From: Judi Krause
To: FionaT Cameron
Date: 4/03/2010 11:21 am
Subject: Psychosis

Hi there
I have just spoken to DB and she had some points to make about the model (unfortunately belatedly!!).
1. psychosis - she felt we had to put something in about young people with treatment resistant psychosis (under who accesses the unit) this is imperative she feels as we would look foolish to adult psychiatrists without this inclusion.
2. she also felt that we should look at that list (of which groups use the unit) and put them in priority of highest users to lower users. She felt it read like eating disorders was a priority area. She also felt we should predicate the diagnostic tables with 'this data reflects past admission profiles' implying that these may change over time with the new MOSD.
3. She could not give clarity re: who would be responsible for managing young people with medical needs i.e. eating disorders but felt that if they were a MH client then QCH would most probably service them
4. She felt it needed strengthening around 'transition' to adult services and integrating rehabilitation. She felt the document was weak in these areas.
5. She felt we needed to articulate a range of evidence based treatments that would be part of the standardised suite of treatments that would then be customised to suit the individuals presentation. She thought this was important in relation to linking these with the groups of diagnoses we had identified in the client profile.
6. She also gave me information to add in my letter - which I am going back to now!!
Breathe.
I will send you through the letter once I have finished!
talk soon
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services
PH:
FAX
Email:

CHS.001.001.6433

1.3 Child and Youth Non-Acute Inpatient Mental Health Services

Level 5 Child and Youth Non-Acute Inpatient Mental Health Services

Service level description

A level 5 child and youth non-acute inpatient mental health service is capable of providing medium- to long-term inpatient mental health care to low, moderate and high risk/complexity inpatients up to the age of 18 years.

Predominantly, this level of service will be delivered by a comprehensive, multidisciplinary team of child and youth mental health professionals who are providing inpatient care to patients across an extended period of time. The primary service site will be co-located with a child/adolescent acute inpatient mental health unit. Alternatively, the primary service site may be delivered via a purpose-designed and built mental health facility. Service provision will include multidisciplinary assessment and targeted interventions by mental health professionals, patient and carer education and information, formal frequent case review, group programs, ongoing support of educational needs and links with educational providers, primary and secondary prevention programs, consultation-liaison with higher and lower level mental health services, and referral where appropriate.

Service characteristics

- This service will provide 24-hour, 7-day care for low, moderate and high risk/complexity voluntary and involuntary mental health inpatients aged up to 18 years.
- This will be an authorised mental health service under the *Mental Health Act 2000*.
- This service will deliver integrated mental health care and will ensure continuity of care for those accessing the service.
- Mental health services provided will include (but not be limited to) the identification, ongoing assessment, monitoring, interventions and rehabilitation of mental health problems ranging in risk and complexity (that may be associated with complex comorbidities and/or indicators of treatment resistance); an integrated approach to the identification, assessment and intervention of any co-occurring substance use disorders; targeted clinical programs for individuals/groups/families (e.g. group therapy for families/carers of patients with a psychotic illness); patient and family/carer engagement; medication management; forward referrals for assessment/diagnosis/intervention as required; development of a comprehensive individual mental health recovery plan within one week of assessment; extensive clinical data collection to inform assessment/diagnosis/intervention/recovery; an extensive range of primary (e.g. parenting support) and secondary (e.g. weight management) prevention services; and psychoeducation for the patient and family/carer (including information about available mental health services, mental health problems and illnesses, indicated treatment options and support services).
- This service will be based within a health service district or be part of a service network that also includes a Level 5 child/adolescent acute inpatient mental health unit.
- Mental health assessments, interventions and monitoring will be conducted by child and youth mental health clinicians of this service.
- Additional mental health interventions may be directly provided by child and youth mental health clinicians using telehealth facilities, visiting and/or community-based workforce.
- Mental health assessments and interventions will reflect multidisciplinary input.
- The target population for this service will include those within the service-identified age range who require: (1) graduated entry back into the community post-hospitalisation; or (2) extended and intensive clinical interventions but do not need or would not benefit from a mental health acute inpatient admission.
- Service provision will occur alongside ongoing consultation-liaison with the referring service/practitioner.

DRAFT

This is a draft working document and does not represent Queensland Health policy at this time. It is not intended for broader distribution.

- A range of additional programs and service components (for example, partial hospitalisation, consultation-liaison services, rehabilitation programs and telehealth) will be provided.
- Service provision may occur across a range of sites (for example, the hospital, school, home, recreational venues) and service capacity and resources must be sufficient enough to transport patients individually and/or as a group.
- As clinically indicated, ECT services may be facilitated and/or provided at this level of service by a mental health service authorised to provide ECT under the *Mental Health Act 2000*. This service will be provided under the care of a registered medical specialist with credentials in psychiatry and a certificate in child and adolescent psychiatry (or equivalent), and in accordance with the *Mental Health Act 2000*.

Workforce requirements

- A level 5 child and youth non-acute inpatient mental health service will be delivered by a comprehensive, multidisciplinary team of mental health professionals (psychiatrists, nurses, allied health) with training/experience in child and youth mental health.
- All clinical staff providing mental health care will have access (weekdays, during business hours) to an experienced registered nurse with mental health endorsement and/or post-graduate qualifications in mental health who can provide advice, support and direction for nursing care.
- Clinicians providing mental health services will participate in clinical practice supervision with mental health clinician/s who are trained/experienced in child and youth mental health.
- This service may demonstrate university affiliations, and will demonstrate evidence of some formal teaching/training roles and research[12] commitments (in local and/or multi-centre research) either via the health service or individual clinician/s.

Medical	• Patient admitted by/under a registered medical specialist with credentials in psychiatry. • 24-hour, 7-day access to a registered medical specialist with credentials in psychiatry and a certificate in child and adolescent psychiatry (or equivalent) for assessment, treatment, case management and case review. • Access to medical support.
Nursing	• The nurse in charge of the unit is a registered nurse who has training/experience in child/adolescent mental health, and demonstrated knowledge and skills in management processes. • The nurse in charge of each shift is a registered nurse with mental health endorsement and/or post-graduate qualifications in mental health who has training/experience in child/adolescent mental health, and demonstrated clinical competencies relevant to the service being provided. • The majority of nursing staff supporting the nurse in charge of the shift will be registered nurses who have mental health endorsement and/or post-graduate qualifications in mental health.
Allied Health	• Access to a comprehensive, multidisciplinary team of qualified (and where mandated, registered) allied health professionals who have training/experience in child/adolescent mental health. • Access to psychology, social work, occupational therapy, speech pathology and dietetic services.
Other	• Access to a range of visiting or local health/mental health specialties. • Access to dedicated pharmacy services[13] for mental health.

[12] 'Research' refers to a commitment to and evidence of the health service's involvement in research projects and service networks to promote best clinical practice. It does not imply that formal university research agreements or a separately funded on-site research institute is necessary to fulfil criteria for a particular level.

[13] A dedicated pharmacy service will be one that is either based on the hospital campus or is a nominated pharmacy in the community with which a service agreement has been established for the delivery of mental health pharmacy services according to ACHS requirements.

	• A comprehensive range of specialist paediatric health service providers will be accessible. • This service may have a program-based qualified and registered teacher dedicated to mental health patients. • Assistants-in-nursing (AIN) (or the equivalent) may complement the clinical team at the discretion of the nurse in charge. These staff members need to demonstrate AIN (or the equivalent) qualifications and/or be undertaking their second or third year of study in an approved Bachelor of Nursing degree.

Work unit requirements

- All policy and procedure documentation and practice will give consideration to the specific needs of children/adolescents.
- Audits of effectiveness of clinical and referral pathways will be conducted.
- Current policy and procedure documentation will inform the service's 24-hour, 7-day response to psychiatric emergencies and high risk situations.
- Patient, carer and staff satisfaction surveys will be conducted with respect to mental health services delivered.
- Formal mechanism/s will be established for the involvement of patients in the planning, operation, monitoring and evaluation of mental health services.
- High levels of clinical expertise will be demonstrated in the assessment/intervention/evaluation of patients presenting with a dual diagnosis of mental health and substance use disorders, with ongoing professional development accessed in this area.
- Current policy and procedure documentation will inform the processes of consultation-liaison with lower level services who are providing a mental health service.
- Service will demonstrate the capability to provide telehealth services and support to other mental health services for children/adolescents.

Guidelines, benchmarks, quality and safety standards

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health.
- Strategic Policy Framework for Children's and Young People 's Health 2002-2007: http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.
- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html.
- Guidelines for the administration of electroconvulsive therapy (ECT): http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars02-03-799_528.htm/$FILE/799_528a.pdf.

Required support services	Level	Notes
Anaesthetics	X	To be discussed further
Diagnostic Imaging	X	To be discussed further
Pathology	X	To be discussed further
Pharmacy – Medication Management	X	To be discussed further
Paediatrics	X	To be discussed further

From: Denisse Best
To: FionaT Cameron
CC: Krause, Judi
Date: 1/03/2010 9:05 am
Subject: Re: Fwd: BAC latest version Fiona FYI

** Proprietary **
Judi sent me the version for comment - here it is as I note Judi is away for a few days

>>> Denisse Best 1/03/2010 7:54 am >>>
Hi judi I have read not quite all
but 2 things stand out

in the pateints to be treated
there is no mention of those with psychosis - and i would think that they would get a priority if it is persistent and needing longer time to treat

and 2 "adventure based" therapy - this can only be provided with an adequately qualified and certified staffing - but I guess this will come out in the wash I guess I might be tempted to say "recreational and adventure based activites subject to the availability of properly certified staff"

From: Trevor Sadler
To: James Scott; Ju...
CC: FionaT Cameron
Date: 22/02/2010 9:16 am
Subject: Re: Document for meeting tomorrow

Dear Colleagues,

I had some software problems, and have only just been able to access my Queensland Health emails.

I just read the minutes of the first meeting. I agree with a number of the comments, including coming under the Mater.

However some of the comments and recommendations were incredibly naive, particularly around treatment issues, clinical issues, comparisons with other units etc. They are simply not supported in the research.

I have spent hours on what is supposed to be an overseas holiday going through my literature searches, getting on to CKN etc. to prepare a paper for what we do. I won't get it finished tonight, but I'll do my best to get it to you as soon as possible. I will try to connect with the next meeting, if my schedule the next day permits me to do so.

The draft MOSD is currently rubbish.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Collaborative on Self Harm
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

>>> Judi Krause 18/02/2010 5:53 pm >>>
Hi there
this is the MOSD draft which Fiona has started to amend with suggestions from the first meeting. This is not completed. We would suggest that you have a copy with you for the meeting tomorrow and we can discuss further.

Please do not make changes directly onto the model we will try to do this in the meeting tomorrow.
Talk to you then.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)

Item	Topic	PN 51426 New 15 Bed Adolescent ETU, Day Centre & School	Action By
	2. Upcoming Milestones 3. Delivery Methodology	Not discussed at this time (4.2 and 4.3)	
5.0	PDP/Design 1. Site Planning Issues 2. Progress Report 3. TCP/ID	Not discussed at this time (5.1 to 5.3)	
6.0	Financial 1. Budget/Cost Report	1. Kitchen facilities/food preparation logistics: SL reported no progress until MOS determined.	
	2. Expenditure 3. Variations 4. Art-Built In Budget/Cost 5. FF&E & IT Budget/Cost	Not discussed at this time (6.2 to 6.5)	
7.0	Decanting 1. Decanting Strategy	Not discussed at this time (7.1)	
8.0	Construction 1. Progress Report 2. General 3. Industrial Relations & Safety 4. Contractual 5. Quality 6. Forecast Practical Completion	Not discussed at this time (8.1 to 8.6)	
9.0	Risk Analysis & Value Management 1. Peer Review	1. Pending completion of MOS review.	TC to initiate Peer Review once MOS review completed.
	2. Project Services	Not discussed at this time (9.2)	
10.0	FF&E 1. Progress Report 2. Budget 3. Expenditure	Not discussed at this time (10.1 to 10.3)	
11.0	Operational /Commissioning 1. Staffing 2. Commissioning	Not discussed at this time (11.1 and 11.2)	
12.0	Communications (Media) 1. Communication Plan	1. FM reported draft Communication Plan still not available.	FM to follow up with Susan Scott
	2. Consultation	2. KE reported recent meetings with local Councillors and MPs re CCU; also able to discuss Adolescent Unit. Positive responses and offers of assistance. Hospital Site Expansion: SL advised public forum will be organised for August 2010.	

As you may be aware implementation of the *Queensland Plan for Mental Health 2007-2017* (the Plan) is underway and includes the delivery of mental health services for Children and Young People.

As part of the Plan, an 8 bed adolescent acute inpatient unit and 14 place day program is being developed in Toowoomba. It is envisaged this service will be commissioned by February 2011.

A 6 bed adolescent acute inpatient unit and 12 place day program is also being developed in Townsville and is expected to be commissioned by September 2011.

Considerable collaboration between Queensland Health and Education Queensland has been undertaken to support a common understanding of the model of service for these units with the provision of education services as a key element.

It is envisaged that every young person enrolled in the day program will participate in the school activities. Those young people engage in the day program will attend for up to six months or in some cases longer. On the other hand, participation of adolescents who are acute inpatients may be more valuable as most will have short admissions. Even so, it is anticipated that connection or re-connection will also be made with Education Queensland staff similar to arrangements at Logan and Robina hospital. These hospitals have acute adolescent mental health units without day programs.

Productive work has also been undertaken at the local program level in Toowoomba and Townsville to reflect the requirements of education service delivery in the designs of the units.

Preliminary advice from Education Queensland has indicated that the allocation of Education Queensland resources to these programs will rely on an existing funding model which provides for a ratio of 1 teacher for 5.94 Students and teacher's aide hours per teacher.

In the absence of historical enrolment data for the new services, Queensland Health has based an estimate of occupancy on the level of service utilisation for existing units to recommend the following.

	Townsville	Toowoomba
Day program places	12	14
Inpatient bed no.s (60-80%)	6 (3.6 – 4.8)	8 (4.8-6.4)
Total No.	15.6 – 16.8	18.8 – 20.4
Potential No. of teachers	2.6 – 2.8 (+ teacher aid hours)	3.1 – 3.4 (+ teacher aid hours)

It should be noted that some clinicians from Townsville suggested that the average occupancy of the service may exceed the historical levels of occupancy on which this data relies, predicting up to 100% occupancy.

The commissioning dates are still subject to some variation. Queensland Health will provide additional information concerning revised commissioning dates as these become available.

The services in Toowoomba and Townsville look forward to your advice as to the resources Education Queensland will be allocating to these services when they are commissioned.

From: Trevor Sadler
To: Brett McDermott; Erica Lee; James Scott; Judi Krause; Michael Daubne...
Date: 22/02/2010 10:57 am
Subject: BAC MOSD
Attachments: BAC MOSD.rtf

Dear Colleagues,

This is part 1 of the comments on our MOSD -developing reference points.

This includes descriptions of the patients, literature reviews on various topics and observations from other inpatient units.

I haven't provided references for the literature reviews. I am on holidays. I ask that you trust my integrity to provide honest accounts from my surveys of the literature. Over the past 10 years I have spent hundreds of hours searching the literature for answers to the problems we face. I have most of these searches on my lap top, so was able to access them easily. Some I needed to update via CKN and my UQ library rights.

What got me riled when I began to read the MOSD were references to evidenced based treatments. This paper explains why I think the concept is naive in the population we see, and why we need to develop an alternate approach. My next paper will outline our observations and approach more thoroughly.

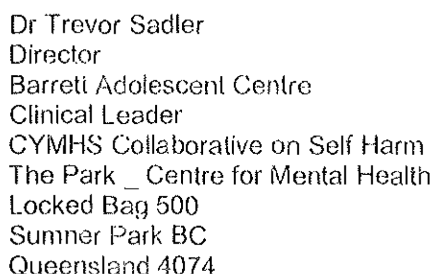
I must point out that our MOSD was the **first draft** of the first CYMHS MOSD in the new format, done just before Christmas. Leanne resigned without providing feedback. It is natural that there were deficiencies. There are no CYMHS MOSD reference points or any feedback to develop it further.

I will comment on other issues in the minutes as I get internet access. I don't think the place we are staying tomorrow night for 6 nights is reliable.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Collaborative on Self Harm
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074



Denisse Best - Re: Agenda: Formation of UGM & FPTM Feedback for today

From: Denisse Best
To: Aaron Groves; Brett Emmerson; Brett McDermott; David Crompton; Debbie Samuels; Elizabeth Powell; Emma Page; Janelle Bowra; Janet Bayley; Joanne King; John Quinn; Michael Daubney; Miranda Claughton; Neil Pratt; Paul Clare; Peter Trevethan; Sanjib Baruah; Sue Leggate; Tamara Madsen; Terry carter; Trevor Sadler
Date: 20/08/2009 10:22 AM
Subject: Re: Agenda: Formation of UGM & FPTM Feedback for today
CC: Brett Bricknell; Glenn Gibson; Kevin Fjeldsoe; Veronica Casey

Security: Proprietary

Dear Miranda
I am an apology for today for the FPTM I am in process of seeing if I can send a Proxy. This may not be possible. I note that my name is absent from the agenda - could you ensure that this error is corrected please.

As I will not be in attendance I would like to request that in future there be provision for telephone conferencing into the meeting. I am sure this would be helpful for other attendees as well where their meeting and other commitments are tight.

I would appreciate it if you could print off this email and pass it to the Chair for inclusion in the discussion.

TOR: I would recommend that some additional objectives be considered.

Ensure the facility is designed to ensure operational costs for maintenance and staffing are as efficient as possible, whilst having regard to the nature of the facility as medium to longer stay hospital Unit.

Ensure the project provides the most optimum clinical outcomes and has clearly defined linkages to the continuum of care for C&Y Statewide.

Make recommendations regarding the governance & integration within the local mental health service and identify any specific supports required from other CYMHS such as the Queensland Children's Hospital.

Secondly: there is another potentially related project to do with discussions with the Child Safety Department and Therapuetic Residentials - whilst this is separate to the task at hand - this group will need to receive regular updates on this aspect and in due course may need to become involved. Could I suggest that this be added to the list of standing items for routine report updates.

See you all next time.

Denisse Best
Executive Director
Child and Youth Mental Health Service
Children's Health Service District

POSTAL ADDRESS:
Mrs Denisse Best
Executive Director
CYMHS

MENTAL HEALTH CAPITAL WORKS PROGRAMME (MHCWP)
METRO SOUTH HEALTH SERVICE DISTRICT

TERMS OF REFERENCE
FOR
FACILITY PROJECT TEAM MEETING (FPTM)

1. PURPOSE OF MEETING

To provide oversight/direction/advice for the development of the New 15 Bed Adolescent ETU, Day Centre & School to be constructed in the Metro South Health Service District at Weippin Street, Redland.

2. OBJECTIVES

- Ensure the project provides the most optimum clinical outcomes.
- Ensure client transfers are managed in a timely and effective manner. There will be some transfer from The Park – Centre from Mental Health.
- Ensure appropriate Human Resources Management for those staff affected by the redevelopment.
- Ensure additional staff recruitments and training is completed prior to commissioning and opening the new facility.
- Ensure the inter-relationship with other Hospital service development plans is co-ordinated to reduce the impact on this project (re-locate existing QH personnel from .... to new location prior to construction commencing).
- Ensure project remain on time and on budget.
- Ensure appropriate consultation is undertaken and effective management of issues as they occur.

3. ORGANISATION

3.1 Membership

MENTAL HEALTH CAPITAL WORKS PROGRAMME (MHCWP)
METRO SOUTH HEALTH SERVICE DISTRICT

TERMS OF REFERENCE
FOR
USER GROUP MEETING (UGM)

1. PURPOSE OF MEETING

To provide oversight/direction/advice for the development of the New 15 Bed Adolescent ETU, Day Centre & School to be constructed in the Metro South Health Service District at Weippin Street, Redland.

2. OBJECTIVES

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- Ensure project remain on time and on budget.
- Ensure appropriate consultation is undertaken and effective management of issues as they occur.

3. ORGANISATION

3.1 Membership

5.2 Distribution

Minutes will be distributed to all members within seven working days of the meeting.

5.3 Location

The original minutes, agenda and other documentation in relation to the meeting will be held by the Minute Recorder.

6. AGENDA

6.1 Format

The Agenda will contain standing items and be prepared in a standard format, similar to those adopted on other projects on the $120M Mental Health Capital Works Program (MHCWP).

Summary of Issues to consider when reviewing the Model of Service Delivery for Barrett Adolescent Centre (BAC)

Previous reviews and reports have outlined concerns including:

Safety concerns – in relation to both clients and staff –

- increase in critical incidents
- increase in 'continuous observations'
- ACHS issued 'high priority' recommendation pertaining to improving patient and staff safety in recent accreditation survey.
- Aspects of building configuration deemed 'dangerous'

Director General of Health Brief noted –

- Profile of BAC is changing
- Increased complexity, increased impairment and co-morbidity
- Less referral out options
- ALOS increased from 4 months (1994) to 10 months 2006.

McDermott Review – issues identified

- Need for more defined admission criteria
- Need for improved risk assessment during admission
- Need for improved risk assessment tool
- Establish better linkages with broader Hospital (The Park)
- Need for staff training
- Issues around whether unit locked/ not locked

Community Visitors Report

- BAC over census
- BAC has clients over 18
- Safety issues for medium to long term residents
- Not all young people participate in programs – some 'optional'

QNU

- Letter of concern relating to staff injuries sustained trying to apprehend a young person absconding

Review of 3 Critical Incidents – key characteristics

- Female
- Over 18
- Severe and complex self harming
- Diagnosis did not reflect complexity, chronicity or severity of behaviors.
- Referral on to adult MHS or more appropriate services had not occurred

-> work plan

Issues considered by recent review (2009):

Governance

Lack of clarity or little evidence re:

- governance structures, lines of accountability to MHD/ Corporate QH
- Policies and procedures
- Staff performance reviews /performance management
- Clinical documentation – audit processes
- Complaints system
- Framework does not align with state legislation or QH policy directives
- Poorly defined scope of clinical practice for medical, nursing and allied health
- Professional development
- Clinical Supervision
- Research and evidence based practice
- Role of BAC in statewide CYMHS plan unclear
- Role of BAC in The Park hospital unclear
- Recording and review of critical incidents and 'near misses'
- Poor communication including handover impacts on continuity of care

Clinical Model

- Lack of evidence based treatments
- Current practices predominantly 'milieu therapy' and 'adventure therapy'
- Poor evaluation of current behavioral management programs and associated staff development and training despite previous recommendations to address this
- Need for individualized behavior management plans
- Alternatives to continuous observations

Nursing Model of Care

- Model unclear – best described as task allocation or functional

Patient Journey

- Long waiting times for admission
- More clarity re: Referral pathways, inclusion and exclusion criteria
- Need access to acute medical management at local hospital
- Need access for more intensive acute psychiatric care
- Intensive discharge planning at point of referral
- Integration of BAC with local community services
- Partial hospitalization – used for transition care back to community care
- Difficulties with discharge planning due to remoteness of referring services
- Out of home care / discharge placement for older adolescents

- Transition to adult MHS
- More assertive discharge planning

Treatment evaluation

- Negligible evaluation

Clinical Leadership

- Lack of clarity and structure

Staffing profiles (nursing)

- Varied skill mix
- Lack of external CYMHS experience
- Vague reporting lines – discipline meeting structures

Nursing staff training and education

- Limited opportunities for Child and Adolescent education
- Problematic Clinical Supervision structures

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From: Judi Krause
To:
CC: Denisse Best; FionaT Cameron
Date: 4/03/2010 1:05 pm
Subject: Covering letter for MOSD BAU

DRAFT

Hi everyone
apologies for the delay in getting this out I have had multiple interruptions this morning. If you have any feedback I need it asap as I have to send this to David/Shirley by 2pm. I am then leaving to attend the Facility Planning meeting at Redlands where I will no doubt have the opportunity to discuss further with David and Shirley. This letter is just in email form at present to make it easier to send around. I will format it appropriately on letterhead.
Regards
Judi

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

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

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

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

In relation to resources required from Redland Hospital it would be envisaged that they would support acute medical emergencies and other medical issues that can be managed locally. AETRC as an integrated component of the Mater/ QCH would have access to a range of specialists who could provide support.

In relation to the proposed building design of AETRC when it is relocated to Redlands it is recommended that this be revised in lieu of the changes to the MOSD. The cottage style of accommodation may not be conducive to the proposed six month treatment model.

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

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are consulted with in relation to any changes that are proposed. The group would further like to be involved in any building re-design.

As you were aware Dr. Trevor Sadler, Clinical Director of AETRC, was unable to participate in these group discussions. He has sent us a range of email information in relation to the current treatment programs at AETRC and his observations from visiting other adolescent units overseas. It should be noted that there was not group consensus on all issues. Trevor felt strongly that model proposed above did not encapsulate the complexity of the AETRC cohort and was simplistic in nature. For your information I have enclosed the information that Trevor forwarded to the group.

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

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

From: David Crompton
To: Judi Krause
CC: Aaron Groves; ED_MHSMetroSouth; Katie E...
Date: 8/03/2010 6:47 pm
Subject: Re: MOSD for Adolescent Extended Treatment and Rehabilitation Centre

Dear Judi
Many thanks for the report. Appreciate the work of those involved and I will write to each person to thank them for the time they gave to this body of work.
Sorry I was unable to attend last week but the District wanted me at another meeting for the day.
I will ask Miranda to set up a meeting to discuss the documents.
We are in the process of developing a PD for a Clinical Director of CYMHS for Metro South MHS that will have responsibility for ensuring the KPIs are delivered.
It is evident this position will need strong links with the broader CYMHS community to ensure monitoring of standards etc.
Regards
David

A/Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych]
FRANZCP FAChAM
Executive Director Mental Health Metro South Health Service District

>>> Judi Krause 5/03/2010 8:33 am >>>
Hi David
please find enclosed the modified draft MOSD for Adolescent Extended Treatment and Rehabilitation Centre. I have enclosed a covering letter to add context to the MOSD changes. I have also enclosed some information Trevor Sadler sent to the group whilst overseas.

I had taken hard copies of this information with me yesterday to the Facility Project Team Meeting at Redlands as I had anticipated that you and Shirley would be there and that we could discuss this further.

The facility project team were keen to hear about the changes to the MOSD in relation to the building design. I mentioned some of the proposed changes but stated that it would be hard to comment on design implications without knowing firstly what current design has been confirmed, now the site has been chosen (most of the CYMHS group were unsure of the status of the current design) and secondly if the MOSD changes would be endorsed and when/how this would occur. We were unclear what the process would be now the CYMHS group have forwarded the recommendations to you.

Katie Eckersley suggested that before decisions could be made about design changes further discussion would need to occur to address the abovementioned issues. This will be reflected in the minutes of the meeting and I am sure Katie will be in touch with you in relation to this.

I would envisage that the next step is for myself and Brett McDermott (as representatives of the broader group) to meet with you to discuss the draft MOSD and further discuss the design and operational implications.

Please do not hesitate to contact me (or any of our working group members) if you require further clarity in relation to any of the enclosed information.
Kind Regards

CHS.001.001.6452

From: "McDermott, Brett"
To: "Judi Krause"
CC: "Denisse Best" "FionaT Cameron" <Fiona...
Date: 4/03/2010 1:54 pm
Subject: RE: Covering letter for MOSD BAU

Hi Judi,
some brief points:
its AITRC (I = integrated)
small point I'm an Executive Director not a clinical Director
big point - I think we should head off some Trevor criticism by talking to it. I would add a second last line of last para (see XXXX) "The group note that Dr Sadler is critical of the 6 month treatment time frame suggesting there is no evidence for this period of care. The group note that there is equally no evidence for a 1-3 year admission and these lengthier periods of care are more costly, block beds and appear developmentally inconsistent with generalising change to the patient's local setting."

cheers,
Brett.

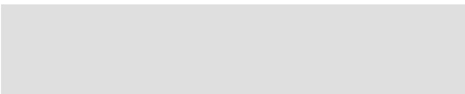
From: Judi Krause
Sent: Thursday, 4 March 2010 1:06 PM
To: McDermott, Brett
Cc: Denisse Best; FionaT Cameron
Subject: Covering letter for MOSD BAU

Hi everyone
apologies for the delay in getting this out I have had multiple interruptions this morning. If you have any feedback I need it asap as I have to send this to David/Shirley by 2pm. I am then leaving to attend the Facility Planning meeting at Redlands where I will no doubt have the opportunity to discuss further with David and Shirley. This letter is just in email form at present to make it easier to send around. I will format it appropriately on letterhead.
Regards
Judi

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

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

Children's Health Services



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From: Judi Krause
To: Shirley Wigan
CC: David Crompton
Date: 10/02/2010 7:53 am
Subject: Outline of meeting to discuss MOSD BAU
Attachments: Summary of Issues to consider when reviewing the.doc

Hi Shirley
As discussed at the Mental Health Capital Works Program meeting last week I have arranged for a meeting with key CYMHS stakeholders to review the Barrett Adolescent Unit Model of Service Delivery.

The expected outcome of this meeting would be to begin to clearly articulate the continuum of care including referral pathways, admission criteria, defined target group, diagnostic groupings, evidence based treatment modalities, staff skill mix, discharge planning and program evaluation/ outcomes. A further consideration would be the resource impact on Redlands Hospital to provide appropriate support to BAU.

I had planned to give a summary of the 2009 Review of BAU outlining only key points to consider in the revised model, rather than any discussion around direct recommendations from the report. I am mindful that this report has not been released to relevant staff at this stage. I have included my summary of this report for your perusal. I felt it was important for all group members to be cognizant of the issues that will guide the review of the MOSD. Please advise me if you feel the summary is too inclusive. I was not intending to give copies to the group.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

RIVENDELL CHILD & ADOLESCENT UNIT

RELATED PAGES ...

Child & Adolescent

Gnakalun Adolescent Unit

Rivendell Child & Adolescent Unit is located at Thomas Walker Hospital which was opened in 1896.

Rivendell is a 20 bed facility that consists of:

1. A child and adolescent mental health service; and
2. A Department of Education school

Location

Hospital Road, Concord West NSW 2138

Turn into Hospital Road from Concord Road and travel past Concord Hospital until you reach the roundabout. Enter the gate and proceed along driveway

Transport: Rail to Strathfield or Rhodes Station and 638 Bus to Concord Hospital

Services

- Inpatient and outpatient care
- Schooling

Provides mental health services for children and adolescents residing in Sydney South West Area Health Service and rural New South Wales. Out-of-area referrals may be accepted with the active involvement of local mental health services or private mental health professionals

Rivendell works in conjunction with the local Community Health Centres and the Community Mobile Adolescent Team

Our inpatient services include comprehensive assessments, second opinions, shared care and outpatient therapy. This care is determined on an individual basis and may incorporate cognitive behavioural therapy, psycotherapy, family therapy or pharmacotherapy

We provide inpatient care on either a residential or day patient basis for those individuals who need more intensive treatment. These young people attend the Rivendell School for Specific Purposes during their admission. The inpatient programs focus on early psychosis, depression, anxiety, school refusal and oppositional defiant behaviour

Rivendell provides community outreach programs during the school holiday periods for young people with special needs, e.g. Indo-Chinese and Latin-American refugees, refugees who have been subjected to severe torture, trauma and other young migrant groups

From: David Crompton
To: Judi Krause
Date: 17/02/2010 10:05 am
Subject: Re: MOSD BAC

Judi I think it is best that we use what fits the groups needs, that in the long term will make it easier for your group.

David
A/Professor David Crompton
Executive Director Mental Health Metro South

-----Original Message-----
From: Judi Krause
To: David Crompton

Sent: 17/02/2010 09:55:23
Subject: MOSD BAC

Hi David
we are about to have our second meeting for the review of the MOSD BAC. I just wanted to clarify how you want our recommendations to be delivered. We can document a list of recommendations and forward these to you. Alternatively we can actually make changes to the MOSD draft document using track changes. We felt the second method whilst time consuming may be more beneficial in the long term. Please advise me which method you would prefer.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

CHS.001.001.6457

From: "McDermott, Brett"
To: "Judi Krause" "James Scott" <James_G_Sc...
CC: "FionaT Cameron"
Date: 11/02/2010 11:55 am
Subject: BAC-AITRC Model of Service Delivery doc- thoughts

Hi Judi,
see below some thoughts from me about the AITRC MSD doc.

Feedback on the AITRC model of service guideline document:

Firstly I concur with some of our senior adult colleagues that the model of service document has some areas which appear ambiguous and hard to follow and there is a general flavour that the documented practices do not appear to be very contemporary.

My overarching philosophical concern is that there is very little evidence in the document that the future AITRC service will be integrated within a CYMHS continuum of care or indeed the state-wide CYMHS model of service. The document says in several places that they are seeking integration and collaboration, however, there is no structural process specified around this. The danger is that Barrett will be perceived as an isolated stand alone and unintegrated service. It will also be in danger of not benefiting from a continuous reform process and we may remain in the unfortunate situation of having serial 3 - 5 year reviews of perceived problems in the AITRC unit.

The solution is clear to me and that is the AITRC service should become part of a larger CYMHS service entity and in fact be line managed by that service. Given AITRC is a state-wide and quaternary service it is my opinion that the ultimate line management should be to the Queensland Children's health district and the Queensland Children's Hospital through Child and Youth Mental Health at the Queensland Children's Hospital. Rather than wait for three years for this to happen it is my advice that the interim solution is that the AITRC service become part of the Mater CYMHS continuum of service. Mater CYMHS already has state-wide services such as the Adolescent drug and alcohol withdrawal service (ADAWS) and so there would be no change in the AITRC state-wide service delivery it would just be managed and integrated with Mater CYMHS. This also makes geographic sense given that it currently resides in the Southern sector and there are strong professional links between some Mater and Barrett staff.

Clinical Governance

My other overarching philosophical issue is the document does not easily afford understanding of the patient's journey through their time at the AITRC service. Different interventions are well enunciated and tabulated, however, this does not give an idea of what actually happens to the client. Normally care in such a unit is phased. The first phase is one of developing rapport, a therapeutic alliance, developing shared treatment goals and a greater understanding of risk. At this stage risk management interventions occur. During phase two of treatment there are less concerns about safety and at this stage of treatment specific therapies such as DBT, IPT, trauma focused CBT can be undertaken within an overarching milieu and systemically informed practice. Phase 3 is a phase of relentless move towards community integration and/or transition back to the referring service or on to adult mental health services. I would like to see the model of service reformulated with this in mind.

Some specific issues from the document:

* Under key functions of AITRC I note it says that they will perform a comprehensive assessment of the adolescent. I think that

CHS.001.001.6458

Intake -

should be more orientated towards building upon the substantial understanding of the adolescent that already exists in referring CAMHS and other services.

* Under the second paragraph and series of dot points this is where I think we can start talking about phases of care.
* Under the two dot points of the bottom of the first page I think this should be rewritten to enshrine line management to CYMHS.
* I think another intervention that will help ongoing integration with CYMHS is that, not dissimilar to the Evolve process, entry to AITRC should be via a complex case meeting process which involves the referring specialists, AITRC team and key senior members of the AITRC service. There might be coopted members who are senior Child Psychiatry or Allied Health practitioners who sit on this panel. This will immediately increase integration and allow some degree of uniformity and consistency of accepted patients with a model of care.
* On page 2 first series of dot points dot point number 3 we need a more comprehensive definition of severe and complex mental illness
* Under dot point 5 I would remove the possibility of referrals by private child and adolescent psychiatrists or psychologists and headspace services. Again this is an expensive quaternary service and there must be the demonstration, though the complex case process, of a purposeful and prolonged period of multidisciplinary care prior to the individual being accepted in the AITRC service. In my view multidisciplinary care is not the combination of a private psychiatrist and psychologist rather it's the application of a dedicated team approach. It may be that the complex case process advises referral to a day program or some other service prior to referral to AITRC.
* At the start of the paragraph 'Various processes of Assessment' the word various should be deleted, it should be a unitary assessment process that involves a complex case discussion.
* Under the heading adolescents may continue beyond their 18th birthday we should include the words 'this is a case by case decision and requires the direct involvement of the Director. In all cases of treatment beyond the 18th birthday there must be an active plan for integration or transition to other services.
* In the bottom of page 2 the dot points about the characteristics of those who go to the unit I would remove the final dot point about psychosis I would include a dot point that says 'adolescents with severe challenging behaviour including persistent deliberate self harm and suicidal behaviour that is usually secondary to complex post traumatic stress disorder'.
* On page 3 under developing networks with CYMHS again I would reword this to enshrine line management to CYMHS.
* Under page 4 when we talk about assessment of mental illness,s assessments of family and carers and developmental services I would reword to emphasise that the onus is on the referring agency to prepare comprehensive information that will be presented at the complex case intake discussion group (this needs clearly a better name) i.e. the onus is on the referring team to actually provide very detailed family development forensic drug and alcohol and other histories.
* Under page 5 under assessment of risk given that these individuals are often at the extreme end of challenging behaviour this section should be more comprehensive, for instance rather than just risk assessments should be conducted on admission and then be routine we should spell out that the referring team needs to provide not only a risk assessment but documentation of all past history of deliberate self harm and the consequence of this behaviour such as therapeutic endeavours related to this, inpatient admissions and the like. I feel that also there should be some distinction between cumulative risk and acute risk where cumulative risk are individuals who have prejudicial histories of child sexual and physical abuse domestic violence or

chronic neglect and are already on a complex PTSD trajectory. This is important because those with significant cumulative risk are more likely to act on acute events.

* On page 7 the "voice" should be reviewed throughout the whole document so for instance it says dot point top of page 7 therapists "should" have recognised training and supervision in family therapy this clearly should read therapists will have recognised training, again the therapist will have continuing supervision later on the therapist will be integrated I think the would should allows an unacceptable amount of leeway.

* Under page 8 there is a series of detailed dot points about care coordination and later in the document it says that the nursing staff are most responsible for care coordination. I think this section needs to be reviewed with a view to the recent recommendations from the Barrett Adolescent Centre review. I think also that there should be thought around more contemporary methods of dealing with individuals presenting with psychosocial complexity we may need the guidance of inpatient NUM's and Directors for this. For instance around some complex cases a mini team is preferable to a case coordination model.

* Page 10 the notes on discharge planning should now be reviewed. Somewhere else in the document it needs to be made clear that we will be advising a maximum episode of care lasting for 6 months at the new AITRC service. This clearly changes the dynamic between the referring service and AITRC in the knowledge that they will be having the patient back sooner rather than later and that discharge and transition planning should occur earlier in the admission and be clearly very comprehensive this section needs to be reviewed with this in mind.

* Page 11 the third series of dot points the dot point team members are fully integrated does not make any sense and two lines down you should remove the words under normal circumstances and start that sentence with care coordination there are no circumstances where a student should coordinate a AITRC patient.

* On Page 12 the dot point at the top I firmly believe that the consultant psychiatrist of AITRC should not be rostered on call and accessible 24 hours 7 day per week. This is extremely worrying in terms of the ability of the consultant to continue this kind of on call roster, the possibility of ever recruiting a successor to undertake this type of roster and ongoing lack of input from other senior psychiatrists in Brisbane. When AITRC is integrated into another CYMHS service clearly the Psychiatrist on that after hours roster would then be those who were on call to AITRC.

* Further down the page staff training needs significant expansion.

* The last paragraph of page 12 is now redundant in that we are advising that AITRC be integrated with another CYMHS Service further a model of care cannot direct it's parent service in the way that this paragraph is written for instance it cannot tell a district adult mental health service that it must consult a child mental health service.
Again the solution to this is integrated into CYMHS.
I hope these comments have been of some help, Brett.

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From: David Crompton
To: Judi Krause
Date: 9/02/2010 7:58 am
Subject: Re: MOSD BAU

Dear Judi
I spoke with Shirley yesterday. Officially Pam Lane has not released the document yet so staff have not seen it. She has asked if you could summarise key points but not include recommendations.
I would suggest do a summary of issues and then let Shirley review. Just include me in the loop.
Shirley is otherwise happy with process.
Thanks
David

A/Professor David Crompton OAM
MBBS Grad Dip Soc Sci [Psych]
FRANZCP FAChAM
Executive Director Mental Health Metro South Health Service District

>>> Judi Krause 8/02/2010 3:11 pm >>>
Hi David
I have arranged a meeting for CYMHS stakeholders for Wednesday to discuss the MOSD for BAU as requested. I was wondering if it was appropriate to circulate the 2009 review of the centre at this meeting or would you prefer we (Brett and I who have been privy to the report) just integrate some of the suggestions into the discussion?

If it is appropriate to circulate this report (to a limited group who would be asked to maintain confidentiality and not circulate further) then please send me through an electronic version.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Service District

From: Judi Krause
To: David Hartman; Geoff Beames; James Scot...
CC: FionaT Cameron
Date: 8/02/2010 3:04 pm
Subject: Barrett Adolescent Unit - Model of Service Delivery (Meeting 10/2 10-11am)
Attachments: AITRC MOSD.doc

Dear Colleagues

As discussed at the Statewide Mental Health Network, Child and Youth Subgroup, on the 28th January 2010, there is a further review of the MOSD for BAU being undertaken. Participants were invited to contact Trevor Sadler directly to express interest in contributing to this. After discussion with Trevor your names have been put forward as key stakeholders. Since the network meeting, the timeline for this review has changed.

The re-development of Barrett Adolescent Unit (BAU) to the Redland Hospital Campus is well underway. The decision has been made that no further planning toward this move can be conducted until the Model of Service Delivery (MOSD) has been finalised as the MOSD is critical to the design of the new facility.

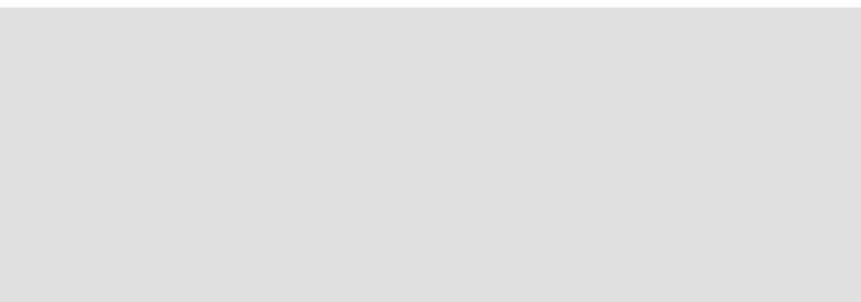
Metro South Management and Mental Health Directorate have requested further clarity in relation to the MOSD. In my role as chair of the CYMHS statewide sub network I have been asked to convene a meeting of key CYMHS stakeholders from the network to review the current draft of the MOSD. The expected outcome of this meeting would be to clearly articulate the referral pathways, admission criteria, defined target group, diagnostic groupings, evidence based treatment modalities, staff skill mix and to consider the resource impact on Redlands Hospital to provide appropriate support to BAU.

The timeframe for this process is very tight. We have been given until March 4th to complete this task. I would like to invite you (or your delegate) to a meeting on **Wednesday 10th February, 10am - 11am at Spring Hill CYMHS in the Seminar Room. Videoconferencing and teleconferencing details are available as below.**

I appreciate that this is short notice but feel we need to make a start to be able to complete this task by 4th March. It is important that a range of CYMHS stakeholders have a chance to contribute to this document.

This meeting will provide an opportunity to share ideas and formulate a consistent approach to articulating how extended treatment services are conducted with a CYMHS cohort. It would be envisaged that the revised draft document could then be circulated amongst the group via email for final modifications / endorsement.

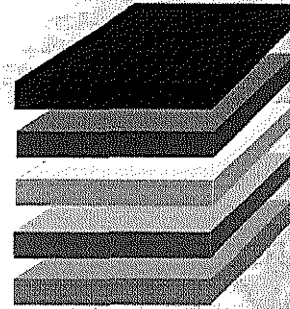
I have enclosed the current draft MOSD (which has been drafted in the new format) for your perusal. Look forward to discussing this further with you on Wednesday.
Kind Regards
Judi



Teleconferencing

towards recovery

Function
Behaviours
Diagnosis
Environment
Substrate



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

Developmental Tasks of Adolescence

Cope with physical changes
Develop cognitive maturity
Negotiate school
Negotiate peer relationships
Develop emotional maturity
Care for the self
Develop moral maturity
Occupy leisure time
Establish boundaries
Develop competencies to become independent
Develop identity
Individuate
Develop life schemas
Develop a sense of future

From: Judi Krause
To: David Crompton
CC: Aaron Groves; Shirley Wigan
Date: 5/03/2010 8:33 am
Subject: MOSD for Adolescent Extended Treatment and Rehabilitation Centre
Attachments: OBSERVATIONS OF ADOLESCENTS WITH SEVERE AND COMPLEX MENTA ILLNESS.doc; REFE
RRAL SOURCESTO THE AITRC.doc; Covering Letter to D.Crompton.doc; AETRC Draf
t MOSD 4.3.10.doc

Hi David
please find enclosed the modified draft MOSD for Adolescent Extended Treatment and Rehabilitation Centre. I have enclosed a covering letter to add context to the MOSD changes. I have also enclosed some information Trevor Sadler sent to the group whilst overseas.

I had taken hard copies of this information with me yesterday to the Facility Project Team Meeting at Redlands as I had anticipated that you and Shirley would be there and that we could discuss this further.

The facility project team were keen to hear about the changes to the MOSD in relation to the building design. I mentioned some of the proposed changes but stated that it would be hard to comment on design implications without knowing firstly what current design has been confirmed, now the site has been chosen (most of the CYMHS group were unsure of the status of the current design) and secondly if the MOSD changes would be endorsed and when/how this would occur. We were unclear what the process would be now the CYMHS group have forwarded the recommendations to you.

Katie Eckersley suggested that before decisions could be made about design changes further discussion would need to occur to address the abovementioned issues. This will be reflected in the minutes of the meeting and I am sure Katie will be in touch with you in relation to this.

I would envisage that the next step is for myself and Brett McDermott (as representatives of the broader group) to meet with you to discuss the draft MOSD and further discuss the design and operational implications.

Please do not hesitate to contact me (or any of our working group members) if you require further clarity in relation to any of the enclosed information.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

4th March 2010

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

Dear David

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

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

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

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

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

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

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

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

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

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

Kind Regards

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

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

Child and Youth Mental Health Service

Adolescent Extended Treatment and Rehabilitation Centre

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

Model of Service

1. What does the Service intend to achieve?

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

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

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

The key functions of the AETRC are to:

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

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

Programs will include:

- phased treatment programs that are developed in partnership with adolescents and where appropriate their parents or carers

- targeted 6 month treatment incorporating a range of therapeutic interventions delivered by appropriately trained staff
- 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment to less intensive care in a day program.
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services

Length of Admission:

- admissions will be for a maximum of 6 months
- in some specific cases an admission beyond 6 months may be considered, if clinically indicated
- where the length of stay is proposed to exceed 6 months the case must be presented to the intake panel for review following the initial 6 month admission

Level of Care:

The level of care is determined by:

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

2. Who is the Service for?

The AETRC is available for Queensland adolescents;

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

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

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

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

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

4. Adolescents with persistent psychosis who have not responded to community based interventions

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

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

- the AETRC director
- referring specialist and/or Team Leader
- representative from the QCH CYMHS (interim arrangements may exist)
- representative from Education Queensland
- other identified key stakeholders

In making a decision the panel will consider the:

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

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

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

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

Admission Risks
Some young people may pose considerable risk to others. Admission to AETRC will be decided on an individual case basis by a multidisciplinary review panel.
Admission risks include but are not restricted to:
- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder

3. What does the Service do?

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

The key components of AETRC are defined below:

Key Component	Key Elements	Comments
Working with other service providers	• the AETRC will develop and maintain strong partnerships with other components of the CYMHS network	• at an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network
	• shared-care with the referrer and the community CYMHS will be maintained	• in the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC
	• the AETRC panel will develop and maintain partnerships with other relevant health services who interact with adolescents with severe and complex mental illness	• this includes formal agreements with QCH and relevant adult health services to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; Surgical management of severe lacerations or burns from self injury
Working with other service providers		

Key Component	Key Elements	Comments
		• this may include developing conjoint programs for youth with developmental difficulties or somatisation disorders • this includes but is not limited to The Department of Communities (Child Safety), The Department of Communities (Disability Services) and The Department of Communities (Housing & Homelessness) and Education Queensland
	• mandatory child protection reporting of suspected abuse or harm	• AETRC staff will comply with Queensland health (QH) policy regarding mandatory reporting of suspected abuse or harm
Referral, Access and Triage	• Statewide referrals are accepted for planned admissions	• this supports continuity of care for the adolescent
	• responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC	
	• all referrals are made to the Clinical Liaison, Clinical Nurse and processed through the panel	• a single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness • it expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted
	• the adolescent is assessed after referral either in person or via videoconference	• the pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission • this assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity
Referral, Access and Triage		• this process monitors changes in acuity and the need for admission to help determine priorities for admissions

Key Component	Key Elements	Comments
	• if there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted	• the Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness
	• priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral	

Key Component	Key Elements	Comments
Assessments **Mental Health Assessments**	• the AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness	assessment begins with the referral and continues throughout the admission
	• the AETRC panel will obtain a detailed history of the interventions to date for the mental illness	• this is obtained by the time of admission
Family/Carers Assessments	• the AETRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care	• this process begins with the referral and continues throughout the admission
	• parents/carers will have their needs assessed as indicated or requested	• parents or carers will be involved in the mental health care of the adolescent as much as possible • significant effort should be made to support the involvement of parents/carers
	• if parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service	
Developmental Assessments	• the AETRC will obtain a comprehensive understanding of developmental disorders and their	• this process begins with available information on referral and during the

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

Key Component	Key Elements	Comments
		drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service

- **Information from the Mental Health, Family/Carer, Developmental and Functional assessments is integrated into a comprehensive formulation of the illness and impairments. Further information from continuing assessments is incorporated into developing and refining the original formulation at the Care Review Meetings**

Key Component	Key Elements	Comments
Recovery Planning	• an initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission	• during admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery • continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies
Clinical Interventions		
<u>Psychotherapeutic</u>	• individual verbal therapeutic interventions utilising predominantly a specific therapeutic framework (e.g. Cognitive Therapy)	• therapists will receive recognised, specific training in the mode of therapy identified • the therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness • the therapist will have access to regular supervision • specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships)
<u>Psychotherapeutic</u>	• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand	• supportive therapies will be integrated into the overall therapeutic approaches to the

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

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

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

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

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

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

4. Service and operational procedures

The AETRC will function best when:

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

Caseload

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

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

Staffing

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

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

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

Hours of Operation

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

Referrals

Referrals are made as in Section 3 above.

Risk Assessment

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

Staff Training

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

Staff from the AETRC will engage in CYMHS training. On occasion AETRC will deliver training to other components of the CYMHS where appropriate.
Training will include:
- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development;
- team work;
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- understanding and use of the *MHA 2000*
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

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

5. Clinical and corporate governance

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

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

The centre will be directly responsible to the corporate governance of the Queensland Children's Health Service District. Operationalisation of this corporate governance will occur through the AETRC director reporting directly to the Executive Director, Child and Adolescent Mental Health Service, Queensland Children's Hospital. Interim line management arrangements may be required.

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

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

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

7. How do Services relate to each other?

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

8. How do consumers and carers improve our Service?

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

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

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

9. What ensures a safe, high quality Service?

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

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

- Child and Youth Health Practice Manual for Child Health Nurses and Indigenous Child Health Workers: http://health.qld.gov.au/health_professionals/childrens_health/child_youth_health
- Strategic Policy Framework for Children's and Young People's Health 2002-2007:

http://health.qld.gov.au/health_professionals/childrens_health/framework.asp.

- Australian and New Zealand College of Anaesthetists (interim review 2008) Recommendation of Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations T1: http://anzca.edu.au/resources/professional-documents/technical/t1.html
- Guidelines for the administration of electroconvulsive therapy (ECT): http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf.
- Royal Australian and New Zealand College of Psychiatrists, Clinical memorandum #12 Electro-Convulsive Therapy, Guidelines on the Administration of Electro-Convulsive Therapy, April 1999: http://health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars02-03-799_528.htm/$FILE/799_528a.pdf.

Legislative Framework:

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

10. Key resources and further reading

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

- Guiding Principles for Admission to Queensland Child and Youth Mental Health Acute Hospital Inpatient Units: 2006
- The Queensland Health Child and Youth Mental Health Plan 2006-2011
- National Child and Youth Mental Health Benchmarking Project
- Consumer, Carer and Family Participation Framework

From: Judi Krause
To: Erica Lee
CC:
Date: 25/06/2010 6:34 pm
Subject: Monday's catch up

Hi Erica
unfortunately I am unable to attend our catch up meeting next week on Monday afternoon. I need to attend an urgent meeting re: a client in CFTU and that is the only time that suited everyone. I am mindful that we need to catch up re: the allied health showcase on 9th July, among other things. My diary is pretty ugly I have only three weeks left before I go on leave.

I have some time on **Monday 5th July from 2 - 4** if you would like to catch up then. We could firm up the presentation for the 9th. In the interim period I can jot down some ideas on the template and send it to you for your input.

Another issue is the Barrett Adolescent Unit Model of Service Delivery. David Crompton (via the Barrett Facility Project Team Meeting yesterday, which I telephone linked into) has indicated that this model needs to be progressed asap. The 'day program' component which David has indicated there is no funding for and needs to be 'dropped' from the facility planning. David has also indicated that there is no additional funds for the 'step down' or parent accommodation that Trevor has referred to previously.
The MOSD needs to be reviewed in lieu of how clients are going to be managed if there is no day component and if there is no capacity for 'step down'.

David is going to contact us all by letter requesting urgent attention to this. Trevor is now on leave in NZ for two weeks. He has suggested that we meet on Thursday July 15th at 10am here at Spring Hill. If this time and date suits you and Brett I will organise for Jaimee to arrange a room and teleconferencing facilities so Michael Daubney and others can be involved. I will also forward an email that Trevor has sent with some of his thoughts around what the Model needs to outline.
The other person we need to meet with is Kevin who I will try to pin down again for some time in the week before I go. He has been very difficult to catch up with. I will keep you posted, talk soon
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

From: Trevor Sadler
To: Judi Krause
Date: 25/06/2010 11:47 am
Subject: BAC MOSD

Hello Judi,

I tried to ring earlier, but you were in a meeting. I'm about to go off on leave to NZ. I'll try to have a holiday this time, but I'm sure there will be some matters I need to attend to.

Would Thursday 15/7/2010 be OK for a meeting? I can make sure any documentation is sent off.

You made a very good point yesterday about the need to be flexible about admitting an adolescent.

All of this is consistent, I think, with best practice. The notion of just supplying beds is archaic.

I have never sought to be an empire builder. Indeed, I advocated strongly for day programs and acute inpatient units in local areas to the Mental health branch in the 1990's. We are in an anomalous situation with our school where it is relatively well resourced. Ed Qld knows that it is, but is happy for that to continue. If they reduced our resources, it will not be to redistribute it to other CYMHS day programs - they will be lost to our system. I am just trying to make our clinical and educational resources available to as many adolescents as possible. If they are there, they should be used to capacity.

My concerns are these:
The MOSD for day programs is much more similar to the AITRC than to acute inpatient units.
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Kind regards,

Trevor

Dr Trevor Sadler

Director
Barrett Adolescent Centre
Clinical Leader
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Locked Bag 500
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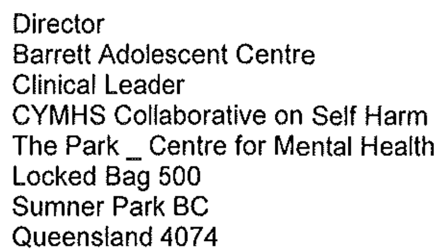
Queensland 4074



From: Judi Krause
To: Erica Lee; Ian Williams; James Scott; ...
CC: Janet Martin; Trevor Sadler
Date: 8/07/2010 10:52 am
Subject: Model of Service Delivery Barrett Adolescent Unit

Dear colleagues
We have been requested by Dr. David Crompton, Director, Metro South Mental Health to continue to progress work to refine the Model of Service Delivery for Barrett Adolescent Unit. Most of you were involved in the initial stages of this project earlier this year.

Trevor is currently overseas on leave but will be back next week. He is confident that we can address the outstanding issues in the MOSD in a timely manner. At the recent Redlands Facility Project Team meeting we were advised that the current funding for BAU is for a 15 bed unit, there is no additional funding for the proposed parents retreat and a day therapy program. It was reiterated that the governance model would be under Metro South Health Service District not QCH as our original document proposed. The Planning team are asking that we address specific areas in relation to the MOSD that may have implications on the site design/ development.

A meeting is scheduled for **Thursday July 15th, 10am at Spring Hill CYMHS in Room 30**.

Teleconference facilities will be available details below.

I look forward to seeing you there, if you are unable to attend on the day, the post meeting revised MOSD will be disseminated via email and we would really appreciate your timely feedback. Thank you all for your ongoing enthusiasm and commitment to ensuring our extended treatment facility for CYMHS is conducive to meeting the needs of the young people within our communities.

Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

From: Judi Krause
To: Trevor Sadler
Date: 29/04/2010 8:09 am
Subject: Re: "Cottages" in the new AITRC

Hi Trevor
thanks for your email I will give you some background to that comment. The working group of the CYMHS sub group that reviewed the MOSD did not have an opportunity to review the plans of BAU. At the Redlands Facility Project team meeting following the review (which neither Shirley or David attended) the project planning team were keen to hear how changes to the MOSD had impacted upon design. I advised them that we had not been able to consider this and that we would be happy to do so, but needed to know what the MOSD would look like to do this. As David Crompton and Metro South have the final say re: MOSD (and we stated that it was not a completed document and needed further work) it was decided to have a further meeting between the original group that met in January (David, Brett, Erica, myself, you and John Quinn and ?Aaron Groves). David was arranging this. The first meeting date proposed was cancelled and has yet to be re-scheduled.

In the interim period John Quinn has given me a copy of the plans and Brett, Erica and I have briefly looked at them. There were questions raised around the HDU area (? need for this) and the configuration of the beds (? safety concerns re: capacity for staff to supervise, especially on night duty). We felt it was hard to have the discussion without you or BAU reps there as we did not have the history (some of which you had provided today) of the design. I had indicated to the facility project team that there were unlikely to be any changes to the school plans or the gym.

So we are waiting for David Crompton to advise us of when we will all meet to discuss this further. There has been no further progress from the last facility project team meeting. I am not sure where this places us for todays meeting. All further progress seems to be reliant upon the MOSD and I am surprised that David hasn't prioritised this meeting as we were initially given such a tight timeframe to review the MOSD as you would be aware. It is somewhat frustrating for us all.

I am not able to attend the meeting today in person but hope to phone in. If you want to discuss further don't hesitate to contact me my work mobile is
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

>>> Trevor Sadler 28/04/2010 11:54 pm >>>
Hello Judi,

In your covering letter to David et al regarding the revised MOSD (which still needs discussion) for the AITRC, you mentioned it may have implications for the "cottage" configuration.

I am not sure exactly what you had in mind here, but I thought I'd explain our thinking.

The word "cottage" is a bit of a misnomer, I believe, and one used by the architects. Basically they are collections of bedrooms with either shared or single en suites. Originally the architects envisaged a small area where they could sit - I think that is worth thinking about, but space may be an issue.

Basically bedrooms can be configured in any way - in a big arc all facing the nursing station, or in a long corridor, or two corridors as we now have, or the configuration we are proposing. Length of stay

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for the proposed configuration is largely irrelevant for any length of stay beyond a month.

I visited a dozen units overseas. Skye House in Glasgow, built within the last 12 months, and with an average length of stay less than 6 months had a similar configuration.

The advantages that we see it is that
the entry to each four room cluster is visible from the nursing station. This is more difficult in a long corridor configuration (8 overseas units had this, and reported this difficulty)
each cluster will be single sex. Modules of four allow for some flexibility when there is an imbalance of sexes. Currently we have an 8 bed and a 10 bed wing. There were times we had 10 girls, could have taken more, and only 2 boys. A four bed module could have allowed for a 12 and 2 split. Separating sexes is imperative - it is easier to identify no-go boundaries beyond which the opposite sex cannot go as opposed to a single corridor.
Even for a length of stay of 3-4 months, adolescents identify it is important to have some sense of personal space to which they can retreat. This configuration offers a sense of what is their area, albeit shared with 3 others, but not the whole group.
Kind regards,

Trevor

Dr Trevor Sadler
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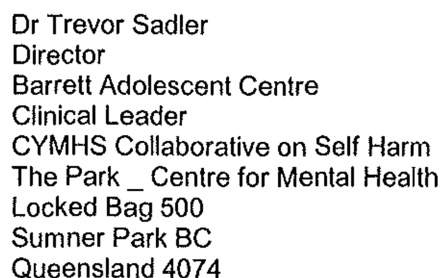

From: Judi Krause
To: Trevor Sadler
Date: 25/06/2010 6:30 pm
Subject: Re: BAC MOSD

Hi Trevor
thanks for this sorry I only just got to your email I have been in meetings all day. I have time on the Thursday 15th at 10am. Hope this suits you I will let Brett and Erica know. At this meeting you can determine who else needs to be consulted and this will probably have to occur via email. I can get Jaimee to set up facilities for teleconferencing so Michael Daubney can link in and potentially Janelle Bowra. I will see if James Scott can attend as well.
Have a great holiday and hope you get a chance to relax
Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

>>> Trevor Sadler 25/06/2010 11:47 am >>>
Hello Judi,

I tried to ring earlier, but you were in a meeting. I'm about to go off on leave to NZ. I'll try to have a holiday this time, but I'm sure there will be some matters I need to attend to.

Would Thursday 15/7/2010 be OK for a meeting? I can make sure any documentation is sent off.

You made a very good point yesterday about the need to be flexible about admitting an adolescent.

All of this is consistent, I think, with best practice. The notion of just supplying beds is archaic.

I have never sought to be an empire builder. Indeed, I advocated strongly for day programs and acute inpatient units in local areas to the Mental health branch in the 1990's. We are in an anomalous situation with our school where it is relatively well resourced. Ed Qld knows that it is, but is happy for that to continue. If they reduced our resources, it will not be to redistribute it to other CYMHS day programs - they will be lost to our system. I am just trying to make our clinical and educational resources available to as many adolescents as possible. If they are there, they should be used to capacity.

My concerns are these:
The MOSD for day programs is much more similar to the AITRC than to acute inpatient units.

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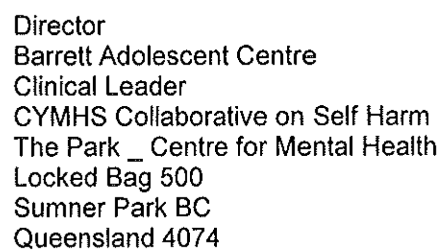

From: James Scott
To: Erica Lee; Judi Krause; Trevor Sadler
Date: 30/05/2010 2:53 pm
Subject: Re: Trivia

Thanks Trevor
one day you should write a paper for Australasian Psychiatry on the BAC. Tio be completely prgmatic, it will be tyhe western suburbs loss and redlands gain. I suspect we will get more questions about funding etc before we are through

cheers
James

Dr James Scott
Child & Adolescent Psychiatrist
E-CYMHS & EVOLVE Therapeutic Services Brisbane North
289 Wardell Street
Enoggera Qld 4051

>>> Trevor Sadler 28/05/2010 5:42 pm >>>
Dear all,

I was perusing some old documents about the establishment of BAC today. The first patients attended as day patients in May 1983. They were all from the western suburbs. We limited numbers to six, because that was the maximum for the one teacher we had. We took our first inpatients in October 1984.

In another words, this month marks 27 years of day program at BAC.

As James commented, moving from here will mean a loss of day program to the western suburbs. It is an integral component of what we do. We have dedicated some staff positions to it, but have also lost positions over the years because Queensland Health in the 1990's refused to recognise day programs, and West Moreton refused to acknowledge that we ran one in terms of our staffing profiles until 2006, although they always knew it was part of our service. They simply didn't want to return the funding they had taken from us. I raised the issue of the day program continuing in some form after we leave. Because it was not factored into MHD planning (they did acknowledge that if we stayed we would provide a day program to the western suburbs, but did not think through what the loss of this would mean to this area if we moved), there is no funding or infrastrucutre to support a local day program. I have toyed with the idea of floating the idea with local parents to take it up with their local member, but I can't see it making any difference.

Regards,

Trevor

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Queensland 4074

From: Judi Krause
To: David Crompton
CC: Erica Lee; Michael Daubney; Trevor Sadl...
Date: 23/05/2010 3:03 pm
Subject: Meeting re: Barrett MOSD impact on building design tomorrow

Hi David
unfortunately I am unable to attend this meeting scheduled for 2pm Monday 24th May. As discussed as an action item from our previous meeting I have forwarded on the plans that Trevor had provided me with electronically, to the broader group. We have been unable to meet within the short timeframe to discuss further and we have identified that the electronic version of the plans require 'walking through' by Trevor.

I have proposed a meeting for this Thursday prior to the CYMHS sub network group to discuss these plans further. Trevor can then provide some further information at the Redlands facility planning meeting later that day. Trevor is also planning on giving the facility planning group a presentation on the Thursday on some of his findings from his recent overseas trip in relation to building design features. I will also be an apology for the Redlands facility planning meeting on Thursday as it clashes with some district planning activities.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

From: Judi Krause
To: Erica Lee; James Scott; Janelle Bowra; ...
CC: Jaimee Keating
Date: 23/05/2010 2:53 pm
Subject: Barrett Adolescent Unit (BAU)- MOSD impact on building design
Attachments: Plans.pdf; Plans 2.pdf

Hi everyone
As discussed in recent Statewide Mental Health Network, CYMHS sub network meetings the MOSD for Barrett Adolescent Unit has undergone some changes. Many of you were actively involved in this process. As you would also be aware BAU is being relocated to Redlands in the future. The facility project team is requesting a review of the current site plans for the redeveloped BAU to ensure these remain conducive to the MOSD changes. There is mounting pressure to provide this information asap as building plans have been put on hold awaiting direction in relation to this matter.

I have enclosed copies of the plans as they currently stand. Trevor has kindly provided these and many of you will be familiar with them. He has added some comments as outlined below:

I am not keen on the amount of space between bedrooms and nursing office. However, I do like the basic configuration of bedrooms - just with the NO closer.

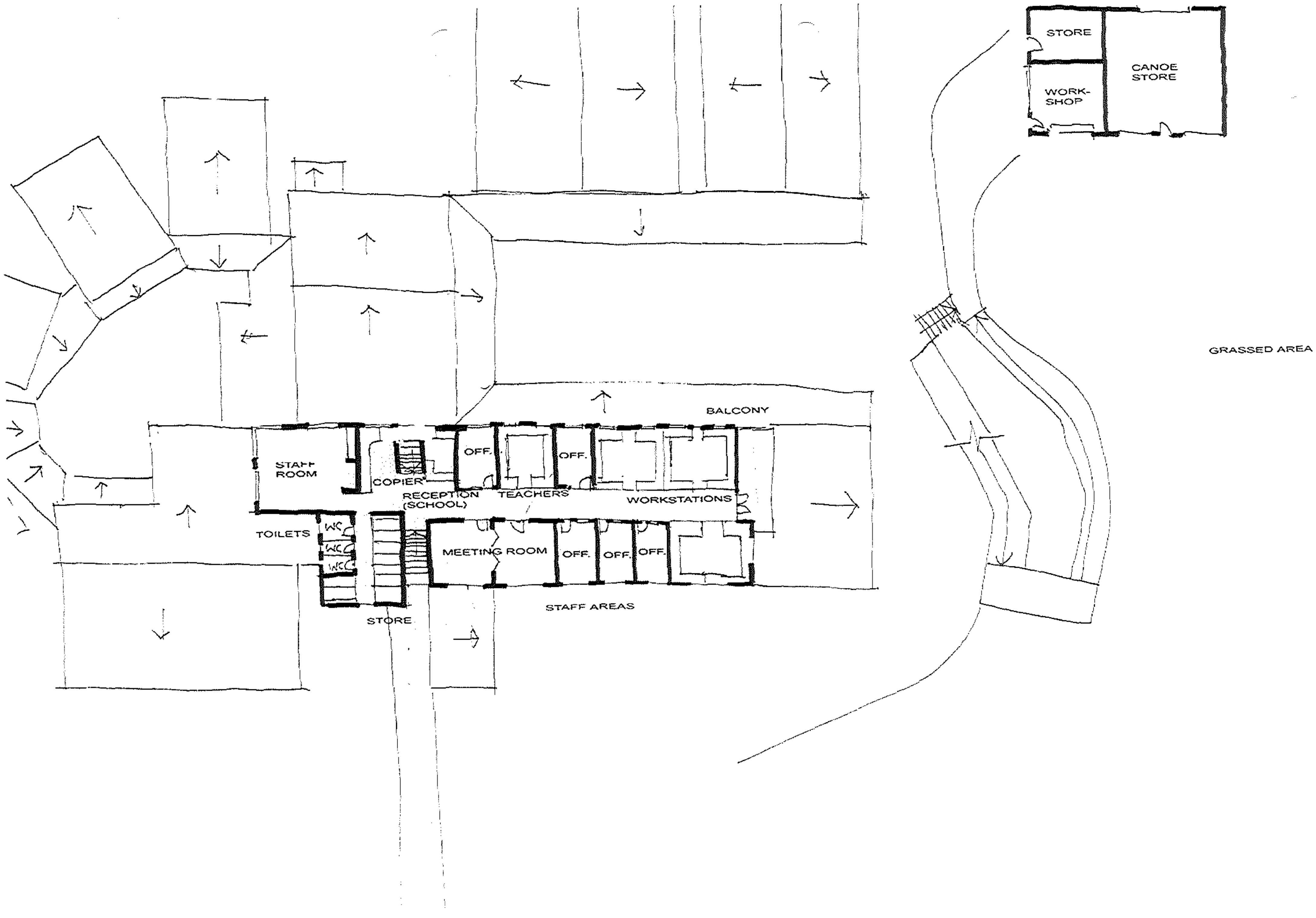
As Trevor has recently been overseas and reviewed adolescent extended treatment facilities he will be able to give further feedback about international examples. Both Trevor and I felt that we needed to have an opportunity for the group to come together and discuss these plans. As we are all very pressed for time I would like to suggest meeting the hour before the CYMHS sub network meeting at **0900 this Thursday 27th May**. Tele conference facilities will be available and details will be sent out to those who are unable to come in person. I would suggest meeting in the CYMHS conference room (the venue for the sub network meeting). If you are aware of other key people who may be able to inform this process then please encourage them to attend.

Please advise Jaimee Keating if you are able to attend. She will send out a formal appointment Monday morning. Jaimee will also advise of the teleconference number to call for those of you not attending in person.

Look forward to talking with you further on Thursday do not hesitate to contact me if you require further clarification.
Kind Regards
Judi

Judi Krause
Acting Executive Director
Child and Youth Mental Health Service (CYMHS)
Children's Health Services

COTTAGE 1
CTTAGE 2
TOILETS
CLASSROOMS
MEDIA RESOURCE
LIBRARY
OPEN ACCESS AREA
COURT
BREAKOUT COURT
NURSES STATION
MULTI-PURPOSE ASSESS ROOM
CLINIC
KITCHEN
CONSULT. ASSESS.
TOILETS
SAND PLAY
SENSORY
ART
GROUP THERAPY AREA
PC
RECEPTION
WAIT
DAY AREA
ENTRY
SUPERVISED ACTIVITIES AREA
HIGH ACUITY AREA
BREAKOUT/ COURT
CAR PARKING


STORE
CANOE STORE
WORK-SHOP
GRASSED AREA
BALCONY
STAFF ROOM
COPIER
OFF.
OFF.
RECEPTION (SCHOOL)
TEACHERS
WORKSTATIONS
TOILETS
WC
WC
WC
MEETING ROOM
OFF.
OFF.
OFF.
STORE
STAFF AREAS