivered by appropriately skilled multidisciplinary staff that has access to professional development and clinical supervision.

The key components of AETRC are defined below:

Key Component	Key Elements	Comments
Working with other service providers	• the AETRC will develop and maintain strong partnerships with other components of the CYMHS network	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network
	• shared-care with the referrer and the community CYMHS will be maintained	• in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC
Working with other service providers	• the AETRC panel will develop and maintain partnerships with other relevant health services who interact with adolescents with severe and complex mental illness	• this includes formal agreements with Metro South facilities (paediatric and adult health services) and/or QCH to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; surgical management of severe lacerations or burns from self injury • this may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • this includes but is not limited to the Department of Communities (Child Safety), the Department of

Key Component	Key Elements	Comments
		Communities (Disability Services) and the Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of a reasonable suspicion of child abuse and neglect	• AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect
Referral, Access and Triage	• Statewide referrals are accepted for planned admissions	• this supports continuity of care for the adolescent
	• responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC	
	• all referrals are made to the Clinical Liaison, Clinical Nurse and processed through the panel	• a single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
Referral, Access and Triage		• this process monitors changes in acuity and the need for admission to help determine priorities for admissions
	• if there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted	• the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness following consultation with the treating

Key Component	Key Elements	Comments
		team
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	
Key Component	**Key Elements**	**Comments**
Assessments **Mental Health Assessments**	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	assessment begins with the referral and continues throughout the admission
	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
Family/Carers Assessments	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care	• this process begins with the referral and continues throughout the admission
	• parents/carers will have their needs assessed as indicated or requested	• parents or carers will be involved in the mental health care of the adolescent as much as possible • significant effort will be made to support the involvement of parents/carers
	• if parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service	
Developmental Assessments	• the AETRC will obtain a comprehensive understanding of developmental disorders and their current impact	• this process begins with available information on referral and during the admission
	• the AETRC will obtain information on schooling as it is available	• this occurs upon admission
Assessments of	• the AETRC will obtain assessments	• this assessment occurs

Key Component	Key Elements	Comments
Function	on an adolescent's function in tasks appropriate to their stage of development	throughout the admission
Physical Health Assessments	• routine physical examination will occur on admission • physical health is to be monitored throughout the admission • appropriate physical investigations should be informed as necessary	
Risk Assessments	• a key function of the panel will be to assess risk prior to admission • risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review • documentation of all past history of deliberate self harm will be included in assessment of current risk • will include a formalised suicide risk assessment	• all risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA) • risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation
General Aspects of Assessment	• assessment timeframes	• routine assessments will be prompt and timely • initial assessments of mental health, development and family are to be completed within two weeks of admission
	• Communication	• the outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)
	• Care Plans	• all assessment processes will be documented and integrated into the care plan
	• *Mental Health Act 2000* assessments	• *Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor
	• drug and alcohol assessments	• assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact

Key Component	Key Elements	Comments
		with the service
• **Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Case Review Meetings**		
Recovery Planning	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• during admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery • continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies
Clinical Interventions **<u>Psychotherapeutic</u>**	• Interventions will be individualised according to the adolescent's treatment needs • individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy)	• therapists will receive recognised, specific training in the mode of therapy identified • the therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • the therapist will have access to regular supervision • specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships) • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
<u>Psychotherapeutic</u>	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.) • individual supportive verbal or non-	• used at times when the

Key Component	Key Elements	Comments
	verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)	adolescent is distressed or to generalise strategies to the day to day environment • staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision • supportive therapies will be integrated into the overall therapeutic approaches to the adolescent
	• psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy)	• as for individual verbal interventions
Behavioural interventions	• individual specific behavioural intervention (e.g. desensitisation program for anxiety)	• behavioural program constructed under appropriate supervision • monitor evidence for effectiveness of intervention
	• individual general behavioural interventions to reduce specific behaviours (e.g. self harm)	• review effectiveness of behavioural program at individual and Centre level
	• group general or specific behavioural interventions	• monitor evidence for effectiveness of intervention
Psycho-education Interventions	• includes general specific or general psycho-education on mental illness	• available to adolescents and their parents/carers
Family Interventions	• family interventions to support the family/carer while the adolescent is in the AETRC	• supportive family interventions will, when possible be integrated into the overall therapeutic approaches to the adolescent • includes psycho-education for parents/carers
Family Interventions	• family therapy as appropriate	• therapist will have recognised training in family therapytherapists will have access to continuing supervision • review evidence for effectiveness of the

Key Component	Key Elements	Comments
		intervention • family therapy will be integrated into the overall therapeutic approaches to the adolescent
	• monitoring mental health of parent/carer	• support for parent/carer to access appropriate mental health care
	• monitor risk of abuse or neglect	• fulfil statutory obligations if child protection concerns are identified
	• promote qualities of care which enable reflection of qualities of home	• review of interactions with staff • support staff in reviewing interactions with and attitudes to adolescent
Interventions to Facilitate Tasks of Adolescent Development	• interventions to promote appropriate development in a safe and validating environment • school based interventions to promote learning, educational or vocational goals and life skills • individual based interventions to promote an aspect of adolescent development	
	• group based interventions to promote aspects of adolescent development which may include adventure based and recreational activities	• individualised according to adolescents in the group • goals to be defined • under the clinical direction of a nominated clinician
Pharmacological Interventions	• administration of psychotropic medications under the direction of the consultant psychiatrist	• education given to the adolescent and parent(s)/carer about medication and potential adverse effects • regular administration and supervision of psychotropic medications • regular monitoring for efficacy and adverse effects of psychotropic medications
	• administration of non-psychotropic medications under medical supervision	• includes medications for general physical health
Other Interventions	• sensory modulation	• utilised under the supervision of trained staff • monitor evidence of effects
	• electroconvulsive therapy	• a rarely used intervention,

Key Component	Key Elements	Comments
		subject to a specific policy compliance with Australian clinical practice guidelines • administered in accord with the *Mental Health Act 2000*
Care Coordination **<u>Clinical care coordination and review</u>**	• prior to admission a Care Coordinator will be appointed to each adolescent The Care coordinator will be responsible for: • providing centre orientation to the adolescent and their parent(s)/carer(s) • monitoring the adolescent's mental state and level of function in developmental tasks • assisting the adolescent to identify and implement goals for their care plan • acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process • assisting the adolescent in implementing strategies from individual and group interventions in daily living	• the Care Coordinator can be a member of the treating team and is appointed by the AITRC director • an orientation information pack will be available to adolescents and their parent(s)/carer(s)
<u>Care Monitoring</u>	• providing a detailed report of the adolescent's progress for the care planning meeting • adolescents at high risk and require higher levels of observations will be reviewed daily	• the frequency of monitoring will depend on the levels of acuity • monitoring will integrate information from individual and group interventions and observations • this includes daily reviews by the registrar, and twice weekly reviews by the consultant psychiatrist
<u>Case Review</u>	• the case review meeting formally reviews the Care Plans which will be updated at intervals of not more than two months	• the Community Liaison Clinical Nurse is responsible to ensure adolescents are regularly reviewed • the adolescent, referring agencies and other key stakeholders will participate in the Case Review process

Key Component	Key Elements	Comments
	• all members of the clinical team who provide interventions for the adolescent will have input into the case review	• the consultant psychiatrist will chair the case review meeting • documented details to include date, clinical issues raised, care plan, contributing team members, and those responsible for actions
	• ad hoc case review meetings may be held at other times if clinically indicated	• these will be initiated after discussion at the case conference or at the request of the adolescent
	• progress and outcomes will be monitored at the case review meeting	• where possible this will include consumers and carers • appropriate structured assessments will be utilised • the process will include objective measures • annual audits will ensure that reviews are being conducted
Case Conference	• a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan	• a consultant psychiatrist should be in attendance at every case conference
	• risk assessments will be updated as necessary in the case conference	• the frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed • risk will be reviewed weekly or more frequently if required
Record Keeping	• all contacts, clinical processes and care planning will be documented in the adolescent's clinical record	• progress notes will be consecutive within the clinical record according to date
	• clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes	• personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date
	• there will be a single written clinical record for each adolescent	• the written record will align with any electronic record
Record Keeping	• all case reviews will be documented	• actions will be agreed to and

Key Component	Key Elements	Comments
	in the adolescent's clinical record	changes in treatment discussed by the whole team and recorded
Discharge Planning	• discharge planning should begin at time of admission with key stakeholders being actively involved.	• the adolescent and key stakeholders are actively involved in discharge planning • discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service
	• discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family	• the AETRC School will be primarily responsible for and support school reintegration
	• discharge letters outlining current treatments and interventions need to be sent to any ongoing key health service providers within one week of discharge	• the Registrar and Care Coordinator will prepare this letter • it should identify relapse patterns and risk assessment/ management information • follow-up telephone with any ongoing key health service providers will occur as well as the discharge letter
	• a further comprehensive Discharge Summary outlining the nature of interventions and progress during admission will be sent at full transfer from the AETRC	• this will be prepared by the clinicians involved in direct Interventions
	• if events necessitate an unplanned discharge, the AETRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessments	
	• in the event of discharge the AETRC will ensure they have appropriate accommodation, and that external services will follow up in a timely fashion	

Key Component	Key Elements	Comments
Transfer	• depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit • transfer to an adult inpatient unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs	
Continuity of Care	• referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission	• referrers and significant stake holders are invited to participate in the Case Review meetings • the Care Coordinator will liaise more frequently with others as necessary
Team Approach	• specifically defined joint therapeutic interventions between the AETRC and the Referrer can be negotiated either when the adolescent is attending the Centre or on periods of extended leave	• joint interventions can only occur if clear communication between the AETRC and external clinician can be established
	• responsibility for emergency contact will be clearly defined when an adolescent is on extended leave	• this will be negotiated between the AETRC and the local CYMHS
	• case loads should be managed to ensure effective use of resources and to support staff	
	• staff employed by the Department of Education and Training will be regarded as part of the team	

4. Service and operational procedures

The AETRC will function best when:

- there is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff
- strong internal and external partnerships are established and maintained
- clear and strong clinical and operational leadership roles are provided
- team members are provided with regular supervision
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service

Caseload
Caseload sizes need to consider a range of factors, including complexity of need, current staff resources within the team, and the available skill mix of the team.

Under normal circumstances, care coordination will not be provided by students or staff appointed less than 0.5 FTE. Typically Care Coordinators are nursing staff.

Staffing

The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry, nursing, psychology, social work, occupational therapy, speech pathology and other specialist CYMHS staff. While there is a typical staff establishment, this may be altered according to levels of acuity and the need for specific therapeutic skills.

Administrative support is essential for the efficient operation of the AETRC.

All permanently appointed medical and senior nursing staff be appointed (or working towards becoming) authorised mental health practitioners.

Hours of Operation

- access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
- nursing staff are rostered to cover shifts 24 hours, 7 days a week
- an on-call consultant child and adolescent psychiatrist will be available 24 hours, 7 days per week
- 24 hours, 7 days a week telephone crisis support will be available to adolescents on leave is available. A mobile response will not be available
- routine assessments and interventions will be scheduled during business hours (9am - 5pm) 7 days a week

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

- written, up to date policies will outline procedures for managing different levels of risk (e.g. joint visiting)
- staff safety will be explicitly outlined in risk assessment policy
- risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team

Staff Training

Consumers and carers will help inform the delivery of staff training where appropriate.

Staff from the AETRC will engage in CYMHS training. On occasion AETRC will deliver training to other components of the CYMHS where appropriate.
Training will include:

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

Where specific therapies are being delivered staff will be trained in the particular modality of the therapy e.g. family therapy, cognitive behaviour therapy.

5. Clinical and corporate governance

The AETRC will operate as part of the CYMHS continuum of care model.

Clinical decision making and clinical accountability will be the ultimate responsibility of the appointed Consultant Psychiatrist - Director. At a local level, the centre is managed by a core team including the Nurse Unit Manager, Senior Health Professional, the Consultant Psychiatrist, an Adolescent Advocate, a Parent Representative and the School Principal. This team will meet regularly in meetings chaired by the Consultant Psychiatrist.

The centre will be directly responsible to the corporate governance of the Metro South Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Director, Child and Adolescent Mental Health Services, Metro South Health Service District. Interim line management arrangements may be required.

- maintain strong operational and strategic links to the CYMHS network
- establish effective, collaborative partnerships with general health services, in particular Child and Youth Health Services and services to support young people e.g. Child Safety Services
- provide education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder;
- develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC.

6. Where are the Services and what do they look like?

The Adolescent Integrated Treatment and Rehabilitation Centre is currently located at Wacol (the Barrett Adolescent Centre). It is anticipated it will move to Redlands Hospital in 2011.

7. How do Services relate to each other?

- formalised partnerships
- Memorandum of Understandings between government departments
- guidelines
- statewide model of CYMHS
- The AETRC is part of the CYMHS network of services in Queensland as described in Section 3

8. How do consumers and carers improve our Service?

Consumer and carer will contribute to continued practice improvement through the following mechanisms:

- consumer and carer participation in collaborative treatment planning
- consumer and carer feedback tools (e.g. surveys, suggestion boxes)
- consumer and carer's will inform staff training

Consumer and carer involvement will be compliant with the National Mental Health Standards.

9. What ensures a safe, high quality Service?

- adherence to the Australian Council of Health Care Standards (ACHS), current accreditation standards and National Standards for Mental Health Services
- appropriate clinical governance structures
- Skilled and appropriately qualified staff
- professional supervision and education available for staff
- evidence based treatment modalities
- staff professional development
- clear policy and procedures
- clinical practice guidelines, including safe medication practices

The following guidelines, benchmarks, quality and safety standards will be adhered to:

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health
- Strategic Policy Framework for Children's and Young People's Health 2002-2007: http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.
- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html

- Guidelines for the administration of electroconvulsive therapy (ECT): http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars02-03-799_528.htm/$FILE/799_528a.pdf.

Legislative Framework:

The Adolescent Extended Treatment Centre is gazetted as an authorised mental health service in accordance with Section 495 of the *Mental Health Act 2000*.

10. Key resources and further reading

- Queensland Plan for Mental Health 2007-2017
- Clinical Services Capability Framework - Mental Health Services Module
- Building guidelines for Queensland Mental Health Services – Acute mental health inpatient unit for children and acute mental health inpatient unit for youth
- Queensland Capital Works Plan
- Queensland Mental Health Benchmarking Unit
- Australian Council of Health Care Standards
- National Standards for Mental Health Services 1997
- Queensland Mental Health Patient Safety Plan 2008 – 2013
- Queensland Health Mental Health Case Management Policy Framework: Positive partnerships to build capacity and enable recovery
- *Mental Health Act 2000*
- *Health Services Regulation 2002*
- *Child Protection Act (1999)*
- State-wide Standardised Suite of Clinical Documentation for Child and Youth Mental Health Services.
- Mental Health Visual Observations Clinical Practice Guidelines 2008
- Council of Australian Governments (CoAG) National Action Plan on Mental Health 2006-2011
- Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services
- Disability Services Queensland – Mental Health Program
- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness 2004
- Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)
- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

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