Developmental Tasks – Establish Boundaries, Develop Moral Maturity

- Room privacy
- Bathroom privacy
- Safe personal storage areas
- Balance between privacy and need for observations (residential)
- Secure record storage
- Confidential (sound proof) staff areas (day and residential)
- Safe interview rooms (day area and residential)

The Tasks of Parenting

Level of commitment
Adequacy of nurturance
Attachment/bonding styles
Met dependency needs
Met protection needs
Levels of consistency, supervision, monitoring
Correction styles
Communication of schemas, values
Adequate boundaries
Emotional containment
Capacity to facilitate transitions
Capacity to understand

Parents

- Access to leave
- Visitor areas (day and residential)
- Rooms for Family Therapy (Day Area)
- Family stay unit

Staff

- capacity to protect - secure building, optimal conditions for continuous observations, high dependency area, adequate observation
- Nurturance/dependency – storage facilities for linen, blankets; kitchen to cater for prepared meals, as well as allow for meal preparation, indoor/outdoor dining areas
- Emotional containment – see tasks for developing emotional maturity

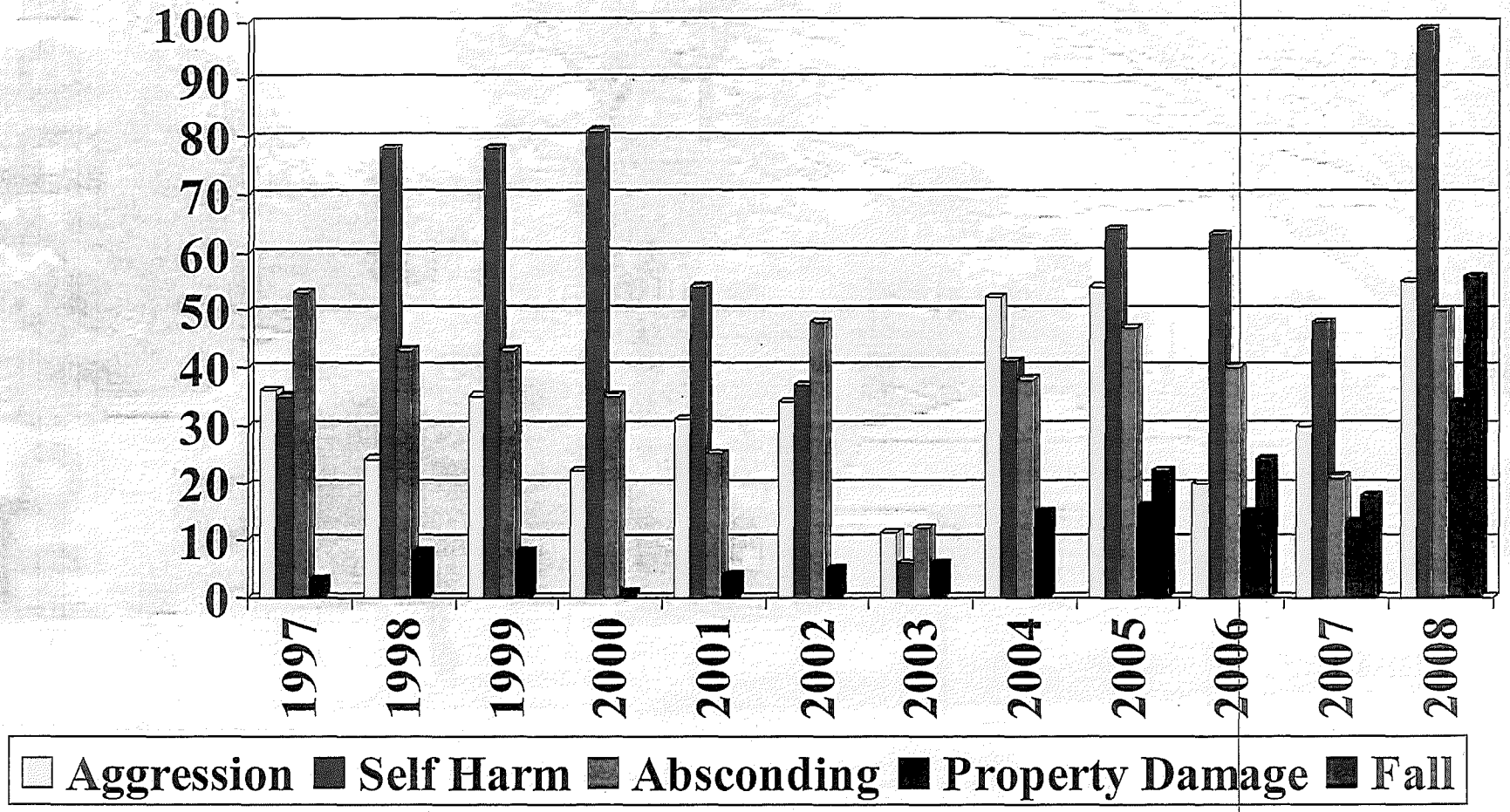
Program Matrix

- Assessment Program (assessment rooms – CLC H
- Therapeutic Program (as described)
- Discharge Program (Cars, room for meeting to develop care plans, step down facility, long term accommodation, videoconferencing facilities)
- Clinical Information Program (records storage, accessibility, reception
- Research Program – Meeting rooms (differing sizes – shared with school), student room
- Staff Development Program – Meeting rooms with data projection facilities
- Consumer and carer development program – meeting rooms, siting of reception, visitor rooms

towards recovery

Risks

Risk Behaviours - Reportable Incidents 1997 - 2007



Risk Behaviours – Hours of Continuous Observation
Hours
Escort
8000
7000
6000
5000
4000
3000
2000
1000
0
1997
1998
1999
2000
2001
2002
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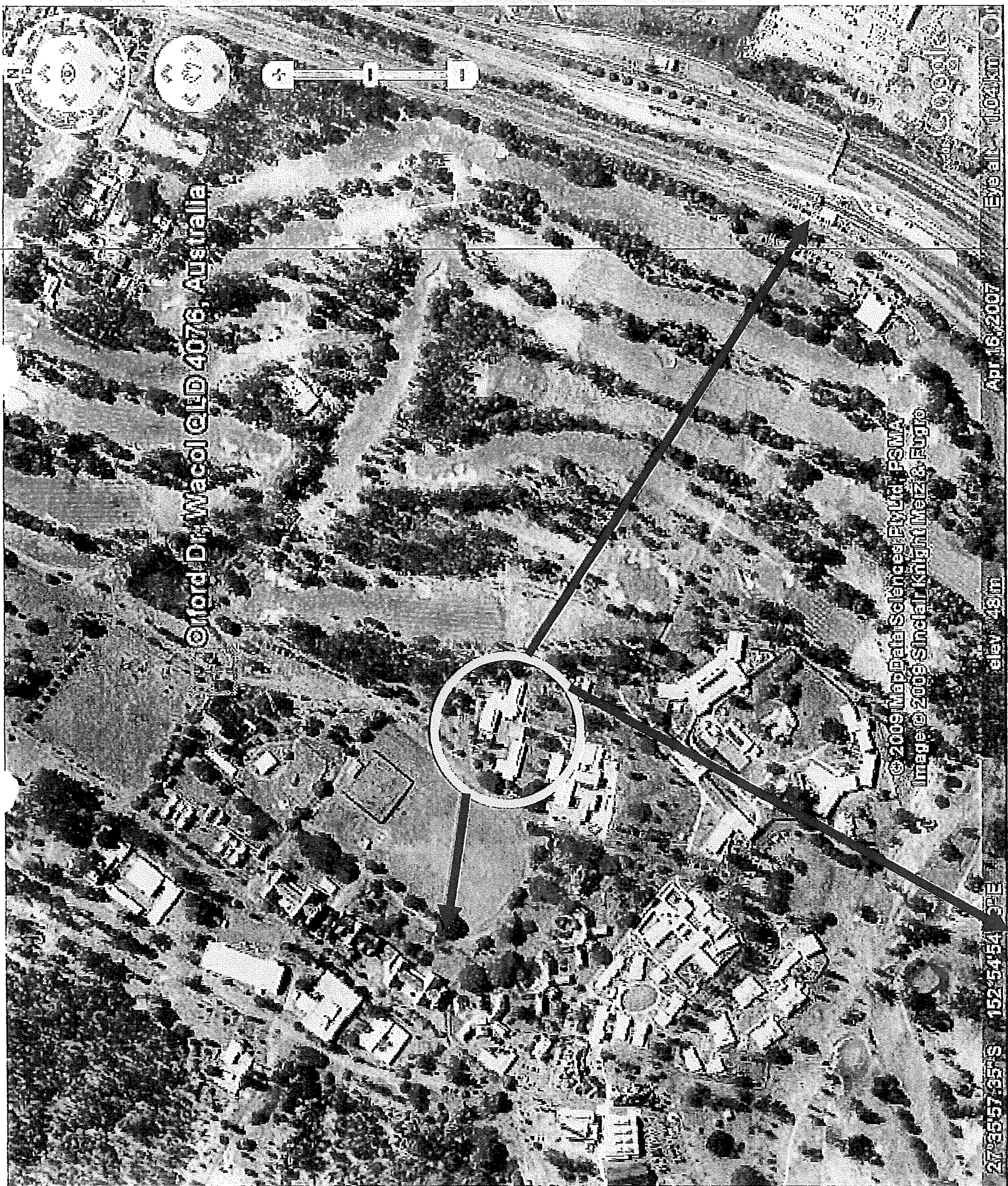
2007
2008
2009


Orford Dr, Wacol QLD 4076, Australia
© 2009 MapData Sciences Pty Ltd, PSMA
Image © 2009 Sinclair Knight Merz & Fugro
Apr 16, 2007
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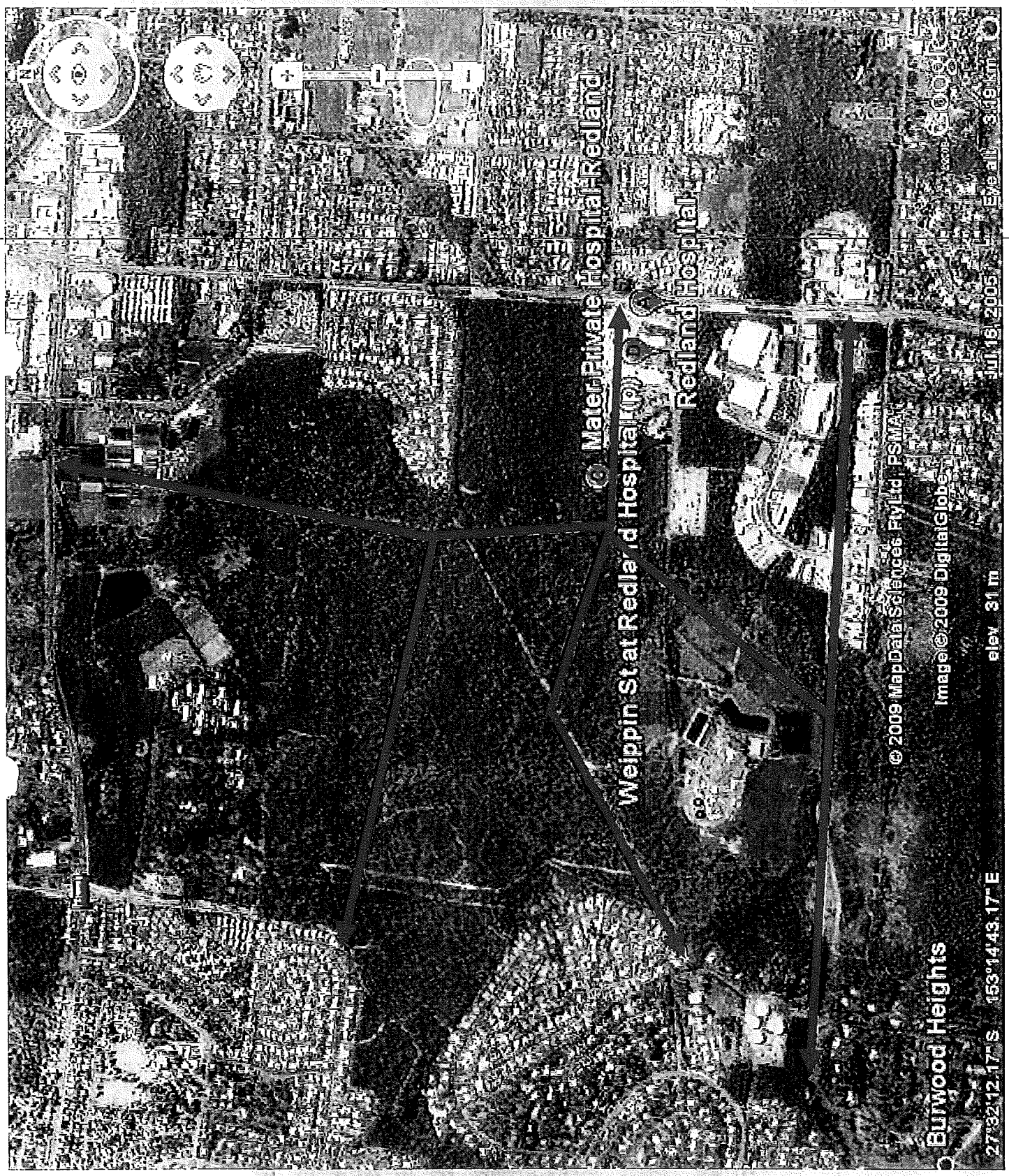
Mater Private Hospital Redland
Redland Hospital
Weippin St at Redla' d Hospital (p)
Burwood Heights
27°32'12.17"S 153°14'43.17"E
elev 31 m
Image © 2009 DigitalGlobe
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Jul 19, 2005

Risk Behaviours – Environmental Considerations

- Adequate observation, particularly in inpatient and high acuity areas
- Area for containment (high acuity)
- Low sensory rooms – day area and residential
- Time out rooms – day area and residential
- Seclusion room
- Safe, contained, outdoors de-stress area
- Areas for emotional expression – day patient and inpatient areas
- Access to physical activity areas – pool, gym, trampoline, bikes etc
- Access to adventure activities
- Buffer zone
- Safe internal environment
- Swipe card access
- Adequate security on building
- Access to hospitals
- Clinic, medication room

The Health of the Nation Outcome Scales for Children and Adolescents in an adolescent in-patient sample

Paul H. Harnett, Natalie J. Loxton, Trevor Sadler, Leanne Hides, Andrea Baldwin

Objective: The primary aims of the study were to examine the reliability and validity of the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) in a sample of adolescents requiring medium to long-term in-patient psychiatric treatment and to examine the association between HoNOSCA scores and age, gender and length of treatment.

Methods: A multidisciplinary team completed the HoNOSCA for 51 adolescent patients at intake and at 3- and 6-months following admission to the unit.

Results: The study provided support for the test-retest reliability, concurrent and convergent validity, but not the internal reliability, of the HoNOSCA. Total HoNOSCA scores at intake were similar to those found in adolescent outpatient samples, although there were some differences at the level of individual items. Similarly, while the total HoNOSCA score showed some sensitivity to change, using the total HoNOSCA score obscured important changes in specific domains of functioning over the course of admission.

Conclusion: The HoNOSCA was found to be a valid measure of global functioning at intake, thereby supporting its use in an adolescent psychiatric unit. However, focusing on individual items, rather than total score, appears more useful in evaluating the impact of inpatient psychiatric treatment on adolescents.

Key words: adolescence, evidence based practice, hospitalized, mental health, outcome assessment.

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Demonstrating the effectiveness of mental health services is a priority identified by the Australian Commonwealth Government in its National Mental Health Strategy [1]. In an attempt to promote an evidence-based approach to service delivery, the health department in Queensland has introduced a data collection procedure in which a battery of assessment instruments are routinely administered at intake and discharge with all clients of child and youth mental health facilities throughout the state [2]. The assessment package includes the Health of the Nation Outcome Scale – Child and Adolescent (HoNOSCA) [3], the Children's Global Assessment Scales (CGAS) [4] and the Strengths and Difficulties Questionnaire (SDQ) [5]. The success of these measures in providing meaningful information for evaluating the impact of child and youth mental health services is yet to be determined. In the present paper we report on the results of a trial in which the HoNOSCA was routinely administered to monitor the progress of consumers in an adolescent mental health in-patient setting.

Paul H. Harnett, Lecturer in Clinical Psychology (Correspondence)

School of Psychology, University of Queensland, St Lucia, Qld. 4072 Australia. Email: p.harnett@psy.uq.edu.au

Natalie J. Loxton, Research Officer; Trevor Sadler, Medical Director; Leanne Hides, Psychologist; Andrea Baldwin, Psychologist

Barrett Adolescent Unit, The Park – Centre for Mental Health, Brisbane, Australia

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The HoNOSCA measures a range of child and adolescent relevant problems, including aggressive behaviour, self-harm, substance misuse, academic problems, psychotic symptoms, and emotional and relationship problems. At least five studies have investigated the feasibility, acceptability, reliability and validity of the HoNOSCA [3,6–9]. Generally, the HoNOSCA has been found to be a feasible instrument for clinicians to administer across a range of settings, to be reliable, have good temporal stability across 1 week [9] and to have moderate to good interrater reliability [3,7,8]. Evidence of convergent validity has been found, with studies showing moderate to strong correlations between HoNOSCA scores at intake and the complexity of patients' presenting problems and circumstances as measured by the Paddington Complexity Scale (PCS) [6], clinician-rated CGAS score [6] and adolescents' self-reported SDQ scores [9], but correlates less strongly with parent-rated measures of child functioning, such as the SDQ [6].

Although there are relatively few studies looking at the relationship between HoNOSCA score and patients' demographics, there appears to be some differences in HoNOSCA score across treatment settings (outpatient *vs* in-patient), age groups and gender. Intake HoNOSCA scores for in-patient samples are typically higher than those for outpatient samples [3,9]. Adolescents tend to score higher than children on suicide ideation, self-injury, substance abuse and depressive symptoms [3,8]. Boys have been reported to score higher than girls on disruptive/aggressive behaviour, over-activity and problems with peers, while girls score higher on self-injury, emotional problems, and problems with family members [8]. There is some evidence that HoNOSCA score at intake is predictive of eventual length in treatment, with a moderate correlation between intake score and the number of subsequent treatment sessions attended [7]. HoNOSCA scores have been found to decrease approximately three points at 3 months and almost four points at 6 months in outpatient samples [7,8] and correlate with clinicians' global impressions of change in functioning [3,7,8].

All these studies, with the exception of Gowers *et al.* [9] have used combined samples of children and adolescents, and either outpatient or mixed in-patient and outpatient samples. Given the differences between children and adolescents, and between in-patients and outpatients, further research is needed on the reliability, validity, and sensitivity to change of the HoNOSCA in a more homogeneous, adolescent-only, in-patient setting [10]. The primary aims of the present study were to: (i) provide preliminary data on the reliability and validity of the HoNOSCA in an adolescent in-patient setting; (ii) compare the HoNOSCA scores of an adolescent psychiatric in-patient sample with reported data on in-patient and outpatient samples; and (iii) report descriptions of the current sample, including changes shown on the HoNOSCA over the course of their admission and the association between HoNOSCA and age, gender and length of stay at the unit. Specific hypotheses were that: (i) HoNOSCA scores would remain relatively stable over a 2-week period of admission (test-retest reliability); (ii) HoNOSCA scores would correlate positively with other measures of psychosocial functioning (convergent validity) and the actual behaviour of consumers during admission (concurrent validity); (iii) consumers in the current inpatient sample would show higher intake HoNOSCA scores than intake scores for outpatient samples; and (iv) that, on average, HoNOSCA scores would decrease over the period of admission (assessed at 3 and 6 months). Given the limited number of previous studies investigating age, gender or length of stay, there were no specific hypotheses regarding age differences, gender differences or length of stay and HoNOSCA score at intake or over time.

Method

Sample

The sample consisted of 51 adolescents admitted to an adolescent psychiatric inpatient unit in south-east Queensland between August 2000 and October 2002. The adolescents had a mean age of 15.05 years at admission (range 12–17) and 41% were female. There was no significant difference in age between boys (mean = 15.87) and girls (mean = 15.57, $t\ (49) = -0.42$, ns). The sample was characterized by a range of psychiatric problems including early onset psychosis, depression, anxiety disorders and conduct disorder. Average length of stay at the unit during the course of the study was 24.28 weeks (range 1–81 weeks). On average, intake HoNOSCA scores were obtained 3.1 weeks from the time of admission.

Setting

The unit is a 15-bed, in-patient facility for adolescents that accepts referrals from throughout Queensland, Australia. The unit is a medium to long-term facility with admissions generally lasting at least 3 months and sometimes for more than 12 months. Patients typically present with severe, complex, long-standing and often treatment-resistant problems, which require intensive, coordinated programs of intervention in order to reduce symptoms and improve functioning. The unit includes a school and therapeutic program delivered by a multidisciplinary team, including teachers, nursing staff, occupational therapist, speech pathologist, social worker, psychologists and psychiatrists.

Measures

Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

The HoNOSCA [3] is a 15-item clinician-rated scale. Ratings of a participants' functioning over the preceding 2 weeks were made on a 5-point scale reflecting severity of problems from no problem (0) to severe problem (4). A total HoNOSCA score is calculated by summing the first 13 items (items 14 and 15, which reflect parent understanding and knowledge are not calculated in the total HoNOSCA score [3]). It has been suggested that the HoNOSCA derives four subscale scores: (i) a Behaviour score, which assesses disruptive behaviour, inattention, overactivity, self-injury and substance misuse; (ii) an Impairment score assessing scholastic impairment, physical illness and disability; (iii) a Symptoms score, which taps psychotic, somatic, and emotional symptoms; and (iv) a Social score, which measures problems with peer and family relationships, poor self-care, and school attendance. Sub-scale scores are calculated by summing items loading on each scale (see [3]).

Paddington Complexity Scale (PCS)

The PCS [6] is a 16-item measure of clinical and environmental complexity, and focuses on three problem areas: psychiatric, physical/developmental and environmental problems. It is a clinician-rated instrument and can be rated retrospectively by a range of professionals in a multidisciplinary team. The PCS derives a total score by summing items. Total score can range from 0 to 32 with higher scores indicating greater severity and complexity of the problem.

Clinician Rated Change Scale

A seven-point perceived patient change scale described by Brann *et al.* [8] was used to provide a retrospective clinician rating of global change. This scale was rated from 'much worse' to 'much better'.

Critical incidents

The average number of critical incidents per month for each patient was recorded. Critical incidents include instances of self-harm, aggression and harm to others, unauthorized absences, accidents and injuries occurring within the unit.

Procedure

All members of the unit's multidisciplinary team were trained in the use of the HoNOSCA. Each patient was rated monthly by a multidisciplinary team at weekly case conferences. A psychologist, trained in its use, completed the PCS for each patient retrospectively after reviewing the patient's psychiatric record. A second psychologist rated 43% of the patients on the PCS to assess interrater reliability. Intraclass correlation coefficients (ICCs) used to assess interrater reliability of PCS scores found a single measure ICC of 0.96 across the two raters, indicating a high level of reliability. To obtain a measure of global change, the unit's psychiatrist, individual therapists (typically clinical psychologists), teachers, and nursing staff were asked to provide a retrospective rating of global change for each patient in their care. The mean rating across informants was used as a summary measure of global change.

Results

Reliability and validity

Test-retest

Test-retest validity was calculated from the initial HoNOSCA score and a subsequent score provided 2- to 4-weeks later. It was expected that within an in-patient sample that functioning would remain relatively stable once the adolescents had had a period to settle into the unit. HoNOSCA scores were found to be stable over this period ($r = 0.80$, $p < 0.001$).

Internal reliability

The HoNOSCA is not considered to be a unidimensional scale, with the initial study finding low intercorrelations between items [3]. The current study similarly found poor internal consistency (Cronbach alpha = 0.45). Further, the internal validity of the four subscales suggested in the original validation study (Behaviour, Impairment, Symptoms and Social) was also poor, ranging from –0.10 for Symptoms to 0.48 for Social [3]. Accordingly, only total HoNOSCA score and individual item scores were used in subsequent analyses.

Convergent validity

Convergent validity was assessed by comparing scores on the HoNOSCA and PCS. There was a moderately strong positive correlation between total HoNOSCA and PCS ($r = 0.46$, $p < 0.01$) showing higher HoNOSCA scores at intake were associated with more complex presenting problems. The mean PCS scores at intake (11.80, SD = 3.95) were associated with higher scores on several items of the HoNOSCA at intake, including overactivity/aggression ($r = 0.66$, $p < 0.001$, one-tail), scholastic/language problems ($r = 0.26$, $p < 0.05$, one-tail), psychotic symptoms ($r = 0.25$, $p < 0.05$, one-tail), peer relationships ($r = 0.33$, $p < 0.05$, one-tail) and self-care and relationship problems ($r = 0.33$, $p < 0.01$, one-tail).

Concurrent validity

Evidence of concurrent validity was demonstrated by the finding that the mean number of critical incidents patients were involved in each per month was positively associated with the intake HoNOSCA score ($r = 0.34$, $p < 0.05$). At the individual item level, there was a positive correlation between number of incidents and disruptive/aggressive behaviour ($r = 0.28$, $p < 0.05$), nonaccidental self-injury ($r = 0.43$, $p < 0.01$), and drug and alcohol difficulties ($r = 0.28$, $p < 0.05$). Further evidence of concurrent validity was shown by a positive association between changes in HoNOSCA scores over the course of admission and clinicians' retrospective reports of change. Specifically, mean ratings of patient's global change between intake and discharge or

between intake and the time of the study for participants who had not been discharged, was 5.12 (SD = 0.82). The mean change in HoNOSCA scores within the subsample of patients clinicians rated as having improved, was 1.96 at 3 months and 3.40 at 6 months, while patients considered not to have changed had HoNOSCA change scores of 0.76 at 3 months and –0.30 at 6 months.

Analysis of HoNOSCA scores

Intake ratings

The mean HoNOSCA score at admission was 15.86 (SD = 5.45). Scores ranged between 5 and 28. Scores on individual items for the current sample and the Australian outpatient sample (for comparison) are presented in Table 1. One patient in the current study was missing individual item scores and therefore was not included.

There was no significant association between age at admission with total HoNOSCA score at intake ($r = -0.08$, ns). Younger patients showed greater disruptive/aggressive behaviour than older patients ($r = -0.40$, $p < 0.01$). No significant difference was found between female (mean = 15.57, SD = 5.74) and male patients [mean = 16.07, SD = 5.33; $t(49) = 0.32$, ns] on total HoNOSCA scores at intake. On individual items boys scored significantly higher on disruptive/aggressive behaviour (1.77 *vs.* 85, $t(48) = 2.56$, $p < 0.05$) and scholastic or language difficulties than girls [1.47 *vs* 50, $t(48) = 2.65$, $p < 0.01$].

Sensitivity to change at 3 months

Change scores were calculated by subtracting HoNOSCA scores recorded closest to 3 months, or for current patients, the most recent HoNOSCA score, from the intake HoNOSCA score. Positive change scores indicated improved functioning, while negative change scores indicated deterioration. Given the directional hypothesis of overall improvement in HoNOSCA score over time, change score analyses were performed using one-tail tests. Forty-five patients (47% female) had HoNOSCA scores at both intake and 3-months (mean number of weeks from admission was 11.69 weeks, SD = 2.70). The mean HoNOSCA change score from intake was 1.51 (9.5% decrease; range –9–12), which represented a statistically significant improvement in functioning [$t(44) = 2.23$, $p < 0.05$]. On individual items a significant decrease in family life and relationship problems was found at 3 months [$t(44) = 3.72$, $p < 0.001$]. Younger patients showed greater improvement than older patients on scholastic/language problems ($r = -0.31$, $p < 0.05$) at 3 months. There was a trend for older patients to display more improvement than younger patients on psychotic symptoms at 3 months ($r = 0.27$, $p = 0.08$). There was a significant time by gender interaction on HoNOSCA total score at 3 months, with boys showing a greater improvement (mean improvement of 2.79 points) at this time than girls [mean improvement of 0.05 points; $F_{1,43} = 4.39$, $p < 0.05$].

There was a moderately strong negative correlation between HoNOSCA change scores at 3 months and PCS scores ($r = -0.47$, $p < 0.01$), indicating that less complex cases improved more than more complex cases. In particular, participants showing less complex presenting problems showed greater improvement in emotional problems ($r = -0.44$, $p < 0.01$) and psychotic symptoms ($r = 0.32$, $p < 0.05$). There was a trend for participants showing less complex presenting problems at intake to show improvement in levels of disruptive/aggressive behaviour at 3 months ($r = -0.29$, $p = 0.06$).

Sensitivity to change at 6 months

A 6-month change score was calculated for patients who stayed at least 20 weeks at the unit. Twenty-five adolescents (60% female) had scores at this time point. The mean change in scores over this 6-month

Table 1. Mean item scores for Australian outpatient sample and inpatient sample at intake, 3 months and 6 months post-intake

Scale	Outpatient sample (n = 113)	Current sample intake (n = 50)	Current sample 3 months (n = 42)	Current sample 6 months (n = 24)
1. Disruptive/aggressive behaviour	1.60	1.40 (1.31)	1.65 (1.21)	1.54 (1.21)
2. Overactivity & attentional difficulties	0.85†	1.42 (1.31)	1.29 (1.44)	1.50 (1.25)
3. Non accidental Self-injury	0.78	0.64 (1.19)	0.62 (1.01)	0.50 (0.93)
4. Alcohol, substance/solvent misuse	0.67†	0.20 (0.73)	0.10 (0.30)	0.17 (0.38)
5. Scholastic/language difficulties	1.30	1.10 (1.33)	1.05 (1.34)	1.50 (1.54)¶
6. Physical illness/disability	0.45	0.64 (1.02)	0.43 (0.94)	0.67 (0.96)
7. Hallucinations/delusions	0.52‡	0.86 (1.28)	0.79 (1.28)	0.67 (1.13)¶
8. Non-organic somatic problems	0.50	0.48 (0.93)	0.36 (0.82)	0.33 (0.56)
9. Emotional & related symptoms	2.29	2.20 (1.14)	2.14 (0.98)	2.04 (1.23)
10. Peer relationship difficulties	1.75†	2.15 (1.33)	2.05 (1.12)	2.04 (1.20)
11. Self-care & relationship problems	0.50†	1.36 (1.37)	1.29 (1.23)	1.46 (1.41)
12. Family life & relationship problems	2.30†	2.70 (.81)	2.24 (1.10)§	2.33 (1.20)¶
13. Poor school attendance	1.40†	0.66 (0.66)	0.71 (1.11)	0.67 (1.17)

Item scores for outpatient sample come from Brann *et al.* (2001); †significant difference between inpatient and outpatient samples, $p < 0.05$; ‡trend towards significance between inpatient and outpatient samples, $p = 0.06$; §significant difference between intake and 3 month score, $p < 0.05$ (one-tail); ¶significant difference between intake and 6 month score, $p < 0.05$ (one-tail).

period (mean = 23.8 weeks, SD = 2.06) was 1.92 (12% improvement; range –7–16) and approached significance [$t(24) = 1.67$, $p = 0.06$, one-tail]. On individual items there was significant improvement in psychotic symptoms [$t(23) = 1.89$, $p < 0.05$, one-tail] and family and relationship problems [$t(23) = 1.90$, $p < 0.05$, one-tail]. Older patients showed greater improvement than younger patients on psychotic symptoms ($r = 0.39$, $p = 0.06$) and displayed more improvement in overactivity/aggressive behaviour ($r = 0.41$, $p < 0.05$) and family life/relationship difficulties ($r = 0.41$, $p < 0.05$) at 6 months. There was no significant difference between boys and girls in change scores at 6 months (2.50 *vs* 1.53 improvement, respectively).

There was no association between the complexity of a participant's presenting problems on the PCS and total HoNOSCA change score at 6 months ($r = -0.05$, ns). For individual HoNOSCA items participants showing less complex presenting problems showed improvement in scholastic/language difficulties ($r = -0.53$, $p < 0.01$) and improved school attendance ($r = -0.48$, $p < 0.05$).

Length of stay

Length of stay was not associated with total HoNOSCA score ($r = 0.03$, ns) or individual item scores at intake. HoNOSCA change scores at 3 and 6 months were negatively correlated with length of stay ($r = -0.36$ at 3 months; $r = -0.35$ at 6 months), showing that, as would be expected, patients who improved more (as rated by the HoNOSCA) stayed at the unit for a shorter time. Longer stays in the unit were associated with higher levels of nonaccidental self-injury ($r = -0.34$, $p < 0.05$) and less improvement in self-care and relationship problems ($r = -0.44$, $p < 0.05$). There was a trend for continuing problems with peer relationship to be associated with a longer stay on the unit ($r = -0.37$, $p = 0.07$). Girls were found to remain at the unit longer than boys [35.12 weeks *vs.* 17.06 weeks, respectively; $t(48) = -3.55$, $p < 0.001$]. Patients who stayed longest on the unit displayed greater variability in their HoNOSCA scores over time. A 'variability' score, calculated for each patient by subtracting their lowest HoNOSCA score during their time in the unit from their highest HoNOSCA score, was strongly positively correlated with length of time spent in the unit ($r = 0.68$, $p < 0.001$).

Discussion

The aims of the present study were to provide preliminary data on the reliability and validity of the HoNOSCA in an adolescent in-patient setting; to compare intake and HoNOSCA change scores of an adolescent psychiatric in-patient sample with reported data on outpatient samples; and to report the relationship between HoNOSCA scores and age, gender and length of stay. The results of analyses used to determine the reliability and validity of the HoNOSCA were favourable. Test-retest reliability was found to be acceptable although internal consistency for the total scale and subscales was poor. This is not surprising given the instrument taps a number of independent psychosocial and psychiatric domains. Thus, while total HoNOSCA score may be a useful indicator of global functioning, individual items rather than subscales appear to be better indicators of functioning in specific domains.

The moderate correlations between intake HoNOSCA score and PCS provides support for the convergent validity of the HoNOSCA. Further support for concurrent validity was the finding that participants with higher HoNOSCA intake scores were involved in more altercations with unit staff, incidents of self-harming behaviour, and absconding from the unit. Not surprisingly, higher scores on disruptive/aggressive behaviour, self-harm, and drug and alcohol problems at intake were associated with greater numbers of incidents.

Although these relationships provide support for the validity of HoNOSCA scores at intake, for an outcome measure to be accepted by clinicians, there needs to be an association between changes on the HoNOSCA and change in the patients as perceived by the clinicians themselves [8]. In the present study agreement was found between changes in the HoNOSCA scores over three and 6 months, and clinician's global ratings of change. It should be noted, however, that not one patient was considered to have deteriorated during their stay at the unit by the clinicians. This result is similar to Brann *et al.*'s [8] findings that only three outpatients in their sample were rated by clinicians as having deteriorated in functioning over time. It could be speculated that while there is agreement between global ratings and a more objective rating scale, clinicians are reluctant to report that a patient in their care has deteriorated and that the HoNOSCA provides a more objective account of a patient's progress. However, an alternative explanation may be that clinicians note specific changes in aspects of the individual's functioning not measured by the HoNOSCA. Generally though, HoNOSCA scores appear to be valid and reliable indicators of patients global functioning.

The present study found lower intake HoNOSCA scores at intake than would be expected in the light of previous studies. Specifically, the mean HoNOSCA score at intake was similar to that reported for adolescents in an Australian outpatient setting (15.21, SD = 6.66) [8] and lower than Gowers *et al.*'s [9] British adolescent in-patient sample (19.6, no SD provided). However, in comparison with the Australian outpatient adolescents [8], the current sample had more severe levels of overactivity and attention difficulties, peer relationship difficulties, family life and relationship problems, and greater levels of psychotic symptoms, while the outpatient sample were characterized by more severe drug and alcohol problems and poorer school attendance than the current sample. Given that the HoNOSCA was rated for the prior 2 weeks, it is possible

that the on-site school and limited access to drug and alcohol on the unit may have been responsible for lower scores on these items. Additionally, as the adolescents in this sample had generally been referred after a period in an acute inpatient unit for medium to long-term treatment, their symptomatology may have settled somewhat prior to admission. Finally, it was noted that family and peer relationship problems were high in this sample and that being removed from these environmental stressors may have contributed to lower scores on the HoNOSCA at intake. In addition, the adolscents may not have developed sufficiently trusting relationships with staff to reveal the extent of their psychopathology. Importantly, the relatively low baseline HoNOSCA scores may, at least in part, explain the limited change in HoNOSCA scores noted at 3 months compared with outpatient samples [8] and the British in-patient sample [9]. It should be noted that while the HoNOSCA intake scores were relatively low, PCS scores at intake in the current study were higher in the present study compared to scores reported for the outpatient sample [6], indicating the presenting problems of the current sample were more complex.

The greatest improvement within the present sample appeared to be the patients' relationships with their family at 3 months; an improvement that remained stable at 6 months. By 6 months, there was a significant improvement in psychotic symptoms. Lack of improvement in other domains may be explained in part by (i) the small number of patients in the sample, especially at 6 months, thereby reducing the power to detect change; and (ii) scores at 6 months reflecting the functioning of longer-term patients who showed less improvement and greater variability in functioning. Indeed, in the present study HoNOSCA scores fluctuated considerably for patients staying at least 6 months at the unit. The presenting problems for these adolescents included predominantly psychotic symptoms and self-harming behaviour that justified ongoing management to contain these symptoms. Outcome evaluations using the HoNOSCA need to acknowledge that simply comparing pre- and postintervention differences will obscure the important contribution of a service in stabilizing the functioning of these individuals. In order to determine the impact of a service in stabilizing fluctuating patterns of functioning, regular monthly administration of the HoNOSCA would be recommended. Further the variability in scores over time means postintervention measures for long-term patients cannot be taken as a reliable measure of functioning, limiting the usefulness of the HoNOSCA as an outcome measure for individuals displaying psychotic and self-harming behaviour.

Little association between total HoNOSCA score and age at admission was found, although younger patients showed greater problems with disruptive and aggressive behaviour. These findings are somewhat disparate from previous studies that found younger patients had greater problems with overactivity/inattention whilst older patients had more severe emotional problems, greater substance abuse, psychotic symptoms and poorer school attendance than younger patients [3,8]. The discrepancy in results between studies may be due to characteristics of the current sample that consisted of only adolescents, rather than including both children and adolescents. There was some degree of association, however, between age and change on HoNOSCA score, with older patients showing greater improvement over the course of their admission, especially in psychotic symptomatology, family life/relationships and disruptive/aggressive behaviour.

There was no gender difference in total HoNOSCA score at intake, although boys showed greater levels of disruptive/aggressive behaviour and scholastic/language problems than girls. Although not significant, there was a tendency for boys to show higher levels of overactivity/inattention than girls and for girls to have greater emotional problems and display more self-harm than boys. This is similar to Brann *et al.*'s outpatient sample [8], however, unlike Brann *et al.* there was no difference between boys and girls in substance misuse, psychotic symptomatology, family life/relationships or school attendance.

Despite the lack of difference in total HoNOSCA score at intake, boys showed more rapid improvement in global functioning than girls. There were no gender differences in the degree of change for adolescents who stayed 6 months or more. Although HoNOSCA score at intake was not predictive of eventual length of stay in the unit, adolescents who stayed in the unit longer showed less improvement than those who stayed for a relatively short-term. This is contrary to Garralda *et al.* [7] who found greater improvement in HoNOSCA score at 6 months for those outpatients who attended a greater number of sessions over this time period. The disparate findings may well reflect differences between in- and outpatient programs. Whilst increased attendance to outpatient therapy would be expected to be positively associated with improved psychosocial functioning, inpatients showing improved functioning are more likely to be discharged from the unit thereby, showing a negative association between length of stay and HoNOSCA change score.

Methodological issues concerning the present study should be highlighted. Notably, the sample size of the present study over the 6-month period was small,

and the HoNOSCA was not compared with other outcome measures currently used in adolescent settings such as the CGAS or the SDQ. Further, the unit under study was a specialized unit that admits patients who have generally benefited minimally from traditional outpatient treatment programs and acute inpatient units.

In summary, the present study found support for the validity of the HoNOSCA and test-retest reliability, but not the internal reliability of the scale. The total HoNOSCA score provided evidence of high levels of mental health problems within the current in-patient sample. However, individual items rather than the total HoNOSCA score revealed important age, gender and length of stay differences. Similarly, while the total HoNOSCA score was sensitive to change, the total HoNOSCA score obscured important changes across gender, age and length of stay in specific domains of functioning over the course of admission. The study identified a subset of long-term patients suffering serious psychiatric conditions that showed fluctuating levels of change over the course of their admission. Successful outcomes for these individuals may be increased stability in functioning rather than improved functioning. However, further research is needed to clarify the variables that predict which individuals respond to in-patient treatment regime and which individuals would benefit from ongoing management of their mental health problems.

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21st March 2012

Dr W Kingswell
A/Director
Mental Health Alcohol Tobacco and Other Drugs Directorate
Butterfield Street
Herston

Dear Bill,

Re: ALTERNATIVE SITE OPTIONS TO REDEVELOP BARRETT

Sorry to write to you privately. There are no channels within Queensland Health to explore this issue.

As you are aware, the Redlands site faces significant hurdles - an over run in estimated cost, gaining DERM approval for the site and weathering community concerns about building on koala land. My understanding is that any of these may become an insurmountable obstacle. Naturally no one discusses possible alternatives while there is hope. My concern is that we may come to a dead end and then begin the process of considering options.

There may be two options (that come to my mind at least).

1. Redeveloping on the current site.

The Site Options Discussion Paper prepared by the Directorate nominated the current site as one of the two possible options. However, they considered only the possibility of a total rebuild, and demolishing the existing buildings.

What is necessary from a patient's perspective is new patient accommodation. Current offices and school classrooms are adequate. They need some upgrade e.g. an adequate duress system and swipe card access. However, of the five current wings in the existing building, we could retain four for the above use and demolish one for rebuilding patient accommodation.

Upgrading patient accommodation, however, is absolutely essential. Four distressed adolescents sharing the same room, and up to ten adolescents (usually girls for this number) sharing the same bathroom causes significant problems. These problems add unnecessarily to clinical difficulties.

The second essential for improved patient care is a step down unit. This was included in the original Site Options Discussion Paper . There is no capacity for it at Redlands. We have adolescents of 16 or 17 who are working towards discharge, but for whom home is unsuitable. A step down unit provides opportunity for continuing final clinical interventions while preparing them for community living. I discussed this with Aaron when he visited at Christmas time.

Without the costs of infrastructure, offices, school buildings etc, I think a rebuild of patient accommodation and a step down unit would be significantly less than the budgeted amount. It would allow extra funding to go towards other projects. It is logistically possible to maintain a limited service while this work is being undertaken.

The main concern with redeveloping at The Park was the proximity to a forensic facility. The proximity to High Secure has never been an issue for patient or parents. With the delayed time scale, we will have two to three years of this to ascertain if there are any problems. I have ideas of how to increase the separation of the two from a parent and patient perspective, yet retain free clinician transit as required. The current site offers other advantages - closer proximity to the CBD, better public transport, easier visual sightings of adolescents if they try to abscond.

2. Redeveloping at Springfield Hospital

I do not know if this is going ahead or when. If it is going to happen, it would be a site that was not on the horizon when the Site Options Discussion Paper was prepared. If land is available, it is a green field site, with no koala habitat. With the train line being extended to Springfield, it will offer the same convenient public transport access. In addition it will have general medical facilities available as Redlands currently does.

I am concerned by the costs of the current proposed redevelopment. It was reduced by approximately 300 square metres (about the size of two ordinary houses) for a reduction in expenditures of about $1,000,000. The reduction in area was just slabs and walls - nothing fancy. Yet two houses of this size could be built for $350,000 (if land was provided).

I am a member of the corporation of Bethany Christian Care which provides a range of care accommodation for elderly people. In 2004 they developed a new complex on a green field site at Eight Mile Plains. I estimate it is two to three times the size of the proposed Redlands development. It offers a high standard of accommodation. In 2004 it cost $6,000,000. Even if we doubled that to equate it to today's money, it still comes in well under the current budget for a much larger facility.

I mention these matters, because if the Springfield Hospital is built by the Mater, they may have more flexibility than Queensland Health to secure builders that can come in within the current budget.

Just a couple of options if Redlands cannot proceed.

Kind regards,

Trevor Sadler

I

From: Trevor Sadler [mailto
Sent: Wednesday, 24 September 2014 2:56 PM
To: 'Kristi Geddes'
Subject: RE: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Ms Geddes,

Thank you for informing me of the change. I am sorry I couldn't take your call when you first rang.

Just to explain why I thought the additional documents were relevant into an investigation into the transitional plans.

I presume you were given a copy of the Clinical Services Capability Framework (CSCF) for mental health, and the draft Model of Service Delivery for the Adolescent Extended Treatment and Rehabilitation Service. Both these documents are Queensland Health documents which define service provision, and by which Health and Hospital Services are required to abide. Both these documents attempt to capture the severity and complexity of adolescents admitted to Barrett. From referral patterns over more than a decade, I estimate the a community clinician (including private child psychiatrists) would only see a young person of this degree of severity and complexity once in every five years or more.

The CSCF describes the capabilities services need to have to be able to treat and manage a person with varying levels of severity and complexity of their mental illness. Barrett was classified as a CSCF Level 6 service. It had to have the highest levels of capabilities to manage the young people being admitted. The Tier 3 service recommended by the Expert Clinical Reference Group (ECRG) report is identified in that report as a CSCF Level 6 service.

This is highly relevant to the transition plans. If the service to which a young person is being transitioned has the same level of capability, the transition plan is around continuity of staffing expertise, and relocation on the day of transition. An example of this is the closure of the Mater Children's Hospital on 29 November, and the transition to Lady Cilento Children's Hospital.

However, if the only services available to which the adolescents can be transitioned have a lower capability to provide services, those developing the transition plans must include a component of improving "wellness" prior to transition so that the receiving service has the capability to manage the young person.

Ideally the service/system managers would work with the transition plan clinicians to determine when the service could close. This would ensure that levels of "wellness" matched the capability of receiving services. Ideally, service managers would ensure that treatment and rehabilitation services were optimised to facilitate "wellness". They could gain some crude measure of the "unwellness" of adolescents by monitoring the frequency and nature of PRIME reports. Ideally, they would then discuss with the clinicians factors – whether in clinicians, the adolescent or the health service – which may impair some young people from proceeding to gain in "wellness".

These issues move from being an ideal to critically essential if service/system managers pre-determine the closure date. The problems are

- the transition time may be less than what adolescents need to achieve wellness and

- if, during this process, transition clinicians are forced to focus on managing continuing high levels of "unwellness" (captured in PRIME reports), there may a moratorium on transition plans facilitating "wellness".

Consequently, when time for closure comes, even though a young person is transitioned to the highest level of available capability, they are still too unwell for the receiving service.

A number of factors contribute to continuing levels of "unwellness" and impair progress to "wellness" in this situation.

- If there is loss of hope and despair in adolescents on hearing the news of the closure (as evidenced in one young person's testimony on www.patientopinion.org.au) this may result in withdrawal from therapy, increased suicidality, increased self harm or a withdrawal from the service. The impact of the news of the closure can be gauged from the nature and frequency of PRIME reports from 1/1/2013 – 5/8/2013 cf 6/8/2013 – 31/12/2013.
- High levels of "unwellness", as indicated by high suicide intent or repeated self harm, requires high levels of observations. This is staff intensive. It therefore stretches the resources available to facilitate "wellness" in other adolescents. These incidents may include adolescents whose charts are not being reviewed. The ward report books provide further information on the situation with the whole ward.
- The need to optimise resources includes the need to provide staffing stability. The impacts of staffing instability on adolescents are recorded in their submissions to a Business Unit Meeting. This was an issue raised with various levels of service management in the preceding two years. High levels of casual nurses result in utilisation of a workforce who are largely unskilled in adolescent mental health; who do not know the adolescents well; whom adolescents do not readily approach with issues and who are not skilled in detecting incidents early. This means that the capacity to manage crises associated with high levels of "unwellness" is impaired, regular staff are more stretched in their capacity to provide therapeutic and rehabilitation interventions because there are fewer of them, and they are managing crises. Crises are more likely to occur because adolescents will not approach unfamiliar staff. This can be a significant contributing factor to a moratorium on transition plans. Staffing lists provide an indication of the level of non-regular staff employed during this period, and be an indication of what service managers did to address this issue. The Quality Network of Inpatient CAMHS (QNIC) of the Royal College of Psychiatrists has established recommendations for acceptable levels of casual staffing, with notes on the implications for patient care.
- If PRIME incidents increased after the announcement of the closure, it may suggest the closure caught adolescents unawares. If clinicians were forced to manage crises because of sudden distress of the announcement, instead of implementing transition plans, this is a severe limitation on the capacity to facilitate "wellness" to a level that the capability of receiving services can manage. This raises the issue of why adolescents (and perhaps parents) were caught unaware. Was information from the consultation process with adolescents and parents/carers prior to the closure (identified in the Project Plan of the Planning Group) not disseminated more broadly? Did clinical leaders have information which should have been known to adolescents and parents/carere prior to 6 August? What was the process of consultation with adolescents and parents/carer regarding service design and delivery in the transition period? (Involvement of "consumer" and carers is a key element of the National Mental Health Plan, of the Mental Health Directorate, and the West Moreton HHS. Active involvement has the capacity to reduce anxiety; provide a collaborative working together towards transition and identify potential issues. This facilitates transition plans.)

I was only involved for the first 5 weeks of the approximately 25 week transition period. I do not have information as to what happened on the unit, and how these issues were managed after mid-September. I do know that three young people with whom I worked are now dead. Others, while not having the same tragic outcome, have experienced far worse outcomes than I had to reason to expect.

Thank you for your time in considering these matters.

Kind regards,

Trevor

From: Kristi Geddes [mailto:
Sent: Tuesday, 23 September 2014 3:43 PM
To: Trevor Sadler
Subject: RE: PRIVATE & CONFIDENTIAL - Health Service Investigation - Barrett Adolescent Psychiatric Centre [ME-ME.FID2743997]

Dear Dr Sadler,

Would it be possible to change your interview time to 1:30pm on Tuesday, 14 October 2014? It will still be at our offices and with both A/Prof Beth Kotze and Ms Tania Skippen.

My apologies for the change.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
www.minterellison.com

RESPONSE TO THE DRAFT MODEL – THE LACK OF EVIDENCE BASE

1. Demographics.

The draft model does not refer to demographics. While there are repeated references to being in or close to the local community, it is not spelt out what this means in the Queensland environment.

For instance, the area from Ingham in the north to Ayr in the south and southwest to Charters Towers (the closest towns to Townsville) contains about 6% of the adolescent population between 13 – 17.11 years. The same area from BAC (west to Toowoomba, south to the border and north to the southern end of the Sunshine Coast) contains about 70% of Queensland's population, in that age group.

Assuming the Gold Coast gets an adolescent day patient unit immediately (11%), that Toowoomba gets a residential facility to cater for all of south-west Queensland in Tier 2b (Level 5 Day Program) (7%), that Townsville gets a residential facility to cater for all of Queensland north of Mackay (16%), that Mater/QCH Day program continues to be fully occupied by young people from the same catchment area (9%), the replacement unit will still need to cater for 57% of Queensland. These include areas such as Rockhampton, Gladstone, Bundaberg, Maryborough and Harvey Bay, as well as Moreton Regional Council, Logan, Ipswich and the Lockyer Valley and Redlands. If a Sunshine Coast Tier 2a or be program came on line sometime after 2016, 50% of Queensland still needs to be served by the replacement unit.

The notion of another 12 – 15 place tier 2a unit at Prince Charles that only serves the Brisbane north region (about 8% of the population) cannot be supported. It must have a super-regional capacity.

2. Lack of clarity about Diagnostic Profile

The terms of the diagnostic profile both in the Word and Power Point documents indicate that this refers to the Level 3 (CSCF AETRC Level 6) service. It does not specify the diagnostic profile for those treated in the Tiers 2a and 2b services (CSCF Day Program Level 5 services). The current Models of Service Delivery are clear on these issues. Without reference to this, there is ambiguity about whom may be treated in each level of service.

3. Residential Component

We were very clear about the residential component in the last meeting – it is accommodation provided for those who cannot access the service locally.

It is not an alternative to inpatient admission for Level 6 patients. There is simply no evidence base for this.

The reference to the Hot House in Cairns lacks any evidence base for adolescents who may currently present to BAC which has been presented to the ECRG.

Accommodation is necessary for day programs like Townsville and Toowoomba which may serve regional and extended regional populations. No rationale is given as to why the Gold and Sunshine Coasts should have a residential component.

4. Inpatient Care (Tier 3, CSCF AETRC Level 6)

The document does not acknowledge that the majority of adolescents currently attending BAC need this level of care. A document was circulated which provides an evidence base for an inpatient component.

Whilst it states in the Power Point that *"Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e. utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established)"* it makes no mention of the risks of this, the lack of efficacy in treatment and the impact on acute services. This a complete violation of evidence which has been presented to the ECRG.

The document demands a 95% occupancy rate for the inpatient unit. It is not clear whether this is based on actual or nominal occupancy. It is not clear why this is specified for this unit and not other Levels.

The document states in the principles *"have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down"*. In spite of the fact that the step=down component is been demonstrated repeatedly to be a necessary component, there is no mention of it when describing Tier 3 in either the Word or Power Point documents. The National Mental Health Plan states *"A national service planning framework will include acute, long stay, 'step up/step down' and supported accommodation services, as well as ambulatory and community based services. It will take account of the contribution of public, non-government sectors and private mental health service providers, and clearly differentiate between the needs of children and young people, adults and older people."*

The document states "Consumers will only access the day and evening sessions (i.e. Day Program components) of the service if they are an admitted consumer." There is no evidence underpinning this inflexible model. In the current service, and services from the UK, there is clear evidence that a mix of inpatient, partial inpatient and day patient services are viable. They maximise the use of resources.

5. The Document does not capture tensions in the National Mental Health Plan for this Population

The Power Point slide states that *"National Mental Health Policy (2008) 'non acute bed-based services should be community based wherever possible"*. This is true.

It also states *"While it is not appropriate or possible that uniform service provision exists in every area or across all age groups, we should strive for equity of access and equity of quality. Services should strive to be accessible and responsive. The level of service provision and the outcomes of care should be transparent to consumers and carers." and "Supporting local solutions for local communities will enable 'wrap around' services to better respond flexibly to individuals with complex needs, while understanding the constraints imposed by geographical location, and workforce availability"*.

This is not just the general population of adolescents who are at increased risk – it is a highly vulnerable population. The National Mental Health Plan specifically mentions these.

1. Those who have been traumatised. *"Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma."*
2. Those at high risk of suicide *"Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them."*
3. *Service options need to be responsive to the needs of different age groups, including young children and older people, and to the differing needs of those who suffer particular illnesses such as perinatal mental health problems and eating disorders"* (my emphasis)

While the National Mental Health Plan is predominantly an adult focussed document, (and so the concept of non acute bed-based services have in mind adult solutions such as the Community Care Units), it also says *"Mental health should be provided at a standard at least equal to that provided in other areas of health."* One of the distinctions about Child and Youth Mental Health Services is that they have a truly increasing level of service provided for those with the most severe and complex needs, similar to paediatric services. This is why Day Patient programs are Level 5 services, and BAC a Level 6 service. Adult services do not have the same level of intensity and breadth of intervention that CYMHS does. Recognition of the National Mental Health Plan is to acknowledge that we are providing the same tiered level of care available to children and adolescents with medical illness.

The document really does not underscore the severe impairments that adolescents admitted to BAC have, nor the necessity under the National Mental Health Plan to address these. The implications are that at times the attention to addressing recovery may be at odds with providing a community based service. It mandates approaches that promote recovery and social inclusion *"Mental health service providers should work within a framework that supports recovery .... — both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person's strengths including coping skills and resilience, and capacity for self determination."* and *"Recovery in the context of mental illness is often dependent on good clinical care, but means much more than a lessening or absence of symptoms of illness. Recovery is not synonymous with cure. For many people who experience mental illness, the problems will recur, or will be persistent. Adopting a recovery approach is relevant across diagnoses and levels of severity. It represents a personal journey toward a new and valued sense of identity, role and purpose together with an understanding and accepting of mental illness with its attendant risks. A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved – the individual consumer, their family and carers, and service providers."* and *"Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models."* and *"Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and effort to remove barriers which lead to social exclusion ....."* and *"People should feel a valued part of their community, and be able to exert choice in where and how they live. Some groups are at risk of entrenched social exclusion, including those with chronic and persistent mental illness. Developing pathways that support community participation and that allow movement towards greater independence minimises the risk of social exclusion. Policy and*

service development needs to recognise the importance of a holistic and socially inclusive approach to health in promoting mental health and wellbeing, that includes social as well as health domains and supports people to establish community engagement and connectivity."

In failing to emphasis these points, the document fails to advocate for adolescents who are at risk of being neglected from the above principles.

Moreover, it fails to state the clear recommendations of the National Mental Health Plan regarding rehabilitation. It states that an aim should be to *"Co-ordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs."* Among the indicators for monitoring change are *"Participation rates by young people aged 16–30 with mental illness in education and employment"* and *"Rates of community participation by people with mental illness."*

While some of these have been incorporated in the Principles, I believe they need to be strongly linked to the National Mental Health Plan, so that inherent tensions within the Plan can be adequately examined.

6. The Documents specify time frames which are not evidenced based.

I outlined in a document I circulated in January the lack of evidence base for a time frame. We agreed at ECRG meetings (or at least the group I was in) that we would delete reference to time frames. Nevertheless, this is stated explicitly throughout the document.

7. The Documents do not align with existing Clinical Services Capability Framework Levels

This was raised and discussed at the last ECRG, although consensus may not have been absolutely determined. This is extraordinarily problematic.

1. Existing services conform to Queensland Health recognised Clinical Services Capability Framework (CSCF) Levels. The tiered levels do not.
2. Until an inpatient service is developed, the current CSCF level 6 service will cease to exist. This will not be duplicated by CSCF 5 services (Tiers 2a and 2b), nor by the current inpatients being cared for in CSCF Level 5 Acute Adolescent Inpatient Units.
3. The absence of a Level 6 service is necessary for the Planning Group to clearly consider risks.

8. The Documents do not outline the time frames or risk management of development of alternative services.

Currently there is no funding for a Day Program in Townsville, no building for a Day Program on the Gold Coast or the Sunshine Coast, and no funding for accommodation to serve extended regional areas in Townsville and Toowoomba. Even in the proposed plan, there is no reference to the implications of this for the current service.

There is a clear evidence base for risks for managing adolescents in BAC in acute inpatient units. This is not mentioned at all. The document does not outline the risks of not having a CSCF Level 6 Inpatient component.

9. The Document states there is no funding for an inpatient unit.

Current Government policy outlined in the *"Blueprint for better health care for Queensland"* enshrines the principles of Contestability and non-Government provision of infrastructure. These documents do not refer to these principles or the implications it could have for developing an inpatient unit.

Barrett Adolescent Centre Responses & Action Plan to Address Recommendations from the External Review September 2003

*need a blurb here at the start about the grouping of responses, purpose of the action plan, staff involved in development of plan, etc

Recommendation	Response	Action Items	Responsibility	Timeframe
Recommendations Associated with the Target Group and Admission Criteria for BAC				
Recommendation 1: In the absence of other forms of outcome measurement, a qualitative and experiential review of the usual clientele admitted to the BAC should be undertaken with a specific objective of considering the most suitable target group.	Qualitative and experiential evidence has been collected, and shows that young people with conduct disorders do not have good outcomes within the BAC environment, but that conditions such as ******* do have good outcomes. Issues of severity, complexity and impairment also need to be considered in such a review. Direction is required from MHU and other CYMH services regarding the target group and how BAC fits into the continuum of care and the National Mental Health Plan. The current role of the BAC and its target group has been presented to the Southern and Central Zone CYMHS committee.	• Contact the Director of Mental Health, Dr Arnold Waugh, to seek advice and approval to progress with the definition of a target group, with input from senior officers in Mental Health Unit.	Mr Kevin Fjeldsoe, Executive Director	5th Sept 03
		• Engage the current Southern and Central Zone CYMHS committee to establish a working party to develop the target group definition and admission criteria for BAC. This group is currently ratifying admission criteria for the CYMHS inpatient units.	Dr Trevor Sadler Mr John Quinn Mr Peter Howard	11th Sept 03
		• Develop target group & admission criteria with working party.	Dr Trevor Sadler Working Party	??????
Recommendation 2: The "have a go" ethos of admitting individuals to the BAC should be stopped and all potential referrals should be considered against strict and mutually accepted criteria.	Over the past 2 years, only 4-5 individual admissions could be considered to be "having a go", each with particular circumstances that made refusal of admission difficult. This is not a common practice for the unit. The development of clear admission criteria known to all services will assist in the prevention of these situations.	• Have target group & admission criteria endorsed by Southern & Central Zones CYMHS and the Director of Mental Health Unit.	Dr Trevor Sadler Mr Kevin Fjeldsoe	??????
		• Develop a marketing strategy for the BAC to include the newly developed admission criteria and target group information. This may include the development of brochures, updating website	Ms Marisse Scheurer, Community Liaison Person. Mr Steve Nicholls, CN	??????

Recommendation	Response	Action Items	Responsibility	Timeframe
Recommendation 3: BAC admission criteria should be more clearly operationalised.	Information on the admission criteria and admission process is currently provided through the role of the Community Liaison Person to other services, to assist in operationalising the criteria.	information, and providing information to specific services. Refer to action items above.	Ms Angela Mulhern, Mental Health Promotions Officer.	
Recommendation 6: It should be more clearly annunciated to referrers, patients, families and staff whether there is a 2 week assessment period at the beginning of a BAC admission.	The terminology around the 2 week assessment period for long term admissions and the 2 week admission has caused some confusion. There is always a 2 week assessment period, after which an intensive case work-up is done by the multidisciplinary team, and a comprehensive care plan is developed.	• Change terminology on admission forms and other documentation, and have description of the 2 week admission and long-term admission in service brochures/information.	Mr Peter Howard	
Recommendation 19: Senior BAC and Park management should, as a matter of some urgency, advance with Queensland Health the issue of the continued funding and support of the BAC. Whilst the current work environment of the BAC may be therapeutic to adolescents, the staff milieu is not promoting motivation and enthusiasm to review risk management and other procedures at the BAC.	The uncertainty of the future of the unit has had an effect on the staff at BAC, however, this has not affected their enthusiasm or motivation for clinical and risk management. The BAC is awaiting a report from Ivan Frkovic at Mental Health Unit on extended treatment in adolescent mental health, which will feed into the review of risk management procedures and other policies and procedures at BAC.	• Incorporate information from the Mental Health Unit report into the review of policies and procedures at BAC.		
Recommendation 20: With contemporary understanding of the burden of youth homelessness and school exclusion, the BAC provides an excellent opportunity for youth with mental health and	Noted.	Refer to action items above.		

Recommendation	Response	Action Items	Responsibility	Timeframe
challenging behaviour to live in a safe environment and receive high quality educational and psychological input. For these reasons the review team recommend advocacy for the BAC. **Recommendation 21:** However the review team recommend further work in the delineation of the BAC in the continuum of care of adolescent mental health services in SE Queensland. Tasks include the current evidence base for adolescent inpatient care and whether the current broad admission brief should not be changed to focus on a more limited diagnostic range or alternatively to focus on particular challenging behaviours such as individuals with internalising conditions and mild externalising behaviour or individuals with sever and ongoing suicidality and self harm.	The BAC has always sought to utilise available evidence in planning and delivering services; however, there is very little conclusive evidence in the literature for the population of adolescents seen by BAC. The use of the HoNOSCA and other outcome measures have been used for the past 3 years in an attempt to develop an evidence base.	• Continue use of HoNOSCA and other outcome measures in developing an evidence base, and identify a staff member responsible for monitoring this information. • Consider other instruments to use to develop and evidence base. • Develop a collaborative partnership with university researchers to assist in data analysis. Refer to action items above.		
Recommendations Related to Assessment and Management of Risk				
Recommendation 4: Risk assessment should be specifically included in the BAC referral form and additional referral information obtained.	Risk assessments are currently used on admission or during the assessment interview, and are completed by the assessing clinician. During admission, the care coordinator completes the risk assessment tool, and a management plan	• Include risk assessment in referral forms for completion by referring agency prior to assessment interview, to assist in determining suitability for admission.		

Recommendation	Response	Action Items	Responsibility	Timeframe
Recommendation 5: An inclusion of risk assessment should be made in the determination of whether an individual is accepted by the BAC. Issues around risk management should be included in information promulgated by the BAC about its program	is discussed and endorsed by the team within the multidisciplinary team meeting. The Nurse Manager documents the management plan on the assessment tool, according to hospital policy.	• Include risk management information in the BAC brochures and information for referring services. • Clarify who does risk assessment within the service both on admission and during the client's stay.		
Recommendation 7: Analysis of risk assessment should be included in the determination of the effectiveness of the two week trial and whether the patient should remain at the BAC.	Risk assessment is currently used in developing the care plan at the end of the 2 week assessment period, which includes the determination of whether the client will remain in the unit.	• Review the use of assessment tools within adolescent mental health, and consider adaptations of the tools for this population. This will include liaising with adolescent mental health services nationally and internationally to review tools and protocols, and gather evidence on use of risk assessments.		
Recommendation 11: The BAC management should review the use of the risk assessment tool in the adolescence population: whether the tool is valid, the clinical use of the assessment tool findings in the BAC and the evaluation of the assessment tool over time	The risk assessment tools at The Park have been developed based on extensive reviews of the literature and tools available, and an adapted version of the tools has been implemented in mental health services across the state. A number of minor changes have been suggested by staff to improve its validity in an adolescent population.	• Develop a local policy on admission procedures, including risk assessment. • Progress planned review of local policies and procedures at the BAC. Utilise weekly meetings with staff to assist with this review.	Mr Peter Howard Ms Marise Scheurer Mr Peter Howard	
Recommendation 12: There are policies related to risk management that have not been reviewed at the BAC for many years, the BAC management should review such policies.	Facility-wide policies of The Park determine much of the risk assessment and management protocols of the BAC. A number of local policies have been developed for BAC where the facility-wide policies do not address issues	• Ensure participation in Service Improvement Council to communicate any concerns that affect the facility-wide policies • Implement the Post-Incident Checklist within the BAC.	Mr John Quinn Mr John Quinn Mr Tom Meehan	

Recommendation	Response	Action Items	Responsibility	Timeframe
	specific to the BAC. A review of these local policies has been planned.			
Recommendation 13: The BAC management should instigate a critical and formal process of risk analysis following incidents where there was actual or potential significant morbidity or potential mortality.	The Park has developed a Post-Incident Checklist that is being implemented in clinical areas. This tool ensures a formal process of risk analysis occurs following incidents of aggression or self-harm.	• Review the A1-A7 program with the adolescents in the unit and the Consumer Representative. • Use the regular pupil-free days to gain consumer feedback and regularly review the service and the purpose of the behavioural management programs.	Dr Trevor Sadler Consumer Representative	
Recommendation 14: The appropriateness of the A1-A7 system should be reviewed in light of contemporary changes in patient presentations at the BAC.	A review of the A1-A7 program was undertaken by Mr Paul Harnett, Psychologist, and **** in (date). Some preliminary work has been undertaken in reviewing the program from the perspective of the adolescents.	• Identify review needs and evaluation of the A1-A7 programs. This could include simple measures of frequency of behaviours before and after the use of the program.	Dr Trevor Sadler Mr Tom Meehan ??	
Recommendation 15: Consideration of the appropriateness of the category red system in the view of the new clientele should be reviewed.		• Develop evaluation around the use of the programs, for ongoing evidence based practice and outcome measurement.	Dr Trevor Sadler Mr Tom Meehan	
Recommendation 16: All BAC staff should have regular inservice training about risk management.				
Recommendation 17: Orientation of new staff should include risk management				

Recommendation	Response	Action Items	Responsibility	Timeframe
Recommendation 18: There should be clarity about the status on the unit in relation to it being an open (and therefore unlocked) unit; such changes to the status of the unit will have legal implications.				
Recommendations Related to Programming and Activities				
Recommendation 8: BAC staff should consider programming in the after school and early evening period as a risk management strategy. **Recommendation 9:** The BAC should consider smaller group size for therapeutic and recreational groups. **Recommendation 10:** The BAC should consider a restructure of its program into smaller functional units including the possibility of having 2 home groups rather than a larger single cohort of adolescents on the unit.		• Recruit for a Leisure Therapist (Occupational Therapist or Sports Psychologist). • Develop recreational programs for consumers in out-of-school hours. • Plan and implement changes to the environment at BAC to provide more opportunities for activities in the afternoons/evenings, eg beach volleyball court. • Improve utilisation of available resources for programmed evening activities, eg soccer field. • Consult with occupational therapists in other services that specialise in activity programs for youth.		