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

COMMENTS:

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

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

Patient Journey

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

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

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

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

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

FACTS: It is unclear from where this information came.

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

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

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

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

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

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

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

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

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

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

An obvious indicator of this constellation of problems is the increasing age of the clients. At the time of the review, one third of the inpatients (3 out of 9) were over the age of , meaning length of stay for them was approaching 2, 3 and 4 years respectively.

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

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

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

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

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

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

***Recommendations*:**

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

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

Treatment evaluation

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

FACTS:

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

Recommendations:

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

Clinical leadership

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

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

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

Director in clinical matters. All Allied Health staff are accountable to their Discipline Seniors in operational matters. This was clearly outlined to the Reviewers on 26/2/3009.

A monthly Business Unit Meeting occurs on the 3rd Tuesday in the months February – November. It is a regular forum which includes the Director, Nurse Unit Manager, Senior Allied Health Professional, and School Principal from BAC, as well as the Assistant Director of Nursing from The Park and Finance Officer.. Other staff may attend. The meetings are minuted by the Centre's Administration Officer. The Centre reports to the Executive Management of The Park through both the Assistant Director of Nursing for BAC and the Nurse Unit Manager, who both attend Executive Meetings.

It was also emphasised at the time that while there is a clear management structure, that there is a strongly collaborative style of management which seeks to utilise the strengths of multiple staff members in developing processes in the unit, and which keeps them informed of decision making processes. This is in line with a Knowledge Management Framework.

In relation to nursing, while nursing staff reported that they weer all were very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted, and the reporting lines were vague.

FACTS: The first part of this comment is again a broad generalisation with nothing in the way of criteria offered against which this is measured. At the time of the review, there were (and continue to be) multiple examples of opportunities to enhance the clinical leadership potential of Clinical Nurses. In the absence of criteria, it is impossible to know if this is what the Reviewers had in mind.

However, it is difficult to know on what basis the Reviewers could make this conclusion. At the time of the Review, there was only one permanent Clinical Nurse who was not on when the Reviewers came. One position was backfilled due to the absence of one Clinical Nurse on long Special Lease. Another position was unfilled

because it had belonged to the recently appointed Nurse Unit Manager, and was being advertised. A number of Registered Nurses had backfilled these two positions to develop experience in being Clinical Nurses.

Regular fortnightly nurses meetings are held on Tuesdays. The reporting lines were outlined in the previous "FACTS".

Similarly, it was unclear whether the Nurse Unit Manager and the Director attended regular meetings in their roles as providing the leadership group at BAC.

FACTS: Minutes of the Business Unit meetings for 2007 – 2008 (the two years prior to the Review) showed 100% attendance by the Nurse Unit Manger or the Acting NUM, and 95% attendance by the Director (on leave).

Recommendations:

1. *The Director should implement professional development seminars for all the staff and these should reflect the practice of other service providers. Examples of new and innovative therapies, presented by people external to BAC, should be included.*

   COMMENT: There is no doubt that there should be more enhancements to professional development. The Recovery Intensive which was run at the time of the Review was an example of a professional development seminar for new staff at the Centre. We currently do not have the budgetary capacity to invite in external speakers. However, as part of the CYMHS network, we receive regular information about upcoming Seminars and Workshops which are either run by CYMHS or external providers. This information is regularly disseminated to all staff. For those which are pertinent to the core business of the Centre, we have been able to make block bookings for multiple staff to attend.

2. *BAC should provide a regular (eg quarterly) report to Park Hospital and State mental health about its programs and use of both tested and innovative approaches.*

Staffing profiles (nursing)

BAC consists of a large multidisciplinary team; as with most inpatient services, the nursing establishment make up the bulk of this team. BAC currently maintains a nursing establishment of 23.9 FTE. Six nurses are rostered on each shift on weekdays. The nurses work continuously in 8 hour shifts. The nursing team is led by the Nurse Unit Manager and 4 Clinical Nurses, one of which holds an Intake/Community Liaison position.

As in all nursing teams, there are varying levels of clinical skill and experience amongst the individuals. At BAC, there are a number of staff who have been working there for many years and some staff who are relatively new to Child and Youth Mental Health (CYMH). Consultations with nursing staff present on the day of the visit suggested that there were no nurses who had experience with another CYMH service outside BAC. This indicates the team may be disadvantaged by a lack of current exposure to contemporary nursing practice within the CYMH speciality.

COMMENTS: This statement is true inasmuch as it states that the current nurses at Barrett have not worked in other CYMHS facilities. We have strongly advocated in the past the need to do 6 month rotations for staff willing to participate with other CYMHS inpatient facilities. We have had no support for this proposal.

However, it is not true in its implication that there is a benchmark of "contemporary nursing practice within the CYMH specialty". Apart from generic professional development activities open to all CYMHS staff, there are no processes to enhance CYMHS specific nursing development. A number of CYMHS inpatient units have a strong component of staff without a mental health background.

This is a systemic issue which we have attempted to address in the past e.g. through discussions with University of Queensland staff responsible for developing post graduate mental health courses, representation to the Queensland Centre for Mental Health Learning in its early days. We gained no support for the development of such courses, and have not recently pursued them.

While all nursing staff reported being very supportive of the relatively newly appointed Nurse Unit Manager, it was apparent that the Clinical Nurses were underutilised in their potential capacity as clinical leaders. It was not clear if regular nursing staff meetings were conducted and the reporting lines were vague.
This paragraph in its entirety is a repeat of a previous paragraph. Objections to statements are noted under the previous paragraph.

Recommendations:

1. *More robust interactions between nursing staff of BAC and other CYMH services should be facilitated; one way to address this may be found in secondment activity negotiated between services.*

Nursing Staff Training and Education

Individual consultations with nursing staff during the visit identified a general desire for more educational/training opportunities, specifically in adolescent mental health. There appeared to some issue with the budget limiting nursing staff access to their professional development funds to pay for development activities.

The previous BAC review conducted by McDermott et al in 2003 recommended more training and education for staff on adolescent issues. It is clear from discussions with nursing staff that this education is still somewhat haphazard and limited.

Clinical supervision structures are problematic. The whole team attends group supervision with a specialist clinical supervisor, who is also a member of the team. Additionally, nursing staff identified a need for more clinical supervision.
FACTS: The Specialist Clinical Supervisor facilitates review sessions after critical incidents and days for team reflection. These are the only group activities. All other supervision is offered on an individual basis.

Over the years, Barrett has lost a senior nursing position (originally had the equivalent of a Nurse Unit Manger and a Clinical Nurse Consultant). After the loss of this

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

Recommendations:

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

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

APPENDIX 1 – DEVELOPING OBJECTIVE CRITERIA FOR REVIEWS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 2 – EVALUATION AND INTERVENTIONS

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

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

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

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

SECTION 1: ASSESSMENTS

1. Psychology Assessments

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

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

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

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

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

2. Occupational Therapy Assessments

Adolescent

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

Parent

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

Ongoing Assessments

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

3. Speech Pathology Assessments

Specialist communication assessments.

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

4. Dietetic Assessments

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

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

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