EXHIBIT 119

# Mildred Creak Unit Patient Journey

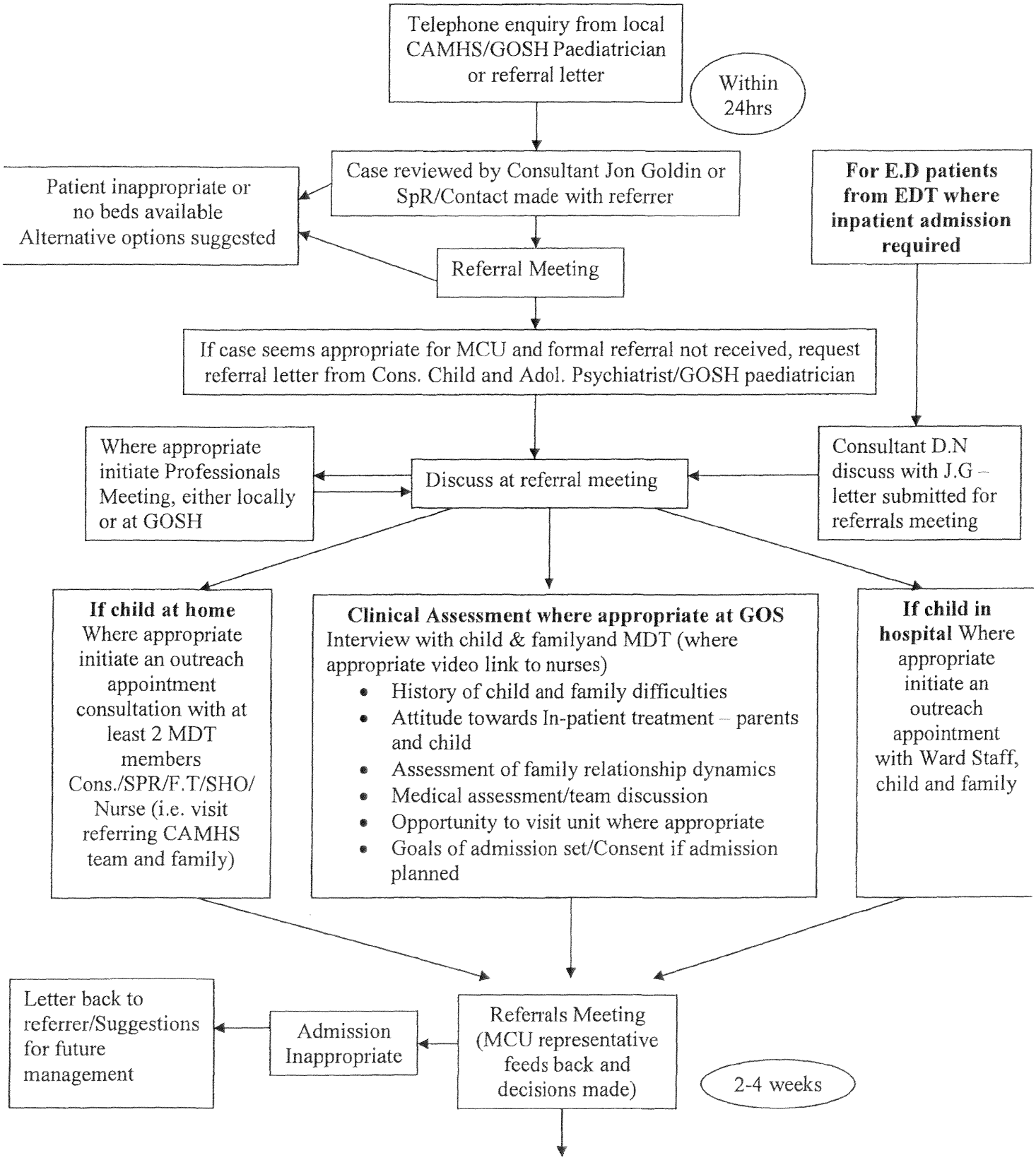

EXHIBIT 119

Admission date offered to family/Pre-admission day visit to unit arranged where helpful

**Pre-admission Home Visit by Keyworkers/Doctor**

- Observing the family in home environment
- Finding out about child's home life, dietary requirements, hobbies, bedtimes, likes and dislikes etc.
- Answering questions and giving info re: admission
- Offering support and reassurance
- Day visit for child to unit arranged where appropriate
- Keyworker to discuss with senior teacher and initiate school liaison

Summary sent to MDT/Referrer and discussed in Ward Round prior to admission

**On Admission**

- Arrives with family, met by nurses/keyworkers and buddy – given timetable for first day and weekly in-house programme
- Meet with other children, unpack and settle into new environment
- Meet with members of team, family therapist, individual therapist, doctors, teachers etc
- Admission clerking by SHO and Nursing Assessment
- Admitting by Keyworkers/Nurse – consent forms signed by parents
- Care plans drawn up by key workers and kept in nursing file
- Review date set for 6-8 weeks – agreed with family (CTM/JG)

**In-Patient Treatment**

- Child attends weekly programme including school (unless child has school difficulties and may need gradual integration)
- Eating disorder patients attend integrated E.D programme alongside other MCU patients
- Child attends individual therapy, keyworker sessions, family therapy, doctors session weekly and group sessions
- Core team meets every 1-2 weeks to discuss child's care plan details and any requests made by child
- Child's treatment reviewed weekly by wider team in Ward Round and recommendations made – feed back to family and child by keyworkers/junior doctors
- Regular (monthly) meetings with Consultant/Core Team Manager and parents
- The first 6 weeks leading up to the initial review is an assessment period where MDT, child and family decide whether ongoing treatment on MCU is indicated. Initial review will conclude this assessment and refine goals of admission.
- Formal review date set every 6-8 weeks – attended by MCU team, family, referring team representative, local school representative (with parent's permission), local CAMHS/Social Services/Paediatrician. Attended in part by child. Further treatment and goals of admission reviewed/discharge planned. Next review date set.

EXHIBIT 119

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# Adolescent Extended Treatment & Rehabilitation Centre Model of Service

## Queensland Public Mental Health Services



Queensland Government

## The model of service template - Queensland public mental health services

- The model of service (MOS) template used in the development of this service component is part of a larger document that will describe public mental health services in Queensland.

- The template for the individual MOS has been developed utilising the UK Department of Health document 'Mental Health Policy Implementation Guide - Community Mental Health Teams' [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_085652.pdf]

- A model of service is being developed to describe each team/service component of the public mental health service in Queensland. It is a 'living' document.

- At this time there are 30 MOS in various stages of development.

- The finalised MOS will:
    - be visionary – the aim is not to describe what currently happens in services but describe what services should be aiming towards in the next five years (2015)
    - include content that describes evidence based best practice
    - include content that is clinically driven, positive and inclusive
    - clearly state targets to measure change and provide a benchmark.

- The attached 10 point template must be used when completing a draft MOS for a service component or team.

- The key components in the table can be adapted to describe the key functions of a particular service. Language that is definitive, succinct and action focussed should be used. Dot points are fine.

- Generic information regarding the Queensland public mental health service will be addressed in the introduction to the MOS document e.g. role descriptions, where to find a service, policy and practice frameworks.

Please note that all drafts need to be forwarded to Leianne McArthur prior to broad dissemination.

For more information, please contact the A/Manager of the Model of Service Project – Leianne McArthur at Leianne_McArthur@health.qld.gov.au or 0439924992.

# Adolescent extended treatment and rehabilitation centre model of service

## 1. What does the service intend to achieve?

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

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

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

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

The key functions of an AETRC are:

- to plan an admission to accommodate the individual characteristics of adolescent.
- ensure a level of admission consistent with least restrictive care and capacity to access the service. Level of admission will range from day admission to partial hospitalisation to providing 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment.
- build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending AETRC
- flexible and targeted programs that can be delivered in a range of contexts including individual, school, community, group and family.
- provide
    - individually tailored,
    - targeted,
    - phased,
    - evidence based

  treatment interventions to alleviate or treat distressing symptoms and that will ultimately assist recovery and reintegration back into the community
- provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness
- provide intensive support to enable successful transition back to the community. This will include the provision of step down accommodation for adolescents who cannot return home, who are in transition to the community and who remain in need of substantial clinical care while preparing for independent living in the community

The aim of these functions of the AETRC contribute to:

- targeted, phased treatment and rehabilitation incorporating a range of therapeutic interventions delivered by appropriately trained staff.
- assertive discharge planning to integrate the adolescent back into their community and appropriate local treatment services.

The principles underlying these functions of the AETRC are to:

- provide care in the least restrictive environment appropriate to the adolescent's developmental stage
- develop treatment and rehabilitation programs in partnership with adolescents and where appropriate their parents or carers.
- provide treatment and rehabilitation with an appropriate timeframe. (In specific cases when the admission exceeds 6 months the case must be presented to the intake panel for review 6 month after admission).
- provide varying levels of care on the basis of acuity of behaviours associated with mental illness; with consideration for the safety of self and others and after consideration of the adolescents capacity to undertake daily self care activities
- assist with establishment of care systems for transition to the community

## 2. Who is the service for?

The AETRC is available for Queensland adolescents:

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

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

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

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

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

- Adolescents with persistent psychosis who have not responded to integrated clinical management (including community-based care) at a level 4/5 service.

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

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

- the AETRC director/delegated senior clinical staff
- referring specialist and/or Team Leader
- representative from CYMHS in the relevant districts.
- representative from Education Queensland
- other identified key stakeholders (including local CYMHS as required)

In making a decision the panel will consider the:

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

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

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

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

Some young people may pose considerable risk to others. Admission to AETRC will be decided on an individual case basis by a multidisciplinary review panel.

Admission risks include but are not restricted to:

- substantiated forensic history of offences of a violent or sexual nature
- adolescents with Conduct Disorder
- ongoing significant substance abuse

When determining the admission of adolescents where recurrent absconding is a significant risk, the likelihood that the adolescent will experience a positive therapeutic outcome needs to be considered.

In specific cases when the admission exceeds six months the case must be presented to the AETRC panel for review following the initial six month admission.

Treatments provided by the ADP will be based on evidence based practices tailored to meet the individual's mental health needs. Interventions will be delivered by appropriately skilled multidisciplinary staff that has access to professional development and clinical supervision.

The AETRC is gazetted as an authorised mental health service in accordance with Section 495 of the Mental Health Act.

### 3. What does the service do?

The key components of an AETRC are defined here. These components are essential for the effective operation of an AETRC.

Table 1: Key components and elements of an adolescent extended treatment and rehabilitation centre

| Key component | Key elements | Comments |
|---|---|---|
| **3.1.0 Working with other service providers** | 3.1.1 The AETRC will develop and maintain strong partnerships with other components of the CYMHS network. | • At an organisational level, this includes participation in the Statewide Child and Youth Mental Health Sub Network. |
| | 3.1.2 Shared-care with the referrer and the community CYMHS will be maintained. | • In the provision of service this includes processes for regular communication with referrers in all phases of care of the adolescent in AETRC. |
| | 3.1.3 The AETRC panel will develop and maintain partnerships with other relevant health services that interact with adolescents with severe and complex mental illness. | • This includes formal agreements with health service district (HSD) facilities (paediatric and adult health services) and/or QCH to provide medical services for treating medical conditions which may arise e.g. medical management of overdoses; surgical management of severe lacerations or burns from self injury.<br>• Dietetic services to liaise with and advise on the management of eating disorders, adequate nutrition, obesity, interactions with psychotropic medications etc.<br>• This may include developing conjoint programs for youth with developmental difficulties or somatisation disorders<br>• This includes but is not limited to the Department of Communities (Child Safety), the Department of Communities (Disability Services) and the Department of Communities (Housing & Homelessness) |

| Key component | Key elements | Comments |
|---|---|---|
| | | and Education Queensland<br>• Mandatory child protection reporting of a reasonable suspicion of child abuse and neglect.<br>Hyperlink to:<br>• meeting the needs of children for whom a person with a mental illness has care responsibilities [http://qheps.health.qld.gov.au/mentalhealth/html/careofchild.htm].<br>child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf].<br>• mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf] |
| | 3.1.4<br>AETRC staff will comply with Queensland Health (QH) policy regarding mandatory reporting of a reasonable suspicion of child abuse and neglect. | |
| | 3.1.5<br>When adolescents have specific needs (e.g. sensory impairment, transcultural) to ensure effective communication, AETRC will engage the assistance of appropriate services | • Certain population groups require specific consideration and collaborative support. This includes people from culturally and linguistically diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people.<br>Hyperlinks to:<br>• interpreter services [http://www.health.qld.gov.au/multicultural/interpreters/QHIS_home.asp]<br>• hearing impaired/deafness [http://www.health.qld.gov.au/pahospital/mentalhealth/docs/damh_con_info.pdf]<br>• transcultural mental health [http://www.health.qld.gov.au/pahospital/qtmhc/default.asp]<br>• Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 [http://qheps.health.qld.gov.au/atsihb/docs/atsiccf.pdf]<br>• Indigenous mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/indigenous.asp]<br>• multicultural mental health [http://www.health.qld.gov.au/mentalhealth/useful_links/multicultural. |

| Key component | Key elements | Comments |
|---|---|---|
| | | asp] |
| **3.2.0 Referral, access and triage** | **3.2.1** Statewide referrals are accepted for planned admissions. | |
| | **3.2.2** Responsibility for the clinical care of the adolescent remains with the referring service until the adolescent is admitted to the AETRC. | • This supports continuity of care for the adolescent. |
| | **3.2.3** All referrals are made to the Clinical Liaison, Clinical Nurse and processed through the intake panel. | • A single point of referral intake ensures consistent collection of adequate referral data and immediate feedback on appropriateness. |
| | **3.2.4** The adolescent is assessed after referral either in person or via videoconference. | • The pre-admission assessment enables the adolescent to meet some staff and negotiate their expectations of admission.<br>• This assessment enables further determination of the potential for therapeutic benefit from the admission, the impact on or of being with other adolescents and some assessment of acuity. |
| | **3.2.5** If there is a waiting period prior to admission, the Clinical Liaison, Clinical Nurse will liaise with the referrer until the adolescent is admitted. | • This process monitors changes in acuity and the need for admission to help determine priorities for admissions.<br>• The Clinical Liaison, Clinical Nurse can also advise the referrer regarding the management of adolescents with severe and complex mental illness following consultation with the treating team.<br>• This expedites an appropriate assessment interview and liaison with the referrer if there is a period of time until the adolescent is admitted. |
| | **3.2.6** Priorities for admission are determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others of admission at that time, length of time on the waiting list and age at time of referral. | |
| **3.3.0** | **3.3.1** | • Initial assessments of mental |

Some process to hold / maintain link / service e.g. monthly meeting / visit

| Key component | Key elements | Comments |
|---|---|---|
| **Assessment** | Assessments will be prompt and timely. | health, development and family are to be completed within two weeks of admission.<br>Hyperlink to:<br>• mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm]<br>• All assessment processes will be documented and integrated into the care plan.<br>Hyperlink to:<br>• child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf]<br>• The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian, and other stakeholders (with consent of the adolescent)<br>Hyperlink to:<br>• *Health Services Act 1991:* Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf].<br>• right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp].<br>• information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].<br>• carers matter [http://www.health.qld.gov.au/mhcarer/]. |
| | 3.3.2<br>A comprehensive clinical formulation is developed from the assessment, which is refined and updated secondary to ongoing assessment processes | • The formulation is reviewed and refined at case review meetings |
| **3.4.0**<br>**Mental Health Assessment** | 3.4.1<br>The AETRC will obtain a detailed assessment of the nature of mental illness, their behavioural manifestations, impact on function and development and the course of the mental illness. | • Assessment begins with the referral and continues throughout the admission.<br>• mental health clinical documentation [http://qheps.health.qld.gov.au/patientsafety/mh/mhform.htm]<br>• adolescent assessment form child |

| Key component | Key elements | Comments |
|---|---|---|
| | | and youth [http:qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_conass.pdf]. |
| | 3.4.2<br>The Consultation Liaison Clinical Nurse will obtain a detailed history of the interventions to date for the mental illness. | ◦ This is obtained by the time of admission. |
| | 3.4.3<br>*Mental Health Act 2000* assessments will be conducted by Authorised Mental Health Practitioner and/or authorised doctor. | Hyperlink to:<br>◦ *Mental Health Act 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf]. |
| 3.5.0<br>Family/Carers Assessment | 3.5.1<br>AETRC will obtain a detailed history of family structure and dynamics, or history of care if the adolescent is in care. | ◦ This process begins with the referral and continues throughout the admission. |
| 3.6.0<br>Developmental Assessment | 3.6.1<br>The AETRC will obtain a comprehensive understanding of developmental disorders and their current impact. | ◦ This process begins with available information on referral and during the admission. |
| | 3.6.2<br>The AETRC will obtain information on schooling as it is available. | ◦ This occurs upon admission and will primarily be obtained by the AETRC school. |
| 3.7.0<br>Functional Assessment | 3.7.1<br>The AETRC will obtain assessments on an adolescent's function in tasks appropriate to their stage of development. | ◦ This assessment occurs throughout the admission. |
| 3.8.0<br>Physical and Oral Health Assessments | 3.8.1<br>Routine physical examination will occur on admission. | ◦ Appropriate physical investigations should be informed as necessary.<br>Hyperlink to:<br>◦ physical examination and investigations form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_physical.pdf].<br>Link to:<br>metabolic monitoring form |
| | 3.8.2<br>Physical and oral health will be routinely assesses and monitored | ◦ Documented evidence of the physical and oral health assessment will be included in the |

| Key component | Key elements | Comments |
|---|---|---|
| | throughout the admission.<br>Additional resources, education and training to improve the physical and oral health management of adolescents with mental illness is available at:<br>Hyperlink to:<br>• activate: mind & body [http://www.activatemindandbody.com.au/] | adolescent clinical record.<br>• Outcomes of physical health assessments will be incorporated in recovery planning.<br>• All efforts will be made to ensure 100% of adolescents have a nominated GP.<br>• Potential physical and oral health problems will be identified and discussed with the GP and/or other primary health care provider |
| 3.9.0<br>Risk Assessments | 3.9.1<br>A key function of the panel will be to assess risk prior to admission. | • All risk assessments will be recorded in the patient charts and electronic clinical record (CIMHA).<br>• Risk assessment will be in accordance with the risk assessment contained in the statewide standardised clinical documentation.<br>• The outcome of assessments will be promptly communicated to the adolescent, the parent or guardian and other stakeholders (if the adolescent consents)<br>Hyperlink to:<br>• CYMHS Risk Screening Tool [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_screen.pdf] |
| | 3.9.2<br>Risk assessments will be initially conducted on admission and ongoing risk assessments will occur at a frequency as recommended by the treating team and updated at case review. | • Documentation of all past history of deliberate self harm will be included in assessment of current risk.<br>• Will include a formalised suicide risk assessment.<br>• The frequency of review of risk assessments will vary according to the levels of acuity for the various risk behaviours being reviewed, with a minimum of weekly reviews to occur. |
| 3.10.0<br>Alcohol and Other Drug | 3.10.1<br>Assessments of alcohol and drug use will be conducted with the adolescent on admission and routinely throughout ongoing contact with the service. | Hyperlink to:<br>• Drug Assessment Problem List [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_drug.pdf]<br>• dual diagnosis policy 2008 [http://www.health.qld.gov.au/mh/docs/ddpolicy_final.pdf].<br>• Interventions range from evidenced for substance use disorders to treatment of primary mental illness |

| Key component | Key elements | Comments |
|---|---|---|
| | | and incorporated in their recovery plan. |
| **3.11.0 Recovery Planning** | **3.11.1** An initial Recovery Plan is developed in consultation with the adolescent and their family/carers on admission. | • During admission, adolescents have access to a range of least restrictive, therapeutic interventions determined by evidenced based practice and developmentally appropriate programs to optimise their rehabilitation and recovery.<br>• Continual monitoring and review of the adolescent's progress towards their Recovery Planning is reviewed regularly through collaboration between the treating team, adolescents, the referrers and other relevant agencies.<br>• recovery plan [http://qheps.health.qld.gov.au/patientsafety/mh/documents/amhs_recplan.pdf].<br>• sharing responsibility for recovery: creating and sustaining recovery orientated systems of care for mental health [http:qheps.health.qld.gov.au/mentalhealth/docs/Recovery.pdf]. |
| | **3.11.2** Every effort will be made to ensure that treatment care planning focuses on the adolescent's own goals | • Where conflicting goals exist they will be clearly outlined and addressed in a way that is most consistent with the adolescent's own goals and values. |
| **3.12.0 Clinical interventions** | **3.12.1** Clinical interventions will be individualised according to the adolescent's treatment needs. All interventions must demonstrate attention to developmental frameworks and will be evidence based. | • Therapists will receive recognised, specific training in the mode of therapy identified.<br>• The therapy is modified according to the capacity of the adolescent to utilise the therapy, developmental considerations and stage of change in the illness.<br>• The therapist will have access to regular supervision. |

| Key component | Key elements | Comments |
|---|---|---|
| **3.13.0 Psychotherapeutic Interventions** | **3.13.1** Psychotherapeutic Interventions can include:<br>• individual verbal therapeutic interventions utilising a predominant therapeutic framework (e.g. Cognitive Therapy)<br>• individual non-verbal therapeutic interventions within established therapeutic framework (e.g. sand play, art, music therapies etc.)<br>• individual supportive verbal or non-verbal or behavioural therapeutic interventions utilising research from a number of specific therapeutic frameworks (e.g. Trauma Counselling, facilitation of art therapy)<br>• psychotherapeutic group interventions utilising specific or modified Therapeutic Frameworks (e.g. Dialectical Behaviour Therapy). | • Specific therapies will incorporate insights from other frameworks (e.g. Cognitive Therapy will incorporate understanding from Psychodynamic Therapies with respect to relationships).<br>• Supportive therapies will be integrated into the overall therapeutic approaches to the adolescent.<br>• Can be used at times when the adolescent is distressed or to generalise strategies to the day to day environment<br>• staff undertaking supportive interventions will receive training in the limited use of specific modalities of therapy and have access to clinical supervision |
| **3.14.0 Behavioural Interventions** | **3.14.1** Behavioural Interventions can include:<br>• individual tailored behavioural intervention for a specific clinical problem (e.g. desensitisation program for anxiety)<br>• group tailored behavioural interventions for a group of adolescents manifesting a common problem<br>• individual general behavioural interventions to reduce specific behaviours (e.g. absconding). These general behavioural interventions will be tailored to individual circumstances<br>• general or specific behavioural interventions to modify the behaviours of a number of adolescents involved in group behaviours<br>**3.14.2** Behavioural interventions for self harm behaviours include:<br>• using questionnaires to determine the reasons for the incident of self | • Behavioural programs are constructed under appropriate supervision.<br>• Evidence for effectiveness of intervention will be monitored.<br>• Effectiveness of behavioural program at individual and Centre level will be reviewed.<br>• Group based interventions are individualised according to adolescents in the group with common issues and may include adventure based and community based activities<br>• All staff should be familiar with specific policy and practice guidelines related to the management of acute behavioural disturbance within the AETRC.<br>• A specific management plan will address the adolescents distress and any associated behavioural disturbance. The plan will include predictors, triggers, signs and symptoms of increasing agitation/impending aggression, and will be developed for every |

| Key component | Key elements | Comments |
|---|---|---|
| | harm<br>• increased visual observations<br>• restricting access to areas of the ward where an adolescent can be observed<br>• use of the de-escalation area ranging from an area to which an adolescent voluntarily withdraws as a safe place up to restraint and seclusion as a last resort<br>• use of medication if indicated<br>The adolescent is informed of and encouraged to utilise strategies to use alternatives to self harm, e.g. talking with staff, use of the sensory room, utilising non-verbal therapies.<br>**3.14.3**<br>Behavioural interventions for behaviours which cause harm to others include:<br>• verbal de-escalation<br>• use of outside environment where safe<br>• use of safe forms of reducing aggression e.g. sensory room, punching bag<br>• use of the de-escalation area ranging from an area to which an adolescent voluntarily withdraws as a safe place up to restraint and seclusion as a last resort<br>• use of medication if indicated<br>• review of precipitants to aggression<br>The adolescent is informed of and encouraged to utilise strategies to use alternatives to aggression, e.g. talking with staff, use of the sensory room, utilising non-verbal therapies. | adolescent whose risk assessment identifies actual or potential aggression as an issue. The plan will list preventative strategies and de-escalation strategies. Intervention strategies will include:<br>• increased visual observation<br>• de-escalation techniques<br>• development of a management plan targeting the specific behaviour/symptom<br>• service provision in a designated de-escalation area with the capacity for high dependency and seclusion<br>• use of medication to relieve agitation/aggression<br>• Only when all other interventions have not had a therapeutic effect, restraint and/or seclusion will be utilised. These interventions are delivered by qualified staff following a comprehensive risk assessment. |
| **3.15.0 Psycho-education interventions** | **3.15.1**<br>Psychoeducation includes general specific or general psycho-education on mental illness. | • Available to adolescents and their parents/carers |

| Key component | Key elements | Comments |
|---|---|---|
| **3.16.0 Family Interventions** | 3.16.1 Family interventions are offered to support the family/carer while the adolescent is in the AETRC. | • This will include and allows for:<br>- psycho education for parents/carers<br>- monitoring of mental health of parents/carers and supporting access to appropriate mental health care as needed<br>- monitoring the risk of abuse or neglect, and fulfilling statutory obligations if child protection concerns are identified<br>- promoting qualities of care which enable reflection of qualities of home<br>- support clinicians in reviewing interactions with and attitudes towards adolescents.<br>• Evidence for effectiveness of the intervention and interactions with staff will be reviewed. |
| | 3.16.2 Supportive family interventions will be integrated into the overall therapeutic approaches to the adolescent. | • Therapist will have recognised training in family therapy and access to continuing supervision. |
| **3.17.0 Interventions to Facilitate Tasks of Adolescent Development** | 3.17.1 Interventions are provided to promote appropriate development in a safe and validating environment. | • Individual based interventions are provided to promote an aspect of adolescent development.<br>• Group based interventions are individualised according to adolescents in the group which promote aspects of adolescent development which may include adventure based and recreational activities.<br>• Interventions are provided under the clinical direction of a nominated clinician and have defined goals.<br>• Schooling is individualised according to an adolescent's current school curriculum, academic capacities and mental state.<br>• The school program is determined by the School Principal after continuing consultations with clinicians. |
| **3.18.0 Pharmacological Interventions** | 3.18.1 Medication will be administered, prescribed and monitored as | • Across all treatment settings all prescriptions, dispensing and administration of medicines will |

| Key component | Key elements | Comments |
|---|---|---|
| | indicated by clinical need, and will involve shared decision making processed between the treating team and the adolescent and their family/carers.<br>- Administration of psychotropic medications will occur under the direction of the consultant psychiatrist.<br>- Administration of non-psychotropic medications (including medications for general health) will occur under medical supervision | comply with Queensland Health policies, guidelines and standards.<br>Hyperlink to:<br>• National Inpatient Medication Chart [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/D0DABD9912D44A14CA257516000FDABB/$File/20795.pdf].<br>• clinical guidelines [http://qheps.health.qld.gov.au/mentalhealth/guidelines.htm].<br>• medication liaison on discharge [http://qheps.health.qld.gov.au/medicines/documents/general_policies/medic_liaison_discrg.pdf].<br>• safe medication practice unit [http://qheps.health.qld.gov.au/medicines/].<br>• therapeutic guidelines-psychotropic [https://online-tg-org-au.cknservices.dotsec.com/ip/].<br>• Queensland Health Medication Management Plan [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/0AAD5CC37045BF99CA257751001C2543/$File/medicationsafetyplan.PDF]<br>• Education is given to the adolescent and parent(s)/carer about medication and potential adverse effects.<br>• The medication goals of the adolescent/guardian will be integrated with evidence based clinical treatment guidelines.<br>• Where needed, strategies focussed on medication adherence will be in place.<br>• Side effect monitoring will be routinely conducted with particular emphasis on metabolic complications of psychopharmacological treatment.<br>• Regular administration and supervision of psychotropic medications occurs. |
| 3.19.0 | 3.19.1 | |

| Key component | Key elements | Comments |
|---|---|---|
| **Other Interventions** | Sensory Modulation is an approach aimed at teaching clients to learn to use their sensory systems to modulate their responses, in order to improve participation in meaningful life activities.<br>**3.19.2**<br>Electroconvulsive therapy (ECT) will be available where indicated and will be provided according to Queensland Health guidelines. | • Sensory modulation is utilised under the supervision of trained staff.<br>• Effectiveness of the approach is monitored.<br>• ECT is subject to a specific policy compliance with Australian clinical practice guidelines, and is administered in accord with the *Mental Health Act 2000*<br>*Hyperlink to:*<br>• electroconvulsive therapy guidelines [http://qheps.health.qld.gov.au/mentalhealth/docs/ect_guidelines_31960.pdf]. |
| | | • All staff will have ABM training at the level deemed appropriate within AETRC<br>7 Refer: High Dependency Unit Guidelines?/hyperlink to policy statement on reducing and where possible eliminating restraint and seclusion in Queensland Mental Health services/Visual observations policy/occupational violence prevention training<br>7 Parents/carers are immediately informed of changes in a child□s behavioural presentation. |
| **3.20.0**<br>**Care Coordination** | **3.20.1**<br>Prior to admission, a Care Coordinator will be appointed for each adolescent. | • The Care Coordinator can be a member of the AETRC treating team and is appointed by the AETRC director |

| Key component | Key elements | Comments |
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| | 3.20.2<br>The Care coordinator will be responsible for:<br>• providing centre orientation to the adolescent and their parent(s)/carer(s)<br>• monitoring the adolescent's mental state and level of function in developmental tasks<br>• assisting the adolescent to identify and implement goals for their care plan<br>• acting as the primary liaison person for the parent(s)/carer and external agencies during the period of admission and during the discharge process<br>• assisting the adolescent in implementing strategies from individual and group interventions in daily living<br>• providing a detailed report of the adolescent's progress for the care planning meeting. | • An orientation information pack will be available to adolescents and their parent(s)/carer(s).<br>• The care coordinator will be noted on CIMHA as principal service provider.<br>Hyperlink cimha business rules<br>Statement on documentation<br><br>All adolescents have a designated psychiatrist on CIMHA<br><br>• The frequency of monitoring will depend on the levels of acuity.<br>• Adolescents at high risk and require higher levels of observations will be reviewed daily<br>• Monitoring will integrate information from individual and group interventions and observations.<br>• This includes daily reviews by the registrar, and twice weekly reviews by the consultant psychiatrist. |

| Key component | Key elements | Comments |
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| **3.21.0 Clinical Review** | **3.21.1** Continual monitoring of the adolescent's progress towards their recovery plan goals will occur through a process of structured clinical reviews involving the AETRC multi-disciplinary team and relevant external community agencies. | • Care Plans are formally reviewed and updated at intervals ideally of two months, but not more than three months.<br>• There will be an established agenda for discussion of cases, with concise documentation of the content of the discussion and the ongoing plan of care recorded on the adolescent integrated mental health application (CIMHA) and on the adolescent care review summary. A copy is to be downloaded and included in the clinical file.<br>• Outcome measures and the adolescent's progress will be reviewed.<br>• The summation should include attendees, clinical issues raised, treatment care plan, requirements for additional collateral and those responsible for actions.<br>• The Community Liaison Clinical Nurse is responsible to ensure adolescents are reviewed<br>• The adolescent, referring agencies and other key stakeholders will participate in the Clinical Review process.<br>• All members of the clinical team who provide interventions for the adolescent will have input into the case review.<br>• The consultant psychiatrist will chair the case review meeting and take responsibility for ensuring that assessments and management plans are adequate, and for decisions taken during formal case reviews.<br>• Annual audits will ensure that reviews are being conducted |
| | **3.21.2** Ad hoc case review meetings may be held at other times if clinically indicated | • These will be initiated after discussion at the case conference or at the request of the adolescent, or may be required to address complex clinical issues and following a critical event.<br>Hyperlink to:<br>• Clinical Incident management |

| Key component | Key elements | Comments |
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| | | implementation standard [http://www.health.qld.gov.au/patientsafety/documents/cimist.pdf].<br>• child and youth recovery plan form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_recovery.pdf]<br>• CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm].<br>• child adolescent care review summary form [http://qheps.health.qld.gov.au/patientsafety/mh/documents/cyms_creview.pdf] |
| **3.22.0 Case Conference** | • a weekly case conference will be held to integrate information from and about the adolescent , interventions that have occurred, and to review progress within the context of the case plan | • available members of the treating team should attend each case conference |
| **3.23.0 Collection of data, record keeping and documentation** | **3.23.1** AETRC will enter and review all required information into the CIMHA in accordance with approved statewide and district business rules.<br><br>**3.23.2** All clinical record keeping will comply with legislative and local policy requirements | Hyperlink to:<br>• CIMHA business rule [http://qheps.health.qld.gov.au/mentalhealth/cimha/factsheets.htm].<br>• progress notes will be consecutive within the clinical record according to date<br>• personal and demographic details of the adolescent, their parent/carer(s) and other health service providers will be up to date<br>• clinical records will be kept legible and up to date, with clearly documented dates, author/s (name and title) and clinical progress notes<br>• all contacts, clinical processes and care planning, including case review, will be documented in the adolescent's clinical record<br>• there will be a single clinical record for each adolescent which will align with any electronic record<br>Hyperlink to:<br>• retention and disposal of clinical records [http://qheps.health.qld.gov.au/policy/docs/pol/qh-pol-280.pdf]. |

| Key component | Key elements | Comments |
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| | |  Clinical Documentation  Accepted Terminology |
| | **3.23.3** AETRC utilise the range of routine outcome measures mandated through the National Outcomes and Casemix Collection (NOCC), including the Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA), the Children's Global Assessment Scale (CGAS) and the Strengths and Difficulties Questionnaire (SDQ). | • Routine outcomes data is utilised at all formal case reviews<br>• Results of routine outcomes data will be discussed with adolescents and their family/carers to consider and monitor changes in symptoms and functioning<br>• Outcomes data is used in developing and reviewing recovery plans. |
| **3.24.0 Discharge Planning** | **3.24.1** Planning for discharge from AETRC should commence when the assessment phase has been completed with key stakeholders and the adolescent being actively involved. | • Discharge planning should address potential significant obstacles e.g. accommodation, engagement with another mental health service.<br>• The decision to discharge is at the discretion of the consultant psychiatrist in consultation with the multidisciplinary team. |
| | **3.24.2** Discharge planning will involve multiple processes at different times that attend to therapeutic needs, developmental tasks and reintegration into the family | • Discharge planning will occur in close collaboration with the adolescent and their family<br>• Discharge planning will consider the adolescent's potential for optimal functioning and determine the level of care required to support that functioning as an inpatient, partial inpatient, day admission or in the community<br>• Discharge planning recognises the needs at times that re-admission may be necessary where risk of relapse is high. |
| | **3.24.3** Discharge planning will require the ascertainment that the potential accommodation is safe and appropriate. In most cases, this will be the family home, or established care arrangements. Where the family home is unsafe, unable to provide the necessary support or | • Where the family home or usual care arrangements are appropriate and supportive, every endeavour will be made to encourage the adolescent to return<br>• The adolescent will be integral to all planning for accommodation on discharge<br>• Parents providing a safe and |

| Key component | Key elements | Comments |
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| | where care arrangements do not exist, safe supervised accommodation with adequate supports will be sought. | supportive environment will always be involved in planning for accommodation on discharge.<br>• The Department of Child Safety will remain primarily responsible for providing timely and appropriate accommodation for an adolescent in their care. ?Hyperlink to MOU between Queensland Health and Department of Child Safety?<br>• Any decision to not return the adolescent to the home of origin will be made in collaboration with the adolescent and their parents as their guardians if they are under the age of 18<br>• If parents are unavailable or unwilling to be involved in negotiations about accommodation, a referral will be made to the Department of Child Safety on the grounds of neglect. If this referral is not accepted, accommodation options will be sought by the AETRC on the basis of being age appropriate, safe, and levels of supervision and support available<br>• The adolescent will be equipped to live independently in preparation for discharge outside of home<br>• The adolescent will be offered trial of independent living in the step down facility attached to the unit as long as they are safe enough to stay there, but require reasonable levels of clinical support during the day and evening |
| | 3.24.4<br>Discharge summaries need to be comprehensive and indicate diagnosis, treatment and interventions provided, progress of care, recommendation for ongoing care and procedures for re-referral. | • The Registrar, Care Coordinator and key clinicians will prepare this letter and the consultant psychiatrist is responsible for ensuring that discharge summaries are sent to key health service providers (E.g. GP) on the day of discharge.<br>• Follow up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure discharge information was received.<br>• Discharge summary should identify relapse patterns and risk |

| Key component | Key elements | Comments |
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| | | assessment/ management information.<br>• this will be prepared by the clinicians involved in direct Interventions |
| | 3.24.5<br>If events necessitate an unplanned discharge, the AETRC will ensure the adolescent's risk assessments were reviewed and they are discharged or transferred in accord with their risk assessments. | |
| **3.25.0 Transfer/Transition of care** | 3.25.1<br>All appropriate community based support will be co-ordinated prior to discharge. The adolescent's community treating team will be identified in the clinical record and communication will be maintained during the transition period. | • Guidelines for internal transfers will be clearly written, and receiving teams will make contact before transfer is concluded. A written and verbal handover will be provided with every transfer/discharge process.<br>• During the transition phase there will be an appropriate plan to ensure smooth transition of care. This will support continuity of care for the adolescent and ensure the early engagement of all service providers in ongoing care.<br>• The AETRC School will be primarily responsible for and support school reintegration.<br>• For adolescents not returning to their homes, the AETRC will ensure adolescents have appropriate accommodation to be discharged to. Preparation for this leave may include trials of leave while still resident in the step down facility.<br>• A community living and management plan will be developed with the adolescent, the community follow up service and the accommodation provider when the young person is not able to live at home.<br>• The community mental health service, whether in the public or private sectors will become the principal service provider when the young person no longer requires any level of inpatient or day service at the AETRC |
| | 3.25.2 | • Transfer procedures will be |

| Key component | Key elements | Comments |
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| | Depending on individual needs and acuity some adolescents may require transfer to another child or adolescent inpatient unit.<br><br>3.25.3<br>Transfer to an adult inpatient unit or community care unit may be required for adolescents who reach their 18th birthday and the AETRC is no longer able to meet their needs. | discussed with adolescents, their family and carers.<br>• Processes for admission into an adolescent acute inpatient unit will be followed, with written and verbal handover provided.<br>• Transfer procedures will be discussed with adolescents, their family and carers.<br>• Processes for admission into an adult acute mental health inpatient unit will be followed, with written and verbal handover provided. |
| **3.26.0 Continuity of Care** | 3.26.1<br>Referrers and significant stake holders in the adolescent's life will be included in the development of Care Planning throughout the admission. Local CYMHS may remain as other service providers. | • Referrers and significant stake holders are invited to participate in the Case Review meetings<br>• The Care Coordinator will liaise more frequently with others as necessary |
| | Responsibility for emergency contact will be clearly defined when an adolescent is on extended leave. | • This will be negotiated between the AETRC and the local CYMHS |
| | 3.27.2<br>Specifically defined joint therapeutic interventions between the AETRC and the Referrer can be negotiated either when the adolescent is attending the Centre or on periods of extended leave | • Joint interventions can only occur if clear communication between the AETRC and external clinician can be established<br>• An example would include the referrer providing parent support while the adolescent is in the AETRC |
| **3.27.0 Team Approach** | 3.27.1<br>A multidisciplinary team approach to care is provided.<br><br>3.27.4<br>Staff employed by the Department of Education and Training will be regarded as part of the team. | • Adolescents and family/carers will be informed of the multidisciplinary approach to mental health care on admission to AETRC.<br>• The discipline specific skills of the multidisciplinary team will be utilised as appropriate in all aspects of service provision.<br>Department of Education and Training supports the AETRC in providing teaching and resource staff for the school. |
| **3.28.0 Working with families, carers and friends** | 3.28.1<br>Adolescents and carers will contribute to continued practice improvement of the service. | • This will occur via:<br>-consume and carer participation in collaborative treatment planning<br>- adolescent and carer feedback tools<br>- adolescent and carers will inform |

| Key component | Key elements | Comments |
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| | | staff training. |
| | 3.28.2<br>Every effort will be made to contact family, carers and significant others promptly on acceptance into EATRC. Family/carers/significant others will be involved in the mental health care as much as possible. Significant effort will be made to support this involvement. | • Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent.<br>• The family/carer is identified in the adolescent clinical record and where relevant, it is clearly identified that they understand the treatment plan and agree to support the provision of ongoing care to the adolescent in the AETRC.<br>• Adolescent/guardian consent to disclose information to and to involve the family/carers in the care will be sought in every case.<br>Hyperlink to:<br>• *Health Services Act 1991*: Confidentiality Guidelines [http://qheps.health.qld.gov.au/lalu/admin_law/privacy_docs/conf_guidelines.pdf].<br>• right to information and information privacy [http://www.health.qld.gov.au/foi/default.asp].<br>• information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm].<br>• *Guardianship and Administration Act (Qld) 2000* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf].<br>• Decision making for children and young people [http://www.childsafety.qld.gov.au/right-to-information/publications/viewpublication.aspx?publication=94]. |
| | 3.28.3<br>Parents/carers will have their needs assessed as indicated or requested. If parent/carer mental health needs are identified the AETRC will attempt to meet these needs and if necessary refer to an adult mental health service. | • Identification of family/carers and their need is part of the assessment process and is included in care planning.<br>Hyperlink to:<br>• carers matter [http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/carersMatterYoureNotAlone_is.asp |
| | 3.28.4<br>Support services will be offered to | • Adolescent consent is not required |

| Key component | Key elements | Comments |
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| | families and carers. | to offer family/carers education and support.<br>• Support may be provided by a member of the MHS or another organisation. |
| | 3.28.5<br>Adolescents of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided/facilitated if needed. | Hyperlink to:<br>• *Child Protection Act 1999* [http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf].<br>• child safety policy [http://qheps.health.qld.gov.au/mhalu/documents/policies/child_protect.pdf].<br>• meeting the needs of children for whom a person with a mental illness has care responsibilities [http://qheps.health.qld.gov.au/mentalhealth/html/careofchild.htm].<br>• mental health child protection form [http://qheps/health.qld.gov.au/patientsafety/mh/documents/child_prot.pdf].<br>• Family Support Form http://qheps.health.qld.gov.au/patientsafety/mh/documents/family_supp.pdf<br>• information sharing [http://qheps.health.qld.gov.au/csu/InfoSharing.htm]. |
| **3.29.0 Mental Health Peer Support Services** | 3.29.1<br>All adolescents will be offered information and assistance to access local peer support services | • Peer support services may be provided by internal or external services. |

## 4. Related services

The AETRC is part of the CYMHS network of services in Queensland and as such maintains strong operational and strategic links to the CYMHS network. AETRC provides education and training to health professionals within CYMHS on the provision of comprehensive mental health care to adolescents with severe and complex disorder.

AETRC operate in a complex, multi-system environment involving crucial interactions with education providers, the Department of Communities (including Child Safety, Disability Services, and Housing and Homelessness services), child health services, alcohol and other drugs services. AETRC will establish and maintain effective, collaborative partnerships with general health services, in particular CYMHS and services to support young people eg Child Safety Services. AETRC will develop Memorandums of Understanding to facilitate these relationships.

??statement about AETRC school
Check if all listed below are correct, or is some missing

The AETRC will develop the capacity for research into effective interventions for young people with severe and complex disorder who present to an intensive and longer term facility such as AETRC. Strong links with universities will be developed to support this process.

Key internal relationships include

- Child and Youth Mental Health Services (CYMHS) including Child and Youth Forensic Outreach Services, Evolve Therapeutic Services
- Other specialist child and youth mental health services (e.g. Early Psychosis)
- Acute inpatient mental health teams (child and youth, adolescent, adult)

Effective relationships (and a working knowledge of the service they provide) will also be developed with other internal service providers including (but not limited to):

- Aboriginal and Torres Strait Islander mental health services
- Queensland Transcultural Mental Health services
- Adult mental health services
- Acute Care Teams
- Community Care Units

Key external (district) relationships include:

- Primary Care Providers
- Department of Education (in particular ADP School)
- Department of Communities
- Queensland Public Trustee

## 5. Caseload

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

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

## 6. Workforce

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

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

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

## 7. Team clinical governance

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

The centre will be directly responsible to the corporate governance of the Health Service District within which the AETRC is located. The operation of this corporate governance structure will occur through the AETRC clinical director reporting directly to the Director, Child and Adolescent Mental Health Services, within the relevant Health Service District. Interim line management arrangements may be required.

## 8. Hours of operation

The AETRC provide a 24 hour service, with nursing staff rostered to cover these shifts.
An on-call consultant child and adolescent psychiatrist is available 24 hours, 7 days per week.
Access to the full multidisciplinary team will be provided weekdays during business hours and after hours by negotiation with individual staff
24 hours, 7 days a week telephone crisis support will be available to adolescents on leave is available. A mobile response will not be available.
While some variation may occur, routine assessments and interventions will be scheduled during business hours (9am -5pm) 7 days a week.

## 9. Staff training

Staff will be provided with continuing clinical education opportunities, mandatory training, clinical supervision, and other support mechanisms to ensure that they are clinically competent. All training and education will be based on best practice principles and evidence-based treatment guidelines, and will be underpinned by the Queensland Government Recovery Framework.

Education and training will include a focus on strategies and mechanisms to foster meaningful adolescent and carer participation across all levels of service delivery, implementation and evaluation. Adolescents and carers need to be involved in the development and delivery of education to staff and other service providers.

Education and training should include (but will not be limited to):

- Queensland Health mandatory training requirements (fire safety, etc)
- AETRC orientation training
- CYMHS Key Skills training
- clinical and operational skills/knowledge development
- team work
- principles of the service (including cultural awareness and training, safety, etc.)
- principles and practice of other CYMHS entities; community clinics, inpatient and day programs
- medication management
- *Mental Health Act 2000*
- developmentally appropriate assessment and treatment
- engaging and interacting with other service providers and
- risk and suicide risk assessment and management.

Staff from the AETRC will engage in CYMHS training. On occasion AETRC will deliver training to other components of the CYMHS where appropriate.

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

**10. The AETRC functions best when:**

- there is an adequate skill mix, with senior level expertise and knowledge being demonstrated by the majority of staff
- strong internal and external partnerships are established and maintained
- clear and strong clinical and operational leadership roles are provided
- all staff are provided with regular supervision, professional support and training
- AETRC is seen by all CYMHS staff as integral and integrated with the CYMHS continuum of service
- there is an explicit attitude that adolescents can and do recover from mental illness
- service evaluation and research are prioritised appropriately
- adolescents and their family/carers are involved in all aspects of care.

EXHIBIT 119

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**Barrett Adolescent Strategy**
*Expert Clinical Reference Group*

# Proposed Service Model Elements
# Adolescent Extended Treatment and Rehabilitation Services (AETRS)

## Preamble

Mental health disorders are the most prevalent illnesses affecting adolescents today. Of particular note is the considerable evidence that adolescents with persisting and severe symptomatology are those most likely to carry the greatest burden of illness into adult life. Despite this, funding for adolescent (and child) mental health services is not proportional to the identified need and burden of disease that exists.

In the past 25 years, a growing range of child and youth mental health services have been established by Queensland Health (and other service providers) to address the mental health needs of children and adolescents. These services deliver mental health assessment and treatment interventions across the spectrum of mental illness and need, and as a service continuum, provide care options 24 hours a day, seven days a week. No matter where an adolescent and their family live in Queensland, they are able to access a Child and Youth Mental Health Service (CYMHS) community clinic or clinician (either via direct access through their Hospital and Health Service, or through telehealth facilities). Day Programs have been established for adolescents in South Brisbane, Toowoomba and Townsville. Acute mental health inpatient units for adolescents are located in North Brisbane, Logan, Robina, South Brisbane and Toowoomba, and soon in Townsville (May/June 2013). A statewide specialist multidisciplinary assessment, and integrated treatment and rehabilitation program (The Barrett Adolescent Centre [BAC]) is currently delivered at The Park Centre for Mental Health (TPCMH) for adolescents between 13 and 17 years of age with severe, persistent mental illness. This service also offers an adolescent Day Program for BAC consumers and non-BAC consumers of West Moreton Hospital and Health Service.

Consistent with state and national mental health reforms, the decentralisation of services, and the reform of TPCMH site to offer only adult forensic and secure mental health services, the BAC is unable to continue operating in its current form at TPCMH. Further to this, the current BAC building has been identified as needing substantial refurbishment. This situation necessitates careful consideration of options for the provision of mental health services for adolescents (and their families/carers) requiring extended treatment and rehabilitation in Queensland. Consequently, an Expert Clinical Reference Group (ECRG) of child and youth mental health clinicians, a consumer representative, a carer representative, and key stakeholders was convened by the Barrett Adolescent Strategy Planning Group to explore and identify alternative service options for this target group.

Between *(date)* and *(date)*, the ECRG met regularly to define the target group and their needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, evidence-based models of care and service types. This included the potential for an expanded range of day programs across Queensland and community mental health service models delivered by non-government and/or private service providers. The ECRG have considered

evidence and data from the field, national and international benchmarks, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended Treatment and Rehabilitation Services in Queensland. This elements document *is not a model of service* – it is a conceptual document that delineates the key components of a service continuum type for the identified target group. As a service model elements document, it will not define how the key components will function at a service delivery level, and does not incorporate funding and implementation planning processes.

The service model elements document proposes four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

- **Tier 1** – Public Community Child and Youth Mental Health Services (existing);
- **Tier 2a** – Adolescent Day Program Services (existing + new);
- **Tier 2b** – Adolescent Community Residential Service/s (new); and
- **Tier 3** – Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Unit (new).

The final service model elements document produced was cognisant of constraints associated with funding and other resources (e.g., there is no capital funding available to build BAC on another site). The ECRG was also mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that *'non acute bed-based services should be community based wherever possible'*. A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.

The ECRG comprised of consumer and carer representatives, and distinguished child and youth mental health clinicians across Queensland and New South Wales who were nominated by their peers as leaders in the field. The ECRG would like to acknowledge and draw attention to the input of the consumer and carer representatives. They highlighted the essential role that a service such as BAC plays in recovery and rehabilitation, and the staff skill and expertise that is inherent to this particular service type. While there was also validation of other CYMHS service types, including community mental health clinics, day programs and acute inpatient units, it was strongly articulated that these other service types are not as effective in providing safe, medium-term extended care and rehabilitation to the target group focussed on here. It is understood that BAC cannot continue in its current form at TPCMH. However, it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based unit is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g., The Walker Unit).

The service model elements document (attached) has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services in Queensland.

EXHIBIT 119



There are seven key messages and associated recommendations from the ECRG that need to underpin the reading of the document:

## 1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

- The proposed service model elements document is a conceptual document, not a model of service. Formal consultation and planning processes have not been completed as part of the ECRG course of action.
- In this concept proposal, Tier 2 maps to the Clinical Services Capability Framework for Mental Health (CSCF) Level 5 and Tier 3 maps to CSCF Level 6.

**Recommendations:**

a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.

b) Formal planning including consultation with stakeholder groups will be required.

## 2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

- It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the following service model elements document.
- From the perspective of the ECRG, Tier 3 is an essential component of the overall concept, as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types (as represented by Tiers 1 and 2).
- The target group is characterised by severity and persistence of illness, very limited or absent community supports and engagement, and significant risk to self and/or others. Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.
- The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit).
- Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.
- Managing this target group predominantly in the community is associated with complexities of risk to self and others, and also the risk of disengaging from therapeutic services.

**Recommendation:**

a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.

## 3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

- Interim arrangements (after BAC closes and before Tier 3 is established) are at risk of offering sub optimal clinical care for the target group, and attention should be given to the therapeutic principles of safety and treatment matching, as well as efficient use of resources (e.g., inpatient beds).
- In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, and those on the waiting list.
- Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff.

**Recommendations:**

a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.

b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.

c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.

## 4. Duration of treatment

- A literature search by the ECRG identified a weak and variable evidence base for the recommended duration of treatment for inpatient care of adolescents requiring mental health extended treatment and rehabilitation.
- Predominantly, duration of treatment should be determined by clinical assessment and individual consumer need; the length of intervention most likely to achieve long term sustainable outcomes should be offered to young people.
- As with all clinical care, duration of care should also be determined in consultation with the young person and their guardian. Rapport and engagement with service providers is pivotal.

**Recommendation:**

a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provisions, there will be a range in the duration of admission.

## 5. Education resource essential: on-site school for Tiers 2 and 3

- Comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness. A specialised educational model and workforce is best positioned to engage with and teach this target group.
- Rehabilitation requires intervention to return to a normal developmental trajectory, and successful outcomes are measured in psychosocial functioning, not just absence of psychiatric symptoms.
- Education is an essential part of life for young people. It is vital that young people are able to access effective education services that understand and can accommodate their mental health needs throughout the care episode.
- For young people requiring extended mental health treatment, the mainstream education system is frequently not able to meet their needs. Education is often a core part of the intervention required to achieve a positive prognosis.
- **Band 7 school – add definition from KR**

**Recommendations:**

a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3.

b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

## 6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

- There is no true precedent set in Queensland for the provision of residential or bed-based therapeutic community care (by non-government or private providers) for adolescents (aged up to 18 years) requiring extended mental health care.
- The majority of ECRG members identified concerns with regard to similar services available in the child safety sector. These concerns were associated with:
  - Variably skilled/trained staff who often had limited access to support and supervision;
  - High staff turn-over (impacting on consumer trust and rapport); and
  - Variable engagement in collaborative practice with specialist services such as CYMHS.

**Recommendations:**

a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.

b) Governance should remain with the local CYMHS or treating mental health team.

c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.

## 7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

- Equity of access for North Queensland consumers and their families is considered a high priority by the ECRG.

**Recommendations:**

a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.

b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.

EXHIBIT 119

**Barrett Adolescent Strategy**

*Expert Clinical Reference Group*

| Proposed Service Model Elements<br>Adolescent Extended Treatment and Rehabilitation Services (AETRS) | |
|---|---|
| **Attribute** | **Details** |
| **Service Delivered** | The aim of this platform of services is to provide medium term, recovery oriented treatment and rehabilitation for young people aged 13 – 17 years with severe and persistent mental health problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development.<br><br>The AETRS continuum is offered across a range of environments tailored to the individual needs of the young person with regard to safety, security, structure, therapy, community participation, autonomy and family capacity to provide care for the young person.<br><br>The AETRS functions as part of the broader, integrated continuum of care provided for young Queenslanders, that includes acute inpatient, day program and community mental health services (public, private and other community-based providers). |
| **Over-arching Principles** | The delivery of an Adolescent Extended Treatment and Rehabilitation Service continuum will:<br>• develop/maintain stable networks<br>• promote wellness and help young people and their families in a youth oriented environment<br>• provide services either in, or as close to, the young person's local community<br>• collaborate with the young person and their family and support people to develop a recovery based treatment plan that promotes holistic wellbeing<br>• collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease<br>• integrate with Child and Youth Mental Health Services (CYMHS), and as required, Adult Mental Health Services<br>• recognise that young people need help with a variety of issues and not just illness<br>• utilise and access community-based supports and services |

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| | where they exist, rather than re-create all supports and services within the mental health setting<br>• treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community-based staff<br>• provide flexible and targeted programs that can be delivered across a range of contexts and environments<br>• have the capacity to deliver services in a therapeutic milieu with family members; support and work with the family in their own environment and keep the family engaged with the young person's problems<br>• have capacity to offer intensive family therapy and family support<br>• have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down<br>• acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person<br>• engage with a range of educational or vocational support services appropriate to the educational needs of the young person and the requirements of their treatment environment, and encourage engagement/reengagement of positive and supportive social, family, educational and vocational connections. |
| **Key Distinguishing Features of an AETRS** | Services are accessed via a tiered, least-restrictive approach, and may involve combinations of service types across the tiers.<br><br>**Tier 1:**<br>**Public Community Mental Health Services (Sessional)**<br>• Existing Locations: All Hospital and Health Services (HHSs).<br>• Access ambulatory care at a public community-based mental health service, within the local area.<br>• Interventions should consider shared-care options with community-based service providers, including General Practitioners and *headspace*.<br><br>**Tier 2a: Level 5 CSCF.**<br>**Day Program Services (Mon – Fri business hours).**<br>• Existing Locations: Townsville (near completion), Mater, Toowoomba, Barrett Adolescent Centre (BAC).<br>• Possible New Locations: Gold Coast, Royal Children's Hospital CYMHS catchment, Sunshine Coast. Funds from existing |

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| | operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal planning process.<br>• Individual, family and group therapy, and rehabilitation programs operating throughout (but not limited to) school terms.<br>• Core educational component for each young person – partnership with Education Queensland and vocational services required. This may be provided at the young person's school/vocational setting, or from the day program site.<br>• Flexible and targeted programs with attendance up to 5 days (during business hours) a week, in combination with integration into school, community and/or vocational programs.<br>• Integrated with local CYMHS (acute inpatient and public community mental health teams).<br>• Programs are delivered in a therapeutic milieu (from a range of settings including day program service location, the family home, school setting etc.).<br>• Programs will support and work with the family, keeping them engaged with the young person's recovery.<br>• Consumers may require admission to Adolescent Acute Inpatient Unit (and attend the Day Program during business hours).<br>• Proposal of 12 - 15 program places per Day Program (final places and budget should be determined as part of formal planning process).<br><br>**Tier 2b:**<br>**[1]Community Residential Service (24h/7d).**<br>• Existing Locations: Nil services currently. Note: Cairns Time Out House Initiative for 18y+.<br>• Possible New Locations: Sites where Day Programs are currently delivered; Townsville identified as a priority in order to meet the needs of North Queensland families. Funding from existing operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal |

[1] Note: The Department of Health takes a 'provider agnostic' view in determining non clinical support and accommodation services. Decisions to contract service providers will be determined by service merit, consumer need and formal planning and procurement processes.

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| | planning process.<br>• Day Program attendance as in Tier 2a during business hours.<br>• This tier incorporates a bed-based residential and respite service for adolescents after-hours and on weekends (in the community).<br>• There is potential for one or more of these services to provide 'family rooms', that will temporarily accommodate family members while their young person attends the Day Program or the Adolescent Acute Inpatient Unit (for example, in Townsville).<br>• Integrated with local CYMHS (acute inpatient, day program and public community mental health teams).<br>• Residential to be a partnership model for service delivery between a community-based service provider and QH – multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider). Partnership to include clinical governance, training and in-reach by CYMHS.<br>• Residential component only provides accommodation; it is not the intervention service provider.<br>• On-site extended hours visiting service from CYMHS Day Program staff.<br><br>**Tier 3: Level 6 CSCF.**<br>**Statewide Inpatient Extended Treatment and Rehabilitation Unit (24h/7d)[2].**<br>• Possible Location: S.E. Qld. Source of capital funding and potential site not available at current time[3]. Acknowledge accessibility issues for young people outside S.E. Qld.<br>• For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care. These young people's needs |

[2] The Department of Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.

[3] Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e., utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established). It is emphasised that this is not proposed to be a clinically preferred or optimal solution, and significant risks are associated with this interim measure.

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| | are not able to be met in an acute setting.<br>• In-patient therapeutic milieu, with capacity for family/carer admissions (i.e. family rooms).<br>• All other appropriate and less restrictive interventions considered/tested first.<br>• Proposal for approximately 15 beds – this requires formal planning processes.<br>• Medium term admissions (approximately up to 12 months; however, length of stay will be guided by individual consumer need and will therefore vary).<br>• Delivers integrated care with the local CYMHS of the young person.<br>• Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week. These must include activity based programs that enhance the self esteem and self efficacy of young people to aid in their rehabilitation. As symptoms reduce, there is a focus on assisting young people to return to a typical developmental trajectory.<br>• Consumers will only access the day sessions (i.e. Day Program components) of the service if they are an admitted consumer.<br>• Programs maintain family engagement with the young person, and wherever possible adolescents will remain closely connected with their families and their own community.<br>• Young people will have access to a range of educational or vocational support services delivered by on-site school teachers and will be able to continue their current education option[4]. There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities.<br>• Flexible and targeted programs will be delivered across a range of contexts including individual, school, community, group and family. |
| **Service specifications and other descriptors to illustrate service elements** | |
| **Target Age** | • 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age. |

[4] The provision of education at this level requires focused consideration; an on-site school and education program is proposed as a priority.

## Barrett Adolescent Strategy

*Expert Clinical Reference Group*

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| **Diagnostic Profile** | • Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development.<br>• Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment.<br>• Mental illness is persistent and the consumer is a risk to themselves and/or others.<br>• Medium to high level of acuity requiring extended treatment and rehabilitation. |
| **Suggested modelling attributes** | |
| **Average duration of treatment** | **Tier 2a:**<br>**Level 5 Day Program Services (Mon – Fri business hours)**<br>• Up to 12 months; flexibility will be essential.<br>• There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this.<br><br>**Tier 2b:**<br>**Community Residential (24h/7d)**<br>• Up to 12 months; flexibility will be essential.<br>• There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this.<br>• Access to a community residential service requires the young person to be actively participating in a program with CYMHS.<br><br>**Tier 3:**<br>**Level 6 Statewide Inpatient Extended Treatment and Rehabilitation Unit (24h/7d)**<br>• Up to 12 months; flexibility will be essential.<br>• There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this.<br>• Young people may be discharged from this Unit to a Day Program in their local community. |
| **Staffing Profile** | **Tier 2a:**<br>**Level 5 Day Program Services (Mon – Fri business hours)** |

## Barrett Adolescent Strategy

*Expert Clinical Reference Group*

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| | • Multidisciplinary, clinical.<br>• Plus staffing from community sector.<br>• DETE.<br><br>**Tier 2b:**<br>**Community Residential Service (24h/7d)**<br>• Multidisciplinary, clinical.<br>• Plus staffing from community sector.<br><br>**Tier 3:**<br>**Level 6 Statewide In-patient Extended Treatment and Rehabilitation Unit (24h/7d)**<br>• Multidisciplinary, clinical.<br>• DETE. |
| **Additional notes** | |
| **Referral Sources and Pathways** | While service provision across all Tiers of this AETRS continuum is based on interdisciplinary collaboration and cross-agency contribution, a referral to Tiers 2a, 2b and/or 3 will require a CYMHS assessment (i.e., single point of entry).<br><br>Increased accessibility to AETRS for consumers and their families across the State is a key priority.<br><br>The Tier 3 statewide service will establish a Statewide Clinical Referral Panel. All referrals will be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and the community sector. |
| **Complexities of Presentation** | • Voluntary and involuntary mental health consumers.<br>• The highest level of risk and complexity. |

This document was endorsed by the Expert Clinical Reference Group of the Barrett Adolescent strategy on _____ (date).

Please read in conjunction with the Preamble.

_____

Dr Leanne Geppert

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**Barrett Adolescent Strategy**

*Expert Clinical Reference Group*

Chair, Expert Clinical Reference Group

EXHIBIT 119

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## Barrett Adolescent Strategy

*Expert Clinical Reference Group*

### Service Elements

| Draft Service Model Elements | |
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| **Attribute** | **Details** |
| Service Delivered | The aim of the service is to provide medium term (up to 6 months) recovery oriented treatment and rehabilitation in a safe, structured and secure environment for adolescents with persistent and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes them from receiving support safely in a less restrictive environment. |
| Key Distinguishing Features | Education component<br>▪ ECRG members agreed that any model that is recommended will **retain** the **education** /vocation development **component**<br>Other<br>▪ Sub Acute Service – Bed based Intensive Care Services as opposed step up/step down or rehabilitation services.<br>▪ Service options include HHS based intensive youth oriented treatment and rehabilitation as well as access to local residential options and a state wide residential service.<br>▪ Services are delivered as collaborations between specialist clinical and community support sector services with residential consumers receiving 24 hour support.<br>▪ Specialist behavioural and symptom management programs<br>▪ Individualised and group rehabilitation programs<br>▪ Ability to continue current education/vocational option is critical.<br>▪ Programs aimed at maximising individual functioning and recovery oriented pre-discharge and community placement planning to support safe transition to more independent living.<br>▪ Encouraged engagement/reengagement of positive and supportive social, family, educational and vocational connections.<br>▪ Services are delivered in a youth friendly environment<br>▪ Level 6 Service as defined by the Clinical Services Capability Framework |
| **Service specifications & other useful description to illustrate service elements** | |
| Target Age: | **13-17 with flexibility in upper age limit**<br>▪ Agreement in principle that the presenting issue rather than the age range flexibility should be the determinant at the higher age range. Further, that the developmental age of the young person rather than chronological age should be considered. |
| Diagnostic Profile | ▪ Severe and persistent<br>▪ Treatment resistance - have not been able to remediate with multidisciplinary community or acute inpatient treatment.<br>▪ Mental illness is persistent ~~from a young age~~ and in adolescence the consumer is becoming a risk to themselves and/or others.<br>▪ Adolescent's needs for care are complex.<br>▪ High level of acuity |
| Avg Incidence | Multiple presentations at community and inpatient units. Difficult to specify a number, but would be where community units determine no |

**Commented [S1]:** I am concerned that we shouldn't make this too much about school, as many kids are beyond schooling by the time they get to BAC (too sick, too disenfranchised) but rather make it about some sort of vocational development.

**Commented [S2]:** I like the comment by another person about engaging family as far as possible, so programme should include capacity to work in a milieu with family members.

**Commented [S3]:** Not sure why we would have to stipulate from a young age??

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## Barrett Adolescent Strategy

*Expert Clinical Reference Group*

| **Draft Service Model Elements** | |
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| **Attribute** | **Details** |
| | further progress can be made from their input. |
| Average unit size and bed rate/100,000 pop. | State wide Residential; 8 bed facility<br>Intensive Treatment and Rehabilitation: ?/100,000 pop. |
| Hours | Residential :24 hours / 7 days<br>Intensive Treatment and Rehabilitation – program offered Monday - Sunday |
| **Suggested modelling attributes** | |
| % Occupancy | 90% |
| Avg length of stay | Up to 6 months as opposed to avg length of stay for step up/step down services and for rehabilitation services. |
| 28 day readmission rate | Not applicable |
| Indicative staffing FTE/Bed | Residential: 1.1 per bed<br>Intensive Treatment and Rehabilitation: ? FTE/ Hospital and Health Service |
| **Reference** | |
| Referral Sources & Pathways | Referral package/parcel- statewide representation |
| Complexities of Presentation | All other appropriate and less restrictive service interventions tested f st. |
| Defining need<br>▪ % of population requiring this service | |

Notes:

I. Step up/Step down and rehabilitation services are provided at a local service level.

II. Step up/Step down service definition:
- Community based residential service
- For consumers who have recently experienced or at risk of experiencing an acute episode of mental illness.
- Symptom reduction an/or distress cannot be provided in the person's home **but**
- Does not require treatment intensity provided by an acute inpatient facility
- **Stepping up** – from the community after becoming unwell, receive treatment to prevent further deterioration and relapse and avoid hospital admission.
- **Stepping down** – from a period of treatment in an acute inpatient facility.
- **Avg length of stay** – up to 28 days

III. Rehabilitation service definition
- Community based residential service
- Primarily focuses on interventions to improve functioning and reduce impairment.
- Addresses the disability dimension of mental illness and promotes personal recovery
- Consumer clinical symptoms are usually relatively stable allowing engagement in rehabilitation activities.
- **Avg length of stay** – up to 6 months

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**Barrett Adolescent Strategy**

*Expert Clinical Reference Group*

**Expert Clinical Reference Group: Feedback Register**

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| | | In regards to the length of stay, I'm wondering if we are talking about a period of 'active treatment' continuing for up to 12 months, but this may not necessarily be an inpatient stay for that period, and may be a combination of inpatient and step down facilities. We could also state something like " if indicated by clinical need, there may be Young people that stay in the inpatient unit for that period, while acknowledging that the average would be around 6 months."<br>I note Kevin's comments about the scope of the Project indicating the need for a replacement for BAC, but think the plan also notes a second phase that acknowledges the roll out of a model that is broader than this scope. I do however note the concern that the current model proposed may not meet the needs of the current inpatients, particularly in the initial stages of implementation. I am not sure that these concerns and clinical risks are clearly articulated and perhaps we need to more strongly highlight our concern? I also like the idea of suggesting funds be quarantined for Tier 3 (as suggested by Josie)<br>In regards to the presentation, I think it is text heavy and I would like to see the slides really highlight only main points while the full document provides the full text. I also think it would be great if some of this information could be presented as a diagram/picture perhaps, and there are some terms like TOHI, DETE that I think we should spell out in full. I'm also not sure how much time you have to present this, but if I was in the audience I would want less slides overall with more high impact points. For more information people could always refer to the handout. I know this may seem like trivial feedback but I there is a lot of information in those slides and people will only take in a proportion.<br>I'm wondering if it would be useful to have a where to from here slide at the end, where we can suggest what we would like to see happen from here in terms of process (but maybe that is already determined?). And perhaps one slide that has only three things that we would want them to remember, if nothing else, since there is so much information. (What are the absolute key messages, no more than 3). | |
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| Expert Clinical Reference Group Feedback Register | | | |
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| | | I am also concerned that if there are any apologies (I know James is one), those not there will not have the opportunity to provide input into the final report. | |
| 23.04.13 | Amelia Callaghan | Having reviewed the emails and the docs I think one of the difficulties is that we are presenting a conceptual model (and in a brief 7 pages!) of an initiative that is complex by nature. The email discussions that are now occurring around things like length of stay, and location of services, funding allocations etc are the beginnings of the next phase of implementation and business planning however due to time constraints these discussions have not occurred in a full and comprehensive manner. My impression is that as a conceptual model there seems to have been agreement generally, & the 'debate' is now about the next level of detail.<br>I note that the Project Plan provided in Kevin's email outlines the development of an Implementation Plan as a task the ECRG, but I don't think we have done this. I think there is another level of Implementation and Business Planning that is still required that will determine the feasibility of what has been suggested and also any financial implications for details such as where new services can be set up, how many beds there can be, staffing profile, length of stay etc. The important question I have is around who will be doing this next stage of work and being involved/consulted in the process?<br>I don't think the service elements documents lends itself to adding implementation recommendations, but this could be done in some slides? For example an implementation slide could talk about the strengths and concerns of an NGO Accommodation component which seems to be an area of concern for the ECRG or maybe it is simply a point on an implementation slide that says something like' the strengths and risk management concerns of an NGO accommodation component should be fully explored and a risk mitigation plan developed prior to proceeding in development and implementation.' I'm wondering if there is also one slide about Evidence base, even if to note the lack of evidence in some of the areas so that it reflects that we did look at models internationally and interstate etc.<br>I agree with the changes made by Michelle and James to the Preamble. | |

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| Expert Clinical Reference Group: Feedback Register | | | |
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| | | ▪ Education is a key component of the BAC service and would need to be a key component of anything that replaces it.<br>▪ Our recent experience in Townsville has been that it has been far from straightforward to obtain DETE support for a teacher position in our inpatient unit / day program.<br>▪ Any redeployment of BAC resources should ideally come with an agreement from DETE to also redeploy the BAC education resources. | *with an agreement from DETE to also redeploy the BAC education resources.* – Needs further discussion and solution |
| 23.04.13 | David Hartman | ▪ I can see that a rough time-line for admissions is required from a planning point of view, but at the same time it should be recognised that in this group of high risk, high complexity clients, we should be open to having some long term day program attendees. We might get out of this dilemma by talking of average durations of treatment, recognising that there will be wide variation | Amended to average length of stay to *average duration of treatment*<br>Amended to *Up to 6 months; recognising that there will be wide variation in treatment* |
| 24.04.13 | Trevor Sadler | I do wonder if the final document was in the format of points that were unanimously accepted, those that were not, and other issues that the group feels is necessary to include.<br><br>With the points not unanimously accepted, I wonder if the names of those who don't agree were recorded (as you suggested) as well as their objections to the point. This is the way many reports are presented were there are dissenting points of view.<br><br>I believe that this summarises the discussion better. While all the current differences of opinion to date may be in email form, the emails do not represent final points of view, or a full discussion on the matter. They would also be confusing to the planning group as a collection of points of view separate from the document.<br><br>The Planning Group has presented a problem by holding the meeting two days after the ECRG meeting, and the intervening day being a public holiday. Normally before a final report is released, all members would see it and affirm that the statements accurately represented their positions. | |

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| | | satisfactory time for a young person to participate and benefit from a therapeutic process and to engage back in education.<br><br>I'd also like to advocate for the importance of having the education facility available at BAC. For some this school can sometimes be the first engagement back in education in a long time.<br><br>I can only relate this to my personal experience, and I'm sure that this isn't new information to you all.<br><br>When I sat down to look at all of the information, I thought back to how scary the time in my life was and how overwhelming and confusing it was in general, let alone adding mental health issues to it as well. What I believe was a significant contribution to improving my mental health was having a safe and secure place where I could explore and feel comfortable enough to talk about my issues away from my family and friends. Even as an adult I've never come across such a place where I could explore my past and my issues in a safe environment with a therapist that lasted for longer than six months. | |
| 23.04.13 | James Scott | Leanne, I would really like the people who make the decisions to hear this feedback from parents and consumers. In other areas of health care, patients aren't excluded from services because their illnesses don't respond to arbitrary time frames. Can you imagine the outcry if we did this to adolescents with leukaemia who don't go into remission quickly enough.<br><br>I am an apology for tomorrow (I am overseas) but the contributions by Kelly and Cheryl-Ann deserves some serious consideration | |
| 23.04.13 | David Hartman | I would like to particularly support Amanda's point about education. | *Any redeployment of BAC resources should ideally come* |

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| Expert Clinical Reference Group: Feedback Register | | | |
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| | | funds and service provision if Tier 3 is not available for some time and Barrett does close.<br>▪ Utilising existing CYMHS resources which already are stretched and where there are not adequate alternatives for the young people that are currently accessing Barrett both from a mental health and educational perspective is a concern. | |
| 23.04.13 | | I'd also like to echo some of the thoughts and others have raised in regards to the time limit of six months.<br><br>In my experience when I was involved in the mental health services, having a time frame in the short stay mental health facilities didn't lead to an overall positive experience. As a young person I was aware of the estimated time I would be leaving and didn't feel that there was an overall commitment to bettering my health and wellbeing in such a short time frame. I personally didn't feel that the large amount of years that I had suffered abuse and therefore led to my depression etc was going to be challenged or provide me with coping strategies to last my adult years in a 1-3 month stay at a short term facility.<br><br>My point here is that if I was only given a six month stay then the hostility that a young person generally feels when they enter a long term facility such as BAC has only just worn off by about month 4 and this is when I and I'm sure others, began to feel safe enough to consider participating in therapy, education etc.<br><br>The stability of staff was also a very important factor – it offered stability and routine, as well as the opportunity, where I felt I could learn about relationship building. I can't speak for all young people, but for those who like myself came from abusive backgrounds – which unfortunately is a high percentage, it took a significant amount of time for relationships to be formed and once they were, for them to be maintained.<br><br>I would advocate for a longer stay of about 12 months for a young person. I believe that 12 months is a | ▪ Time limitations – Note that it is **average** length of stay<br>▪ Amended to *'up to 6 months but flexibility is important'* |

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| | | Are there adverse effects to not getting in? I have heard anecdotally of a number with whom we missed a window of opportunity, and the outcome was poor. There is little evidence of improvement (again anecdotally) without intensive intervention.<br><br>I suspect the need could be closer to 40 referrals per year. There is no rationale for suggesting an inpatient unit of 10 beds. I wouldn't recommend going above 12 - 15 beds, but I would recommend to meet the demand, that there would also be a non-inpatient accommodation component and a step-down facility. Bed block is inevitable without these. | |
| 23.04.13 | Amanda Tilse | It isn't easy to consider changes and make recommendations of change to a service that has been part of our clinical lives for some time.<br><br>▪ I am happy to support the documents. I support the changes that Michelle and James have made to the preamble.<br>▪ I am pleased that we have included the tiered approach and that consideration to enhancing services in regional areas has been included in the document. This gives families a greater opportunity to remain involved in treatment, perhaps also assists in reintegrating the young person with their local community.<br>▪ However, I think there needs to be more emphasis in relation to the education component in Tier 3. For fear that we may lose this valuable resource.<br>▪ Is it possible to suggest that young people who are attending Tier 2a in some districts may also access the educational component in Tier 3 as a step up or step down alternative depending on geographical location?<br><br>Management of waitlists I think remain a challenge going forward no matter what the bed a capacity is.<br><br>▪ I also feel we do need some further discussion and recommendations in relation to allocation of | Education component to be discussed further |

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| | | From the CYMHS Collaborative, we know that the average CYMHS clinician's workload is about 5% who are longer term i.e. longer than 6 months - about 450 per year. We could measure those who stay with the one service (but may need admission to a paediatric unit under that service), but not so well those who may have been admitted to an acute adolescent inpatient unit where the service is closed and re-opened on discharge. The best estimate was that this could be another 100 young people, although most of these would not have had multiple admissions. Private child and adolescent psychiatrists have a significant proportion (but ultimately unknown) of longer term young people. Altogether we might be looking at 500 - 800 adolescents needing longer term treatment. Of these, about 5% will be referred to BAC - again more likely to be a conservative estimate of need.<br><br>There are some longitudinal studies of adolescent disorders and behaviours. A recent Australian study published in the Lancet found that 1 - 2% of young people in adolescence who self harmed continued to self harm into their early 20's. That is, about 0.1% of the population. Some of these would be referred to Barrett. Some studies indicate that after 3 years, 10% of young people with anorexia continue to struggle with the disorder. There is little estimation of the rates of those with severe incapacitating (as opposed to moderate or mild) anxiety disorders in adolescence. There is similarly scant data on adolescents with severe and persistent psychosis who need longer treatment and rehabilitation. However, from studies we do have, the figure of 30 per year is likely to be a conservative estimate.<br><br>I agree with David that the actual BAC referral rates are probably an under-estimation of need. There are several factors - the length of the waiting list is sometimes a deterrent, high clinician turnover and junior clinicians are often less likely those at the severe end of the spectrum, the threshold for admission is higher in regional areas. A waiting list is useful - it sorts out those who benefit from another 3 - 6 months of community treatment, and those who are truly persistent. We are currently managing 20 adolescents as inpatients or day patients, and have another 16 on the waiting list. | |

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| | | I would like to make comment on the following two areas.<br>▪ Firstly, with regard to time limitations - many adolescents have only started to settle into a facility such as BAC in the first six months. Only after that time and when the inpatient's condition is stabilised sufficiently can educational and social initiatives be introduced. These sometimes work on two steps forward and one step back approach as well. Any mandated time limit on admission risks failure for many patients.<br>▪ Secondly, with regard to staff - commitment is the stand-out feature of the permanent staff at BAC. Patients develop positive relationships with staff and anecdotally they will not interact with casuals to the same extent as permanent staff with whom they have a close rapport. Any private service delivery organisation is under no requirement for consistency of staff. They will supply whom they presently have to hand. Their backgrounds may not necessarily be attuned to adolescents and their needs. | |
| 22.04.13 | Trevor Sadler | I specifically want to comment on David's comments about estimating need.<br><br>As David says, there is no way to really estimate need. However, we can use some reasonable figures, I think.<br><br>From the epidemiological perspective, there are about 300,000 adolescents in Queensland in the 13 - 17.11 year age group. Adult mental health epidemiology indicates that 1% of the population have a severe mental illness, meaning either schizophrenia or a severe disorder that is persistent and causes significant impairment. If that was applied to adolescents, that would be about 3000 adolescents in the state.<br><br>Current rates of referrals are now running at about 30 per year or about 1% of those who could be at the severe end, or about 0.01% of the adolescent population. This certainly does not seem to be an excessive number. It would be at the low end of estimates. | |

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| | | there be extra $s until the Tier 3 can be achieved? Should we make a point for quarantining this money to contribute to a Tier 3 facility?<br>▪ I agree with the corrections made by Michelle to the preamble, particularly the 3rd last paragraph which was confusing.<br>▪ Agree with David re making a statement about the under-estimate using BAC wait-list as there are so many who don't get put on the wait list (once you hear how long it is) but would be ideal candidates for BAC treatment.<br>▪ As Kev points out the objective was to replace existing BAC services, but in the Outcomes section of the document from Chris Thorburn, it appears to go broader, saying the endorsed model was to articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland and that the final endorsed model(s) of care will replace the existing services provided by BAC.<br>▪ We could make it clear that only Tiers 2b and 3 are the alternatives for current BAC funding?<br>▪ Kev also mentions the threat to the teaching allocation of 10 bed proposal for Tier 3. I'm thinking this would be co-located with either an acute care unit or the day programme so would still qualify for a f/t teacher? However the document does not address staffing numbers so this point can't be covered here.<br>▪ Re Trevor's point about proximity to local community. Perhaps what we need to acknowledge that with the constraints of geographical distances ease of access is the next consideration. We have not made mention of a consideration for accommodating family to mitigate the family and community isolation for the adolescent. This would use up quite a bit of funds. | points.<br>▪ *We could make it clear that only Tiers 2b and 3 are the alternatives for current BAC funding?* – Needs discussion with the group |
| 22.04.13 | | I firstly would like to thank the members of the ECRG for the opportunity to participate in the Group's deliberations. Irrespective of outcome, the intensity of effort and commitment to a better future for mental health challenged adolescents in Queensland by all ECRG members is inspiring. | ▪ Time limitations – Note that it is **average** length of stay<br>▪ Amended to *'up to 6 months but flexibility is important'* |

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| | | (mainly women) suffering from complex trauma. We treat young people who have been most severely impacted by their complex trauma. Our anecdotal evidence is that half will require only outpatient services, most of the other half will not need to access adult outpatient mental health services for their trauma, and only a couple have required recurrent admissions for some years.<br><br>There is a considerable literature on the persistence of severe anxiety disorders into adult life and the subsequent impacts on long term impairment. I was hoping that we might be able to treat the anxiety disorder better with some young people - now I am resigned to helping them cope as well as possible in spite of their anxiety.<br><br>Unfortunately the research on early psychosis features more on early intervention and less so on the range of interventions with those with a persisting disorder.<br><br>I don't expect all of this to be added in. Just making the case that a reference to persistence into adulthood should emphasise persistence and impairment in those whom we have been discussing. | |
| 22.04.13 | Josie Sorban | I think I got as much out of the comments by other members as the document itself.<br>Extra thoughts I had was that<br>▪ Defining the length of stay in Tiers 2 a&b makes the foci about school curriculum instead of the clinical and therapeutic milieu; also potentially disadvantage those commencing part-way through school term. Should be stated simply as months/weeks.<br>▪ Note also the limitations of referral sources for Tier 2a - only CYMHS is listed, yet power-point and principles talk about collaboration with external services.<br>▪ I remain concerned about the quality and capacity of the non-govt accommodation where minders are minimally trained - a far cry from the health-trained service in acute settings and BAC.<br>▪ The 4-bed week-end component of Tier 2b is far short of what currently available so wouldn't | ▪ Length of stay in Tiers 2a & b amended to 'up to 6 months'<br>▪ CYMHS is identified as the single point of entry to the Day Programmes. Multiple points of entry is not advocated.<br>▪ Collaboration and partnership with external services is an essential component in the continuum of care.<br>▪ 3rd paragraph – amended to Michelle Fryer's suggested version.<br>▪ Power point Slide 39 amended to reflect David's |

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| | | does not provide an alternative model for BAC.<br>2. It does not incorporate decisions made at ECRG meetings. This has been outlined in the attached document<br>3. There are many statements which are not evidenced based. This is a clear mandate of the ECRG<br>4. While acknowledging the long term need for an inpatient unit, it really glosses over interim arrangements for adolescents who either are in inpatient care or will require it in the future.<br>5. It does not outline risks if certain levels only are adopted, or the risks associated with various interim arrangements.<br>6. It appears that funding from the current + Redlands service will be re-allocated to future Level 2 a/b services. Although the evidence suggests that a replacement model for BAC requires an inpatient unit (which may be operated by a private provider under Government policy), there are no mechanisms to preserve this funding. Again, this reflects the strengths of this document as a Directorate planning document, rather than as an alternative to BAC document. | |
| 22.04.13 | Trevor Sadler | I endorse James' comments. I would make them even stronger.<br><br>Not only does mental illness in adolescence carry the greatest burden of illness into adult life, but there is considerable evidence that those with severe, persisting illness are those most likely to carry a great burden of illness into adult life.<br><br>There are several studies to show that young people with an eating disorder of three years or more have a considerably increased risk of developing a severe and enduring eating disorder (SEED). By 5 years, this probability increases to 90%.<br><br>The Australian Institute of Health and Welfare in one of its publications stated that childhood sexual abuse is the leading contributor to burden of illness in women in their third and fourth decades. Certainly adult services in Queensland have multiple presentations for admission from adults | Amended to the following:<br>*Mental health disorders are the most prevalent illnesses affecting adolescents today and in particular, there is considerable evidence that adolescents with persisting and severe and symptomatology are those most likely to carry the greatest burden of illness into adult life. Funding for adolescent (and child) mental health services is neither historically nor currently proportional to the identified need and burden of disease that exists.* |

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| | | ▪ The Tier 3 service (P.4/5) does not articulate the Non Government accommodation services discussed.<br><br>▪ The staffing profile for Tier 3 does not reflect the Non Government accommodation services discussed.<br>▪ As I indicated to the group a critical number of around 15 is important to maintain a DETE school with the service. This program would support those living in the more secure Unit and those accommodated in the Non Government accommodation service. If the Unit only has up to 10 adolescents you will have one teacher come from the local high school to support the complex educational needs of the group. | *Government accommodation services discussed.* – for further discussion |
| 22.04.13 | Trevor Sadler | I do have major concerns about the documents sent through, and the proposed draft. The question continually in my mind is "**If we were to close on 30 June, would the proposed model provide an acceptable alternative for the adolescents we have?" The answer is no.**<br><br>I have outlined my concerns in the attached document. I will briefly highlight/outline the issues here.<br><br>1. Of the 54 adolescents admitted since 2008, none could have been avoided by a Level 2a or 2b in Toowoomba or the Sunshine Coast, one would have been avoided by a Level 2a facility at the Gold Coast, 6 from a Level 2b admission to Townsville and 3 from a Level 2b facility on the north side. On the other hand 8 would miss out from the current Level 2a facility at BAC because they live at Ipswich. In other words, 80% of adolescents admitted in this period required the CSCF Level 6 inpatient facility. Opening Level 2a programs in the Gold and Sunshine Coasts is an important step which will meet a currently unmet need in those areas. The evidence is that it will not divert admissions away from the need for an inpatient unit. The document is a good future planning document from the Directorate perspective. It | |

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| | | ▪ Might be better to just leave this out, or perhaps to indicate that the need is <u>at least</u> equivalent to BAC current level of activity, and note BAC waiting lists and that BAC is not equitably accessed by regional QLD.<br>▪ I would be interested in Trevor's thoughts on how many places / beds would be required for BAC to offer a service <u>without</u> waiting lists. This would give some indication of need, but would still be an under-estimate because the presence of the waiting list is a deterrent to making referrals. | |
| 19.04.13 | Michelle Fryer | Overall, happy to support documents<br>▪ Some of the preamble language is confusing.<br>▪ Agree with James Scott and David Hartman's comments<br>▪ Power ppt – Slide 13; talks about acute and subacute in-patient units.<br>▪ Not sure what the 'subacute' refers to?<br>▪ Should it just say acute units? | Noted reference to subacute - to be clarified at ECRG meeting?<br>Suggested changes to preamble wording incorporated.<br>*Funding for adolescent (and child) mental health services is neither historically nor currently proportional to the identified need and burden of disease that exists.* |
| 19.04.13 | Kevin Rodgers | ▪ The preamble (which will include James' amendment) was clear and provides a good introduction.<br>▪ The service elements to me are unclear and I am concerned that if that is the case for me it may be even less clear for others who have not been involved in the process.<br>▪ I have a real concern that the ECRG has completed a task they were not asked to do.<br>▪ If you read the project plan written by Chris Thorburn (attached) it seems clear to me that the ECRG was tasked to provide a service model only for those adolescents presently served by BAC.<br>▪ By producing a tiered model of service delivery the task seems to have been extended to other adolescents in the state with mental health issues.<br>▪ The use of the common Queensland Health language of levels of service would be better than tiers. This was certainly discussed but perhaps had no resolution. | Amendment to Service elements document<br>▪ CSCF levels added to Tier 2a/2b as Level 5; Tier 3 as Level 6<br>▪ Number of beds in Tier 3 amended to 15<br>▪ *The Tier 3 service (P.4/5) does not articulate the Non Government accommodation services discussed.*- further discussion<br>▪ *The staffing profile for Tier 3 does not reflect the Non* |

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| 17.04.13 | James Scott | Comments Re preamble<br>▪ Mental illnesses do carry the greatest burden of illness into adult like, in fact only after back pain, depression causes the greatest loss of disability adjusted life years globally according to our GBD2010 study (published last year in the lancet).<br>▪ So I'd advise deleting "have the potential to" in the preamble.<br>▪ Secondly, health care funding to adolescent is minute in Australia.<br>▪ The historical lack of funding should be stated in the preamble to explain why we are in this current dilemma of asking for more | Preamble document amended to reflect suggested changes.<br>▪ 'have the potential to" deleted<br>Added the following:<br>*It should be noted that child and youth mental health services are historically under funded both at national and state levels. The constraints in resource and funding availability have therefore also been a key consideration in the final determination of the proposed service model elements.* |
| 17.04.13 | Philip Hazell | No comments | |
| 19.04.13 | David Hartman | Happy to support these documents but note the following:<br>▪ **Tier 2:** Townsville has a site for day program but doesn't at this time have a funded day program.<br>▪ **Length of stay:** I would suggest the same length of stay for tier 2 and tier 3, i.e. six months. One term may be sufficient for some clients but it is unduly optimistic to expect this to be an average.<br>▪ Agree with James's comments on the Preamble.<br>**Slide 39** defining need - the % of population requiring this service.<br>▪ This is a difficult one to answer because the number of clients going through BAC is not an accurate reflection of state-wide need for this kind of service, and it would be a significant piece of work to do thorough state-wide needs assessment.<br>▪ I am not aware of any literature that would give population numbers for adolescents with this level of mental health problems. | Amend service element document to reflect the following:<br>▪ Added day program + residential to Townsville<br>▪ Amended Tier 2a length of stay to 'up to 6 months'<br>▪ Amended slide 39 to include:<br>o At least equivalent to current BAC level of activity<br>o BAC is not equitably accessed by regional QLD |

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Pages 192 through 203 redacted for the following reasons:
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