where their needs cannot be met by other services CYMHS combines hospital and community-based facilities to provide free consultation, assessment and treatment of children and young people experiencing

As part of CHQ, a new purpose-designed Queensland Children's Hospital (www.health.qld.gov.au/childrenshospital) is being built at South Brisbane and is expected to open in late 2014. The hospital will bring together existing specialist paediatric services of the Royal Children's Hospital and the Mater Children's Hospital (www.mater.org.au) and will be the central point of a statewide paediatric network, designed to cater for the future health care needs of children and youth.

The position of CYMHS Clinical Quality & Safety Manager may officially relocate to the new Queensland Children's Hospital when the new children's hospital is commissioned, which is expected to occur late 2014.

For further information about Children's Health Queensland please visit http://www.health.qld.gov.au/rch/

Want to know more?

- For details regarding salary information, leave entitlements, flexible working arrangements and other benefits please refer to the *Working for CHQ HHS, Applicant Information* provided with the advertised vacancy or visit the Queensland Health website at: www.health.qld.gov.au
- For further information about the Lady Cilento Children's Hospital please visit: www.health.qld.gov.au/childrenshospital
- For further information about the Children's Health Queensland Hospital and Health Service please visit: www.health.qld.gov.au/rch/

Pre-Employment screening

Pre-employment screening, including criminal history and discipline history checks, may be undertaken on persons recommended for employment. The recommended applicant will be required to disclose any serious disciplinary action taken against them in public sector employment.

Roles providing health, counselling and support services mainly to children will require a Blue Card. Alternatively a risk assessment of the role may have identified a requirement for a Blue Card. Please refer to the Information Package for Applicants for details of employment screening and other employment requirements.

Health professional roles involving delivery of health services to children and youth

All relevant health professional (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or youth has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to Child Safety Services, Department of Communities.

All relevant health professional are also responsible for the maintenance of their level of capability in the provision of health care and their reporting obligations in this regard.

Immunisation

Hepatitis B immunisation is a mandatory condition of employment in CHQ facilities for all employees who have direct contact with patients or who in the course of their work may be exposed to blood/body fluids or contaminated sharps.

CHQ highly recommends that employees are immunised against vaccine preventable infectious diseases that may occur in the workplace. For further information and guidance on immunisations, refer to the Queensland Health Policy for Immunisation of Health Care Workers http://www.health.qld.gov.au/chrisp/ic_guidelines/23563.pdf

Salary Packaging

To find out whether or not your work unit is eligible for the Public Hospital Fringe Benefits Tax (FBT) Exemption Cap please refer to the Salary Packaging Information Booklet for Queensland Health employees available from the Queensland Health Salary Packaging Bureau Service Provider – RemServ at http://www.remserv.com.au. For further queries regarding salary packaging Remserv's Customer Care Centre may be contacted via telephone on 1300 30 40 10.

Disclosure of Previous Employment as a Lobbyist

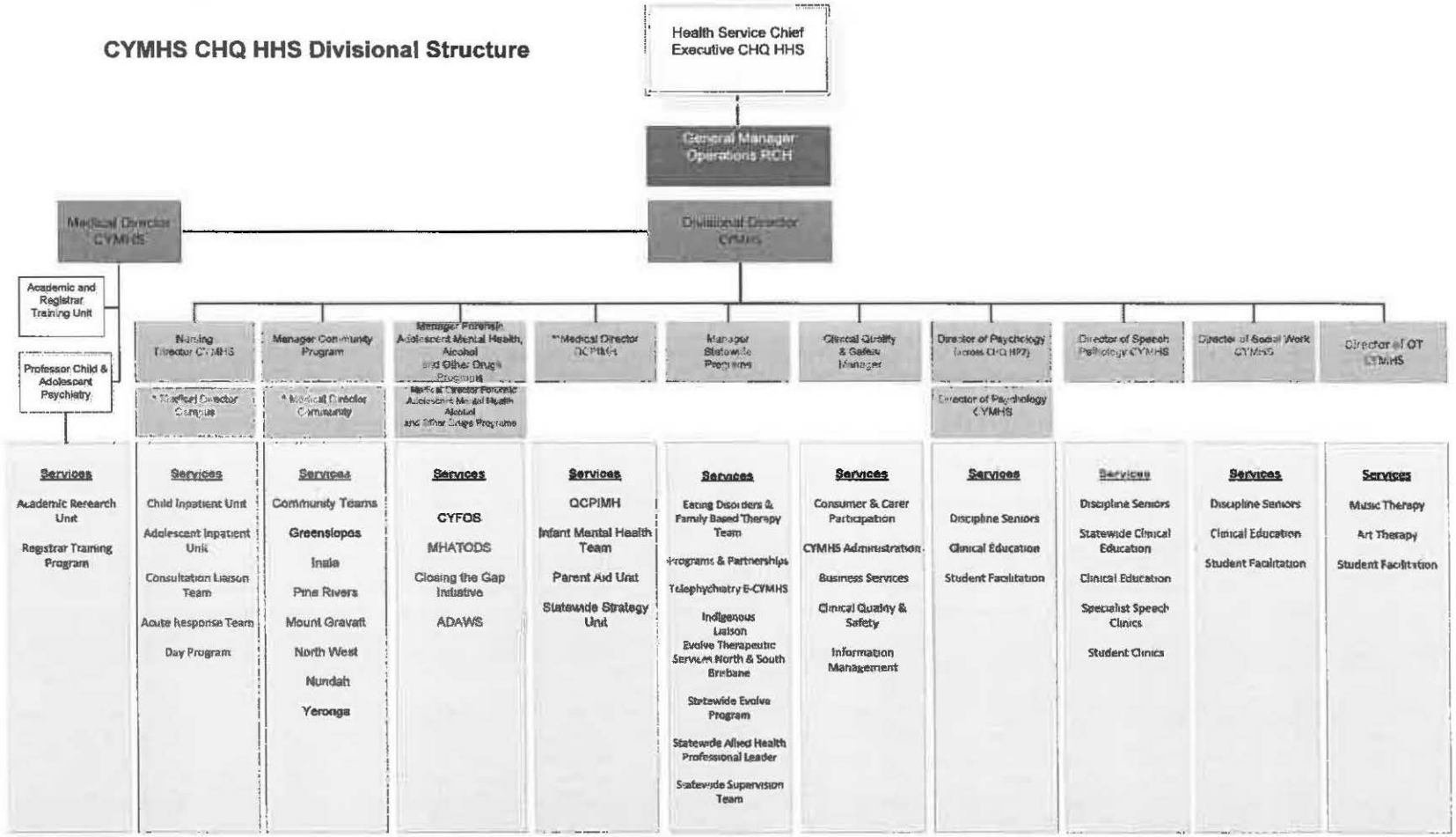
Applicants will be required to give a statement of their employment as a lobbyist within one (1) month of taking up the appointment. Details are available at http://www.psc.qld.gov.au/library/document/policy/lobbyist-disclosure-policy.pdf

Probation

Employees who are permanently appointed to Queensland Health may be required to undertake a period of probation appropriate to the appointment. For further information, refer to Probation HR Policy B2 http://www.health.qld.gov.au/hrpolicies/b_resourcing.asp

ORGANISATIONAL CHART

CYMHS CHQ HHS Divisional Structure

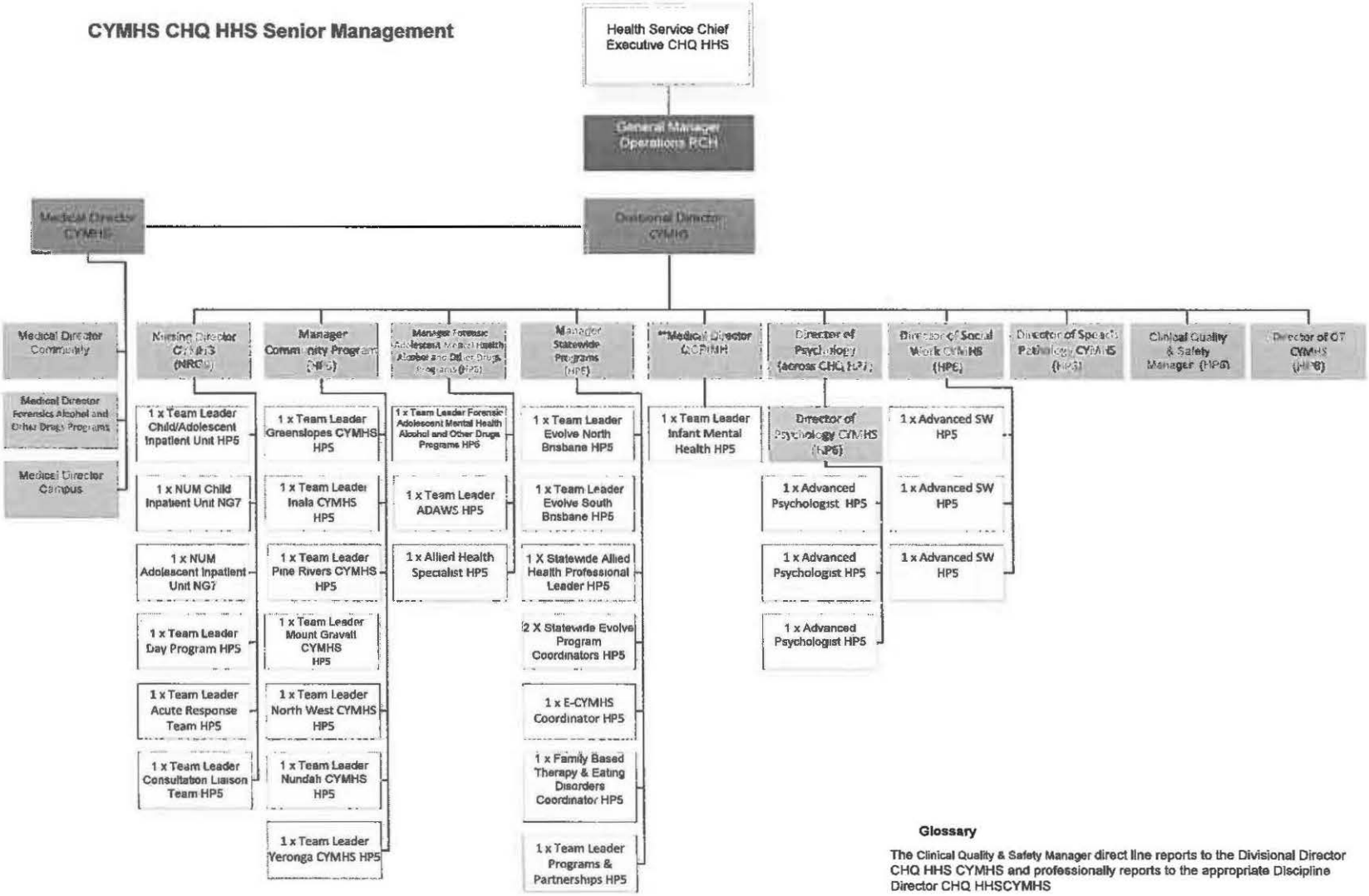


Glossary

* Direct Line and Professional Report to Medical Director CYMHS

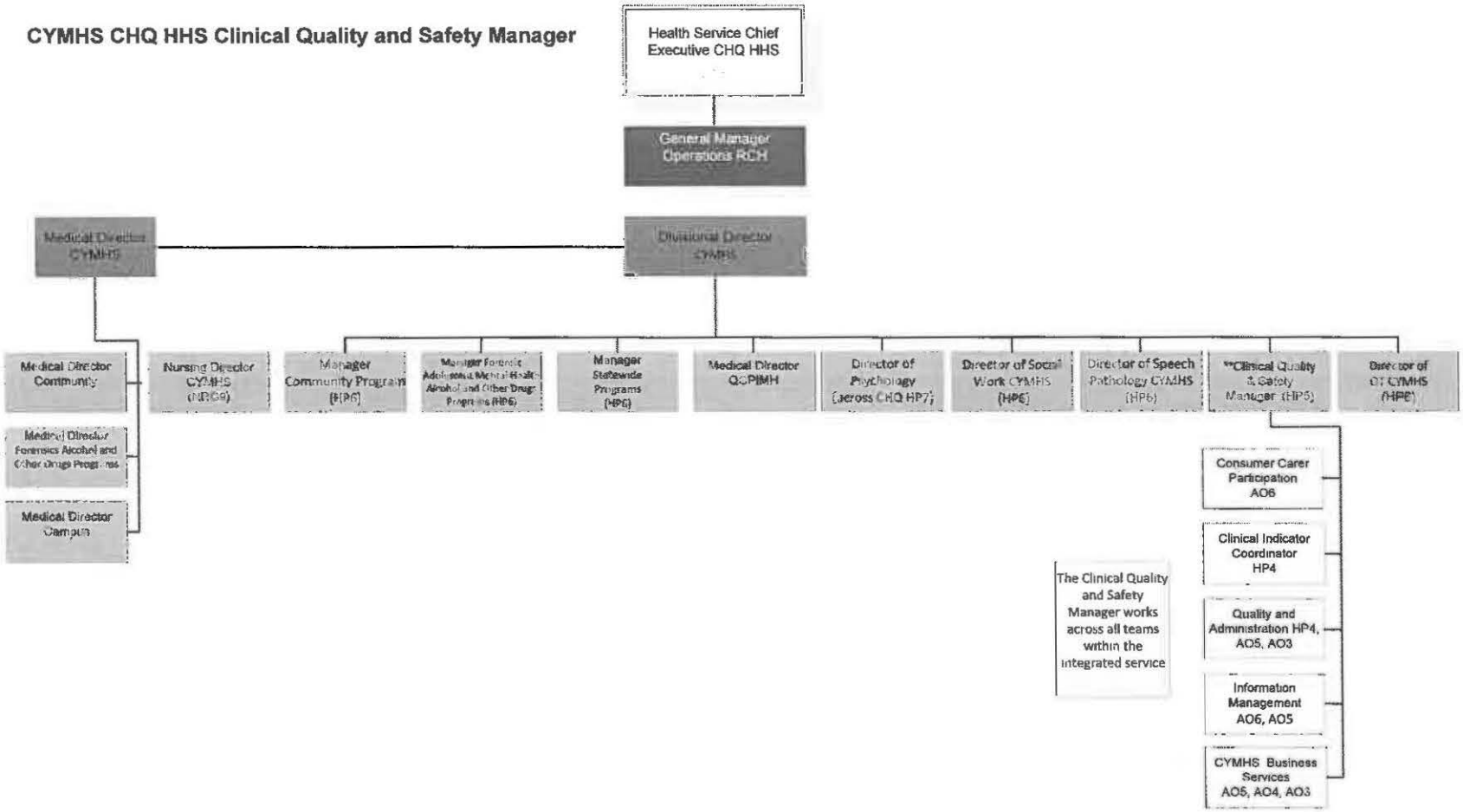
** Direct Line Report to DD CYMHS, Professional Report to Medical Director CYMHS

To find out more about Queensland Health, visit www.health.qld.gov.au



To find out more about Queensland Health, visit www.health.qld.gov.au

CYMHS CHQ HHS Clinical Quality and Safety Manager



Glossary

** The Clinical Quality and Safety Manager CHQ HHS CYMHS direct line reports to the Divisional Director CHQ HHS CYMHS and professionally reports to the appropriate CHQ HHS CYMHS Discipline Director

To find out more about Queensland Health, visit www.health.qld.gov.au

Queensland Government

Children's Health Queensland Hospital and Health Service

Job ad reference:	
Role title:	Director, Child and Youth Mental Health Service - Campus
Status:	Permanent Full-Time (This position is a full-time role. For the first 3 years of operation, this role will have accountabilities as a Medical Director. At the expiration of the 3 year period, the incumbent will retain a role as a Senior Medical Officer, however, the Director component of the role will be renegotiated in the employment contract).
Unit/Branch:	Division of Child & Youth Mental Health Service (CYMHS),
Hospital and Health Service:	Children's Health Queensland Hospital and Health Service (CHQ HHS)
Location:	Brisbane *Note: Please refer to 'About CHQ HHS' section of this document for further information regarding the location of this role.*
Classification level:	L18-L29
Salary level:	154,957 - 179,993 (L18-L24) 185,304 – 196,468 (L25-L27) $204,764 - $215,837 (L28-L29) A Clinical Manager's allowance will be negotiable
	*Note: Following recommendations outlined in the **Queensland Government Blueprint for Better Health Care**, work is currently underway to introduce contracts for senior medical officers (SMOs) and visiting medical officers (VMOs) throughout Queensland Health. These new contracts are scheduled to be signed by the end of April 2014 and commence on 1 July 2014 for both VMOs and SMOs who choose to sign. Your employment will be regulated by the Medical Officers (Queensland Health) Certified Agreement (No. 3) 2012 while it is in force until such time as you elect to sign a contract and this contract comes into effect.*
Closing date:	
Contact:	Dr. Stephen Stathis, Clinical Director, CYMHS
Telephone:	
Online applications:	http://www.smartjobs.qld.gov.au

SPECIAL CONDITIONS – TARGETED ADVERTISING (PHASE 1 – AT LEVEL POSITIONS)

This vacancy is only available to eligible CHQ HHS and Mater Health Service (MHS) employees.

CHQ HHS and MHS EMPLOYEES

To be eligible to apply for a Phase 1 position at the Lady Cilento Children's Hospital, applicants **must meet** the following criteria:

- Be a **permanent employee** of CHQ HHS or MHS whose substantive position is at the same classification level as the advertised position and is involved in the delivery of paediatric services within CHQ HHS or the Mater Children's Hospital (MCH).

  NOTE: Permanent CHQ HHS employees includes employees of CHQ HHS whose position is involved in the delivery of paediatric services who are on secondment to another HHS or agency.

- Be a **temporary employee** of CHQ HHS or MHS whose temporary position is at the same classification level as the advertised position and is involved in the delivery of paediatric services within CHQ HHS or MCH and **all** of the following criteria are met (as prescribed in Public Service Commission Directive No. 20/10 *Temporary Employment)*:

  - At the time of advertising, you have performed the same or similar role for a continuous period of two (2) years or more; and
  - During the previous two (2) year period in the same or similar role, the combined total breaks in employment does not exceed three (3) months; and
  - The position you are currently in was advertised and you were appointed to the position through an open merit process; and
  - You have been assessed as meeting the agreed performance objectives of the position

  NOTE: If there is no written evidence of advertising of your current position and/or appointment on merit then you cannot be considered for a LCCH position in this phase of the recruitment process.

Applicants that do not meet eligibility requirements will not be considered.

Targeted Advertising is specified in section 9.7 of the *Recruitment and Selection Directive No. 15/13* where a chief executive may elect to limit the advertising to a specific agency where exemption from or limited advertising will prevent the displacement of existing permanent public service employees.

About our organisation

Queensland Health's purpose is to provide safe, sustainable, efficient, quality and responsive health services for all Queenslanders. Children's Health Queensland Hospital and Health Service (CHQ HHS) has adopted the **five core values** that guide our behaviour:

- **Caring for People:** We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.
- **Leadership:** We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.
- **Partnership:** Working collaboratively and respectfully with other service providers and partners is fundamental to our success.
- **Accountability, efficiency and effectiveness:** We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.
- **Innovation:** We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Purpose

The Director, Child and Youth Mental Health Service - Campus will:

- Lead and manage the delivery of high quality tertiary campus-based child and youth mental health services across CYMHS, CHQ HHS following the opening of the Lady Cilento Children's Hospital (LCCH) in late 2014.

- Prior to this, assist the Medical Director CHQ HHS lead and manage the safe and efficient transition of campus-based child and youth mental health services in CHQ HHS and community-based child and youth mental health services in Mater Hospitals and Health Services to community-based child and youth mental health services across CHQ HHS.

Your key responsibilities

You will fulfil the accountabilities of this role in accordance with Queensland Health's core values, as outlined below.

PEOPLE

- Lead and manage the staff of the service using contemporary human resource practices.
- Ensure all staff of the service are provided with comprehensive orientation and onboarding.
- Ensure that training and supervision of staff is consistent with the requirements of CHQ and relevant professional and regulatory bodies.
- Implement effective performance appraisal and staff development systems within the service.
- Promote and develop a multidisciplinary team using well-developed professional and interpersonal skills, fostering and promoting and environment of participation and collaboration for service developments, improvements and innovations.
- Develop a positive culture which encourages and recognises high performance, builds leadership capabilities and supports staff to maximise their health and wellbeing.

SERVICE

- Provide ethical decision making and effective issues management and communication in the achievement of organisational goals, ensuring issues are resolved effectively and in a timely manner.
- Model positive leadership behaviours and contribute to the health service and professional community and affairs.
- Develop a high functioning service inclusive of inpatient, outpatient, outreach, telehealth and evidence based models of care as appropriate within a multidisciplinary team environment.
- Actively promote and model family centred care principles and practices in the design and delivery of services. Involve consumers in design and evaluation of services.
- Build effective and timely communication and consultation processes within the service, and with families, referring clinicians and other health services.
- Support the planning and service capacity in outer locations across South East Queensland and within the context of the Southeast Queensland Paediatric Planning Report.
- Actively explore and implement alternatives to hospital admission where clinically appropriate.
- Undertake inpatient and outpatient consultation and treatment of patients in Child and Youth Mental Health.

SAFETY AND QUALITY

- Implement the Children's Health Queensland Patient Safety and Quality Improvement Strategy as it applies to Child & Youth Mental Health.
- Lead and model a 'just' approach to staff, promoting open and honest identification of hazards and incidents, and taking action to address quality and safety gaps.
- Develop, maintain and report on measures of the quality of the services provided across all domains of quality, using data to drive continuous improvement. Benchmark service performance with peer services in Australia and internationally.
- Drive reliability and consistency of clinical services through the use of standard operating procedures, procedures, care pathways, and appropriate training, assessment and coaching of staff.

- Actively engage in early identification and resolution of patient/family and staff complaints using open disclosure principles.
- Maintain a regular audit schedule focussed on known risk areas, and use this audit data to inform and prioritise improvement efforts.
- Ensure compliance with contemporary healthcare safety and quality standards and participate in CHQ assurance processes including Accreditation.

VALUE

- Develop an annual operational plan for the service in line with CHQ planning, and addressing budget, activity and quality.
- Actively monitor and manage balanced scorecard performance and take action to address poor performance.
- Explore innovative ways to improve value for money services.
- Drive transparency of service and individual performance and productivity. Benchmark with peers in Australia through Health Round Table and other relevant service groupings.

RESEARCH

- Encourage and support the development of high quality research by departmental staff across all elements of the multidisciplinary team.
- Contribute to the development of contemporary evidence in Child & Youth Mental Health.
- Use research evidence to improve practice and care outcomes.

Position Reports To

The Director, Child and Youth Mental Health Service - Campus:

- Reports directly to the Medical Director of CYMHS, CHQ HHS

Staffing and Budgetary Responsibilities

The Director, Child and Youth Mental Health Service - Campus:

- Has service-line management responsibility in accordance with the attached organisational chart.
- Has delegations in accordance with the CHQ delegations manual for financial and human resources.
- Will manage staff in accordance with Queensland Health human resource management practice and principles, equal employment opportunity and anti-discrimination requirements.

Qualifications / Professional registration / Other requirements

Mandatory

- Current registration with/or eligible for registration with AHPRA (Australian Health Practitioner Regulation Agency), as a specialist in psychiatry, and possessing a Certificate in Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists.

- Appointment to this position is dependent upon written confirmation of a Scope of Clinical Practice (SOCP) from the Executive Director of Medical Services. The candidate will be required to provide appropriately validated documents for credentialing purposes.

Are you the right person for the job?

You will be assessed on your ability to demonstrate the following key attributes. Within the context of the responsibilities described above, the ideal applicant will be someone who can demonstrate the following:

- You will be recognised by your peers for your abilities as a child and adolescent psychiatrist.
- You will have a successful track record as a leader and manager within a tertiary paediatric hospital or service.
- You will have advanced leadership abilities with demonstrated ability to build trust and positively influence professional peers in order to deliver high quality services.
- You will be an exceptional communicator; able to adjust your communication style for the audience and with a high levels of emotional intelligence.
- You will have a track record of successfully leading change at a service level. You are proficient in redesign methods and will have been responsible for driving measurable improvement in service outcomes
- You will be a team player, and will be recognised for your abilities to bring together staff from various professional disciplines and to build effective and cohesive teams.

How to apply

Please provide the following information to the panel to assess your suitability:

- **Complete Attachment A – Resume Template** (no more than 4 pages. Should you wish to provide a more extensive employment history, you may do so in a separate attachment. Please ensure you use the same format as outlined in Attachment A).

  Please include two referees that can attest to your performance and conduct in the workplace. By providing the names and contact details of your referee/s, you consent for these people to be contacted by the selection panel.

- **Complete Attachment B – Application Template**. Please provide a brief summary of no more than 2 pages addressing how your skills, experience and knowledge meet the requirements of the role listed under "Are you the right person for the job" in the context of the "key responsibilities" of the role.

For guidance on how to complete Attachments A and B please refer to the *Lady Cilento Children's Hospital job application guide* attached to the advertised vacancy.

Additional Information for Applicants

- All relevant health professionals (including registered nurses and medical officers) who in the course of their duties formulate a reasonable suspicion that a child or youth has been abused or neglected in their home/community environment, have a legislative and a duty of care obligation to immediately report such concerns to Child Safety Services, Department of Communities.
- Pre-employment screening, including criminal history and disciplinary history checks, may be undertaken on persons recommended for employment. Roles providing health, counselling and support services mainly to children will require a Blue Card.
- A minimum probation period of three (3) months may apply for permanent appointments.
- All newly appointed applicants who have been employed as a lobbyist in the previous two (2) years are required to provide a disclosure to the Director-General within one (1) month of taking up the appointment in accordance with the Disclosure of Previous Employment as a Lobbyist policy.
- Travel may be a requirement.
- Applications will remain current for twelve (12) months and may be considered for other vacancies which may include an alternative employment basis (temporary, full time, part time).

About Children's Health Queensland Hospital and Health Service

Children's Health Queensland provides:

- Paediatric services to its local community
- Tertiary paediatric services at the Royal Children's Hospital (Brisbane)
- Child and Youth Mental Health Service
- Child and Youth Community Health Service
- Outreach children's specialist services across Queensland
- Implementation and support for new and enhanced emergency, inpatient and ambulatory children's services in Greater Metropolitan Brisbane
- Paediatric education and research

As part of CHQ HHS, the new purpose-designed Lady Cilento Children's Hospital (formerly the Queensland Children's Hospital) is being built at South Brisbane and is expected to open in late 2014 (www.health.qld.gov.au/childrenshospital). The hospital will bring together the existing specialist paediatric services of the Royal Children's Hospital and the Mater Children's Hospital (www.mater.org.au) and will be the central point of a statewide paediatric network, designed to cater for the future health care needs of children and youth.

The Director, Child and Youth Mental Health Service - Campus will officially relocate to the new Lady Cilento Children's Hospital when it is commissioned in late 2014.

Want to know more?

- For details regarding salary information, leave entitlements, flexible working arrangements and other benefits please refer to the *Working for CHQ HHS, Applicant Information* provided with the advertised vacancy or visit the Queensland Health website at: www.health.qld.gov.au
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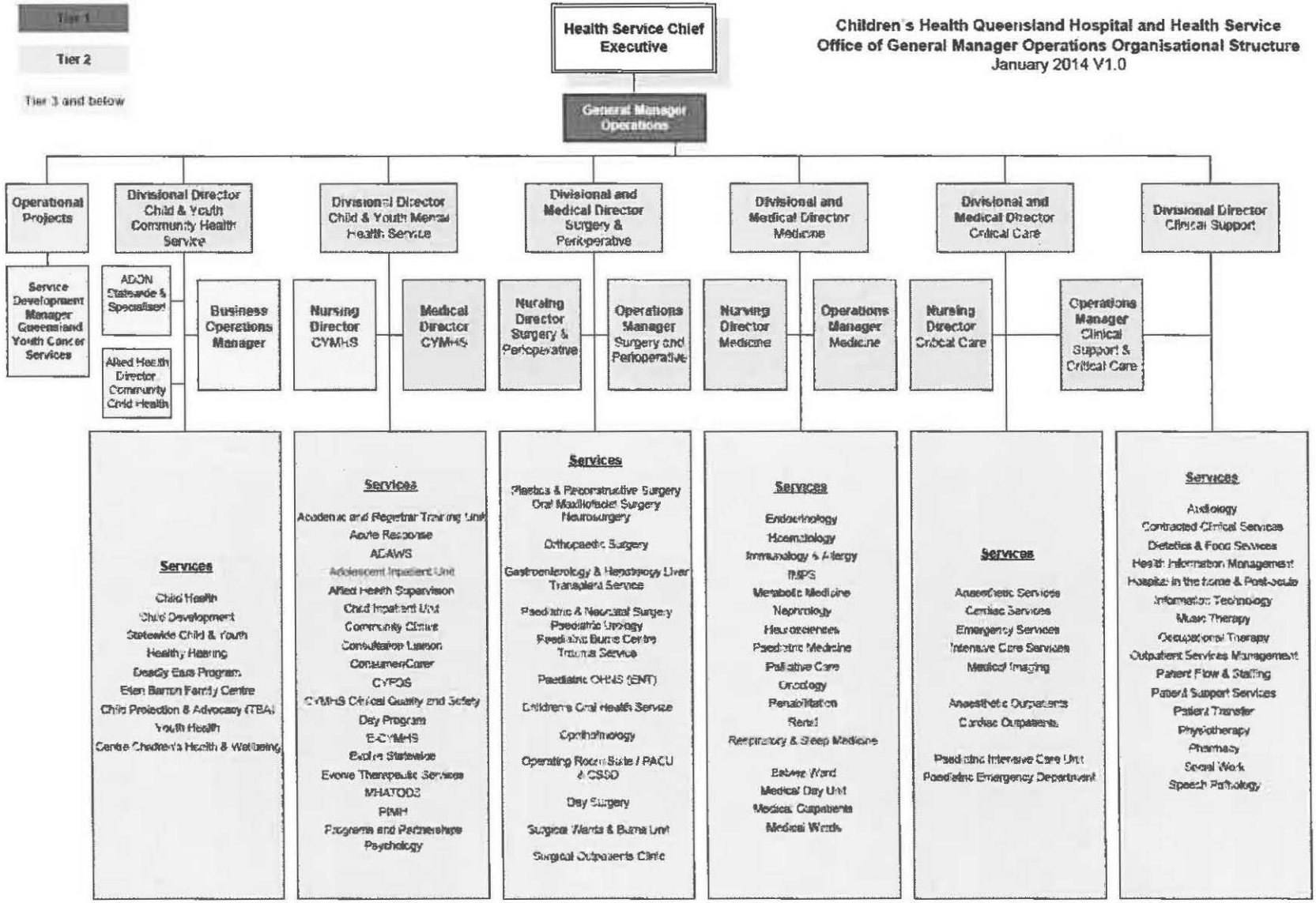
- For further information about the Children's Health Queensland Hospital and Health Service please visit: www.health.qld.gov.au/rch/

Tier 1

Tier 2

Tier 3 and below

Children's Health Queensland Hospital and Health Service
Office of General Manager Operations Organisational Structure
January 2014 V1.0



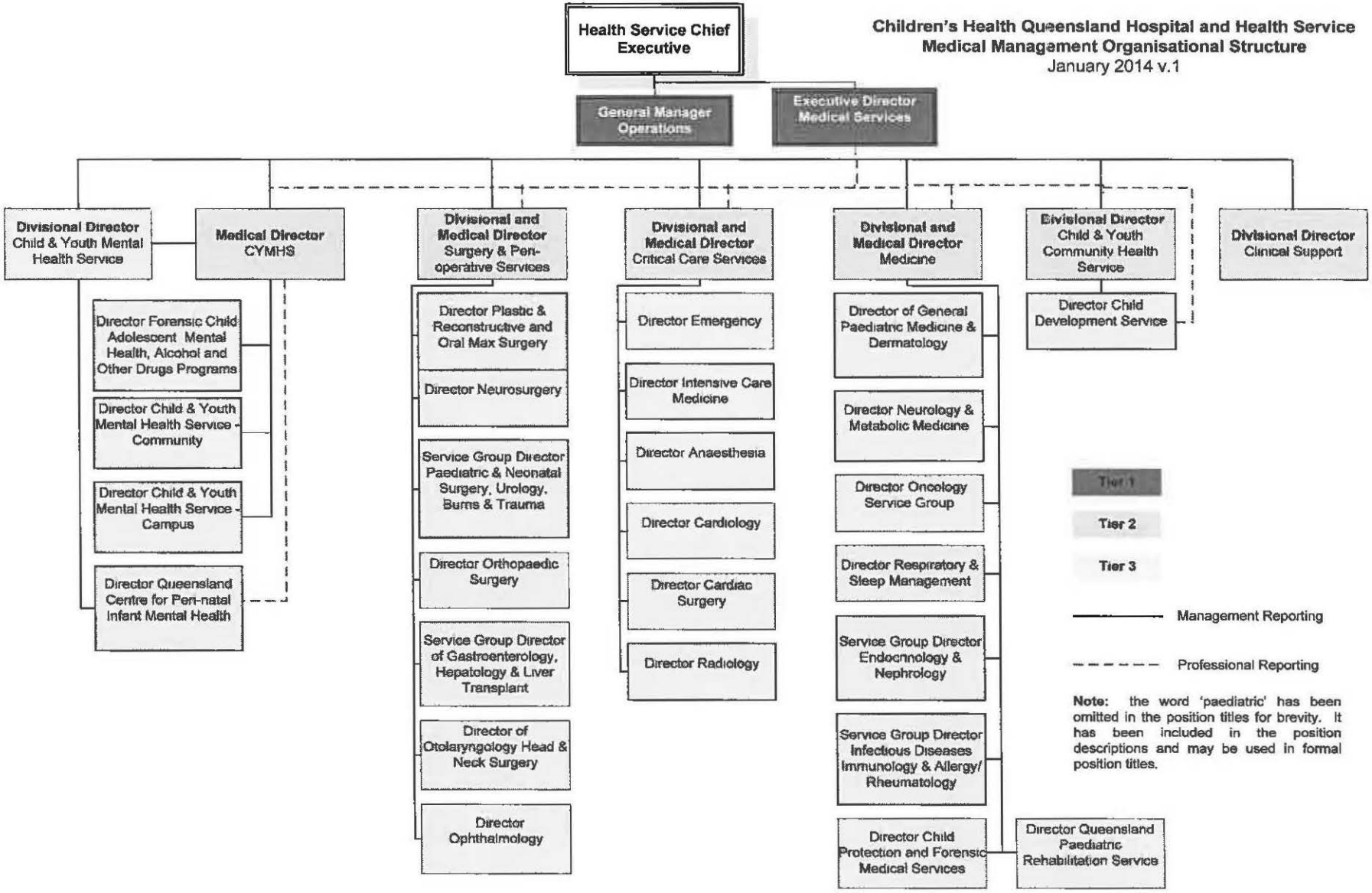

Health Service Chief Executive
Children's Health Queensland Hospital and Health Service
Medical Management Organisational Structure
January 2014 v.1
General Manager Operations
Executive Director Medical Services
Divisional Director Child & Youth Mental Health Service
Medical Director CYMHS
Director Forensic Child Adolescent Mental Health, Alcohol and Other Drugs Programs
Director Child & Youth Mental Health Service - Community
Director Child & Youth Mental Health Service - Campus
Director Queensland Centre for Peri-natal Infant Mental Health
Divisional and Medical Director Surgery & Peri-operative Services
Director Plastic & Reconstructive and Oral Max Surgery
Director Neurosurgery
Service Group Director Paediatric & Neonatal Surgery, Urology, Burns & Trauma
Director Orthopaedic Surgery
Service Group Director of Gastroenterology, Hepatology & Liver Transplant
Director of Otolaryngology Head & Neck Surgery
Director Ophthalmology
Divisional and Medical Director Critical Care Services
Director Emergency
Director Intensive Care Medicine
Director Anaesthesia
Director Cardiology
Director Cardiac Surgery
Director Radiology
Divisional and Medical Director Medicine
Director of General Paediatric Medicine & Dermatology
Director Neurology & Metabolic Medicine
Director Oncology Service Group
Director Respiratory & Sleep Management
Service Group Director Endocrinology & Nephrology
Service Group Director Infectious Diseases Immunology & Allergy/ Rheumatology
Director Child Protection and Forensic Medical Services
Director Queensland Paediatric Rehabilitation Service
Eivisional Director Child & Youth Community Health Service
Director Child Development Service
Divisional Director Clinical Support
Tier 1
Tier 2
Tier 3
Management Reporting
Professional Reporting
Note: the word 'paediatric' has been omitted in the position titles for brevity. It has been included in the position descriptions and may be used in formal position titles.

EXHIBIT 176

QHD.900.010.0052

Child and Youth Mental Health Services

Guiding Principles for Admission to Queensland Health Child and Youth Mental Health Acute Inpatient Units

Queensland Government

CONTENTS

1. Introduction

These guiding principles are concerned with access to and provision of treatment for children and adolescents (0-18 years) who require admission to a Queensland Health child and youth mental health acute inpatient unit. The admission criteria and priorities, referral and admission processes and pathways, minimum standards and transfer processes are intended to assist clinician, consumer and carer decisions in acute and emergency mental health situations. The guidelines are not designed to replace clinical judgement, but to provide principles and minimum standards to enhance service delivery and assist practitioners in their decision-making, with an emphasis on promoting best practice and improving consumer outcomes.

As outlined in the *Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996)*, an underlying principle of child and youth inpatient treatment is to keep periods of hospitalisation to a minimum. In general, community-based care is the primary aim, and inpatient care is reserved for those who either fail to respond to community approaches or require more intensive forms of care and additional benefits of the inpatient setting.

Implicit in this document is the recognition that hospital-based treatment is just one component of an overall package of acute care in child and youth mental health service delivery; hence every admission will have specific indications and aims. Child and Youth Mental Health Services (CYMHS) function as an integrated whole, with maximum flexibility for children and adolescents to move between acute inpatient and community-based treatment according to need at different phases and stages of mental health problems. As with all other aspects of mental health care in Queensland, partnership and collaboration with the consumer's carer and/or family, the referring agent and any other service providers involved is emphasised in all decision making.

This document emphasises the need to fully articulate the reasons for considering admission to hospital, and describes how priorities will be determined, in order to lead to more purposeful interventions and optimal use of limited inpatient resources.

2. Scope and purpose

This document aims to assist in the safe and effective assessment and treatment of children and adolescents who require child and youth mental health acute inpatient care by defining:

- the process for making a referral for admission
- the process of determining acceptance for admission
- the safe transport of patients between health facilities
- clear admission criteria and priorities
- admission processes
- contingency plans for bed management at times of peak demand.

This document applies to all Queensland Health (QH) child and youth mental health acute inpatient units in Queensland, and will provide guidelines for mental health clinicians, general practitioners, private psychiatrists and other referrers. The guidelines take into account:

- the needs of people of Aboriginal or Torres Strait Islander background
- the needs of people from non-English speaking backgrounds
- issues of gender, physical and intellectual disability and age
- consumer and carer values and participation
- rural and regional issues
- the recovery model of mental health service provision.

2.1. Clinical Services Capability Framework

The Clinical Services Capability Framework (CSCF) outlines the minimum standards around workforce, quality and safety, support services and other requirements required in both public and licensed private health services to ensure safe and appropriately supported clinical services. The CSCF defines child and youth inpatient services from levels 2 to 6. The CSCF is available on the Planning and Coordination Branch web page on QHEPS.

The CSCF recognises that children and adolescents will at times receive inpatient treatment in settings that are not specialist child or adolescent inpatient beds because of ease of access, urgency, or in the interests of keeping the child or adolescent close to the home community. As suggested in the CSCF, services at levels 2, 3 and 4 should have service level agreements with a specified level 5 service, and this would include criteria and

processes for transfer of children and young people who cannot be treated appropriately in their local area.

2.2. National Standards for Mental Health Services

These guidelines have been informed by the *National Standards for Mental Health Services (2010)* with particular reference to the following criterion:

1.9 The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.

2.11 The MHS conducts risk assessment of consumers throughout all stages of the care continuum, including consumers who are being formally discharged from the service, exiting the service temporarily and/or are transferred to another service.

4.1 The MHS identifies the diverse groups (Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD), religious/spiritual beliefs, gender, sexual orientation, physical and intellectual disability, age and socio-economic status) that access the service.

6.16 The right of consumer to have visitors and maintain close relationships with family and friends is recognised and respected by the MHS.

9.3 The MHS facilitates continuity of integrated care across programs, sites and other related services with appropriate communication, documentation and evaluation to meet the identified needs of consumers and carers.

10.1.1 The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.

10.1.2 The MHS treats consumers and carers with respect and dignity.

10.3.3 The MHS has a documented system for prioritising referrals according to risk, urgency, distress, dysfunction and disability with timely advice and/or response to all those referred, at the time of assessment.

2.3. Adolescent Extended Treatment and Rehabilitation Centre

The Adolescent Extended Treatment and Rehabilitation Centre (AETRC), formally Barrett Adolescent Centre, provides extended (up to 12 months) specialist assessment and treatment and rehabilitation to young people between 13-17 years of age with severe persistent mental illness/es. As the AETRC has its own admission processes, the scope of this document does not include admission to the AETRC. At times the transfer of young people between the AETRC and acute inpatient units will be required. A current review of the AETRC will clearly articulate referral processes, at which time this document will be updated to reflect these changes. In the interim, discussions regarding referrals to the AETRC should be made between the referring service to the AETRC Clinical Liaison, Clinical Nurse.

3. Admission criteria

As outlined in the *Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement (1996),* a child and youth acute inpatient unit provides assessment and short-term intensive treatment, as part of the continuum of care, for children and adolescents experiencing acute episodes of mental illness who cannot be treated more appropriately in community settings. Inpatient units provide 24 hours a day, seven days a week, treatment during an acute episode of mental illness, in a structured environment, as part of a longer-term treatment plan. Admissions occur when the presenting behaviour cannot be safely managed in the community, or when treatment cannot be provided at a less intensive level. Access to inpatient beds will only be available following assessment by a child and youth mental health clinician. This may occur as a planned admission or following a crisis assessment in an emergency department or community setting. The decision to admit a child or young person should be a clinical judgement which integrates the following five elements:

1. Clinical criteria
2. Vulnerability criteria
3. Admission priorities
4. Risks associated with admission
5. Other (non-clinical) considerations.

3.1. Clinical criteria

A child or adolescent is admitted to a child and youth mental health acute inpatient unit for the following clinical reasons:

- recognised or probable psychiatric illness or disorder and reasonable likelihood that inpatient care will result in substantial benefit

  AND at least one of the following:

- previous unsuccessful trial of intervention in a less restrictive setting, or circumstances do not allow such a trial to be considered
- high level of vulnerability to harm (as defined by the vulnerability criteria stated below)
- the presence of a significant co-existing medical condition which would complicate or increase the risk to the consumer or others if treatment of the psychiatric illness is provided in a less restrictive setting
- significant impairment of self-care skills and social functioning at home and at school, as a result of a mental illness or disorder, where the disorder cannot be adequately treated in a community setting
- there is a requirement for specialised psychiatric treatment such as the provision of intensive psychotherapeutic interventions or the introduction of medication that is not able to be safely delivered in a less restrictive setting
- the diagnostic or systemic complexity of the case requires a range of assessments which cannot be done in a less restrictive setting.

3.2. Vulnerability criteria

A high level of vulnerability to harm will be evidenced by one or more of the following:

Danger to self:

- significant recent life threatening attempt at self-harm with confirmed imminent risk
- specific suicidal intentions with high lethality and availability of means
- risk of suicide or serious self-harm that cannot safely be managed in a less restrictive setting
- a level of impulsiveness and impaired judgement which places the child or adolescent at significant risk of being harmed by others.

Danger to others:

- significant recent violent acts and continued imminent risk
- specific threats of violence with high lethality and available means
- behaviour that poses a significant risk of social, financial or psychological harm to others
- level of dangerousness to others that cannot be managed in a less restrictive setting.

Access to appropriate care and services:

- where community-based CYMHS cannot provide the necessary range or intensity of services to meet the child's or young person's needs in terms of risk management or effective treatment
- where the child's or young person's parents, family or carers are unable to meet their needs or provide adequate care and safety during a period of mental illness/instability.

3.3. Admission Priorities

On occasions the need for child and youth acute inpatient beds may exceed availability. Consequently it is important that there is statewide consistency in determining the clinical need for inpatient resources and that access to these resources is equitable across Queensland. When one bed is available but there are two or more eligible referrals, then the inpatient unit will use these guidelines to determine admission priority. The **level of risk** is always the primary consideration, with the secondary consideration being the **safety** and **suitability** of current care arrangements.

Level of risk:

- priority one - there is an immediate risk of death or serious physical harm, either to the child or adolescent, or to others
- priority two - there is a clear risk of suicide, self harm or violence, but without immediate intentions or access to the means
- priority three – there are distressing and incapacitating symptoms, or progressive deterioration and loss of function with regard to self-care and social functioning
- priority four - the child or adolescent requires complex multi-disciplinary assessment in an inpatient setting.

Level of current care:

- priority one - the child/adolescent is at home or in another community setting
- priority two - the child/adolescent is in a setting that can provide a level of safety but can offer only very short-term care, e.g. an emergency department
- priority three - the setting can provide a level of safety but cannot provide adequate mental health treatment, e.g. a paediatric or medical ward, or a youth detention centre
- priority four - the child/adolescent is in an adult mental health unit.

3.4. Risks associated with admission

The benefits of admission should always be weighed against the potential risks associated with admission. Potential risks to consider include:

- Some children and adolescents experience a negative clinical reaction to the environment and peer group of a child or adolescent inpatient unit. This can take the form of regression, acting-out behaviour and increased self-harm or aggression.
- Separation from family, friends, school, and other ecological support systems can hinder or negate some essential elements of the recovery process, and undermine the ability of consumers and carers to cope with the mental illness in a 'real world' setting.
- Separation from family, friends and community can be very distressing for the child or adolescent, particularly for those of Aboriginal or Torres Strait Islander, and those of culturally and linguistically diverse (CALD) backgrounds.
- When a child or adolescent is admitted to a unit which is a significant geographical distance from their home, it can be difficult to deliver effective treatment because of the impossibility of providing effective family therapy and other systemic interventions.
- In some instances, outcomes of previous inpatient admissions may have demonstrated that further admissions are likely to be unhelpful or counterproductive for the child or adolescent.
- Adolescents with autism and intellectual impairment (without comorbid mental illness) often do not benefit from admission because the change of environment may be unsettling and distressing. In addition, the positive behavioural changes achieved in an inpatient setting are often not generalised to the home environment. Adolescents with autism and intellectual impairment who are referred for acute inpatient admissions should only be admitted as part of an interagency process involving the Department of Communities (Disability and Community Care Services). In general, admission of such

consumers to an adolescent acute inpatient unit is not advisable and careful consideration of the risks and benefits of admission is required.

Taking these potential risks into account, the referrer may be advised to consider alternatives such as intensive community support, or admission to a less specialised unit (CSCF level 2, 3 or 4) in the consumer's local area. In these cases, the child or adolescent inpatient unit has a responsibility to give advice on alternative units or services, and to liaise with these units.

3.5. Other considerations

In addition to clinical factors, there are other considerations which should be taken into account when deciding whether or not to admit a child or adolescent including:

- the needs and choices of the consumer, carer and/or family according to geographical proximity to place of usual residence
- the expectations of the referring agent, and whether these can be met by the inpatient unit
- whether admitting a particular consumer may create difficulties regarding confidentiality or the specific management of another child/adolescent
- when the child or adolescent or family member has an outstanding serious complaint regarding the particular mental health service where the inpatient unit is located.

4. Referral and admission processes

4.1. Referral

Referral to a child or adolescent acute inpatient unit should ideally be made by a CYMHS clinician in consultation with the treating CYMHS psychiatrist. In an emergency situation, for example when the child or adolescent has been seen in an emergency department, the referral may be made by a general adult mental health psychiatrist or psychiatric registrar.

In rural areas where CYMHS clinicians or psychiatrists are not available, a referral may be made by a hospital medical officer or a general practitioner (GP). If the referral is made by a medical officer or a GP, then the referrer should discuss the referral directly with the intake officer of the relevant child and youth mental health acute inpatient unit (refer to

Appendix A) who, if necessary, will discuss with the consultant psychiatrist on call for the inpatient unit. If there is no local CYMHS worker involved in the referral, then the admitting unit should alert the local hub CYMHS service or E-CYMHS.

The referral may be initiated at any time, 24 hours a day, seven days a week, by means of a telephone call to the intake officer (or equivalent) at the relevant child or adolescent inpatient unit. The referrer must also provide the intake officer with a comprehensive written clinical assessment, either by fax, or electronically through the Consumer Integrated Mental Health Application (CIMHA). The clinical assessment will include:

- a mental state examination
- diagnosis / provisional diagnosis / formulation
- physical status / medical clearance if indicated
- *Mental Health Act (2000)* status
- medication history
- risk assessment and risk management plan
- accommodation / support details
- referrer's goals for admission of the child or adolescent.

Prior to making a referral, the referrer is encouraged to seek expert advice which is available 24 hours/day, seven days a week through the on-call services at the Mater Children's Hospital, the Child and Family Therapy Unit at the Royal Children's Hospital (RCH), and the Adolescent Unit at the Royal Brisbane and Women's Hospital (RBWH). Referrers from the South Brisbane and South Queensland areas should contact the Mater Children's Hospital, and referrers from North Brisbane, Central Queensland or North Queensland should contact the RCH or RBWH.

NB. Prior to any transport for the young person being arranged, a destination bed must be negotiated with the receiving inpatient unit.

4.2. Decision to accept the referral

The intake officer will consider the admission based on the criteria and priorities outlined in this document; the current capacity of the inpatient unit; and the distance from the referring service. The intake officer will only accept the admission after consultation with the accepting inpatient team and after comprehensive written clinical information, including a **Transport Risk Management Plan** (p.13) has been provided.

Local referrals

Where the child or adolescent is being referred within metropolitan south-east Queensland or within a regional district with a child and youth mental health acute inpatient unit, the following should apply:

- If the child or adolescent meets the criteria and the inpatient unit has capacity, then they should be admitted as soon as possible.
- If the inpatient unit does not have the beds or capacity to admit the child or adolescent, the intake officer should advise the referrer on which other child or adolescent inpatient unit may have beds or advise on alternative crisis management strategies.

Regional, rural or remote referrals

Where the child or adolescent is being referred from a district without a child and youth mental health acute inpatient unit, the following should apply:

- If the child or adolescent meets the criteria and the inpatient unit has capacity, then the referrer and the admitting unit should reach mutual agreement regarding the time of their transfer and arrival at the unit.
- As a general rule, the transfer should be planned, so that the child or adolescent arrives within daylight hours with adequate time for the receiving unit to carry out the admission process.
- If this cannot be achieved, then the referrer may be advised to arrange for the child or adolescent to be admitted to a local level 2, 3 or 4 service overnight or as otherwise agreed with the admitting unit.
- If the child/adolescent is admitted to a local level 2, 3 or 4 service, it is good practice for them to be reassessed by a CYMHS clinician before being referred for admission to a child or adolescent acute inpatient unit. If a CYMHS clinician is not available then the child/adolescent should be reassessed by a mental health clinician or medical officer. If the level of risk has reduced, it may be that admission to a child or adolescent acute inpatient unit is no longer indicated

4.3. Transport

Transport Risk Management Plan

All consumers will have a written Transport Risk Management Plan completed by the referring clinician, which should address the following:

- the possible risks during the transport process (such as absconding, violence, self harm, suicide, and undue patient distress)
- plans to minimise these risks such as the *Mental Health Act (2000)* status, the nature of the escort, level of observation, the mode of transport, medication prior to departure, Pro re nata (PRN) medication during transport, contingency plans and contact people in the event of a crisis.

If the child or adolescent cannot be transported safely, then they should be stabilised at the current location and not transferred.

Mode of transport

Transport options include:

- private vehicle
- public transport: taxi, bus, rail or aircraft
- QH vehicle
- Queensland Ambulance Service (QAS) vehicle
- Queensland Police Service (QPS) vehicle
- Air retrieval as coordinated through Retrieval Services Queensland.

Escort options include:

- family member
- QH staff
- QAS staff
- QPS staff
- air retrieval service provider staff.

The appropriate mode of transport, escort and crew mix will be agreed on by the referring clinician, the inpatient unit intake officer, the child's or adolescent's carers, and if appropriate the QAS Transport Centre, the QPS, or the Queensland Emergency Medical System Coordination Centres (for emergency and/or air transport). The mode of transport will depend on clinical factors as well as distance: as a general rule air transport is used for journeys of more than 2.5 hours by road. Where a private vehicle, public transport, or a QH vehicle is to be used, it is the responsibility of the referring service to coordinate transport arrangements. Where a QAS or QPS vehicle or aircraft is used, it is the responsibility of the inpatient unit to coordinate the arrangements with the relevant communications centre.

Communication

The referrer should make telephone contact with the inpatient unit at the time of the child's or adolescent's departure to update the inpatient unit on their status and travel arrangements.

Aircraft transport

The referrer should be aware of the relevant air retrieval service provider's policies for risk assessment and risk management, such as the possibility that physical restraint and general anaesthetic may be required during air transportation. The level of possible distress, the *Mental Health Act (2000)* requirements, and the need for safe extubation of an anaesthetised child or adolescent at the receiving hospital should be considered. The Director of the receiving unit should be involved in the planning of all admissions where transport by aircraft will be required.

Police Assistance

Police assistance may be requested for the transport of a child or adolescent who is subject to the *Mental Health Act (2000)*; however the QPS are not regarded as a primary transport provider. Health service staff will accompany any child or adolescent being transferred by police vehicle.

Sedation for purposes of transfer

On occasion it may be necessary to offer the use of sedation before or during the transport process. The sedation plan should be discussed between the referrer and the intake officer (or equivalent), and should be in keeping with the CYMHS Acute Sedation Guidelines (when developed), which can be provided to the referrer if necessary. In the case of a child or adolescent being transported by aircraft, the sedation plan will be in keeping with the relevant air retrieval service provider's guidelines. A list of all medication prescribed before and during transfer should accompany the consumer and the escort to the inpatient unit, and the escort should record the time and dose of all PRN medications administered on the journey. Depending on the level of sedation, it may be necessary for the consumer to be taken to the emergency department for assessment prior to admission to the inpatient unit. This decision should be made in consultation with the on-call psychiatrist at the receiving service prior to the consumer being transferred.

4.4. Admission process

Intakes that result in admission during the hours of 0800 – 1600 will:

- present directly to the ward at an agreed time which has been negotiated with the intake officer / shift coordinator / psychiatric registrar / principal house officer or resident medical officer, who will be required to review the patient when they arrive on the ward
- require the admitting inpatient unit to make contact with the consumer's local CYMHS upon admission or as soon as possible afterwards (if this had not already occurred).

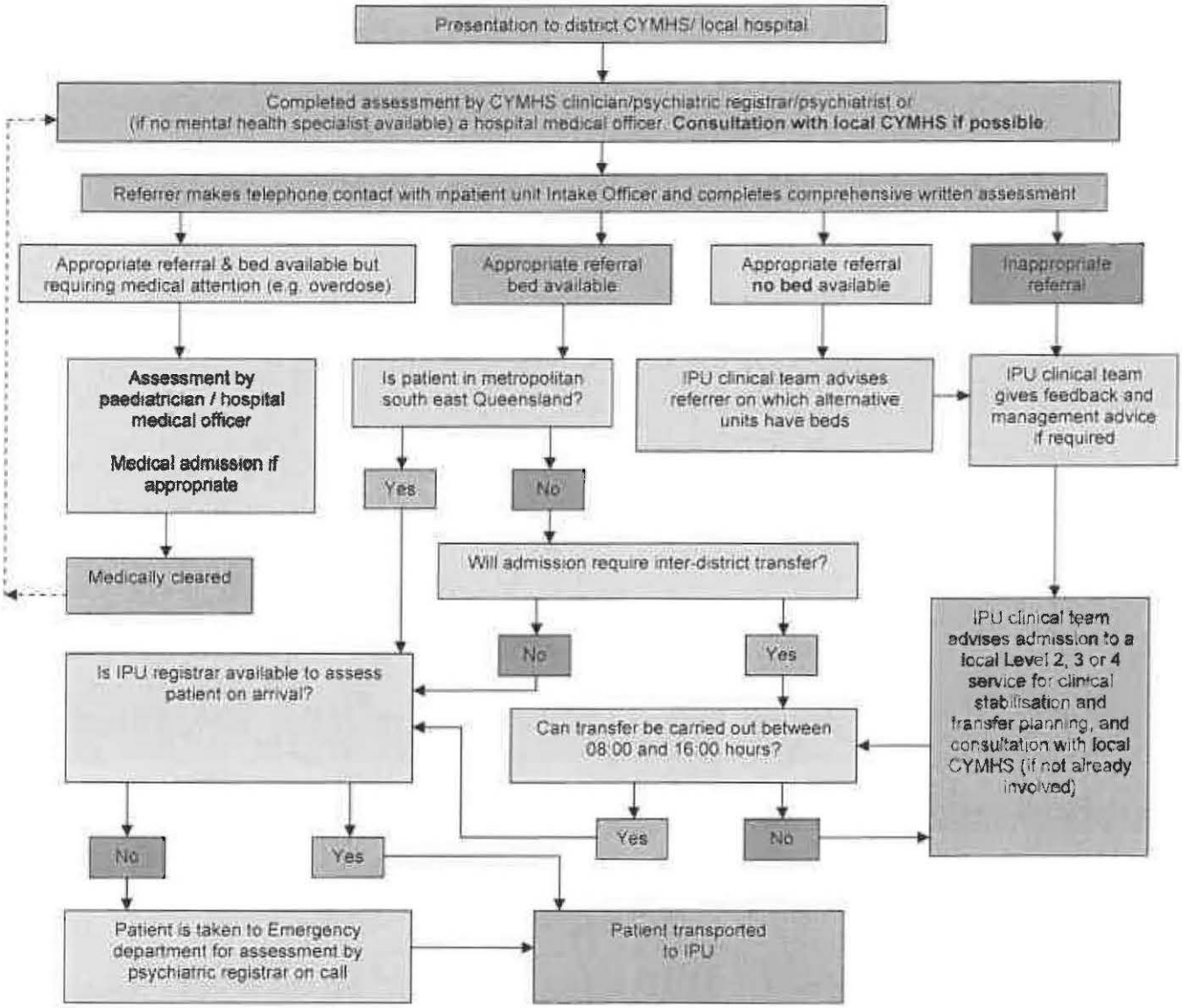
Intakes that result in admission after 1600 hours OR result in an admission during 0800 – 1600 hours when there is no psychiatric registrar / principal house officer on the ward will:

- be discussed between the intake officer / shift coordinator and the psychiatric registrar on call
- require an assessment by a psychiatric registrar and be medically cleared at the emergency department, prior to acceptance for admission
- require a review by the psychiatric registrar of the intake assessments and document a treatment plan in the emergency department when the patient arrives, ensuring that physical examination has been completed prior to acceptance to the ward.

N.B. Original *Mental Health Act (2000)* paperwork should accompany the patient when admitted to the unit.

5. Referral and Admission Pathways

5.1. Flowchart



NB: A written Transport Risk Management Plan must be completed by the referring clinician and provided to the IPU prior to transportation

Flow Chart Key: IPU = Inpatient Unit **CYMHS = Child and Youth Mental Health Service**

5.2. Children and adolescents under the care of Department of Communities (Child Safety Services)

When a child or adolescent is admitted from a foster care or residential care placement, it is to be expected that:

- prior to admission, there is an identified child safety officer (CSO) for purposes of liaison, supporting the young person, and care planning
- Child Safety Services can identify a discharge residential address before the child or adolescent is accepted for admission (exceptions to this rule can only be authorised by the Director of the inpatient unit or the after-hours on-call consultant psychiatrist)
- Child Safety Services will engage with both the inpatient unit and the community CYMHS in relation to care planning for a child or adolescent who is subject to ongoing Child Safety Services interventions
- Child Safety Services will prescribe, in writing, the visiting arrangements for parents/carers visiting the inpatient unit and provide supervision of these visits if required
- Child Safety Services will ensure that adequate support is provided to the child or adolescent such as planned visits from a carer, non government organisation (NGO), service provider or CSO
- the Interim Memorandum of Understanding between CYMHS and the Department of Communities is referred to by both departments to assist in the discharge planning process.

5.3. Aboriginal and Torres Strait Islander children and adolescents

When the referred child/adolescent identifies as Aboriginal and/or Torres Strait Islander, the inpatient unit should consider the impact of separating them from their community and family, and admitting them to an inpatient environment where they may feel isolated and distressed. As a minimum, the local Indigenous Mental Health Worker or Aboriginal and Torres Straight Islander Hospital Liaison Officer should be informed of the planned admission before the child/adolescent is admitted. It is strongly recommended that if available, an Indigenous Mental Health Worker is involved in the admission process, to consult with the referrer, advise on treatment needs, provide cultural advocacy, and if necessary advise and support the child's/adolescent's family and be present when they are admitted. It is important to also consider specific cultural and linguistic needs of parents/carers of this consumer group. Parents/carers may also require communication with

an Indigenous Mental Health Worker for cultural safety reasons or translation assistance. For example, information about the diagnosis, treatment plan and medications should be explained in easily understood terms, or translated into the appropriate language as required.

Differences between Aboriginal and Torres Strait Islander cultures should be recognised.

5.4. Culturally and linguistically diverse (CALD) children and adolescents

The inpatient unit should plan for the specific needs of children and adolescents from a CALD background, including Aboriginal and Torres Strait Islander backgrounds where traditional languages are the first spoken language. The unit should ensure that written information is available to the child/adolescent and their family in the appropriate language (as far as possible), that a suitable interpreter is available at the time of admission (and as required during the inpatient stay), and that their dietary and other cultural needs will be catered for on the unit.

5.5. Children and adolescents with disabilities

Before accepting for admission a child or adolescent who has a significant physical disability, the unit management should consider whether the unit's design (i.e. disabled access features) will meet their needs, or whether an alternative unit may be more suitable. However these concerns should not impede the child's/adolescent's access to appropriate mental health care. In the case of Deaf consumers, an interpreter should be available at the time of admission and as required during their stay.

6. Alternatives to admission

These guidelines have noted that inpatient beds are a limited resource and have indicated the clinical situations which are prioritised for admission, and the safety considerations and other constraints which might place delays on the admission process.

Inpatient beds will not always be available when they are needed and requested by referrers. However, it is recognised that child and adolescent inpatient units are not only a resource for admissions but can also be a source of consultation and expert advice. When admission is not possible or not appropriate, the inpatient unit consultant psychiatrist (or other appropriate staff) should provide the referrer with useful advice on the following:

- other inpatient services which might be able to admit the child/adolescent
- when the child/adolescent is already in an inpatient service (such as a general medical, paediatric or adult mental health unit), advice on measures which will assist with short term treatment, crisis management and crisis resolution
- short term measures to ensure the child's/adolescent's safety in a community setting.

6.1. Admissions to out of area child and youth mental health acute inpatient units

When urgent admission is required to a child or adolescent inpatient unit but there is no bed available, the unit should advise the referrer on which other unit(s) to contact. This advice may be derived from the intake officer's knowledge of the bed status of other units, or may be derived from standing arrangements for service provision according to the consumer's location (see appendix A, p.23).

If there are no available beds in the local child or adolescent inpatient unit then a referral should be made to an alternative unit (as per the table in appendix A). The alternative unit should take responsibility for the child or adolescent treatment until the reason for admission has been resolved or they can be transferred safely back to the local unit or community mental health services. If the child/adolescent is a past or existing consumer of the local area inpatient unit then the alternative unit should liaise with the local inpatient unit about the child's/adolescent's treatment needs and discharge arrangements.

6.2. Adult Mental Health or Paediatric Units

In keeping with the CSCF (refer to section 2.1, p. 5), it may be considered appropriate for temporary care and stabilisation of a child up to 14 years to be provided in a paediatric inpatient unit until their physical or mental state is such that they can be transferred to an available child and youth mental health inpatient bed. Similarly it may be considered appropriate for temporary care and stabilisation of a adolescent 16 years or older to be provided in a adult mental health acute inpatient unit until their mental state is such that they can be managed in the community or transferred to an available child and youth mental health inpatient bed. In some cases where an adolescent 14-16 years has physical and emotional maturity, or where there is no alternative, it would be acceptable for the consumer to be admitted to an adult mental health unit, with the provision of adequate

measures to maintain the adolescent's safety. In these situations a safety plan must be completed prior to admission.

If the admission is appropriate and no beds are available, the receiving adolescent unit will recontact the current treating team when a bed becomes available. The current treating team is also expected to maintain communication with the receiving inpatient unit to update the unit's intake officer on the consumer's clinical status.

6.3. Short term management in a community setting

When appropriate, the inpatient unit staff (usually the consultant psychiatrist or another senior clinician) may advise the referrer on strategies to manage the crisis until a bed is available, or until a bed is no longer required. However the inpatient unit should take into account the clinical capabilities of the community-based service and if possible assist in identifying local resources.

- The referrer should reach an agreement with the consumer and carer and/or family about the length of time for which the current situation can be managed, and about strategies to relieve distress and manage risk.
- The referrer should have a collaborative discussion with the consumer and carer and/or family in relation to alternative admission options (adult mental health or paediatric units as outlined above) or alternative accommodation arrangements (respite or emergency residential care).
- The referrer should explore the range of crisis intervention measures available locally to ensure safety and follow-up (for instance, use of extended hours service, Emergency Department, linkage with Adult Mental Health, follow up by inpatient unit staff, community CYMHS intensive follow up etc).

7. References

1. *National Standards for Mental Health Services (2010).*
2. *Clinical Services Capability Framework Version 3 (2009) Section 1.2.*
3. *Queensland Medical Transport System. Transport of people with a mental illness from rural, remote and regional Queensland. Standard Operating Procedures (2006).*
4. *Queensland Mental Health Patient Safety Plan 2008–2013.*
5. *Queensland Mental Health Services Guidelines for inter-district transfers of consumers.*
6. *Interim Memorandum of Understanding between Queensland Health Child and Youth Mental Health Services and Department of Communities Child Safety, Youth and Families 2010–2013.*
7. *Future Directions for Child and Youth Mental Health Services Queensland Mental Health Policy Statement, 1996.*
8. *Mental Health Act (2000).*

Appendix A:

Child and Youth Mental Health Acute Inpatient Units

Admission priority

The following table outlines the order of priority that services should attempt to use when seeking a child/adolescent inpatient admission. If primary and secondary facilities are not able to admit then other facilities will need to be sourced.

Referring Area	Adolescent Primary Access	Adolescent Secondary Access	Child Primary Access	Child Secondary Access
Bayside	Logan	Mater	Mater	Gold Coast
Gold Coast	Gold Coast	Logan	Gold Coast	Mater
Logan	Logan	Gold Coast	Mater	Gold Coast
Mater	Mater	Logan	Mater	Gold Coast
Toowoomba	Mater	Logan	Mater	Gold Coast
West Moreton / South Burnett	Logan	Gold Coast	Mater	Gold Coast
Southern Qld Rural Districts	Mater	Logan	Mater	Gold Coast
For all areas North of the Brisbane River [c]	RBWH [a]	Mater	CFTU-RCH [b]	Mater

[a] Royal Brisbane and Women's Hospital. [b] Child and Family Therapy Unit, Royal Children's Hospital. [c] Includes North Brisbane (RCH & Redcliffe/Caboolture), Sunshine Coast, Wide Bay, Central Queensland, Central West, Mackay, Townsville, Mt Isa, Cairns and Hinterland, Cape York, Torres Strait and Northern Peninsula.

MODEL of SERVICE for the STATEWIDE SUBACUTE BEDS

What does the service intend to achieve? (Key functions –description)

"Inpatient Child Psychiatry should be seen as a mode of treatment and not a bureaucratic convenience or a form of substitute care." Green 1992

The statewide subacute beds (SSB) form part of a continuum of care for adolescents requiring extended mental health treatment and rehabilitation in Queensland.

As a statewide subacute service, the SSB will provide medium term intensive hospital treatment and rehabilitation services in a safe, structured environment for young people with severe or complex symptoms of mental illness and associated significant disturbance in behaviour that precludes them receiving treatment in a less restrictive environment.

A range of individual, group and family-based assessment, treatment and rehabilitation programs will be offered, aimed to treat mental illness, reduce emotional distress, and promote functioning and wellbeing within the community. This will include recovery-orientated treatment and discharge planning that will support the safe transition to more functional or independent living.

The service will meet and exceed National Standards for Mental Health Services and the Equip National Safety Standards.

A number of factors will facilitate the continuum of care approach:

1. ***Clear pathways between the different parts of the continuum.***
2. ***Clarity in Clinical Governance and facilitation of communication with attendance of relevant Case Conferences of different parts of the Continuum and written de escalation plans.***
3. ***Each part of the continuum articulating its local application of the stae-wide MOSD's so each part of the continuum can be aware of the models and similarities.***
4. ***Regular meetings between the staff of the day programs, AMYOS, subacute beds and the Adolescent Inpatient Unit.***
5. ***A number of joint education sessions where the current evidence base and models in the literature discussed***

Who the service is for? (Target group)
Diagnostic Profile: Young people aged 13-18 with

1. a diagnosis of schizophrenia or other psychotic illness,
2. severe mood disorder,
3. complex trauma with significant deficits in psychosocial functioning which ma present with severely disorganised behaviour characterised by impaired impulse control, emerging personality vulnerabilities, risk of self-harm, or difficulties managing activities of daily living.
4. marked anxiety with social avoidance
5. No matter what the presenting diagnosis, many will experience chronic family dysfunction, which serves to exacerbate the severity and persistence of the disorder and associated disabilities.

What does the service do?

The key functions:

- Build upon existing comprehensive assessment of the adolescent (utilising the thorough treatment history obtained from service providers and carers) to assess the likelihood of therapeutic gains by attending the SSB.
- Provide individually tailored **evidence-informed 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 **3 - 6 month** targeted and phased treatment program that will ultimately assist recovery and reintegration back into the community.

Treatment programs will include an extensive range of therapeutic, educational/vocational interventions and comprehensive activities to assist in the development and recovery of the adolescent. The program will follow structured phases incorporating assessment, establishment of therapeutic alliances, development of 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.
- A comprehensive family assessment completed within the first **2** weeks of admission.
- Targeted treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff.
- Access to schooling within the hospital campus.
- Access to Indigenous and transcultural support services.
- 24-hour inpatient care for adolescents in a safe, structured, highly supervised, and supportive environment.
- Flexible and targeted programs that can be delivered in a range of contexts including individual, family, group, school, and community.
- Assertive discharge planning to integrate the adolescent back into their community of choice, including appropriate local mental health treatment, education or vocational services, and accommodation.

Referral /Access

- Queensland CYMHS services will act as the referral agency.
- All referrals will be processed through a designated intake officer. This single point of referral ensures consistent collection of adequate referral data and immediate feedback on appropriateness. It also expedites a pre-assessment interview (see below) and liaison with the referrer if there is a wait time until the adolescent is admitted.
- As a statewide subacute service, referrals will be assessed for suitability for a planned admission via a formal Statewide Assessment Panel. The Panel will be chaired by the **Medical Director, State-wide Service CYMHS CHD and a Child and Adolescent Psychiatrist from each QHealth Cluster, namely Northern, Central and Southern Cluster.**
- On acceptance, the adolescent will be assigned a Case Manager, who will be responsible for organising admission and ongoing liaison with the referring HHS.

- Responsibility for the clinical care of the adolescent remains with the referring HHS until the adolescent is admitted to the SSB. It is anticipated that adolescents will also remain actively engaged with local mental health and other support services prior to, and during the course of, their admission into the SSB.
- Priorities for admission will be determined ***on the potential for therapeutic benefit from the admission,*** the basis of levels of acuity, the risk of deterioration, the current mix of admitted adolescents, the potential impact on the adolescent and others, length of time on the waiting list, and age at time of referral.
- A pre-admission assessment of the adolescent and family (if appropriate) will be incorporated into the referral process. This may be done in person or via videoconference. The pre-admission assessment enables the adolescent and parents/carers to meet staff and negotiate their expectations regarding treatment and discharge planning. It also allows further determination of the potential for therapeutic benefit from the admission, the impact of being with other adolescents, and some assessment of acuity and risk.

Assessment

Mental Health Assessment

- The Case Manager 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. This assessment will begin with the referral and continues throughout the admission.

Family/Carer Assessment

- A Family Assessment is considered essential. The Case Manager will obtain a detailed history of family structure and dynamics, or a history of care if the adolescent is in care. This process will begin with the referral and continues throughout the admission.
- It is expected that the family will be available to complete a comprehensive family assessment and that parents/carers will be involved in the mental health care of the adolescent as much as possible. A significant effort will be made to support the involvement of parents/ carers. As part of this comprehensive assessment, **families will be expected to travel to Brisbane for up to a week.** The cost of transport, accommodation, meals, and incidentals will be covered by the referring HHS.
- If parent/carer mental health needs are identified, the Case Manager will attempt to meet these needs and, if necessary, refer to an adult mental health service or other appropriate supports.

Developmental/Educational

- School-based interventions, to promote learning, educational or vocational goals, and life skills, are a key feature of the assessment process and treatment plan. Access to on-site schooling will be available to all inpatients.
- The Case Manager will obtain a comprehensive understanding of any developmental, cognitive, speech and language, or learning disorders and their impact on the adolescent's mental health and schooling. This process begins with available information on referral and during admission.

Physical Health

- Routine physical examination will occur on admission and be monitored throughout admission.
- Appropriate investigations will be completed as necessary.

- The SSB will have access to local tertiary paediatric consultation services if required.

Risk Assessment

- Risk assessments will be conducted on admission. Ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review.
- Risk assessments will be conducted in accordance with the statewide standardised clinical documentation.

Alcohol and other Drugs

- Assessments of alcohol and other drug use will be conducted during the referral process, on admission, and routinely throughout treatment.
- There will be capacity for adolescents with substance dependence issues to detoxify on admission although this is not the primary function of admission.

Child Safety

- Child safety concerns will be addressed in accordance with legislative mandatory reporting requirements.

Recovery Planning and Clinical Interventions:
All adolescents will have a designated consultant psychiatrist.

Service Inclusions

Whilst in any treatment, there are limitations as to what can be offered and achieved with understandable disappointment, early open discussion of these issues with adolescents and families are an important part of treatment. Dealing with parents and other systems expectations of Statewide Subacute beds is very important.

A Recovery Plan will be developed in consultation with the adolescent and their family/carers on admission. Adolescents will have access to a range of least restrictive, therapeutic interventions determined by evidence-informed practice, and developmentally appropriate programs to optimise their rehabilitation and recovery. The adolescent's progress against their Recovery Plan is regularly reviewed through collaboration between the treating team, the adolescent, their family/carer, the referrer/s, and other relevant agencies. ***Being part of a continuum of care and therefore one part of their treatment over time, treatment needs to be integrated both with the adolescent's environment and wider service provision.***

Clinical Interventions will include:

Therapeutic Alliance and Milieu and Treatment Planning:

Whilst there are differing definitions in the literature for milieu, there is an agreement on important factors contributing to a therapeutic milieu- consistency of approach, good communication between adults, clear communication of expectations and boundaries, firmness without retaliation or aggression, appropriate privacy, remaining reality orientated and not fostering regression. It requires clear leadership, reflective practice, an awareness of common countertransference reactions, supervision, clear, well-structured operational protocols and clear response to aggression. Much of the therapeutic work is by the day to day interactions with the nursing staff, with more targeted individual

interventions being done by staff with appropriate training and experience. Also the use of healthy peer relationships through community groups and joint projects is promoted.

The glue that holds the multiple strands of treatment together is a functioning multi disciplinary case conference, reflective practice and clear respectful communication.

Outcomes
Routine outcome measurement should be occurring. This information needs to be included both in Case Conference as well as included in the Quality Improvement ethos and planning of each part of the continuum. Data on client and family satisfaction as well as staff morale and turnover is important.

Discharge/Transition Planning

- *Discharge planning should begin at time of admission, with key stakeholders being actively involved. Discharge planning will address potential significant obstacles, such as accommodation, engagement with other child and youth mental health services, and transition to adult mental health services.*
- *Discharge planning will involve multifactorial components that attend to therapeutic needs, developmental tasks, and reintegration into the family if appropriate.*

The school linked to the SSB will have primary responsibility for school reintegration, and /or vocational options, and the support required during this process

Psychotherapeutic:

Individual and group-based interventions will be developed according to the adolescent's treatment needs. This will include a range of therapeutic and supportive verbal and non-verbal modalities and frameworks. ***Potentially there is a range levels as the focus of intervention from behavioural to deeper attachment needs. The focus given the length of admission should be on improvement of safety, appropriate rehabilitation (recovery focused) and skills acquisition (including mentalization and other affect regulation strategies) whilst understanding attachment informed practice. Treatment planning and cohesion is facilitated by an individualised formulation and treatment plan with clear goals and the ward having an overarching model to understand cases and treatment.***

Family Interventions:

- Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent, where possible. This will include psycho-education for the parents and carers ***as well as building on existing strengths and developing coping skills.*** Where possible, family therapy will also be integrated into the overall therapeutic approaches to the adolescent during admission and as part of their discharge plan. This may include videoconference family therapy support to local mental health services.

Tasks to Facilitate Adolescent Development and Schooling:

- The SSB will offer a range of 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 and group-based interventions to promote aspects of adolescent development, which may include local adventure-based and other recreational activities.

Pharmacological:

- Administration will occur under the direction of a consultant psychiatrist.
- Regular administration and supervision of psychotropic medications will include monitoring for efficacy and adverse effects of psychotropic medications.
- Education will be given to the adolescent and parent(s)/carer about medication and potential adverse effects.

Clinical Intervention: * Service Exclusions

- Secure forensic beds are not offered as part this service.
- It is also not anticipated that young people with a primary diagnosis of an eating disorder will be accepted into the SSB.

Care Co-Manager / Continuity

- The Case Manager will monitor the adolescent's level of risk, mental state, and function in developmental tasks throughout admission.
- The Case Manager will act as the primary liaison person for the parent(s)/carer and external agencies on admission and during the discharge process.
- Depending on their skill set, the Case Manager will provide therapeutic input over the course of admission.

Frequency of activity

- Access to the full multidisciplinary team will be provided weekdays during business hours.
- Nursing staff will be rostered to cover shifts 24 hours, 7 days a week.
- An on-call consultant child and adolescent psychiatrist, with Registrar support, will be available 24 hours, 7 days per week.

Average Length of Stay
90 days with an expected maximum stay of less than 180 days.

Hours of Operation
24 x 7

Unit Size / Facility Features
Gazetted. 2 to 4 beds. Seclusion room.

Staffing/Workforce

- The staffing profile will incorporate the child and adolescent expertise and skills of psychiatry (consultant psychiatrist and psychiatry registrar), mental health nursing, psychology, social work, occupational therapy, speech pathology, and other specialist

CYMHS staff. The registrar position will be accredited for basic or advanced training by the Royal Australian and New Zealand College of Psychiatrists.

- 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 SSB.
- All permanently appointed medical, allied health, and senior nursing staff are (or are working towards becoming) authorised mental health practitioners.
- 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, case management will not be provided by students or staff appointed less than 0.5 FTE.

The effectiveness of the SSB is dependent upon an adequate number of appropriately trained clinical and non-clinical staff. The complexity of the mental health needs of children and adolescents suggests the need to provide staff with continuing education and professional development programs, clinical supervision, mentoring, and other appropriate staff support mechanisms. The SSB will undertake recruitment and retention strategies, such as providing clinical placements for students, encouraging rotation of staff from other areas of the integrated mental health service through the unit, and supporting education and research opportunities.

Geographic Location
The SSB will be located on a hospital campus in Children's Health Queensland catchment (Brisbane).

Funding
Recommended Clinical Staff per 4 beds:

- Psychiatrist: 0.2 FTE
- Registrar: 0.4 FTE
- Total Nursing: 5.1 FTE
- Psychologist: 0.2 FTE
- Social Work: 0.2 FTE
- Occupational Therapist: 0.2 FTE
- Speech Therapist: 0.2 FTE
- Recreational Officer: 2.2 FTE
- Administration Officer: 0.2 FTE

Governance
The SSB will operate under the governance of Children's Health Queensland Hospital and Health Service (CHQ HHS), within a statewide integrated mental health service

- Operational governance will occur through the SSB Clinical Director reporting directly to the Divisional Director, CYMHS CHQ HHS.
- Clinical governance will occur through the SSB Clinical Director reporting directly to the Divisional Medical Director, CHQ HHS.
- Interim line management arrangements may be required.

Related Services / Other Providers
integrated and co-ordinated with partnerships and linkages to other agencies and specialist mental health services for adolescents, to ensure continuity of care across the service