Queensland Government
Queensland Health

Clinical Practice Improvement Centre

ATTACHMENT 3:
Recovery Support workers in Child & Youth Mental Health Services

1. Description of the Problem

Child and Youth Mental Health Services (CYMHS) are encountering difficulty in maintaining adequate workforce availability and skill mix to support a recovery focus. Contemporary mental health services' focus is now aligned to the recovery model of care.

CYMHS are critical to a comprehensive network of care across the spectrum. However, demand on services for acute assessment and intervention is increasing. Within the current workforce availability and mix, this demand is reducing capacity to implement the recovery approach by way of more intensive support services. There is a need to explore alternative ways to develop the workforce to provide a stronger recovery support capacity.

2. Size of the Problem

Without an adequate workforce, service delivery is limited. CYMHS predominantly provide clinical services at a secondary/tertiary level to children and young people suffering severe and complex mental disorders. CYMHS also allocate resources to supporting primary care, health promotion and interagency co-ordination.

CYMHS utilise a range of health professionals who are highly skilled and require considerable investment in supervision and ongoing upskilling. Services focuses on the delivery of clinical and therapeutic assessment and treatment services to individuals, families and groups.

Increasingly professional staff are under pressure, with demand and acuity constantly increasing. For therapy to be powerful, clinical staff are also providing support, psycho-education, practical service co-ordination and liaison.

3. Description of the Proposed Intervention

Funding will be used to explore the employment and utilisation of youth and family support workers within CYMHS clinical teams. It is proposed that by employing a cohort of semi-professional staff who could provide support services under direction of health professionals, there would be a twofold effect.

I. Professional staff would be freed up to provide more intensive clinical therapy interventions and also provide assessment and treatment planning to an increased caseload.

II. Enhanced support services will be available to young people and their families while engaged in treatment, thereby reducing service gaps and enhancing recovery.

Possible duties and responsibilities of the support workers can include: telephone contact including assertive follow-up; structured skills training; role modelling; assistance with engagement and followup by enabling higher level of contact; setting up liaison meetings and minuting clinical planning; provision of structured psycho-education information; accompanying clinical staff on home visits where necessary; life skills support; group therapy support and assistance with health promotion activities.

Project Plan

- Establish a suitable reference group for project support and guidance.
- Investigate workforce models and similar systems already in use.
- Consult Central Area CYMHS and scope of practice.
- Define duties and draft Job Description.
- Investigate IR/HR issues.
- Establish career structure and on the job supervision and reporting.
- Define competencies and determine those qualifications and course programs that can supply a suitable workforce.
- Trial a small cohort and evaluate to determine feasibility.

4. Details of Supporting Evidence

- Workforce Data
- Recovery Policy
- CYMHS Future Directions Policy

5. Measurement of Impact

I. Investigation of the applicability of semi-professional support staff within CYMHS teams.
II. Practical resolution of a range of IR/HR issues and appropriate drafts and recommendations for Job Description, career structure, etc.
III. Results of trial, including recommendations for full implementation and proposed staffing ratios and location.

6. Support

1 x AO6 Workforce (21 months)
Non labour budget
Computer/Communications
Travel

Plus a budget for the trial of the workforce for 12 months

Total budget: $487 197

Kids in Mind

BARRETT ADOLESCENT CENTRE

CONSULTATION on AGGRESSION and VIOLENCE at the BAC

August 2003

Consult on Aggression & Violence 2003

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TES4005

Additional copies of the report can be obtained from:
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Disclaimer
The opinions expressed in this report are those of the authors and are not necessarily those of any of the existing Barrett Adolescent Centre workers, CYMHS Team Leaders, or Queensland Health. Information in this report is from a combination of new data obtained from the Barrett Adolescent Centre and interviews with Queensland Health staff. The evaluation team are responsible for the methodology, data collection, analysis and conclusions drawn from this data. We thank the Barrett Adolescent Centre for their cooperation with this process, the many discussions around their endeavours and the data made available. Any similar process is fraught with omissions; events, forms, sheets, and questionnaires. We have attempted to minimise such loss, but note it will occur to some degree with this type of project.

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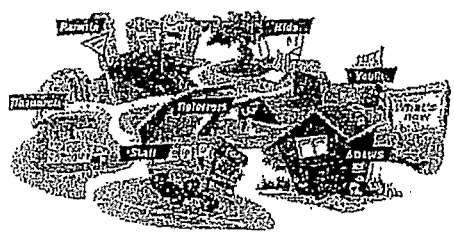

www.kidsinmind.org.au

Acknowledgements

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Mater Child & Adolescent Health Service

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Executive Summary

The Barrett Adolescent Centre (BAC) has been providing medium to long term therapy for Queensland adolescents for 20 years. Of itself, this is a commendable record of continuous service provision to a group considered by many parents and professionals to be extremely challenging. In recent times it is likely the client group of the unit has changed with admission of more individuals with challenging, predominantly externalising behaviour, more individuals with broad internalising and externalising behaviour and more serious self harm. This brief review considered the impact of critical incidents at the BAC from a multi-domain perspective: the current risk on the BAC from the perspective of the BAC clientele, BAC management practices, staff, environment and systemic issues, as well as a review of BAC responses to critical incidents.

The review found that there is a significant burden of critical incidents at the BAC across issues dealing with aggression and assault, self harm and being away from the unit without permission. Less prominent incidents included property damage and injuries. The major critical incidents co-occurred in vulnerable individuals. This means that if a patient was involved in an assault they were more likely to be involved in both future assaults as well as self harm incidents. Additionally, it appears that girls were likely to be involved in aggressive behaviour at rates higher than the societal norms.

The review team identified areas for the BAC management to consider in a broad response to critical incidents. Recommendations include consideration of the group most likely to benefit from care at the BAC, more structured and clear admission criteria, greater inclusion of risk management assessment in the clinical care pathway, more scrutiny of the usefulness and application of the risk assessment tool and consideration of staff and environment issues. Changes should include consideration of the current relationship with other service units at The Park as well as BAC responses.

To invest in significant program revision, and policy and procedural change requires enthusiasm and motivation. The review team feel that this is impeded by the current uncertainty about the future of the BAC. In a broad sense, securing certainty about the BAC is an outcome that has a clear implication for improved risk management at the BAC.

RECOMMENDATIONS

The recommendations section is structured as:

(1) General recommendations relating to the BAC target group, clinical care pathway and interventions,

(2) Recommendations pertaining to specific risk management issues,

(3) Over arching recommendations that relate to the continuation of funding of the BAC and the motivation and enthusiasm of staff to implement change. The overarching recommendations should be seen as fundamental to, and equally important to 1 & 2.

(1) General recommendations relating to the BAC target group, clinical care pathway and interventions:

1. In the absence of other forms of outcome measurement, a qualitative and experiential review of the usual clientele admitted to the BAC should be undertaken with a specific objective of considering the ~~most suitable target group for the~~ BAC.

2. The "have a go" ethos of admitting individuals to the BAC should be stopped and all potential referrals should be considered against strict and mutually accepted criteria.

3. BAC admission criteria should be more clearly operationalised.

4. Risk assessment should be specifically included in the BAC referral form and additional referral information obtained.

5. An inclusion of risk assessment should be made in the determination of whether an individual is accepted by the BAC. Issues around risk management should be included in information promulgated by the BAC about its program.

6. It should be more clearly annunciated to referrers, patients, families and staff whether there is a 2 week assessment period at the beginning of a BAC admission.

7. Analysis of risk assessment should be included in the determination of the effectiveness of the two week trial and whether the patient should remain at the BAC.

8. BAC staff should consider programming in the after school and early evening period as a risk management strategy.

9. The BAC should consider smaller groups size for therapeutic and recreational groups.

10. The BAC should consider a restructure of its program into smaller functional units including the possibility of having 2 home groups rather than a larger single cohort of adolescents on the unit.

(2) Recommendations pertaining to specific risk management issues

11. The BAC management should review the use of the risk assessment tool in the adolescence population: whether the tool is valid, the clinical use of the assessment tool findings in the BAC and the evaluation of the assessment tool over time.

12. There are policies related to risk management that have not been reviewed at the BAC for many years, the BAC management should review such policies.

13. The BAC management should instigate a critical and formal process of risk analysis following incidents where there was actual or potential significant morbidity or potential mortality.

14. The appropriateness of the A1-A7 system should be reviewed in light of contemporary changes in patient presentations at the BAC.

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15. Consideration of the appropriateness of the category red system in view of the new clientele should be reviewed.

16. All BAC staff should have regular inservice training about risk management.

17. Orientation of new staff should include risk management.

18. There should be clarity about the status of the unit in relation to it being an open (and therefore unlocked) unit; such changes to the status of the unit will have legal implications.

(3) Over arching recommendations that relate to the continuation of funding of the BAC and the motivation and enthusiasm of staff to implement change.

It is the opinion of the review team that a significant amount of money is required to be spent on the BAC environment. Further significant emotional investment in changes of policies and practices is required. Given this burden:

19. Senior BAC and Park management should, as a matter of some urgency; advance with Queensland Health the issue of the continued funding and support of the BAC. Whilst the current work environment of the BAC may be therapeutic to adolescents, the staff millieu is not promoting motivation and enthusiasm to review risk management and other procedures at the BAC.

20. With contemporary understanding of the burden of youth homelessness and school exclusion, the BAC provides an excellent opportunity for youth with mental health and challenging behaviour to live in a safe environment and receive high quality educational and psychological input. For these reasons the review team recommend advocacy for the BAC.

21. However the review team recommend further work in the delineation of the BAC in the continuum of care of adolescent mental health services in SE Queensland. Tasks include the current evidence base for adolescent inpatient care and whether the current broad admission brief should not be changed to focus on a more limited diagnostic range or alternatively to focus on particular challenging behaviours such as individuals with internalising conditions

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and mild externalising behaviour or individuals with severe and ongoing suicidality and self harm.

1. BACKGROUND

1.1 HISTORICAL CONTEXT OF THE BAC

The BAC was established in 1983. The unit was established with an overarching treatment ethos of milieu therapy and this has been a unifying treatment theme over the last 20 years. The last 5 years have seen a significant expansion in the number of inpatient child & youth mental health beds across south east Queensland. This includes the opening of inpatient units at The Royal Brisbane Hospital, Mater Children's Hospital, Logan, Gold Coast and Toowoomba, as well as a significant expansion in the community CYMHS clinics. It should be noted that for the new inpatient beds were conceptualised as acute beds, aimed at providing brief admissions around clarification of an individual's mental health diagnosis, the initiation of treatment and movement of the patient back to the community with follow-up by a CYMHS clinic or private practitioner. No other inpatient unit for adolescents has been established with a long stay brief. The Day Program of Mater CYMHS is potentially long stay (1 to 2 school terms) and includes the ability to attend the Mater Children's Hospital school, but has no residential capacity. ?

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With the increase in inpatient beds in south east Queensland the commitment to fund the Barrett Adolescent Centre has become less certain, and indeed at one point it was widely thought the BAC would close. Whilst this clearly did not happen it is true that there is significant ongoing apprehension amongst BAC staff about the continuing funding of the BAC. Further there is considerable discussion amongst staff about how, if it is to continue, the BAC will function within the current South East Queensland continuum of adolescent mental health care.

1.2 Terms of Reference of the current review

- To review the incident profile of the unit over the last four years and to consider the nature and extent of the risk associated with the profile
- To consider the relationship between risks and the current target population, associated diagnostic profile and service model
- To consider the organisational response to the incidents

- To consider the risk management approach in terms of individual risk identification and response efficacy
- To suggest strategies which may reduce the likelihood of further serious incidents.

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2. VIOLENCE AND AGGRESSION: DEFINITIONS, PREVALENCE, DETERMINING FACTORS AND IMPACT ON STAFF.

Definitions of Aggression: Multiple definitions for aggression have been suggested. Definitions include 'any threatening verbal or physical behaviour directed toward self or others,' (Owen, 1998), "an act whose goal-response is injury to another organism," (Dollar et al., 1989). Many authors have subdivided aggression type, including O'Leary-Kelly and colleagues. In a review of the literature, they found that terms such as hostile aggression, violent aggression, affective aggression, angry aggression, bullying, emotional and instrumental aggression, impulsive and reactive aggression, environmental aggression and enraged aggression or enraged violence dominate the literature (1996); the schema of Rippon states, "aggression can be physical or verbal, active or passive, and can be focused on the victim(s) directly or indirectly" (2000). Several authors have noted instrumental aggressive "does not have strong emotional basis and yet can be extremely violent" (Buss, 1961).

Definitions of Violence: Steinmetz (1986) defined violence as, 'an act carried out with the intention, or perceived as having the intention, of physically hurting another person". Steinmetz included a broad range of incidents from minor common assault to premeditated murder as violent acts. Others including Strasburg (1978) included legal concepts in a definition of violent behaviour, 'illegal use or threat of force against a person'. Strasborg included a range of crimes such as assault, robbery, sexual impositions and sexual assault, arson, threatening behaviour, kidnapping, burglary and murder. Rippon stated that "by definition, violence is synonymous with aggression", then went on to suggest a distinction by severity, "however, violence is reserved for those acts of aggression that are particularly intense, and are more heinous, infamous irreprehensible" (2000). The Department of Employment, Training and Industrial Relations, in its April 1999 brochure on 'Violence at Work' defined violence as 'the unwarranted or unjust use of force or power'.

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In summary, the literature in this area is hampered by significant differences in the definitions of the core constructs. One useful theme is that violence is the act or the behaviour that often follows aggression, whereas aggression is the intent to commit a violent act or forms of behaviour. Examples of these include verbal abuse and physical intimidation that fall short of a physical act against another person.

The following discussion briefly considers violence and aggression prevalence, determining factors and impact on staff. The current literature in this area is predominantly derived from studies of adult mental health units. Generalising these findings to child and adolescent units requires caution.

Prevalence: Many studies have reported the prevalence of mental health staff being involved in acts of violence and aggression. The US Department of Justice statistics report (1992-1996) that 79.5 out of 1000 mental health workers have experienced nonfatal workplace violence. The British Columbia workers compensation board received 600 claims from nurses and health care workers for time lost from acts of violence or force, 10 times more than that from any other occupation. More than half of these are injuries suffered by nurses, care aides and other health care workers while working in long term care facilities, psychiatric hospitals, group homes and acute care hospitals. (Duxbury 2002).

Verbal aggression and threats of violence appear more prevalent than acts of violence, although research reports vary widely. Duxbury (2002) reported that incidents of patient aggression (an expression of hostility or intent to do harm) accounted for 70% of incidents (n= 157) and involved verbal abuse and verbal threats in total, whilst violence accounted for only 13.5% (n=30) of the incidents recorded. However, Nolan et al (1999) reported that 18% of staff had been threatened verbally and that 50% of psychiatric staff have been physically assaulted at some time during their careers. Similarly, Ruben et al., (1980) and Madden et al., (1976) concluded that approximately 50% of psychiatrists had been assaulted during the course of their work and in a multinational survey Poster (1996) found that 75% of mental health nurses had been physically assaulted at least once in their careers. The Poster report is in accordance with Whittington and Wykes (1994) who found 65% of nurses in their study had been violently assaulted by patients and led to their conclusion that there is overwhelming evidence that nurse are more likely to be physically

assaulted, threatened or verbally abused that any other health professional group. (Whittington et al 1996).

Clearly not all patients are violent, indeed, Weiser (1994) estimated that approximately 10% of psychiatric patients are violent towards staff. This includes perpetrating the most serious acts of violence with several documented cases of mental health clinicians being murdered in Australia by current or former patients. There is a poverty of research on aggression and violence by child and adolescent mental health clients, with most studies focusing on adults.

Determining Factors: Studies of adults with mental illness finds a range of illnesses associated with an increase in aggression and violence, including mania (Lion et al, 1981,) schizophrenia (Pearson et al., 1986), borderline personality disorder (Hansen, 1996) antisocial personality disorders and psychotic disorders (Whittington 1997). Other factors include male gender (Duxbury, 2002; Morrison et al,2002), age ranging from 15 to 30 (James et al; Noble and Rogers, 1989; West, 1974), a previous history of violence.(Flannery et al., 1994; Whittington, 1998; Owen et al., 1998 b) and patients who were on a high level of medications (Duxbury, 2002; Lion et al., 1981; Pearson et al., 1986; Finke 2001). Others report substance abuse (Lanza, 1988; Flannery et al 1994; Royal College of Psychiatrists, 1988) as a key indicator for potential for violence.

Length of stay has been reported as being an influential factor with long stay adult patients most likely to be violent (Morrison et al., 2002; Barber, Hundley, Kellogg, 1988). Studies on adolescents concur with these findings (Finke, 2001; Owen et al., 1998). Involuntary status under a mental health act was found to be a factor in patients most likely to be violent. Other precursors to violence and aggression were confusional states, non-compliance with medication (Whittington et al., 1996) and short hospital stays in overcrowded wards (Edwards and Reid).

Staff factors were seen to be important by Duxbury, "Factors including staff gender, experience, training and grade are also believed to have some impact upon the incidence of patient aggression and violence" (2002). Vanderslott found that male nursing staff were more commonly attacked than female staff, possibly because they are frequently involved in containing aggressive outbursts (1998). Hatch and colleagues postulated that, "female staff might also use non-aggressive strategies to de-escalate tension and aggression rather than the traditional male, "police-like"

techniques that could generate a power struggle instead of diffuse anger" (2002). This opinion has not been universally replicated with some studies suggesting that women are at higher risk (Binder, Ednie, Lanza and Wykes). However, in a general a review the consensus appears to be that women in mental health care settings are not at increased risk for patient assault.

A caveat may be the pregnant female staff member. Binder (1991) reviewed this literature and concluded that pregnancy remains a significant mental health work-related issue. The literature repeatedly reports instances of patients experiencing envy, abandonment, rejection maternal transference and aggression toward the therapist, including fantasies of hurting or killing both the therapist and the infant. Overall the literature in this area points to pregnancy as a significant risk factor for women, particularly in violence prone environments such as acute care wards, emergency rooms and forensic settings.

Research supporting the argument that staff grade may be correlated with the incidence of patient aggression or that less senior nursing staff are more commonly the victims of aggression and violence is inconclusive. Hodgkinson and colleagues 1985 found that student nurses were assaulted more often than trained or qualified staff (1985). Vanderslott reported that care assistants who are most at risk (1998). Other studies suggest students are at greater risk. In one study student nurses student nurses making up 19% of staff, but sustaining 24% of assault caused injury (doc 15). In another study physical assaults were higher among student nurses especially those with no training in conflict resolution (Grenade and Macdonald 1995). Nursing seniority may confer protection through experience and competent. Alternatively less senior staff may spend more time with patients and this in turn may make them more vulnerable to acts of violence and aggression. (Whittington and Wykes 1994b; Vanderslott 1998). With psychiatrists age and experience also appear to be linked with risk; younger clinicians with less experience were at a significantly greater risk for patient assault than older more experienced psychiatrists.

When: The literature is varied as to when violent and aggressive incidents occur. Results differ markedly with reports showing time periods for incidents are across the day (Cottrell, 1980; Whittington and Wykes, 1994b; Vanderslott 1998), with fewer incidences at lunch or after midnight. Low levels of staffing, such as when handovers occur (Carmel & Hunter 1993) and when staff are handing out medication and around meal times (Owen et al., 1998; Carmel & Hunter, 1993) are other predictive factors for increases in violence and aggression.

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Where: Issues that have been examined include building deficits such as limited space or provisions for privacy, overcrowding, hospital shifts, the timing of assaults, raised temperature and additional poor environmental provisions (Nijman et al 1999). However, Blair and New argue that most studies in this area are inconclusive (1991). Recent guidelines by the royal college of psychiatrists (1998) recommend that hospital environments should be comfortable, safe, private, homely and free from noxious environmental factors as far as possible. Staff most commonly identified factors contributing to the development of patient aggression as problematic interactions and restrictive environments. The latter was deemed to cause over one-quarter of all incidents reported. High-risk areas, include bathrooms and bedrooms, ward corridors and dayrooms.

Why: Human resource issues are a common theme. Reduced numbers of staff, and an overuse of casual staff (Turnbull and Patterson 1999), inexperience, increased workload and low levels of training are probable factors. Management of the milieu has been implicated, mediated by numerous factors: the impact of varying staff, controlling styles, negative interactions, poor or limited communication and interaction with patients, authoritarian management approaches, and punitive management and interventions (Morrison, 2002; Anderson & Roper 1991; Garrison et al., 1990; Goren, Singh & Best, 1993).

The issue of negative staff interactional styles and limited communication skills is a cause for concern, particularly given the evidence of staff lack of awareness about the impact of these deficits. In one research project (staff) when surveyed did not view their interaction with patients to be problematic despite finding that almost one fifth of incidents of the incidents in practice (MSOAS) were reported to be the direct result of staff-patient interaction. Concomitant with poor staff insight may be lack of training in precursors to patient aggression such as self presentation and self awareness (Farrell and Gray 1992) to limited interaction with patients prior to incidents (Whittington and Wykes 1994a, 1994b.)

Impact on staff: There is an ever prevailing theme of a cultural acceptance of violence and aggression in mental health facilities. Most nurses believe that violence and assault are part of the job, and also that workplace violence has a normative effect, meaning that violent acts and aggression become accepted as a normal part of the workplace culture (Erikson & Williams Evans, 2000; Thomas, 1995; Scott, 1999). One reason for denial may be that mental health care

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provider's overestimate their ability to remain objective toward their patients in the face of personally disturbing incidence and deal with their assault at a cognitive rather than emotional level. (Wykes & Whittington 1998)

Workplace violence literature notes that the issues of cost to the organization remains of paramount concern (Wykes & Whittington 1998). Cost is typically conceptualized in terms of the individual worker (physical/physiological and mental/emotional issues) and the organization. At the individual level, physical cost refer to consequences of workplace violence such as disrupted sleep, cardiopulmonary problems, fatigue, hypertension, and susceptibility to illness, while emotional costs encompass issues such as depression, loss of self esteem, family conflict, cynicism, anger and impaired coping. At the organizational level, costs are associated with decreased worker productivity and morale, lost working days, legal liability costs, employee turnover and resources allocated to rehiring and retraining. (Barrett et al., 1997).

Wykes & Whittington (1998) found that of the psychiatric intensive care nurses who had reported being recently assaulted, 25% reported feeling jumpier, overly alert, and bothered by recurrent thoughts about the incident. One third of the assaulted nurses indicated they experienced significant psychological distress and anger following the incident. Assault victims see themselves as weak and often continue to fear the patient after the assault. Threats were reported to be as likely to cause psychological distress and disruption of service delivery in staff as were physical or sexual assaults (Flannery et al., 1995). There is evidence that increasing numbers of nursing and other health professionals are suffering the effects of PTSD (Rippon 2000), anxiety, impaired work performance (Robbins, 1997) and difficulties with sleep as a result of hostility and violence in the workplace (Fisher et al., 1995).

3. INTRODUCTION TO THIS CONSULTATION

The review team consisted of Melissa Kyte, consumer consultant at the Barrett Adolescent Centre, Ms Karen Gullick, Manager of The Hollywood Clinic, Hollywood Private Hospital in Perth, Western Australia and Dr Jacinta Powell from the Mental Health Unit, Queensland Health. Associate Professor McDermott, Director of the Mater Child and Youth Mental Health Service was the Chair of the Review Team. Context expertise in child and adolescent mental health was provided by members Gullick and McDermott. Ms Gullick has many years experience in various roles within child and adolescent mental health, and for 7 years managed an inpatient child and adolescent mental health unit. Dr Powell has extensive experience in reviews of risk management including recent reviews of adult mental health units. Melissa Kyte's consumer experience of child and adolescent mental health services included admission at the Barrett Adolescent Centre.

3.1 Staff and consumers consulted

The review team worked for three days at the BAC, and during this period, consultation time was offered to all staff members. Staff appeared very interested in the review and were open and helpful during the process. They were consulted individually and in small groups and whilst no staff member requested confidentiality per se, the review team consider it more appropriate to indicate the professional background of staff consulted rather than a list of individual staff members.

Table 3.1: Professions of staff consulted.

BAC Medical Director
BAC Nursing Practice Coordinator
Senior nursing practitioner (level 3) ?Nursing Unit Manager
Nursing staff (level 2)
Specific nurses involved in critical incidents
Community Liaison Officer
Adventure therapy coordinator
School teachers
Occupational Therapist
Consumers (specifically consulted by the consumer representative of the review team)
Police liaison officer
Social worker

The consultation included two meetings with the Executive Director and Clinical Director of The Park.

3.2 Access to documentation

Access to policy manuals, orientation information, standard forms and patient records was provided as requested by the review team.

The review team specifically considered the patient medical records of four critical incidents. These incidents were considered by staff to have conferred a high degree of risk to staff and/or patients of the BAC. Such charts were reviewed initially against BAC polices and procedures as given by existing BAC documentation and then against current best practice (as agreed by the review team). A number of charts randomly drawn from current BAC patients were also considered.

3.3 Access to Data

Summary data on critical incidents presented in graphical form was made available to the review team and is included in the appendices of this report.

The review team were interested in the whether the critical incident data was of sufficient quality for more detailed analysis. All critical incident forms completed at the BAC were obtained from 2000 until June 2003, entered and analysed. Details of this analysis are in section 4.1.b.

4. CURRENT STATUS OF RISK ON THE BAC

4.1. Client Profile of the BAC

The review team were informed that the current bed platform of the BAC was 15 beds with an additional 5 outpatient places. Occasionally there are more inpatients and indeed during the week of the consultation, there were 16 patients. A presentation from the Director of the BAC delineated the type of clientele seen at the BAC. Diagnoses of patients attending the BAC are listed below.

Table 4.1: Range of diagnostic groups admitted to the BAC

Psychosis,
Depressive disorders,
Avoidant anxious disorders,
OCD,
Tourette's Syndrome,
Eating disorders
Traumatic stress disorders,
Asperger's Syndrome.

From this presentation it was noted that the BAC accepted a wide range of individuals with a wide range of presentations and would generally give many individuals "a go" to see whether they could use the therapy offered at the BAC. This philosophy was stated by most senior clinicians, and they were clear that the admission criteria were quite open, i.e. from 13 to 17 years of age with a clear psychiatric illness, and suitable to be on an open unit and with evidence of client and family commitment. Individuals with substance abuse, with a diagnosis of only conduct disorder or who had moderate or severe intellectual handicap were excluded from the BAC.

There was a clear perception from all levels of clinical and management staff that the type of clients seen at BAC has changed over recent years. Many clinical staff noted there was a mismatch of recently referred adolescents with the original treatment philosophy at the unit, mainly manifest by an increase in the amount of disturbed behaviour including increased client histories of aggression and social problems. Some clinicians felt there were more patients with co-morbid drug and alcohol problems or adolescents from geographically remote locations, including Darwin. Some clinicians noted that the recent occurrence of finding several patients in possession of weapons was very unusual in the long history of the BAC. Lastly, many staff felt that the unit was under increasing pressure from external stakeholders to accept children whose presentations did not meet the admission criteria for the unit, and who in fact would previously have been excluded because of those presentations. Examples included adolescents on remand from the Brisbane Youth Detention Centre.

4.2 Risk Profile: Review of existing data analysis

The review team were provided with a powerpoint presentation of the incident profile of the BAC from January 2001 to March 2003. This information is found in Appendix 1, Figure A1 The Adolescent Incident Profile 2001-03, in which incidents have been aggregated into aggressive incidents, absent without leave (AWOL), self harm and 'other' incidents. In the 28 months graphically represented, 12 months have incidents from all 4 different categories recorded. Ten months have 3 different types of incidents, 6 months have only 2 types of incidents, no month has only one type of incident. There is no month at the BAC without a recorded incident. The range of incidents over this period is from 26 incidents occurring in June 02 and March 03 to a low of 3 incidents occurring in February 03. There is no significant seasonal variation with all types of incidents evenly spread across the reporting period. The most frequent type of incident by month was aggression and self harm. Both categories were represented in 24 of the 28 month reporting period, followed by 'other' (22 of 28 months) and AWOL (20 of 28 months).

Some analysis is provided in the BAC briefing material. The relationship between assault and aggression and absconding can be found also in Appendix 1 page 2. It is reported that 17 of 19 adolescents who absconded from the unit were also involved in aggression. Reasons for

absconding varied. Some absconding behaviour was driven by suicidal intent, peer pressure and a desire to obtain drugs. Six of 19 individuals used alcohol or substances when they absconded. Some comment is also included on page 3 of the relation to prior aggression stating that the group with the highest incidence of aggression prior to admission were a group who were reported as "violent at home", had perpetrated "physical attacks on parents" or demonstrated "excessive violence towards siblings". However, it was reported that only one of this group was involved in aggression at BAC. Nine of 34 adolescents involved in incidents of aggressive assault had antecedent conduct disturbance. The analysis does not mention the type of statistical test employed or the level of significance of the finding.

4.3 Risk profile: new data analysis

Critical incident reports were available on 93 patients. The mean patient age during the admission was 15.37 years (SD 1.25yrs), ages ranged from 13 to 18 years. There was a non significant over-representation of female patients (52.1% versus 47.9%). The majority of patients involved in critical incidents were Australian born (94.5%), all spoke English in the family home. No patient in this sample identified their ethnicity as Aboriginal or Torres Strait Islander.

Table 4.1:

total number of incidents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	42	45.2	45.7	45.7
	2.00	14	15.1	15.2	60.9
	3.00	5	5.4	5.4	66.3
	4.00	5	5.4	5.4	71.7
	5.00	4	4.3	4.3	76.1
	6.00	3	3.2	3.3	79.3
	7.00	2	2.2	2.2	81.5
	8.00	3	3.2	3.3	84.8
	9.00	1	1.1	1.1	85.9
	10.00	2	2.2	2.2	88.0
	11.00	2	2.2	2.2	90.2
	13.00	2	2.2	2.2	92.4
	16.00	2	2.2	2.2	94.6
	18.00	1	1.1	1.1	95.7
	19.00	1	1.1	1.1	96.7
	29.00	1	1.1	1.1	97.8
	37.00	1	1.1	1.1	98.9
	70.00	1	1.1	1.1	100.0
	Total	92	98.9	100.0	
Missing	System	1	1.1		
Total		93	100.0		

An important consideration about this analysis is that the results presented are indicative only. The analysis does not at present meet a research standard, given the need to further review and clean the data. Most variables have between 5-15% of missing data and this could be improved with further work. Further, most analyses were run without the results of one patient, an individual who was a significant statistical outlier. This person was responsible for 70 critical incidents whilst at the BAC, approximately 16 times the average incidents per patient in the CI sample.

Table 4.1 above highlights that out of 463 incidents 45.7 percent of patients accounted for only one incident, 60.9 percent account for 2 incidents. However, there is a substantial minority of patients would are involved in repetitive critical incidents, and indeed 12% of this sample were involved in 10 or more incidents.

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Figure 4.1: Relative frequency of Critical Incident Type

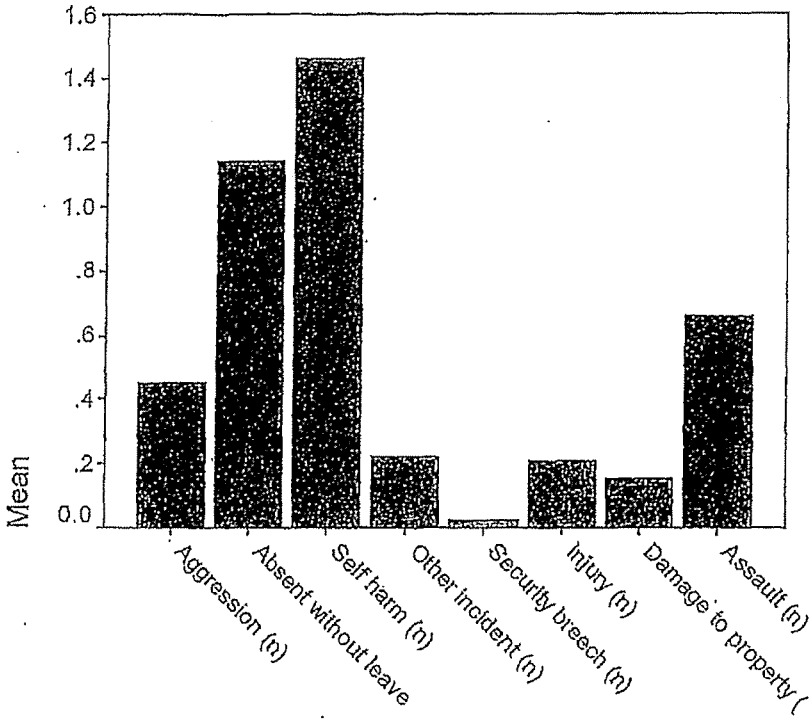

Figure 4.1 above depicts critical incident by incident type.

Self-harm was the most common critical incident occurring at the BAC. During this reporting period there were 134 incidents of self harm occurring in 33.7% of the critical incident patient sample. If self-harm occurred the patient was likely to do so on multiple occasions, given only 10.4% of the self harm group did so on only one occasion. In contrast approaching half of the sample (43.3%) of the self-harm group did so on 10 or more times. Self harm was significantly more likely to be perpetrated by female patients (female mean self harm = 2.703, male = 0.714, T_{70} =-2.232, p = .029). There was no correlation between patient age and number of self harming incidents. Self harm by gender is graphically represented in Figure 4.2.

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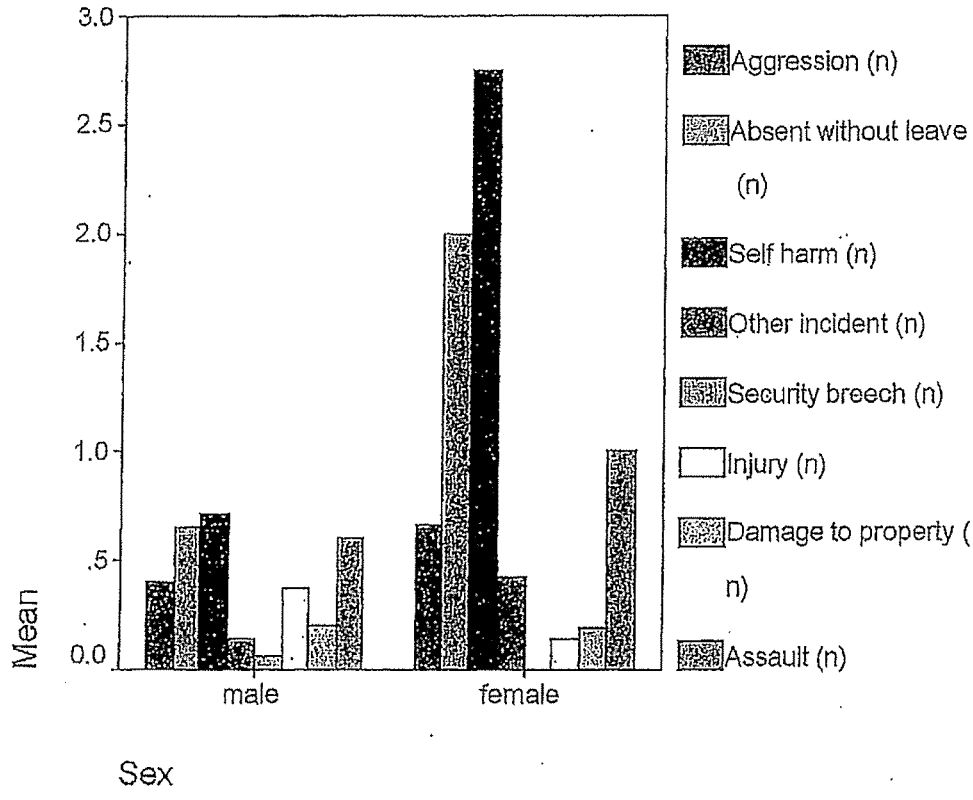
Figure 4.2 Critical Incident category by Gender



An **absent without leave (AWOL)** critical incident was recorded 104 times during the reporting period. 41 individuals were involved in one or more AWOL incidents, 22.2% of the CI sample had at least one AWOL incident. AWOL incidents were less likely to be multiple than self harm incidents: 54% of AWOL patients did so on only one occasion, 83% between 1 and 3 occasions and only 15% on more than 6 occasions. Significantly more female patients were involved in AWOL incidents (mean female AWOL = 2.000, male = 0.657, $T_{69} = -2.470$, $p = 0.016$). There was a trend ($p = .076$) for AWOL incidents to involve older patients.

An incident of **assault** was recorded 50 times during the reporting period. 33 individuals were involved in one or more assault incidents, 25.3% of the CI sample had at least one assault

incident. Similar to the AWOL data, multiple incidents of assault was uncommon, 69% of patients were involved in one assault incident rapidly declining to 12% involved in two assaults and 18% in more than 2 assaults. The data suggests some tolerance to an act of assault: 2 patients were involved in 4 assaults, 3 patients in 5 assaults, 1 patient in 6 assaults. There was no gender or age difference in patients involved in assault incidents.

An incident of **aggression** was recorded 41 times during the reporting period. 24 individuals were involved in one or more aggressive incidents, 17.4% of the CI sample had at least one assault incident. Similar to the AWOL and assault data, multiple incidents of aggression was uncommon, 67% of patients were involved in one aggressive incident declining to 21% involved in two assaults and 12% in more than 2 assaults. Three individuals accounted for 4, 5 and 6 aggressive incidents respectively. There was no gender or age difference in patients involved in assault incidents.

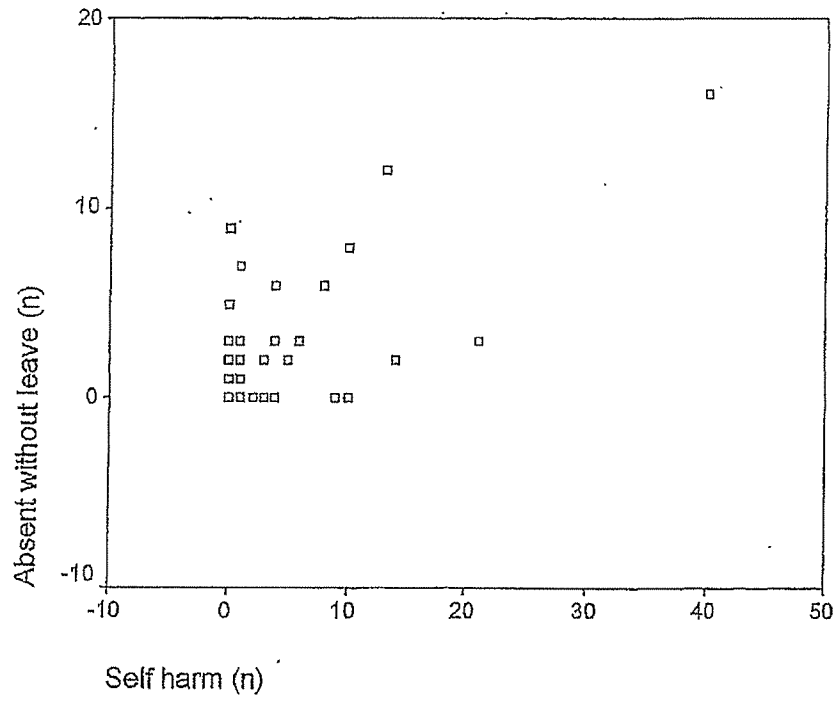
No separated analysis was performed on low prevalence incidents such as injury (n = 20, 4.3% of all incidents), 'other' (n = 20, 4.3% of all incidents), property damage (n = 19, 4.1% of all incidents) and security breach (n = 2, 0.4% of all incidents).

Table 4.2 below, highlights the significant relationship between the most common variables with significant bivariate correlations between incidents reported as aggression and assault, AWOL and self harm, assault and AWOL and self harm and AWOL. The example of self harm and AWOL is graphical depicted in Figure 4.3. Whilst a higher order factor such as gender may be found following multivariate analysis with a larger sample size these results suggest that multiple forms of critical incidents cluster in individuals. The clinical implication is that if a patient is involved in one form of critical incident, the clinical staff should be aware of the potential for further incidents in that as well as in other domains of critical incidents.

Table 4.2 Summary of Bivariate analyses (Pearson's correlation) of the four most common critical incidents

	Aggression	Assault	AWOL	Self harm
Aggression: p (2-tailed)		.000	.000	.000
Assault			.033	NS (.183)
AWOL				.000

Figure 4.3 Simple Scattergram of AWOL versus Self-harm incidents



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4.4 Current service delivery model

The BAC model was described to the review team as a milieu therapy model with adjunctive therapy mainly in the form of adventure therapy, individual therapy and psychopharmacology. The medical support to the BAC and hence the medication prescribers were the BAC Director and a psychiatry registrar. Individual therapy was provided formally primarily by allied health professionals. The form of individual therapy depended on the therapist: cognitive – behavioural and psychodynamic approaches were cited. It was not clear whether all adolescents were offered individual therapy, and on what grounds it was offered. The nursing case management role is also central to the therapeutic process, and during the course of an admission, would constitute a significant long term relationship for the adolescents admitted. Several staff members noted the current limited family therapy capacity due to an unfilled allied health position.

Certain aspects of the therapy programme seemed unclear to some staff. An example of this is the two week assessment period. Several staff were unsure about whether that still happened or not. In any case, there did not appear to be a formal review following the two week assessment, and nor was the outcome made overt to any of the relevant parties.

4.5 Current Admission Pathway

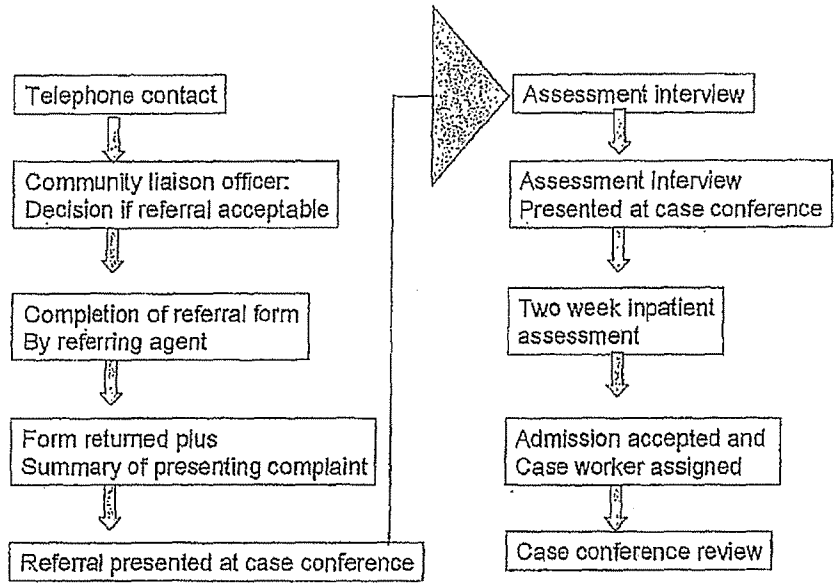
Figure 4.4 below, highlights the BAC clinical and administrative pathway from the first telephone contact with the BAC until a patient is accepted for an inpatient treatment stay.

Central to this process is the Community Liaison Officer's role. The role includes (1) Triaging telephone referrals, including the initial decision as to whether the patient seems acceptable, (2) presenting the case at the referral meeting, (3) completing the assessment interview with the registrar and (4) presenting the case at case the conference. The centrality of this worker clearly provides some consistency to the process, but may at some level not be appropriate. Issues include potential differences in the understanding of suitable referrals between the Community Liaison Officer and nursing staff or senior clinical staff.

Secondly, there is the potential for idiosyncratic practices or detailed understanding of systemic issues and processes residing in one individual and not generalising to the broader clinical team.

Another issue noted by several staff was that referrals were often considered at the end of the case conference. The identified problems arising from this process included staff having to

Figure 4.4: BAC Referral and Admission acceptance pathway



leave the meeting prior to discussing new referrals, time constraints on this item of discussion and fatigue at the end of an otherwise busy meeting. Given the importance of selecting appropriate adolescents for the milieu, it would appear that this process needs to be managed differently.

4.6 Treatment Model

Most staff stated that the BAC had an over-arching theme of working in a milieu therapy model with an adjunctive individual, group, family and adventure based therapy. A recent staff vacancy had diminished the availability family therapy. It was the opinion of the reviewing team that a more indepth understanding of the milieu model was not easily accessible either from staff or from the documentation provided. It was also apparent that whilst the senior and long serving

members of the team appeared to have a common understanding of the meaning of this model, newer staff felt that they hadn't been orientated to this, and felt that they were expected to learn on the job. Given the importance of staff roles in 'maintaining the milieu', this would need to be addressed.

4.7 Specific risk strategies

The **A1-A7 programs** are a series of behaviour management programs employed at the BAC. They are well documented, available to all staff as typed sheets and have been in use for many years. The review team noted the programs were developed before the current clientele with the more recent emphasis on externalising behaviour and consider the relevance of these programs to this client group is untested and there is no documented evidence that these programs change/effect behaviour. The programs could be seen to create a consistent response to behaviour, however, individual patients contexts differ, and a patient centred response that requires an adolescent to accept responsibility and participate in negotiating consequences may be useful. The review team felt that compliance with the 'A' program could be erroneously seen as the young person accepting responsibility.

Programs are a very 'public' response to behaviours. Some programs require restrictions to be in place for up to 48 hours. The review team were unsure that this fits with 'short, sharp and meaningful' consequences to behaviour. Further, the program would be 'monitored' by a number of staff over that period, leaving it open to interpretation. Indeed, some staff mentioned that they make modifications to the programmes when implementing them. Some consequences seem dissonant with the 'offence'; for instance a 48-hour response for a consistently untidy bedroom (A3).

More broad responses (other than A1-7) include '**suspension**' from BAC. Staff were of the opinion this was used more in the past, but homelessness and patients from geographically isolated areas make that impossible in some instances. Suspension was seen as a valuable response to some situations, as it allowed some "cooling off" and reflection on the part of the adolescent, and enabled a re-negotiation of expectations on return. The other advantage was that

family members were involved, and their support in the process had the potential to strengthen the relationship between them and the BAC.

4.8 Staff issues

An overarching staff issue was the concerns by BAC staff that the ongoing funding uncertainty hampered the capacity of the BAC to recruit and retain high quality staff. Many staff members felt that staff would preferentially move to or apply to units with a more certain future.

There were a range of staff issues that individual BAC staff members felt were related to critical incidents on the unit. Certainly there appears to be a growing lack of confidence in the BAC and Park's ability to respond in a timely and safe way to unexpected incidents, and this is affecting morale. There is a current position open for a family therapist, and staff felt that this position would not only increase the range of therapy available at the BAC but also the skills of a family therapist in thinking systemically were also valued. The position remains unfilled due to the need to fund the increased staff required when a category red is in place. Staff noted that the gym equipment available at the BAC was presently not able to be used because of the lack of a qualified trainer who could supervise the use of this equipment. Staff noted that this was a source of frustration for many patients who enjoyed using gym equipment and this form of exercise was a pro-social use of energy.

There review team also heard many positive comments about the internal peer support within the BAC. However, there was a sense of resignation to the continuation of the untenable position of being uncertain about the future.

4.9 Environmental issues

Maintaining a safe environment includes the need to ensure that all equipment (including furniture) is well maintained, especially in high-risk areas. This is fundamental modelling, in that it gives the adolescents a clear message about the importance of living in a clean and functional environment. It also impacts on staff morale.

The review team noted that whilst the main dining/ recreation areas appeared to be very clean, tidy and light, there did appear to be a lot of 'clutter' in other areas, including broken and unused equipment.

Added to this, the majority of staff cited concerns about the physical environment of the BAC. All staff stated that of the two accommodation corridors presented a considerable risk, especially the corridor furthest from the nursing station, which was not in line of sight of nurses. The other corridor was visible to nursing staff, however, the bedrooms at the far end of the corridor were still reasonably inaccessible. Staff also noted that the age of the building and the style of the building made for many small and out of the way spaces that were potential places for an individual to self harm or to hide belongings that were not allowed on the BAC and indeed this has been their experience.

The staff involved in the critical incident in which a chair was thrown through a glass window were very clear in their concerns about the extensive amount of glass in the unit. The likelihood is that this glass is not of a suitable strength to be in this type of unit, nor is it covered by a protective film that would stop the glass breaking into shards. It was of interest to note that the police liaison officer, who has some experience in matters related to physical safety of environments, has ongoing concerns about the safety of the environment at the BAC. It was the opinion of the review team that the building looked dated and that it would benefit from a process that established whether it could be improved by significant modifications or a new type of facility was required. A major advantage to the BAC was the space and parkland around the unit. However, this was not itself without problems in that the review team was told that the access to the oval had been recently restricted because of the oval being sold. In addition access to a nearby auditorium that had been fairly extensively used by BAC for badminton and other activities had also been stopped.

4.10 Systemic issues

The relationship between BAC and the Park: Staff cited considerable uncertainty about the ability and willingness of staff members from other Park areas to be of assistance to the BAC during critical incidents. Indeed several examples were given including one response by other staff members of The Park to a critical incident, where the response included a 'drive by' and the discovery that a serious incident was occurring only happened fortuitously. Some staff noted that The Park redevelopment and the creation of more discreet service entities, in their opinion, diminished the ability of units to cooperate on the campus. Other staff noted, in their opinion, a campus wide lack of appreciation of both the type of patients seen at the BAC and the potential for dangerousness of the BAC patient group.

The relationship between BAC and the other CAMHS units: this was difficult to assess given comments were only available from BAC staff. It was stated by staff that the BAC received referrals from CYMHS teams in all regions and that suitable working relationships existed with other CYMHS units.

Staff team relationships: Staff reported excellent communication between school and nursing and allied staff, and the teaching staff reported that they feel very well supported by nursing staff if there is a problem. Teachers reported 'useful' things as being: peer support from other teachers; nurses on duty in the school; they don't ever feel that people are critical; they have regular meetings to discuss issues; they have regular meetings with the nurses to handover info; the common understanding that 'we're all here to help the kids'.

The BAC and the Brisbane Youth Detention Centre (BYDC): there had been several individuals referred from the Brisbane Youth Detention Centre which is geographically close to the BAC. Whilst there was an overall ethos of the BAC of giving youth "a go" and seeing who could benefit from the program, given the types of offence that have led individuals to be in the Brisbane Youth Detention Centre it is likely that this group is at greater risk of creating critical incidents on the BAC. In-reach services would seem to be more appropriate, but this issue is outside the scope of this review.

Geographically isolated patients: It was the opinion of many staff that current patients were increasingly likely to be admitted from geographically very distant areas. Clear problems with such a regime included the decreased probability of visiting from friends and relatives, the diminished possibility of going on outings away from the unit with friends and relatives and the psychological implications of being dislocated from your local social network. In this regard there was some degree of double jeopardy: (a) you are going to a new residential environment which involves group living that the adolescent may have not experienced before and (b) this new residential experience is far from the normal place of abode and social networks. It was the opinion of staff that such individuals were more likely to be distressed through this process and this was a possible risk factor for critical incidents.

4.11 Risk Management Related Training

All Park staff attend compulsory training in manual handling, CPR, fire procedures and aggression management training (PART program, 3 days duration followed by refresher program). All staff spoken to believed that the PART program was both useful and relevant. Apart from the compulsory training, there does not appear to be any BAC unit based training.

4.12 Orientation of new staff

An orientation manual and checklist for new staff exists. This process covers all administrative requirements for new staff coming into the BAC, however there was some difficulty obtaining a copy of the manual, and it appears that the information needs updating in some areas. Several newer staff reported that they had not in fact been orientated to the unit.

5. CURRENT RESPONSES BY THE BAC

Current responses to escalating issues include the use of the various behaviour management plans, and include completing documented risk management ratings. The review team noted that there was little coherence between documented risk and management plans on occasion. It was difficult to establish what the management plan was apart from the typed multidisciplinary plan, which prescribed generic interventions. Documentation of management plans following case conferences varied greatly in the notes reviewed.

Recent events have left several staff feeling very unsupported, and indeed with unresolved stress related issues. Whilst all staff who spoke to the review team felt that there was very good internal and informal support following incidents, the lack of formal review process and subsequent changes to policy, practice or procedure left staff feeling that there was little between then and the next incident. Recently there has been use of an external facilitator on two occasions, however, their role appeared more debriefing than process analysis.

5.1 Review of case notes

Rather than provide outlines of individual cases and reported critical incidents, this section will details themes across the cases reviewed, including issues from case files and issues that arose when discussing cases with staff.

The review team found little evidence either documented or from staff report that a review of process related to critical incidents takes place. Risk management is not a theme that is easily found in case notes apart from the risk assessment forms. It was difficult to find specific and individualised plans that relate to self harm, aggression of AWOL incidents. This extended to the individual care plans, which were often not ungraded in general as well as specifically about

risk. From a review of some notes, the level of risk assessed did not appear to influence decision-making in some instances.

AWOL was specifically mentioned in case notes with case note information and Staff report suggesting that the "retrieval from AWOL rate" is very high. Verbal report indicates that staff, with the aid of security staff, pursue young people in the local area, and will use physical methods to return young person to the BAC. If this occurred with a voluntary patient, the review team were unsure of the legality of such a procedure. Clearly a negative of the physical environment is the amount of open space that can be used to abscond too. It seems that many patients undertake a 5-minute walk across parkland to train station.

5.2 Review of Policies and procedures

It is a BAC policy to complete risk assessment relating to absconding, self harm and aggression: (1) prior to admission by the referring agent, (2) on admission, (3) reviewed at case conference and (4) post-incident.

The review team identified several issues with the risk assessment protocols. The risk assessment tools did not clearly indicated how to score or interpret the results of the assessment, and staff reported that they were not trained in its use. There was no clear pathway between assessment and a proactive management plan with the exception of placing the patient on a CAT RED. There was no available evidence that the risk assessment tool was relevant to or had an evidence-base in the adolescent population

Some risk assessment and management polices and procedures appeared overly universal for instance searching bags and rooms, locking bedrooms during the day, searching day patient's bags. Whilst such activities may have uncovered prohibited weapons or substances there was no evidence of the efficacy of such activities, no obvious audit of this practice and in the opinion of the review team, it has the potential to create a culture of mistrust. "Living up" to this mistrust may increase\the overall risk in the unit.

Many staff demonstrated confusion between critical incident stress debriefing (CISD) and a risk review and management process. When CISD was mentioned the 'informal' nature of the debriefing was cited by some staff as useful.

A brief review of the adventure therapy programme manual was undertaken, as well as informal discussion with the coordinator. The standards set by several outside organisations in relation to adventure therapy, and the components of it, are adhered to in this programme. The low critical incident rate whilst adolescents (and indeed staff) are participating in the programme is testament to the adherence to those standards, and to the carefully planned and managed events. The philosophy of adventure therapy as explained to the review team and would appear to contribute to the risk management in this programme. The maintenance of equipment and emergency plans also contributes. Nevertheless, involving a group of adolescents presenting with psychiatric and behavioural problems does increase the risk factor. The fitness level of staff may present a risk at another level.

5.3 Review of Critical Incident process

The review team found little evidence that a review of processes related to critical incidents takes place in any consistent or meaningful way. Indeed many staff confused this question with the opportunity for staff support and debriefing following an incident, citing that an external facilitator has been used recently after a critical incident.

The review team are of the opinion the BAC needs to establish a process whereby incidents considered to have potentially major consequences are investigated.

The review team are of the opinion The Park needs to consider updating incident forums for the risk assessment to include looking at the

(1) actual outcome,
(2) potential outcome,
(3) likelihood of the event re-occurring and then
(4) looking in-depth at the responses. (A root cause analysis or similar process)

This process needs to become the basis for change in practice as it related to risk and critical incidents. Such an analysis would include what happened, why and how it happened, what opportunities are there to prevent further occurrence. A response should consider communication, training and experience, fatigue and rostering, environment and equipment, rules, policies and procedures, and other barriers that become the evident. It will assist the staff to identify deficits in policy, procedure, education and skills of staff etc.

For example a review of the incident when the window was broken by a thrown chair would have inevitably lead to an urgent need to ensure that all glass is replaced or protected in some way, as well as a change to the Park wide response process when a 'Code Black' is called. It may also have lead to changes in protocol related to outings and pro-active communication with others on the Park site prior to outings occurring. The failure to look at potential risk management issues resulting from service incidents could be seen as negligent.

5.4 Wider Park issues

It appears that issues related to budgetary processes are not necessarily transparent, and may not reflect the level of activity and risk profile of the BAC. Staff reported accruing extremely high numbers of TOIL hours, and felt they had little possibility of being able to take that time. Costs for provision of Category Red care need to be acknowledged, as there is an assumption that not filling staffing positions is to save money for cat reds. The belief is that the programme is compromised as a result of this. Capital works funding is an issue and is mentioned in the recommendation section.

5.5 Response to Codes

The review team noted an absence of an enforced protocol about who makes up the response team, and the timeliness and process of their response. Any review of critical incidents should include looking at whether this protocol was observed. There needs to be opportunities to practice this on a regular basis, and a process of review afterwards.

6. POSSIBLE IMMEDIATE ACTIONS

Possible immediate actions are also detailed in the report recommendations. Whilst specific actions will be discussed the overarching need for a secure future for the BAC is an important action with a direct relationship to risk management.

6.1 Clinical Issues

6.1.1 **More clear admission criteria.** The review team felt the BAC should undertake a purposeful process to determine which patients are most likely to receive benefit from the BAC program, and how this fits with the current continuum of client care across SE Queensland. The review team were surprised with both the range of potential diagnoses of individuals at the BAC and the often stated ethos by all levels of staff of "having a go" with most types of presenting problems. A review of the target group need not only be diagnosis driven. For example a role for individuals with severe, persisting self-harm (therefore problem based) may be equally as valuable.

6.1.2 **Regular program review.** The BAC should consider closing the program for 1-2 days twice a year to invest time in management, procedure and training issues. Other inpatient units have been able to schedule regular program reviews. The potential benefits of this would significantly outweigh the costs.

6.1.3 **Structure.** The review team were interested in the relative absence of critical incidents at the BAC school, and on the adventure therapy programme. Small group size and highly structured time seem important determinants. Based on this observation the BAC staff should consider more structure in the after school and evening time.

6.1.4 **Group size.** Following on from 6.1.3 above the therapy group size seems very large and division of the group should be considered.

6.1.5 **"Home groups" within the BAC.** To further impart structure, control and a sense of belonging, the BAC staff should consider two home groups within the BAC program rather than one larger group of adolescents.

6.1.6 **Drug and Alcohol detoxification.** Given greater numbers of youth with dual diagnosis, the BAC staff should consider developing a relationship with the Adolescent Drug & Alcohol Withdrawal Service to up-skill BAC staff in contemporary drug withdrawal management, as well as the possibilities of additions to the BAC therapeutic program on drug and alcohol issues.

6.2 Policies & Procedures

The review team identified a range of BAC policies that were several years over the documented time for review, or had been created more than 4 years ago and had not obvious review schedule. The BAC should invest in a quality activity to review and where appropriate update all policies. Policies should be written from a patient centred, risk management, point of view, and should be separate from procedures.

6.3 Risk Assessment Tool

The Park risk assessment tool does not clearly indicate how to score or interpret data. Further there is no available evidence that the risk assessment tool is relevant to the adolescent population. The review team feel that there should be greater scrutiny of the tool as it relates to the prediction of further critical incidents and the more general outcome of that individual at the BAC. Note that part of this increased scrutiny is the new data analysis included in this report. Other analysis is possible with the BAC collection of HoNOSCA and CBCL data.

6.4 Decisions following on from the risk management process

Some risk management strategies seem to be universal at the BAC, for example searching bags and rooms, locking bedrooms during the day and searching day patient's bags. The danger of

universal interventions is engendering a culture of "mistrust" in response to risk management, which in turn affects interactions and relationships between staff and patients. Policies such as these should be reviewed by the team.

Specific issues, highlighted by case note review, include the review team feeling that there should be increased clarity of the pathway between risk assessment and a pro-active management plan, including placing the patient on CAT RED. The review team feel a more formal process review should occur after significant incidents. Documented care plans do not appear to be updated during the adolescents stay in response to risk assessment outcomes. . The requirement to have a multidisciplinary care plan does not disallow a nursing care plan, or a behavioural management plan being written and updated on a regular basis.

If programmed responses such as the A1-7 and Cat Red processes to risk taking behaviour are to continue, the review team are of the opinion BAC staff need to:
(1) review current programs and update them in relation to current patients,
(2) Document patient compliance and responses to the program,
(3) Monitor usefulness overall of such programs in modifying behaviour and
(4) Give consideration to a process whereby the adolescent and staff member sit down together to discuss and agree on logical consequences following risk taking behaviours. Age and developmental maturity may influence the outcomes.

6.5 BAC Management issues relating to critical incidents

BAC staff need to establish a process whereby incidents considered to have potentially major consequences are investigated. Park needs to consider updating incident forms to include risk assessment of the incident looking at the actual and potential outcomes rather than as primarily a reporting tool. Simple categories could include; What happened, Why and how did it happen, What opportunities are there to prevent a further occurrence?

A broad BAC response would include better communication about risk and risk management, more focused training, consideration of fatigue and rostering issues, environment and equipment needs, reviewing relevant rules/policies/procedures and other barriers that become evident. This process needs to become the basis for changes in practice. For example a review of the 'chair through the window' incident would have inevitably led to the urgent need to ensure that BAC glass is replaced or in some other way the clients are protected. A failure to look at potential risk management issues resulting from serious incidents could be seen as negligent.

6.6 Training, Education and Orientation for all staff

Many staff stated there was no regular inservice program or training days programmed at the BAC or for BAC staff. The review team feel that regular and ongoing training for BAC staff, in risk management and other issues should be mandatory. Such training should be consistent with the severity of problems that BAC patients present and the issues around intense medium to long term admissions for adolescents. A special focus should be training and education for new staff on adolescent issues. This currently appears to be ad hoc, with some staff reporting they were not offered any training opportunities related to working with adolescents or developing their understanding of adolescence. It was clear that opportunities for personal clinical supervision should also be explored and incorporated into the BAC processes.

Example of potential risk management training would be regular participation in a program of local critical incident response training, which would include:

(1) Fire evacuation,
(2) Managing aggression,
(3) Managing a medical emergency (eg an adolescent who looses a significant amount of blood after cutting themselves; or where an adolescent is found unconscious, with several empty pill packets next to them)
(4) Secluding a patient.
(5) CPR

Orientation: the review team feel the orientation process and documentation should be improved, specifically:

(1) The manual needs to be updated, and several copies need to exist.

(2) All new staff need to be orientated including casual staff. Consideration be given to developing a competency based orientation programme, where staff need to be able to demonstrate skills and understanding of processes, developmental issues and therapies.

(3) Consider making up a 'cheat sheet' orientation for casual staff with the absolutely essential information to manage for a shift on it.

7. LONG TERM ISSUES THE CONTINUING ROLE OF THE BAC

This report has focused on critical incidents and risk management at the BAC. However, a pervasive theme amongst staff, and in the review teams opinion a significant barrier to change at the BAC is the uncertainty of the unit.

The review team encourage The Park and BAC management to activity pursue clarity of this issue. In doing so the review team note contemporary themes, not necessarily core to mental health but clearly related to adolescent mental health, that are reasons why the BAC offers a unique opportunity to severely troubled youth. Firstly most BAC clients have been serially suspended or excluded from the education system. Cessation of schooling confers a further and serious impairment to this client group. The BAC provides a unique educational opportunity for this group, with good evidence of major academic gains being made by clients during their BAC stay.

Secondly, youth homelessness is unacceptably high and the BAC clients are at the severe end of the spectrum of risk factors that lead to homelessness. Without the BAC many of this client group will become homeless and denied a place of safety, therapy and education. In brief without the BAC many of this group will still need accommodation somewhere, but alternative accommodation could not provide the possibility of restoration and rehabilitation which the BAC staff work so hard to provide to a very disenfranchised group of adolescents.

All services should change over time, and the BAC has this challenge. Precipitous action such as closure of the unit without a process of re-orientation with other SE Queensland service units could remove a part of the continuum of care that is extremely difficult to replace and simply transfers the burden to other areas of the wider system.

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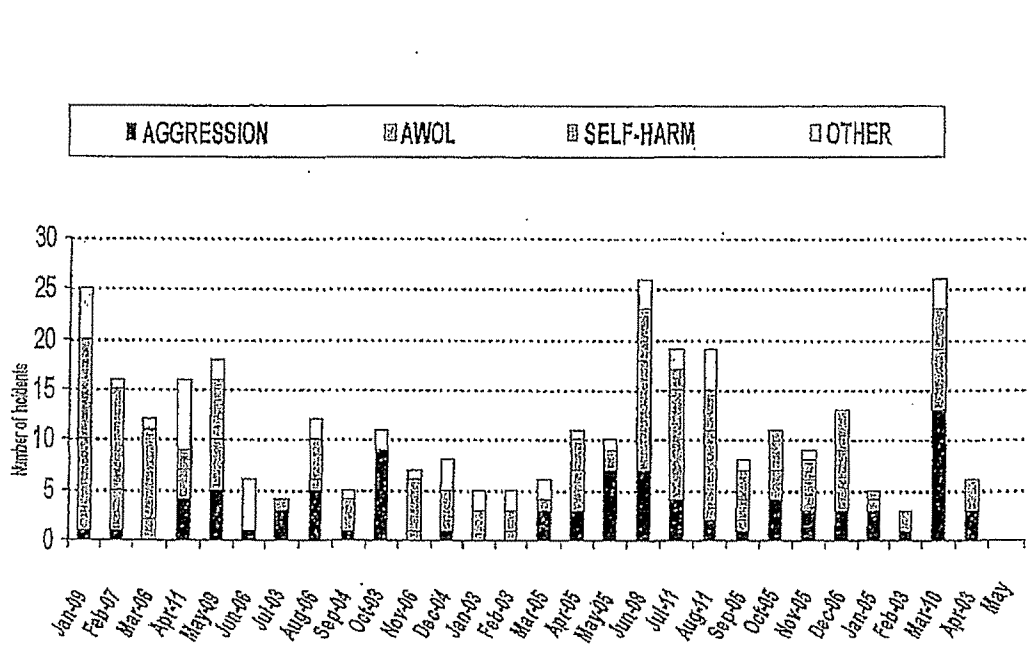
Appendix I: Information provided by the BAC

Figure A1: Summary of Critical Incident by Incident Month.



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2009 REVIEW OF BARRETT ADOLESCENT CENTRE

(Final Report)

Reviewers: Garry Walter, Martin Baker, Michelle George

BACKGROUND

For a considerable period of time, concern has been expressed about the role, function and capacity of the Barrett Adolescent Centre (BAC) to provide an appropriate, effective and safe service for its client group. Most recently, the ACHS indicated concerns about the capacity of BAC to provide safe care. The local governing body has decided that environmental changes (including relocation) are necessary. These have been agreed to and are underway.

The present review has been commissioned in the knowledge that the proposed environmental/geographical shift will take place. The reviewers were asked to focus upon the philosophy and clinical practices of the unit, with a view to assessing whether the unit is safely meeting the needs of the consumer group, and to make recommendations for change and improvement.

PREVIOUS REVIEWS AND REPORTS

ACHS Review

In a recent accreditation survey by the ACHS, BAC received a "High Priority Recommendation" from the ACHS to ensure that immediate modifications are made to improve patient and staff safety. In making this and other recommendations, the ACHS observed:

- Patients admitted to BAC have severe and complex clinical pictures;
- BAC has limited choice over which patients it accepts;
- In the Park Hospital redevelopment, BAC has lost access to facilities;
- There are aspects of BAC's configuration and related building issues that are dangerous;
- There has been an increase in critical incidents;

- There has been an increased use of "Continuous Observation".

The ACHS made a number of other recommendations around staffing and infrastructure needs.

DOH Brief

A brief to the Director General of Health in Queensland noted that the profile of consumers treated in BAC had changed since the opening of the new Acute Child and Youth Mental Health Beds in Queensland and that BAC was now treating more complex and impaired cases. Apparently, the Acute Units are now referring to the BAC if there are no obvious community placement options.

FACT: Since the commissioning of Acute Units, referrals have always been on the grounds of clinical severity, complexity persistence and impairment. Community placement options are not relevant – the only consideration is the need for intensive treatment and rehabilitation.

This has resulted in more complex cases in BAC and even less "referral out" options. In support of this contention is the fact that Average Length of Stay in BAC has risen from four months in 1994 to ten (8) months in 2006.

McDermott Review

This review considered: the impact of critical incidents on BAC; current risks at BAC; BAC management practices, staff, environment and systemic issues; and, BAC responses to critical incidents. The recommendations included:

- Admission criteria and a more clearly defined target group;
- Better Risk Assessment in the admission process;
- Improvement of the risk monitoring process, especially the "Risk Assessment Tool";
- Improving the relationship with other parts of Park Hospital;
- Pro more certainty about the future of BAC.

Also included were recommendations about staff training, whether the unit is open or locked, the material fabric of the Unit, and the role of BAC within Queensland Mental Health Planning.

Community Visitors Report

This report noted that:

- BAC was over Census;
- BAC had clients in it who were over age;
- "The Unit is not of a standard to safely house medium to long term residents";
- "Not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis".

FACT: There is an expectation that as adolescent will participate in groups which are likely to progress their treatment. This is discussed in greater detail in further comments made under Model of Care.

Queensland Nurses Union

The Union had written a letter of concern, specifically around the injuries sustained by a nurse trying to apprehend a client who had run away.

CRITICAL INCIDENTS

In addition to the above reports, the present reviewers were provided with three incidents to consider. The local governing body believed these to be emblematic of the difficult issues BAC faces and expressed a desire for the reviewers to examine these incidents within the broad purpose of the review. These reports related to [redacted] who had been inpatients at BAC for some time. The reviewers found that the incidents that occurred were characterised by the following elements:

[redacted]

- All exhibited severe and complex ;
- All had been given diagnoses that did not seem to adequately reflect the chronicity, severity and complexity of the behaviours;
- Referral on to Adult Mental Health Services or other more appropriate services did not appear to be an option that had been realistically considered for any of the patients.

FACT: This is difficult on two counts.

1. and would not be admitted into an Adult Mental Health Service.
2. The team considered referral to an Adult Mental Health Service for the young . However there were concerns that the Adult Mental Health Service lacked adequate resources to treat mental health disorder..

The reviewers conducted an incident and file review of the cases and have incorporated considerations around the incidents into the broader observations and recommendations of the report.

On the basis of the above materials, meetings with stakeholders and key staff on 26 and 27 February 2009, and attendance at a staff/stakeholder ongoing education meeting, we offer the following observations and recommendations:

FACTS:

1. Time spent with key staff was very limited. Many were running the second part of a Recovery Intensive off site.
2. Two of the reviewers attended part of this, but a part which we thought would be least relevant to them.
3. The value of having a single meeting with a group of ten staff key to many interventions running a two day workshop over lunch is doubtful.

4. Although they met with staff responsible for delivering a number of specific therapeutic interventions over lunch, staff reported that they appeared to be interested in only one particular aspect of the therapeutic program – that of adventure therapy. (We had spent the previous three hours of that morning describing the some of the therapeutic interventions, and more were described the next day – a fairly comprehensive account.)
5. Although an outline of the Model of Service Delivery was presented initially the first day for their consideration, so that they could ask specific questions of the Director the following day, they did not follow up with any questions, nor were interested in exploring it further.)
6. The available nursing staff on the unit on the day consisted predominantly of new staff and casuals with only one experienced staff member in the morning shift, and two on afternoon shift as experienced nursing staff were attending or presenting at the workshop.

OBSRVATIONS AND *RECOMMENDATIONS*

Governance

In terms of both corporate and clinical governance, a number of the usual mechanisms, processes and systems for ensuring proper governance did not appear to be in place at BAC. Specifically, there did ***not*** appear to be:

- Clear lines of responsibility and accountability to senior levels within Queensland Health for the overall quality of clinical care;

FACT: The Park – Centre for Mental Health and the West Moreton South Burnett Health Services District (as the Governing Body for most of the time since the 2003 Review) have always actively overseen the quality of clinical care through a variety of mechanisms. Some of these are documented in the ACHS Reviews of the District.

- Clear local policies that are integrated with wider policies aimed at managing risks;

FACT: The policies utilised by the Barrett Adolescent Centre are those of The Park – Centre for Mental Health and the West Moreton South Burnett Health Services District. These include policies for managing risks. These policies are implemented at the Barrett Adolescent Centre.

- Procedures for all professional groups to identify and remedy poor performance;

FACT: The reviewers noted later in the report that they did not specifically ask about performance reviews. These are regularly conducted for all nursing staff, all health professional staff and the psychiatry registrar. Had they asked specifically, they could have been pointed to documented evidence of processes in place to identify and remedy (within the constraints of Public Service procedures) the poor performance of a few staff

- Much in the way of Quality Improvement activities. A comprehensive approach would include consideration and use of
    - Clinical guidelines/Evidence-based practice;
    - Continuing Professional Development;

FACTS: Unfortunately the terms Clinical Guidelines, Evidence-based practice and Continuing Professional Development refer to complex issues that are not as easily dealt with in two lines. They will be discussed individually:

Clinical Guidelines. Various clinical guidelines are published for disorders or behaviours seen in the adolescents. Reference is made to these individually because the applicability to adolescents varies according to the condition or behaviour.

The RANZCP published clinical practice guidelines for the treatment of Anorexia Nervosa[1] (2004). The treatment approach at BAC was consistent with the recommendations of these guidelines for at least a decade before they were published, with the exception of utilisation of a Dietitian. (We have certainly utilised the excellent services of Dietitians employed by The Park since at least 2004.) At no stage did the Reviewers ask questions about our treatment approaches to adolescents

[1] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*

with Anorexia to determine whether it consistent with these guidelines. These guidelines also raise issues of difficulties with guidelines. They point out clearly the lack of evidence for clear treatment approaches (thus challenging the notion that there are clear evidenced- based treatments). They were also published 5 years before the review was completed. Thus there is a further five years of research on which to build clinical practice. Unfortunately, in the case of management of eating disorders, treatment approaches have not substantially advanced. The most important advance from our perspective is the emerging recognition of the concept of Severe and Enduring Eating Disorders.

The RANZCP has only published guidelines for adults with self harm[2]. As Clinical Leader of the CYMHS Collaborative on Self Harm I concur that the literature supports a distinction between adult and adolescent self harm. Approaches to adult self harm can not necessarily be translated to adolescents. The NICE clinical guidelines on self harm[3] are for primary and secondary care. As far as these guidelines are applicable (given this is a quaternary care environment), our practice is consistent with these guideline. They are currently developing a paper on "*Self harm (longer term management")*, with discussions continuing through until 2011.

The Reviewers were presented with evidence of our treatment approaches in adolescents with PTSD secondary to sexual abuse, including our experience with psychological treatments listed in the Australian guidelines for the treatment of PTSD[4]. (The *Practice parameters for the assessment and treatment of children and adolescents with PTSD* from the American Academy of Child and Adolescent Psychiatry was published in 1998. Although relevant in many areas, it is considered too old to be a credible practice guideline. The NICE guideline[5] is limited, but

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[2] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-harm (2004) Australian and New Zealand clinical practice guidelines for the management of adult deliberate self-harm *Australian and New Zealand Journal of Psychiatry 38:868–884*

[3] National Collaborating Centre for Mental Health Royal College of Psychiatrists' Research Unit (2004) The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care *National Institute for Clinical Excellence National Clinical Practice Guideline Number 16*

[4] Forbes D, Creamer M, Phelps A, Bryant R, McFarlane A, Devilly GJ, Matthews L, Raphael B, Doran C, Merlin T, Newton S. (2007) Australian guidelines for the treatment of adults with acute stress disorder and post traumatic stress disorder *Australian & New Zealand Journal of Psychiatry* 41:637-648

consistent with the Australian guideline.) The reviewers sought no further specific information than what was presented to them.

In summary, recommendations of Clinical Guidelines have been incorporated in day to day practice of the Barrett Adolescent Centre. They are regarded as standards by which to monitor programs, but because of their static nature, not as criteria for improvement.

Evidenced-based Practice. This is a more valid marker of a Quality Improvement Activity. The term is often loosely used, so I will incorporate definitions from the Sicily Statement on Evidenced Based Practice. The process of evidenced based practice is conceptualised in five steps

1. Translation of uncertainty to an answerable question.
2. Systematic retrieval of the best available evidence.
3. Critical appraisal of evidence for its validity, clinical relevance and applicability.
4. Application of the results in practice.
5. Evaluation of performance.

These are particularly important processes in interventions with adolescents with persistent, severe and complex (in terms of co-morbidities and family functioning) disorder with impairment who have already not responded to the more straight forward evidenced based treatments (as far as they exist for many of the disorders we see). The Reviewers recommendations around evidenced based treatments (see later) are indications of the failure to appreciate the clinical relevance, and application of this in practice. Evidence for an evidenced based approach in this population will not be found in asking for a list of treatment approaches for a particular disorder, but rather asking clinicians about the decision making processes around the application of certain interventions at any time, the evidence base for those applications, and what would lead them to choose one intervention at one time for one adolescent, and another intervention for another adolescent.

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[5] National Collaborating Centre for Mental Health Royal College of Psychiatrists' Research Unit (2005) Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care National Institute for Clinical Excellence National Clinical Practice Guideline Number 26

Had the Reviewers asked key staff about the process of Evidenced Based Practice, they would have been shown clear evidence of activities and literature around Steps 1 – 4 of this process. Staff expected to be questioned on this in detail in the limited time that was allocated to spend with the Reviewers, given the nature of the Centre. Limited presentations of some of the evidenced based rationale for our treatment approaches were outlined, but not followed up by the Reviewers. Indeed the Recovery Intensive being run at the time of the Review was a presentation of the incorporation of evidenced based approaches into practice, and developing evidenced based practice in a complex environment.

Evidenced based practice is obviously a quality improvement activity that is ongoing. The volume of literature about any aspect of practice is enormous, so there will always be gaps. However, our biggest challenges are in steps 3 – 5, particularly around application in practice and evaluation of performance, and matching this with the aspects of patient values.

Continuing Professional Development: Had the Reviewers asked to see the Performance Reviews of staff, they would have seen adequate evidence of continuing professional development – supervision both within and out of the Centre, enrolment in higher education, attendance at workshops, conferences, courses, literature reviews, self directed learning (reading journals etc), preparing lectures providing supervision. Staff are regularly informed of upcoming workshops of relevance. Staff are regularly made aware of professional development activities. I am not aware of any regular staff who were asked about their Continuing Professional Development Activities.

- Clinical Audits;

FACTS: A number of clinical audits are conducted by The Park including critical incidents, the use of continuous observations as well as the use of seclusion and restraint. The latter is benchmarked against other adolescent units as part of a State wide collaborative on seclusion and restraint. These are reviewed by management in the Business Unit Meetings, and then discussed with staff. It is acknowledged, however, that a greater range of clinical audits eg, around medication use could be implemented.

- The effective monitoring of clinical care deficiencies;

FACT: All significant incidents (including "near misses") are recorded on Prime, and are reported to the Director and Nurse Unit Manager. In the 15 months prior to the review, there were two incidents which were clear examples of deficiencies of clinical care (although one was not due to deficiencies of staff from the Centre.) one of these resulted in a Root Cause Analysis, the other in a Critical Incident Review. They contained clear comments about deficiencies of care, and the action taken was documented. Both these and other Critical Incident Reviews were available to the Reviewers had they wished to inspect them.

The charts of the three adolescents reviewed by the Reviewers contained numerous examples of critical incidents. Associated with these were extensive documentations of clinical decision making processes pre and post the incident.

- Research (see Appendix 3) and development;
- "Caldicott principles" to manage the collection and use of patient information;

To elaborate, the role of BAC in the hospital and State plan remains unclear. BAC does not feature in the hospital organisational charts, nor is its role articulated in a State-wide plan for child and adolescent mental health services. While patient safety was certainly a priority at BAC, there was a focus on physical environmental issues and less emphasis on a systematic approach that included formal reporting and documenting in the medical record for all incidents, including "near misses", and a process for reviewing incidents to inform staff and to effect change in client management to improve patient safety.

FACTS:

1. All incidents of absconding, self harm requiring medical attention, aggression and change in medical condition (e.g. collapse) are recorded on PRIME.
2. A review of the charts of the three adolescents whom the Reviewers were asked to review (for up to 12 months prior to the Review in one adolescent or

from admission for the other two charts) showed that all significant events (including "near misses" were recorded on PRIME.

3. In addition there was corresponding documentation in the medical record for these PRIME events, although incomplete in one instance.
4. This incomplete documentation was noted in a subsequent Clinical Incident Review.
5. The charts contained comprehensive reviews by either the psychiatrist or registrar, with a review of the management plan. The latter included the development of comprehensive plans documented in the chart.
6. Specific plans were printed and placed in a prominent position in the nurse's station so that all staff were made aware of a consistent plan and approach.
7. These were further reviewed in the next case conference (with associated documentation).
8. A systemic review of the preceding eight weeks of both behaviours and management plans in the Intensive Case Workup was documented.

To support the above process and address other clinical documentation issues, regular reviews of medical records (file audits) are often used in other centres; this did not seem to be the practice at BAC.

FACTS:

1. Clinical chart reviews (currently and at the time of the review) are conducted on a quarterly basis.
2. The results collated by the Nurse Unit Manager.
3. The information is disseminated to staff at a regular staff meeting in the morning.
4. Any particular action taken is compiled in a report compiled and forwarded to the Service Improvement Coordinator at The Park. This is in line with standard procedures at The Park.
5. In addition, the Director reviews charts at Case Conference on Monday for information, and comments on information that is missing, poor documentation, and will speak to staff who fail to write notes. This is an ongoing process.

Policies and procedures sighted had been in place a long time with little evidence of a review of their continued appropriateness.

FACTS:

1. It is unclear where the policies and procedures sighted by the Reviewers were located. It is possible old copies may have not been destroyed.
2. The Barrett Adolescent Centre follows the Policies of The Park which are updated at regular intervals.
3. There are Workplace Instructions governing particular procedures not covered by these policies. They had been written or updated by the Nurse Unit Manager in consultation with staff less than two years before the review. (The computer system had crashed, requiring all policies be re-written).

There did not appear to be a system in place to manage, respond to or analyse complaints either from within the client population in the unit or from the broader community.

FACTS:

1. At a formal level, The Park has clear procedures on managing and responding to complaints from adolescents or their parents. Barrett Adolescent Centre follows these procedures. Documented evidence of complaints and responses to complaints is available.
2. In addition, a Community Visitor from the Children's Commission visits monthly to meet with the adolescents. They provide written reports to The Park and the District.
3. The Children's Commissioner provided annual reports to the Director General and District Manager.
4. Barrett Adolescent Centre was the first CYMHS service to employ a Consumer Consultant (an older adolescent who had been a patient at BAC) to meet with adolescents, help them articulate complaints, and either represent these complaints directly, or support adolescents to voice complaints (and suggestions for improvements) at an monthly Administration Meeting with senior management of BAC. Actions for improvement are noted by staff, and reported back to the meeting the next month with regard to their progress. Minutes of these meetings would have been available to the Reviewers.

5. Finally, a meeting is held with adolescents and staff on four mornings a week to review the day's activities, and raise issues of concern or suggestions for improvement from both adolescent and staff perspectives. These meetings are minuted, and would have been available to the reviewers. The chairing of this morning meeting is the responsibility of the adolescents, as a means of assisting development of meeting skills, co-operation, and empowerment.

While we did not specifically ask about this issue, it is feasible that Performance Reviews are not a regular part of professional practice at BAC and, if they are, they do not appear to be targeted at assisting clinicians to maintain best practice and improve patient care.

FACT: See above comments about performance reviews.

BAC does not appear to have a framework which aligns with State legislation, Queensland Health policy directives, and local protocols governing the credentialing and defining the scope of clinical practice of medical, nursing and allied health practitioners working in the unit.

FACTS:

1. Medical staff. The psychiatrist is enrolled in the Continuing Professional Development program of the RANZCP. He has exceeded minimum requirements for the period he has kept records (2004 – 2009). This is part of his credentialing by The Park (in compliance with Queensland Health policy) as a child and adolescent psychiatrist, although he is not credentialed to administer ECT. Registrar training always exceeds the minimum RANZCP requirements for mandatory supervision.
2. Nursing staff. All nursing staff comply with the policies of Queensland Health policies for registration. Most have mental health endorsement, although this was not able to be a condition of employment in line with local policies. Credentialing for nurses is currently being developed and encouraged, even within the last 12 months since the Review process.
3. Allied Health. All allied health disciplines, (except Social work) have to be registered with the Office of Health Practitioner Registration Board, located in Charlotte Street. All Allied health are required to forward evidence to their Discipline Senior, of their continued registration on a yearly basis. An

> April 2010 draft Queensland Health document[6] states: *"Unlike the process for medical practitioners, credentialing and defining the scope of clinical practice will not be required for all allied health professionals working in Queensland Health due to the rigorous verification processes that occur at point of employment by selection panels. It is the intent of the process that very few allied health professionals will be required to apply for credentialing and defining scope of clinical practice."*

Barrett Adolescent Centre has always complied with State legislation, Queensland Health policy directives and local protocols regarding staffing issues. That stronger credentialing and definition of the scope of practice could assist in recruitment and may promote professional development is undeniable. Such mechanisms for all professional groups are rudimentary at best

In the absence of this framework, aspects of recruitment, the capacity to adopt particular clinical models and a coherent approach to professional development and clinical supervision are all compromised. For example, it was evident that clinical practice at the unit was established on principles that had been developed some time ago. Apart from the external reviews of the unit, there was little evidence that BAC had recently reviewed and audited its clinical model against current accepted best practice and evidence based care.

FACTS:

1. As part of the process of redevelopment, the Mental Health Branch (now Directorate) in March 2008 organised a review of the Model of Care which was presented to senior CYMHS clinicians, including the Directors of most of the acute adolescent inpatient units. The model was presented to a broader forum of CYMHS clinicians in May 2006. The intention of both of these meetings was to provide an external review of the model.
2. The Director has presented the Model at his presentations to CYMHS psychiatrists at quarterly Grand Rounds at Spring Hill in 2007 – 2008.
3. The United Kingdom has a process of unofficial accreditation of adolescent inpatient units against a set of standards[7]. (This is described in Appendix 1,

[6] An Allied Health Clinical Governance Framework in Queensland Health. Discussion Paper (2010) Section 2.2 *Principles of credentialing and defining the scope of allied health professionals*

together with a self rating of how Barrett Adolescent Centre performs against these standards.) This measure provides some objective means of evaluating aspects of the unit. It is acknowledged within the UK[8,9,10] that they do not, provide a guide to the Model of Clinical care underpinning the service. (This is in the same way that the National Mental Health Standards provide a standard for services which allows for a number of differing models of clinical care.) These standards are the closest document to anything accepted as "best practice", although they actually only define some elements of practice.

4. No consensus exists in the literature about "Accepted best practice" for a clinical model. The literature describes multiple models of clinical care of individual units. Many variables are evident in the literature which does exist - some have a mix of acute and long term patients, others operate Monday to Friday, others do not take patients who are regulated or who are of high acuity. Many of these variable are critical to developing a clinical model.
5. Reference is made to the previous comments about developing an "evidence base". Had the Reviewers specifically enquired, they would have been shown the process of developing an evidence base for the unit. The naivety of their comments about "evidence base" will be discussed in more detail later. The evidence base for our clinical model has been drawn from an extensive literature, including that of interventions for particular disorders or behaviours, literature around rehabilitation and recovery, developmental and attachment literature etc. This is totally consistent with the **process** of evidence based practice – asking the question, seeking relevant research, critically examining the research and observing its applicability.
6. The Reviewers were presented with a brief overview of the Model of Care on 26/2/2009, (including the methodology for examining the literature to develop the model, and an evaluation of the impact of this model for adolescents with

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[7] Davies G, Thompson P, Landon G (Eds) (2007) Quality Network for Inpatient CAMHS 4th Edition Royal College of Pyschiatrists.
[8] Gowers SG, Cotgrove AJ, (2003) The future or in-patient child and adolescent inpatient services *British Journal of Psychiatry 183:479-80*
[9] O'Herlihy A, Worrall A, Lelliott P, Jaffa T, Hill P, Banerjee S (2003) Distribution and characteristics of child and adolescent inpatient services in England and Wales *British Journal of Psychiatry 183:547-551*
[10] Tulloch S, Lelliott P, Bannister D, Andiapan M, O'Herlihy A, Beecham J, Ayton A (2008) The costs, outcomes and satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study. *Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSD0)*

histories of severe abuse). This overview was given so that the Reviewers had time to think about it overnight, and ask questions of the Director on the morning of 27/2/2009. They asked nothing about the model – only questions about the impact of the move to Redlands, procedures for selecting nursing staff etc.

Communication around continuity of care of clients in the unit, but particularly between nursing staff on each shift and between shifts, is poor and poorly documented.

FACTS: This statement lacks specifics, with no clarification in the recommendations as to what is meant. One of the Reviewers co-authored a paper[11] reviewing nursing handovers. This paper defined the aims of nursing handover being to directly improve patient care, decrease repeated patient questioning, attempt to reduce errors and enable every clinician treating a patient where the last clinician left off. To achieve these aims, they outline a number of optimal conditions for handover. Handover is in a comfortable room away from high stress environments where confidentiality is assured. It is done at set times, attendance is mandatory, is patient focussed, allows provision for questions, led by most senior nurse, and both reviews the most recent shift as the planning of care for the day. It is preferably multidisciplinary. It allows for staff support and debriefing. The amount of information should be monitored, so that there is enough to be adequate, but not too much to be overwhelming. They also discuss the medium for information – both written and verbal (and raise issues with respect to utilising technology).

The process of communication at Barrett is consistent with these conditions, within the constraints of the nursing conditions at The Park (8 hour shifts potentially do not allow for handover). This is addressed in part by staggered shifts to ensure some overlap. There are nursing handovers from night to morning, and from morning to afternoon staff. The biggest potential loss of information is not between shifts, but across shifts – incidents form the previous evening may not be adequately communicated to staff the next day.

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[11] Cleary M, Walter G, Horsfall J 2009 Journal of Psychosocial Nursing and Mental Health Services 47:28-33 Handover in psychiatric settings: is change needed?

In addition, there is a formal multidisciplinary handover on four mornings a week (the Monday Case Conference replaces this handover). The Reviewers had access to the Report books which contain a summary of relevant information for each patient, which is supplemented by verbal information.

Clinical Model

Noting that the clinical population serviced by BAC has changed in recent years (with a greater proportion of more severely ill clients, extensive comorbidity etc), one of the major problems is the apparent lack of evidence-based treatments employed by the unit. (See Appendix 2)

The reviewers had a number of interventions described to them; however, Milieu Therapy and Adventure Therapy were the two overriding interventions highlighted as encapsulating the clinical approach of the programme.

FACTS: Adventure Therapy and other Therapeutic Interventions. The Reviewers spent only an hour over lunch at a workshop we were running with 6 staff involved in delivering specific therapies. Only two of these staff were involved in adventure therapy. Adventure therapy is less than 15% of the time spent for these two clinicians in the total of their therapeutic interventions. Components of the adventure therapy program are run on 20 days a year. Given the limited number of staff involved and limited time devoted to Adventure Therapy, it is hardly likely they would have given the Reviewers the impression it was a major component of the service.

Had the Reviewers taken the opportunity to ask all of those staff and the Psychiatrist, about therapeutic interventions, a range of interventions would have been described including a range of CBT based therapies, some interventions from a more psychodynamic perspective for adolescents with backgrounds of trauma (including utilisation of different media e.g. art, sand play), family therapy, a range of group interventions (including DBT), behavioural interventions for anxiety disorders,

interventions specific to a range of Occupational Therapy interventions, specific interventions by nursing staff for symptoms of trauma which occurred more often in the evening and night..

Entries in the Clinical Record (including the three available to the Reviewers) of specific interventions are clearly marked "Care Coordinator", "Family Therapy", "Individual Therapy", "Groups", "Occupational Therapy", "Speech Pathology" etc. In the charts available to the Reviewers, there is clear documentation of the content of individual sessions with adolescents which make it clear in most cases about the nature of the intervention, and processes or goals of that session.

Milieu Therapy: It is acknowledged that the term "therapeutic milieu" has resulted in understandable confusion, although it is used in a general sense in a similar way in the child and adolescent inpatient literature[12,13]. We have deliberately chosen an environment which is not similar to that of "Milieu Therapy". Barrett Adolescent Centre is definitely not run as a "Therapeutic Community". The following outlines our approach to the environment or "milieu" in which adolescents live. This environment is not simply a passive context for therapeutic and rehabilitative interventions, but has the potential to enhance those interventions and provide an intervention in itself for rehabilitation.

1. Severe, persistent and complex mental illness in many adolescents is associated with impairments in adolescent development – the ability to negotiate school, develop peer relationships, develop competencies for independence, adequately care for themselves, develop organisational skills, occupy leisure skills, plan for the future, individuate from families, achieve moral maturities, identify and explore boundaries etc. These moratoriums on development then perpetuate the mental illness or may engender others – e.g. prolonged absence from school secondary to persistent depression may be associated with secondary social anxiety.

[12] Green J, Jacobs B, Beecham J, Dunn G, Kroll L, Tobias C, Briskman J (2007) Inpatient treatment in child and adolescent psychiatry – a prospective study of health gains and costs *Journal of Child and Adolescent Psychology and Psychiatry 48:1259-1267*

[13] Jacobs B, Green J, Kroll L, Tobias C, Dunn G, Briskman J (2009) The effects of inpatient care on measured Health Needs in children and adolescents. *Journal of Child and Adolescent Psychology and Psychiatry 50:1273-1281*

2. The difficulties many adolescents have being able to recognise, identify, and appropriately express emotions contributes to the perpetuation of their mental illness.
3. The literature on rehabilitation in adolescents is relatively sparse, but there is an extensive literature on adolescent development. We have identified from this developmental literature 14 tasks of adolescent development (some of which are listed in point 1 above.
4. We use these 14 tasks as a framework to assess an adolescent's functioning in each task to gain a profile of strengths and impairments. This is an application from standard developmental literature to adolescent rehabilitation, given the lack of literature.
5. The BAC utilises numerous interventions to specifically address many of these developmental moratoriums.
6. There is an important non-specific opportunity to use the day to day routine, the day to day structure and underlying principles and regulations governing the unit to actively promote adolescent development rather than simply provide custodial care.
7. As well as day to day routine, the daily adolescent-adolescent interactions provide opportunities to promote various tasks of adolescent development e.g. social development, boundaries, moral development, leisure etc.
8. Adolescent-staff interactions in day to day life are also important in enabling the adolescent to reflect on qualities of parenting which may have been a major contributing factor to their current mental state.
9. Interactions with staff and other adolescents inevitably will arouse some emotions which the adolescent has found confusing in the much closer family context. These can be discussed with care co-ordinators, staff they trust at the time and with their individual therapist.
10. The day to day environment also provides opportunities to generalise skills learned in other tailored interventions.
11. Regular meetings between staff and adolescents enable the adolescent to have an input into their environment which contributes to their development of life schemas.

These apparently unstructured, but thoughtfully considered processes in points 6 – 11 describe what was referred to as the "therapeutic milieu". Nursing staff typically oversee these periods. The fact that it requires the observational, conceptual, assessment and capacity to implement interventions of the registered nurse rather than semi-skilled carers is an indication of the level of this intervention. It is an important component of the therapeutic and rehabilitative process. All elements are drawn from published literature, although not from one single comprehensive model. It awaits being given a more suitable name which encapsulates all of the above functions.

There is no doubt that while the value and nature of these interventions have been understood and incorporated into day to day interactions by many senior and key staff, this "therapeutic milieu" requires a less confusing name, better articulation, and specific training of staff.

Typically, **Milieu Therapy** is a form of psychotherapy that involves the use of therapeutic communities. It has been used as a viable treatment modality for children for over fifty years in residential and inpatient settings. Milieu Therapy is potentially a powerful therapeutic tool when individual dynamics and the social system can be combined in a planned and meaningful way to manage and change behaviour and relationships in settings such as BAC.

COMMENT: There is an overlap between what was described previously as occurring in the day to day environment of Barrett and the thrust of Milieu Therapy as described by the Reviewers in last sentence of the above paragraph. There are two fundamental differences. The program at Barrett is more structured, with more directions from adults compared to traditional Milieu Therapy. Secondly, group dynamics and interventions (particularly reflections on the intra-group dynamics in the milieu and group decision making) play an important role in Milieu Therapy, This contracts with the milieu at Barrett where interventions by nursing staff are much more individualised, so that the adolescent is assisted to progress and implement new skills within the context of the milieu.

There was little evidence presented to the reviewers that Milieu Therapy at BAC is a planned intervention in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence.

FACTS: Multiple lines of evidence were available to the Reviewers of planned specific interventions for enhancing social skills and building confidence which are generalised through the everyday events and interactions. These would be documented in the clinical record as joint interactions between the care co-ordinator and the occupational therapist, psychologist, speech pathologist, teachers etc, and communicated to other staff via specific plans or in case conference and reinforced within the intensive case workup.

Rather, the evidence and the finding of the reviewers was that afternoons and evenings are unstructured times with no program and that the BAC nursing staff are not engaged in this type of therapy, partly because they are not trained in it and partly because they spend much time in the continuous observation of clients.

FACTS: There are three issues here.

1. Structured activities e.g. groups, do occur in the afternoon into early evening on two afternoons a week. These groups were certainly running in February 2009. Little is planned on Friday afternoons because of the variable times a number of adolescents go on leave.
2. This is balanced against the need to make some time available for individual therapies and assessments outside of school time, as there are already a number of incursions into that time. These are scheduled into the other two afternoons of the Monday – Friday week.
3. All week day evenings contain some structured time for homework both to support the school program and because this is developmentally normalising.
4. During the so called "unstructured time" in the evening and on weekends, a range of interactions between nursing staff and adolescents occur. Some of these are planned e.g. an outing, a particular activity in which some adolescents are interested. These activities generalise the effects of specific group processes with respect to social interactions, leisure skills etc as well as generalising therapeutic interventions for anxiety etc.
5. The comments about nursing staff spending so much time on continuous observations is a clear indication by the nursing staff of their awareness of the impact that the lack of these interactions has on those adolescents for whom they are not available.

6. A decision was made some years ago to incorporate unstructured time into the program because adolescents going home on leave to unstructured environments retreated back to isolative activities, without knowing how to fill that time. We considered this to be more developmentally normalising, than providing structure throughout the evening and weekend.
7. Although nursing-adolescent interactions are important during this unstructured time, it is also important to provide opportunity for adolescent-adolescent interaction with supervision that it is maintained within appropriate parameters. Adolescents who have been socially isolated for lengthy periods typically find it easier to interact with adults than with peers. Ensuring there are opportunities for peer only interactions is important to overcoming social isolation outside the unit

Adventure Therapy is the creation of opportunities to explore the unknown in a safe environment through team based adventure activities. This therapeutic approach has the capacity to engage adolescents and young people. There is a small body of literature about the intervention and, while the data about effectiveness from that literature is equivocal, its use at BAC is not contraindicated. Its drawbacks, however, are that it is not an activity that can be intensively introduced into the day to day running of the unit and that as a stand-alone intervention its outcomes are poor.

COMMENT: We would not disagree with any of these observations about adventure therapy, although only partially describes the adventure therapy program at Barrett. As was noted previously, it is not a major intervention, but rather one which is considered as facilitating other, more primary interventions. The literature is indeed equivocal at best. All the literature we have examined has considered the outcomes of Adventure Therapy as a stand alone intervention. We incorporate it into our program on the basis of A-B-A outcomes in an individual (which varies from individual to individual and from disorder to disorder). It is has many components, some of which are described above.

It is noted that the loss (as reported in early reviews) of positions and facilities will have compromised the capacity of BAC to successfully implement structured out of hours activity and the Adventure Therapy Programme.

FACTS: The loss of positions and facilities has had an impact on structured out of hours activities, but not the Adventure Therapy Program.

The A1-A7 programs are behaviour management programs employed to manage difficult and challenging behaviours. It has been previously noted that they have been used for many years without documented evidence that they are effective or that they have been systematically reviewed.

FACTS: The A1-A7 programs are a relatively minor part of the overall behavioural management program. Individual programs are a greater component, and were very much evident in the charts which the Reviewers reviewed. This is consistent with a fundamental principle of behaviour management programs that they are designed around an individual after an assessment of behaviour.

There is also a requirement from an adolescent's perspective that staff responses are consistent and perceived as being fair. This is the place of the A1-A7 programs for reinforcing the basic rules of the Centre. There can be tensions between the principle of providing individual behaviour programs and the principle of having a consistent response to challenging behaviours.

The A1-A7 programs are basic programs in managing a range of behaviours e.g. self harm, absconding, aggression, teasing, smoking etc. Adolescents are not automatically placed on a program when a behaviour is first manifest. The first decision is whether one of these programs is the most appropriate response. For example, the most appropriate response to the first incident of self harm may be being placed on continuous observations. An incident of physical aggression may result in an interview with police, and suspension from the unit rather than being placed on the A1 program.

Basically the programs describe a change in access to a range of activities available to the adolescent over a period of 24 hours. Modifying access to these activities has the potential for that behaviour being repeated. The effectiveness of this program is reviewed after a 24 hour period. Contrary to the Reviewers comments, this is then documented in the chart at the end of the 24 hour period, and patterns of behaviour over a week are reviewed at Case Conference, and documented in the chart. The

programs provide some process of uniformity of approach from the adolescent's perspective.

If behaviour continues beyond the 24 hour period, or patterns of behaviour are noted at the Case Conference to exist, individual behaviour programs are developed in consultation with key staff – typically the Care Coordinator, the psychologist and the Registrar or Psychiatrist. These are documented in the charts, and often individual behaviour programs are drawn up and displayed in the Nurses Station (with a copy in the chart).

The Reviewers examined charts of three adolescents. These contained many incidents of behaviours with a potentially damaging outcome for the adolescent or others. Instances of the use of the A programs was rare – mostly we relied on individual behaviour programs specific to that adolescent, with a clear indication of expected outcomes, documented evidence of reviews of the behaviour and the outcome.

In summary, comments about the A programs need to be considered in the context of their documented reviews at the time, and their rather limited scope in the range of behavioural interventions utilised at BAC.

A previous review conducted in 2003 recommended the BAC close the programs for several days each year to invest time in program review, management, procedural and training issues. There is no evidence that this recommendation has been acted upon.

The recommendation made previously (2003) to close the program for several days to undertake review and development activities is considered to remain integral to the successful functioning of BAC.

Behaviour management plans continue to have a place within the clinical model in managing difficult behaviours; however, these plans may benefit from being individualised more, and eliminating their availability in pre-typed form that serves to inhibit consumer and staff creative problem-solving skills.

FACTS: The clinical records which the Reviewers were asked to Review contained multiple examples of highly individualised behaviour management plans, with

evidence of monitoring outcomes and adjusting the plan according to the outcome. Any variations or decisions not to follow through with a particular plan were documented in the chart. There was clear evidence in these adolescents with complex behaviours that behaviour programs were overwhelmingly individualised rather than using pre-typed forms.

Time and effort could be directed at identifying interventions, other than continuous observation, that are suitable for maintaining the safety of consumers and others when consumers present with severe behavioural disturbance. Pursuing the idea of a high dependency unit may prove to be the most judicious use of human and financial resources.

FACTS: There was evidence available to the Reviewers of multiple interventions aimed at managing risk other than continuous observations (mainly used for severe and recurrent self harm). These include the use of high acuity, limiting areas into which they could go where they would be likely to harm themselves etc. The nature of much of the self harm e.g. attacking wounds, insertion sites for fluids etc means that even in a high dependency area, continuous observations would still be required. This has been borne out by clinical experience with the high dependency unit built at about the time the report was completed.

Recommendations about unstructured periods of the day made here are reiterated from those made in the previous review (McDermott et al, August 2003, p 40) that the risk of critical incidents occurring could be reduced by ensuring small group sizes and structuring time outside of school hours with therapeutic group activities.

FACTS: Issues around unstructured time were mentioned previously. This comment relates to the risk of critical incidents occurring during unstructured time.

1. Of 18 critical incidents occurring in the six months prior to the review, 10 occurred in structured time (0800 – 1700 hours).
2. 4 of the 8 incidents occurring in the period of "unstructured time" (1700 – 0800 hours) were reports of self harm by adolescents returning from leave.
3. The other 4 critical incidents from 1700 – 0800 hours of were self harm. There is a clear clinical pattern in adolescents who have been abused reporting increased levels of trauma related symptoms in the evenings which are related to the self harm. At times they utilise the activities in the unit to

distract themselves in these stressful periods. At other times they are overwhelmed by the symptoms.

4. Attention is drawn to a paper around critical incidents from the Rivendell Unit[14] in which at lest one of the Reviewers worked. This describes a not dissimilar pattern of critical incidents. Half the critical incidents (mainly aggression) occurred during structured times. Self harming incidents occurred more in the evening. However any acknowledgement of increase in trauma related symptomatology was conspicuously absent in this paper. This is in part related to the difficulties this unit had in managing these adolescents on a Monday to Friday unit, where they required admission to either an acute adolescent inpatient unit or an acute adult unit.
5. The evidence available to the Reviewers does not support the claim that critical incidents were related to periods of unstructured activities.

The therapeutic milieu and adventure therapy style interventions may be utilised - the important aspect here is that they are planned and integrated into a holistic therapeutic approach

FACT: There was ample evidence available to the Reviewers that they are.

It is worth emphasising that while it may be argued that the various types or aspects of treatment – Milieu Therapy, Adventure Therapy - described above have a role, these should not be the cornerstone of a contemporary treatment program, nor the optimal "model of care". For example, patients with eating disorders may benefit from using the "Maudsley Eating Disorders Model", those with challenging personalities may warrant Dialectical Behaviour Therapy (DBT), etc.

FACTS: There is no disagreement that Adventure Therapy and Milieu Therapy should not be the cornerstone of a contemporary treatment program. They never have been a cornerstone at Barrett, although thinking through the various aspects of the milieu is a core part of the program,

The Reviewers propose alternate cornerstones namely two therapies specific to particular clinical issues. The Maudsley Eating Disorders Model is regarded as the

[14] Barton G, Rey JM, Simpson P, Denshire E (2001) Aust NZ J of Psych 35:155-159 *Patterns of critical incidents and their effects on outcomes in an adolescent inpatient service.*

closest to being an evidence based treatment for eating disorders in adolescents. DBT has an evidence base in the treatment of dysregulated behaviours in adults with Borderline Personality Disorder. Recommending these therapies highlight some issues with evidence based treatments in practice which are rarely made explicit.

1. In recommending these treatments, the Reviewers did not seem to appreciate that Barrett Adolescent Centre is a quaternary service. One could anticipate that as these approaches are most commonly recognised, they will have been tried in community CYMHS and acute adolescent inpatient units in the 12 – 24 months before the adolescent is admitted to BAC.
2. The Reviewers seem to be unaware of both the limitations in any treatment described in the literature to be effective for all people with a disorder and also the gap between treatments described in the literature for a disorder and difficulties in treating that disorder when it is severe and persistent. For example, the Maudsley model involves stages of family therapy over a period of time (around six months) according to gains in weight. Nowhere does the relatively sparse literature on the model describe repeated cycles of the treatment when the disorder relapses. Yet this is implied in the Reviewers recommendation
3. The Reviewers appeared to be unaware of potential difficulties in the application of an essentially adult based disorder (DBT) to adolescents. A literature is emerging, but even so there can be difficulties in its application I practice (a cornerstone of evidence based practice. Had they asked, the Reviewers would have been informed of our experience with DBT, the difficulties in its use with adolescents, and how the core elements have been adapted for adolescents at BAC. Among the difficulties we have encountered in adapting it to adolescents are difficulties in recognising emotions, difficulties in monitoring cognitions and difficulties for those who have experienced abuse in tolerating increased levels of awareness. Had they asked, they would have been informed of a capacity to utilise a therapeutic intervention at one stage of treatment which they had not been able to utilise some months before.
4. The Reviewers appeared to be unaware that although the two mentioned have an evidence base for the treatment of the specific disorders, there are in fact multiple types of single interventions are described in the literature as being

effective for a range of disorders. These trials of interventions either involve small numbers, or have no control groups. For example, Motivational Enhancement Therapy and Acceptance Commitment Therapy have both been described in the treatment of an eating disorder. Whilst the evidence base is not as strong, they may have a role in a particular adolescent. Our approach has been to encourage staff to gain expertise in a range of interventions, so that they can be adapted to a particular adolescent.

5. The Reviewers appeared to be unaware of an implicit paradox in the literature between evidence based treatments and clinical guidelines. For example, the RAZCP Guidelines on Anorexia Nervosa[15] describe a range of interventions delivered by a multidisciplinary team (including a Dietitian) in the management of anorexia. In contrast, the treatment literature describes single modes of intervention. Neither the Maudsley Model nor CBT-E includes a Dietitian in their approach. It is clear from a careful examination of the literature that the Maudsley Model is applicable to a sub-set of the whole population covered by the Clinical Guidelines.
6. The Reviewers ignore the considerable literature which attempts to examine the complexities of how measuring and describing the interaction of multiple interventions which clinicians in many settings utilise for those with more severe and persistent disorder. Because of these complexities, the level of evidence base for multiple interventions will never approach that for single interventions. The failure to recognise this ensures that interventions for adolescents with severe and complex illness will always lag behind those with less severe forms of disorder.

Finally a previous review noted that "not all the young people participate in all of the programs. The young people are encouraged to choose the groups they are comfortable with on a voluntary basis" While appreciating that attainment of autonomy is an important task of adolescence, the reviewers believe a more directive approach about treatment in agreement with the client will be more productive.

[15] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Anorexia Nervosa (2004) Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa *Australian and New Zealand Journal of Psychiatry 2004; 38:659–670*

FACTS: These comments are based on comments from the Community Visitor's Report, not from interviews with staff. The process of developing and participation in groups is outlined below.

1. Adolescents are assessed with respect to a range of skills, needs, emotional problems etc. Group interventions are designed around the needs of groups of adolescents (this different groups will be run from time to time to meet the needs of a group of adolescents).
2. Clinicians decide which adolescents will participate in any particular group. Factors taken into account in forming a group include clinical need (as outlined above), risk issues, benefits from any previous similar groups, potential for negative adolescent-adolescent interactions for particular combinations of adolescents, potential for disruptive behaviours.
3. Adolescents are informed about their inclusion or non-inclusion in the group.
4. Participation is mandatory if the group is regarded as core to their treatment or rehabilitation, unless there is a clinical reason not to e.g. level of risk has changed.
5. A suitable behavioural management program is implemented for non-participation in a group due to simple non-compliance.
6. The only exception have been where the level of anxiety involved in participation are greater than initially assessed, and the adolescent would be likely not to benefit. An example is an expressive arts group where an abused adolescent may be exceedingly fearful that participation may result in expressions in art about their abuse which they were not able to cope with exploring at that stage.

Recommendations:

1. The recommendation made previously (2003) to close the program for several days to undertake a review and development of a model of care is reiterated.

Nursing Model of Care

It is unclear which model of care the nursing staff at BAC are presently utilising. However, it appears that the Functional or Task Allocation model may be closest to reflecting how the team are functioning. In this model, the nurse is allocated tasks to complete, rather than patients to care for. The particular tasks that may be allocated to a nurse working at BAC include continuous observation, medication and escort.

The *Queensland Health Nursing Model of Care – Toolkit for Nurses* (2003) notes that while this model may useful in situations where there is a staffing crisis or that it may be more efficient for certain care, its weaknesses include depersonalised care, ritualised and repetitive tasks, and reduced job satisfaction.

FACTS: Barrett Adolescent Centre for many years utilises the Primary Nurse Model with components of the Case Management Model. This would have been clear to the Reviewers with multiple entries in the clinical records they had at their disposal marked "Care Coordinator" and signed by the relevant staff member with RN besides the name. In addition one of the Reviewers worked for several years at BAC in this model. They were very proficient in the role of Primary Care Nurse, did Case Management and should have been well aware of these roles. In addition the other two Reviewers attended a section of the Recovery Intensive where the Nursing Model was presented, and ways in which it could be generalised to community settings discussed.

These models are used in combination to facilitate a supportive environment and high standard of care for adolescents in longer term care with a stable core of staff. Adolescent and staff needs can be addressed on a shift basis. According to the *Queensland Health Nursing Model of care – Toolkit for Nurses (2003)* the strengths of the Primary Nursing Model are:

- Continuity of care, better discharge planning
- Improved patient satisfaction
- Professional satisfaction – more sophisticated nursing skills developed
- Works well in mental health etc.

The potential weaknesses (with comments in the Barrett environment in parentheses) are:

- Needs full time staff to work well *(Generally stable staffing at BAC with average lengths of stay in excess of two years. This may have not been as evident to the reviewers as a number of longer term staff had resigned in the preceding twelve months.)*
- Assumes longer length of stay *(therefore applicable to BAC)*
- Resource intensive – all RN workforce with high level of skill *(therefore applicable to BAC)*
- Lack of variety –care of same patients/long inpatient stay *(because of the active rehabilitation/treatment environment, the reverse is true – it enhances professional satisfaction)*
- Medical staff may resist due to perceived loss of control *(the reverse is true – the Director perceives the value to enhanced patient outcomes by having a skilled nursing staff whose professionalism is stimulated by the role)*

Aspects of the Case Management Model relate to continuity of care into the community and when the adolescent is on trial leave, or changes status from full inpatient to either partial hospitalisation or day patient. According to the *Queensland Health Nursing Model of care – Toolkit for Nurses (2003)* the strengths of the Case Management Model are:

- Patient centred
- Better for chronic illness
- Better transition to the community
- Improved quality of care for the patients
- Early intervention – prevent readmission

The potential weaknesses (with comments in the Barrett environment in parentheses) are:

- Attachment of nurse, patient and patient dependence on nurse. *(Adolescents have inputs from a number of staff besides the care co-ordinator. This minimises the risks of attachment to an individual. On the other hand, where an adolescent has experienced disrupted attachments over a considerable period, the Primary Nurse Model and Case Management Model enables stability and the opportunity to work through issues pertaining to the qualities of parenting they have experienced.*

Each patient is assigned a Case Coordinator (CC), a Registered nurse, who is responsible for the Coordination of care from the time of admission until discharge. It is felt that this model is best for continuity of care, consistency, development of a therapeutic alliance with the patient and allows for ongoing contact with the patient following discharge. In addition it helps to streamline communication with the multidisciplinary team, primarily through the weekly Case Conference meetings and the bi-monthly Intensive Case Workups. On a shift-by-shift basis the Case Coordinator or associate (registered nurse, enrolled nurse) is the main contact for the patient and at times when they are not on shift the Clinical Nurse acts as 'surrogate CC'. When the CC is on leave a detailed handover is given to an acting CC who fills the role in their absence. Care co-ordination is a means of advocating for the adolescent, providing personalised care and adds to job satisfaction.

The allocation of tasks is part of the day to day management of any inpatient nursing environment. Task allocation is seen as the most practical and safe way to effect certain tasks on a daily basis:

- Risk Management. Both continuous and intermittent observations are shared amongst the staff as evenly as possible according to a roster drawn up by the CN at the beginning of each shift. In line with The Park observation policy, staff are not allocated more than two hours continuously (in practice usually one hour); or more than four hours total per shift (usually less) of continuous observation. The same consideration is given to the allocation of intermittent observations.
- There is a "clinic nurse" assigned to medications, first aid, physical obs etc. This is rostered among RNs on a shift by shift basis. This leaves less room for medication error through miscommunication.
- A nurse is assigned by the Clinical Nurse on shift to carry a two way radio to respond to duress alarms
- If a heightened need for consistency is identified, a patient may be assigned an 'allocated nurse' for each shift.

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